

 **Ombudsman**

Fairness for all

OPCAT FINDINGS REPORT

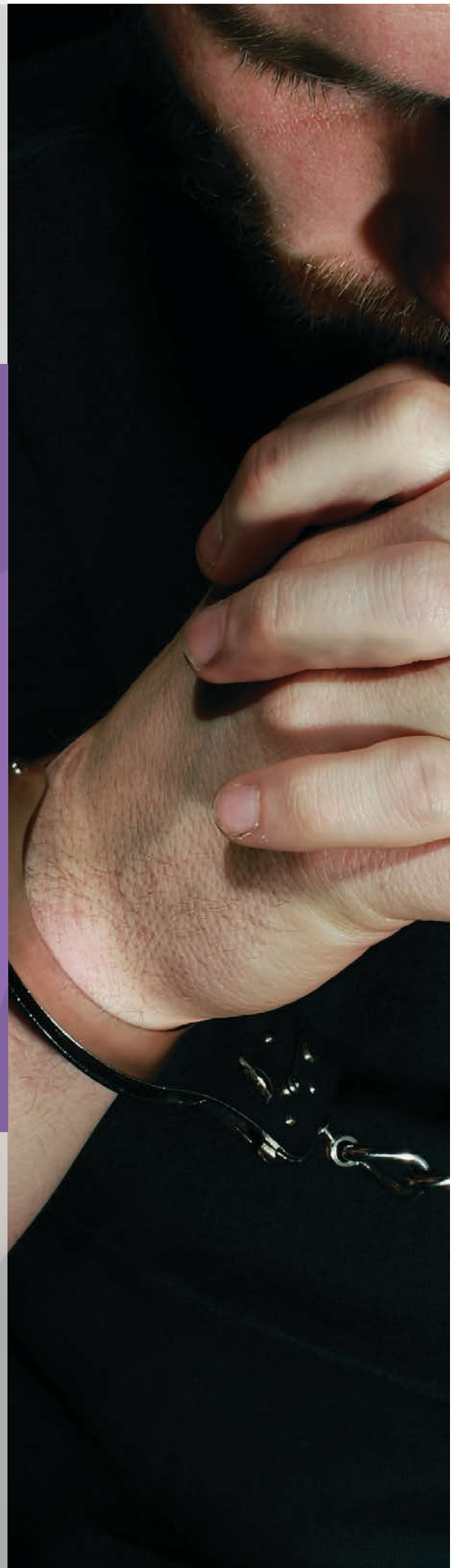
A question of restraint

Care and management for prisoners
considered to be at risk of suicide and
self-harm: observations and findings
from OPCAT inspectors

1 March 2017

Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



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Introduction

New Zealand signed the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in September 2003 and ratified OPCAT in March 2007. The objective of OPCAT is to establish a system of regular visits by international and national bodies to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

OPCAT is incorporated into New Zealand law through the Crimes of Torture Act 1989 (COTA).

The Ombudsman was designated a National Preventive Mechanism (NPM) in respect of:

- prisons;
- premises approved or agreed under the Immigration Act 1987; and
- health and disability places of detention.

Unlike other human rights treaty processes that deal with violations of rights after the fact, OPCAT is primarily concerned with preventing violations. Our visits are carried out with a view to strengthening protections against ill treatment and improving conditions of detention, taking into account international human rights standards. This preventive approach aims to ensure that sufficient safeguards against ill treatment are in place and that any risks, poor practices or systemic problems are identified and addressed.

Each place of detention we visit contains a wide variety of people, often with complex and competing needs. Some detainees are difficult to deal with – demanding and vulnerable – others are more engaging and constructive. All have to be managed within a framework that is consistent and fair to all. While we appreciate the complexity of running such facilities and caring for detainees, our obligation is to ensure that appropriate standards are maintained in the facilities, and to prevent torture and other cruel, inhuman or degrading treatment or punishment.

By their very nature, prisons house difficult to manage, sometimes dangerous and often vulnerable prisoners who can push boundaries and challenge the system. In coercive establishments such as prisons, there is a danger that security is overemphasised to the detriment of the dignity of prisoners. This year we found examples where order and security prevailed too easily over dignity and fairness; specifically, the care and treatment of adult prisoners considered to be at risk of suicide and self-harm.

This report highlights our observations and findings over the reporting period July 2015 – June 2016 and focuses on the comprehensive inspections of five prison sites: Arohata Women's Prison, Manawatu Prison, Rolleston Prison, Invercargill Prison and Otago Corrections Facility. Additional visits to Auckland Prison, Auckland Regional Women's Corrections Facility, Auckland South Corrections Facility (managed by SERCO), Christchurch Men's Prison and Rimutaka Prison are also referred to in the body of the report and help inform the overall findings in this report.

In coercive establishments such as prisons, there is a danger that security is overemphasised to the detriment of the dignity of prisoners. This year we found examples where order and security prevailed too easily over dignity and fairness; specifically, the care and treatment of adult prisoners considered to be at risk of suicide and self-harm.

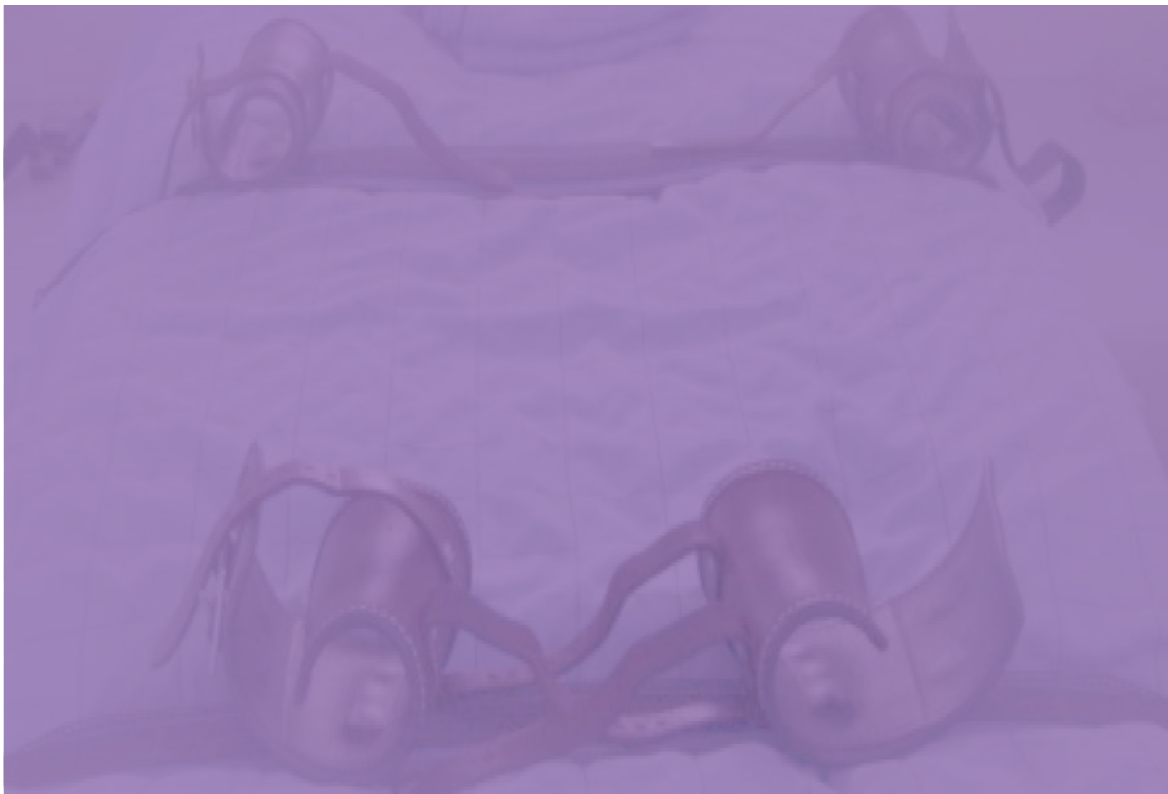
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Executive summary

Background

In 2007, the Ombudsmen were designated as one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of detainees in New Zealand prisons.

This report details observations and findings relating to prisoners who have been considered at risk of suicide and self-harm, who are managed in At-Risk Units (ARUs) in New Zealand prisons; and focuses on the comprehensive inspections of five prison sites.



Summary of findings

My findings may be summarised as follows:

- Of the 18 prisons across the country, 14 have a designated ARU. At-Risk cells at best can be described as sparsely furnished rooms, which are constantly monitored by a live camera-feed, including the unscreened toilet. Staff of either sex, in the course of their work, can observe At-Risk prisoners in various states of undress. Prisoners' clothing is removed on admission to ARUs and replaced with anti-rip gowns to minimise opportunities for self-harm.
- Routines within ARUs are similar to the regimes within management/separates units.¹ At-Risk prisoners are placed in isolation with limited interaction and therapeutic activities.
- ARU paperwork and directed segregation (for medical oversight) is not always fully completed and lacks specificity and personalisation.
- Training for staff working in ARUs is basic.
- Staff interactions with At-Risk prisoners are limited.
- There were incidences of At-Risk prisoners being restrained on tie-down beds by their legs, arms and chest over prolonged periods.
- There were incidences of At-Risk prisoners being restrained in waist restraints with their hands cuffed behind their backs.
- We discovered incidences of tie-down beds and possibly waist restraints being used for behaviour modification purposes at some sites.
- Prisons were not following their own procedures in respect of the application of mechanical restraints.
- The interface between Corrections and Regional Forensic Psychiatric Services appears not to be working as effectively as it could. Gaps in service provision were evident.

I consider that the use of the tie-down bed and/or waist restraints in the circumstances of Prisoners A, B, C, D and E² amounted to cruel, inhuman or degrading treatment or punishment for the purpose of Article 16 of the Convention against Torture. Furthermore, I believe the ability of prison staff to access footage of prisoners undertaking their ablutions constitutes degrading treatment or punishment under Article 16 of the Convention.³

1 Management units accommodate prisoners undergoing a period of segregation due to disciplinary issues or medical oversight (section 58-60 Corrections Act). Separate units accommodate prisoners serving a penalty of cell confinement following a misconduct hearing.

2 See page 24 and following

3 See <http://www.hrweb.org/legal/cat.html>

About the Optional Protocol to the Convention Against Torture (OPCAT)

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 detention can best be achieved by a system of independent, regular visits to all places of detention. During such visits, the treatment of, and conditions for, detainees are monitored.

States that ratify 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 places of 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; and
- 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 whom it wishes to interview;
- access information about the number of people deprived of their liberty, the number of places of detention and their location; and
- access information about the treatment of, and conditions for, detainees.

