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He Ara Tika
A pathway forward

The scope and role of the Optional Protocol to the Convention against Torture (OPCAT) in relation to Aged care and disability residences and facilities

Michael J V White

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June 2016

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He aha te mea nui o tea o
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It is the people, it is the people, it is the people

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1. Introduction

The right to liberty and freedom of movement is a fundamental human right. However, it is not absolute. States can deprive people of their liberty through a variety of means where the reasons for deprivation of liberty are prescribed by law. Deprivation of liberty in a broad sense means the placement of a person in a setting which that person is not free to leave. Traditionally this has referred to situations in which people have been arrested, are in detention, imprisonment and psychiatric internment. However, there is growing recognition that there are other places, such as residences and facilities, where a person may effectively be deprived of their liberty.

These include locked aged care facilities, dementia units, compulsory care facilities, community-based homes and residences for disabled persons, and other situations where children and young people are placed under temporary State care. People held in these facilities are potentially vulnerable to ill-treatment that can remain largely invisible.

State obligations apply to these facilities under the International Covenant on Civil and Political Rights (ICCPR), the Convention against Torture and other Cruel, Inhuman or Degrading Treatment (CAT) and the Convention on the Rights of Persons with Disabilities (CRPD). These international instruments encourage States to limit the deprivation of liberty. They also acknowledge that people deprived of their liberty are vulnerable and particularly at risk of other human rights violations. Monitoring places where people are deprived of their liberty is an integral part of the measures that States must take to fulfil their international human rights obligations.

The Optional Protocol to the Convention against Torture (OPCAT) provides a unique and robust framework for preventive monitoring of places where people are deprived of their liberty, founded on the recognition that prevention is more effective than dealing with human rights abuses after the fact. However, since its inception, a number of issues relating to the scope of monitoring under the OPCAT have emerged.

In many countries a number of situations where people are deprived of their liberty are not currently monitored under OPCAT. Although these facilities may be subject to various types of general monitoring by different government agencies, such monitoring can lack rigorous preventative oversight from an OPCAT-specific perspective. OPCAT monitoring could complement and enhance existing systems of oversight and audit.

In light of growing concerns about the treatment of people residing in those facilities listed above, this report reviews the applicability of the OPCAT to those situations. In particular, it considers whether the scope of the OPCAT should be expanded in New Zealand to include the monitoring of aged care facilities and disability residences, places in which residents often have physical and mental vulnerabilities.

In New Zealand aged care and disability care services are provided by private providers, through contractual arrangements with government. Legislation governs the standards of care and facilities are subject to audit requirements. As such, the government has some regulatory control over the provision of care in these situations. Moreover, while some residents will be privately paying for their care, many will be receiving some form of government subsidy. On this basis those aged care and residential disability care providers who

provide services – in a manner in which individuals are, or may be, prevented from leaving at will – could be considered to fall within the ambit of the OPCAT. Whether specific facilities prevent (or can prevent) people from leaving at their will is something that will need to be considered on a case by case basis.

This report concludes by recommending that the Government:

1 As already recommended by the UN Sub Committee on the Prevention of Torture, commit without delay to meeting with National Preventive Mechanisms to discuss gaps in the OPCAT monitoring framework and to develop a plan, with relevant sector bodies and civil society, to address these gaps.

2 Designate a body under the Crimes of Torture Act to ensure that those aged care and disability residences where a person is or may be prevented from leaving at their will are monitored. In doing so the Government must ensure that that body is appropriately resourced.

3 Commit to working with the National Preventive Mechanisms to develop a framework for preventive monitoring of these facilities which is fit for purpose and complements the existing oversight mechanisms.

While this report focuses on the New Zealand situation, the principles and the analysis it undertakes will be a useful resource for other jurisdictions.

2. International law

It is well accepted that the prohibition on torture and other forms of ill-treatment is one of customary international law and a norm of *jus cogens*;[2] that is, it has the highest standing in customary law and is so fundamental that it supersedes all other treaties and customary laws.[3] As a consequence, all States are bound by international law not to subject anyone to torture, or cruel, inhuman or degrading treatment or punishment, regardless of whether a particular State is a party to a treaty expressly containing the prohibition.

As a norm of *jus cogens*, torture and other ill-treatment is subject to universal jurisdiction, meaning that any State can exercise its jurisdiction, regardless of where the act took place, the nationality of the perpetrator(s) or the nationality of the victim(s). However, there is no forum at the international level to which an individual can make a complaint based solely on a violation of customary international law.

Furthermore, holding a State to account is problematic. Although the International Court of Justice has the capacity to declare whether a violation of customary international law has occurred,[4] any sanctions will only be invoked where there is political will among other States to hold one another responsible.

For these reasons, despite the prohibition on torture and ill-treatment being a *jus cogens* norm, the extent of all States' obligations to prevent torture and ill-treatment is largely determined by international treaties and the bodies that interpret them.

In 1948, following the horrific abuses of World War II, the General Assembly of the United Nations inserted the prohibition against torture in the landmark Universal Declaration of Human Rights. Article 5 states:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

This ban on torture and other ill-treatment has subsequently been incorporated into the extensive network of international and regional human rights treaties, which are legally binding on those States that have ratified them.

Ratifying these treaties imposes obligations and duties on State Parties to guarantee the rights they contain domestically. It is now accepted that these duties can be divided into three general categories: the duties to respect, protect and fulfil.

- **The duty to respect** is the negative obligation. It requires State Parties to refrain from acting in a way that deprives people of the guaranteed right.
- **The duty to protect** relates to third parties. It requires State Parties to ensure that third parties do not deprive people of the guaranteed right.
- **The duty to fulfil** is the positive obligation. It requires State Parties to take steps and establish systems that provide access to the guaranteed right for all members of society.

Most treaties establish committees, which are mandated to monitor States' compliance with their obligations under the treaties. These committees are composed of independent experts and meet to consider State

Parties' reports as well as individual complaints or communications. They may also publish general comments on human rights topics related to the treaties they oversee.

Some committees may visit the territory of a State Party. The Committee against Torture and other Cruel,

Inhuman and Degrading Treatment, for example, may visit a country where there is a well-founded indication that torture is being systematically practiced.[5] Such visits can only made with the State's explicit consent and are rare.

Other special mechanisms can be established under the UN Human Rights Council to investigate, discuss, and report on specific human rights issues under a country mandate or thematic mandate. Relevant mechanisms currently include the UN Special Rapporteur on Torture and the UN Working Group on Arbitrary Detention.

In 2007 the Universal Periodic Review (UPR) mechanism was introduced by the UN Human Rights Council. The UPR is an examination of the human rights situation in all member States. It is based on the Charter of the United Nations, the Universal Declaration of Human Rights, Human Rights instruments to which the State is a party and other voluntary pledges and commitments made by States.

2.1 The International Covenant on Civil and Political Rights (ICCPR)

The 1966 International Covenant on Civil and Political Rights (ICCPR) was the first universal human rights treaty to expressly include a prohibition on torture and other cruel, inhuman or degrading treatment or punishment (thereafter referred to as ill-treatment). Article 7 of the ICCPR states:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

This is one of the few absolute rights in the ICCPR, with no restrictions permitted. It is also a non-derogable right, which means that states can never derogate from it, even in times of public emergency that threatens the life of the nation.[6] Other non-derogable rights include:

- right to life (Article 6)
- prohibition of medical or scientific experimentation without consent (Article 7)
- prohibition of slavery, slave trade and servitude (Article 8)
- recognition everywhere as a person before the law (Article 16)
- freedom of thought, conscience and religion (Article 18).

The aim of Article 7 of the ICCPR is to "protect the dignity and the physical and mental integrity of the individual."[7] The prohibition relates to acts that cause physical pain as well as acts that cause mental suffering.[8]

The UN Human Rights Committee (HRC)[9] interprets Article 7 broadly. In its General Comment on Article 7, it stated that it did not consider it necessary to establish sharp distinctions between torture and other forms of ill-treatment.[10] In the HRC's view the ill-treatment prohibition extended to chastisement or disciplining of children, and to individuals in educational and medical institutions, as well as arrested or imprisoned individuals.[11]

The HRC has further indicated that the assessment of whether particular treatment constitutes a violation of Article 7 "depends on all circumstances of the case, such as the duration and manner of the treatment, its physical or mental effects as well as the sex, age and state of health of the victim".[12] Elements such as the victim's age and mental health may aggravate the effect of certain treatment, therefore bringing it within the scope of Article 7.

Interestingly, unlike the Convention against Torture and other Cruel Inhuman or Degrading Treatment (CAT) discussed below, there is no requirement in the ICCPR for a level of involvement or knowledge of a State official. The HRC has confirmed that:[13]

It is the duty of the State Party to afford everyone protection through legislative and other measures as be necessary against the acts prohibited by Article 7, whether inflicted by people acting in their official capacity, outside their official capacity or in a private capacity.

Article 7 of the ICCPR is complemented by the positive requirements of Article 10, paragraph 1 of the Covenant, which stipulates that:

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

The HRC has interpreted Article 10 to mean that detainees may not be "subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons".[14] Therefore Article 10 imposes a lower threshold of severity than Article 7; in other words it covers treatment that may not be sufficiently severe to qualify as cruel, inhuman or degrading.

The HRC has stated that Article 10, paragraph 1 "imposes on State parties a positive obligation towards persons who are particularly vulnerable because of their status as vulnerable persons deprived of their liberty".[15]

2.2 Convention against Torture and other Cruel Inhuman or Degrading Treatment (CAT)

The Convention against Torture and other Cruel Inhuman or Degrading Treatment (CAT) was adopted by the UN in 1984 and came into force three years later.

Unlike the ICCPR, the CAT does not contain any provision providing for a human right to personal dignity or to be free from torture, cruel, inhuman or degrading treatment. However, by making reference to Article 7 of the ICCPR, it has been suggested that the CAT "presupposes the existence of this human right and, in 'desiring to make more effective the struggle against torture' and cruel, inhuman or degrading treatment, creates a number of specific additional State obligations aimed at preventing and punishing torture and cruel, inhuman or degrading treatment".[16]

Article 1 of the CAT provides a definition of torture:

For the purposes of this Convention, the term 'torture' means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

The CAT makes a distinction between torture on the one hand, and ill-treatment on the other. Article 2(1) requires State Parties to take effective legislative, administrative, judicial and other measures to prevent torture in any territory under their jurisdiction. Article 16 creates a corresponding duty on State Parties to prevent ill-treatment.

Both torture and ill-treatment under the CAT require the involvement of a public official or someone acting in an official capacity or the acquiescence of such a person. However, the CAT does not further provide a definition of acts of cruel, inhuman or degrading treatment and the definitional threshold between cruel inhuman and degrading treatment and torture can be unclear.

In 2005 a UN Special Rapporteur on Torture took the position that:[17]

A thorough analysis of the travaux preparatories[18] of articles 1 and 16 of [UNCAT] as well as a systematic interpretation of both provisions in light of the practice of the Committee against Torture leads one to conclude that the decisive criteria for distinguishing torture from [cruel, inhuman or degrading treatment] may best be understood to be the purpose of the conduct and the powerlessness of the victim rather than the intensity of the pain or suffering inflicted.

If this interpretation is followed, while torture is absolutely prohibited, the circumstances in which other forms of treatment are perpetrated will determine whether they qualify as ill-treatment. Accordingly, Nowak and McArthur consider that if force is used legally and for a lawful purpose, and the force applied is not excessive and is necessary to

meet the purpose, then it will generally not qualify as cruel, inhuman or degrading treatment. However, in circumstances where someone is deprived of their liberty no such test of proportionality applies. In their opinion, any form of physical or mental pressure or coercion in such a case constitutes at least ill-treatment.[19]

2.3 The Convention on the Rights of Persons with Disabilities (CRPD)

The most important argument for a convention [on the rights of persons with disabilities] is perhaps that of 'visibility'....The thrust of the visibility argument is that a sustained focus on the rights of persons with disabilities is needed to ensure consistent treatment of their rights.[20]

The protection of the rights of people with disabilities has been significantly influenced by the adoption in 2008 of the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD adopts a social model of disability and defines disability as including "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".

Article 15 of the CRPD reflects the ICCPR in prohibiting torture and ill-treatment. It adds however, that States must take action to protect persons with disabilities "on an equal basis with others".

