

Corrections breaches UN Convention

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The Department of Corrections has breached the Convention against Torture as well as its own legislation, in the way it manages some at-risk prisoners in New Zealand prisons, the Chief Ombudsman says.

In a report into the care and management of prisoners considered to be at risk of suicide and self-harm, Chief Ombudsman Peter Boshier found incidents of at-risk prisoners being restrained on tie-down beds by their legs, arms and chest over prolonged periods; and in waist restraints with their hands cuffed behind their backs.

The Chief Ombudsman also found the general management of at-risk prisoners across the country to be substandard and detrimental to their well-being.

The use of tie-down beds and waist restraints is only lawful in New Zealand prisons as a last resort, and in very prescribed circumstances, to protect prisoners from harming themselves or others. Mechanical restraints must be used in a manner that minimises harm or discomfort to the prisoner and must never be used for disciplinary purposes.

The Chief Ombudsman's Optional Protocol to the Convention Against Torture (OPCAT) inspectors found in one case at Auckland Prison a prisoner was secured to a tie-down bed for 16 hours at a time, for 37 nights in a row.

Judge Boshier says this prisoner spent 592 hours restrained on the tie-down bed, including in some cases being toileted on the bed. The prisoner's limbs were not moved during these prolonged periods of restraint in contravention of the Corrections Act and Corrections' policies to prevent associated medical issues from immobilisation.

Corrections also breached its own regulations by failing to seek medical approval to secure the prisoner to the tie-down bed 36 out of 37 times. Corrections' own rules around tie-down beds require that a new medical approval is issued before each new period of confinement.

The Chief Ombudsman's report also identified a failure to follow protocol in securing prisoners to tie-down beds, with up to 14 Corrections Officers in the cell while one prisoner was being restrained. *'It appeared disorganised at best and dangerous at worst.'*

Corrections told the Chief Ombudsman's inspectors the man was tied down to prevent wound-tampering and self-harm. However, during day time hours, the man was successfully managed through observation by Corrections staff, with no significant episodes of self harm. His restraint on the tie-down bed each night coincided with reduced staffing levels.

Judge Boshier acknowledges the difficulty of managing prisoners with complex behaviour but says *'tying an individual to a bed for up to 16 hours each day as a way to manage resourcing pressures is not appropriate'*.

In another case at Otago Corrections Facility, a prisoner was continuously kept in a waist restraint with his hands cuffed behind his back, after self-harming. The cuffs were used for 12 weeks prior to his release from prison, and were removed for two hours during the day, and every four hours at night.

The prisoner was locked in his cell for 21 hours a day. Despite a recommendation that the prisoner be treated by an experienced psychologist, this did not occur during the 12 weeks he was restrained with hand cuffs or prior to his release into the community.

The prisoner's medication was stopped upon his imprisonment. The prisoner reported his mental health deteriorated in the absence of the medication, and his self-harm escalated.

Judge Boshier says the wait list to see a psychiatrist for prisoners is routinely several weeks. The Ombudsman's inspectors had been unable to determine how often prisoners' medication was stopped on their entry to prison, and the flow on impact on their health and wellbeing.

Issues raised in the report include:

- Tie-down beds and waist restraints being used as a threat to force prisoner compliance.
- Corrections' basic procedures regarding the safe use of restraints not being adhered to.
- Paperwork in relation to the use of tie-down beds and management of at-risk prisoners being insufficient or absent.
- At-risk prisoners being monitored by cameras including while toileting, with television monitors visible to anyone in staff offices, including visitors.
- At risk units exacerbating mental health issues, with prisoners spending up to 24 hours a day alone, with no reading or writing material, and no opportunity for social contact, despite withdrawal from social contact being identified as a sign of at-risk behaviour.
- Lack of intervention – Ombudsman inspections found no evidence of at-risk prisoners taking part in any sort of structured activity. There was little record of at-risk prisoners seeing social workers, therapists, psychiatrists, cultural advisors or chaplains. Staff contact with at-risk prisoners was generally perfunctory due to time constraints.
- Training for staff working in at-risk units being of a basic level despite the complex needs of at-risk prisoners.

- Problems with communication between Corrections and Regional Forensic Psychiatric Services, resulting in at-risk prisoners not getting the level of healthcare or treatment required.

The Chief Ombudsman is encouraged that the Department of Corrections has undertaken to review its At Risk programme as a result of this report.

The full report can be found at <http://www.ombudsman.parliament.nz/resources-and-publications/documents/a-question-of-restraint>.

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