



Human Rights Commission
Te Kāhui Tika Tangata

2017/18

Monitoring Places of Detention

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

1 July 2017 to 30 June 2018



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Foreword

March 2017 marked the 10th anniversary of New Zealand's adoption and ratification of the Optional Protocol to the Convention Against Torture (OPCAT). Despite this significant milestone, the agencies designated as New Zealand's National Preventive Mechanisms (NPMs) continue to encounter a range of persistent issues as they monitor detention facilities.

This report summarises the activities of the NPMs and the Human Rights Commission, which operates as the Central National Preventive Mechanism (CNPM). The report covers the period of 1 July 2017 – 30 June 2018. This was a particularly busy time for the NPMs, three of whom experienced changes to their designations which had the effect of extending the range of facilities they are responsible for monitoring under the OPCAT framework.

Co-operation

During the reporting period, staff members from within the individual NPMs met regularly to discuss operational matters and their collective work (operations meetings). These operations meetings take place more frequently than the standard chairs' meetings held between the Chief Ombudsman, the Children's Commissioner, the Chair of the Independent Police Conduct Authority, the Inspector of Service Penal Establishments and the Chief Human Rights Commissioner.

The NPMs collaborated on a joint submission for New Zealand's third universal periodic review by the United Nations Human Rights Council and prepared joint submissions on relevant domestic legislation.

Where there is overlap in monitoring designations (whether through legislation or by interest), the NPMs cooperate to carry out inspections together

where possible. In the current period, the Office of the Children's Commissioner and the Chief Ombudsman carried out joint inspections of the Mothers with Babies Units within the three women's prisons.

Finally, staff from the NPMs participated in a joint training day where they were able to discuss matters of mutual interest. The training focused on human rights treaties and frameworks, and how these could be utilised in OPCAT monitoring.

The NPMs look forward to further opportunities for cooperation and collaboration in the future.

Mental health

The mental health of people detained in places of custody remains a significant concern for all the NPMs. There is a particular concern about detention facilities being used to hold people awaiting assessment by mental health professionals due to a lack of suitable alternatives.

In the reporting period, the Chief Ombudsman continued to monitor places of compulsory detention under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and the Mental Health (Compulsory Assessment and Treatment) Act 1992. Concerns were identified regarding seclusion and restraint practices in both types of facilities and the Chief Ombudsman also highlighted the importance of ensuring patients receiving compulsory treatment are involved in decision making about their care.

Māori

Over-representation of Māori in all places of detention remains a concern for the NPMs. In care and protection residences, mokopuna Māori make up 71% of the population, and they make up 80%

of the youth justice residence population. Māori also continue to be over-represented in Police and prison custody numbers. All NPMs raised concerns about the way in which places of detention are taking into account the particular needs of Māori in places of detention.

This will continue to be a focal point for the NPMs in the coming years.

Children and Young People

Depriving young people of their liberty and the treatment of young people in places of custody continues to raise concerns with the NPMs.

While the Office of the Children's Commissioner and the Ombudsmen share the designation for care and protection facilities and youth justice residences it is agreed between the two NPMs that in practice the Children's Commissioner carries out the monitoring functions of both these institutions. While youth facilities generally met OPCAT requirements, they did not always reflect aspirations for promoting children's rights or enhancing their wellbeing.

The Ombudsmen are also responsible for health and disability places of detention, including child and adolescent inpatient units, and youth intellectual disability units.

Young people can still be held in Police custody under New Zealand law. While the total number of youth in Police custody for more than 24 hours fell during this period, in some cases these remands were for prolonged periods. It is agreed amongst the NPMs that Police cells are not an appropriate environment for young people.

A time of change

In this period, the Human Rights Commission farewelled former Chief Commissioner, David Rutherford, with Disability Rights Commissioner Paula Tesoriero taking over as acting Chief Human Rights Commissioner in May 2018 for the end of this reporting period.



Paula Tesoriero MNZM
Acting Chief Commissioner (May – January 2019)
Human Rights Commission



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



Judge Peter Boshier
Chief Ombudsman
Office of the Ombudsman



Judge Colin Doherty
Chairperson
Independent Police Conduct Authority



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

Human Rights Commission Te Kāhui Tika Tangata

The Human Rights Commission (the Commission) is the designated Central National Preventive Mechanism (CNPM) under the Optional Protocol to the Convention against Torture (OPCAT).

This role entails coordinating with NPMs to identify systemic issues within New Zealand detention centres. The Commission also liaises with government and the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) to strengthen protections against torture and ill-treatment.

The fundamental premise of OPCAT is to prevent violation of rights before the fact. The Commission's responsibilities, as agreed with the NPMs, include:

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

Activities during reporting period

The Commission organised and hosted two chairs' meetings with the head of each NPM agency. The Chief Ombudsman, Children's Commissioner, Chief Human Rights Commissioner, Chair of the

Independent Police Conduct Authority and the Inspector of Service Penal Establishments attended, along with relevant staff from their respective agencies. They shared monitoring developments from within their organisations and discussed issues faced by the NPMs. These included the scope of the OPCAT designations, NPM funding levels, contributions to the Mental Health Inquiry, young people in prisons, and reporting to the United Nations against New Zealand's compliance with international human rights obligations. The Commission also organised and hosted four operational meetings with staff members from within the individual NPMs (the operations group). The operations meetings aim to increase collaboration and share experiences as well as identify ways to work together more effectively and progress work requested by the NPM Chairs.

In February 2018, the Commission hosted a training day for NPM staff working in the OPCAT area. This aimed to provide new frameworks and perspectives that could be incorporated into monitoring activities. It also provided an opportunity for staff from the different NPMs to get to know one another and to discuss matters of mutual interest. The training focused on human rights treaties and how these could be utilised in OPCAT monitoring. Specific sessions covered the United Nations Declaration on the Rights of Indigenous Peoples, the Convention on the Rights of Persons with Disabilities and the experiences of Dame Lowell Goddard, DNZM, QC who was a member of the United Nations Subcommittee on the Prevention of Torture.

In October 2017, the Commission drafted a coordinated briefing to the incoming Minister of Justice, Andrew Little, on behalf of the NPMs. The briefing outlined the role and duties of the NPMs, and the NPMs' concerns around designations

and resourcing. The brief concluded with several recommendations for the Minister to consider; including updating NPM designations and considering funding increases for those NPMs that require it.

In July 2018, the NPMs drafted a joint submission for New Zealand's 3rd Universal Periodic Review before the United Nations Human Rights Council. The submission highlighted a number of areas of concern to all NPMs. These included access to mental health services, the over-representation of Māori in the prison system, seclusion and restraint practices in New Zealand, age-mixing in prisons, the detention of young people in police cells, and the overall increase in the prison population.

The Commission also utilised a number of opportunities to raise OPCAT related issues in its broader United Nations human rights treaty monitoring work. This included highlighting in its submission to the Committee on the Elimination of All forms of Racial Discrimination the need for a cohesive approach across the justice, law enforcement and penal systems to address the significant ethnic disparities in detention rates and criminal justice outcomes.¹

In October 2017, the Commission submitted to the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee), identifying the overincarceration of Māori women as a key issue of concern. Māori women make up approximately 60% of the female prison population.

The Commission has also maintained an ongoing relationship with the Department of Corrections to advance the rights of transgender prisoners. In March 2018, Corrections released the new Management of Transgender Prisoners policy. Guidance and training have been developed for frontline staff to educate them on the unique issues faced by transgender prisoners in Corrections custody. The policy had been in development for a number of years and draws heavily on input from the Commission.