The CRPD does not create any new rights. It does however, provide guidance on what the prohibition on torture and ill-treatment means and, as described below, can be a powerful instrument in interpreting a State's obligations. One area of particular importance in this regard relates to involuntary or coercive treatment. The CRPD clarifies what constitutes improper coercion. "[R]espect for inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons"[21] is at the core of the CRPD. Accordingly, in the health care context, care must be provided on the basis of free and informed consent.[22] The existence of a disability cannot be used to deny this right.

Article 12 of the CRPD provides special protections to ensure that people with disabilities enjoy legal capacity, including the right to make legal decisions. The CRPD requires States to provide disabled people with access to support to exercise their legal capacity. A corollary of this is that a failure to do so – in other words adopting a substituted decision-making process – removes a disabled person's autonomy which can, in some circumstances, amount to a deprivation of their liberty.

In its General Comment 1 the CRPD Committee states:[23]

Respecting the right to legal capacity of persons with disabilities on an equal basis with others includes respecting the right of persons with disabilities to liberty and security of the person. The denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, is an ongoing problem. This practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention. States parties must refrain from such practices and establish a mechanism to review cases whereby persons with disabilities have been placed in a residential setting without their specific consent.

The Committee has also developed guidelines on interpreting Article 14, in which it states:[24]

Involuntary commitment of persons with disabilities on health care grounds contradicts the absolute ban on deprivation of liberty on the basis of impairments (article 14(1)(b)) and the principle of free and informed consent of the person concerned for health care (article 25). The Committee has repeatedly stated that States parties should repeal provisions which allow for involuntary commitment of persons with disabilities in mental health institutions based on actual or perceived impairments. Involuntary commitment in mental health facilities carries with it the denial of the personís legal capacity to decide about care, treatment, and admission to a hospital or institution, and therefore violates article 12 in conjunction with article 14.

The Committee makes similar comments in relation to persons with disabilities who are deprived of their liberty on the basis of care needs. In relation to monitoring, the Committee considers:[25]

Article 16(3) of the Convention explicitly requires monitoring of all facilities and programmes that serve persons with disabilities in order to prevent all forms of exploitation, violence and abuse...

2.4 Other relevant standards

In addition to international human rights law, a considerable range of other rules and standards have been developed to safeguard the right of all people to protection against torture and other forms of ill-treatment. Although not of themselves legally binding, they represent agreed principles which should be adhered to by all States and can provide important guidance for judges and prosecutors. These include:

- Standard Minimum Rules for the Treatment of Prisoners (1957 as amended in 2015); Nelson Mandela Rules
- Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1975)
- Code of Conduct for Law Enforcement Officials (1979)
- Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1982)
- Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power (1985)
- Basic Principles on the Independence of the Judiciary (1985)
- Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules) (1987)
- Body of Principles for the Protection of all Persons under any Form of Detention or Imprisonment (1988)
- Basic Principles for the Treatment of Prisoners (1990)
- Basic Principles on the Role of Lawyers (1990)
- Guidelines on the Role of Prosecutors (1990)
- Rules for the Protection of Juveniles Deprived of their Liberty (1990)
- Principles on the Effective Prevention and Investigation of Extra-legal, Arbitrary and Summary Executions (1990)
- Basic Principles on the Use of Force and Firearms by Law Enforcement Officials (1990)
- Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)
- Declaration on the Protection of All Persons from Enforced Disappearance (1992)
- Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Istanbul Protocol) (1999).

2.5 What duties are placed on States Parties?

The ICCPR and the CAT place six broad duties on States parties:

- a duty to protect/prevent from torture or ill-treatment
- a duty to investigate
- a duty to enact and enforce legislation criminalising torture
- a duty to exclude statements obtained by torture or ill-treatment
- a duty to grant redress and compensation
- a duty to train personnel and provide procedural safeguards.

For the purposes of this report it is useful to consider the scope of two specific duties, namely the duty to protect/prevent, and the duty to train personnel and provide procedural safeguards.

2.5.1 A duty to protect/prevent torture of ill-treatment

The HRC has made it clear that the prohibition in the ICCPR applies regardless of whether the acts were committed by public officials, other person acting on behalf of the State, or private persons.[26] The prohibition also applies to acts where the State was encouraging, ordering, perpetrating or tolerating them.[27]

It is the duty of the State Party to afford everyone protection through legislative and other measures as be necessary against the acts prohibited by Article 7… [28]

The HRC has stated that Article 10, paragraph 1 "imposes on State parties a positive obligation towards persons who are particularly vulnerable because of their status as vulnerable persons deprived of their liberty". [29]

The HRC considers that States must implement a system of impartial supervision of places where people are deprived of their liberty.[30] Although there is little specific guidance on what this monitoring framework should look like, some insight can be gleaned from the Committee's Concluding Observations. For example, in its 2004 Concluding Observations on Namibia, it found that, while magistrates were mandated to carry out independent inspections of detention centres, there was a need to establish:[31]

an additional external and independent body entrusted with the functions of visiting the centres and receiving and investigating complaints emanating from such centres... A strong and independent mechanism is also required for the investigation of allegations of acts of police brutality in general

Furthermore, in *Alzery v Sweden,* the HRC concluded that private access to the detainee and inclusion of appropriate forensic and medical expertise was required.[32]

The CAT applies when the pain or suffering be inflicted at the instigation, or with the consent or acquiescence, of a public official or other person acting in an official capacity. This means that generally speaking States Parties are not responsible for acts beyond their control. States Parties can, however, be responsible for acts of torture and ill-treatment inflicted by private individuals if they fail to respond adequately to them, or fail to take measures to prevent them.

While the CAT is interpreted to include an obligation to respect the right not to be subjected to torture or other cruel, inhuman or degrading treatment, the main emphasis is on the obligation to *fulfil*. This means that States must enact laws, provide an effective remedy, procedural guarantees, and establish relevant legal institutions and other measures that will ensure that people can live free of torture and other cruel treatment. Arguably the best way to achieve this is to take preventive measures.

In its Concluding Observations, the CAT Committee includes a recommendation that States "establish a systematic and independent system" to monitor the treatment of those deprived of their liberty, encouraging both preventive monitoring and a framework for *ex post facto* review.

It is clear that the duty on States to establish an independent body mandated to monitor places where people are deprived of their liberty arises under both the ICCPR and the CAT.

The ratification of the OPCAT and the creation of independent national bodies to carry out unannounced visits to all places where people are deprived of their liberty is an effective measure to prevent torture and cruel inhuman and degrading treatment. If implemented well, such a mechanism goes a significant way toward fulfilling a State's obligations under CAT, the ICCPR and the CRPD. The OPCAT is discussed in more detail in the following section.

2.5.2 A duty to train personnel and provide procedural safeguards

People deprived of their liberty are vulnerable and more at risk of finding themselves in situations where torture and ill-treatment can more readily occur. Both the CAT Committee and the HRC interpret their treaties to include a specific duty to introduce and monitor compliance with procedural safeguards, and to train staff that may, in a professional capacity, have contact with those deprived of their liberty.

In its General Comment on Article 7 the HRC has recognised the importance of training, stating:[33]

Enforcement personnel, medical personnel, police officers and any other persons involved in the custody or treatment of any individual subjected to any form of arrest, detention or imprisonment must receive appropriate instruction and training.

The Committee further considers that the prohibition on ill-treatment must be incorporated into operational rules and ethical standards.[34]

In relation to procedural safeguards, the HRC has clearly set out its expectations in General Comment on Article 10 where it invites State Parties:[35]

To indicate in their reports to what extent they are applying the relevant United Nations standards applicable to the treatment of prisoners: the Standard Minimum Rules for the Treatment of Prisoners (1957), the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988), the Code of Conduct for Law Enforcement Officials (1978) and the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1982)

These rules require measures to be taken such as:

- ensuring detailed registers are kept
- ensuring legal advice and medical care is available
- ensuring that force may only be used when strictly necessary and only to the extent required
- ensuring adequate access to the outside world.

The impartial monitoring frameworks mentioned above are also relevant to expectations that State Parties train personnel and provide procedural safeguards. Such monitoring frameworks can help ensure training is appropriately undertaken and that procedures comply with the United Nations standards relating to treatment of persons deprived of their liberty.

3. The OPCAT

Linked to the strength of the prohibition of ill-treatment at international law is a corresponding commitment from States and the international community to adopt innovative means of addressing torture and other ill-treatment through prevention.

The OPCAT is an international human rights treaty designed to strengthen the protection of people deprived of their liberty. Its adoption by the United Nations General Assembly in 2002 reflected a consensus among the international community that people deprived of their liberty are particularly vulnerable to ill-treatment, and that efforts to combat such ill-treatment should focus on prevention. OPCAT embodies the idea that prevention of ill-treatment in places where people are deprived of their liberty can best be achieved by a system of independent, regular visits that monitor conditions and treatment.

OPCAT came into force in 2006, signalling a paradigm shift in the ways in which incidences of torture and ill-treatment are best dealt. The OPCAT does not set out additional standards or create new rights, but assists States to implement their existing obligations at international law – to prevent torture and ill-treatment in places where people are deprived of their liberty.

The OPCAT is premised on the principle that prevention is more effective than dealing with problems after the fact. The Association for the Prevention of Torture (APT) highlights 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".[36] The Subcommittee on the Prevention of Torture (SPT) notes that:[37]

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, 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.

The SPT has outlined the preventive approach as follow, stressing the broad nature of the concept:[38]

In this sense, the prevention of torture and ill-treatment embraces – or should embrace – as many as possible of those things which in a given situation can contribute towards the lessening of the likelihood or risk of torture or ill-treatment occurring. Such an approach requires not only that there be compliance with relevant international obligations and standards in both form and substance but that attention also be paid to the whole range of other factors relevant to the experience and treatment of persons deprived of their liberty and which by their very nature will be context specific.

It features a twin pillar approach to the prevention of ill-treatment, based on the establishment of regular independent visits to places where people are deprived of their liberty by international and national bodies. These bodies work together to establish effective measures to prevent ill-treatment and to improve conditions.

The preventive approach of the OPCAT encompasses

direct prevention (identifying, and mitigating or eliminating risk before violations can occur) and indirect prevention (the deterrence that can be achieved through regular external scrutiny of what are, by nature, closed environments).

States that ratify the OPCAT are required to designate a 'national preventive mechanism' (NPM). This is a body or group of bodies that regularly examine the treatment of detainees, make recommendations, and comment on existing or draft legislation with the aim of improving treatment and conditions in detention.

In order to carry out its monitoring role effectively, the NPM must:

- be independent of government and the institutions it monitors
- be sufficiently resourced to perform its role
- have personnel with the necessary expertise and who are sufficiently diverse to represent the community in which it operates.
- Additionally, the NPM must have the power to:
- access all places of detention (including those operated by private providers)
- conduct interviews in private with detainees and other relevant people
- choose which places it wants to visit and who it wishes to interview
- access information about the number of people deprived of their liberty, the number of places of detention and their location
- access information about the treatment and conditions of detainees.

The NPM must also liaise with the SPT, an international body established by the OPCAT with both operational functions (visiting places of detention in States parties and making recommendations regarding the protection of detainees from ill-treatment) and advisory functions (providing assistance and training to States parties and NPMs). The SPT is made up of 25 independent and impartial experts from around the world, and publishes an annual report on its activities.

The UN Special Rapporteur on Torture when commenting on the OPCAT stated:[39]

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.

3.1 Relationship between OPCAT and other international instruments

3.1.1 International Covenant on Civil and Political Rights

The UN Human Rights Committee, has welcomed the ratification of OPCAT[40] and has noted that it provides a better platform for compliance with Article 7 of the ICCPR[41] which states:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Article 10 of the ICCPR which requires States to ensure humane conditions of detention is also relevant.

3.1.2 Convention against Torture and other Cruel, Inhuman or Degrading Treatment

All States Parties to the OPCAT will also be party to the CAT. The aim of the OPCAT is to establish a mechanism to assist States in fulfilling their obligation to prevent torture and other forms of ill-treatment under Article 2(1) and 16(1) of the CAT.[42]

The CAT Committee in its General Comment on the implementation of Article 2 noted that the measures that States can adopt to prevent torture and other types of ill-treatment include the establishment of "impartial mechanisms for inspecting and visiting places of detention and confinement".[43]

Many States ratify the OPCAT for this very reason; that it is "definitely one of the ways of making [the CAT] more effective."[44]

3.1.3 Convention on the Rights of Persons with Disabilities

As noted above the CRPD Committee considers that:[45]

… Article 16(3) of the Convention explicitly requires monitoring of all facilities and programmes that serve persons with disabilities in order to prevent all forms of exploitation, violence and abuse …

The OPCAT provides a framework for States Parties to fulfil their obligation under Article 16(3) of the CRPD.

