Human Rights Commission
Te Kāhui Tika Tangata

Monitoring Places of Detention

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

1 July 2012 to 30 June 2013

IPCA
Independent Police Conduct Authority
Whaia te pono, kia puawai ko te tika

Ombudsman
Fairness for all

Manaakitia a tatou tamariki, taiohi hoki
Children's Commissioner

The Judge Advocate General of the Armed Forces

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Preface

The Optional Protocol to the Convention Against Torture (OPCAT) is an international treaty that focuses on the prevention of human rights abuses. This includes the prevention of intentional infliction of severe physical and mental pain and the imposition of cruel or unusual punishment by agents of the state. OPCAT also requires regular review of places of detention and consideration of the manner in which detainees are treated.

OPCAT was ratified by New Zealand in 2007. The practical mechanisms for ensuring compliance with OPCAT obligations are contained in the Crimes of Torture Act 1989. This legislation designates certain agencies to act as National Preventative Mechanisms (NPMs) to examine the conditions of detention applying to detainees and the treatment of detainees.

The Human Rights Commission is designated as the Central National Preventative Mechanism (Central NPM). The Central NPM is responsible for coordinating the activities of the NPMs and maintaining effective liaison with the United Nations Subcommittee on Prevention of Torture (SPT) which is appointed to oversee OPCAT.

This report provides information about the work undertaken by the NPMs during the 2012-2013 period. A number of significant activities have taken place during this time.

New Zealand received its first visit from the SPT in May 2013. A delegation of six independent experts visited places of detention. The SPT met with the Government, civil society organisations, the Central NPM and the NPMs responsible for monitoring places of detention, and conducted interviews with detained persons.

The report and recommendations from the SPT will be submitted to the Government and will form the basis for further improvements to New Zealand's detention system in future.

A key focus of the past year has been the review, assessment and improvement of monitoring processes by the NPMs. NPMs have undertaken an internal review of OPCAT procedures over the first five years of operation.

Monitoring places of detention and preventing ill-treatment is an on-going task. Guidance issued by the SPT notes that:

> *The development of national preventive mechanisms should be considered an ongoing obligation, with reinforcement of formal aspects and working methods refined and improved incrementally.*[1]

Taking the opportunity presented by the five-year milestone, the Central NPM and the NPMs have examined progress, challenges and achievements and have identified areas where we could do better. While we are proud of what we have achieved, we also know that there is room for continual learning and improvement. This review provides a solid basis for ensuring that we continue to carry out this important work as effectively as possible.

The Association for Prevention of Torture (APT) has provided invaluable assistance since the establishment of NPMs in New Zealand. With the support of APT we have undertaken some important strategic and operational planning and have developed an NPM Action Plan.

The past year has been particularly busy for all the NPMs and has been a year of change and development. As chair of the Central NPM I would like to take this opportunity to draw attention to and acknowledge the work of all New Zealand's NPMs. The Ombudsman, the Independent Police Conduct Authority, the Office of the Children's Commissioner and the Inspector of Penal Service Establishments have all demonstrated unwavering commitment to ensuring detainees in New Zealand are treated in accordance with our international obligations. These organisations have also contributed to the ongoing improvement of detention facilities in New Zealand. Much progress has been made due to the care and effort that NPM personnel have applied to their work.

David Rutherford
Chief Commissioner, Human Rights Commission
Te Amokapua, Te Kāhui Tika Tangata

1 Subcommittee for Prevention of Torture, (2011), Analytical Self-Assessment Tool for National Preventive Mechanisms, 18 October 2011, CAT/OP/12/8, para 3.

Human Rights Commission

The Crimes of Torture Act 1989 designates the Human Rights Commission (the Commission) as the Central National Preventive Mechanism for New Zealand. In this role the Commission is required to coordinate with NPMs, identify systemic issues and liaise with the UN Subcommittee on Prevention of Torture (SPT).

The Commission is an independent Crown entity with a wide range of functions under the Human Rights Act 1993. One of the Commission's primary functions is to advocate and promote respect for, and an understanding and appreciation of, human rights in New Zealand society.

The Commission's functions may be undertaken through a range of activities, including advocacy, coordination of human rights programmes and activities, carrying out inquiries, making public statements and reporting to the Prime Minister on any matter affecting human rights. This includes the desirability of legislative, administrative or other action to better protect human rights. The Commission also administers a dispute resolution process for complaints about unlawful discrimination.

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

Context

The Commission's role as Central NPM is established under sections 31-32 of the Crimes of Torture Act 1989 (the Act). The Act outlines in general terms, the coordination role played by the Central NPM.

As part of the review and strategic planning activities undertaken this year, the Commission has worked with NPMs to examine their needs and the support required from the Commission, and has developed a clearer definition of the Central NPM role.

This includes:

1 publication of the annual report

2 addressing systemic issues and advocating on issues of common concern

3 liaising with the SPT

4 coordinating and maintaining NPM policies and procedures

5 maintaining an online workspace for NPMs to share information

6 coordinating and facilitating outreach activities, including an annual programme of engagement with civil society

7 organising training and development activities, such as thematic workshops

8 convening regular meetings of NPMs

9 providing expert human rights advice

10 assisting with NPM monitoring.