The NPM must also liaise with the Subcommittee on Prevention of Torture (SPT), an international body established by OPCAT with both operational functions (visiting places of detention in State parties and making recommendations regarding the protection of detainees from ill treatment) and advisory functions (providing assistance and training to State 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.⁴

⁴ See www.ohchr.org

New Zealand's NPMs

Along with the Ombudsman, a number of other organisations are also designated as NPMs, namely:

- The Independent Police Conduct Authority, for the purposes of examining and monitoring the treatment of people detained in police cells, or otherwise in the custody of the Police.
- The Children's Commissioner, for the purposes of examining and monitoring the treatment of children and young persons in care and protection and youth justice residences established under section 364 of the Children, Young Persons and Their Families Act.
- The Inspector of Service Penal Establishments (as appointed in accordance with section 80 of the Court Martial Act 2007), for the purposes of examining and monitoring the treatment of people detained in service penal establishments, as defined in section 2 of the Armed Forces Discipline Act 1971.

Central National Preventive Mechanism

The Human Rights Commission (HRC) has been designated as the Central National Preventive Mechanism.

Section 32 of COTA states that the functions of the Central National Preventive Mechanism are to:

- co-ordinate the activities of the NPMs; and
- maintain effective liaison with the SPT.

In carrying out its functions, the Central National Preventive Mechanism is to:

- consult and liaise with the NPMs;
- review the reports prepared by the NPMs under section 27(c) of COTA⁵, and advise the NPMs of any systemic issues arising from those reports;
- coordinate the submission of the reports prepared by the NPMs under section 27(c) of COTA to the SPT.

⁵ Section 27(c) requires each NPM to prepare at least one written report each year on the exercise of its functions under COTA during that year.

Rationale for this report

The SPT undertook a visit to New Zealand in late April 2013. During their two-week visit the SPT visited 36 places of detention, including seven prisons, and made a significant number of recommendations for improvement. A particular area of attention was the mental health of persons in places of detention.⁶

Three specific recommendations relating to health were to;⁷

1. Develop a comprehensive national policy for access to healthcare and mental healthcare services across the criminal justice system;
2. Ensure all officers are provided with adequate training; and
3. Audit the healthcare needs in institutions and ensure adequate access to mental health services.

Over the course of our nationwide inspections, my Inspectors have consistently raised concerns about the treatment and management of prisoners with mental health issues in the prison environment; particularly those assessed as suicidal or at risk of self-harm, who are placed in At-Risk Units (ARUs) or in safe cells, and who appear to have limited access to appropriate mental healthcare and therapeutic interaction.

Over the past 12 months, Inspectors have made numerous recommendations to Corrections in relation to the management of prisoners who are routinely placed in ARUs or safe cells. These recommendations have been made to Corrections on a prison-by-prison basis and have not previously been presented as part of a wider, thematic approach.⁸

In March 2016, my Inspectors learned about the extended restraint of a male prisoner in the ARU in Auckland Prison.⁹ The prisoner was strapped to a restraint-bed by his ankles, wrists, and waist, following several episodes of self-harm. I raised concerns regarding the ongoing restraint of this specific prisoner to the Deputy Chief Executive of Corrections on 27 April 2016. Corrections confirmed that it would conduct an immediate review into this case,¹⁰ given our concerns over the length of time and frequency the prisoner had been secured to the tie-down bed¹¹ and that it would release the report findings at the end of June 2016. Corrections released their report findings to the Office of the Ombudsman on 5 September 2016.

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6 The SPT did not visit any mental health facilities in New Zealand.

7 See http://tbinternet.ohchr.org/Treaties/CAT-OP/Shared%20Documents/NZL/CAT_OP_NZL_1_7242_E.pdf.

8 The Ombudsman's Office is currently working towards the publication of OPCAT reports on its website.

9 Auckland Prison is the only prison in New Zealand that holds maximum-security prisoners.

10 This review included the Prison Operations Manual on the use of tie-down beds, issuing a Corrections Services Circular on 13 May 2016 reiterating the requirement that prisoners are only restrained for the least time necessary to safeguard their wellbeing, as well as emphasising other measures to minimise the adverse physical and psychological effects.

11 See <http://www.radionz.co.nz/news/bites/303046/corrections-reviewing-tie-down-beds>.

Following this specific case, my Inspectors undertook to examine the management of several prisoners in other ARUs and safe cells across the country who presented a high risk of self-harm.¹²

These enquiries heightened my team's concerns about the management of these individuals and the effectiveness of ARUs generally. This report will:

- detail the OPCAT team's recent observations in relation to ARUs and safe cells in prisons across the country;
- review the level of training and support that custodial staff receive in working with prisoners at risk of suicide and self-harm;
- address the extended use of mechanical restraints, including tie-down beds and waist restraints (handcuffs) to manage self-harm;
- explore the interface between Corrections and Mental Health Services, particularly in relation to prisoners with personality disorders;
- examine access to appropriate therapeutic interventions for prisoners with mental health issues; and
- assess the quality of related policies, procedures and associated paperwork.

It is for Corrections to develop policies, strategies and best practice on how they manage prisoners at risk of self-harm and suicide in a way that ensures they receive optimal care and treatment and are managed in a safe and humane manner. It is hoped that our findings and observations will help Corrections to make advances in this challenging area and to desist from practices that breach Article 16 of the Convention Against Torture.

As part of our regular prison inspections we will continue to monitor progress in relation to prisoners considered to be at risk and make recommendations to Corrections as required.

This report will:

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It is hoped that our findings and observations will help Corrections to make advances in this challenging area and to desist from practices that breach Article 16 of the Convention Against Torture.

¹² In commenting on the draft report, Corrections asked that the report include reference to the fact that it is already taking action to develop a comprehensive national policy for access to healthcare and mental healthcare services, audit the healthcare needs in institutions and ensure adequate access to mental health services. This was the first communication my office has received about this from the Department of Corrections, in spite of the previous Chief Ombudsman asking that such a policy be developed in June 2015 (and prior to that in October 2012), and that she be kept abreast of developments. Corrections invited my Chief Inspector to attend a meeting on 16 December 2016, where she was briefed on the Department's plans to 'Transform Intervention and Support for At-Risk Prisoners.'

At Risk Units (ARUs)

At Risk Units– what are they?

An ARU is designed to enable the observation and safe management of prisoners at risk of harming themselves. Correction's website states *'For prisoners identified as at-risk we have 14 specifically designed at-risk units. The units accommodate prisoners who have been assessed as potentially suicidal or wanting to self-harm. These (safe) cells have limited fixtures and fittings and have been designed to reduce the ability to self-harm. The cells are under 24-hour camera observation. Special clothing and bedding is also provided to minimise opportunities to self-harm'*.¹³ Most ARUs are similar in design (see Figures 1 and 2 below).

An ARU is designed to enable the observation and safe management of prisoners at risk of harming themselves.



Figure 1: Typical at risk cell – Arohata Women's Prison

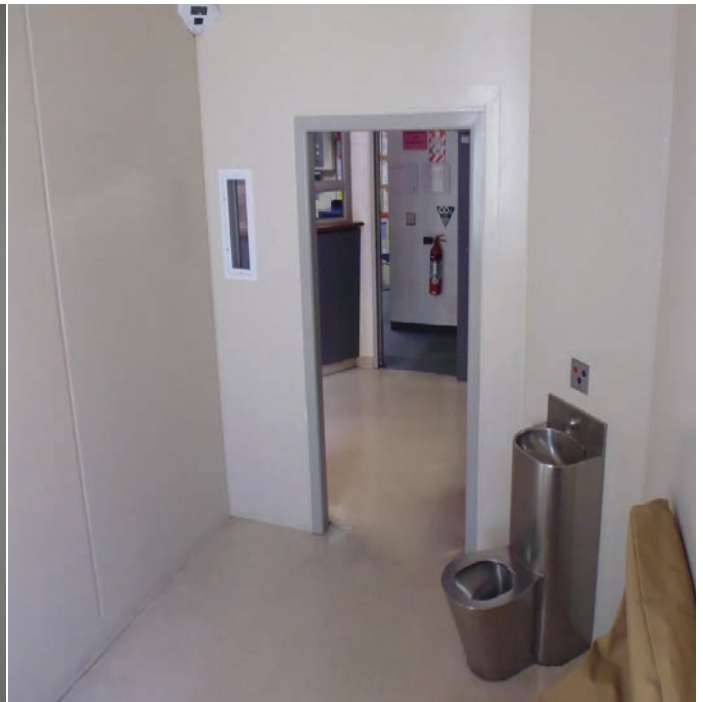


Figure 2: At risk cell – Arohata Women's Prison

There is no designated ARU at Manawatu Prison. However, three safe cells (and two small yards) are located in the remand wing and accommodate prisoners considered to be at risk. The facility is not fit for purpose.¹⁴

¹³ See <http://www.corrections.govt.nz/>

¹⁴ COTA Report – unannounced visit to Manawatu Prison (Jan 2016).



Figure 3: Safe cell – Manawatu Prison



Figure 4: Safe-cell yard – Manawatu Prison

Rolleston and Tongariro prisons have no ARU. Prisoners who are assessed as requiring a period in at-risk are transferred to a prison with a designated ARU.

At-risk policies and procedures

The Prison Operations Manual (POM)

The POM states the purpose of the at-risk assessment is to identify the level of self-harm risk that each prisoner presents and to minimise this risk as quickly and safely as possible. All staff are responsible for the early identification of a prisoner's at-risk status, and for taking immediate action when such risk is identified.¹⁵

The Prison Operations Manual (POM) states the purpose of the at-risk assessment is to identify the level of self-harm risk that each prisoner presents and to minimise this risk as quickly and safely as possible.

¹⁵ We have provided an abridged version of the at-risk process from POM in this paper (p10). The full version can be requested from the Department of Corrections.

According to the Department, 'It must be the primary responsibility of our staff to ensure that prisoners within our care, particularly prisoners identified as being vulnerable, are safely and humanely managed. The first performance area targeted for improvement under the review of prisoners at risk of self-harm and suicide is the process of assessment.'¹⁶

Risk assessments

Each assessment is tailored to address specific areas of risk. They are:

- Reception risk assessment - the purpose of which is to identify the level of self-harm risk that each prisoner presents at reception and to minimise this risk as quickly and safely as possible; and
- Review risk assessment - the purpose of which is, after initial reception, to target specific times or circumstances that could cause a prisoner's level of risk to change.

Recently Corrections has added further questions to the reception risk assessment to help identify vulnerable prisoners on admission. This appears to be in response to New Zealand's Suicide Prevention Action Plan 2013 – 2016.¹⁷

Assessed at-risk

Prisoners who have been assessed at-risk must:

- be strip-searched when they are initially received into the ARU and any other time they return to the ARU from areas used by other (non-segregated) prisoners; and
- have the same opportunities for involvement in prison activities as other prisoners, consistent with maintaining their safety and the safety of others.