3.2 Benefits of the OPCAT Framework

As described above, the obvious benefit of the OPCAT framework is that it is a mechanism to fulfil a State's obligations under other international instruments, but there are wider benefits. Independent visits not only have a deterrent effect but they enable monitors to identify inadequate systems, many of which can be improved through the regular monitoring. It also provides an opportunity to build ongoing and sustainable working relations with the relevant authorities.

The system of periodic and follow-up visits required by the OPCAT recognises that protecting the human rights of persons deprived of their liberty requires a comprehensive system of inspection and investigation in addition *to* a complaints-based system. This is the case for two key reasons:

- Complaints-based systems are, typically, reactive and ill-adapted to identifying and responding to systemic human rights issues
- In many situations of detention, there is a significant power imbalance between the detaining authority and detainees. As a result, detainees who have been the subject of ill-treatment may be reluctant to make complaints about their treatment. This is particularly the case where there is no independent body to which such complaints may be made.
- There are a number of other factors that can render complaints processes inaccessible and ineffective to disabled people. Many of these factors are inherent to impairment, including:
- Inability to personally give voice to a complaint (e.g. by those who are non-verbal)
- Perception that understanding of what has happened is limited (e.g. those with intellectual/learning disabilities)
- Perception that the testimony of people with unstable moods is questionable (e.g. those with mental illness)
- The details of incidence can be quickly forgotten (e.g. those with dementia)
- Reliance on staff for personal care.

Often domestic monitoring frameworks and mechanisms lack independence, as agencies often monitor themselves. Furthermore, findings are often not published by these bodies. The system of investigation and inspection required by OPCAT complements existing mechanisms and enhances the important standards of independence, transparency and accountability.

The purpose of OPCAT is to prevent ill-treatment where and when it is most likely. Older people and disabled people are particularly vulnerable.

4. Defining Deprivation of Liberty – Scope of international obligations for States

Beyond traditional detention facilities there are many people in different settings who potentially are or are at risk of being "deprived of their liberty" by virtue of the type of care or treatment that they are receiving, or restrictive practices to which they are subjected. This leads to the question, what constitutes a deprivation of liberty at international human rights law?

The HRC has confirmed that persons deprived of their liberty in Article 10(1) of the ICCPR includes:[46]

Anyone deprived of liberty under the laws and authority of the State who is held in prisons, hospitals – particularly psychiatric hospitals – detention camps or correctional institutions, or elsewhere. States parties should ensure that the principle stipulated therein is observed in all institutions and establishments within their jurisdiction where persons are being held.

Lines can become blurred however, when considering deprivation of liberty on an involuntary basis in the health or care sector. The Human Rights Committee addressed the question of the deprivation of liberty in the context of mental health problems in the case of *A. v. New Zealand*.[47]

The case concerned the detention of A. for nine years on the grounds that he was paranoid and a danger to himself and others. The HRC took note that: a careful and lengthy psychiatric examination was carried out by three specialists; A. had the opportunity to challenge his placement before several courts; and detention was in compliance with national legislation.

In the HRC's view, therefore, "the deprivation of [A's] liberty was neither unlawful nor arbitrary and thus not in violation of Article 9, paragraph 1, of the Covenant". In addition, A's detention was regularly reviewed, which meant no violation of Article 9 (4) could be established either.

The CRPD does not refer explicitly to involuntary placement. Article 14(1) reiterates the formulation of the right to liberty and security of the person and clearly states that the deprivation of liberty based on the existence of a disability would be contrary to the CRPD and discriminatory. The Office of the High Commissioner for Human Rights suggests the following interpretation of Article 14:[48]

[Article 14] should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis.

4.1 The United Kingdom Approach

In the recent case of *P v Cheshire West and Chester Council*[49] *(Cheshire West)* the United Kingdom Supreme Court considered whether living arrangements for mentally incapacitated people necessarily constitute a deprivation of their liberty. While this case focuses on a particular situation – those who are mentally incapacitated – it provides guidance on the approach to be taken when considering whether a particular situation constitutes a deprivation of liberty. It is also a significant decision because it confirms that where a deprivation of liberty is found, safeguards must be put in place.

Chesire West related to three individuals who had Down syndrome and learning disabilities. Two of them lived in disability residences and one in a foster home. Although these environments were considered to be as close to "normal life" as possible in the circumstances, all three were closely controlled and supervised. Two of the individuals were occasionally subjected to the use of restraints for their own safety, and none of them could leave at will (although two of them did attend college every day).

The majority of the Supreme Court concluded that these living arrangements constituted a deprivation of liberty.

"A gilded cage is still a cage"

– Baroness Hale

In the leading judgment, Baroness Hale set out the main features of a deprivation of liberty:

- the objective extent of the individual's liberty
- the subjective extent of the individual's liberty
- the "concrete situation".

Lady Hale's starting point was the universality of human rights. As she put it "the first and most fundamental question is whether the concept of physical liberty protected by Article 5 is the same for everyone, regardless of whether or not they are mentally or physically disabled".[50] On this point Lady Hale held that it was:[51]

[.] axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as that for everyone else. This flows inexorably from the universal character of human rights, founded on the inherent dignity of all human beings, and is confirmed in the United Nations Convention on the Rights of Persons with Disabilities. Far from disability entitling the State to deny such people human rights: rather it places upon the State (and upon others) the duty to make reasonable accommodation to cater for the special needs of those with disabilities.

Those rights include the right to physical liberty, which is guaranteed by article 5 of the European Convention. This is not a right to do or to go where one pleases. It is a more focused right, not to be deprived of that physical liberty. But, as it seems to me, what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage.

Following Lady Hale's rationale, whether or not restrictions are required – or in some cases are arguably in the best interests of an individual – it still amount to a deprivation of liberty if those individuals are required to live in a certain place, unable to leave at will and subject to constant monitoring and control.

4.2 The OPCAT

Article 4 of the OPCAT states:

1 *Each State party shall allow visits … by the mechanisms referred to in Articles 2 and 3 to any place under its jurisdiction and control* ***where persons are or may be deprived of their liberty****, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (hereinafter referred to as places of detention) …*

2 *For the purposes of the present Protocol, deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial administrative or other authority.*

*Emphasis added

Article 4 does not provide a list of places that should be subject to visits. During the drafting of the Protocol many delegations pointed out that "deprivation of liberty" was commonly used in the human rights arena and that "detained" could be a too narrow definition.[52] Article 4(1) as finally drafted suggests that the OPCAT extends to detention by non-State actors but only if the State is aware of this and does not prevent it. Nowak and McArthur therefore believe that the OPCAT could cover private hospitals and care homes.[53]

Article 4(2) expands the coverage of the OPCAT to places that persons are not permitted to leave at will by order of a public authority.

Antenor Hallo de Wolf opines that there are therefore three key criteria for considering whether or not a particular place can be regarded as a place of detention that needs to be visited under OPCAT:[54]

a Whether the place falls under the jurisdiction and control of the State Party

b Whether the place deprives persons of their liberty

c Whether the deprivation of liberty is linked to a decision, act, or the conduct of a public authority.

The second aspect suggested by de Wolf concerns whether or not a particular place actually deprives someone of their liberty. The European Court of Human Rights has given this concept some consideration. The Court considers that in determining whether someone is deprived of their liberty requires a careful consideration of "a range of criteria such as the type, duration, effects, and manner of implementation of the measure in question".[55]

Guidance can also be gleaned from the Inter-American Commission on Human Rights. Its Principles and Best practices on the Protection of Persons Deprived of Liberty define deprivation of liberty as:[56]

Any form of detention, imprisonment, institutionalization, or custody of a person in a public or private institution which that person is not permitted to leave at will, by order of or under de facto control of a judicial, administrative or other authority, for reasons of humanitarian assistance, treatment, guardianship, protection, or because of crimes or legal offenses.

The final criteria suggested by de Wolf – whether the deprivation of liberty is linked to a decision, act, or the conduct of a public authority – is more nuanced. The OPCAT requires that the deprivation of liberty is based on a public order, or with the State's acquiescence or consent. For traditional places of detention this poses little issue. However, it is more problematic for "non-traditional places of detention" where people may be held on a "voluntary" basis, or with their family's consent, without any official or public intervention.

The SPT has also grappled with this issue and has stated in relation to Article 4:[57]

Article 4 contains two sub paragraphs which need to read consistently together and which places within the scope of the OPCAT any public or private custodial setting under the jurisdiction and control of the State party, where persons may be deprived of their liberty and are not permitted to leave, either by an order given by any judicial, administrative or other authority or at its instigation or with its consent or acquiescence.

It is inevitable that there will be a degree of opaqueness about the precise parameters of the definition when translated into operational practice. However, the preventive approach which underpins the OPCAT means that as expansive an interpretation as possible should be taken in order to maximise the preventive impact of the work of the NPM.

The SPT therefore takes the view that any place in which a person is deprived of liberty (in the sense of not being free to leave), ***or where it considers that a person might be being deprived of their liberty, should fall within the scope of its visiting mandate*** *– and, in consequence, under the visiting mandate of an NPM –* ***if it relates to a situation in which the State either exercises, or might be expected to exercise a regulatory function.****

As a tool of prevention, the NPM ought therefore to be able to access as broad a range of potential places of deprivation of liberty as possible in order to determine whether the State ought to be exercising such a regulatory function, as well as to examine the manner

in which existing detention powers and regulatory functions are being exercised. In so doing, the NPM ought to be mindful of the principle of proportionality when determining its priorities and the focus of its work.

*Emphasis added

Drawing on the SPT's conclusion, any place where people may not be free to leave is subject to the regulation or oversight of the State – or should be the subject of the State's regulatory functions – and could potentially fall within the scope of Article 4. This would include facilities and residences which are subject to national standards, rules or guidelines administered by the State.

The approach taken by the SPT appears to differ from that advanced by de Wolf which expressly requires the deprivation of liberty to be linked to a public act, decision or the conduct of a public authority. However, the SPT appears to be incorporating that part of the deWolf test in its requirement that the situation in which a person is deprived of their liberty is one where the State exercises or should exercise regulatory functions. In other words, the conduct of regulating – or the fact that the State should be regulating – creates the necessary link between the public authority and the place of deprivation of liberty. In line with Article 4(2) of the OPCAT, the SPT's approach and the test set out by *de Wolf* acknowledges that the deprivation of liberty does not always have to be based on an order by a public authority as long as there is consent or acquiescence by the State.

It should be noted that just because a facility fits within the visiting mandate of OPCAT, this does not mean that it should necessarily be subject to its preventive monitoring framework. This is a matter that needs to be determined by giving due consideration to the existing legal and regulatory environment and country specific circumstances. As the SPT notes above, while an NPM should have access to as broad a range of potential places of deprivation of liberty as possible, the NPM must determine its priorities and focus of its work.

5. Risk of ill-treatment in aged care facilities and community based disability residences

The risk of abuse of power by people in positions of authority is an unfortunate part of society. This risk significantly increases in closed environments – in institutions or facilities where people are not free to leave of their own will.

Many people are vulnerable before they are deprived of their liberty.

Placing someone in a place in which they are deprived of their liberty inevitably puts that person in a vulnerable situation, one in which they are reliant on others for their basic needs and in some cases, dependent on others for decisions about their care, wellbeing and safety. Many people who end up in these situations, however, are vulnerable even before they lose their liberty. For example, people with disabilities and older people.

5.1 Aged care facilities

A test of a people is how it behaves toward the old. It is easy to love children. Even tyrants and dictators make a point of being fond of children. But the affection and care for the old, the incurable, the helpless are the true gold mines of a culture.

– Abraham J Heschel

New Zealand has a higher proportion of people in residential care than most other countries. While the use of institutional care is decreasing in most OECD countries, it is still common in New Zealand.[58] There are currently 691 aged care facilities contracted by District Health Boards (DHBs) in New Zealand.

