NZ Human Rights.
Human Rights Commission
Te Kāhui Tika Tangata

2018/19

Monitoring Places of Detention

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

1 July 2018 to 30 June 2019

IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Manaakitia ā tātou tamariki
Children's Commissioner

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

Ombudsman
Fairness for all

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Foreword

The Optional Protocol to the Convention against Torture ("OPCAT") is a ground-breaking United Nations instrument which recognises that people deprived of their liberty are particularly vulnerable to torture and ill-treatment.

At the heart of OPCAT is the idea that regular, independent visits to places of detention provide a proactive safeguard against human rights abuses in places that, by their very nature, fall outside the public gaze. Therein lies the uniqueness of OPCAT: encouraging cooperation between detention agencies and independent monitoring bodies to address conditions which create a risk of torture and ill-treatment, before an event occurs. The purpose of OPCAT monitoring visits and inspections is to strengthen the protections and improve the circumstances of people detained within these facilities, not just to ensure that the minimum material conditions of detention are met. For this reason, inspections can and, in appropriate circumstances, should look beyond immediate material conditions of detention.

The New Zealand National Preventive Mechanism (NPM) is comprised of the Office of the Ombudsman, the Office of the Children's Commissioner, the Independent Police Conduct Authority and the Inspector of Service Penal Establishments. Over the last 12 years they have developed a robust system to examine, and where appropriate make recommendations to improve, the care and treatment of people deprived of their liberty under New Zealand law.

The NPMs have identified a number of persistent issues that arise in detention settings in Aotearoa New Zealand.

NPMs encourage places of detention to ensure that those who are detained have sufficient access to their whānau and community, and have meaningful access to employment, training and education. They also encourage policies and practices that are responsive to the over-representation of Māori in detention.

This report outlines the activities of the NPMs during the reporting period 1 July 2018 – 30 June 2019. Examples of NPM insights featured in this report include:

- Further development of the Office of the Children's Commissioner inspection domain *Responsiveness to Mokopuna Māori*. This domain assesses the Government's responsibilities under the Treaty of Waitangi to partner with, protect and ensure participation for Māori. In the reporting period, mokopuna Māori made up 62% of the children and young people in Oranga Tamariki care and protection residences and 73% of the youth justice residential population. The Office of the Children's Commissioner advocates strongly for services and policies that reduce inequalities and improve outcomes for mokopuna Māori.
- The Chief Ombudsman remains concerned that the growing prison population is resulting in a high percentage of prisoners being transferred out of their home region, compromising access to legal representation and whānau. Time out of cell for many prisoners and access to timely case management was poor. Facilities for intellectual disabilities inspected were no longer fit for purpose, and the high occupancy levels in mental health units was detrimental to providing optimal nursing care.

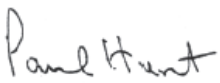
- The extent to which the rights of individuals are being protected remains an area of concern for the Independent Police Conduct Authority, particularly around the provision of basic hygiene products like toothbrushes and sanitary products for female detainees. It was also identified that Police cells have a limited ability to properly cater to detainees with physical disabilities.

This year, NPMs also engaged with our Australian counterparts as Australia begins to develop their Preventive Mechanisms.

In early 2020, the SPT will be conducting both an advisory and inspection visit to Australia. In preparation for this, the Commonwealth Ombudsman has reached out to New Zealand's NPMs for advice on implementing a successful NPM system under OPCAT.

Within this context, it is important for New Zealand to remain not only committed to the prevention of torture and ill-treatment but a leader in preventive monitoring under OPCAT.

The latest annual report of the UN Subcommittee on Prevention of Torture (SPT) specifically mentions the need to avoid complacency in a time where "*in many parts of the world there appears to be backward movement concerning commitments to the prevention of torture and ill-treatment.*" [1]



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Human Rights Commission

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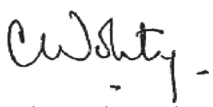

Judge Colin Doherty
Chairperson
Independent Police Conduct Authority

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) and, domestically, the Crimes of Torture Act 1989. The CNPM role entails coordinating with the four National Preventive Mechanisms (NPMs) to identify systemic issues arising out of their OPCAT monitoring. 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 violations of the rights of people who are detained by the State. While NPMs have statutory powers to independently inspect places of detention, with or without notice, the Commission's role is more focussed on coordinating the activities of the NPMs including:

- facilitating annual meetings of the NPMs;
- meeting with international bodies;
- making joint submissions to international treaty bodies; and
- providing communications and reporting/ advocacy opportunities.

The Commission also provides support to the NPMs through expert human rights advice, maintaining effective liaison with the SPT, coordinating joint submissions of the NPMs to the SPT and Parliament, and facilitating engagements with international human rights bodies.

Activities during reporting period

This year the Commission organised and hosted two meetings between the heads of NPM agencies and three meetings between the NPM agency staff at an operational level.

The purpose of these meetings is to share monitoring developments and discuss both issues faced in the exercise of monitoring functions and wider concerns regarding people in detention.

During this period, there were a number of legislative and policy developments which impacted those deprived of their liberty. Following the joint-NPM submission to the Corrections Amendment Bill in early 2017, the NPMs collaborated again to provide comment on the Cabinet Paper on the Supplementary Order Paper for the Corrections Amendment Bill and the Cabinet Paper on Amendments to Corrections Regulations. The submissions included comments on the care and management of prisoners vulnerable to self-harm; the use of police jails; reviews of mother and baby placement decisions; prisoners' knowledge of disciplinary offences; medical restraint practices and search powers.

The Commission was encouraged to see a number of the recommendations made by the NPMs adopted in the final legislation; however, concern remains about the extent to which the proactive purpose of OPCAT is understood at government level, and the limited awareness of the expertise that the NPMs have in steps required to prevent torture and ill treatment. The Commission continues to encourage pro-active engagement from detention agencies and the Government on all matters that impact people deprived of their liberty by the State.

In February 2019, Commission representatives and the General Manager of the Independent Police Conduct Authority spoke with the Chair of the SPT, Dr Malcolm Evans. As well as having a preventive mandate, the SPT provides guidance to NPMs on effective operational practice and how best to reinforce their powers, independence and capacities in order to strengthen safeguards against ill treatment. This teleconference was the first between the Commission and the SPT following Dr Evan's appointment as Chair and Special Rapporteur for New Zealand. We look forward to further developing our relationship with the SPT in the future.

Continuing on from efforts in 2018, the Commission coordinated another training day for NPM staff

working in the OPCAT area. The 2019 training day focussed on *how* NPMs monitor and provided an opportunity for staff from the different NPMs to get to know one another and understand how each NPM conducts monitoring activities. The day was structured to encourage open discussion and sharing of experiences about the monitoring context. In multi-NPM jurisdictions, like New Zealand, it is important that NPMs have opportunities to share their institutional knowledge and learn from one another.