At-risk management plan

Prisoners who have been assessed as being at-risk must have an at-risk management plan.¹⁸ The management plan must:

- reflect their at-risk assessment; and
- be developed in consultation with appropriate support personnel, including input from health services medical staff, cultural advisers and whānau.

Cell confinement

Isolation, segregation, separation and cellular or solitary confinement are some of the terms used to describe a form of confinement whereby prisoners are held alone in their cell for up to 24 hours a day, and are only allowed to leave it, if at all, for an hour or so of outdoor exercise.¹⁹ Based on this definition, prisoners assessed as at risk and managed in safe cells are essentially in solitary confinement.

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Department of Corrections

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¹⁶ Corrections' Prison Service Memorandum dated 21 July 2010.

¹⁷ New Zealand Suicide Prevention Action Plan 2013 – 2016. Ministry of Health.

¹⁸ (M.05.03 Form.02 – At-Risk Management Plan).

¹⁹ See http://solitaryconfinement.org/uploads/sourcebook_web.pdf.

During the course of our inspections, prisoners in at-risk cells informed us that they are generally only allowed to leave their sparsely furnished cell for one hour to exercise, alone, in a barren yard; typically only wearing an anti-rip gown and no shoes.²⁰ They stated that they do not have access to a TV in their cell or reading and writing material, as this is deemed a safety risk (some sites exercise discretion and provide reading and writing material in their cell). On occasions, false teeth and prescription glasses are also removed.



Figure 5: Anti-rip gowns



Figure 6: Tracksuit – used in some ARUs

Most prisoners reported having to eat their meals, usually finger food as cutlery is not permitted, in their cell next to an uncovered toilet. Some sites provide paper utensils.²¹

Observation of at-risk prisoners

There is a live camera feed from each safe cell, so the prisoner can be observed at all times from staff offices and master control rooms.²² Anyone in the office, including visitors, can see the footage. The prisoner can be seen using the toilet, as there is no privacy screen between the camera and the toilet (Corrections views the use of a privacy screen as a safety risk). There is no existing policy preventing staff of a different gender observing prisoners via camera feed in various states of undress

²⁰ Some sites allow prisoners to wear a tracksuit when they leave their at-risk cell and go to the yards/dayroom e.g. Rimutaka Prison and Waikeria Prison.

²¹ See prisoner quotes - Appendix 1

²² Master control is the main centre of audio and visual operations for the site.

or toileting. Most safe cells also have internal windows which allow staff, other prisoners and visitors to casually observe prisoners from the corridors.

Corrections Officers based in the ARU conduct regular formal observations of each at-risk prisoner (the frequency of which will be detailed in their personal management plan). Staff will fill out corresponding observation sheets detailing what the prisoner is doing at the time of the observation. From samples of observation sheets collected from ARUs across the country and from our observations of live camera feeds, at-risk prisoners appear to spend the majority of their time alone in their cell, on their bed, which is typically a concrete plinth with a mattress. Heating appears to be inadequate at times, and there is usually minimal natural light and fresh air.

Interventions, referrals and activities

Generally, at-risk prisoners are visited at least daily by a member of the healthcare team during medication rounds. Care is somewhat perfunctory due to time constraints and there tends to be a lack of privacy for the prisoner to discuss health matters (health staff are escorted by Corrections Officers). However, health staff and the forensic liaison nurse are consulted during the at-risk review process and liaise with ARU staff to discuss discharge procedures. Multi-disciplinary notes by nursing staff, the doctor and forensic team are available to custodial staff; however, they are typically a record of observations rather than proposed interventions that could be applied to support at-risk prisoners. Electronic medical notes "Medtec" are used to document consultations with the visiting psychiatrist.

At-risk prisoners can receive visits from chaplains, social workers, therapists, psychiatrists and cultural advisors. Prisoners' management plans contain a section to record these referrals and visits. My Inspectors reviewed plans for five prisoners and, with the exception of one, they did not find any recorded referrals for any prisoner in any of the ARUs at the time of inspections.

Each ARU has a designated activities room; these rooms are stark and sparsely furnished. Over the course of our past five prison inspections, we have not observed any at-risk prisoners taking recreation in the activities room. We have not located any schedule of basic activities for at-risk prisoners at any of the prisons.

We have found no evidence of at-risk prisoners taking part in any form of structured activity or intervention. We have only witnessed a basic yard-to-cell regime. This is at odds with Corrections policy which states *'[at-risk prisoners] have the same opportunities for involvement in prison activities as other prisoners, consistent with maintaining their safety and the safety of others.'*²³

In commenting on the draft report, Corrections advised that it is planning on undertaking a review of the management of at-risk prisoners, and that ARUs will include access to occupational therapy activities, and dedicated custodial staff and case managers with training in mental health.

We have found no evidence of at-risk prisoners taking part in any form of structured activity or intervention. We have only witnessed a basic yard-to-cell regime. This is at odds with Corrections policy which states *'[at-risk prisoners] have the same opportunities for involvement in prison activities as other prisoners, consistent with maintaining their safety and the safety of others.'*²³

²³ Corrections Prison Operations Manual.



Figure 7: Day room – Auckland Prison

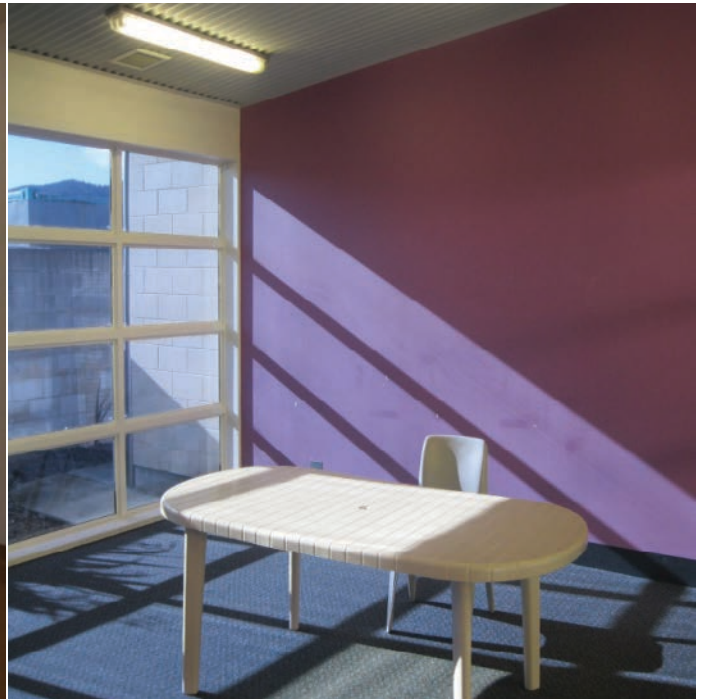


Figure 8: Day room – Otago Corrections Facility

Suicide awareness training for staff

General training

Initial training for Corrections Officers in suicide awareness and prevention is a part of the Corrections Officers Development Pathway that consists of a one-year programme in six phases. Phases 1 – 4 take place at the National Learning Centre and the workplace over 12 weeks and incorporate classroom learning, on-the-job learning and work experience, followed by practise in a simulated environment.

The two-hour suicide awareness session is scheduled in week 1 and provides an overview of:

- suicide;
- suicidal behaviours and ideation in the community and in prison;
- static and dynamic risk factors; and
- common myths and misconceptions.
- Staff are told about warning signs, behaviours and body language that they should look for in assessing prisoners. Staff are briefly introduced to Corrections' assessment and management processes for dealing with individuals considered at risk of suicide and self-harm. Training takes place over a day and also includes interview techniques and use of the Department's electronic records system.

All staff are issued with *Caring for Prisoners at Risk - A Guide for Staff* which summarises the Department's approach and includes brief notes on mental health, describing the symptoms of a range of diagnoses. Staff are required to undertake a half-day refresher training every two years, which summarises the awareness training and at-risk processes described in POM.

ARU staff training

Corrections Officers who work in ARUs do not receive any specialist training beyond the generic suicide awareness and prevention programme. Corrections Officers working in an at-risk environment typically reported to the Inspectors a number of areas where they would like to see improvement:

- It was recognised by staff carrying out an at-risk assessment, which is a structured interview process with prescribed questions and set time standards for completion and recording of assessments, that there is a risk of not fully observing body language or not engaging fully with the individual.
- While team work among Corrections Officers is an aspect of the role that they enjoy, they felt that ARU multi-disciplinary working could be better.
- It was felt that 'clinical confidentiality' inhibited the exchange of information that they believed would help them manage and understand the prisoners better.
- Awareness of the symptoms and behaviours associated with a range of emotional and mental health issues, and ways to manage such behaviours, was identified as a training need.
- Staff commented that there was very little for at-risk prisoners to do and attributed this to the focus on control measures to 'eliminate; isolate; minimise', resulting in an austere and impoverished environment that inhibits open communication between staff and prisoners and may have unintended consequences.
- Concern was expressed at the wide range of challenging behaviours presented by a disparate group of prisoners residing in the ARU, who may not be at risk of suicide or self-harm.
- Opportunities to debrief and access support after incidents could be improved.



Although Corrections Officers are not technically clinicians, those who work with complex prisoners who are seriously self-harming and suicidal may benefit from clinical supervision. This support provision does not currently exist for Corrections Officers or health staff.

The length of placement in ARUs for Corrections Officers varies. Much of their training is acquired 'on the job' and described as 'a steep initial learning curve' by some of the staff. By the time staff leave the unit, they have built up a great deal of knowledge and expertise. However, there is no established mechanism to impart this knowledge to new staff members through a structured handover or shadowing period; limited resources and staffing pressures do not appear to permit this.

New Zealand Ministry of Health guidelines state '*All clinicians who work with people who self-harm or are suicidal should be in regular clinical supervision to mitigate the negative impact that this work can have both on them and on the quality of their work with suicidal people.*'²⁴

Although Corrections Officers are not technically clinicians, those who work with complex prisoners who are seriously self-harming and suicidal may benefit from clinical supervision.²⁵ This support provision does not currently exist for Corrections Officers or health staff.

²⁴ See https://www.health.govt.nz/system/files/documents/publications/suicide_guideline.pdf.

²⁵ This recommendation has been made in previous COTA reports for nursing staff e.g. Auckland Prison (2010) and Otago Corrections Facility (2014).

Inspectors' analysis of practice in ARUs

Accommodation

From our observations of ARUs and from speaking with prisoners, it appears Corrections primarily takes an environmental approach to managing at-risk prisoners. The Department's area of focus is on safe containment, taking the prisoner from a busy and often challenging space to a quiet, calmer area of the prison and placing them in a safe cell, where minimal opportunities exist for a prisoner to cause harm to themselves.