For a number of years there has been growing concern about the quality of aged care, and there have been several publicised incidents of abuse by staff in residential care settings. In 2008, for instance, *The New Zealand Herald* reported 21 cases of elder abuse in care facilities.[59]

The Health and Disability Commissioner (HDC) has also highlighted shocking cases of abuse and neglect. In 2015 the HDC released a report that highlighted the distressing abuse of an elderly woman by a healthcare assistant that left the former unable to walk.[60] The woman was residing in a facility that provides residential care for older people and in 2013, suffering from worsening dementia, she was admitted to the facility's dementia unit where she remained for nine days. The HDC found that on the sixth evening a healthcare assistant slapped the woman's upper arms and thighs, causing bruising. While the abuse was observed by another healthcare assistant, the incident was not reported until the following morning, and did not include details such as the complaint that the bruising was caused by a staff member. The morning following the incident the woman was unable to walk.

This is by no means an isolated incident. In the year to 2015 the HDC received 104 complaints relating to aged care. This is an improvement from 2010 where some 342 complaints were received, however, the categories of complaints in 2015 remain very similar to those identified by the Acting Health and Disability Commissioner in 2010.[61]

Issues essentially fall into the following categories: lack of appropriate knowledge and experience in specialist areas such as dementia care, communication (particularly with families and legal representatives (enduring powers of attorney), wound care, falls (and fractures), nutrition and fluid management, medication, end-of-life-care, and a lack of coordination of care. Concerns that there has been a failure to seek medical assessment soon enough, or that injuries have been missed, are also common.

If residents received as much care as prisoners, they would receive daily showers, warm dry rooms, television, free medical and dental care, computers, good food and high staff ratio and all that would be required in addition would be the opportunity to be free to go outside the facility at will. This should not be too much to ask for those who have helped to develop this country and have also fought overseas for our freedom. It would appear that prisoners are more highly thought of than the older citizens.

– Grey Power New Zealand

However, despite the increased media attention to abuse in aged care, neglect is less visible.

New Zealand's population is ageing. The number of people aged 65+ doubled between 1980 and 2012,[62] and is likely to double again by 2036, reaching between 1,440,000 and 1,660,000 by 2061.[63] It is imperative to ensure that the aged care system provides adequate protection for the health and well-being of this ageing population and to ensure the prevention of abuse and ill-treatment.

There are 138 locked aged care facilities in New Zealand. In addition, approximately 70% of people living in non-secure aged care facilities are experiencing dementia.[64] This group may be inadvertently or deliberately deprived of their liberty. Of the 32,000 residents currently in aged care, about 49% are at rest home level, 38% at hospital level and 13% in dementia/psychogeriatric beds.[65]

The people cared for in secure facilities are highly vulnerable – they have moderate to severe dementia and it has been determined that they need a high level of care. The Northern Region Dementia Working Group (NRWG) notes that typical cognitive problems leading to the need for secure care include disorientation and impaired ability to safely navigate the community.[66] This group also often has complex additional care needs including with showering, dressing and eating.[67] However, despite cognitive impairments people cared for in secure dementia care are almost all independently mobile.

One issue which creates added complexities to the care situation for this group is the fact that socially unacceptable behaviours such as physical or verbal aggression, disrobing, incontinence and sexual behaviours manifest themselves in the progression of dementia. Dealing with these behaviours is often difficult and if not managed properly can create an environment conducive to abuse and ill-treatment.

The NRWG notes that although "the use of formal seclusion seems to be rare in secure dementia units, there is potential for less formal 'isolation' of people who display behaviours which cause distress to other residents".[68] The NWRG raised particular concerns about the proliferation of secure dementia facilities with inadequate access to the outdoors, excluding residents from opportunities for exercise and recreation. This can be contrasted with the position in the criminal justice system where, in the case of *Reekie v Attorney General*[69], it was found that denying a prisoner the right to recreation time and the opportunity to take physical exercise outside the cell was not humane treatment consistent with human dignity.

Despite the use of seclusion in dementia units being rare, less formal isolation of people who display behaviours which cause distress to other residents does occur. Hands-on restraint can also occur when residents are helped to shower and dress.

Due to the high care needs of residents there are situations where practices aimed at facilitating efficiency inadvertently deprive residents of autonomy and liberty. The Commission has heard of situations where older people were placed in a chair with a tray in front of them. They were unable to move this unaided and were left there for many hours.

Design features can also significantly impact on

residences liberty and other human rights. The NWRG states:[70]

The proliferation of multi-storey accommodation reflects economic drivers in all types of housing, not solely aged care. However for most people living in multi-storey dwellings they have the opportunity to leave and interact with the wider world, and obtain exercise.

This may not be the case for older people, particularly those suffering from dementia who may not be able to independently navigate elevators or stairs. The NWRG comments that the alternative, of staff taking people outside from an upper storey, is not a practical option. Staffing levels don't allow for staff to take residents outdoors on request, and people with moderate or severe dementia will struggle to remember scheduled walking times.[71]

Their lived experience will be of being locked within a building with no exit.

In other cases the physical design features of such places, such as coded locks, heavy doors and the location of exits can prove problematic for those suffering from even mild dementia, resulting in them effectively living in a locked/closed environment.

Many older people in such environments are reluctant to complain for a variety of reasons including fear of being penalised, cultural differences and in some cases being disempowered by the care environment itself.

The elderly of Mum's generation have always been brought up with a reluctance to complain or speak up. They were taught not to question ēauthorityí and experience genuine fear of repercussions surrounding the quality of care they receive, should they complain.

. . .

I found my mother, who suffered from dementia, sitting naked in a lazy-boy chair. I was afraid to complain about this because I feared she would be victimised.

– Submissions to investigation into the quality of New Zealand's rest homes and home support services (2010).[72]

Despite many improvements in the quality of care over recent years, residents in aged care facilities remain vulnerable and can be at risk of abuse and ill-treatment. The inherent power imbalance in such a care environment may mean that residents (and their families) are reluctant to voice their concerns and raise complaints.

The United Nations Working Group on Arbitrary Detention noted, following its visit to New Zealand, that:[73]

. . . despite the increasing phenomenon of older people staying in residential care, there is very little protection available to ensure that they are not arbitrarily deprived of their liberty.

The Working Group recommended that the Government develop a comprehensive human rights-based legal framework to govern the provision of services to older persons.[74]

The NRWG has also suggested that the current model of aged care operates on the assumption that a person moving into care is an informed consumer or that the person has an agent who can make decisions on their behalf. This can prove problematic when considered in context, as people with dementia commonly lack the ability to make decisions about many aspects of their care. The process of appointing a guardian, either through an enduring power of attorney or a court order, is complicated and is often dogged by delays and confusion around who is responsible for the process.

The NRWG suggests that this framework is in stark contrast to those deprived of their liberty in other settings which are mandated by robust legal process and timely access to legal support and appeal. The use of such substituted decision making without robust safeguards can expose those concerned to additional risk of abuse, neglect or mistreatment.

Furthermore, anecdotal evidence suggests that in some situations agents can themselves fail to act in the best interests of the older person. This can result in disenfranchisement and, in extreme cases, physical and emotional abuse.

5.2 Disability residences

Throughout the world, people with disabilities are subject to mistreatment in psychiatric hospitals, orphanages, nursing homes, and other institutions. Much of this abuse is a product of neglect and lack of care. In other cases, however, pain and suffering can be a consequence of treatment practices.

Recently there have been numerous publicised events highlighting the vulnerability of those in disability residences. For example, in 2015 the Irish Health Information and Quality Authority (Hiqa) sent a report to the Irish Government outlining what it had observed in its inspections of disability services run or funded by the Health Service Executive.[75] In this report Hiqa stated it was seriously concerned about standards in disability services and that human rights were being denied in certain services where a "strong culture of neglectful care exists".[76] Hiqa further explicitly noted that its inspectors witnessed what could be viewed as "inhuman or degrading treatment".[77]

Similar concerns have been raised in New Zealand. A 2013 study by Tairawhiti Community Voice (2013 report) highlighted the hidden nature of much abuse directed against disabled people within the community.[78] A particular concern related to people in home-care/live-in support situations. In these situations people may have limited ability to verbalise or communicate what is happening to them, or may be reliant on the abuser for day-to-day support and assistance. Over recent years there has also been a marked increase in the use of compulsory community treatment orders in mental health settings.

In April 2014, the CRPD Committee identified the detention of persons with disabilities whose legal capacity has been denied in institutions against their will (either without their consent or with the consent of a substitute decision-maker) as vulnerable to ill-treatment. In particular the Committee highlighted the use of seclusion and restraint and unconsented medical treatment.[79]

As at October 2012[80] there were 102 contracted Disability Support Service providers in New Zealand, providing 563 facilities with five or more beds, and 846 with less than five.

Abuse and ill-treatment in residential settings is common. Such settings, in the New Zealand context, include nursing homes, specialist residences for people who have experienced a brain injury, mental health issues or intellectual disabilities. and homes for people in need of intellectual care. Locked-in abuse is often raised as a concern in residential settings. This is where a disabled person's mobility and/or ability to communicate is removed.

I am prevented from leaving and am fully reliant on my care giver. It is completely humiliating and disempowering.

In my view I was raped by the hospital system. I started menstruating when I was nine and I happened to be in hospital because my father needed some respite from looking after me. So what happened was that I was almost hogtied on the floor of the hospital. I was screaming. They held me down as a nurse inserted a full-length tampon. I was totally humiliated. They thought it was the best approach but I felt completely exposed and disempowered. Absolutely vulnerable.

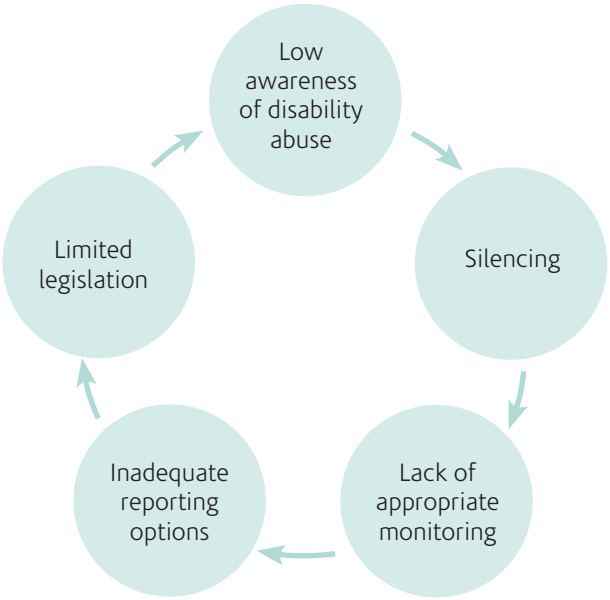
I sent an email to the CEO of X [homecare service] and asked if he could look into some issues I was having with my care workers. I told him that I had raised the issue with two of his managers but they hadnít done anything. It has been six months and I still haven't heard back.

– Comments from Participants in *The Hidden Abuse of Disabled People Residing in the Community: An Exploratory Study* Roguski, M (18 June 2013)

Types of Abuse experienced by Disabled People	
Type of Abuse	**Examples of Abuse**
Psychological / Verbal / Emotional abuse	Verbal aggression; threats; threats to children and pets; being ignored; breaches of privacy Isolation; threats to take children away; turning children against their family, intrusion, domination, humiliation Not following care instructions
Physical abuse	Being pushed down stairs; special equipment being thrown across room or cut up; petrol bombs or bricks thrown through window; stabbing; strangulation: being dragged by hair Hitting, slapping, punching, rough handling
Financial abuse	Theft Denial of funds, taking control of finances, not paying for required prescriptions Extortion Personal assistance providers showing up late, but receiving full pay
Neglect	Failure to check skin properly resulting in bedsores; urinary infections due to not checking leg bag or not providing enough hydration; the rushing of health checks Caregivers turning up to work late and arriving at work under the influence of drugs or alcohol Not providing specialised equipment or medication
Poor care	Poor health care, such as that which can result in bedsores, urinary tract infections, bruises, falls et al. Other examples include poor sterilisation of equipment leading to infections, and people being put into excessively hot bath water, causing burning.
Sexual abuse	Rape; sexual assault; forced sex Care that was exchanged for sex Inappropriate touching; coerced oral sex Being duped into sex by partners

Source: *The Hidden Abuse of Disabled People Residing in the Community: An Exploratory Study* Roguski, M (18 June 2013)

The 2013 report identified a number of factors that continue to enable an environment where abuse and ill-treatment occurs and is tolerated. These factors are interrelated and are presented below in schematic form:



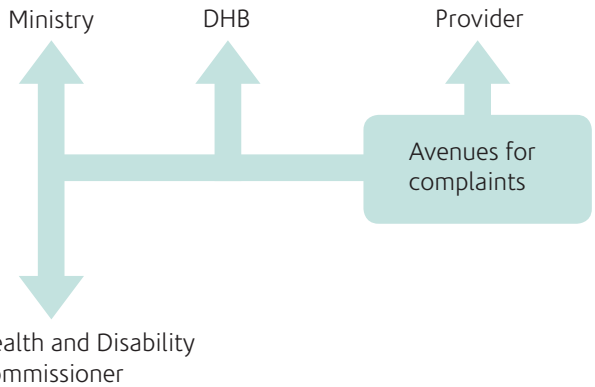
The lack of appropriate monitoring of residential care services is particularly problematic. Those involved in the 2013 report "unanimously regarded residential and home-based provision of care services as insufficiently monitored and stated that the lack of monitoring of the provision of care was the most common issue that maintains disabled people's vulnerability to abuse."[81] In particular, the current monitoring framework was criticised because it places the onus on the disabled person to complain.