Summary of activities

In its role as the Central NPM, the Commission has convened six roundtable meetings of NPMs for the purpose of sharing information and discussing key issues. In addition, the Commission has liaised with NPMs and hosted various other meetings related to NPM activities.

A focus this year has been working with NPMs to review and develop practices and processes. A review of the first five years of OPCAT implementation, *OPCAT in New Zealand: 2007-2012*, was completed and is available on the Commission's website: http://www.hrc.co.nz/human-rights-environment/monitoring-places-of-detention.

The review helped to inform a two-day strategic planning workshop, facilitated by members of the APT. Building on the five-year review findings, the workshop identified weaknesses and challenges of NPM operations, defined collective priorities and began developing an NPM Action Plan for the coming year.

The Commission has continued to progress a number of follow-up actions from the strategic planning workshop, including the development of the NPM Action Plan. The Action Plan covers outreach activities; developing

a business case and securing resources; building the collective NPM evidence base; leadership and coordination and general NPM operations (for example access to expertise, multidisciplinary teams, and cultural diversity).

During their visit the APT also provided a half-day training workshop on preventive monitoring and drafting recommendations. Three Commission staff attended the training, in order to build capacity and capability within the Commission to assist NPMs with monitoring visits.

The first visit to New Zealand by the UN Subcommittee for Prevention of Torture this year was another major milestone for OPCAT in New Zealand. The Commission liaised with the SPT Secretariat in relation to the SPT's visit and hosted a day and a half of discussions between NPMs and the SPT.

The SPT consists of independent experts in their own right, nominated and elected by the States who have signed up to OPCAT. Members are drawn from a wide range of expertise, regions and backgrounds, such as law, medicine, academia, monitoring or oversight bodies, and individuals experienced in the administration of detention facilities. The SPT is assisted by a secretariat, based in the UN Office of the High Commissioner for Human Rights (OHCHR).

The delegation to New Zealand consisted of six SPT members, assisted by four secretariat staff. During their 10 day visit, the SPT travelled around New Zealand and visited:

- 16 police stations
- 5 District Courts
- 7 prisons
- 2 Defence Force sites
- 3 Child, Youth and Family residences
- 2 immigration facilities.

The SPT also met with relevant Government agencies, representatives of civil society and with the CNPM and all of the NPMs.

Going forward

As well as the review activities undertaken with other NPMs, the Commission completed an internal structural review and reorganisation. Over the next year, this new structure will allow the Commission to effectively progress the NPM Action Plan, working with NPMs.

Office of the Children's Commissioner

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

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

The Children's Commissioner has joint responsibility with the Ombudsman to monitor children and young people in residences established under section 364 of the CYPFA. In effect, the Office carries out residence visits and refers reports and findings to the Chief Ombudsman for input, including recommendations that office wishes to make.

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

Context

Child, Youth and Family are responsible for nine residences for children and young people, established under section 364 of the CYPFA. These include four care and protection residences, four youth justice residences and a specialist residence for young men who have displayed sexually inappropriate behaviour.[2]

A Senior Advisor from the Office has had particular responsibility to carry out NPM work on behalf of the Children's Commissioner.

Summary of activities

A schedule of visits is established at the beginning of each year, ensuring each of the section 364 residences is visited once every two years. The Children's Commissioner also has separate responsibilities to visit section 364 residences as part of his general monitoring role. Information gathered from the Commissioner's general monitoring visits and quarterly reports received from the residences' Grievance Panels can raise issues to be followed up at a later stage during NPM work. During the 2012/13 financial year, the Office carried out unannounced visits to four facilities.

The unannounced visits have made it harder for the visiting team to meet with all relevant staff, due to shift work. An internal review is currently underway to consider how the Office's NPM monitoring visits will be conducted in the future, along with a wider review of the monitoring function. While there will always be a place for unannounced visits, to follow up on intelligence or concerns received by the Office it is likely that routine visits will be conducted following some level of preparation or notice.

While a Senior Advisor has led all NPM visits, they are always accompanied by an NPM inspector from another agency, or another staff member of the Office. This cross-fertilisation is worthwhile, with benefits extending to a better understanding of the role and improved procedures for collecting information, interviewing, analysis and reporting.

Before an NPM visit is undertaken, the Office checks:

- Child, Youth and Family's annual residential audit of compliance with the Children, Young Persons and Their Families (Residential Care) Regulations 1996 (the Regulations)
- quarterly grievance panel reports.

In the course of residence visits, the Office looks at:

1 **Treatment:** identifying any incidents of torture, cruel or inhuman treatment, the use of isolation and/or of force and restraint.

2 **Protection measures:** provision of information such as complaint, inspection, and disciplinary procedures and how such incidents are recorded.

2 The day-to-day running of which is undertaken by Barnardos.

3 **Material conditions:** accommodation, lighting and ventilation, personal hygiene, sanitary facilities, clothing and bedding, and food.