Conclusion

During 2018/2019 the Commission looks forward to developing its role as the Central NPM and assisting the NPMs to effectively carry out their preventative monitoring responsibilities.

**Office of the
Children's
Commissioner
Manaakitia A
Tātou Tamariki**

Overview

Since 1989, the Office of the Children's Commissioner (OCC) has had a statutory responsibility to monitor how well the organisation now known as Oranga Tamariki-Ministry for Children (Oranga Tamariki) delivers services for children and young people. When New Zealand ratified the United Nations' Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2007, OCC gained an additional and specific mandate to monitor Oranga Tamariki secure residences. There are a total of nine secure Oranga Tamariki residences in New Zealand – five are care and protection residences and four are youth justice residences². The OCC also conducts joint monitoring visits with the Ombudsman's Office to the three Mothers with Babies Units (MBUs) within prisons, operated by the Department of Corrections.

Introduction

Between July 2017 and June 2018, the OCC conducted 12 OPCAT monitoring visits to Oranga Tamariki residences to assess their compliance with the six internationally recognised OPCAT domains:

- Treatment
- Protection system
- Material conditions
- Activities and contact with others
- Medical services and care
- Personnel

In addition to the standard OPCAT domains, the OCC routinely monitors facilities' responsiveness to mokopuna Māori (Māori children and young people). The government has responsibility under the Treaty of Waitangi to partner with, protect and ensure participation for Māori. Connection with culture has been shown to be vital to young people's sense of wellbeing, identity and belonging.

Improving systems, services and supports for mokopuna Māori and their whānau (extended family) is a key priority for the Children's Commissioner.

Māori make up about 15% of the New Zealand population, but 71% of the children and young people in care and protection residences and 80% in youth justice residences are Māori³, and sometimes much higher in individual residences. We advocate strongly for services and policies that reduce inequalities and improve outcomes for Māori.

Another priority for OCC is encouraging Oranga Tamariki in its transformation of the care and protection and youth justice systems. One of our focus areas is advocating for the phased closure, over time, of the national care and protection residences. Notwithstanding the higher number of young people expected to come into the youth justice system as of 1st July 2019 (see page 12 for more details), we would also like to see a reduction in the percentage of young people on remand in the national youth justice residences (currently at approximately 80%).

The OCC's monitoring visits in 2017–18 occurred in the year immediately following Child, Youth and Family's transformation, on 1st April 2017, into a new agency, Oranga Tamariki. Although many large Oranga Tamariki transformation initiatives and residence-related improvement projects were being planned by national office, these had not yet had time to be implemented in the residences.

Of the OPCAT visits conducted, six were pre-arranged and six were unannounced. The key strengths and areas for development for each of the domains are described below. For each OPCAT domain, we provide a summary statement, followed by a description of the key findings for that domain. Quotes from young people we interviewed are in italics.

OPCAT findings by domain

During this monitoring period, we found that all Oranga Tamariki residences generally met the standards required by the OPCAT domains. It is important to note that these standards are minimum requirements – they do not fully reflect our aspirations for promoting children's rights or enhancing their wellbeing.

Treatment

Young people are generally treated well in the residences. They are given a voice in matters that affect them, but often feel powerless to influence their environment or the bigger decisions in their life.

Young people reported feeling safe most of the time and having good relationships with at least some of the staff. Young people were usually given opportunities to have a say in decisions that affect them, and had a number of avenues to have their voices heard in residence. However many felt that their voice had little influence, particularly for bigger decisions in their life.

"I feel safe, and know how and who to tell."

"They (staff) all treat us pretty cool and lots of us form close bonds with them....they don't make it a negative time, they make it positive and funny."

Community meetings? "We raise our issues about what's going on and that. It's alright."

"They don't give me a say in my plan; they ask me where I want to go; I write it down on paper and give it to them; in the last meeting I had, I finally got what I actually wanted, but it took 6 years to get it."

A key area for development in this domain is the consistency of staff responses to young people. Many young people told us that the Behaviour Management System (BMS) is applied unfairly and/or differently by some staff. For staff to respond as consistently as possible to young people's challenging behaviour, it is vital they understand the impact of trauma on young people. We found that staff had different understandings about the impact of trauma and how to best respond to challenging behaviour.

"Sometimes there are staff who think they're tough and try to intimidate or try to have conversations with you when you don't like them."

"Different shifts emphasise different things; get marked down in the second shift when they try to implement something else."

Another key area for development is the planning and coordination of young people's transitions from the residence. Residence staff struggled to get enough support from field social workers to enable timely, well-coordinated transitions for young people. This must be a priority for Oranga Tamariki. Otherwise, the good work done in residences can be easily undone. A notable exception was one residence that was piloting the provision of intensive transition support using their own staff.

"Just a bit frustrating because I don't know how long I am going to be in here for."

"I don't know where my next home is going to be... you don't really get a say. You just get taken."

Protection system

Residences generally have adequate protection systems in place, but young people lack confidence in the complaints system.

Residences are generally good at supporting young people to understand the complaints system, Whaia te Maramatanga. Most young people we spoke to knew how to ask for a complaint form and how to submit the form.

"Everybody has to watch the [Whaia te Maramatanga] video. If you don't like something you will get a grievance paper. You put it in an envelope and then in the thing [mailbox]. You can make a suggestion too. The staff check it and then they talk to you."

However, the majority of the young people we interviewed told us they lack confidence that making a complaint results in meaningful changes for them. Many young people said that investigations take too long (two weeks). Requesting a complaint form from staff in front of other young people can be difficult, and the requirement to complete a written form can be onerous.

"Whaia te Maramatanga, it's alright. Because you have to go through these people first and a complaint, it has to go higher. Shouldn't have to go through people here"

because of course they will side with the people here. It should go to national office or somewhere where people will listen to us."

"I don't wanna go through that whole process, cause nothing really happens at the end of it anyway. Can't really be bothered with it. I just keep to myself."

"The grievance process takes too long to go through. I will just talk to someone if I need to."

Some residences struggled to attract and maintain a sufficient number of grievance advocates who are able visit young people regularly. Young people rarely requested the support of a grievance advocate to help them to make a complaint – many of the young people did not understand their role.

Material conditions

The physical environment of most residences is inadequate, but the food is varied and usually of sufficient nutritional value.

Most residences were not originally designed in a way that is youth-friendly or conducive to therapeutic care. With only a couple of exceptions during this monitoring period, residences felt institutional and some were run down. One residence failed compliance with this domain twice during this monitoring period. Many residences had issues with the acoustics and air temperature control in different areas.

"The walls need to be painted. There's too much tagging. It was there before I got there, scratched into the walls... Every window has scratching on it"

"Windows don't open to get fresh air. I don't get why we can't open them. We are covered in cages and can't get out so I don't get why we can't open a window or even on a metal latch."

"I would rather be at home. But here I get food 4-5 times a day and I don't have to pay for anything."

While not all young people liked all the food they were offered, there was usually a wide variety of nutritious food available. Young people typically had limited input into the type of food provided.

"The food is good. I think they have to make it healthy for us, like they run it by the national health guideline. We get fed real nicely, like big feeds."

"The food is alright – would prefer no fish. Don't really get a chance to give feedback on food."

Activities and contact with others

Residences offer a range of activities to young people, but these are not always tailored to young people's needs. Young people usually have contact with the people they care about, but the frequency of face-to-face visits is variable, particularly for those who are distant from home.