5.3 How are situations of abuse currently dealt with?

Residents or their families can make complaints through a number of avenues. Each provider must, under the terms of their contract with District Health Boards (DHBs) have an internal complaints procedure. Residents can also complain to the Health and Disability Commissioner (HDC) for potential breaches of the Code of Health and Disability Services Consumers' Rights,[82] or to their local DHB or the Ministry of Health regarding the quality of their care. Investigations into incidents in residential care facilities can also be conducted by the Police, the Accident Compensation Corporation or a coroner.

The New Zealand Productivity Commission[83] makes the point that it is relatively unusual to have a number of complaints avenues within one regime. From one perspective, this is positive, as residents or their families can choose that which best suits them. However, multiple avenues may confuse the public about where they should complain, which can dissuade people from lodging complaints, or lead to multiple, duplicative complaints. Dividing responsibility for complaints amongst other bodies can make it harder to collect and use complaints data to identify system-wide issues. Under current arrangements, there is no systemic collection and analysis of complaints from the four main complaints avenues described above. Quoting the Australian Productivity Commission, it also noted that multiple complaints mechanisms may also lead to people in similar circumstances being treated in materially different ways, procedurally or substantively.

Avenues for complaint (Productivity Commission 2014)



A resident in rest home care had a number of concerns about the care she was being provided by the rest home. These included: the poor response when she rang her call bell (either a delay in responding or responding by turning it off but then not returning to assist her); that her chair was not being cleaned; the lack of ability among staff to use the transfer belt for transfer of residents; and the lack of suitable meals given her physical impairment, which made eating difficult. HDC referred the matter to the Advocacy Service. An advocate assisted the resident to write a letter outlining her concerns and supported her at a meeting with the Facility Manager and Clinical Manager. A complaint resolution agreement was reached, which included that: a new lead and wall point would be put in place for the call bell, and further discussions had with the rest home owners regarding addressing the faulty connections throughout the facility; the cleaning roster would specify a weekly clean of the residentís chair; staff who have difficulty with the transfer belt would be identified and further training provided; the Facility Manager and cook would review all personal eating plans and ensure that needs were clearly identified. The complainant confirmed with the advocate that there had been improvement in the meals and call bell responses. She said she felt more confident that she would be able to raise any future issues with the rest home, and that she could access the Advocacy Service if required.

– HDC Annual Report 2015

5.3.1 Particular issues in the disability residential sector

A review of Disability Support Services (DSS) "Putting People First",[84] produced for the Ministry of Health in 2013, was critical of the way in which the current system responds to incidents of abuse, and manages complaints.

Disabled People lack a voice

The report asserts that:[85]

Disabled people suffer from many forms of abuse, a number of which reflect the nature of their disability and the care and support they need to enable them to live with some ease. Their need for this care has resulted in many learning to be silent for fear of losing access to a service or care-giver on which they depend. Others have learnt not to speak up through a fear of being punished, or experiencing a repeat of a previous negative incident

Under the current structure, DSS sits under National Services Purchasing, the National Health Boardís funder and purchaser of services. Not surprisingly, when staff spoke of DSS's role in residential services, it was largely as the funder or purchaser of disability services, rather than as a body whose purpose is to ensure disabled people receive high quality, safe services. Given this is clearly a key aspect of DSS's role and its underlying intent, it is important that this is reflected in the design of roles and responsibilities.

Complaint resolution processes are unsafe

Secondly, the report asserts that disabled people are not always safe during an abuse investigation, and that the process of investigating serious complaints is not sufficiently independent:[86]

Family members spoke of their experiences of reporting abuse and of the disabled person, or people, continuing to be subjected to abuse while their case was being investigated. Disabled people also spoke of their fear of being punished if they speak up, which kept them quiet. Similarly, when people experience repeated negative experiences,

particularly when intensified in an attempt to coerce them into withdrawing a complaint, they are less likely to continue to take a case. Accordingly, if there is potential for a disabled person to be harmed in any significant way once a complaint has been laid and the case is being investigated, there is a need to remove the alleged perpetrator from contact with the injured party(s) during this period.

Serious complaint investigations are not sufficiently independent

In relation to serious complaints the report makes a case for a change in the way they are managed:[87]

At present, when the Ministry [of Health] receives a serious complaint in relation to a residential service, one of the next steps it takes is to contact the provider to find out what happened. If it has not already done so, the provider then conducts an internal investigation into the case and reports back to the Contract Relationship Manager. The outcome of this investigation then informs the series of actions the Ministry takes to resolve the case. While it is appropriate for providers to be given the right of reply in response to a complaint being laid against them, and while it is evident that some providers will be open and transparent and deserve the trust implicit in the Ministry's actions, the reliance the Ministry has historically placed on providers to report back honestly is equally likely to have been misplaced.

As long as there is a benefit to covering up abusive or neglectful behaviour, and as long as there is an advantage to those involved to collude and find against the case put forward, these behaviours will continue. The only way to obtain an accurate account of what happened is to undertake a rigorous, independent investigation of the incident(s) that is fair and equitable to all concerned. This should occur as quickly as possible after receipt of the complaint, to support the collection of all relevant evidence.

The following recommendations were made:

- Set up an Expert Panel to provide expert advice and support to the Ministry of Health. Membership on the panel should be based on the fit between the individual members' specialist knowledge and expertise and the range of skills needed to respond to the serious incidents, complaints and issues that occur in the sector.

  This could include people with:

  - the skills and understanding to communicate with disabled people who have severe cognitive impairments including a limited ability to verbalise
  - knowledge and expertise relating to the different types of abuse disabled people suffer, including physical, sexual, and psychological abuse
  - relevant clinical knowledge
  - relevant legal expertise
- Membership could also include appropriately skilled disabled people with a lived experience of the issues or abuse involved. It is recommended that membership on the panel be for a set term.
- Conduct a timely, independent investigation into all serious complaints in a manner that is fair and equitable to all concerned. Those members of the Expert Panel who have the most appropriate skills undertake the investigation and report back to the Ministry.

As a result of these recommendations the Ministry has committed to a number of improvement activities, including:

- Contract specialist investigator(s) to manage and carry out complaint investigations
- Review and improve the existing complaints management system
- Provide training to Disability Support Services staff on the improved complaints management system.

The way incidents of abuse are managed in disability residential care may very well change to some degree in the relatively near future due to these commitments.

6. The application of OPCAT to aged care and residential disability residences

The jurisprudence has shown that what constitutes a deprivation of liberty for the purposes of international law is given a broad interpretation. It will depend on the particular circumstances of a case and the extent to which someone's freedom of movement is limited or potentially limited.

What is important from an OPCAT perspective is whether places in which people are or could be deprived of their liberty (that is, where they are not free to leave) is subject to the regulation or oversight of the State. In cases in which they are, the SPT has confirmed that they will come within the ambit of the OPCAT monitoring framework. In many cases therefore, aged care facilities and disability residences will meet this criteria as they are services either contracted to external parties by the state, funded to some degree by the state, or subject to regulations and some level of governmental oversight. In other cases people are placed in these facilities by an order of the court through some form of guardianship order.

While many countries do not consider aged care facilities and community based disability residences as falling within the scope of OPCAT monitoring, both Germany and Austria do. This section considers approaches in these two jurisdictions and how they might align with the New Zealand context.

6.1 German NPM

The principal task of the German NPM is to visit those facilities in which people are deprived of their liberty ("places of detention"), to draw attention to problems and to make recommendations and suggestions to the authorities for improving the situation of detainees and for preventing torture and other forms of ill-treatment. To achieve this it has taken the approach that, in accordance with Article 4 of the OPCAT, considers places of detention as any place under a State Party's jurisdiction and control, and where persons are or may be deprived of their liberty either by virtue of an order given by a public authority or at its instigation, or with the public authority's explicit consent or acquiescence. Some 11,000 homes for the elderly and nursing homes have been classed as places of detention in this sense of the meaning.

According to a newspaper article published in Germany in 2013,[88] at the time that NPM announced its intention to visit rest homes, there were an estimated 250,000 patients suffering from dementia who were chemically restrained on a daily basis to compensate for staff shortages, and another 36,000 that were thought to be left hungry and thirsty as no staff were available to feed them. Furthermore the prevalence of physical restraints without court order, verbal and physical abuse and neglect was identified.

6.2 Austria

In implementing the OPCAT into domestic law, Austria deliberately chose not to provide a conclusive definition of "places of detention". Instead it made reference to the definition outlined in Article 4 of the OPCAT.[89]

That is, whether or not a social facility is a "place of detention" and therefore can be visited unexpectedly at any time depends on three factors:

1 are social facilities subject to the jurisdiction of the State or its control?

2 can the deprivation of liberty be imputed to the State?

3 are people – at least potentially – deprived of their liberty in these places?

In accordance with the Vienna Convention on the Law of Treaties a treaty shall also be interpreted in the light of its aim and purpose. According to Article 32 of the Convention, in the case of ambiguities recourse may also be taken to the preparatory work of the treaty. As noted above, it can be quite clearly deduced from historic materials of the OPCAT, that the definition of "place of detention" can be broadly interpreted.[90] According to the Austrian NPM, Article 4 of the OPCAT not only include prisons and classical places of detention in the fields of police and justice, but also social care homes and homes for elderly people whose personal liberty is or may be restricted.

The Federal Law on the Protection of Personal Freedom for people staying in homes and other care facilities came into force in 2005. The Act regulates in detail the preconditions as well as the investigation of violations of the right to personal freedom. The Act ensures that such violations are also investigated in facilities for elderly people, people dependent on care, people with disabilities and in hospitals caring for at least three mentally ill or mentally disabled persons.

In Austria, facilities for elderly people are clearly considered to fall within the ambit of the OPCAT, that the OPCAT framework provides an appropriate mechanism to ensure that those who find themselves in social services are protected from harm and abuse. It also provides the basis for ongoing improvement of care and rights protections within the sector.

The Austrian NPM has undertaken intensive preparatory work and publicity amongst public and private retirement and nursing home operators and their umbrella organisations in Austria. As a result all governmental as well as private nursing homes fall under the OPCAT mandate.

6.3 New Zealand

Aged residential care is designed to assist people who can no longer manage safely at home. There are broadly four types of care: rest home, dementia rest home, private hospital and specialist private hospital. As mentioned above all facilities must be certified by the Ministry of Health. Legislation governs the standards of care and auditing is overseen by Standards New Zealand and the Ministry of Health. District Health Boards (DHBs) are responsible for funding residential care services for older people under the Social Security Act 1964. Under the Social Security Act the Ministry of Social Development carries out a financial means assessment that considers the person's assets and income. If the person has assets above the applicable threshold, then the person is liable to pay for the costs of their care up to the maximum contribution. The government clearly has a regulatory and oversight role.

Similarly, community based disability residences are subject to contractual and legislative requirements and auditing overseen by the government. Funding from government is also provided in most circumstances.

The question therefore of whether aged care facilities and community based disability residences come within the scope of Article 4 of OPCAT is based on the extent to which they can be considered places where people are or can be deprived of their liberty. It will depend on the particular circumstances of a case and the extent to which someone's freedom of movement is limited or potentially limited.

People can enter aged care facilities on their own accord. However, the vast majority enter after having a needs assessment from a DHB or local DHB-funded Needs Assessment and Service Coordination Agency. A needs assessment can also be undertaken by a specialist while someone is in hospital. A needs assessment determines the level of care needs of that individual. In particular, it determines:

a whether or not the person has a condition that can be reversed

b whether or not the person can be safely supported in the community

c if the person needs long-term residential care indefinitely, what level of care is needed in a rest home or hospital.