The Commission also utilised a number of opportunities to raise OPCAT-related issues in its broader work. Outside of the Commission's responsibilities under OPCAT, the Commission is the National Human Rights Institution of New Zealand responsible for promoting and monitoring the effective implementation of international human rights standards at a national level. This involves international treaty reporting as well as domestic submissions into matters which raise important issues of human rights in New Zealand.

The Commission was encouraged to see that a number of the recommendations made to the New Zealand government in their Universal Periodic Review related to strengthening protections for people in detention. [2]

In January 2019, the Commission provided a submission to and subsequently appeared before the Justice Committee on the Criminal Cases Review Commission Bill. The Bill sought to establish a Commission to look into miscarriages of justice occurring during conviction and/or sentencing. Among other things, the Commission encouraged the Select Committee to extend the powers of the Criminal Cases Review submission to enable it to initiate its own inquiries into thematic or systemic issues within the Criminal Justice system. The Commission is encouraged to hear the Criminal Cases Review Commission will commence in 2020.

In May 2019, the Commission appeared in the Waitangi Tribunal and provided human rights guidance on prisoner voting rights, particularly for Māori. Māori make up 50% of the prison population which results in disproportionate unenrolment of the Māori voting population relative to the non-Māori population. The Commission submitted that this impact was not consistent with good kāwanatanga and undermined the tino rangatiratanga of Māori. The Tribunal also heard evidence of how disenfranchisement was continuing to impact Māori individuals, whānau and hapū following release from prison. The Tribunal found that prisoner disenfranchisement was a breach of Te Tiriti and recommended not only repeal of the section but also further efforts to educate prisoners of their voting rights and encouragement to vote in future elections.

Finally, the Commission continued to cooperate with our international counterparts in developing understanding on the Convention Against Torture and OPCAT. The Commission participated in the Asia Pacific Regional Seminar on the Convention Against Torture, engaged with the Commonwealth Ombudsman of Australia on designating national preventive mechanisms, spoke with visiting nations about OPCAT and hosted a Churchill Fellow who was investigating overseas practices of monitoring under OPCAT.[3]

Looking ahead

The Commission looks forward to further supporting and assisting NPMs to effectively carry out their monitoring responsibilities under OPCAT. In 2019/2020, the Commission is looking forward to:

- Continuing to provide opportunities for NPMs to work together on issues of mutual significance;
- Raising the profile of systemic issues across detention settings;
- Advocating for the achievement of basic human rights for those deprived of their liberty by the State; and
- Holding the Government to account on their international and domestic human rights obligations to prevent torture and ill-treatment in places of detention.

Office of the Children's Commissioner

Manaakitia ā Tātou Tamariki

The Office of the Children's Commissioner (OCC) has a statutory mandate to monitor and support the development of the policies and practices of Oranga Tamariki under section 13 of the Children's Commissioner's Act. Furthermore, under section 12 of the Act, the Children's Commissioner has a mandate to advocate for the rights of all children. Specifically, we assess how well the organisation now known as Oranga Tamariki (Ministry for Children) delivers services for children, young people and their families.

The OCC is also a designated National Preventive Mechanism (NPM) responsible for monitoring New Zealand's compliance with United Nations (UN) Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in relation to children and young people in secure Oranga Tamariki residences.

We monitor all secure Oranga Tamariki residences throughout New Zealand.

In 2018–19 there were:

- Four *Youth Justice* residences for young people aged 13–16 years, and some aged 17 years who offended when they were 16. Most young people in youth justice residences have been charged with an offence and are on remand, that is, awaiting their next appearance in the Youth Court. These residences also accommodate a number of young people who have been sentenced under section 311 of the Oranga Tamariki Act (1989) to a Supervision with Residence order by the Youth Court.

  In total, there are 156 youth justice residence beds. These include places for a small number of sentenced young people who have committed serious criminal offences that have been dealt with in the adult court and who have high needs and/or are too young to be placed in an adult prison. These young people are placed in an Oranga Tamariki Youth Justice Residence by agreement with the Department of Corrections.
- Four *Care & Protection* residences for children and young people aged 9 –18 years who have high and complex needs, have experienced significant trauma and are at risk of harming themselves or others. In total there are approximately 33 care and protection beds. It is encouraging that Oranga Tamariki has begun to phase out these large institutional residences, replacing them with smaller, more home-like environments. One of the four residences transitioned into the new Community Residential Service Auckland that opened in February 2019. This service consists of a small entry and assessment hub and two fully staffed residential community-based group homes elsewhere in Auckland. The hub has the capacity to provide care for up to five children and young people and one secure room which can be used for young people for brief periods if required. The group homes each have capacity for four young people.
- One *Special Purpose* residence. Oranga Tamariki contracts Barnardos, a non-government organisation, to provide secure care and specialist therapeutic treatment for a small number of children and young people with at-risk sexual behaviours and/or high and complex needs due to trauma. We did not visit this residence under our OPCAT mandate in 2018–19. However, we did visit under our general monitoring mandate.

In conjunction with the Office of the Ombudsman we also monitor:

- Three *Mothers with Babies Units*. These units are managed by the Department of Corrections and based in women's prisons. We conduct joint monitoring visits with the Office of the Ombudsman. The focus of our monitoring is the protection and wellbeing of the babies, who live in the units with their mothers until they are two years old. We also monitor the level of support provided to mothers in caring for their babies. These units are available in three different women's prisons.

The domains that form the basis for OPCAT assessments in secure residences are:

- Treatment,
- Protection system,

- Material conditions,
- Activities and contact with others,
- Medical services and care, and
- Personnel.

In addition to the standard OPCAT domains, the OCC has added one additional New Zealand-specific domain:

- Responsiveness to mokopuna Māori (Māori children and young people) and their whānau (extended family).

We routinely monitor this domain because our government has responsibility under the Treaty of Waitangi to partner with, protect and ensure participation for Māori. Identity and belonging are fundamental for all children and young people to thrive. For mokopuna Māori, being supported to have a positive connection to identity is critical to wellbeing.

Mokopuna Māori are placed in secure residences at a higher rate than non-Māori. Mokopuna Māori made up 62% of the children and young people in Oranga Tamariki care and protection residences and 73% in youth justice residences.[4] These percentages are down slightly from 30 June 2018, when Māori made up 71% of children and young people in care and protection residences and 80% in youth justice residences.