By placing a prisoner in a safe cell with limited ligature points and no items or clothing that can be used to inflict injury, a prison will minimise the risks of a person taking their own life or self-harming. However, from our observations, the stark, austere cell and limited access to activities is likely to exacerbate their poor state of mental health.

Isolation and seclusion

Social and physical isolation and lack of accessible supportive resources intensify the risk of suicide.²⁶ An important element in suicide prevention is meaningful social interaction. Prisoners placed in ARUs are fundamentally isolated or secluded – they do not meaningfully interact with other prisoners and staff interaction is limited, yet a great deal of research states that isolation increases suicidal ideation. In fact, the Corrections staff guide on '*Caring for Prisoners at Risk*' identifies withdrawing from social contact as risk-type behaviour. Prisoner placement in an ARU tends to severely restrict positive social contact.

International research states '*a suicidal prisoner should not be placed in isolation if constant supervision cannot be provided when needed; the inmate should not be isolated. Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes.*'²⁷

From our observations of ARUs and from speaking with prisoners, it appears Corrections primarily takes an environmental approach to managing at-risk prisoners.

26 See http://solitaryconfinement.org/uploads/sourcebook_web.pdf A sourcebook on solitary confinement – Dr Sharon Shalev.

27 Prison Suicide: An overview and guide to prevention by Lindsay M.Hayes. National Centre on Institutions and Alternatives, Massachusetts. 1995. <http://www.ncianet.org/>.

Inspectors have concerns about the level of isolation prisoners who are at risk of suicide and self-harm experience whilst in an at-risk unit. Seclusion has been described by Professor John Gunn as: *'a nursing technique on the one hand and a punishment strategy on the other. It is a useful nursing technique in the management of highly disturbed, usually psychotic and violent patients who are a danger to others. It is never used in a hospital setting for suicidal patients because it is a depressing experience that can increase suicidal ideas....In short, seclusion is anti-therapeutic.'*²⁸

The use of seclusion in New Zealand mental health facilities should be a rare event after all other alternatives have been exhausted. This is supported by the Health and Disability service standards which state *'Seclusion should be used with extreme caution in the presence or likelihood of self-injurious behaviour.'*²⁹ In New Zealand mental health settings, seclusion is not used for managing depression or self-harm and is only used in the context of aggression or violence.

In ARUs and in the wider prison context, individuals are not provided with strategies to manage and address their self-harm or suicidal behaviour. This can create a revolving-door scenario between the ARUs and mainstream units.

Family involvement

The impact of being placed in the ARU goes beyond the effects on the prisoner and staff. Family members and friends of prisoners have spoken with Inspectors and stated they were disturbed by accounts of how their relatives had been contained and managed at such a distressing time. This places considerable strain on family members.

Other prisoners described their experiences of being bullied and "stood-over" as the primary reason why they declared an intention to self-harm, as they knew they would be removed from that environment and placed in the ARU. Staff also recognised that some prisoners, typically those with little or no previous experience of imprisonment and those with mental health issues, find mainstream units to be a frightening environment in which they feel vulnerable and unsafe.

The process to admit a prisoner to an ARU is far simpler than the process to segregate a prisoner. The use of segregation in prisons is regulated by sections 58 to 60 of the Corrections Act.³⁰ Inspectors have concerns that some prisoners are being inappropriately held in the ARU when they are not at risk and should instead be segregated. This practice undermines the purpose of an ARU.

Inspectors have concerns about the level of isolation prisoners who are at risk of suicide and self-harm experience whilst in an at-risk unit.

28 Professor John Gunn. HMIP - Suicide is Everyone's Concern. HMIP: 1999.

29 Ministry of Health 2010. Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992. <https://www.mentalhealth.org.nz/assets/ResourceFinder/seclusion-guidelines-feb10.pdf>

30 The opportunity of a prisoner to associate with other prisoners may be restricted or denied in accordance with sections 58 to 60 of the Corrections Act 2004.

At-risk paperwork

Overall, the quality of the reception at-risk assessments assessed by Inspectors was completed to a reasonable standard; however, review risk assessments in many instances were lacking signatures and dates. At-risk management plans (M.05.03 Form 2) were identical in many instances, regardless of security classification or level of observation, and Section C, relating to specialist support, was blank in most cases.

Daily observation sheets lacked meaningful entries, including when prisoners were engaged in activities outside their cells (showers, yard and telephone).

ARU CCTV monitoring

As previously detailed, prisoners in safe cells can be constantly monitored through live-camera feeds and watched whilst toileting. In respect of previous inspection reports, we have made seven recommendations requesting that cameras do not cover toilet areas. Corrections has declined to accept these recommendations. Its view is that, *‘Corrections views the matter of prisoner dignity and privacy seriously. All possible steps are therefore taken to ensure that privacy is provided where it is possible and appropriate. However, we do not consider that any form of privacy screening should be used in the safe cells.*

The absence of privacy screening is necessary to safeguard the wellbeing of prisoners who are assessed as at risk of self-harm. Please note that the absence of privacy screening is compliant with Schedule 2, Part C of the Corrections Regulations 2005, which specifies the items and features of cells for prisoners at risk of self-harm. The Schedule states that “no privacy screening or any other barrier that prevents a full view of the cell from the door window” should be a feature of the cell. Corrections consider that the installation of privacy screens around the toilet area in separate cells is not appropriate because it would not be consistent with the safe custodial management of prisoners.³¹

As this privacy issue has been ongoing I met with the Corrections Deputy Chief Executive – Corporate Services on 21 June 2016 to discuss the issue. The Department’s view is that such surveillance of high-risk prisoners is necessary because they may harm themselves when out of camera view and they are concerned that such an incident would leave Corrections vulnerable to criticism.

I do not agree with this approach. The view I have come to is that, while some camera surveillance of cells in which at-risk prisoners reside is responsible, insistence on camera surveillance while prisoners are abluting can and should be avoided. I believe there are ways in which reasonable surveillance can be maintained, yet at the same time affording some human dignity. A partial screen or pixilation of images showing toilet areas should be an option.³²

The view I have come to is that, while some camera surveillance of cells in which at-risk prisoners reside is responsible, insistence on camera surveillance while prisoners are abluting can and should be avoided.

³¹ Otago Corrections Facility COTA report (2016).

³² Corrections has requested the establishment of a working party comprising custodial management, privacy experts and representation from the Ombudsman’s Office to examine options to balance prisoner observation with privacy expectations.

The Serco-run Wiri Prison in Auckland utilises privacy screens safely and effectively in its At-Risk Unit. It is also noted from our extensive inspections of health and disability places of detention in New Zealand that there is no camera surveillance of service-user bedrooms and bathrooms. Further, I note that the UK Department of Health's guide for the design of Adult Acute Mental Health Units specifies that CCTV should not cover bedrooms or toilet and shower areas (other than the entrance/exit to these areas).³³

Staff-prisoner relationships

From our observations, relational management generally appears to be lacking in the care of at-risk prisoners; perhaps this is to be expected with the rapid increase in the prison population and subsequent staffing pressures. Many staff attempt to do their best, but do not have the time to meaningfully interact with at-risk prisoners, as they have other duties to perform in the day-to-day running of the unit. Some prisoners have commented on the positive support they received from staff whilst in the ARU. However, quality of care appears to vary from prison to prison and from shift to shift.

On a recent inspection to Manawatu Prison, interactions with prisoners in safe cells were extremely limited. There is no designated ARU, so at-risk prisoners are situated on a busy remand unit, where staff are occupied with movements, escorts and unit duties. We observed limited meaningful interactions with the two prisoners by any staff over the course of our five-day inspection.

The England and Wales prison suicide awareness strategy is based on a prison community approach, which encourages supportive relationships in the belief that a suicidal prisoner can be helped to cope, subject to his/her willingness to receive help on offer. The emphasis is on suitable shared accommodation to prevent isolation, unless there are clear reasons to the contrary.³⁴ Such an approach reduces the risk of prisoner isolation when staff are unable to interact with prisoners due to resourcing issues, and should be considered in New Zealand.

33 See www.gov.uk/government/collections/health-building-notes-core-elements. Adult Mental Health Units: Planning and design (HBN 03-01) 20 March 2013.

34 Her Majesty's Inspectorate of Prisons for England and Wales – Suicide is everyone's concern – A Thematic Review. 1999.

Use of mechanical restraints in managing prisoners at risk of self-harm

The Corrections Act 2004 allows Corrections to use specified mechanical restraints, including tie-down beds and waist restraints if necessary, to protect a person from injury, including self-harm.³⁵

The Corrections Act 2004 states 'A mechanical restraint may not be used for any disciplinary purpose: Must be used in a manner that minimises harm and discomfort to the prisoner. A prison manager may authorise the use of a mechanical restraint on a prisoner for more than 24 hours, only if, in the opinion of a medical officer, continued restraint is necessary to protect the prisoner from self-harm.'

What is a tie-down bed?

A tie-down bed is a form of mechanical restraint. It is a specialist bed comprised of attached ankle, torso and wrist restraints. An individual tied to such a bed is rendered incapable of free movement. The only movement they will have is the ability to move their head from side to side.



Figure 9: Tie-down bed - Auckland Prison

Tie-down beds are not permitted for use in New Zealand mental health settings, but only in New Zealand correctional facilities.

³⁵ See <http://legislation.govt.nz/>

Tie-down beds are not used in comparable jurisdictions that have ratified the OPCAT, such as England and Wales, Scotland and Sweden.

What are waist restraints?

Waist restraints restrict the movement of an individual's arms and hands by securing their wrists in handcuffs to a belt around their waists. Their hands can be attached in two positions; together in front of the body (one set of handcuffs) and at the sides of their body (two sets of handcuffs). Handcuffs can be applied behind the prisoner's back, but not in conjunction with a waist restraint, as demonstrated in figures 10 and 11.³⁶

The Department's policy on 'applying handcuffs to the back of a prisoner' makes no reference to handcuffs being used in conjunction with a waist restraint. Further, the Department's policy on waist restraints states '*A belt that is secured around the waist with the hands attached to cuffs in the front of the belt.*'³⁷

In commenting on the draft report, Corrections advised that, while it is very rare for a waist restraint to be used in conjunction with hands cuffed behind the back, it does not agree that this is an impermissible management approach, and further noted that it has commissioned a review into its policies.

We consider that this method of restraint is at odds with section 87(4) of the Corrections Act, as it does not minimise discomfort to the prisoner.



Figure 10: Waist restraint – behind the back



Figure 11: Waist restraint – behind the back (side view)

36 Figures 10 and 11 are of a member of the OPCAT team demonstrating the waist restraint position used on Prisoner D and E referred to later in the report.

37 Department of Corrections. Health Services Manual. Waist-Restraints - Policies and Procedures (Oct 2012).

The use of the tie-down bed in New Zealand prisons

This section of the report will cover my Inspectors' observations on the restraint of three prisoners on the tie-down bed at Auckland Prison.