Young people had opportunities to participate in range of recreational, educational, sporting, vocational, and cultural activities. However, the number and type of activities varied from residence to residence, and there was a lack of individual tailoring of activities to the unique needs and wishes of young people. Many told us they would like to participate in more cultural and off-site activities. Young people on remand, who continue to make up the majority of those in youth justice residences, had limited access to programmes held off-site.

"The café is awesome, I do the food, I prepare it to go on the plates...."

"I speak Māori and play the guitar. There should be more cultural programmes like hangi [cooking food in an earth oven], music, diving, and hunting."

"I want to learn more about my culture."

"Doing well with learning here. Haven't been to school since I was 12. Had a fight with the teacher and got stood down. When I went to the school here they get you into the mood and then you want to learn."

Young people told us they have regular phone contact with their families and whānau, via daily

phone calls. Face-to-face visits varied in frequency across residences from about once a week to once every 12 weeks, or longer. Regular face-to-face contact was a particular challenge for young people whose families or whānau live outside of the local area and therefore have more financial and practical barriers to visiting the residence. Many young people said they would like to see their families, whānau or other loved ones more often.

“My family will book a visit and just come in. We get a phone call every night before bed, for 7 minutes and sometimes longer. It’s all good; you get to talk to your family”.

“Contact is shit, because you don’t have video calls.....mums only been here once since I’ve been here. They haven’t found a placement for me yet....”

“Last time I saw them [family members] was at Easter [5 months ago].”

Medical services and care

Young people generally have good access to primary and specialist health care.

Young people told us they know how to make an appointment to see a nurse from the on-site health team. Many young people told us that their time in the residence provided an opportunity to ‘catch up’ on medical and dental treatment. There were a few exceptions where access to specialist mental health services was more difficult.

“It’s easy to see the doctor and nurse if I want.”

“I feel healthy now [no drinking and smoking]. Every 2 weeks I see health and drug and alcohol counselling. Got ears checked and diseases and stuff.”

Personnel

Residences usually have sufficient staff to keep young people safe, but the level of professional supervision⁴ for staff is inadequate.

Residence staff were generally committed to making a difference for children and young people in residences. Staff worked well together to keep young people and themselves safe. However, we

heard many examples where the number of floor staff was insufficient to enable young people to participate in off-site activities or attend off-site health appointments.

“I feel that staff mostly do a good job of protecting”

“There is not much staff here. They need more. Heaps of staff do doubles and they’ll be grumpy and stuff and that makes us grumpy.”

During this monitoring period, the frequency of professional supervision for care staff was not always sufficient to enable them to meet the complex needs of the young people in their care. We heard examples of some staff feeling overwhelmed by the challenges of this work.

Responsiveness to mokopuna Māori

Residences are not providing sufficient opportunities for young people to connect with their culture.

Three residences were doing reasonably well enabling young people to learn about their whakapapa⁵ and engage in tikanga Māori⁶, for example teaching young people their pepeha⁷, or involving young people in pōwhiri⁸. These residences were also supporting young people to engage in a variety of cultural activities.

“They’re actually quite big on cultural stuff here. Lots of Māori and PI (Pacific Island) staff here which is pretty cool.”

“I want to learn more te reo (Māori language)....learn more about the culture itself....don’t get much of that unless we in [Maori focus unit].”

It is desirable for mokopuna Māori to be connected to their culture. However, this was not the experience for most young people in residences. Nor were most residences engaging sufficiently with whānau, hapū (kinship group or subtribe) and iwi (extended kinship group or tribe), or adequately supporting the development of the cultural capability of staff to improve outcomes for mokopuna Māori.

During this period of monitoring, the OCC made recommendations in most of our reports for Oranga Tamariki to improve their responsiveness to mokopuna Māori. Two residences failed their compliance with this

domain, due to a lack of planning and prioritisation of this area. The ongoing lack of cultural responsiveness is concerning.

“They don’t do nothing for my culture”

“I speak Maori and play the guitar. They should do more cultural programmes like hangi, music, diving and hunting”

Oranga Tamariki response to OCC recommendations

This period of monitoring occurred during a time of significant transformation for Oranga Tamariki. Although the national office of Oranga Tamariki had many significant initiatives underway to address most of the issues identified above, it was too early to see significant changes in the experiences of young people in residences.

Fortunately, since the monitoring period covered by this report, several youth justice residences have undergone significant refurbishments to improve their material conditions. We are also now seeing increasing levels of responsiveness to mokopuna Māori in some residences, for example clearer plans and actions to partner with local iwi.

This is partly in preparation for new legislation that will come into effect on 1 July 2019. Section 7AA of the Oranga Tamariki Act 1989 gives the Chief Executive of Oranga Tamariki new obligations to: reduce disparities for Māori; have regard to the cultural principles considered vitally important to Māori (whakapapa, whanaungatanga⁹, mana tamaiti¹⁰); and to form strategic partnerships with Māori to improve outcomes for mokopuna Māori.

Another positive development is the new non-government organisation, VOYCE- Whakarongo Mai, trialling the provision of advocacy services to young people in a few residences. We anticipate that the new organisation will enhance young people’s access to advocacy for grievances and other matters.

We are encouraged by the potential benefits for children and young people of several large Oranga Tamariki transformation initiatives, including:

- **A new care framework** – The new care framework has four priority areas to improve

outcomes for children and young people in care, one which recognises the need to move away from institutionalised residential care for young people with care and protection needs. The proposed new approach for residential care aims to create smaller, homely, community-based environments where young people can live short-term, in a situation that more closely resembles a home. Initial planning is underway to transition children and young people out of one large (secure) residential facility in Auckland into smaller, community-based group homes.

- **Care standards which come into effect by 1 July 2019** – these set out the standards of care for children and young people in care. We expect to see improvements in the care young people receive across all care settings, including care and protection residences, smaller community-based group homes, and one-to-one care placements.
- **Youth justice child-centred residences project** – this project is focused on developing a therapeutic model of care for youth justice residences and increasing the level of supervision and coaching available to care staff.
- **Remand homes project** – this project is expected to increase the availability of out-of-home group home placements for young people on remand so that remand placements within youth justice residences are significantly reduced.
- **Raising the youth justice age project** – from 1 July 2019 the age of young people eligible to go through the youth justice court and receive youth justice services will rise from 16 to 17 years old. As Oranga Tamariki becomes responsible for 17-year olds, more young people will receive the benefits of youth justice services which aim to address the underlying causes of the offending.
- **Te Kete Ararau** – this is a new cultural confidence tool and software application that has been developed and launched to increase Oranga Tamariki staff confidence, knowledge and capability to work effectively with mokopuna Māori and their whānau.
- **New practice standards** – Oranga Tamariki has implemented a new practice framework across all

Oranga Tamariki sites and residences, designed to improve staff practices. The framework provides high level practice guidance across eight practice standards. One practice standard, Whakamana te Tamaiti, is focused on improving practice to reduce disparities for mokopuna Māori. This supports the operationalisation of s.7AA of the Oranga Tamariki Act 1989, due to come into force by 1 July 2019. We expect this new practice standard to improve residences' responsiveness to mokopuna Māori over time.