We advocate strongly for services and policies that reduce inequalities and improve outcomes for mokopuna Māori. As long as mokopuna Māori continue to be placed in secure residences, Oranga Tamariki must provide services that are responsive to their needs.[5]

OCC Findings 2018–2019

Oranga Tamariki residences

In the twelve months from July 2018 until June 2019, the OCC conducted thirteen visits to Oranga Tamariki secure residences. Five of these were undertaken under our OPCAT mandate and are the subject of this report. The others were carried out under our Children's Commissioner's Act 2003, s 13 (1) (b) which is our mandate to 'monitor and assess the policies and practices' of Oranga Tamariki.

Of the five OPCAT visits conducted by the OCC, one was pre-arranged and four were unannounced. Two visits were to youth justice residences and three to care and protection residences.

The five Oranga Tamariki residences we monitored during this period, both care and protection and youth justice, generally met the standards required. 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.

Overall ratings improved for both the youth justice residences we visited. Overall ratings for two of the care and protection residences remained the same and the rating for one declined.

Themes across our five monitoring visits

Key strengths:

- Good access to primary and specialist health services;
- Improved training for residential staff;
- Strong relationships between staff and children and young people;
- Balanced and varied diet provided;
- Individualised experiences of education;
- Improved access to activities outside the residences.

We also found many other improvements specific to individual residences.

Key areas for development were the need for:

- Maintaining an intensive focus on the development of smaller home-like community placements to enable children and young people to be closer to their whānau when they cannot live at home.
- More opportunities for children and young people to have a say in their daily life at the residence and see change occur based on their suggestions.
- Better support for children, young people and their whānau to be involved in their plans.
- Improvement in Whāia te Māramatanga (the residence complaints, suggestions and feedback

system, also known as the grievance system) to ensure children and young people have confidence that using it will lead to change.

- Improved access for staff to individual professional supervision.[6]
- Strengthening of partnerships between residences and mana whenua.[7]

Findings by domain

For each OPCAT domain, we provide a brief description of our main findings, followed by a description of the key findings for that domain. Quotes from children and young people we interviewed are in italics.

1 Treatment

Children and young people experience warm, caring relationships with staff. While there are many challenges, becoming more child-centred appears to be a key focus for many staff. Children and young people often tell us they feel loved, cared for and respected by staff.

The practice of Oranga Tamariki staff is becoming more informed by an understanding of the effects of trauma. Staff are being trained in the Managing Actual and Potential Aggression (MAPA) programme in care and protection residences and Safe and Tactical Approach and Response (STAR) programme in youth justice residences. These approaches focus on responding early to prevent escalation of behaviour. They also support staff to learn how to apply physical restraints safely, when deemed necessary for the safety of children and young people, and staff. Further embedding of this knowledge is needed across all areas of practice. Some children and young people told us they felt supported to learn and change while in residence. Others told us the use of the secure care unit (an area in a residence where children and young people are separated from others) and restraints is difficult for them.

"Most of the staff here are really good. They really care about you and I feel like they are listening to you."

"I actually feel like I have changed a bit and woken up... getting back to my normal self."

"In the secure care unit] you feel lonely and you feel sad that there's nowhere to go and you can't talk really."

Children and young people feel they do not have sufficient say in matters that are important to them. Children and young people told us opportunities to have a say are limited. For example, youth forums are infrequent or those that are held are not child centred and do not lead to change. We found that multi-disciplinary teams work well to complete assessments and develop plans for children and young people. However, children and young people often tell us that they, or their whānau, do not have meaningful input into these plans.

"Staff have unit meetings everything Tuesday but like it goes in one ear and out the other and it takes like ten years for them to say yes or no."

"People don't listen to my whānau."

Children and young people need better support to learn about their cultural identity. While residences have a role in supporting young people to learn about their cultural identity, the best way for them to learn about who they are is from their whānau, hapū and iwi. Oranga Tamariki need to better support children and young people to be connected with their families and to learn, through them, about their whakapapa [8] or where they are from.

2 Protection System

Whāia te Māramatanga is generally administered soundly. Children and young people are supported to know how to use Whāia te Māramatanga (WTM) and many do so. However, we are concerned that some children and young people continue to tell us that using WTM is seen as *snitching*. Residences must work to overcome this culture by further educating children and young people, and staff about the importance of the grievance system and responding appropriately to grievances submitted by children and young people. Furthermore, we have long thought that the WTM process needs fundamental change to make it more accessible

and independent. Oranga Tamariki are planning developments to improve WTM and we look forward to these being implemented as soon as possible.

"I use WTM all the time. It usually makes it through to the grievance panel and they come and see us."

"We don't really make WTM here cause It doesn't make a difference, us boys here have a code to not snitch or you get a hiding."

Most residences had a lack of access to advocates for children and young people. Access to advocates was limited for both general advocates and WTM advocates more specifically. *VOYCE – Whakarongo Mai* [9] is becoming more active in many residences. Residences engaging fully with *VOYCE – Whakarongo Mai* will enable advocacy to be relevant and accessible.

Children and young people need better support to fully understand their rights. They are mostly given information about their rights when they are admitted to the residence. However, there is often limited support to help children and young people fully understand their rights during their stay in residence as well as their rights under the Children's Convention.

"Sometimes we do [programmes on the Residential Care Regulations] but only after someone has played up to remind us of the rules in residence."

We found one residence had a strong programme which supports children and young people to understand their rights and we encourage this to be shared amongst other residences.

3 Material Conditions

The physical environment of youth justice residences has improved significantly. Inside spaces in these residences were refreshed in 2018. While these environments are mostly institutional spaces which have not been designed to be young people centred, attempts have been made to decorate spaces brightly. Some residences allow children and young people choice in how their rooms are decorated and personalised.

Some refresh to material conditions is needed in care and protection residences. Oranga Tamariki are planning to replace care and protection residences with smaller community-based alternatives. Consequently, only minor refurbishments are planned. However, these environments need to continue to be maintained to a high standard for the wellbeing and morale of children, young people and staff currently living and working there.

"There is spiders and tagging and it's hot."

"My family always says I can't hear you or the phone keeps cutting out or just sounds like echoing."

A balanced diet is provided. Children and young people are often positive about the food. However, they would generally like more say in the menu options and for their feedback to be taken seriously.

"Happy with the kai. It's more than I'm used to on the outside."

"We could rate [the food] and write a letter about what they need to work on, but they don't write back to us and tell us if they are going to do it or not."

4 Activities and Contact with others

Most children and young people have access to a variety of activities throughout the day. Safe ways of enabling young people on remand to access off site activities has improved since our last report. Experiences of cultural programming for children and young people vary between residences. We recommend a focus on providing engaging experiences in order to support children and young people to learn more about their cultural backgrounds.