I will also share my Inspectors' observations on the prolonged incapacitation in waist restraints of a prisoner at Otago Corrections Facility and the use of both waist restraints and the tie-down bed on a prisoner at Christchurch Men's Prison.

All of these prisoners were assessed as at risk of suicide or self-harm and they were all being managed in ARUs. I believe in each of these cases their care was in breach of Article 16 of the Convention, i.e. amounting to inhuman and/or degrading treatment of prisoners. All of these restraint incidents have occurred over the past eight months.

Auckland Prison

Prisoner A – background

My Inspectors receive Corrections daily notifications which detail any significant events across the prison estate. On 1 March 2016, through the notification system, the Inspectors became aware of a prisoner (referred to as Prisoner A for the purpose of this report) who was being repeatedly restrained on a tie-down bed at Auckland Prison.

Corrections stated the reason for the prisoner being secured on the tie-down bed was as a result of his serious self-harming behaviour. Corrections had referred him to the Mason Clinic³⁸, but he was declined admission.

Overview

Prisoner A self-harmed during the night on three occasions between 21 and 28 February 2016, and required hospital treatment as a result. He had a history of self-harm.

Prisoner A then spent 37 consecutive nights secured on the tie-down bed at Auckland Prison from 28 February to 5 April 2016. We observed (via video footage) a spit-hood being applied to the prisoner's head on at least one occasion.

As a result of Prisoner A's episodes of self-harm, Corrections implemented an interim management plan to minimise his self-harm episodes. Each day, Prisoner A was under constant one-to-one observation in his ARU safe cell³⁹ from approximately 8.30am to 4:00pm. At 4:00pm (to coincide with after-hours reduced staffing ratios), he was secured on the facility's tie-down bed until 8.30am the following day (approximately 16 hours each day/night) for 37 consecutive nights.

³⁸ The Mason Clinic is a Regional Forensic Psychiatric Services secure unit, part of Waitemata DHB.

³⁹ The prisoner was being watched by a Corrections Officer sitting outside his cell looking through a window with the door locked.

Prisoner A spent approximately 592 hours⁴⁰ restrained on the tie-down bed.

There is a regulatory provision that a Visiting Justice (VJ) must provide approval for a period on the tie-down bed of 24 hours or longer. At 16 hours per restraint episode it can be argued that, technically, Prisoner A's case did not require VJ oversight despite restraint for over 500 hours of cumulatively. The Department, although not being legally required to do so, contacted the local VJ in respect of Prisoner A's restraint.

Under Reg 80(b) of the Corrections Regulations, a Medical Officer must be notified promptly when any prisoner is placed under a mechanical restraint (unless the Medical Officer has recommended the use of the restraint). Under Corrections' tie-down bed instructions, the tie-down bed can only be used under medical approval. Approval to tie Prisoner A to the bed was given by the Medical Officer, in accordance with a decision by a multi-disciplinary team that included the Mason Clinic Forensic Team. However, Corrections failed to follow correct procedures during the first two weeks of using the tie-down bed as the required paperwork had not been approved and signed by the Prison Director. Furthermore, the Department's tie-down bed instructions provide, *'On release (from the tie-down bed), if the prisoner again exhibits behaviour that warrants restraint using a tie-down bed, this is a new approval and advice is required.'* Prisoner A had one approval over the 37 nights.

Prisoner A was secured to the tie-down bed by his wrists, torso and ankles. This contravenes Schedule 5 of the Corrections Regulations, which states *'tie-down beds may only be used in conjunction with one or both of the following: a wrist bed restraint; a torso restraint; and may only be used on medical advice.'* It is further specified that wrist bed restraints *'must not be used around the ankles of any prisoner, unless for medical reasons any other form of restraint would be impractical.'* Specified medical advice was not sought to permit ankle restraint.

Concerns regarding the repeated use of the tie-down bed were raised with the Chief Inspector of Corrections on 14 March 2016 by one of my Prison Investigators. Investigation of Prisoner A's management was then referred to a Department of Corrections Inspector. On 21 March 2016 the Corrections Inspectorate stated (by email) that they were *'happy with the measures taken'* in respect of Prisoner A's management.

During a visit to Auckland Prison on 11 April 2016, my OPCAT Chief Inspector Jacki Jones and Inspector Emma Roebuck spoke with Prisoner A, Prisoner B (referred to later in this report), the Prison Director, Unit staff, the Prison Chaplain, the Health Services Manager and the Mason Clinic Psychiatrist. Telephone conversations were conducted with the Prison Psychologist, the VJ and the Medical Officer.

My Inspectors also observed approximately 77 hours of video footage of Prisoner A and Prisoner B on the tie-down bed and had serious concerns about the management of both prisoners.

Prisoner A was secured to the tie-down bed by his wrists, torso and ankles. This contravenes Schedule 5 of the Corrections Regulations, which states *'tie-down beds may only be used in conjunction with one or both of the following: a wrist bed restraint; a torso restraint; and may only be used on medical advice.'*

40 Based on 37 nights' restraint at 16 hours per episode.

Tie-down bed policy, procedures and staff training

No specific training for staff exists, at the time of writing, on how to secure a prisoner safely to a tie-down bed. A tie-down bed procedure can be located on Corrections' intranet.

The procedure states that, *'as advised by the Health Unit release and flex the prisoner's limbs one at a time and [staff should]; Monitor and Record – fluid intake, food intake, visits by staff of Health Unit and flexing of prisoners-limbs.'*

The limb-movement policy exists because immobilisation creates discomfort and significant health risks (such as deep vein thrombosis) to the individual, who must be robustly monitored.

Viewing selected footage, Inspectors identified that these basic procedures had not been followed in the case of Prisoner A. Prisoner A did not have any of his limbs flexed in the total 64 hours of his restraint that we observed. This was a breach of section 87(4)(b) of the Corrections Act 2004, which requires that *'A mechanical restraint must be used in a manner that minimises harm and discomfort of the prisoner'*. It also breached the Corrections tie-down bed procedure. Moreover, fluid intake sheets could be located for only three of Prisoner A's 37 nights of restraint.

Inspectors noted that a five-step guide detailing best practice on how to secure a prisoner to the tie-down bed was displayed in the ARU guard station. Staff had attached a post-it note to the guide with a highly inappropriate comment: *'Step 6, when all clear is given, release lethal injection.'* This denotes a lack of professionalism and respect for the prisoner. Corrections has conducted a separate investigation into this matter.

The Corrections intranet (Corrnet) contains an instruction that the prisoner should leave the tie-down bed to use the toilet. We observed (through recorded video footage) non-compliance with this instruction with the toileting of Prisoner A. On some occasions he was toileted on the bed – urinating in a bottle. On other occasions he was escorted to the toilet, sometimes in handcuffs and sometimes without. There did not appear to be a formal system for ablutions, which leaves staff open to criticism. It was improper for staff to be touching the prisoner's genitalia with a urine bottle, for prolonged periods, whilst he was tied to the bed during the toileting process. Toileting on the bed whilst restrained was degrading and dehumanising for the prisoner.

Prisoner A did not have any of his limbs flexed in the total 64 hours of his restraint that we observed. This was a breach of section 87(4)(b) of the Corrections Act 2004, which requires that *'A mechanical restraint must be used in a manner that minimises harm and discomfort of the prisoner'*. It also breached the Corrections tie-down bed procedure.

Staffing ratios and resourcing

My Inspectors assess that restraining Prisoner A on a tie-down bed from approximately 4.00pm each day until the following morning was not a targeted response to his individual medical situation and the threat of imminent self-harm, but instead aligned with prison regimes and resources. Prisoner A was tied to the bed at the same time each day. The stated purpose of his extended restraint was to prevent wound-tampering and further self-harming. An e-mail from the Corrections Inspectorate to an Ombudsman Prison Investigator (dated 21 March 2016) stated *'Please note Prisoner A is only on the tie down bed at night when staff are reduced to one.'* Prisoner A was secured to the tie-down bed at approximately 4.00pm before staff finished their shift, and before staffing levels were reduced significantly for the night shift. Prisoner A was being appropriately and successfully managed with constant observations during the day with no significant episodes of self-harm. Securing him on a tie-down bed each day at 4.00pm was not responsive to his individual medical situation or any signs of imminent risk, but was instigated to fit in with routines, associated resources and convenience.

Prisoner A's complex behaviour inevitably required extra resources for continuous observation and emergency medical escorts to hospital. However, tying an individual to a bed for up to 16 hours each night as a way to manage resourcing pressures is not appropriate.

Corrnet information on tie-down bed restraint states that *'Normally, five officers are required; four to restrain the prisoner and one to apply restraints.'* Footage from 15 March 2016 showed up to 14 Officers in the tie-down bed cell, whilst Prisoner A was resisting restraint. It was difficult to identify who was leading the Control and Restraint procedure. It appeared disorganised at best and dangerous at worst. The large number of custodial staff present during the restraint of Prisoner A could increase the risk of positional asphyxiation. On four observed occasions where Prisoner A actively resisted being restrained on the tie-down bed there was an average of 10 custodial staff in the cell – some actively involved in the restraint and some observing. Prisoner A was naked for two of the four observed restraints (having been restrained in his ARU cell and then forcibly moved into the tie-down bed cell).

The Multi-Disciplinary Team (MDT) approach

As a consequence of Prisoner A's self-harming and subsequent restraint, a multi-disciplinary team was established, consisting of custodial staff, medical staff, psychological services and forensic liaison staff. MDT attendees usually consisted of four staff from Auckland Prison. There were no external participants or quality assurance mechanisms in the MDT process.

In the case of Prisoner A, my Inspectors had concerns that the tie-down bed was being utilised for behaviour modification purposes and not for the sole purpose to prevent injury in an emergency where all other interventions have failed (see details below). Conversations with the Prison Director and the Prison Psychologist support that Prisoner A was kept on the tie-down bed as part of his management plan (detailed below), despite his risk of self-harm having reduced.

Prisoner A was secured to the tie-down bed at approximately 4.00pm before staff finished their shift, and before staffing levels were reduced significantly for the night shift. Prisoner A was being appropriately and successfully managed with constant observations during the day with no significant episodes of self-harm.

The Mason Clinic Psychiatrist, who had signed off on Prisoner A's management plan was not fully aware of how Prisoner A was managed on the tie-down bed, nor was the Prison Psychologist. Neither had either observed him being secured on the tie-down bed or visited him during any of his 16-hour confinements on the bed. The Psychiatrist mistakenly believed that Prisoner A had two officers in the cell with him (engaging with him) while on the tie-down bed and felt this was better than leaving him in isolation with no one to speak to. From the footage observed, and from reviewing observation sheets, it is evident that Prisoner A was alone in the tie-down bed cell for the duration of his restraint, with the exception of staff entering the room to address his toileting needs. He was observed either through a cell window or via video-feed, with his movements written on observation sheets at 5-minute intervals.