In some circumstances it is not possible for a person to give their informed consent to having a needs assessment, to going into residential care or which facility they go to. In many cases these choices are made by a substitute decision maker, such as an enduring power of attorney or welfare guardian or by virtue of a personal order from the Court on the recommendation of family or healthcare professionals. For those who do not have a substitute decision maker decisions are made on the basis of the Health and Disability Commission's Code of Consumer Rights. Regulation 7(4) provides:

4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -

a) It is in the best interests of the consumer; and

b) Reasonable steps have been taken to ascertain the views of the consumer; and

c) Either, –

i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or

ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

People placed in community based disability residences will invariably have been placed there by virtue of some form of substituted decision making.

While substituted decision making will in some circumstances be necessary, it is important to recall Article 12 of the CRPD which provides special protections to ensure that people with disabilities enjoy legal capacity, including the right to make legal decisions on an equal basis with others. The CRPD requires States to provide access to support required for disabled people to exercise their legal capacity. A corollary of this positive duty on States is that a failure to do so (in other words, adopting a substituted decision making process) and thereby removing a disabled person's autonomy can in some circumstances effectively amount to a deprivation of their liberty.

Notwithstanding the protections provided by the CRPD, the use of substituted decision making in these circumstances shows the particular vulnerability of the people most affected. Being placed in a care environment, because people have already been determined to lack autonomy, would seem to place them at increased risk of being further deprived of their liberty, either intentionally or inadvertently through practice.

As noted above, 70% of people living in residential care facilities are experiencing dementia. Challenges for general residential facilities include the management of behaviours in an environment not suited to this type of care. This can result in practices being adopted that limit an individual's freedom of movement and autonomy. Individuals can also be deprived of their liberty by virtue of facility designs which may prevent or discourage people from leaving the buildings, or having access to the outdoors and wider community.

A re-assessment of needs can occur when a person's behaviour becomes unsafe or unmanageable and the person can be moved to a different facility, such as a secure dementia unit. In these situations a person's freedom of movement will be significantly restricted and they will be unable to leave the facility at their own will.

The SPT has made it clear that any place where someone may be deprived of their liberty falls within the scope of Article 4 of OPCAT. There will be cases where it can clearly be shown that a person is deprived of their liberty in a care setting, such as one in which they are placed in a secure dementia unit. In other cases, the freedom of movement and autonomy may be less restricted. However, given the vulnerability of this group, the framework for entering care, the environment in which care is provided and the changing needs of individuals affected, there is a real risk that by residing in such facilities they may be deprived of their liberty.

7. OPCAT in New Zealand

New Zealand has had a strong commitment to the protection and promotion of human rights, and has been at the forefront of international efforts to curb the use of torture and ill-treatment. New Zealand signed the CAT on 14 January 1986, and ratified it on 10 December 1989. The delay in ratification was to allow legislation to be passed to criminalise torture and impose penalties on those who engaged in the practice.

New Zealand ratified OPCAT on 14 March 2007, following the enactment of amendments to the Crimes of Torture Act 1989 (COTA), to provide for visits by the SPT and the establishment of NPMs.

New Zealand's designated NPMs are:

1 the Independent Police Conduct Authority – in relation to people held in police cells and otherwise in the custody of the police

2 the Inspector of Service Penal Establishments of the Office of the Judge Advocate General – in relation to Defence Force Service Custody and Service Corrective Establishments

3 the Office of the Children's Commissioner, in relation to children and young persons in Child, Youth and Family residences

4 the Office of the Ombudsman, in relation to prisons, immigration detention facilities, health and disability places of detention, and Child, Youth and Family residences

5 the Human Rights Commission, which has a coordination role as the designated Central National Preventive Mechanism (CNPM).

OPCAT envisions a system of regular visits to all places of detention.[91] The designation of a CNPM aims to ensure there is coordination and consistency among multiple NPMs so they operate as a cohesive system. Central coordination can also help to ensure any gaps in coverage are identified and that the monitoring system operates effectively across all places of detention.

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

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

New Zealand's 2015 OPCAT Annual Report notes:[92]

Since 2007 the National Preventive Mechanism has provided a system of independent monitoring. The National Preventive Mechanism and the individual agencies that comprise it make recommendations to detaining agencies to strengthen human rights protections and improve conditions of detention and sector capability according to international human rights standards. Further to its preventive monitoring work, the National Preventive Mechanism seeks to contribute to developing a culture where the rights of all persons deprived of their liberty are protected and respected.

8. Current auditing and monitoring of aged care and disability residences in New Zealand

The main legislation governing the residential care sector in New Zealand is the Health and Disability Services (Safety) Act 2001. The purpose of the Act is to:

a promote the safe provision of health and disability services to the public

b enable the establishment of consistent and reasonable standards for providing health and disability services to the public safely

c encourage providers of health and disability services to take responsibility for providing those services to the public safely

e encourage providers of health and disability services to continuously improve the quality of those services.

All hospitals, rest homes and providers of residential disability care with more five or more beds are required by the Act to be certified, and must provide care to their residents that meets the Health and Disability Services Standards 2008. The Standards are approved by the Minister of Health and published by Standards New Zealand. The revised Health and Disability Services Standards 2008 are made up of four sets of Standards:

- NZS 8134.0:2008 Health and Disability Services (General) Standards
- NZS 8134.1:2008 Health and Disability Services (Core) Standards
- NZS 8134.3:2008 Health and Disability Services (Restraint Minimisation and Safe Practice) Standards
- NZS 8134.3:2008 Health and Disability Services (Infection Prevention and Control) Standards

The Standards cover:

Standard	Content
Consumer rights	• Consumer rights during service delivery • Independence, personal privacy, dignity and respect • Recognition of Māori and Pacific values and beliefs • Recognition and respect of individual's culture and beliefs • Non-discrimination • Communication • Informed consent • Advocacy and support • Links with family/whanau and other community resources • Complaints management

Organisational management	• Governance • Service management • Quality and risk management systems • Adverse event reporting • Consumer participation • Family/whanau participation • Human resource management • Service provider availability • Consumer information management systems
Continuum of service delivery	• Entry to services • Declining referral/entry to services • Service provision requirements • Assessment • Planning • Service delivery/interventions • Evaluation • Referral to other health and disability services • Transition, exit, discharge or transfer • Use of electroconvulsive therapy • Medicine management, • Nutrition, safe food and fluid management
Safe and appropriate environment	• Management of waste and hazardous substances • Facility specifications • Toilets, showers and bathing facilities • Personal space/bed areas • Communal areas for entertainment, recreation and dining • Cleaning and laundry services • Essential, emergency and security systems • Natural light, heating and ventilation
Safe restraint practice	• Restraint approval and processes • Assessment • Safe restraint use • Evaluation, monitoring and quality review
Seclusion	• Safe seclusion use • Approved seclusion rooms
Infection prevention and control	• Infection control management • Implementing the infection control programme • Policies and procedures • Education • Surveillance • Antimicrobial usage

8.1 Contracting and certification framework

All aged care and disability residential providers are subject to both contractual and certification requirements.

The national aged residential contract covers rest home, dementia and geriatric hospital level care delivered in a residential care setting. The contract ensures that there is a national standard of services that are provided to residents in long-term residential care. Each year there is a national review of the Age Related Residential Care contracts between DHBs and providers. There are approximately 656 aged care facilities contracted by DHBs. They are all required to be certified by HealthCERT.

Disability support services for people under 65 years old are provided by the Ministry of Health through the Disability Support Services Group. The contracted services relevant to this paper are Community Residential Support Services (intellectual disability) and Community Residential Support Services (physical disability). All disability residential care providers are contracted by the Ministry but only those with five or more beds are certified by HealthCert.

Auditing agencies are designated under Section 32 of the Health and Disability Services (Safety) Act by the Director-General of Health. Providers must select and contract with one of the currently Designated Auditing Agencies (DAAs). Although there are currently six DAAs, only five are designated for aged care and disability services.

DAAs are subject to certification requirements under the Health and Disability Services (Safety) Act and must be accredited by a third party. There are currently two third party bodies approved by the Ministry: the Joint Accreditation System of Australia and New Zealand, a government-appointed body established under Treaty between Australia and New Zealand, and the International Society for Quality in Health Care Incorporated, an internationally recognised membership-based organisation headquartered in Ireland.

8.1.1 Types of audit

Disability residences and aged care facilities are potentially subject to five different types of audit.

Provisional audit

A prospective provider applying for certification of an existing service must undergo a provisional audit to establish the prospective provider's preparedness to provide a health and disability service. The audit includes an interview with the prospective provider to establish their preparedness to deliver a health and disability service, and an audit of the current facility against all Standards.

Partial Provisional audit

A partial provisional audit is undertaken to establish the level of preparedness of a provider (certified or prospective) to provide a new or reconfigured health and disability service.

The audit applies to a:

- certified provider applying to add a new kind of service to an existing certificate (e.g. certified rest home adding a hospital)
- certified provider applying to change the configuration of existing services (e.g. adding dementia services in a rest home that has previously not had dementia care or increasing the number of beds within an existing service type)
- certified provider or prospective provider applying for certification of a new premise (e.g. adding a new building as an extension to an existing site or for a building that is not currently providing health and disability services on a new site).

Certification audit

This audit applies to all providers providing a health or disability service required to be certified under the Act. A certification audit is undertaken to determine if a provider is meeting the relevant service standards. A period of certification for up to five years may be provided.[93]

Both HealthCERT and DSS report that the average certification period for all certified facilities is three

years. Similarly, the Office of the Auditor General reported in 2009 that 80% of rest homes were certified for three years.[94] To determine the period of certification, HealthCERT uses the audit results in combination with other information such as complaints, the provider's past performance, and relevant information provided by DHBs.

DHBs gather information about provider risk and performance from a variety of sources such as complaints, clinicians, admissions to acute hospital services, and community groups engaged with facilities.

All providers are required to have one surveillance audit[95] at the mid-point of their certification period unless:

- an additional surveillance audit is required as a result of information disclosed in the provider surveillance declaration; or
- significant shortfalls are identified following an inspection or issues-based audit; or
- a condition of certification is the submission of a mid-point surveillance declaration (e.g. residential disability – intellectual, physical, sensory).

All certified aged care and disability residential providers must submit an annual declaration to their DAA by the end of each calendar year for every year in which they have not had a certification or surveillance audit. Service providers are required to undertake regular monitoring to verify that they are conforming to certification requirements, and their monitoring records must be available for review by their DAA on request. The declaration asks for confirmation regarding internal audit, quality and risk management plans, staffing, medicines training for staff, whether or not there have been legislative compliance issues, and the resolution of issues from the last certification audit.[96]

Surveillance audit

A surveillance audit is undertaken by the service provider's DAA part-way through a service provider's period of certification to assure the Ministry that the provider continues to meet all relevant standards. The focus of the audit is on service delivery and review of criteria not fully attained at the previous audit. All surveillance audits carried out as part of aged care residential audits must be unannounced. The period of certification does not change. However, a new or amended schedule of corrections may be issued in response to the audit result.

Issues-based audits

Issues-based audits usually result from ongoing complaints or concerns about the service the provider is delivering. Audits for Ministry-funded disability providers are approved and commissioned by the Disability Services Quality and Audit team. No-notice issues-based audits can be conducted on any service when there are severe quality concerns or complaints, or if requested by another agency such as the HDC or Police, with urgency.

HealthCERT may approve a combined audit when another audit activity is imminent. If a partial provisional audit is combined with an unannounced surveillance audit, the latter audit must still be unannounced.

Audits specific to disability services – Developmental evaluation audit

This is the contractual audit for providers of residential disability services. It usually substitutes for a surveillance audit at the mid-point of the certification period.

All contracted facilities receive a developmental evaluation audit. Because facilities with five and more beds get audited regularly through the certification process, and the Ministry does not want to burden facilities with more than one audit, developmental evaluation focuses on facilities with five or fewer beds.

Facilities with five or fewer beds are evaluated approximately every five to eight years. The Ministry of Health's goal is to visit all facilities at least once every three to five years, and it is steadily increasing the number of facilities it is visiting. It is the Ministry's expectation that over 150 facilities will be visited in 2016/17.

The developmental evaluation applies only to homes providing services to disabled people. If a home has

a resident who also has mental health conditions, the surveillance audit is carried out. A surveillance audit may also be used if high-risk issues have been identified in a home.