"We have good as kapa haka teachers."

"Anything Māori is done in the classroom."

Positive educational experiences are often a highlight for children and young people while in residences. Many have been disengaged from education for long periods prior to being placed in residence. Meaningful progress, such as gaining

NCEA credits, is an important achievement for many young people.

"I am getting back to my education and stuff. When I was offending I didn't really go to school that much."

"The teacher is so supportive, makes me enjoy being back in school."

Children and young people want more kanohi ki te kanohi (face to face) contact with their whānau. For many children and young people, the residence is a long distance from their family and community. While they are well supported to contact their whānau by phone, many would like more face to face contact. Residences work with Oranga Tamariki local service delivery sites to overcome logistical challenges to face to face visits. Further support is needed to encourage and develop these connections.

"I hate [my whānau] coming here because they've got to drive for an hour and a bit."

"Talking on the phone is ok but I want to see [my whānau]."

5 Medical Services and Care

Most children and young people have easy access to primary and specialist health care services. On-site nurses are easily accessed in residences. Additional specialist health needs are also well met such as dentists and alcohol and other drug services. When children and young people are placed in a secure residence away from their local area, it is often difficult to access longer term therapeutic programming.

"The nurses are pretty good with giving medicine and sorting things out for me if I need them."

6 Personnel

A new residence induction programme for staff has been well received. Oranga Tamariki has developed a new induction programme, Te Waharoa, which staff have responded to positively. Specific training, such as on trauma informed care, has also been implemented.

Individual professional supervision remains a challenge. Staff working daily in frontline roles with children and young people are mainly provided with group supervision. One to one supervision is provided on a case by case basis. This is in line with the current Oranga Tamariki supervision policy. However, the importance of individual professional supervision is particularly apparent as Oranga Tamariki develops new care options and staff adjust to new practice approaches.

7 Responsiveness to mokopuna Māori

More residences are developing plans to improve their responsiveness to Māori. Two of the five residences we visited had an active plan to support their responsiveness to Māori and another was planning to reinstate a previous plan as a priority. However, tangible progress against these plans was not yet evident. We encourage all residences to develop and implement a plan for improving outcomes for mokopuna Māori.

Establishing relationships with mana whenua continues to be at an early stage for most residences. These relationships need to be strengthened so that all staff, children and young people can deepen their connections to the places and people where they are living.

Many mokopuna Māori want further opportunities to learn more about and express their culture and identity. It is encouraging that most of the residences are implementing actions to support staff to learn more about tikanga Māori[10], such as group training days or ongoing education programmes. However, many children and young people told us they want more support to use their knowledge and learn more about their identity.

"You should always do karakia when you wake up, when you go to sleep…"

"I'm really good at Māori but I haven't been learning here."

Oranga Tamariki initiatives addressing OCC recommendations

An ongoing priority for the Office of the Children's Commissioner is encouraging Oranga Tamariki in its transformation of the care and protection, and youth justice systems.

Significant changes have been made in the following areas:

Phased closure of care and protection residences

It is vital that a range of community-based alternatives to institutional environments are developed for children and young people in care. Oranga Tamariki have begun to transition from using large national care and protection residences to smaller, more home-like environments.

Whakatakapokai residence in Auckland is no longer operating as a care and protection residence. Community Residential Service Auckland consists of a small entry and assessment hub, located in the wharenui of the old residence site, and two community-based group homes. Children and young people are admitted to a small *hub*, on a short term, maximum two-week basis. The two community homes are the *spokes*, which children and young people can transition into after an initial assessment in the *hub*. The goal is then for children and young people to transition home or into a longer-term placement.

We commend Oranga Tamariki on beginning this transition from institutional to community care. At the same time, we encourage timely and continued progress on the phased closure of other large institutional care and protection residences.

Ongoing development of remand homes

Oranga Tamariki have so far developed five remand homes in the community for young people on remand pending their first youth court hearing. The homes aim to provide safe, nurturing and stable care for young people in a whānau like environment in or close to their community. It is expected that young people will remain in the home for four to six weeks while they progress through the youth court process.

OCC would like to see a reduction in the percentage of young people on remand in the national youth justice residences (around 74% of young people in youth justice residences are on remand). We remain concerned about:

- young people being placed on remand in large, institutional environments;
- young people on remand living with those who have been sentenced to residential supervision;
- young people being placed long distances away from their whānau.

We are also advocating that young people should no longer be able to be remanded into police cells by the youth court after their first court appearance. We believe s238(1)(e) should be repealed.

The development of remand homes is providing a positive solution to these concerns.

Whakamana Tangata

Oranga Tamariki have been developing and trialling this restorative practice approach. A pilot has been underway in one 10 bed unit of a youth justice residence. Along with others, OCC is on the reference group for this approach. This practice approach uses Māori values and restorative justice principles to support the operating model of the residence. There are plans to implement Whakamana Tangata throughout the four youth justice residences.

Department of Corrections

Mothers with Babies unit (MBU) in prisons

In the 2018–19 period, we conducted a pre-arranged monitoring visit to one MBU, in partnership with the Ombudsman's office. MBUs are self-care units within the 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.

We found that, overall, babies are safe, and they are in an environment where they are able to be supported by their mothers. Our overall rating remained the same as our previous visit to the same MBU in 2016; developing with well-placed elements. There has

been an improvement in the rating for Personnel; the ratings for Material conditions, Protection system and Activities and contact with others remained the same; the ratings for Treatment and Responsiveness to Māori have deteriorated.

Babies are well treated by their mothers, and generally mothers are well treated by staff. They live in flats that are comfortable, eat well, and have good access to medical care, activities and programmes.

However, there are several areas where development is needed, and some concerning practices that need to be addressed. We heard about Corrections officers handcuffing women during labour, and/or shortly after giving birth. We have recommended urgent attention from the Department of Corrections to ensure that practices and policy concerning the use of handcuffs are clear, humane, and prioritise the wellbeing of babies.

Women in MBUs rarely use the complaints system. They told us that Corrections staff make inappropriate comments when women request complaint forms. We recommend that the manager ensures women know that all complaints are taken seriously and are responded to promptly. We were also concerned to hear about Corrections staff over-riding advice from health professionals.

We assessed the domain Responsiveness to Māori for the first time for a monitoring visit to this unit. There have been improvements in this domain under the current leadership who have a supportive and receptive attitude. While this is a start, we are concerned that a lack of clear direction, planning, and embedding of cultural programmes and te ao Māori activities within the MBU will limit the benefit this will have for mokopuna Māori and their mothers.