- **Te Waharoa** – this programme is designed to improve staff capability across residences. It provides a professional development pathway for residence staff and is expected to strengthen the induction and ongoing training for staff within the next year.
- **Transitions** – From 1 July 2019, Oranga Tamariki will be implementing a new transition service to support young people leaving care and youth justice. For eligible young people transitioning from residence this will mean additional support to their 21st birthday, and the ability to request advice or assistance up to the age of 25 years. The transitions programme has a longer term aim of supporting young people as they transition to adulthood and sits alongside the shorter-term reintegration support young people receive as they transition from residence.

The OCC looks forward to seeing the fruits of these initiatives during our next year of monitoring.

Mothers with Babies Units (MBUs) in prisons

In this 2017–18 period, we also conducted a pre-arranged monitoring visit to one MBU, in partnership with the Ombudsman's Office. MBUs are self-care units within each of New Zealand's three women's prisons, managed by the Department of Corrections. Mothers who meet certain criteria may be given the opportunity to live with their babies in an MBU, up until their baby turns two years of age.

The MBU we monitored was generally compliant with the OPCAT domains. We found that babies and mothers at the MBU are well treated by staff; the flats they reside in are comfortable; they have good

access to medical care; and regular opportunities to visit with family and whānau.

However, there had been a deterioration in four out of seven domains between our latest visit and our previous visit to the same MBU in December 2014. This is consistent with one staff member's comment, "*the spotlight has gone off the MBU*".

Key areas for development included: an insufficient number of Corrections Officers working in the MBU; no tailored induction or training in place for MBU staff; and limited opportunities for babies and their mothers to be exposed to Māori practices that develop their cultural identity and sense of belonging.

One concerning finding was the inappropriate process being used to remove babies from their mothers in the event a mother becomes ineligible to stay in the MBU with her baby. Fortunately, when we expressed concern to the Department of Corrections about the potential negative implications for babies (and mothers) in the MBU, the response was positive and prompt.

Department of Corrections' response

The Department accepted all of our recommendations and has made significant progress since our monitoring visit to the MBU. A major initiative that the Department of Corrections has underway over 2018/19 is the development of a national operating model for MBUs as part of their Women's Strategy 2017-2021. The operating model will include input from women currently in the MBUs, academic researchers, community services, iwi and Corrections staff. We expect the new operating model to honour the Treaty of Waitangi and to improve the quality and consistency of practice across the three MBUs in New Zealand.

We are particularly pleased that Corrections has completed initial training in child development and attachment at two out of the three women's prisons, and work is underway to develop online training to support staff who are working in the MBUs. We hope to see Corrections staff receive regular, ongoing, and relevant professional development to better support mothers and babies who are in prison.

Evolving the way we monitor

We continue to evolve and improve the way we monitor Oranga Tamariki. Since late 2017, we have been using our new monitoring approach, called '*Mana Mokopuna*'. This approach is based on a Māori world view but is appropriate for all children and young people and focuses on the experiences of children and young people and their families and whānau. It is designed to ensure that we consider the cultural values and beliefs that are important to indigenous children and their families, whānau, hapū and iwi.

During our latest round of monitoring visits, we have sought to conduct in-depth, one-to-one interviews with all children and young people. We have used our Mana Mokopuna approach to inform the way we engage with young people and the questions we ask them. These interviews and the Mana Mokopuna approach have enabled us to more deeply consider young people's views and experiences when assessing the performance of Oranga Tamariki against the OPCAT domains. As a result, the voices of young people are more visible in our reports.

Another significant project we have underway is co-developing (with Oranga Tamariki) an evaluative rubric to increase the transparency and robustness of our OPCAT monitoring. The OPCAT rubric will define good practice for every element we assess under each OPCAT domain. The new rubric will consist of a four point rating scale – excellent, good, inadequate and harmful – where the highest two ratings represent compliance with the OPCAT standards and the lowest two ratings show non-compliance. We expect to begin piloting the new rubric by July 2019.

Office of the Ombudsman Tari o te Kaitiaki Mana Tangata

In this section we give an overview of our work under the *United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment* (OPCAT), and discuss issues arising in prisons, immigration detention facilities and health and disability places of detention.

Under the Crimes of Torture Act 1989 (COTA), the Ombudsmen are a designated *National Preventive Mechanism* (NPM) for the OPCAT in New Zealand, with responsibility for examining, monitoring and making recommendations to improve the conditions and treatment of detainees, and to prevent torture, and other cruel, inhuman or degrading treatment or punishment, in:

- 18 prisons;
- 77 health and disability places of detention;¹¹
- three immigration detention facilities;
- four child care and protection residences; and
- five youth justice residences.

The designation in respect of child care and protection and youth justice residences is jointly shared with the Children's Commissioner, although the Children's Commissioner takes responsibility for the monitoring functions.

This year our mandate was further extended to include residences established under section 114 of the Public Safety (Public Protection Orders) Act 2014, and privately run aged care and court facilities. This will entail examining the treatment of service users in approximately 227 privately run aged care (locked dementia) facilities, as well as detainees in approximately 60 court cells across the country. Work to scope these new designations is currently underway. We expect to significantly increase the number of inspections and visits as a result of these

new designations. However, this will be dependent on receiving increased funding from 2019/20 onwards. We are currently funded for eight Inspectors and other specialist advisors to assist us in carrying out our NPM function.

In 2017/18, we committed to carrying out 35 visits to places of detention. We exceeded this commitment and carried out a total of 39 visits, including 12 formal inspections. Thirty-four visits (87 percent) were unannounced.

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

The 12 formal inspections were at the sites set out in the table on page 16.

Name of facility	Type of facility	Recommendations made	Visit type
Te Awhina Whanganui District Health Board	Acute Mental Health Inpatient Unit	4	Unannounced
Stanford House Whanganui District Health Board	Extended Secure Regional Rehabilitation Forensic Service	5	Unannounced
Te Whare o Matairangi Three District Health Boards – Mental Health, Addictions and Intellectual Disabilities Service ¹²	Acute Mental Health Inpatient Unit	9	Unannounced
Te Whare Awhiora Hauora Tairāwhiti District Health Board	Acute Mental Health Inpatient Unit	5	Unannounced
Ngā Rau Rāku Hawkes Bay District Health Board	Acute Mental Health Inpatient Unit	16	Unannounced
Arohata Upper Prison	Women's Prison	25	Unannounced
Christchurch Women's Prison (follow-up visit)	Women's Prison	6	Announced
Te Awakura Canterbury District Health Board	Acute Mental Health Inpatient Unit	11	Unannounced
Haumietiketike Three District Health Boards – Mental Health, Addictions and Intellectual Disabilities Service	Adult Forensic Intellectual Disability Unit	15	Unannounced
Rangatahi Three District Health Boards – Mental Health, Addictions and Intellectual Disabilities Service	Regional Adolescent Inpatient Unit	10	Unannounced
Whanganui Prison	Men's Prison	37	Unannounced
Te Puna Waiora (follow-up visit) Taranaki District Health Board	Acute Mental Health Inpatient Unit	6	Unannounced

We reported back to all 12 places of detention within eight weeks of concluding the inspection. This brings the total number of visits conducted over the 11-year period of our operation as an NPM to 477, including 183 formal inspections.

This year, we made 149 recommendations, of which 137 (92 percent) were accepted or partially accepted as set out in the table below.

Recommendations	Accepted/partially accepted	Not accepted
Prisons	63	5
Health and disability places of detention	74	7

Twenty-seven informal visits were conducted at the sites set out in the table below.