The developmental evaluation audit tool is focused on personal and social needs considered to be more appropriate to the disability sector than a health-dominated audit. It covers the following:

Domain	Outcome
Identity Individuals are respected for their human worth and dignity, and receive services in a manner that results in the least restriction of their rights and opportunities.	• People choose and realise personal goals • People choose services • People choose where and with whom they live • People choose their place of work/day service • People have friends • People have intimate relationships • People are satisfied with services • People are satisfied with their personal life situations
Autonomy	• People make decisions about their daily routine • People have time, space and opportunity for privacy • People decide when to share personal information • People live in integrated environments
Affiliation Service users have the right to live in and be part of the community	• People participate in the life of the community and interact with members of the community • People perform different social roles
Safeguards Service users have the right to pursue any grievance in relation to services without fear of the services being discontinued for any form of recrimination.	• People are connected to natural support networks • People are safe
Rights	• People exercise rights • People are respected and treated fairly
Health and wellness	• People have the best possible health • People are free from abuse and neglect • People experience continuity and security

8.1.2 Content of audits

The audit approach requires a service to determine, through its DAA, the level of attainment it currently achieves for each relevant criterion. The levels of attainment are incremental, based on a model of continuous quality improvement. The audit framework attainment levels are:

a Continued Improvement

b Fully Attained

c Partial Attainment

d Unattained

e Not Applicable.

The audit process requires the facility to identify the degree of risk to consumers' safety associated with levels of attainment of Partially Attained or Unattained for any criterion. A Risk Management matrix requires the service to:

a Assess the consequence on consumers' safety of the criterion being only partially, or not, attained to be assessed, ranging from extreme/actual harm occurring, to no significant risk of harm occurring;

b Assess the likelihood of this adverse event occurring as a result of the criterion being only partially, or, not, attained, ranging from being almost certain to rare; and

c Plot the findings on the Risk Assessment Matrix to establish the level of priority for action according to the level of risk that results from the combination of severity of outcome and likelihood of occurrence.

Action required is rated as:

a **Critical:** Immediate corrective action is required in order to fix the identified issue including documentation and sign off by the auditor within 24 hours

b **High:** a negotiated plan is required in order to fix the issue within one month or as agreed between the service and the auditor

c **Moderate:** a negotiated plan is required in order to fix the issue within a specified and agreed timeframe such as six months

d **Low:** a negotiated plan is required to fix the issue within a specified timeframe such as one year

e **Negligible:** no additional planning or action is required.

Audit reports are published on the Ministry of Health's website.[97]

8.1.2.1 Corrective actions

An example of corrective actions identified for one rest home, showing the levels of attainment and the level of risk associated with each is detailed on page 39.[98] Issues from this rest home's last audit are listed in the corrective actions table, along with the action required to fix the issue.

8.2 Guidelines

HealthCERT has developed guidelines to encourage best practice within the residential care sector. These guidelines help auditors interpret the obligations of residential facilities consistently.

8.2.1 Environmental restraint guideline

The standards require that residents should not be subject to environmental restraint unless it is clearly supported by clinical assessment and when no other solutions are available.

Specifically, in instances in which a provider has a locked door (not in a secure unit), the following matters should be included in the audit:

- Is the rationale for the locked door documented?
- What minimisation strategies are implemented? These may include staffing rationales and use of alternative interventions.
- What are the risks associated with a locked door and with an unlocked door?
- How often is the locked door rationale reviewed?

Corrective actions	
Consumer rights	• All residents have an appointed Enduring Power of Attorney (EPOA). If an EPOA is not in place, the provider is supporting actions to have one appointed.
Organisational management	• The service organisation philosophy and strategic plan reflects a person/family-centred approach to all services. • All staff have completed dementia training as set out in the ARRC agreement.
Continuum of service delivery	• Specialist referral to the service is confirmed; EPOA has consented for the resident to be admitted. • Resident files reviewed for behaviour management plans including triggers and interventions for behaviours. • A holistic 24/7 approach to activities is available and includes aspects of the resident's life and past routines. • Nutritional needs are met and include the availability of snack food available 24/7.
Safe and appropriate environment	• The environment design should provide safe areas that encourage purposeful walking; this includes easy access to a safe outdoor area. • The services emergency plan considers the special needs of people with dementia in an emergency.

Where a door is locked for a specific resident, that resident's care plan should detail clinical justification for the restraint.

For a number of residents, using a locked door as an environmental restraint is clinically justified. However, there must be evidence of appropriate assessment and/or referral to external agencies for reassessment, where applicable. Where there is a locked door for a resident (or a group of residents), interviews with other residents and families should validate that those other residents can freely enter and exit the facility.

Audit evidence must also verify the locked door is linked to fire systems.

8.2.2 Design guidelines for residential secure dementia units

Currently there are no formally agreed national guidelines for the design of secure dementia units for New Zealand. Expectations for the design of such units are also unclear.

The Ministry of Health has started a project to develop national guidelines for the design of residential secure dementia units. It is intended that the guidelines will provide best practice guidance to all stakeholders and inform providers of aged care about what HealthCERT and DHBs expect in relation to that design.

The objectives of the project are to:

- improve the lives of people with dementia by developing secure units that are dementia friendly
- agree on design principles that are evidenced-based, including principles about the size of units
- implement a nationally consistent approach to the design of secure dementia units.

However, it must be noted that it is not HealthCERT's intention that the guidelines become an audit tool.

8.3 Ministry Inspections

The Ministry can carry out unannounced inspections in the event of a serious complaint. These are usually undertaken by Contract Relationship Managers employed by Disability Support Services (DSS).

8.4 Section 31(5) reporting

Section 31(5) of the Health and Disability Services (Safety) Act applies to all certified providers, and requires that they report to the Director General of Health through HealthCERT:

- Any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided e.g. evaluations, fire, flood equipment failure.
- Any investigation commenced by a member of the police into any aspects of the service e.g. intruders, assault, missing medication, missing residents, theft, or suspicious deaths.
- Any death of a person to whom they have provided services, or occurring in any premises in which services are provided, that is required to be reported to a coroner under the Coroners Act 1988.

Summary of audit programme for Disability Services

	Developmental evaluation	Certification audit	Surveillance audit	Annual declaration form	Issues-based audit	No-notice audits	Incident reporting
Frequency	Every 3 years	Every 3-5 years	Mid-point of the certification period	In every year in which no audit takes place	As required	As required	As required – immediate
Managed by	NQG	HealthCERT	HealthCERT/ NQG Usually substituted with a developmental evaluation	HealthCERT	NQG May consult/ combine with HealthCERT	NQG May consult/ combine with HealthCERT	NQG/ HealthCERT
Derived from	Contract	Legislation	Legislation	Legislation	Contract and/ or legislation	Contract and/ or legislation	Contract Legislation – Section 31 (5)
Carried out by	Lead developmental evaluators	DAA	DAA, or Lead developmental evaluator	Provider/DAA			Provider
Applies to	All funded services Including residential services with less than 5 beds	Residential services with 5 or more beds	Certified residential services	Certified residential services	All funded services	All funded services	Contract - all funded services Section 31 – all certified providers

Summary of audit programme for aged residential care					
	Certification audit	**Surveillance (spot) audit**	**Annual declaration form**	**Issues-based audits**	**Incident reporting**
Frequency	3-5 years (typically 3)	Mid-point of the certification period	In every year in which no audit takes place	As required	As required – immediate
Managed by	HealthCERT	HealthCERT/DHB Includes contractual requirements	HealthCERT	DHBs	DHB/HealthCERT
Derived from	Legislation	Contract and legislation	Legislation	Contract	Contract Legislation – Section 31 (5)
Carried out by	DAA	DAA	Provider/DAA	SSA or DAA	Provider
Applies to	All ARC facilities	All ARC facilities	All ARC facilities	All ARC facilities	All ARC facilities

8.5 Enforcement

The Ministry of Health has the primary responsibility for enforcement. Where audits identify weaknesses in the provision of care, the Ministry may require the provider to take corrective action or add conditions to the provider's certification. The Ministry can also require more frequent audits, if there are concerns about a provider's performance. The Ministry may impose financial penalties for offering health services without certification, or for obstructing or misleading an audit or inspection. DHBs do not have regulatory enforcement powers regarding aged care providers, but do have a number of levers they can use through the funding contract, such as the ability to appoint a temporary manager to a facility or cancel its funding.

Where an Health and Disability Commissioner (HDC) investigation into a complaint indicates that there may have been a serious breach of the Code, the Director of Proceedings may lay a disciplinary charge with the Health Practitioners Disciplinary Tribunal (where the medical professional is registered under the Health Practitioners Competence Assurance Act) or the Human Rights Review Tribunal (for other health service providers).

9. Efficacy of the current framework

The audit system as the primary tool for monitoring and promoting quality of care in residential care is inherently limited. Audits can never eliminate the risk of poor care, and can only establish whether, at a particular point in time, a facility has the systems and processes in place to minimise that risk.

Concerns have been raised by consumers and advocacy groups about the independence of some of the auditing process, particularly in situations where facilities appoint DAAs. The audit system is also complex and resource intensive.

In 2009 the Office of the Auditor General (OAG) published its report of its investigation into the effectiveness of the arrangements to monitor the standard of care provided in rest homes.[99] Its overall findings were that certification (introduced in October 2002) had not provided a consistently adequate level of assurance that rest homes met all the criteria in the Standards, that the effectiveness of certification had been compromised by inconsistent auditing by DAAs, and that there was insufficient sharing of information between different relevant organisations.

The OAG report reflects on the findings of an earlier report the Ministry of Health commissioned in 2004/5 in which serious weaknesses were found common to most DAAs.

In 2012 the OAG carried out a performance audit to assess the progress that the Ministry of Health and DHBs had made since the publication of the 2009 report. The report notes that the Ministry had improved its auditing methods. The routine contractual audit that was carried out by DHBs was integrated with the certification audit. The frequency of audits was in line with the Ministry's risk assessment of rest homes, and unannounced spot audits were introduced as a result of the pilot project conducted in 2009.

However, the OAG argued that the effect of these improvement on the quality of care delivered to rest home residents was unclear. The primary recommendation from its 2012 investigation was that the Ministry needed to shift the focus of rest home audits towards ensuring that documented policies and procedures result in safe quality care being delivered to residents.

The OAG notes that respondents to its online survey described the certification process as an exercise that was more concerned with compliance than outcomes for residents. Suggestions from the OAG included spending more time with residents and their families rather than looking at files, and actively observing staff behaviour.

The 2013 review of disability support services, 'Putting People First', also reflects on the limitations of the audit process, describing a reactive, risk averse, bureaucratic culture of 'ticking the boxes'.

As a result of the "Putting People First" (2013) quality review the Ministry of Health committed to 60 activities identified to achieve the report's recommendations. Those that pertain to auditing and monitoring include:

- Review feedback on the performance of contracted evaluation agencies

- Introduce a new incident reporting form for all providers
- Develop guidance for service providers on what is a 'significant incident' and how to use the new reporting form
- Assess other Ministry of Health electronic provider databases for potential use by Disability Support Services
- Tender for evaluation services
- Develop a database to improve the capacity of Disability Support Services to manage service provider data and performance
- Investigate the development of a sector-wide tool for reporting, storing and analysing incidents and risks
- Review the criteria the Ministry uses for deciding when to carry out issues-based audits
- Improve processes for monitoring action plans resulting from issues-based audits
- Review service provider performance reporting tools
- Investigate a new evaluation tool that covers service quality and quality of life measures.

The audit does not measure the effectiveness of care delivered – it manages compliance with documented processes to achieve certification. In some instances the audit report has been very positive, but the standard of care delivered has been found to be poor.

– Office of the Auditor General (2009)

10. Conclusion – The role of the OPCAT in aged care and residential disability services in New Zealand

New Zealand has obligations at international law to ensure that the rights and dignity of persons deprived of their liberty are protected. These obligations primarily stem from the Convention against Torture and other Cruel Inhuman and Degrading Treatment (CAT), the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Rights of Persons with Disabilities (CRPD) to which New Zealand is a State Party. Additional rules and standards have been promulgated internationally to guide the interpretation and implementation of these obligations.

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

– Article 10(1) ICCPR

When considering the inherent vulnerability of people deprived of their liberty, the right to be protected from torture or ill-treatment is paramount. While it is acknowledged that the threshold required to establish torture is high, the risk of abuse and ill-treatment in closed environments – in institutions or facilities where people are not free to leave of their own will – is well established.