Response from the Department of Corrections

The Department of Corrections are developing and consulting on a National Operating Model for MBUs. The vision of the model is to "*build safe whanau [sic] centred spaces where babies and mothers grow together, are valued and are connected to their community and culture*."[11] The Department of Corrections are also developing a Māori strategy.

In response to the handcuffing practices, a review of escorting documentation and policies around temporary removals of pregnant women was carried out. Work is being undertaken by Corrections to review and update the Prison Operations Manual regarding the use of restraints and processes surrounding practices during labour, birth and postnatal care. This review will aim to ensure the particular needs of mothers and their babies are considered.

Management have addressed the concerns around access to complaint forms and have committed to providing women with information about how to use the complaints system on a regular basis and address any concerns they have. They are also working to ensure that health plans and information are followed and not over-ridden by staff.

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

Improve the conditions and treatment of people in detention

The Ombudsman has been designated, since 2008, as a National Preventive Mechanism (NPM) under OPCAT to examine, and make 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;
- 88 health and disability places of detention[12] and approximately 227 aged care secure facilities;
- 3 immigration detention facilities;
- 4 child care and protection residences;
- 5 youth justice residences;
- 1 Public Protection Order (PPO) unit;
- 1 Substance Addiction (Compulsory Assessment and Treatment) unit; and
- 58 court facilities.

The designation in respect of child care and protection residences and youth justice residences is jointly shared with the Children's Commissioner. The designations in respect of privately-run aged care facilities, courts, and the PPO unit were given to the Ombudsman in June 2018.

Visits and inspections

In 2018/19, I carried out a total of 40 visits, including 22 formal inspections. Thirty-six visits (90 percent) were unannounced.

Each place of detention contains a wide variety of people, often with complex and competing needs. All have to be managed within a framework that is consistent and fair to all. While I appreciate the complexity of running such facilities and caring for detainees, my 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 the Ombudsman's power to make recommendations with the aim of improving the treatment and the conditions of people deprived of their liberty, I also review and comment on proposed policy changes and legislative reforms relevant to these places of detention.

This year I scoped the necessary resource to conduct regular inspections of the designations received in June 2018. This scoping exercise informed a funding request to the Officers of Parliament Committee for the 2019/20 year onwards. In 2018/19, I engaged with the aged care sector to explain the NPM function, and update them on my work to date preparing to implement the new designation. I also conducted some visits to court facilities.

Table 1: Formal inspections

The 22 formal inspections were at the sites set out in the table below.

Name of facility	Type of facility	Recommendations made	Visit type	Report published
Te Whare Manaaki Canterbury District Health Board	Forensic Unit	7	Unannounced	No
Te Whare Hohou Roko Canterbury District Health Board	Forensic Unit	2	Unannounced	No
Psychiatric Service for Adults with an Intellectual Disability (PSAID) Canterbury District Health Board	Intellectual Disability Unit	13	Unannounced	No
Assessment, Treatment and Rehabilitation (AT&R) Unit Canterbury District Health Board	Forensic Intellectual Disability Unit	11	Unannounced	No
Auckland South Corrections Facility (SERCO)	Men's Prison	36	Announced	Yes
Te Whare Maiangiangi Bay of Plenty District Health Board	Acute Mental Health Inpatient Unit	14	Unannounced	No
Mental Health Services Older Persons Bay of Plenty District Health Board	Older Persons Mental Health Service	10	Unannounced	No
Te Toki Maurere Bay of Plenty District Health Board	Acute Mental Health Inpatient Unit	13	Unannounced	No
Hawke's Bay Regional Prison (follow up visit)	Men's Prison	23	Unannounced	Yes
Ngā Rau Rākau (follow up visit) Hawke's Bay District Health Board	Acute Mental Health Inpatient Unit	11	Unannounced	No

Name of facility	Type of facility	Recommendations made	Visit type	Report published
Ward BG Older Persons Mental Health Service Canterbury District Health Board	Older Persons Mental Health Service	6	Unannounced	No
Child Adolescent and Family Unit Canterbury District Health Board	Children and Adolescence Inpatient Unit	9	Unannounced	No
Te Whare Awhiora (follow up visit) Tairāwhiti District Health Board	Acute Mental Health Inpatient Unit	10	Unannounced	No
Ward 9A Southern District Health Board	Forensic Inpatient Unit	13	Unannounced	No
Ward 9B Southern District Health Board	Acute Mental Health Inpatient Unit	11	Unannounced	No
Otago Corrections Facility (follow up visit)	Men's Prison	9	Unannounced	Yes
Northland Regional Corrections Facility	Men's Prison	31	Unannounced	Yes
Southland Inpatient Mental Health Unit Southern District Health Board	Acute Mental Health Inpatient Unit	10	Unannounced	No
Assessment, Treatment and Rehabilitation Unit Southern District Health Board	Older Persons Mental Health Service	11	Unannounced	No
Invercargill Prison (follow up visit)	Men's Prison	6	Unannounced	Yes
Tongariro Prison	Men's Prison	17	Unannounced	Yes
Te Whare Oranga Tangata o Whakaue Lakes District Health Board	Acute Mental Health Inpatient Unit	15	Unannounced	No

I reported back to 21 places of detention (95 percent) within 12 weeks of concluding the inspection. This brings the total number of visits conducted over the 12-year period of the Ombudsman's operation as an NPM to 517, including 205 formal inspections.

Table 2: Recommendations

This year, I made 288 recommendations, of which 266 (92 percent) were accepted or partially accepted as set out in the table below.

Recommendations	Accepted/partially accepted	Not accepted
Prisons	115	7
Health and disability places of detention	151	15

Table 3: Visits

Eighteen visits were conducted at the sites set out in the table below.

Name of facility	Type of facility	Visit type
Nova STAR (Christchurch)	Supported Treatment & Recovery Unit	Unannounced
Kennedy Centre (Christchurch)	Detox Unit	Unannounced
Christchurch Men's Prison	Men's Prison	Unannounced
Te Awakura Canterbury District Health Board	Acute Mental Health Services	Unannounced
Wellington District Court	Courts	Announced
Gisborne District Court	Courts	Unannounced
Napier District & High Courts	Courts	Unannounced
Hastings District Court	Courts	Unannounced
Auckland Region Women's Corrections Facility (Mothers and Babies)	Women's Prison	Announced
Christchurch District Court	Courts	Unannounced
Community Secure Facility (Christchurch) Emerge Aotearoa	Community secure home for clients with intellectual disabilities	Unannounced
Wakari Hospital – Ward 9C Southern District Health Board	Acute Mental Health Inpatient Unit	Announced
Wakari Hospital – Ward 10A Southern District Health Board	Forensic Intellectual Disability Unit	Unannounced
Wakari Hospital – Helensburgh Cottages Southern District Health Board	Forensic Intellectual Disability (stepdown cottages)	Unannounced
Dunedin District & High Court	Courts	Unannounced
Dunedin Hospital – Ward 6C Southern District Health Board	Older Persons Mental Health Service	Unannounced
Invercargill District & High Court	Courts	Unannounced
Rotorua District & High Court	Courts	Unannounced

Prisons

This year, I further reviewed my trial prison inspection criteria,[13] and incorporated prisoner focus groups, staff forums, and regular unit muster checks into the inspection methodology.