4 **Regime and Activities:** contact with family and the outside world, outdoor exercise, education, leisure activities, and religion.

5 **Access to medical services:** access to medical care on and off-site.

6 **Personnel:** staff conduct and training.

During the 2012/13 financial year, the Office undertook four inspections. The Office visited Te Oranga (Care and Protection) in September 2012; Korowai Manaaki (Youth Justice) in November 2012; Epuni (Care and Protection) in February 2013; and Whakatakapokai (Care and Protection) in May 2013.

During the visits, there were discussions with children and young people, staff, management and external stakeholder agencies. Each visit took one to three days[3] and required extensive verification of processes to ensure children and young people were not exposed to torture, cruel, inhuman or degrading treatment or punishment. Following each visit a comprehensive report was completed and a series of recommendations made.

During the year the Office met with the delegation from the SPT. The opportunity to meet with the delegation and talk about our visiting structure and processes was appreciated. The Office looks forward to receiving formal feedback from their visit.

Key findings for 2012 / 2013

The key findings made in this financial year are:

a within each of the nine residences, processes are in place to ensure that children and young people are not exposed to torture, brutality or inhuman treatment

b all residences have complied with their obligations under OPCAT to ensure children and young people are not exposed to torture, brutality or inhuman treatment. Most of these processes are prescribed by the Regulations. Child, Youth and Family audits compliance against these Regulations annually

c Child, Youth and Family and Barnardos management continue to be helpful in facilitating access to the residential facilities, staff, residents and to written documentation. The Office's reports have been well received, with recommendations promptly addressed and responded to.

Although the Office found that residences are generally complying with the Regulations, there is always room for further improvement and we identified a number of areas where improvements could be made. These were reported back to Child, Youth and Family which has provided an assurance that these are being addressed. The Office will continue to monitor these during next year's visits.

Strengths

The Office was pleased to see improved leadership across most residences and notes that Child, Youth and Family's National Office is helping to lift and shape practice improvements. One residence has developed an excellent incident analysis system that is being introduced across all youth justice residences. In general, residences have strengthened their assessment and planning processes with plans now individualised and young people having increased access to education, training and employment opportunities.

Areas for improvement

The Office would like to see all residences consistently focus on the positive aspects of each child or young person's behaviour, recording their strengths and interests as well as identifying particular needs and risks. It is noted that Child, Youth and Family has been developing national

3 Depending on the size of the residence and issues being explored.

and regional relationships with the Ministry of Health and district health boards (DHBs) in order to access mental health support. This is an area that requires ongoing collaboration between the Ministry of Health, DHBs and Child, Youth and Family to ensure that children and young people are accessing timely and appropriate mental health and crisis response services.

Resources

The Office continues to undertake its NPM responsibilities with no additional funding. It also continues to meet the number of visits suggested in international guidelines.[4] The organisational culture within a residence can change quickly depending on the leadership and the make-up of staff and residents at each facility. If the Office was to receive extra funding, it could undertake a greater number of visits and, where necessary, work with a multi-agency reviewing team, to further strengthen the preventive focus of these visits. This issue has been referred to in greater detail in the OPCAT five-year review.

Review of the detention of young people in Police cells

The Office is responsible for two recommendations from the Joint Thematic Review of the policies and practices in relation to the care of young people detained in Police cells. The recommendations relate to the information and training being given to adults who act as a nominated person for any young person arrested by the Police. Reponses to these have since been discussed with the Ministry of Justice.

Going forward

During 2013/14, the Office will continue to undertake all NPM visits in conjunction with other NPM agencies and to complete reports. As the current review of the Office's monitoring function is completed it will assess the optimum balance between NPM and general residence monitoring for the year to come.

4 International guidelines suggest that each facility must be visited at least once every four years. It is suggested that facilities that house children and young people are visited more frequently.

Independent Police Conduct Authority

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

The Authority is an independent Crown entity, which exists to ensure and maintain public confidence in the New Zealand Police. The Authority does this by considering and, if it deems necessary, investigating public complaints against Police of alleged misconduct or neglect of duty and assessing Police compliance with relevant policies, procedures and practices in these instances.

The Authority also receives from the Commissioner of Police notification of all incidents involving Police where death or serious bodily harm has occurred. It may investigate those incidents and other matters involving police policy, practice and procedure where it is satisfied that it is in the public interest to do so.

Judge Sir David Carruthers is the Chair of the Independent Police Conduct Authority, having been appointed to a five-year term in April 2012.

Summary of activities

Visits

In its role as NPM for Police detention, the Authority conducted 11 site visits during the 2012/13 reporting year. The visits covered custody facilities in Police Districts not previously inspected by the OPCAT team and predominantly involved urban sites.

Throughout the reporting year the Authority received close to 2,000 complaints from members of the public or by notification from the Police, 11.8% of which were identified as having OPCAT related issues.

In respect of future site visits, the Authority, in collaboration with Police, will be developing a set of National Standards in relation to custodial facilities. It will then seek annual reports from the Police on the extent to which custodial facilities have met the Standards. This will allow for a more efficient and effective form of preventive reporting. The Authority will then undertake periodic audits of the annual reports from Police on a planned and agreed basis.