As part of its commitment to its international legal obligations and to the prevention of torture and cruel, inhuman or degrading treatment, New Zealand has ratified the OPCAT and has established NPMs to undertake preventive monitoring of places of detention.

The Crimes of Torture Act 1989 (COTA) is the primary legislation governing torture in New Zealand. It provides for visits by the SPT and the establishment of NPMs to monitor places of detention.

Section 16 of the COTA defines being deprived of liberty as:

Any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order or agreement of any judicial, administrative, or other authority.

That same section of the COTA defines a 'place of detention' as:

*any place in New Zealand where persons **are or may be deprived of liberty***, including, for example, detention or custody in:*

(a) a prison:

(b) a Police cell:

(c) a court cell:

(d) a hospital:

(e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003:

(f) a residence established under section 364 of the Children, Young Persons, and Their Families Act 1989:

(fa) a residence established under section 114 of the Public Safety (Public Protection Orders) Act 2014:

(g) premises approved under the Immigration Act 2009:

(h) a service penal establishment as defined in section 2 of the Armed Forces Discipline Act 1971

*Emphasis added

Under the COTA the Minister of Justice has the power to designate one or more National Preventative Mechanism (NPM), as well as a Central NPM (CNPM) to set out the powers and functions of those bodies. Under section 27 of the COTA, the functions of an NPM include examining the conditions of detention and treatment of detainees, and making recommendations to improve conditions and treatment to prevent torture or other forms of ill-treatment.

In New Zealand, the Minister of Justice has designated four NPMs and a CNPM, and since inception these NPMs have provided robust independent monitoring of police custody, defence custody, Child, Youth and Family residences, prisons, immigration detention facilities, and health and disability places of detention.

However, there is a substantial number of places in which people are deprived of their liberty and not currently monitored by NPMs. Beyond the more traditional detention settings, there are many more people being deprived of their liberty by virtue of the type of care or treatment that they are receiving, or the level of restrictive practices they are subjected to. People who end up in these situations are often vulnerable; it is up to governments to ensure that their rights are protected and they are treated with dignity.

The UN Sub Committee on the Prevention of Torture (SPT), in its 25 August 2014 report following its visit to New Zealand, expressed concern about the overlaps and gaps in NPM designations. It stated:

There are … issues concerning gaps and overlaps in the NPMs mandates which need addressing. For example, it appears that 161 facilities for the care of persons with dementia are not covered by the NPM.

To address these gaps and overlaps, the SPT recommended that the Government:

Organise as a matter of priority a meeting with the NPMs collectively in order to discuss in depth their challenges, including gaps in their respective mandates.

Concerns about ill-treatment of those residing in aged care facilities and community based residences have been the subject of significant public attention over recent years both in New Zealand and globally. These facilities are subject to a State's international obligations under the ICCPR, CAT and CRPD. It is therefore incumbent upon States to take measures to fulfil these obligations, including to prevent torture and cruel, inhuman or degrading treatment.

In the New Zealand context a multifaceted auditing framework has been established to assess the compliance of such facilities with a variety of standards. Some of these standards reflect human rights principles such as those around environmental restraints. The Development Evaluation audit, referred to above, in relation to disability residences is also well grounded in human rights.

However, despite the variety of audits that are undertaken they do not seem to be working to improve conditions and to prevent ill-treatment. More needs to be done.

Concerns have been raised that the current auditing process is generally focused on a review of certification criteria and compliance with prescribed standards rather than improving outcomes. Many of the audits do not appear to conduct a robust assessment of material conditions. As mentioned above, concerns have also been raised by consumers and advocates about the actual or perceived independence of the audit process.

Perhaps more worrying is that the views of residents are not always included in the audit process. It seems that residents are only engaged where an audit or inspection takes place in response to serious complaints. This is problematic given that people in aged care and community based disability residences are often reluctant to complain or raise concerns. Where there are allegations of ill-treatment, they do not automatically form part of a particular audit processes. Rather, they are dealt with through separate complaints procedures. The voice of affected people must be central to any monitoring and oversight framework.

Because the residential disability sector is comprised of many small facilities, only a sample of facilities is audited. Sampling takes into account variations in the size and complexity services, geographical locations,

previously identified service delivery issues, and whether or not a home has been recently audited or undergone a developmental evaluation.

The sample size is determined by the following formula: Sample size = √X * 0.6, X = total number of facilities. Using this formula, of the 563 (approximately) residences with five or more beds, 18 will be audited in any one year. An additional number will receive a mid-point audit.

10.1 The OPCAT, aged care and residential disability care situations

The OPCAT preventive monitoring framework provides a number of benefits that could address the gaps in the current auditing framework. In particular, it provides for an independent process of unannounced visits focused on the progressive improvement of treatment and conditions.

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

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

1 preparatory work, including collecting information and identifying specific objectives, before a visit takes place

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

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

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

NPM's assessment of the conditions and treatment of detention facilities takes account of international human rights standards, and involves 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; and

6 Staff: conduct and training.

Aged care facilities and disability residences can, in certain circumstances, be considered closed environments: environments where individuals are dependent on others for the basic necessities of life and where their freedom of choice or movement can be limited or taken away. In other words, where people are not permitted to leave at will. Although providers might not intend to deprive residents of their liberty, such deprivation can often be the case, due to the high level of care that residents need.

The SPT has made it clear that the visiting mandate of NPMs should extend to all places of deprivation of liberty.[100]

The OPCAT requires that the deprivation of liberty is based on a public order, or with the State's acquiescence or consent. For traditional places of detention this poses little issue. However, for non-traditional places of detention where people may be held on a voluntary basis, or with their family's consent without any official or public intervention, it is more problematic.

The UN Subcommittee on Prevention of Torture (SPT)

has grappled with this issue and has stated in relation to Article 4 of the OPCAT:[101]

Article 4 contains two sub paragraphs which need to read consistently together and which places within the scope of the OPCAT any public or private custodial setting under the jurisdiction and control of the State party, where persons may be deprived of their liberty and are not permitted to leave, either by an order given by any judicial, administrative or other authority or at its instigation or with its consent or acquiescence.

It is inevitable that there will be a degree of opaqueness about the precise parameters of the definition when translated into operational practice. However, the preventive approach which underpins the OPCAT means that as expansive an interpretation as possible should be taken in order to maximise the preventive impact of the work of the NPM.

The SPT therefore takes the view that any place in which a person is deprived of liberty (in the sense of not being free to leave), ***or where it considers that a person might be being deprived of their liberty, should fall within the scope of its visiting mandate*** *– and, in consequence, under the visiting mandate of an NPM –* ***if it relates to a situation in which the State either exercises, or might be expected to exercise a regulatory function.****

*Emphasis added

Drawing on the SPT's conclusion any place where people may not be free to leave that is subject to the regulation or oversight of the State would fall within the scope of Article 4. This would include facilities and residences which are subject to national standards, rules or guidelines administered by the State. This is consistent with the approach adopted by both Germany and Austria in interpreting the scope of "deprivation of liberty".[102]

Aged care and residential disability care in New Zealand is provided by private providers, through contractual arrangements with the Ministry of Health and/or local DHBs. Legislation governs the standards of care and facilities are subject to audit requirements. As such, the government clearly has some regulatory control over the provision of care in these situations. In addition, although some residents will be privately paying for their care, the majority will be receiving a government subsidy for their care.

On this basis aged care and residential disability care services – that is, situations in which people are or may be prevented from leaving at will – can be seen to fall within the ambit of Article 4 of the OPCAT. Identifying the specific facilities that prevent (or can prevent) people from leaving at their will needs to be considered on a case by case basis. For instance, a contracted residential care facility with residents who maintain a relatively high degree of independent functioning and can come and go at will, would not meet the requirements. At the other end of the spectrum, locked aged care facilities would. As noted above, there are 138 locked aged care facilities in New Zealand. In addition, approximately 70% of people living in non-secure aged care facilities are experiencing dementia,[103] a group that may be inadvertently or deliberately deprived of their liberty. Of the 32,000 residents currently in aged care in New Zealand, about 49% are at rest home level, 38% at hospital level and 13% in dementia/psychogeriatric beds.[104]

In between these extremes there are a variety of facilities in which medium to high needs individuals live, in which their liberty is limited or removed to varying degrees.

10.2 Adapting to the New Zealand framework

The COTA provides that the Minister may designate NPMs to monitor places of detention. The definition of places of detention is non exhaustive. It is therefore feasible that a designation be made to monitor aged care facilities and community based disability residents. This begs the question as to which body may be the most appropriate to conduct such monitoring.

One possible solution is that the Minister designate this task to an existing NPM or within another independent body, such as the Health and Disability Commissioner. Based on current designations the

most appropriate NPM would be the Office of the Ombudsman, as it has existing responsibility for health and disability detention. However, the Ombudsman has noted that:[105]

While private sector dementia units might technically be considered to be Health and Disability Places of Detention, we consider that constitutional constraints would render it inappropriate for that role to sit with the Ombudsman. This is because of our constitutional function as an independent watchdog for public sector agencies. Extending our jurisdiction into the private sector would be constitutionally anomalous and at odd with our other functions. In this regard it is significant that the public/private sector distinction with respect to the role of the Ombudsman is preserved in the context of the Protected Disclosures Act – while the Protected Disclosures Act applies to both the public and private sector (and we can give guidance to any whistleblower), constitutional constraints reflected in the legislation mean we can only investigate protected disclosures relating to public sector bodies – if we receive a disclosure about a private sector company or organisation we are obliged to refer it to another appropriate authority for investigation.

On this basis the Ombudsman has concluded that it is inappropriate for it to monitor private sector dementia units and requested that the government appoint another agency to do so. The same rationale could be applied to private aged care facilities and residential disability services.

The OPCAT monitoring function of the Ombudsman should be seen as distinct from its other constitutional functions. The OPCAT is unequivocal about the need for operational and financial independence.[106] When an NPM is established within an existing body such as a National Human Rights Institution or an Ombudsman, the SPT has stated that NPMs must be capable of acting independently, not only from the State but also from these bodies.

On that basis it is possible to consider expanding the scope of the Ombudsman's monitoring under its operational and financially independent NPM function, while ensuring that it would not be affected by constitutional restraints relating to its core functions. However, that does not mean that it is necessarily desirable in the New Zealand context. The public/private sector distinction, which is at the centre of the Ombudsman's concerns, is clearly preserved in other areas. (For instance, in relation to New Zealand's Protected Disclosures legislation the Ombudsman can give guidance to any whistleblower. However if it receives a disclosure about a private sector company or organisation, it must refer it to another appropriate authority for investigation.)

Regardless of which body or bodies are designated to monitor places of detention, it is critical that such bodies are independent, appropriately resourced and have the requisite expertise for the task, including capability around engaging with affected people. As with other areas, the way in which monitoring is undertaken will need to be context-specific, taking into account the New Zealand environment and its regulatory framework. Guidance can be gleaned however from the German NPM, which is in the process of developing a monitoring framework for rest homes.

It is also important to recall that the adoption of OPCAT monitoring to any environment needs to complement and reinforce the existing audit and oversight framework.[107] The current audit system in New Zealand is complex and can already be arduous for some providers. The burden of multiple audits is a factor that needs to be taken into account and should be weighed against the benefit of improving care conditions and preventing ill-treatment.

OPCAT monitoring should not increase the compliance burden for providers. Rather it should be a mechanism that provides for ongoing proactive monitoring which could provide the framework for a more robust, independent and streamlined auditing framework.

1 **Drawing on the recommendation from the SPT, it is recommended that the Government commit without delay to meeting with NPMs to discuss gaps in the OPCAT monitoring framework and to develop a plan, with relevant sector bodies and civil society, to address these gaps.**

2 Acknowledging the obligation to enable NPMs access to all places of deprivation of liberty, it is recommended that the Government designate a body under the COTA as a NPM to ensure that those aged care and disability residences where a person is or may be prevented from leaving at their will are monitored. In doing so the Government must ensure that that body is appropriately resourced.

3 It is recommended that the Government commit to working with the NPMs to develop a framework for preventive monitoring of these facilities which is fit for purpose and complements the existing oversight mechanisms.

Endnotes

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32 Human Rights Committee, *Alzery v Sweden, Communication No. 1416/2005,* UN Doc CCPR/C/88/D/1416/2005 (2006) AT 11.5.

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