My assessment of prisons across New Zealand continues to be varied, and I reported concerns that were similar to those raised in previous years, including:

- the number of prisoners transferred outside of the region;
- time out of cell for prisoners; and
- prisoners' access to timely case management.

Prisoners transferred out of region

In last year's report, I raised concerns over the increase in the prison population that had placed significant pressure on accommodation, staffing levels, and effective prisoner processes. Changes and expansion to the prison system/operations, due to the increase in prison population, has now resulted in a high percentage of prisoners being transferred out of their home region. The Department of Corrections advised that, as at 30 April 2019, 20 percent of prisoners were out of region.[14]

As a consequence, opportunities for maintaining family contact, keeping connections with whānau, and access to existing legal representation were compromised. In the past 12 months, I conducted three prisoner surveys that highlighted difficulties in maintaining family contact for prisoners out of region. In response to the survey question *'Is it easy for your family and friends to visit you here?'* an average of 60 percent of all survey respondents answered *'No'*.[15] In response to the survey question, *'Do you usually have one or more visits per week from family and friends?'* an average of 77 percent of all survey respondents answered *'No'*.[16]

Time out of cell

The amount of time that prisoners receive out of their cells continues to be poor for many. Only 22 percent of prisoners responding to my survey reported that they were out of their cell for more than eight hours on weekdays. Eleven percent reported that they were out of their cell for less than two hours a day.[17] Inspections found that staff shortages in some prisons affected time out of cell.

While unlocked, prisoners are expected to attend work, education, and training, and use their time constructively to engage with health services, case management, and to take exercise. It is also an opportunity for basic domestic tasks, such as showering, cleaning cells, eating meals, and telephoning family and whānau. I continue to find that prisoners spend far too much time locked up and not able to access these services leading to frustration, boredom, and often deteriorating physical and mental health.

I also found that operational practices had become less predictable, which prisoners found frustrating and unsettling. Prisons were operating temporary restricted regimes. This meant that prisoners were often locked earlier, affecting their access to the telephone and contact with families.

Prisoners' access to timely case management

Case management—the process to identify the needs of the prisoner population—was poorly effected across most prisons I inspected. Timeliness and quality of case management practice needed to improve, including prisoners' access to a case manager.[18]
Key problematic factors included:

- delays in accessing rehabilitation programmes which impacted prisoners' sentence progression;
- timeliness in providing reports to the New Zealand Parole Board; and
- case managers' non–attendance at meetings designed to discuss a prisoner's sentence progression and re–integration needs.

Good practice

I have also observed various examples of good practice during inspections.

Auckland South Corrections Facility (ASCF) should be recognised for its installation of in-cell telephones and user interfaces. This is a positive initiative that ensures that prisoners with disabilities are afforded reasonable accommodation.

Prisoner comments from surveys

[The Prison] needs more support for education and more case managers as I've done three years and still not met a case manager and I have parole soon.

The level of support within this jail is poor and getting things done on time for Parole Board and other important meetings leaves you unsure as to what's happening. Parole Board submissions and information don't arrive to the Board on time and at times important information is missing. Having other important objectives achieved for the Parole Board not done does not give me confidence of a positive outcome.

[I need] to see a case manager so I can progress with my offender plan and still waiting nine months later… all I have to do is my course before next parole only four weeks away and no case manager to help.

Prisoners who have been going up for parole are doing so only to be told that they are stood down pending courses when those services should have been made available or offered to prisoners way before parole dates come up… Prisoners shouldn't have to go to parole to be told that they can't have parole because they haven't done things not made available.

At-risk cells were still subject to CCTV monitoring. However, ASCF should also be commended for having privacy screening in place to maintain the dignity of prisoners when carrying out their ablutions.

Tongariro Prison is considered to be a centre of excellence in terms of establishing and embedding the Corrections' Te Tokorima a Māui values and consulting with paihere[19] on issues that impact on their care.

Intellectual disability facilities

This year, I inspected two Regional Intellectual Disability Secure Services (RIDSS), the Assessment, Treatment, and Rehabilitation (AT&R) Unit, and the Psychiatric Service for Adults with an Intellectual Disability (PSAID) Unit operated by the Canterbury District Health Board.

These inspections identified that improvements were required in four key areas:

- living conditions for patients;
- patients' access to fresh air;
- patients' access to the complaints system; and
- training for staff to enhance their knowledge and skills in working with clients who have high and complex needs.

Both units were tired, dated, and no longer fit for purpose. Built in the 1970s, the units lacked space to de-escalate patients and were, therefore, incompatible with modern treatment practice.

The required complaints process was not readily available to patients in either unit, including how to access the District Inspector and advocacy services. Patients also had limited opportunities to spend time outside in the fresh air due to locked courtyard doors.

Training and support for staff who work with patients displaying unpredictable and assaultive behaviour needed to be enhanced.

I will continue to work with the Ministry of Health on these concerns.

Mental health facilities

I conducted inspections of 12 mental health inpatient units in 2018/19,[20] including two follow up inspections. Similar to last year, I observed a number of units using seclusion rooms as bedrooms due to unit capacity issues. The effect of high occupancy levels has a detrimental effect on the health of staff and patients as well as reducing the ability of staff to provide optimal nursing care.

Despite the apparent declining number of seclusion events, the length of time of events in some units had increased.[21] Māori continue to be over-represented in seclusion statistics.

I observed open units routinely locking their exit doors (environmental restraint).[22] This restricts patients' ability to come and go freely, including access to the outdoors and fresh air. This practice affected both formal and informal patients.[23] Locking exit doors was not recorded as an episode of environmental restraint by all units.

Access to the complaints process and contact details for the District Inspector were often not available or accessible to all patients,[24] including patients in de-escalation, low stimulus, and seclusion areas.

As reported last year, the majority of mental health units inspected did not routinely invite patients to attend their multi-disciplinary team (MDT) meeting review, nor did they receive a copy of the meeting minutes. Additionally, consent for treatment was poorly documented.