Name of facility	Type of facility	Number of visits
Tawhirimatea (announced) 3 District Health Boards – Mental Health, Addictions and Intellectual Disabilities Service	Regional Rehabilitation and Extended Care Inpatient Service	2
Nā Rau Rāku (announced) Hawkes Bay District Health Board	Acute Mental Health Inpatient Unit	1
Arohata Women's Prison (unannounced)	Women's Prison	3
Te Whare Manaaki (unannounced) Canterbury District Health Board	Forensic Unit	1
Kennedy Detox Unit (unannounced) Canterbury District Health Board	Drug & Alcohol Unit	1
Assessment, Treatment & Rehabilitation Unit (unannounced) Canterbury District Health Board	Forensic Intellectual Disability Unit	1
Seager Clinic (unannounced) Canterbury District Health Board	Forensic Rehabilitation Unit	1
Child Adolescent & Family Service (unannounced) Canterbury District Health Board	Children and Adolescence Inpatient Unit	1

Psychiatric Services for Adults with Intellectual Disability (unannounced) Canterbury District Health Board	Intellectual Disability Unit	1
Christchurch Men's Prison (unannounced)	Men's Prison	1
Rolleston Prison (unannounced)	Men's Prison	1
Manawanui & Whakaruru Cottages (unannounced) Three District Health Boards – Mental Health, Addictions and Intellectual Disabilities Service	Forensic Intellectual Disability (stepdown cottages)	1
Hikitia Te Wairua (unannounced) Three District Health Boards – Mental Health, Addictions and Intellectual Disabilities Service	Forensic Intellectual Disability Youth Unit	1
Te Aruhe (unannounced)	Secure community home for clients with an intellectual disability	1
Nga Taiohi (unannounced) Three District Health Boards – Mental Health, Addictions and Intellectual Disabilities Service	Forensic Inpatient Youth Unit	1
Rangatahi (unannounced) Three District Health Boards – Mental Health, Addictions and Intellectual Disabilities Service	Regional Adolescent Inpatient Unit	2
IDEA Services	Secure community home for clients with intellectual disabilities	1
Auckland South Corrections Facility (unannounced)	Men's Prison	2
Auckland Region Women's Corrections Facility (unannounced)	Women's Prison	1
Haumietiketike (unannounced)	Forensic Intellectual Disability Inpatient Unit	1
New Plymouth Remand Centre (unannounced)	Gazetted Prison (Whanganui Prison)	1
Mt Eden Corrections Facility (announced)	Men's Prison	1

Prisons

This year, we further reviewed our trial prison inspection criteria¹³ and incorporated prisoner focus groups, staff forums and regular unit prison population checks into our inspection methodology. It is our intention to publish these criteria once they have been developed fully and undergone consultation.

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

- the increase in the prison population, particularly female prisoners;
- levels of violence, particularly prisoner-on-prisoner assaults; and
- the effectiveness of the prisoner complaint process.

Increase in prison population

The prison population has continued to increase rapidly, particularly for women and remand prisoners. The impact of the increased population has placed strain on accommodation, staffing levels and effective processes.

In February 2017, due to the significant increase in the women's prison population, the Department of Corrections reopened Rimutaka Upper Prison to accommodate 112 women.¹⁴ On inspection, it was clear the Upper Prison was facing considerable challenges. Resources, infrastructure and staffing were under pressure, which was compounded by the geographical separation from the administrative centre at Tawa.

Opportunities for maintaining family contact were inadequate. Many women did not receive visits due to distance and associated travel costs, and the earlier lock up prevented most women from telephoning their children after they had finished school. Limited visits combined with restricted access to telephones and an unsatisfactory mail system affected the women's mental wellbeing.

In November 2017, a follow-up inspection to Christchurch Women's Prison highlighted similar concerns with high-security prisoners on restrictive

regimes, and low-security prisoners living far from their family.

In 2018, the Department of Corrections announced an additional 44 beds would be added at Arohata Upper Prison, 120 at Arohata Prison, and 120 at Christchurch Women's Prison over the next 12 months.

Levels of violence

We remain concerned about the levels of violence in prisons, particularly prisoner-on-prisoner assaults, which evidence suggests are under-reported. Fifty-five percent of prisoners surveyed in the last twelve months across three prisons¹⁵ stated they have been assaulted and not reported the incident. Amongst the reasons that prisoners gave for not reporting assaults was that *'staff don't take reports seriously, complaints are ignored, and fear of reprisals'*.

The rise in the prison population, by approximately 20 percent since 2013, may continue to contribute to tensions that result in violence. However, the negative influence and impact of gangs in prisons is also a significant contributing factor.

Prisoner complaint system

We are concerned that the prisoner complaint system launched on 1 December 2016 has not been embedded effectively. In the last 12 months, we conducted three prisoner surveys which continued to indicate that prisoners still do not have faith and confidence in the system. Recently, the Department of Corrections has initiated an independent review of its complaints processes.

New prison initiatives, strategies and projects

The Department of Corrections has launched several new initiatives and projects during this reporting year. We will monitor the progress of the following initiatives over the coming year:

- The Intervention and Support Project – funding to design and trial a new prison-wide model of care for prisoners vulnerable to self-harm or suicide.
- Review of At-Risk Units and Separates cells – this piece of work is currently being led by the Chief Custodial Officer and aims to identify options for enhancing privacy for prisoners in the Intervention

and Support Units (formerly known as At-Risk Units) and Separates cells.

- The National Gang Management Strategy.¹⁶
- Wahine – E rere ana ki te pae hou¹⁷ 2017-2021 – a new approach to Corrections' management of women prisoners.
- Making Shifts Work – which is intended to redesign the current roster patterns for custodial staff and to adapt the operational effects of new schedules.

Intellectual disability

There are two types of facility which meet the definition of a place of detention for care recipients under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR) – Regional Intellectual Disability Secure Services (RIDSS) and Regional Intellectual Disability Supported Accommodation Services (RIDSAS). RIDSAS services for secure care recipients are delivered in residential homes in the community. There are a number of homes in a region that may be designated secure and meet the definition at any given time.

This year we conducted a comprehensive visit of Haumietiketike Unit (Capital & Coast DHB), a RIDSS, and identified that improvements were required in three key areas:

- the use of seclusion rooms as long-term bedrooms;
- better recording systems for seclusion and restraint events; and
- training for staff to enhance their knowledge and skills in working with clients who have high and complex needs.

Three persons had been in the Unit (and long-term hospital care) for a significant number of years. Their particular behaviour has made it difficult to achieve the necessary rehabilitative goals for transition into the community. Care in some instances was based on containment and management rather than rehabilitation and treatment. Most clients were unable to mix with others in the Unit, which added another layer of complexity for staff trying to provide care on a day-to-day basis.

Seclusion and restraint paperwork and corresponding data was incomplete. We therefore had no confidence in the way the Unit recorded restraint, including environmental restraint.

We will continue to engage with the Ministry of Health about our concerns in this area.

Mental health

We noted some recurring themes during the reporting period, alongside evidence of good practice.

We continue to observe pressure on acute inpatient mental health beds, as noted in last year's annual report. The issue of insufficient bed numbers and high occupancy continues to result in the inappropriate use of designated seclusion rooms for both long-term and temporary bedrooms for service users.¹⁸

Some units were not recording when clients were locked in their rooms or other areas as a 'use of force event' in accordance with the Ministry of Health Night Safety Procedures: Transitional Guideline.¹⁹ We were concerned that the recording of both seclusion and restraint in some units was not always occurring. For example, one unit was still using 'Night Safety Orders' (now known as Night Safety Procedures), which they monitored and kept records of to categorise seclusion and restraint action. As people being locked in their rooms overnight was not considered a reportable event by the Unit, the hours were not captured in the overall number of seclusion hours for the service. The Ministry of Health Night Safety Procedures: Transitional Guideline states:

Locking a patient in their room is a restrictive practice, and constitutes a use of force...

