



Ombudsman Quarterly Review

The quarterly update of Ombudsman news, reports, investigations and more.

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Ombudsman
Tuia kia ōrite • Fairness for all

From the Chief Ombudsman

Tēnā koutou

As this issue of OQR demonstrates, my Office has been busier than ever in the last quarter. Complaints resolution and investigation are maintaining their pre-COVID responsiveness and timeliness, and we've conducted investigations and produced reports on matters of significant public interest and importance.

Among these is *He Take Kōhukihuki--A Matter of Urgency*, my report concerning the policy and practice of Oranga Tamariki—Ministry for Children around the uplift of newborn pēpi.

A Matter of Urgency is perhaps the most significant report I've published during my time as Chief Ombudsman. It was the main focus of discussions during my formal meeting with the Māori King, Te Ariki Tuheita, at Turangawaewae marae, Ngaruawahia, on August 10.

My visit to Turangawaewae took place at Kingiitanga's invitation, and was the first formal meeting between New Zealand's Chief Ombudsman and the Māori King or Queen. An unforgettable event, and a great honour.

Hei konā mai

Peter Boshier, Chief Ombudsman

Tari o te kaitiaki mana tangata



Investigations

[He Take Kōhukihuki—A Matter of Urgency](#) reports on the policy and practice of Oranga Tamariki—Ministry for Children when removing newborn pēpi from their parents and whānau.

The Chief Ombudsman found the Ministry had been using its powers to remove newborn pēpi more by routine than exception. He made 32 recommendations and has requested quarterly progress reports.



[Off the Record](#) focuses on the Ministry of Health’s collection and use of information about the deaths of people with intellectual disabilities receiving full-time residential support.

The investigation found that information collected by the Ministry was not complete, accurate, or sufficient, and there was no evidence of the information that was collected being used to make improvements in practice. The Chief Ombudsman made 10 recommendations and is monitoring their implementation.



Disability rights

[Making Disability Rights Real—Whakatūturu Ngā Tika Hauātanga](#) is the latest report of New Zealand’s Independent Monitoring Mechanism (IMM), which includes the Office of the Ombudsman.

The report covers New Zealand’s progress over the last five years towards implementing the Disabilities Convention.

It identifies education, housing, and the use of seclusion and restraint in health and disability facilities as among the most pressing issues, with the disproportionate use of seclusion and restraint for Māori a particular concern.

The other three areas highlighted for government attention are data, access to information and communications, and employment.



Inspections and monitoring

During lockdown Levels 4 and 3, the Chief Ombudsman's OPCAT (Optional Protocol to the Convention Against Torture) teams carried out COVID-19 inspections at nine Prisons, six secure aged care facilities, and five mental health and addiction facilities.

The purpose was to ensure that facilities were taking the necessary precautions to protect residents from COVID-19, without unnecessarily compromising their treatment and conditions.

The Chief Ombudsman has now published thematic reports that draw together key findings and recommendations from the OPCAT COVID-19 inspections:

[OPCAT COVID-19 report on inspections of Prisons](#)

[OPCAT COVID-19 report on inspections of aged care facilities](#)

[OPCAT COVID-19 report on inspections of mental health facilities](#)



Under his OPCAT designation, the Chief Ombudsman is now also responsible for [inspecting and monitoring isolation and quarantine facilities](#). Orientation visits took place in August, and inspections will start in September.

At the end of August the Chief Ombudsman published five OPCAT reports on inspections of acute adult mental health units carried out between October 2019 and March 2020; and a report of an inspection of Waikeria Prison in October 2019.

[Report on inspection of Te Whare o Matairangi Mental Health Inpatient Unit, Wellington Hospital.](#)

[Report on inspection of Waiatarau Mental Health Inpatient Unit, Waitakere Hospital Campus, Auckland.](#)

[Report on inspection of He Puna Wāiora Mental Health Inpatient Unit, North Shore Hospital Campus, Auckland](#)

[Report on inspection of Kensington Centre Mental Health Inpatient Unit, Timaru](#)

[Report on Tumanako Mental Health Inpatient Unit, Whangarei Hospital Campus, Whangarei](#)

[Report on an unannounced inspection of Waikeria Prison](#)

Case notes and guides

Case notes

In the last quarter, the Chief Ombudsman published his first six case notes concerning tamariki and rangatahi in care:

[Treatment of disabled mother and removal of newborn child](#)

[Complaint from a young person in a Care and Protection Residence](#)

[Full Practice review of social work practice after notification of investigation](#)

[Complaint about the reimbursement of costs when attending the Chief Executive's Advisory Panel](#)

[Cancellation of access between mother and son due to COVID Alert Level 4 lockdown](#)

[Call to avoid the pending removal of a newborn baby](#)



Guides

[The OIA and inquiries: the interaction between the OIA and the Inquiries Act 2013](#) aims to answer questions about where and how the two pieces of legislation interact. It includes links to relevant case notes and opinions concerning requests for information about Operation Burnham, the Spring Creek Coal Mine, and Pike River Mine.

[Checklist: protecting whistleblower confidentiality](#) helps organisations to ensure they comply with the confidentiality requirements of the Protected Disclosures Act when receiving a protected disclosure about serious wrongdoing in the workplace.

[Proactive release: good practices for proactive release of official information](#) pulls together the Ombudsman's previous guidance on proactive release, and complements existing guidance from the State Services Commission and Cabinet Office.



Office of the Ombudsman

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