Seven of the units inspected reported issues with staff retention and high turnover rates. This was highlighted by security staff being observed in a number of inpatient units assisting with the personal restraint of patients and conducting patient searches, which I considered to be sub-optimal.

I raised concerns at the time of the inspection, and ongoing discussions are being held with the Director of Mental Health and Addiction Services to find a workable solution to these issues.

Good practice

I was pleased to report that patients had unrestricted access during the day to kitchen facilities at a number of units.[25] This practice allowed patients the independence to access hot and cold drinks and snacks throughout the day. While this access is not yet commonplace in inpatient services, I was pleased to note a number of units normalising this practice.

Ward BG, an older persons' mental health unit at Burwood Hospital, had eliminated the use of all forms of mechanical restraint.[26] This significant change was reportedly brought about by increased staffing levels on the unit, the use of one-to-one supervision, and the therapeutic benefits of the new, purpose-built facility.

Independent Police Conduct Authority

Mana Whanonga Pirimana Motuhake

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 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 joint jurisdiction with the Office of the Ombudsman over those facilities.

Visits and inspections

Special Project

The Authority was funded to conduct an 'OPCAT Special Project' in 2018/19. The overall purpose of this project was to undertake an audit of the condition and operation of Police custody units throughout New Zealand in which detainees may be routinely held overnight, and to determine whether, and if so to what extent, they are suitable for the short-term detention of remand or sentenced prisoners.

The Authority completed a comprehensive audit of all 31 such custody units. This included the collection of statistics, a detailed inspection of every facility, discussions with relevant staff and discussions with detainees.

The custody units visited were Whangarei, Kaitaia, Kaikohe, Waitakere, Auckland Central, Counties Manukau, Hamilton, Te Awamutu, Tauranga, Rotorua, Whakatane, Taupo, New Plymouth, Palmerston North, Levin, Taumaranui, Whanganui, Hastings, Gisborne, Wellington Central, Levin, Chatham Islands, Nelson, Blenheim, Greymouth, Westport, Christchurch Central, Timaru, Dunedin, Queenstown and Invercargill.

Individual reports are being produced for each custody unit. The reports assess staffing levels, governance, the physical conditions, detainee monitoring, the extent to which the rights of the individual are protected, and the reception and detention process. Issues arising from a visit were discussed with the relevant Police district. The Authority will monitor the actions taken to

implement recommendations and undertake follow-up visits where necessary. An overall report on the use of Police cells for remandees is also being prepared and published.

The key issues identified to date include:

Staffing levels

There is a mixture across the country of constabulary staff and Authorised Officers (AOs) working in custody. The Authority has identified that AOs provide a better level of service and care for detainees as they build up higher levels of knowledge and greater familiarity with custody policy, practice and procedure. Generally, there needs to be better inductions for all custody staff, with an accompanying desk file. In some custody units the fact that staff have dual custody and watchhouse duties impact on their ability to provide the appropriate level of care and welfare for detainees.

Custody unit governance

There needs to be consistent internal auditing of custody records to ensure standards in custody are maintained.

In the custody suite

Ligature points are still present in many custody units and need to be removed. The privacy of detainees during ablutions is not always provided and the general cleanliness of older custody blocks requires improvement.

Rights of the individual

Minimum standards of care are not always provided. The quality of available food varies across the country; toothbrushes and toothpaste are often not provided to overnight detainees; generally, there is no clothing selection available other than paper suits; sanitary products are available, but this is not advised to female detainees; and there is a limited ability to deal with detainees with physical disabilities. This is an area of concern.

Reception and detention processes

Detainee property and medication is not consistently managed in accordance with policy.

Many of the Police custodial facilities are not suitable for managing Corrections prisoners because they cannot provide the conditions prisoners and remandees are entitled to under the Corrections Act 2004.

Routine audits

The Authority has worked 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 five audits were conducted of Central, Northland, Wellington, Tasman and Waikato 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 appropriate.

Complaints and incidents

During the reporting year the Authority received 3026 complaints and referrals, compared to 2592 complaints and referrals in the previous year. Of these complaints and notifications 124 (4%) were identified as having OPCAT-related issues. These included general OPCAT issues, such as risk assessment and monitoring in detention, use of force, 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.

The main issues identified included:

- Lack of appropriate prisoner welfare assessments
- Frequency of monitoring
- Lack of medical assistance provided
- Inadequate or inappropriate searches
- Use of force
- Cell conditions

Recommendations included:

- Remediation work in cells
- Review of equipment
- Further training for custody staff

Not all investigations have been completed and further issues and recommendations may yet be identified.

Court cells

The Ministry of Justice has completed its Court cells refurbishment programme. The 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.

The Authority will work with the Office of the Ombudsman to develop a programme of inspection of Court cells for the 2019/20 year.

The Authority will continue to work with Police, the Office of the Ombudsman and the Ministry of Justice to improve conditions and management practices in court 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 by 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 block in Linton Camp is no longer suitable for purpose and has been closed. Linton based soldiers in need of temporary periods of confinement are held in the RNZAF Base Ohakea Cell until a new facility in Linton is constructed.

Inspections

In the year ending June 2019, two of the eight permitted no notice inspections were conducted by the ISPE. 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.

The Deputy Judge Advocate General of the Armed Forces, Judge Taumaunu accompanied the ISPE during one inspection to SCE, in order to get a better insight into detention as a punishment.

Detention and Rehabilitation

There were two detainees convicted by the Court Martial of New Zealand in the reporting period: both faced Dismissal from Her Majesty's Armed Forces and detention periods of 126 and 365 days respectively. Twenty one other detainees served short sentences of detention at SCE (generally 14–28 days) during the reporting period. All sentences of detention arose from convictions in the Summary Court.

Armed Forces detainees, like prisoners, have no freedom of movement, are locked down at night and are closely supervised at all times. Detainees find themselves 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 the Service environment. If a detainee is facing discharge from the Service on release, corrective training aims to develop personal qualities which enhance their prospects for successful integration into civilian society.

Punishments of detention of less than 14 days are required from time to time. The aim is to provide a short shock reminder about standards, and it is deemed punitive in nature and lacks the time to address issues of rehabilitation in the programme.

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 court facilities, in police cells, and of persons otherwise in the custody of the New Zealand Police.
2. the Inspector of Service Penal Establishments of the Office of the Judge Advocate General – in relation people detained in service penal establishments under the Armed Forces Discipline Act 1971.
3. the Office of the Children's Commissioner – in relation to children and young persons in care and protection and youth justice residences.
4. the Office of the Ombudsman – in relation to prisons, immigration detention facilities, health and disability places of detention including privately run aged care facilities, youth justice residences, and care and protection residences, public protection order units and court facilities.
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.