Once the National Standards have been agreed and the reporting and auditing process established, the Authority envisages the development of a programme of action to address substandard facilities over time which may include, but will not be limited to, supplementary site visits.

Fewer sites were visited than planned during the reporting period because the Authority was developing its new monitoring process. It therefore reduced the number of site visits to allow time for the development of the new process.

Engagement

New Zealand Police

The Authority has continued to engage with Police during the course of this reporting year, through its site visits and its consideration of complaints by members of the public and by referrals from the Police where there has been a death or serious injury occurring in Police custody.

The Authority continues to have a measurable effect on Police custodial processes and procedures. This has been achieved through engagement with Police National Headquarters and OPCAT site visits. The Authority also applies an OPCAT perspective to its independent investigations and reviews. While independent investigations and reviews are a separate statutory function of the Authority, the human rights principles and standards applied in the OPCAT context are equally relevant to the Authority's general oversight role.

In the 2012/13 reporting year the Authority identified a number of recurring issues in custodial facilities. In the normal course of business it undertook a number of independent investigations and reviews into incidents involving detainees in Police custody. The Authority's independent investigations and reviews covered issues

such as attempted suicide and allegations of serious bodily harm while in Police custody. Other issues identified as areas of concern for the Authority included the processes for assessing the mental health of detainees; the difficulties in accessing mental health services for that purpose; and inadequacies in the training and knowledge of custodial staff in providing required standards of care.

In order to assist in identifying trends or "hot spots", the Authority is changing its complaints database so that the information it receives on a daily basis will more clearly identify those matters which refer to Police activities in custodial facilities. This change will provide more accurate about what happens in custodial facilities, including patterns of complaints, which will then provide material for more focussed activities.

NPMs

The Authority continued to work closely with other NPMs during the reporting period. It remains committed to working with NPMs on reviewing its prevention methodologies and identifying avenues for further development moving forward.

Going forward

In the coming year the Authority will implement its new approach to OPCAT work with the introduction of National Standards for Police custodial facilities along with a robust reporting and auditing process supplemented by a programme of action to address substandard facilities.

Inspector of Service Penal Establishments

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

The appointment of the ISPE is tied to the appointment of the Registrar of the Court Martial of New Zealand, an official appointed independently by the Chief Judge of that jurisdiction by the provisions of the Court Martial Act 2007 (sections 79 (1) and 80).

Context

The Services Corrective Establishment (SCE) is located in Burnham Military Camp just south of Christchurch. In addition, there are a limited number of holding cells in each of the more significant New Zealand Defence Force base or camp facilities that are used to confine members of the Armed Forces for a few days at a time.

While there are no detention facilities off-shore currently available to the NZDF on NZ Navy Ships or for the forces on operational deployments, they can be arranged relatively readily when required as the Armed Forces Discipline Act section 175(1) permits the Chief of Defence Force from time to time to:

> *set aside any building or part of a building as a service prison or a detention quarter; or*
> *declare any place or ship, or part of any place or ship, to be a service prison or detention quarter.*

Approach

The ISPE has no staff, but has the capacity to second staff if required to assist in meeting OPCAT objectives to ensure that all members of the Armed Forces deprived of their liberty are treated with humanity and respect, and not subjected to torture or to cruel, inhuman or degrading treatment or punishment.

The ISPE continues to arrive unannounced at the reception office of the SCE. After presenting credentials, it meets with the Chief Warden before reviewing documentation, inspecting the facilities and interviewing each detainee individually and in private. Feedback is provided routinely at the conclusion of the inspection to the Commandant of SCE and to the Chief Warden. Any significant concern identified is reported directly to the Chief of Defence Force.

Summary of activities

While up to eight inspections are authorised each year, two inspections of SCE were conducted in 2012/13. The cells at HMNZS PHILOMEL in the Naval Base in Devonport and SCE were also inspected by the United Nations Subcommittee on Prevention of Torture (SPT) during their inspection tour of New Zealand in April/May 2013, although its report on the inspection is not yet available.

Issues

The ISPE continues to receive cooperation at all levels in the NZDF. The Armed Forces comply with its obligations to OPCAT.

The SCE is a fairly modern but small detention facility that can cater for up to eight male and two female detainees at any one time. It has a professional staff of Non Commissioned Officer wardens drawn from all three Armed Services. They are supported by a senior officer from Headquarters 3 Land Force Group who holds a dual appointment that includes the position of Commandant SCE in his or her job description.

The ISPE is satisfied with the treatment and conditions of detention and with the measures in place there, and the attitude of the management and staff at SCE suggests that torture and ill treatment in the future is highly unlikely.

While detention as a punishment is vital to the maintenance of good order and military discipline, it is a punishment for serious offending, and as such is sparingly assigned by Disciplinary Officers exercising their responsibilities at Summary Proceedings Hearings. During the reporting period, one member of the Armed Forces was sentenced to six months detention and dismissal

from the Forces by the Court Martial of New Zealand, but most of the balance of detainees over the reporting period served sentences of less than 20 days detention.