If a Corrections Officer is available to make observation records every five minutes over the course of a 16-hour period, there should be opportunities for positive engagement, as opposed to simply documenting that the prisoner has been observed. In the specific case of Prisoner A, positive engagement became increasingly rare due to the breakdown of his relationship with staff.

It is recognised that Prisoner A's behaviour had been extremely challenging and still is, yet my Inspectors observed little evidence of any meaningful therapeutic interaction with him during their visit and by reviewing his notes.

Prisoner A confirmed to my Inspectors that he was not included in any part of the MDT process regarding his management at the time of our enquiries. Some forensic notes consisted of a few lines with no detail as to how to progress his care.

Management Plan

Prisoner A's at-risk Management Plan⁴¹ was relatively comprehensive – detailing that he would receive continuous observations day and night. However, though Prisoner A was observed whilst on the tie-down bed, no Officer was in the cell with him; effectively he was in seclusion.

Prisoner A's health notes (in his Management Plan) stated that he would be managed in his cell from 8.30am to 4.00pm. The plan detailed unlocking and tie-down staffing ratios. It also required that *'he be under constant obs and at lock up he be placed on the tie-down bed till unlock as his self-harm was occurring after hours when there was reduced custodial staff on site and no health staff; although there is an afterhours nurse on call.'*

The 'counselling by specialist staff' section of the plan indicated that he would be seen regularly by the Prison Chaplain.

If a Corrections Officer is available to make observation records every five minutes over the course of a 16-hour period, there should be opportunities for positive engagement, as opposed to simply documenting that the prisoner has been observed.

41 M.05.03.Form.02 dated 17 March 16.

The Psychiatrist/Forensic Mental Health section of the Management Plan suggested the tie-down bed was being used, not to manage imminent risk, but as a behaviour-modification tool, states:

'[We] felt it best to target two sets of behaviours that he would need to manage in order to gain a reduction of time on the tie-down bed. We considered the following to be situationally important:

- *Access to his wound and the concomitant need for hygiene (showers).*
- *His wrestling his wrist loose from the restraints in the middle of the night (effectively seen as self-harm in itself).*

Compliance with each of these will result in the benefit of 20 mins less on the tie down bed at the beginning of the tie-down for the first behaviour and 20 mins at the end of the tie-down for the second behaviour. It means that he doesn't have to do both to get both; he only has to comply with one to get the reward. The rewards are also incremental: it becomes 40 mins, then 60 mins, then 80 mins and so on i.e. an extra 20 mins.'

The Management Plan was approved by the ARU Principal Corrections Officer (PCO).

Aside from the detailed reduction of time on the tie-down bed for compliant behaviour, there was no detail in the management plan as to how to address Prisoner A's self-harming or how to effectively engage with him.

For the following reasons, in my opinion the treatment of Prisoner A breached Article 16 of the Convention:

- Corrections acted contrary to a number of legislative requirements and Corrections policies in its treatment of Prisoner A;
- The tie-down bed was at times used to modify Prisoner A's behaviour, rather than to prevent an imminent risk of self-harm or harm to others, contrary to the requirements of the Corrections Regulations;
- Prisoner A was tied down for longer than necessary to prevent self-harm; and
- Prisoner A's treatment was, in my view, degrading and dehumanising, and contrary to Prisoner A's inherent dignity as a person. This is particularly so in respect of toileting Prisoner A on the tie-down bed and failure to flex his limbs in the course of the 16-hour nightly tie-down periods.

Prisoner B

Prisoner B, who was also in Auckland ARU, was secured on the tie-down bed on 5 April 2015 after self harming, attempting suicide and expressing suicidal thoughts.

Video footage from 5 April 2016 revealed that, following Prisoner B's restraint on the tie-down bed, no staff member entered his cell for over 13 hours. His limbs were not flexed and he was not provided with any fluids. He had been placed on the bed as he was deemed a suicide risk, yet nobody came and spoke directly with him in the observed 13-hour period, provided him with fluids or moved his limbs. During this period he covered his face with his blanket (using his teeth). From the footage it was

For the following reasons, in my opinion the treatment of Prisoner A breached Article 16 of the Convention:

- Corrections acted contrary to a number of legislative requirements and Corrections policies in its treatment of Prisoner A;
- The tie-down bed was at times used to modify Prisoner A's behaviour, rather than to prevent an imminent risk of self-harm or harm to others, contrary to the requirements of the Corrections Regulations;
- Prisoner A was tied down for longer than necessary to prevent self-harm; and
- Prisoner A's treatment was, in my view, degrading and dehumanising, and contrary to Prisoner A's inherent dignity as a person. This is particularly so in respect of toileting Prisoner A on the tie-down bed and failure to flex his limbs in the course of the 16-hour nightly tie-down periods.

difficult, on occasion, to ascertain if he was breathing.

Having read his medical notes, management file and spoken with Prisoner B, my Inspectors believe that less restrictive alternatives to the tie-down bed should have been implemented. The failure to flex Prisoner B's limbs breached section 87(4)(b) of the Corrections Act 2004, which requires that *'A mechanical restraint must be used in a manner that minimises harm and discomfort of the prisoner'*. It also breached the Corrections tie-down bed procedure.

Prisoner B was secured to the tie-down bed by his wrists, torso and ankles. This contravenes Schedule 5 of Corrections Regulations, which states, *'tie-down beds may only be used in conjunction with one or both of the following, a wrist bed restraint: a torso restraint; and may only be used on medical advice'*. It is further specified that wrist bed restraints *'must not be used around the ankles of any prisoner, unless for medical reasons any other form of restraint would be impractical'*. Specified medical advice was not sought to permit ankle restraint.

Placing Prisoner B on the tie-down bed for 13 hours without any interaction from staff, provision of fluids or flexing of his limbs breached Article 16 because it caused severe suffering, and showed a lack of respect for Prisoner B's dignity.

Prisoner C

On 16 April 2016, Prisoner C was involved in a Use of Force⁴² incident in the ARU at Auckland Prison. During Prisoner C's restraint he reportedly indicated a strong desire to commit suicide. Consequently, the duty Principal Corrections Officer (PCO) decided to secure Prisoner C to the tie-down bed. A Corrections nurse was present in the ARU during the restraint. The Duty PCO then rang the Prison Director for subsequent approval to use the tie-down bed (as per Corrections policy). The duty PCO briefed the Prison Director, who noted a doctor had not been consulted as required by Corrections policy and the Corrections Regulations. The Prison Director decided that use of the tie-down bed was not appropriate in this case and did not approve its use.

Prisoner C had been secured to the tie-down bed for a period of 22 minutes before he was untied and returned to his safe cell. My Inspectors agree with the Prison Director's assessment in this case. In my view, the use of the tie-down bed was in breach of the requirement to first obtain medical advice, and Article 16 of the Convention.

42 The use of force in prisons is regulated by section 83 of the Corrections Act. According to which, physical force can only be used in prescribed circumstances and if reasonably necessary. Additionally, the level of force used must be reasonable. Where force has been used, prisoners must be examined by a registered health professional.

Summary

In the cases of Prisoners A, B and C, custodial staff did not comply with guidelines and procedures. These basic procedures are intended to safeguard against harm to the prisoner and also to protect Corrections from criticism regarding the safe and humane containment of individuals. It is of concern that, in such complex cases with a serious potential impact on both the physical and mental wellbeing of the prisoners concerned, basic procedures were not being followed. The absence of daily reviews at a senior level as to how these prolonged restraints were being implemented is concerning.

I appreciate the difficulties dealing with this small group of prisoners with high and complex needs. However, I believe that the excessive use of the tie-down bed in Auckland Prison's ARU had become normalised by unit staff. The extended period of Prisoner A's restraint was no longer regarded as exceptional and as a means of last resort, but rather as a management tool. I consider that this is also demonstrated in the case of Prisoners B and C's unnecessary restraint on the tie-down bed.

In the cases of Prisoners A, B and C, custodial staff did not comply with guidelines and procedures. These basic procedures are intended to safeguard against harm to the prisoner and also to protect Corrections from criticism regarding the safe and humane containment of individuals. It is of concern that, in such complex cases with a serious potential impact on both the physical and mental wellbeing of the prisoners concerned, basic procedures were not being followed. The absence of daily reviews at a senior level as to how these prolonged restraints were being implemented is concerning.

Tie-down beds and mechanical restraints at other prisons

In recent months my Inspectors have also undertaken visits to Christchurch Men's Prison, Rimutaka Prison, Arohata and Auckland Regional Women's Corrections Facility, to examine the use of tie-down beds at these facilities. We discovered there is limited compliance with Reg 127 (2) of the Corrections Regulations 2005, which requires the recording of the use of the tie-down bed. Consequently, staff were relying on memory to recall when the tie-down bed was last used. Enquiries indicated variations on the threshold for administering the tie-down bed, which varied from Prison Director to Prison Director. Some Directors stated that they would not use the tie-down bed as it was inhumane, whereas others stated it would be used when a prisoner presented a serious risk of harm. Other Prison Directors said they did not want to use the tie-down bed if it could be in any way avoided and would implement all other possible measures before resorting to its use.

The only privately-operated prison, South Auckland Corrections Facility (run by SERCO) does not have a tie-down bed.

In April 2016, we requested the following information on tie-down beds from Corrections National Office;

1. Which sites have tie-down beds?
2. Which sites have used the tie-down beds between 1 April 2013 and 12 April 2016?
3. On how many occasions have they been used?
4. What was the duration of each tie-down episode?
5. How many prisoners have been secured on tie-down beds during this period?

The Department informed us there is no central recording system for documenting tie-down bed use and that individual prisons do not record the information in log-books. This was reflected in the information provided to us by National Office, as it did not entirely correlate with our own enquiries and findings. For example, the duration of Prisoner B's restraint at Auckland Prison was recorded as 10 hours by National Office, whereas we observed over 13 hours of video footage of his ongoing restraint.

The information provided by National Office to our information request is detailed below.

The following sites have tie-down beds – Northern Region Corrections Facility; Auckland Prison; Auckland Regional Women's Corrections Facility; Spring Hill Corrections Facility; Waikeria Prison; Hawke's Bay Regional Prison; Rimutaka Prison, Christchurch Men's Prison and Otago Corrections Facility.

Tie-down beds have been used at Auckland Prison; Rimutaka Prison; Waikeria Prison and Christchurch Prison over the past three years.

The following chart sets out the data that Corrections provided us on the recorded use of tie-down beds including the location and duration of each episode of restraint.