The Office of the Children's Commissioners' monitoring approach [32] [33]

From 1 July, 2019 we will be using our new OPCAT evaluative framework. This is currently being developed in consultation with Oranga Tamariki and Barnardos. We changed our OPCAT rating system from a 5 point to 4 point rating scale. The overall question our OPCAT monitoring seeks to answer is: To *what extent does Oranga Tamariki have the enablers*

in place that support children and young people to have the desired experience? (for each element that we assess under each domain) Enablers we look at include: systems, structures, policies, procedures, opportunities and practice.

We start by listening to children and young people.

We think children and young people are the best people to tell us what living in residential care is like. They also have the right to be heard. As part of our visits to residences, we ask young people a range of questions based on Mana Mokopuna, our child-centred approach to monitoring. Mana Mokopuna identifies six principles – whakapapa, whanaungatanga, aroha, kaitiakitanga, rangatiratanga and mātauranga – from which a set of desired experiences for all children and young people are drawn. These principles focus intentionally on the experiences of children and young people in relation to the services they receive.

Our Mana Mokopuna-based questions cover all six international OPCAT areas as well as an additional area specific to Aotearoa New Zealand – Responsiveness to mokopuna Māori.

We ask children and young people about things that matter to them.

We try to talk to everyone – not just a few. During our visits to residences we make ourselves available for one-to-one conversations with as many children and young people as we can. What children and young people tell us is confidential, unless it is about something that could harm themselves or someone else. We ask them about things like their safety and access to health care, whether they have a say in decisions that affect them, if they are helped to stay in touch with whānau, and whether they have opportunities to learn about themselves, their whakapapa and the world.

We also ask children and young people to show us around residences so we can see how well they are being cared for, the range of activities they take part in and what their living conditions are like. We usually eat a meal with them too, to check the quality of the food.

We talk to staff and review children and young people's written plans and records.

We interview residential staff about the way they work. We also talk with health and education staff based at the residence. We review individual care plans that staff make with children and young people and their whānau. These plans include information about children and young people's needs and goals as well as their preferences, strengths and risks. We check the details of any serious incidents that have recently taken place – for example, when a child or young person is restrained, or when they are placed in a secure unit. We review the conditions, reasons and length of time a young person is restrained or placed in a secure unit. We also check that residences have made the changes we recommended as the result of our previous visit.

We make recommendations to improve the quality of care for children and young people.

During our visits, we share what we've learned with children and young people and staff. We then write a more detailed report for Oranga Tamariki and the Minister for Children. This describes what we've found, using quotes from young people to illustrate the themes and insights that have emerged. We take care to ensure that nothing is included, in any of our reports, that identifies the young people we've talked to. We assess each residence and make recommendations for individual residences and Oranga Tamariki's national office to action.

Our reports include things residences are doing well and should keep on doing, as well as things they need to do differently. We also make recommendations about things they need to start doing. When our draft report is completed, we carry out a final check with Oranga Tamariki on the accuracy of the information on which our findings are based. We then seek Oranga Tamariki's agreement to our recommendations. Once our report is finalised, we meet regularly with senior managers at Oranga Tamariki, to the action they have taken.

Endnotes

1 See at and around paragraphs 51 and 52 of the Twelfth annual report of the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, CAT/C/66/2, available at https://tinyurl.com/rsxskrc.

2 The "Report of the Working Group" is available at: https://tinyurl.com/vsbey8h. The Report includes content and recommendations relating to detention, including recommendations about health services for people in prison (122.67 and 122.68).

3 Andreea Lachsz, *2018 Churchill Fellowship To Investigate Overseas Practices Of Monitoring Places Of Detention*, November 2019, publicly available on https://tinyurl.com/vxlkd2n, accessed 10 December 2019.

4 Oranga Tamariki data as at 30 June 2019.

5 See Appendix One at the end of the report for more information on the way OCC monitors.

6 In a social work context, supervision means the process by which a supervisor enables, guides and facilitates a social worker to meet organisational, professional and personal objectives: professional competence, accountable and safe practice, continuing professional development, education and support.

7 Groups of Māori (indigenous people of Aotearoa New Zealand) who have historical rights of ownership, control and sovereignty over particular areas.

8 Genealogy, places of significance, ancestors, events and stories.

9 Voice of Young and Care Experienced. This independent non-governmental organisation exists to amplify the voices of children in care and ensure that they are heard. VOYCE was codesigned by children with care experience for children with care experience.

10 Māori customs and practices.

11 Response from Corrections letter dated 18 June 2019.

12 This is 10 more than last year across both intellectual disability community facilities and locked mental health units.

13 There are currently six prison inspection criteria.

14 Tongariro Prison (51 percent), Otago Corrections Facility (9 percent), Auckland South Corrections Facility (ASCF 9 percent), and Invercargill Prison (7 percent).

15 ASCF (50 percent), Northland Region Corrections Facility (NRCF 71 percent), Tongariro Prison (60 percent).

16 ASCF (60 percent), NRCF (82 percent), Tongariro Prison (88 percent).

17 ASCF (16 percent), NRCF (6 percent), Tongariro Prison (6 percent).

18 The Department of Corrections requires that case managers meet with every new prisoner on their caseload within 10 working days of allocation.

19 Paihere is the term used to describe prisoners at Tongariro Prison. It means 'in search of something better' and was developed in conjunction with local iwi.

20 Three facilities were older persons' mental health units.

21 Te Whare Maiangiangi, Te Whare Oranga Tangata o Whakaue, and Te Whare Awhiora.

22 An open unit does not have the exit doors locked at all times. In contrast, a designated 'locked unit' is where 'the locked exit is a permanent aspect of service delivery.' *New* Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards. Ministry of Health. 2008.*

23 Formal patients are patients detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). Informal patients have agreed to be admitted to an inpatient unit, but are not subject to the MHA.

24 Te Whare Manaaki, Ward BG, Ward 9A, Ward 9B, Te Whare Awhiora, Gisborne Mental Health, Te Whare Maiangiangi, Ngā Rau Rākau, and Tauranga Hospital's Mental Health Services for Older People.

25 Ward 9B, Te Whare Oranga Tangata o Whakaue and Southland Hospital's Inpatient Mental Health Unit.

26 Mechanical restraint includes the use of chair restraints, lap belts, and Posey vests.

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, page 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.

32 https://www.occ.org.nz/our-work/monitoring/monitoring-work/how-we-monitor/.

33 https://www.occ.org.nz/assets/Uploads/OPCAT-Visits-D5-Web.pdf.

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