If the SCE remains resourced and managed at current levels the ISPE is confident that it is unlikely to generate OPCAT issues.

Going forward

It is intended to complete up to eight OPCAT inspections of SCE in the 2013/14 year.

Further visits to camp and base holding cells will also be arranged to ensure the facilities meet minimum requirements and that the management of detainees is robust enough to ensure that OPCAT objectives continue to be met by the New Zealand Armed Forces.

Ombudsman

The Ombudsman has been designated as the NPM for prisons, immigration detention facilities, health and disability places of detention, and child and youth residences.

The Ombudsman has wide statutory powers to investigate complaints against central and local government agencies. The functions and powers of the Ombudsman are set out in several pieces of legislation, including the Ombudsman Act 1975.

The Ombudsman's role includes providing an external and independent review process for individual prisoners' grievances, as well as the ability to conduct investigations on their own motion.

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

Overview

The Ombudsman has responsibility for monitoring and making recommendations to improve the conditions and treatment of detainees, and to prevent torture, and other cruel, inhuman or degrading treatment or punishment in:

- 17 prisons
- 102 health and disability places of detention
- 1 immigration detention facility
- 4 child care and protection residences
- 5 youth justice residences.

There are also an additional 132 aged care facilities with dementia units that may fall within the Ombudsman's designation in respect of health and disability places of detention. If so, the Ombudsman would need to seek additional funding in order to conduct regular inspections of these facilities.

The designation of child care and protection and youth justice residences is jointly shared with the Office of the Children's Commissioner.

Two Inspectors exercise delegations from the Ombudsman in carrying out our NPM functions under the Crimes of Torture Act 1989 (COTA). In 2012/13 the Ombudsman committed to carrying out 32 visits to places of detention. It well exceeded this commitment and carried out a total of 45 visits, including 22 formal inspections. 35 visits (just over 77%) were unannounced.

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

Name of facility	Type of facility	Recommendations made
Ward K1, Princess Margaret Hospital, Canterbury DHB	Acute assessment (organic brain disorders)	1
Hohou Roko, Hillmorton Hospital, Canterbury DHB	Forensic rehabilitation	-
Rimutaka – Upper Prison	Prison	7
Waiatarau Unit, Waitakere Hospital, Waitemata DHB	Acute mental health	-
Tongariro – Cedar Units	Prison	1
Wahi Oranga Unit, Nelson Hospital, Nelson & Marlborough DHB (follow-up inspection)	Acute mental health	-
He Oranga Kahurongi Unit, Grey Hospital, West Coast DHB	Dementia unit	1
Manaakitanga Unit, Grey Hospital, West Coast DHB	Acute mental health	1
Rimutaka – Management Unit	Prison	6
Starship Child and Family Unit, Auckland Hospital, Auckland DHB	Child and adolescence	1
Te Whare Awhiora, Gisborne Hospital, Tairawhiti DHB	Acute mental health	-
Totara Unit, Mason Clinic, Waitemata DHB	Forensic unit	5
Tanekaka Unit, Mason Clinic, Waitemata DHB	Forensic rehabilitation	-
Ward 36, Henry Bennett Centre, Waikato DHB	Acute mental health	-
Puna Poipoi, Henry Bennett Centre, Waikato DHB	Forensic rehabilitation	-
Ward 9b, Wakari Hospital, Southern DHB	Acute mental health	-
Helensburg Cottage, Wakari Hospital, Southern DHB	Forensic rehabilitation/Intellectual disability	-
Auckland East – Management Unit and ARU	Prison	6
Rimutaka – Management Unit (follow-up)	Prison	5
Te Whare O Matairangi, Wellington Hospital, Capital & Coast DHB	Acute mental health	-
Mt Eden – Management Unit and CSI Unit	Prison	5
Christchurch Men's – Management Unit	Prison	1

The Ombudsman reported back to 20 places of detention (91%) within three months of conducting an inspection and made 40 recommendations of which 35 were accepted or partially accepted.

- **Prisons:** 30 accepted, one not accepted.
- **Health and disability places of detention:** five accepted, four not accepted.

Prisons

Segregation facilities (management units)

In last year's Annual Report, two prisons were identified (Auckland and Waikeria), where there were significant variances within the directed segregation regimes being applied to prisoners pursuant to sections 58(1)(a) or (b) of the Corrections Act 2004. Directed segregation units house prisoners who pose a risk to the security and good order of the prison. There were particular variances in the amount of time prisoners were allowed out of their cells, particularly in the open air. This year the inspectors maintained their focus on segregation facilities at a further three sites: Rimutaka Prison, Mt Eden Corrections Facility and Christchurch Men's Prison. A fourth follow-up inspection was also undertaken at Auckland Prison.[5]

Segregated prisoners at Auckland and Mt Eden prisons had particularly bad living conditions with dirty toilets and graffiti on cell walls. The lack of appropriate management facilities at Auckland Prison means segregated prisoners are housed with non-segregated prisoners including, on occasion, remand prisoners. This mixed regime, along with reduced unlock hours (8.30am to 11.30am and 1.30pm to 4.30pm) dramatically reduces the time out of cells for prisoners. This is exacerbated by a lack of stimulation for those held on long term segregation. Although it has been indicated that a new, maximum security prison will replace the current one at Auckland Prison, this is several years away. In the meantime, accommodation for those prisoners currently undergoing a period of segregation is well below standard and could be considered cruel and inhuman for the purposes of the Convention Against Torture. Two new stainless steel cells are being piloted with a view to rolling out similar cells to replace the existing cells. These cells are similarly substandard and the Ombudsman is in active discussions with the Department about upgrading the plans. The Department said that the construction of an interim Management Unit is scheduled to commence in early 2014, with completion in September 2014.