The Department informed us there is no central recording system for documenting tie-down bed use and that individual prisons do not record the information in log-books.

Table 1: Tie-down events between 1 April 2013 and 12 April 2016⁴³

	Date	Duration	Date	Duration
Auckland Prison	02/08/2013	20mins	15/03/2016	15hrs 45mins
	23/05/2014	11hrs 55mins	16/03/2016	17hrs 18mins
	09/06/2014	2hrs 5mins	18/03/2016	15hrs 33mins
	18/08/2015	5hrs 35mins	19/03/2016	14hrs 53mins
	16/09/2015	6hrs 2mins	20/03/2016	14hrs 20mins
	19/02/2016	3hrs 10mins	21/03/2016	14hrs 35mins
	28/02/2016	16hrs 10mins	22/03/2016	13hrs 2mins
	29/02/2016	16hrs 20mins	23/03/2016	13hrs
	01/03/2016	15hrs 45mins	24/03/2016	12hrs 26mins
	02/03/2016	15hrs 40mins	25/03/2016	12hrs 47mins
	03/03/2016	16hrs 15mins	26/03/2016	14hrs 38mins
	04/03/2016	16hrs 9mins	27/03/2016	14hrs 8mins
	05/03/2016	15hrs 55mins	28/03/2016	12hrs 13mins
	06/03/2016	15hrs 55mins	29/03/2016	13hrs
	07/03/2016	18hrs 35mins	30/03/2016	13hrs 40mins
	08/03/2016	16hrs 20mins	31/03/2016	13hrs 40mins
	09/03/2016	17hrs 30mins	01/04/2016	14hrs 20mins
	10/03/2016	16hrs 18mins	02/04/2016	14hrs 15mins
	11/03/2016	16hrs 11mins	03/04/2016	15hrs 20mins
	12/03/2016	16hrs 10mins	04/04/2016	15hrs 25mins
13/03/2016	15hrs 48mins	05/04/2016	10hrs	
14/03/2016	15hrs 50mins	18/04/2016	22mins	
Christchurch Men's Prison	06/05/2016	10hrs	11/06/2016	3hrs
Rimutaka Prison	16/09/2014	4hrs 30mins	24/09/2014	15hrs 30mins
Waikeria Prison	24/06/2013	17hrs	04/06/2014	13hrs
	29/06/2013	1hr	05/06/2014	21hrs
	11/10/2013	10mins	14/06/2014	22hrs
	19/10/2013	21hrs	20/06/2014	22hrs
	29/03/2014	17hrs		

It may be of note that, of the 57 recorded episodes of restraint on the tie-down bed over the past three years, none have exceeded the 24-hour period which requires Visiting Justice approval. Forty-four incidents have been for longer than 12 hours.

⁴³ Information provided by Corrections, Deputy Chief Executive Corporate Services, 30 May 2016.

Although the tie-down bed has not been used in a women's prison in the past three years, on 19 April 2015, one prisoner who had been self-harming at Arohata Women's Prison was 'warned' that she may be restrained on the tie-down bed. As Arohata Prison does not have a tie-down bed on site, the bed from Rimutaka Prison was placed in a van and transported to Arohata where it was shown to the prisoner. Correspondence between management and a Custodial Officer referring to the incident states *'had a discussion with her [the prisoner] and showed her the tie-down bed, she now changes her tune and will behave.....'*

Use of the tie-down bed at Christchurch Men's Prison

Prisoner D

Inspectors also observed footage and reviewed the associated paperwork in the case of Prisoner D, who was placed in waist restraints (cuffed behind his back) on 5 May 2016 and later restrained on the tie-down bed at Christchurch Men's Prison on 6 May 2016 for 10 hours.

Prisoner D was residing in the at-risk unit and had been exhibiting very challenging behaviours and self harming (whilst in waist restraints and an anti-rip gown) and was consequently restrained on the tie-down bed.

Prisoner D was placed on a movable tie-down bed that was located in an interview room with a glass-fronted observation panel in the ARU. This room was located off a walkway that was used to exit and enter the ARU. Prisoner D could be easily observed by anyone exiting and entering the ARU; he was afforded little privacy whilst tied to a bed, immobilised, in an anti-rip gown. In my view, this amounts to humiliating treatment that diminished Prisoner D's dignity in breach of Article 16 of the Convention.

Prisoner D was secured to the tie-down bed by his wrists, torso and ankles. This contravenes Schedule 5 of Corrections Regulations, which states *'tie-down beds may only be used in conjunction with one or both of the following: a wrist bed restraint; a torso restraint; and may only be used on medical advice'*. It is further specified that wrist bed restraints *'must not be used around the ankles of any prisoner, unless for medical reasons any other form of restraint would be impractical'*. Specified medical advice was not sought to permit ankle restraint.

The rationale for the approval of Prisoner D's waist restraint was unclear.⁴⁴ The use of mechanical restraints from 5 May to 11 May 2016 had been approved by a Medical Officer and the Visiting Justice had been notified. Approval had been signed by the Custodial Systems Manager and, although it stated the Prison Director had given verbal approval, there was no signature from the Prison Director on any of the associated paperwork as per Corrections policy.

44 IR.05.Form 04. Request the approval to use mechanical restraint beyond 24 hours

Following this incident, Inspectors were unable to ascertain from Prisoner D's recorded electronic notes (IOMS)⁴⁵, if he had received any form of meaningful intervention to address his self-harming and challenging behaviours. There was no recorded intervention on the computer system.

Use of mechanical waist restraints at Otago Corrections Facility

Prisoner E

Over a three-and-a-half month period in 2016 Prisoner E was being almost continuously kept in a waist restraint with his hands cuffed behind his back, due to self-harming. This intensive restraint lasted for approximately 12 weeks (1,764 hours) prior to his release from prison.⁴⁶ Cuffs were removed every two hours during the day and every four hours at night in order to stretch his muscles, take a shower, use the toilet or eat his meals.

The Prison Director informed my Inspectors that he wished to avoid restraining Prisoner E on the tie-down bed if possible.

Prisoner E was locked in his cell for approximately 21 hours a day. He was able to watch some TV in his cell from late afternoon; however, he was unable to read as he could not turn the pages of a book or magazine due to his hands being cuffed behind his back.

Prisoner E's physical care was of a high standard. His wounds were cleaned and dressed and a nurse visited him to monitor his wounds and assess for any infection three times a day. However, in our opinion Prisoner E's mental healthcare was inadequate.

A Consultant Psychiatrist assessed Prisoner E approximately a month after he was put into the restraints, and recommended a raft of interventions and support including psychotherapy and counselling. From reading Prisoner E's file and subsequent discussions with him and staff in the ARU, Prisoner E did not receive any counselling or psychotherapy during his 12-week restraint; or prior to his release to the community under Community Probation Services. Inspectors are aware of the difficulties experienced by Corrections in securing appropriate and responsive forensic services. They noted that there were no scheduled appointments with the Corrections psychologists. The prison's forensic liaison nurse attended weekly MDT meetings but did not have regular one-on-one sessions with Prisoner E to develop strategies to reduce his self-harming.

Staff were busy locking and unlocking prisoners in the ARU, monitoring showers, providing meals and completing paperwork. We did not observe Corrections staff spending any meaningful time talking and interacting with Prisoner E during the week of our inspection.

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45 Integrated Offender Management System is the Department's electronic record system.

46 Hours of restraint are calculated at 21 hours a day (average three hours unlock per day).

Prisoner E's Management Plans⁴⁷ were basic and lacked specificity. His weekly plans were identical with the exception of a variation in the tightness of his handcuffs.⁴⁸ There was no evidence of therapeutic intervention or psychological support having taken place for Prisoner E, or any of the other three at-risk prisoners in the unit at the time of inspection. Prisoners in the unit were not consulted as part of the Management Plan process and did not contribute to their own plan. This is by no means unique to OCF; Inspectors observed it in four of the five prisons they have inspected over the past 12 months.

Prisoner E reported that he had been prescribed a medication for a mental health condition whilst in the community and that, on admission to prison, it was stopped.⁴⁹ The Health Care Manager informed us that this type of medication can only be prescribed by the Psychiatrist. Routinely, the waitlist to see the Psychiatrist can be several weeks. Prisoner E stated that his mental health deteriorated as a result of discontinuing this drug and that his self-harm escalated. We have been unable to determine the extent of the practice of discontinuing medication on admission.

Prisoner E's treatment breached Article 16 of the Convention. His self-harm could have been managed in a way that caused him less physical discomfort, for example by attaching handcuffs to the side of the waist restraint and providing ongoing supervision. Prisoner E's mental healthcare was inadequate and exacerbated his mental suffering.

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47 (M.05.03.04) Management Plan

48 Plans checked 20, 26, 29 April 2016 and 02, 05, 11 and 17 May 2016.

49 The abrupt cessation of the medication concerned outside a therapeutic setting is contrary to accepted medical practice.

Health services in prisons

The minimum standard for the healthcare of prisoners is set out under section 75 of the Corrections Act 2004. Section 75 provides that a prisoner is entitled to receive reasonably necessary medical treatment, of a standard reasonably equivalent to the standard of healthcare available to the public.

Primary healthcare services (including mental health)

Corrections is responsible for the provision of primary healthcare services to prisoners. Access to community and hospital-based primary, secondary and tertiary health services for all prisoners is determined by local District Health Boards (DHBs), based on clinical criteria. A memorandum of understanding (MOU) between Corrections and the Ministry of Health details a range of issues affecting the health of offenders and possible ways of working more collaboratively to address some of the key issues.⁵⁰

From observations and from speaking with staff and prisoners over the last 12 months, primary healthcare provision was considered by Inspectors to be reasonable overall, with access to an appropriate range of services. Waiting times for most clinics were acceptable, except for the dentist and some GP clinics. Some restrictive practices around medication management, specifically the prescribing of medication considered 'tradable' in the prison setting, is not commensurate to prescription practices in the community; night sedation is routinely dispensed between 6 – 8pm, which is too early clinically.

All new arrivals into custody receive a health screening, including mental health and substance misuse checks,⁵¹ by a registered nurse and appropriate referrals are made. A follow-up general health check within seven days is also offered. We observed good communication between healthcare staff and prisoners across all five sites.

Primary mental health services were limited and generally focused on crisis management. Visiting medical officers were the main point of contact for prisoners with mild to moderate symptoms of mental illness. Nursing interactions were restricted to medication rounds. There was very little in the way of mental health promotion across all five sites.

We have been informed by Corrections that they have received close to \$14 million in budget 2016 from the Justice Sector Fund for mental health and reintegrative services over the next two years.

Secondary mental health services and hospital level care

Regional Forensic Psychiatry Services (RFPS) support Corrections to assess and treat prisoners with high and complex mental health needs. Prisoners may be

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⁵⁰ Ministry of Health. Memorandum of understanding. 4 December 2012.