A number of facilities were locked during the day.²⁰ Many did not have notices detailing the process for entry and exit for informal service users and visitors.

We found a number of District Health Boards' internal complaints processes, including how to contact the District Inspectors, was either not displayed in the unit or not readily available in all areas of the unit.²¹ Lack of access to telephones, as well as privacy, when using them, was also an issue.²²

The majority of mental health units inspected over the year did not invite service users as a matter of routine to attend their multi-disciplinary team meeting (MDT) review, nor did they receive a copy of the meeting minutes.²³ We are concerned that a high number of facilities do not routinely give service users a copy of their treatment plan.

Good practice

Despite these recurring themes, we were pleased to see that Te Awhina Unit ran an integrated model of care where the community senior medical officer remained the treating clinician for the duration of the service user's stay. This provided consistency and ongoing engagement throughout the service user's recovery. This service also used a peer-led organisation to facilitate client debriefs after a period of seclusion.

Clients at Stanford House were given the opportunity to be fully involved in their care plans at every stage of their recovery. They were able to attend regular MDT meetings as well as being engaged in their care plan review process.

Te Whare Awhiora had a strong focus on cultural engagement, and offered effective support for service users through assessment, community engagement, and group work. From November 2016, there was a significant reduction in the readmission rates for Māori clients within this particular service.

Independent Police Conduct Authority

Whaia te pono, kia
puawai ko te tika

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

The Authority is an independent Crown entity established under the Independent Police Conduct Authority Act 1988. It exists to maintain and enhance public trust and confidence in New Zealand Police.

The Authority fulfils its role by considering and, if it deems necessary, investigating complaints of alleged misconduct or neglect of duty by Police, assessing Police compliance with relevant policies, procedures and practices, and making recommendations for change.

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

In addition, the Authority entered into a Memorandum of Understanding in 2013 with Police under which the Commissioner of Police may notify the Authority of incidents involving offending or serious misconduct by a Police employee, where that matter is of such significance or public interest that it places or is likely to place the Police reputation at risk. The Authority acts on these notifications in the same manner as a complaint.

There are two aspects to the Authority's NPM work: firstly, oversight of the nature and quality of Police custodial facilities; and secondly, oversight of the operation and management of both those facilities and other places in which custodial management is the responsibility of the Police.

Police operate 437 custodial management facilities nationwide. The majority of these are cell blocks situated at police stations. In addition, however, Police have responsibility for prisoners in District Courts. While Police are not responsible for the physical nature of the cell facilities, which are the responsibility of the Ministry of Justice, the Authority nevertheless has jurisdiction over those facilities.

Visits and inspections

Periodically during the reporting year when the Authority has visited Police facilities in the course of its ordinary work, the opportunity has been taken to conduct an unannounced visit of the attached custodial facility.

Such visits were made to Wellington, Porirua, and the Chatham Islands, supplemented by follow-up inspections of Nelson, Masterton, Christchurch, Auckland and Waitakere.

The Authority has worked closely with Police to develop National Standards for the management of detainees in Police custodial facilities. A programme of audits of individual districts on a rolling basis to monitor compliance with these Standards has subsequently been established. During this year three audits were conducted of Auckland City District, Eastern District and Counties Manukau District respectively. Results were provided to Police National Headquarters and the appropriate District, and discussions were then held about the required response to any recommendations made. The IPCA continues to monitor the actions taken to implement recommendations, and undertakes follow-up visits where necessary.

Complaints and incidents

During the reporting year the Authority received 2592 complaints and referrals, compared to 2614 complaints and referrals in the previous year. Of these complaints and notifications 4% were identified as having OPCAT-related issues. These included general OPCAT issues, such as risk assessment and monitoring in detention, cell conditions, and detention of young persons. Where complaints or referrals are identified

as having an OPCAT-related issue, the Authority categorises them into those that are the most serious and require independent investigation, and those that are suitable for other action including referral back to Police for investigation under the Authority's oversight.

There were 63 OPCAT matters referred to the Authority. Not all investigations have been completed and further recommendations may yet be identified.

The main issues identified included:

- Cell conditions
- Lack of appropriate prisoner welfare assessments
- Frequency of monitoring
- Lack of medical assistance provided
- New Zealand Bill of Rights Act breaches
- Inadequate or inappropriate searches
- Poor equipment

Recommendations included:

- Remediation work in cells
- Review of equipment
- Further training for custody staff
- Changes to Police policy

Particular areas of focus

In the reporting period the Authority has particularly focused on the extent to which those experiencing a mental health crisis are being detained in Police custody; the use of Police custody units for those remanded in custody by the courts awaiting trial or sentence; the physical state of court cells; and the number of young people in Police cells.

Detention of those experiencing a mental health crisis

In previous annual reports, the Authority has expressed its concern at the large numbers of persons experiencing a mental health crisis who are detained in Police cells awaiting a mental health assessment. These people end up detained in a Police cell due to a lack of other suitable facilities and the unavailability of mental health professionals. But as the Police themselves recognise, the Police are not

the appropriate agency to deal with those in mental distress. The Authority has facilitated a number of workshops between Police and mental health services throughout New Zealand with a view to improving interagency practice in this area. It is therefore very pleased to report that the numbers of such people being detained in Police cells has declined significantly in the last four years – from 4,995 in 2014 to 1,996 as at 30 June 2018. This substantial decrease has been achieved through a concerted Police effort to liaise more effectively with mental health services, combined with the development of more suitable facilities within accident and emergency departments to cater for mentally distressed patients awaiting assessment.

However, the Authority continues to receive many complaints and referrals where mentally distressed people have been dealt with inappropriately because of substantial gaps and deficiencies in the provision of services. When these cases arise, the Authority works with the local district to identify opportunities for improvements in practice.

Detention of remandees in Police custody units

The Authority has been concerned for some time about the number of remandees that are detained in Police cells – generally for two or three nights, but sometimes considerably longer. The reasons for these detentions vary. They may sometimes arise from the fact that a person has been remanded for a short period to re-appear in a local court, and it is not worth transporting them to and from the nearest prison in the time available. More often it arises from general transportation difficulties confronted by Police or Corrections or both, particularly in remote geographical locations.

The Authority's concerns have been exacerbated by the use of Police cells over the last 2-3 years to deal with Corrections overflow when prisons in particular areas have reached capacity. The use of cells for this purpose would be extended by a proposed amendment to the Corrections Act 2004 that would allow any gazetted Police jail, or any part of a Police jail, to be gazetted as part of an established Corrections prison. This would enable remandees and sentenced offenders to be held in such a jail, staffed and maintained as a Corrections facility, for a single period not exceeding 7 days and a

cumulative period of not more than 21 days over a 12 month period.

The Authority has examined the reasons for prolonged detention of remandees in Police cells when particular cases have been drawn to its attention. It has also worked with Police on an ad hoc basis to consider the way in which transportation arrangements can be improved. However, at the present time neither Police nor the Authority has a complete inventory of the extent to which Police cells are being used for remandees; the reasons why this is occurring; the extent to which Police cells adhere to minimum standards for such prisoners; the safe limits in the number of such persons that can be detained; and the minimum staffing limits that are required for that purpose. In the 2018/19 financial year, the Authority will therefore be undertaking a comprehensive audit of all custody units in which detainees are currently being held overnight. This will include the collection of statistics, a detailed inspection of every facility, and discussions with relevant staff. Issues arising from a particular visit will be discussed with the relevant district. An overall report on the use of Police cells for remandees will also be prepared and published.