Generally, the documentation relating to those held on segregation was used inconsistently and was poorly completed, with essential details missing. In most cases, reviews of prisoners on segregation remained perfunctory, with little emphasis on reintegration to a normal residential unit or meaningful programmes to challenge and address poor behaviour. Inadequate records management and a general lack of managerial oversight seemed to be a significant issue across the board.

Most prisoners placed on directed segregation were not receiving their daily minimum entitlement of one hour in the open air at Rimutaka, Mt Eden and Auckland. However, Rimutaka had addressed this issue by the time a follow-up inspection was carried out in April 2013.

The management cells at Mt Eden are included in the overall prison muster resulting in some newly arrived inmates having to be located in the unit for several days, until a bed becomes available in the main prison. This is considered to be inappropriate.

Meal times

The Ombudsman expressed concerns this year about the truncated period in two prisons between breakfast and dinner (8.15am and 3.30pm and 4pm respectively). It is understood from visits in previous years that this condensed meal time is a broader problem. The Ombudsman is in discussions with the Department as to how this might be resolved across the board.

Use of force and restraint

The term "use of force or restraint" covers a wide range of actions or equipment that restrict a prisoner's movement. "Trifling" is a relatively new term that describes when a member of staff has placed a hand on a prisoner to guide them to, or remove them from, a particular location or situation. Incidents that Corrections categorise as "trifling" are not recorded (unlike use of force), and are therefore not open to scrutiny by senior management. The same applies to incidents where mechanical restraints (handcuffs) have been applied to a prisoner for non-escort purposes.

5 The previous inspections were in 2010, 2011 and 2012.

Concerns were expressed by two prisoners who felt excessive force was used against them during incidents in their respective units. When inspectors queried the incidents, management described one as a "trifling" event and the other as applying mechanical restraints to a prisoner for non-escort purposes.

Neither event requires recording under Department of Corrections policy. Further investigation, including the viewing of video footage, revealed force had in fact been used against each prisoner and the under-reporting by staff failed to trigger the necessary checks by senior management. Both prisoners were located in Rimutaka Prison. The prison has since implemented a process whereby all "trifling" incidents and applications of handcuffs for non-escort purposes will be reviewed by the Residential Manager, in addition to an official review process.

The Ombudsman will be monitoring other facilities to determine whether there is a need to recommend a broader review of the policy not to record "trifling" incidents and the application of mechanical restraints for non-escort purposes. Such a review would bring the prison facilities regime into line with the mental health facilities regime.

Good practices at the five prisons visited

- At Mt Eden, weekly segregation review panels and a health screening algorithm are used to review prisoners' behaviour before, during and after a period of segregation. Some prisoners (based on risk) are able to associate with other prisoners while in the management unit, but others have gradual reintegration back in their units prior to the completion of segregation.
- The Care, Support and Integration Unit at Mt Eden is a therapeutic unit run by a multi-disciplinary team of staff. It predominately caters for those prisoners considered to be at risk of harm to themselves and in need of greater levels of intervention with regard to their mental health. This unit is a model of good practice in the balance it achieves between therapeutic and custodial regimes. Furthermore, the Unit's mental health outreach team is a positive addition to the mental health work already being undertaken across the site.
- The mental health course being undertaken by some custodial officers at Mt Eden (funded by Serco) gives staff the opportunity to enhance their knowledge and skills of general mental health issues.
- In December 2012, the Department opened a 20-bed High Dependency Unit in Rimutaka Prison. This much needed facility is a first for New Zealand prisons and will hopefully address some of the growing concerns relating to the aging prison population. Although the Ombudsman has not undertaken a formal inspection, there was the opportunity to look around the unit during the open day.

Health and disability places of detention

Intellectual Disability (Compulsory Care and Rehabilitation) Act

The Ombudsman visited one, relatively new intellectual disability facility this year: Helensburgh Cottage at Wakari Hospital. The cottage is a step down facility for clients/care recipients with an intellectual disability and has four beds. Generally, clients move to the less restrictive environment and continue the gradual reintegration process back into the community. One of the current clients was previously located in a secure unit, in Wakari, when the site was visited in 2008. It was encouraging to see the client in such a contrasting environment and the client's general improvement since the last visit.