⁵¹ In accordance with New Zealand Suicide Prevention Action Plan 2013 – 2016. See MOH website.

transferred to a secure forensic mental health facility for treatment in a therapeutic environment.⁵² There are five RFPS supporting 18 prisons.⁵³ The total number of RFPS beds currently is 266.5,⁵⁴ slightly more than reported in the Forensic Mental Health Services Census (2005). 236 beds are for acute admissions from community, courts and prisons. Forensic services are funded by the Ministry of Health via DHBs.

Acute forensic units accept referrals from a number of sources including the courts and the community. At times, these admissions appear to take priority over prisoners being admitted for assessment and treatment⁵⁵ (otherwise referred to as 'waitlisted' prisoners) on the basis that the prison environment is relatively controlled and secure.

The number of prisoners transferred from prison to hospital from year to year has varied significantly. Over the past fourteen years, the average number of prisoners transferred annually is 112.⁵⁶

Since 2001, the prison population has risen from approximately 6,000 to over 10,000. The prison population has risen by seven per cent this year and is forecast to rise by a further one per cent annually for the next nine years.⁵⁷ In 2006, the number of prison beds increased with the opening of four regional prisons; Otago, Spring Hill, Northland and Auckland Women's. In 2010 double-bunking increased bed capacity again.⁵⁸ Forensic beds appear not to have increased at the same rate, which would suggest lengthier waiting times for prisoners.

My Inspectors have spoken with a number of acutely unwell prisoners in ARUs waiting for a forensic bed. Some prisoners had been waiting several months with little to no therapeutic interaction. While forensic liaison nurses attend ARUs most days (Monday – Friday), interactions and engagements with prisoners appear to be perfunctory and only deal with crisis management and keeping prisoners physically safe. There is limited therapeutic engagement, either individually or in groups, for prisoners under the care of forensic mental health within a prison setting. This may be because RFPS are only required to provide primary mental healthcare to those prisoners waitlisted for a forensic bed.

Service Level Agreements (SLAs) between RFPS and prisons are out of date, lack specificity and are managed regionally rather than at individual sites. SLAs make no reference to prisoners with challenging behaviour such as personality disorders.

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Service Level Agreements (SLAs) between RFPS and prisons are out of date, lack specificity and are managed regionally rather than at individual sites. SLAs make no reference to prisoners with challenging behaviour such as personality disorders.

52 Office of the Director of Mental Health Annual report 2014, p.13.

53 Mason Clinic (Auckland), Henry Rongomau Bennett Centre (Waikato), Ratonga-Rua-o-Porirua (Central), Hillmorton Hospital (Canterbury) and Wakari Hospital Hospital (Southern). Stanford house (Whanganui) is a long-term forensic unit and part of Central RFPS.

54 Mental Health and Addictions Expenditure Report 2014/15, Ministry of Health.

55 Under the Mental Health (Compulsory Assessment and Treatment) Act 2003

56 Office of the Director of Mental Health Annual Report 2014.

57 Ministry of Justice Sector Forecast. May 2016.

58 There have been prison closures: Wellington Prison, New Plymouth Prison, Rimutaka (top jail), Waikeria (top jail).

Personality disorders

The prevalence of personality disorders is significantly higher in prisons than in the community. Personality disorders are difficult to diagnose because of co-morbid conditions. Consequently, people may be prescribed medication or therapies that are unsuitable for them. Often they are excluded from health services because of their diagnosis or their behaviour. This may be because staff lack confidence and skills to deal with these conditions or have negative attitudes towards people with the disorder.⁵⁹

Borderline Personality Disorder is characterised by significant instability of interpersonal relationships, self-image and mood, and impulsive behaviour. There is sometimes a pattern of rapid fluctuation from periods of confidence to despair, with fear of abandonment, rejection, and a strong tendency towards suicidal thinking and self-harm. Personality disorder is often co-morbid with depression, anxiety, and alcohol and drug misuse.

Antisocial Personality Disorder includes impulsivity, high negative emotionality, low consciousness and associated behaviours, including irresponsibility and exploitative behaviour, recklessness and deceitfulness. As a result of Antisocial Personality Disorder, people may experience unstable interpersonal relationships and may disregard the consequences of their behaviour and the feelings of others. Antisocial Personality Disorder is often co-morbid with depression, anxiety, and alcohol and drug misuse.

From a forensic service point of view, personality-disordered offenders are generally considered to be untreatable and therefore their admission to a forensic unit is seen as the ineffective use of a bed space that could be occupied by an individual with a more 'treatable' disorder.

59 National Institute for Health and Care Excellence. Personality disorders: borderline and antisocial. Quality standard, June 2015.

Prisoners' thoughts on healthcare services

As part of the inspection process, an anonymous prisoners' questionnaire was distributed across the five sites. Inspectors spoke with prisoners individually and in groups to explain the purpose of the survey. The results of the questionnaire relating to healthcare are as follows:

Table 2: Access to healthcare

	Arohata	Manawatu	Rolleston	Invercargill	OCF
Number of prisoners on the day	62	270	256	158	432
Number of questionnaires handed out	62	241	221	143	417
Number of completed questionnaires	56 (90%)	140 (52%)	174 (68%)	126 (80%)	287 (66%)
% Reported having difficulty accessing the nurse	13%	30%	2%	20%	37%
% Reported having difficulty accessing the dentist	59%	65%	40%	79%	73%
% Reported having difficulty accessing the doctor	35%	48%	16%	60%	62%
% Reported having emotional/mental health needs	53%	32%	29%	44%	49%
% that felt unsupported with identified need while in prison	23%	74%	37%	78%	72%
Overall quality of healthcare service					
Good	84%	62%	86%	39%	44%
Bad	16%	38%	6%	41%	42%
Don't Know	-	-	8%	13%	13%

Prisoner survey results varied with regard to the overall quality of healthcare services. Many prisoners who consider themselves as having emotional/mental health needs did not feel the prisons supported them in addressing their needs.

My Inspectors have made several recommendations⁶⁰ to Corrections to carry out annual health needs assessments in order to identify future service delivery needs. This recommendation was also made by the SPT in 2013. To date, to my knowledge, these recommendations have not been implemented.

60 Auckland Prison (2010) and Otago Corrections Facility (2014).



Conclusion

I consider that the use of the tie-down bed and/or waist restraints in the circumstances of Prisoners A,B, C, D and E⁶¹ amounted to cruel, inhuman or degrading treatment or punishment for the purpose of Article 16 of the Convention against Torture.

It is troubling that in the case of Prisoner A, whose restraint on a tie-down bed at Auckland Prison lasted for 37 consecutive 16-hour periods, there was no indication of intervention from either the Corrections' Inspectorate or Corrections' National Office, in spite of the failure to comply with basic elements of the policy, including the need for medical approval.

Prisoner A's extended restraint without limb-flexing breached section 87(4)(b) of the Corrections Act 2004, which requires that '*A mechanical restraint must be used in a manner that minimises harm and discomfort of the prisoner*'. Similarly, Prisoner B's restraint on the tie-down bed without limb-flexing breached section 87(4)(b).

In the case of Prisoner E, the forced, unnatural position in which he was restrained created major strain both physically and mentally. The length of time in restraints will have caused significant physical and mental distress for the prisoner. The prolonged use of the handcuffs behind the back also breached section 87(4)(b). The continued and prolonged use of handcuffs behind the back to manage an individual's self-harming behaviour is considered disproportionate and unreasonable.

Some procedural practices relating to prisoners considered to be at risk of suicide and self-harm were not being adhered to. Gaps in procedural practice and record-keeping also exist. I urge Corrections to consider new approaches in the care and management of prisoners assessed as being at risk and generally address the issue of the prevention of cruel, inhuman and degrading treatment or punishment. There is much in the way of international good practice in the care of at risk prisoners that incorporates a more person-centred approach, which involves interactive, supportive contact and not mere observation.

At risk units by their very nature tend to create an environment where isolation and minimal regimes are the norm, and where prisoners are unwell and unable to advocate for themselves effectively. This must be mitigated rather than exacerbated.

We encourage the Government to action the 2013 SPT's recommendations and audit the healthcare needs of prisoners. This will enable Corrections to clearly articulate their needs to the Ministry of Health and District Health Boards.

My Inspectors will continue to monitor ARUs across the country as part of our inspection mandate and make recommendations for improvement on a prison-by-prison basis. By collating our findings and observations from the past 12 months in a more thematic way, we hope the information provided will assist Corrections to implement necessary changes in the delivery of care to at-risk prisoners.

I consider that the use of the tie-down bed and/or waist restraints in the circumstances of Prisoners A,B, C, D and E⁶¹ amounted to cruel, inhuman or degrading treatment or punishment for the purpose of Article 16 of the Convention against Torture.

We encourage the Government to action the 2013 SPT's recommendations and audit the healthcare needs of prisoners. This will enable Corrections to clearly articulate their needs to the Ministry of Health and District Health Boards.

61 See page 24 and following

Acknowledgements

I appreciate the co-operation extended by the Prison Directors and staff to my Inspectors during their visits to the respective prisons referred to in this report. Also, thank you to the various prisoners and their families around the country who have discussed difficult and personal information with my team. I also acknowledge the work that would have been involved in collating the information sought by my Inspectors. Finally, I would like to thank my Inspectors for providing me with such a comprehensive analysis of the work undertaken over the past twelve months.

Judge Peter Boshier

Chief Ombudsman
National Preventive Mechanism

Appendix 1.

Prisoner quotes on their experience in ARUs

'I wasn't allowed my dentures and I wasn't allowed cutlery - they gave me an apple!'

'I had a pie sandwich for my meal.'

'I had no contact with the staff other than at meal times when they gave me sandwiches.'

'They gave me a yoghurt, but I wasn't allowed cutlery.'

'If I wasn't depressed going in, I would be coming out – no distractions – zero stimulation.'

'The help is not helpful.'

'You're powerless.'

'Feeling so isolated was terrifying.'

'All I could do was stare at the walls.'

'I think I needed to have some extra support when I came in but the next day I was feeling better but couldn't move on when I was ready – that made me feel pretty helpless.'

'I learnt not to talk.'

'It's too cold- I spend all day in bed.'

'I was alone with my thoughts – they weren't good.'

'Due to being new, my phone-list wasn't approved, so I couldn't contact any support outside.'

'The staff were awesome, but I wouldn't tell anyone if I wasn't going so good in case they sent me back to the ARU.'

'If I told them how I felt, they would have kept me in there.'

'It was a zoo where I was before, noisy and scary after lock up.'

'Being in here [ARU] gets you away from the bullshit and bullying.'

'It's too big a step to go from here [ARU] back to the Units, I don't feel safe.'

 **Ombudsman**
Fairness for all