Court cells

The Authority has continued to monitor progress in addressing the substandard physical conditions of Court cells throughout the country. These pose a significant risk to prisoner safety, and often pose hazardous working conditions for staff.

Since 2016, the Ministry of Justice has been working through the implementation of a remediation programme and has prioritised areas of greatest need. This programme is designed to modernise cell conditions to the extent that resources allow and to remove obvious areas of risk such as ligature points that provide opportunities for self-harm. However, the Authority was concerned at the prolonged period of time over which the remediation programme was to be implemented and expressed this concern to the Ministry at regular meetings. The Authority is therefore very pleased to report that the Ministry has managed to devote additional resources to the programme during the current reporting period, and is intending to complete the remediation programme by the end of June 2019.

In the meantime, the Authority has conducted a number of inspections of court cells over the past year, and generally found that court cells are not fit for purpose. Ligature points remain; there is sometimes inadequate monitoring; exchange of information between Police and Corrections (eg about risk of self-harm) is poor or non-existent; and there were several escapes from Court cells during the year because of poor security procedures. The Authority will continue to work with Police and the Ministry of Justice to improve conditions and management practices in court cells.

Youth in police cells

The number of youth held in Police custody for more than 24 hours fell to 165 by March 2018, after reaching a peak of 284 in June 2017.²⁴ However, in some cases, these remands were for prolonged periods. Amnesty International also reported that the average length of time spent in a Police cell was 2.6 days.

Young people aged 17 and under are vulnerable. Police cells are not an appropriate environment for them. Young people in these circumstances have reported being treated as an adult rather than a young person, being treated unfairly, having force used on them, feeling discriminated against, and not having their medical and/or mental health needs met.²⁵ Police cells are unlikely to provide adequate hygiene facilities, appropriate support, adequate food, fresh air, and natural light. Because these young persons are being held in a Police cell and are legally unable to be held with adults, they are effectively in solitary confinement. This can lead to physical, mental, and emotional harm.²⁶ The experiences of young people in Police detention are inconsistent with the right to be protected from cruel, inhuman, or degrading treatment.

As a general rule, if a young person needs to be detained they should be held in accommodation appropriate for young people.

The Authority has had discussions with other agencies about this issue, and will continue to monitor whether appropriate steps are being taken to minimise the number of young people in Police cells.

Inspector of Service Penal Establishments

The Inspector of Service Penal Establishments (ISPE) is the National Preventative Mechanism (NPM) charged with monitoring New Zealand Defence Force (NZDF) detention facilities. The Registrar of the Court Martial is appointed ISPE as set out in section 80 (1) of the Court Martial Act 2007 in respect of service penal establishments (within the meaning of section 2(1) of the Armed Forces Discipline Act 1971).

Facilities

Detention as a punishment in the Armed Forces is second only to imprisonment and dismissal from Her Majesty's Forces, so it remains important that places of detention in the New Zealand Armed Forces are monitored. OPCAT success is based on the premise that regular independent visits prevent torture and other cruel, inhuman or degrading treatment, so regular OPCAT inspections remain relevant despite the absence of ill treatment of detainees in the Armed Forces to date.

The NZDF has one facility that caters for the military punishment of detention. Detention is confined to Navy ratings of able rank, Army privates and Royal New Zealand Air Force leading aircraftsmen. The Services Corrective Establishment (SCE) is based at Burnham Military Camp, Christchurch.

SCE can hold 10 detainees of either gender at any one time. However, staffing levels indicate a maximum of six detainees better caters for the supervision of staff and the ongoing training of detainees. Retraining is fundamental, immediate and not optional. Corrective training centres on, but is not confined to, the maintenance of discipline through physical training, drill on the parade ground, physical work and equipment husbandry.

The SCE is responsively supported on call by the local Chaplain, Burnham Camp Social Worker, a Visiting Officer appointed by the local commander and the Medical Officer. Psychiatric care is readily arranged in Christchurch when there is a requirement. While the facility is approaching 30 years since it was built, it shows signs of wear and tear but remains, in the ISPE's opinion, fit for purpose.

In addition, members of the Armed Forces can be confined in Ship, Camp and Base facilities when close

arrest is ordered. These periods of confinement are rarely ordered and confinement exceeding 12 hours is highly unusual.

The cell facilities in HMNZS PHILOMEL remain closed and instead a barrack room is being used until a new facility is delivered in the Devonport Naval Base. The cell facilities in RNZAF Base Woodbourne are well advanced in planning an upgrade.

Inspections

In the year ending June 2018, two of the eight permitted *no notice* inspections were conducted by the ISPE. At the second inspection to SCE there were no detainees under punishment. The inspection included a physical review of the facilities, a discussion with the manager of the facilities, reviewing documentation and a private interview with those undergoing punishment. Feedback is provided routinely after the inspection to the Officer Commanding of SCE. There was nothing untoward to report from either inspection.

Detention and rehabilitation

There were 14 detainees who served sentences of detention at SCE during the reporting period; this is the lowest recorded occupancy rate at this facility. (2016/2017 recorded 17 detainees – the lowest occupancy until this year.)

Of those detainee's, one was sentenced by the Court Martial to 112 days detention, with the balance of sentences of less than 28 days detention through the Summary Court available in the Military jurisdiction. While detainees have no freedom of movement, are locked down at night and closely supervised at all times, they are gainfully employed outside their cell environment for most of the day.

Military training is supplemented by assisting the Environmental Land Management Officer (ELMO) with an ongoing beautification scheme, scrub cutting under the guidance of the ELMO, the development and maintenance of an unfunded “drop in” centre located in the Community Centre and cutting firewood for local welfare needs and learning how to maintain and sharpen chain-saws.

Corrective training programmes are directed at detainees facing a minimum of 14 days detention. It is designed to improve or restore a detainee’s self-confidence, self-respect, and motivate them to a level where they can adjust to the structure and discipline of a Service environment. If facing discharge from the Service on release, corrective training aims to develop personal qualities which will enhance their prospects for successful integration into civilian society.

Punishments of less than 14 days are required from time to time but they are deemed punitive in nature and fail to address issues of rehabilitation.

The Inspector remains confident from inspections at SCE and visits to Camps and Bases throughout New Zealand that the culture of the New Zealand Armed Forces vigorously supports the prevention of Torture and other Cruel, Inhumane or Degrading Treatment in its ranks.

Appendix:

OPCAT background

Introduction to OPCAT

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

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

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

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

Preventive approach

The Association for the Prevention of Torture (APT) highlights the fact that “prevention is based on the premise that the risk of torture and cruel, inhuman or degrading treatment or punishment can exist or develop anywhere, including in countries that are considered to be free or almost free from torture at a given time”.²⁷

On the principle of prevention, the SPT noted that:

“Whether or not torture or other cruel, inhuman or degrading treatment or punishment occurs in practice, there is always a need for States to be vigilant in order to prevent ill-treatment. The scope of preventive work is large, encompassing any form of abuse of people deprived of their liberty which, if unchecked, could grow into torture or other cruel, inhuman or degrading treatment or punishment. Preventive visiting looks at legal and system features and current practice, including conditions, in order to identify where the gaps in protection exist and which safeguards require strengthening.”²⁸

Prevention is a fundamental obligation under international law, and a critical element in combating torture and ill-treatment.²⁹ The preventive approach of OPCAT encompasses direct prevention (identifying and mitigating or eliminating risk factors before violations can occur) and indirect prevention (the deterrence that can be achieved through regular external scrutiny of what are, by nature, closed environments).