Mental Health (Compulsory Assessment and Treatment) Act

Guidance on seclusion and "night safety procedures"

Historically, the human rights of patients have been affected by controlling practices, so it has been pleasing to see a general improvement in the philosophy of care used in most mental health facilities visited over the last

three years. However, one forensic unit, Tōtara Unit in the Mason Clinic (Waitematā DHB), still has controlling practices in place and a blanket policy of locking patients in their bedrooms overnight pursuant to outdated "night safety" procedures.

An inspection also found patients were unable to freely access their bedrooms throughout the day as all internal doors were operated by a swipe card held by staff. Patients are advised that there are no staff in the bedroom area in the daytime, which means their door will remain locked to maintain the security and safety of the area. If patients request to go to their room for a rest, they are locked in.

The *Night Safety Procedures* guidance document written in 1995 allowed some informal patients and patients within some forensic units to have their bedroom doors locked overnight. However, it has been superseded by the Ministry of Health's 2010 publication, *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. The practice of locking someone in their bedroom (at any time of the day or night) should be considered a period of seclusion and reported as such. There was no such reporting at the Tōtara Unit.

Until recently, Pūrehurehu Unit at Te Korowai-Whāriki forensic mental health service (Capital and Coast DHB (CCDHB)) also had a blanket policy for locking patients in their bedrooms overnight. The Unit has now initiated individualised plans for those patients requiring night seclusion, but it is still not recording these as seclusion events.

As a result of the Ombudsman's report, the Mason Clinic has taken steps to remove blanket night safety procedures. The Ministry has also advised that it is reviewing its seclusion guidelines.

Patient held in seclusion on semi-permanent basis

In September 2011, the Ombudsman identified a patient in Tawhirimatea Unit, Korowai-Whāriki forensic mental health service who was being held in seclusion on a semi-permanent basis. A recommendation was made that "A more appropriate facility needs to be sourced for the client". A follow-up visit in June 2012 found the patient in the same situation and a repeat recommendation was made. Although the formal diagnosis has been subject to some dispute, the patient is being detained under section 30 of the Mental Health (Compulsory Assessment and Treatment) Act. The CCDHB, with the involvement of the Ombudsman, has been seeking to resolve the current situation.

In light of the seriousness of the situation, the Ombudsman initiated an investigation this reporting year under section 13 of the Ombudsmen Act to look into the overall treatment and management of the patient by CCDHB, with a particular focus on the extensive use of seclusion and the failure to arrange a more appropriate placement.

In early August 2013, the Director of Area Mental Health Services CCDHB confirmed that funding had been secured for a targeted service for the patient in the community.

Privacy and dignity

The following recommendation was made in the Tōtara Unit report: "All bathrooms and toilet doors should be lockable from the inside." The Unit's response was:

> *None of the bathrooms have locks, noting that in this acute end of the service self-harm is a real risk with consequential delays for staff intervention if individual locking in was possible. There are engaged/vacant tabs on the doors and patients/staff know to knock before entering. The patients have separate male/female bathroom areas.*

This approach does not adequately maintain the dignity and privacy of patients. The explanation was unsatisfactory as many mental health facilities visited have internal doors that can be overridden by staff, should they need to gain access in an emergency.

The Ombudsman has recently been advised that the Director of Mental Health will raise the issue of the lack of internal locks on toilet and bathroom doors during his

visit to Waitemata DHB's mental health and addiction facilities later in the year.

Good practices

- At Hohou Roko forensic rehabilitation unit (Canterbury DHB), work is being undertaken to provide consumers with access to the internet in preparation for their reintegration back into the community.
- Waiatarau mental health service (Waitemata DHB) has implemented a seclusion and restraint minimisation policy that has seen a substantial reduction in the use of both seclusion and restraint within the unit.
- Te Whare Awhiora mental health unit (Tairawhiti DHB) has developed a Recovery Action Plan document for patients upon their discharge from the unit.

Other activities

Office of the Inspector Custodial Services – Perth

In October 2012, one of the Ombudsman's Inspectors was invited to join the Office of the Inspector Custodial Services in Perth on a 6 day inspection of Greenough Regional Prison. Greenough Prison is situated 420 kilometres north of Perth and can house up to 239 male and female prisoners. This was a good opportunity to share learning and best practice in inspecting and monitoring places of detention and to form working relationships with another jurisdiction.

Association for the Prevention of Torture

In November 2012, the APT Secretary-General provided a keynote address at the 10th World Conference of the International Ombudsman Institute in Wellington. During the conference, the APT agreed to facilitate a two and a half day strategic planning workshop for all of the NPMs in New Zealand. A stimulating workshop and inspection training programme was held in April 2013.

United Nations Subcommittee on Prevention of Torture

The SPT made its first visit to New Zealand from 29 April 2013 to 8 May 2013. During the visit, SPT members met with relevant national authorities and representatives of civil society, and conducted visits to places of detention, including seven prisons. They dedicated one day of the visit to working alongside all of the NPMs and accompanied the Ombudsman's Inspectors on a follow-up visit to Rimutaka Prison. This was an opportunity to work alongside the international NPM and gain an insight into some of its working practices.

APPENDIX 1: OPCAT background

Introduction to OPCAT

The Optional Protocol to the Convention Against Torture (OPCAT) is an international human rights treaty that New Zealand ratified in 2007. It is designed to assist States to meet their obligations to prevent torture and ill treatment in places where people are deprived of their liberty. Unlike other human rights treaty processes that deal with violations of rights after the fact, the OPCAT is primarily concerned with preventing violations. It is based on the premise, supported by practical experience, that regular visits to places of detention are an effective means of preventing ill treatment and improving conditions of detention. This preventive approach aims to ensure that sufficient safeguards against ill treatment are in place and that any problems or risks are identified and addressed.

OPCAT establishes a dual system of preventive monitoring, undertaken by international and national monitoring bodies. The international body, the UN Subcommittee for the Prevention of Torture, will periodically visit each State Party to inspect places of detention and make recommendations to the State. At the national level, independent monitoring bodies called National Preventive Mechanisms (NPMs) are empowered under OPCAT to regularly visit places of detention, and make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing torture or ill treatment.

Preventive approach

The Association for Prevention of Torture (APT) highlights the fact that "prevention is based on the premise that the risk of torture and ill-treatment can exist or develop anywhere, including in countries that are considered to be free or almost free from tortures at a given time".[1]

> "Whether or not torture or other cruel, inhuman or degrading treatment or punishment occurs in practice, there is always a need for States to be vigilant in order to prevent ill-treatment. The scope of preventive work is large, encompassing any form of abuse of people deprived of their liberty which, if unchecked, could grow into torture or other cruel, inhuman or degrading treatment or punishment. Preventive visiting looks at legal and system features and current practice, including conditions, in order to identify where the gaps in protection exist and which safeguards require strengthening."[2]

Prevention is a fundamental obligation under international law, and a critical element in combating torture and cruel, inhuman or degrading treatment and punishment.[3] The preventive approach of OPCAT encompasses direct prevention (identifying and mitigating or eliminating risk factors before violations can occur); and indirect prevention (the deterrence that can be achieved through regular external scrutiny of what are, by nature, very closed environments).

> "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."[4]

1 APT (March 2011) *Questionnaire to members states, national human rights institutions, civil society and other relevant stakeholders on the role of prevention in the promotion and protection of human rights*, p. 10.

2 Subcommittee on Prevention of Torture (May 2008). *First Annual Report of the Subcommittee on Prevention of Torture*, CAT/C/40/2, para 12.

3 It sits alongside the obligations to criminalise torture, ensure impartial investigation and protection, and provide rehabilitation for victims.

4 UN Special Rapporteur on Torture, Report of the Special Rapporteur on torture to the 61st session of the UN General Assembly, A/61/259 (14 August, 2006), para 72.

Implementation in New Zealand

New Zealand ratified OPCAT in March 2007, following the enactment of amendments to the Crimes of Torture Act, to provide for visits by the UN Subcommittee and the establishment of NPMs.

New Zealand's designated NPMs are:

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

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

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

4 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

5 the Human Rights Commission has a coordination role as the designated Central NPM.

Functions and powers of National Preventive Mechanisms

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

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

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

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

The amended Crimes of Torture Act enables the Minister of Justice to designate one or more NPMs as well as a Central NPM and sets out the functions and powers of these bodies. Under section 27 of the Act, the functions of an NPM include examining the conditions of detention and treatment of detainees, and making recommendations to improve conditions and treatment and prevent torture or other forms of ill treatment. Sections 28-30 set out the powers of NPMs, ensuring they have all powers of access required under OPCAT.

Central National Preventive Mechanism

OPCAT envisions a system of regular visits to all places of detention.[5] The designation of a central mechanism 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 Central National Preventive Mechanism (CNPM) are set out in section 32 of the Crimes of Torture Act, and are to coordinate the activities of the NPMs and maintain effective liaison with the UN Subcommittee on Prevention of Torture. In carrying out these functions, the CNPM is to:

1 consult and liaise with NPMs

2 review their reports and advise of any systemic issues

3 coordinate the submission of reports to the Subcommittee

5 OPCAT, Article 1.

4 in consultation with NPMs, make recommendations on any matters concerning the prevention of torture and ill treatment in places of detention.

Monitoring processes

While the 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 OPCAT organisations have developed procedures applicable to each detention context.

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

1 Preparatory work, including information collection and identifying specific objectives, before a visit takes place.

2 The visit itself, during which the NPM visitors speak with management and staff, inspect the institution's facilities and documentation, and speak with people who are detained.

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

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

NPMs' assessment of the conditions and treatment of detention facilities takes account of international human rights standards, and involves looking at:

1 Treatment: any allegations of torture or ill treatment; the use of isolation, force and restraint.

2 Protection measures: registers, provision of information, complaint and inspection procedures, disciplinary procedures.

3 Material conditions: accommodation, lighting and ventilation, personal hygiene, sanitary facilities, clothing and bedding, food.

4 Activities and access to others: contact with family and the outside world, outdoor exercise, education, leisure activities, religion.

5 Health services: access to medical care.

6 Staff: conduct and training.

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