The UN Special Rapporteur on Torture remarked that:

“The very fact that national or international experts have the power to inspect every place of detention at any time without prior announcement, have access to prison registers and other documents, [and] are entitled to speak with every detainee in private ... has a strong deterrent effect. At the same time, such visits create the opportunity for independent experts to examine, at first hand, the treatment of prisoners and detainees and the general conditions of detention ... Many problems stem from inadequate systems which can easily be improved through regular monitoring. By carrying out regular visits to places of detention, the visiting experts usually establish a constructive dialogue with the authorities concerned in order to help them resolve problems observed.”³⁰

Implementation in New Zealand

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

New Zealand’s designated National Preventive Mechanisms are:

- 1 the Independent Police Conduct Authority – in relation to people held in police cells and otherwise in the custody of the police.
- 2 the Inspector of Service Penal Establishments of the Office of the Judge Advocate General – in relation to Defence Force Service Custody and Service Corrective Establishments.
- 3 the Office of the Children’s Commissioner – in relation to children and young persons in Child, Youth and Family residences.
- 4 the Office of the Ombudsman – in relation to prisons, immigration detention facilities, health and disability places of detention, youth justice residences, and care and protection residences.

- 5 the Human Rights Commission has a coordination role as the designated Central National Preventive Mechanism.

Functions and powers of National Preventive Mechanisms

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

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

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

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

The amended Crimes of Torture Act enables the Minister of Justice to designate one or more National Preventive Mechanisms as well as a Central National Preventive Mechanism and sets out the functions and powers of these bodies. Under section 27 of the Act, the functions of a National Preventive Mechanism include examining the conditions of

detention and treatment of detainees, and making recommendations to improve conditions and treatment and prevent torture or other forms of ill treatment. Sections 28-30 set out the powers of National Preventive Mechanisms, ensuring they have all powers of access required under OPCAT.

Central National Preventive Mechanism

OPCAT envisions a system of regular visits to all places of detention.³¹ The designation of a central mechanism aims to ensure there is coordination and consistency among multiple National Preventive Mechanisms so they operate as a cohesive system. Central coordination can also help to ensure any gaps in coverage are identified and that the monitoring system operates effectively across all places of detention.

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

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

Monitoring process

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

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

- 1 Preparatory work, including the collection of information and identification of specific objectives, before a visit takes place
- 2 The visit itself, during which the National Preventive Mechanism monitoring team speaks with management and staff, inspects the institution's facilities and documentation, and speaks with people who are detained
- 3 Upon completion of the visit, discussions with the relevant staff, summarising the National Preventive Mechanism's findings and providing an opportunity for an initial response
- 4 A report to the relevant authorities of the National Preventive Mechanism's findings and recommendations, which forms the basis of ongoing dialogue to address identified issues.

The assessments undertaken by the National Preventive Mechanisms take relevant international human rights standards into account and, and involve looking at the following six domains:

- 1 Treatment: any allegations of torture or ill-treatment; the use of isolation, force and restraint
- 2 Protection measures: registers, provision of information, complaint and inspection procedures, disciplinary procedures
- 3 Material conditions: accommodation, lighting and ventilation, personal hygiene, sanitary facilities, clothing and bedding, food
- 4 Activities and access to others: contact with family and the outside world, outdoor exercise, education, leisure activities, religion
- 5 Health services: access to medical and disability care
- 6 Staff: conduct and training.

Endnotes

- 1 Human Rights Commission, *Submission in relation to the twenty-first and twenty-second periodic review of New Zealand under the Convention on the Elimination of All Forms of Racial Discrimination*, July 2017, https://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/NZL/INT_CERD_IFN_NZL_28240_E.pdf
- 2 Oranga Tamariki contracts the management of one care and protection residence to a non-government organisation, Barnardos NZ.
- 3 Oranga Tamariki data as at 30 June 2018.
- 4 Professional supervision is the process through which a supervisor enables, guides and facilitates social workers and other professional staff to meet organisational, professional and personal objectives. These objectives are professional competence, accountable and safe practice, continuing professional development, education and support.
- 5 Whakapapa is about blood lines, genealogy, and places of significance for Māori. It includes significant ancestors, events, and stories.
- 6 Tikanga Māori refers to Māori culture. It is Māori protocols and conventions – the customary system of values and practices that have developed over time and are deeply embedded in the social context.
- 7 Pepeha is one's tribal motto or set form of words that encapsulate many Māori values and human characteristics, such as ancestors, parents, place of birth, mountain or river of significance etc.
- 8 Pōwhiri is the welcome ceremony used on a marae.
- 9 Whanaungatanga is about children and young people having strong and positive relationships with their family, whānau, hapū, iwi and family group.
- 10 Mana tamaiti is about upholding the intrinsic value, inherent dignity and influence of children and young people.
- 11 There are three less community secure facilities this year than the 2016/17 period.
- 12 Three District Health Boards: Capital & Coast DHB, Hutt DHB and Wairarapa DHB.
- 13 There are currently six prison inspection criteria.
- 14 Rimutaka Upper Prison is a satellite site of Arohata Women's Prison, and referred to as Arohata Upper Prison. The Upper Prison is located on the grounds of Rimutaka Men's Prison, but separate from the male site. Arohata Women's Prison is located in Tawa, Wellington.
- 15 Christchurch Women's, Christchurch Men's, and Arohata Upper Prisons.
- 16 The strategy is currently half way through its second year of implementation.
- 17 Women rising above a new horizon.
- 18 Haumietiketike, Te Whare o Matairangi and Te Awakura.
- 19 Te Puna Waiora, Haumietiketike, Rangatahi and Te Whare o Matairangi.
- 20 Te Whare o Matairangi, Te Whare Awhiora, Te Awakura and Te Puna Waiora.
- 21 Te Awhina, Te Whare o Matairangi, Te Whare Awhiora, Nga Ra Raku and Stanford House.
- 22 Te Awhina, Te Whare Awhiora, Nga Ra Raku, Rangatahi and Te Whare o Matairangi.
- 23 Of the eight mental health units inspected, seven units did not invite service users to attend their MDT's.
- 24 www.amnesty.org.nz/soaring-rate-youth-held-police-cells
- 25 www.hrc.co.nz/files/5914/2550/8314/HRC_IPCA_OOC_2012_-_Joint_thematic_review_of_young_persons_in_prisons.pdf
- 26 www.hrc.co.nz/files/8514/9255/4659/FINAL_Onepager_Police_cells31_March_2017.pdf
- 27 APT (March 2011) Questionnaire to members states, national human rights institutions, civil society and other relevant stakeholders on the role of prevention in the promotion and protection of human rights, p. 10.
- 28 Subcommittee on Prevention of Torture (May 2008). First Annual Report of the Subcommittee on Prevention of Torture, CAT/C/40/2, para 12.
- 29 It sits alongside the obligations to criminalise torture, ensure impartial investigation and protection, and provide rehabilitation for victims.
- 30 UN Special Rapporteur on Torture, Report of the Special Rapporteur on torture to the 61st session of the UN General Assembly, A/61/259 (14 August 2006), para 72.
- 31 OPCAT, Article 1.

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