



Ombudsman

Fairness for all

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OPCAT Report

Report on an unannounced inspection of Matawhāiti Residence under the Crimes of Torture Act 1989

December 2020

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Peter Boshier


Chief Ombudsman

National Preventive Mechanism

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Office of the Ombudsman

Tari o te Kaitiaki Mana Tangata





OPCAT Report: Report of an unannounced inspection of Matawhāiti Residence under the Crimes of Torture Act 1989

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Foreword

The following report has been prepared in my capacity as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA). My function under the COTA is to examine, and make any recommendations that I consider appropriate to improve, the treatment and conditions of detained persons in a number of places of detention, including residences established under section 114 of the Public Safety (Public Protection Orders) Act 2014 (the Act). This report examines the treatment and conditions of persons detained in Matawhāiti Residence (the Residence).

The Residence opened in January 2017 and is located on one hectare of land in the grounds of Christchurch Men's Prison. At the time of the inspection, the Residence was a 12-bed facility. Three residents were detained in the Residence.

I authorised my Inspectors to conduct a one-day inspection of the facility in February 2020, using defined criteria to assess the treatment residents were experiencing, and their living conditions.

There were a number of positive practices in the Residence. Residents' accommodation was of an adequate standard and provided reasonable accommodation for persons with disabilities. Records showed that only one use of force incident had occurred since the Residence opened. However, I note that the residents involved were not seen by a registered health professional within three hours.

Levels of violence in the Residence were low, with only one resident-on-resident assault since the Residence opened. My Inspectors also observed positive and respectful interactions between staff and residents.

However, there were some matters that in my view need attention. Staff expressed concerns about whether the staffing levels would enable staff to respond to any situation where a resident became violent.

Information about the process for making complaints was inconsistent and did not always reflect the requirements of the Act. Recommendations of the expert Review Panel, a key safeguard of residents' rights, had not been implemented in a timely manner.

Under the Act, residents can be given a leave of absence from the Residence for medical appointments, court appearances, and for rehabilitative or humanitarian purposes. In practice, however, leave of absence was only granted for medical appointments and to attend court proceedings. I am concerned that the Residence did not give residents leave of absence from the Residence for rehabilitative or humanitarian purposes.

I also have concerns about the low level of rehabilitation provided within the Residence. Information provided to my Inspectors indicated that the number of rehabilitative sessions had recently increased, but that this may only have been temporary. I would also like to see formal employment opportunities for residents, where possible, to assist with rehabilitation.

I consider that failure to provide further rehabilitation, on a permanent basis, would create a risk of arbitrary detention and could amount to cruel, inhuman or degrading treatment under Article 16 of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment.

In conclusion, I wish to acknowledge and express my appreciation to the managers and staff of the Residence for the full co-operation they extended to my Inspectors.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Facility facts

Matawhāiti Residence (the Residence) is Aotearoa New Zealand's civil detention facility for people detained under the Public Safety (Public Protection Orders) Act 2014 (the Act).¹

The Residence is located on one hectare of land in the grounds of Christchurch Men's Prison.

The Residence opened in January 2017 and is operated by the Department of Corrections.

Operating capacity

The Residence was designed to accommodate 24 residents. At the time of the inspection, 12 of the 24 residential units had been built. Six of the 12 units became operational in 2019. None of the new units were occupied at the time of the inspection.

Resident Manager

Andrew Burger

Previous inspections

An unannounced visit of the Residence was undertaken in 2018. The February 2020 inspection was the first full inspection.

¹ Linda Pullan and Andrew Burger (2019) 'Matawhāiti Residence – Public Protection Orders' *Practice: The New Zealand Corrections Journal*, Vol. 7, Issue 1.

The Inspection

Ombudsmen are designated as one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining the treatment of, and conditions applying to, detainees in New Zealand prisons.

In 2018, the Ombudsmen's designation was amended to include examining and monitoring the treatment of persons detained in residences established under section 114 of the Public Safety (Public Protection Orders) Act 2014 (the Act).

To be detained under a Public Protection Order (PPO) a person must be aged over 18 and have served a prison sentence for a serious sexual or violent offence, or be subject to the most intensive form of an extended supervision order.² Section 13 of the Act requires that the person must also pose a very high risk of imminent and serious sexual or violent offending and be assessed as having each of the following characteristics:³

- an intense drive or urge to commit a particular form of offending;
- limited self-regulatory capacity, evidenced by general impulsiveness, high emotional reactivity, and inability to cope with, or manage, stress and difficulties;
- absence of understanding or concern for the impact of their offending on actual or potential victims; and
- poor interpersonal relationships or social isolation.

PPOs are granted by the High Court for an indefinite period, but are reviewed annually by a Review Panel.

On 24 February 2020, a team of three Inspectors (the Team) – whom I have authorised to carry out visits to places of detention under COTA on my behalf – made an unannounced one-day inspection of the Residence. This was the first full inspection of the Residence.

There were three residents in the Residence at the time of the inspection. One resident was subject to a permanent PPO and two were subject to an interim PPO.

Methodology

Inspection criteria

I have developed six core inspection criteria (the criteria), each of which describes the standards of treatment and conditions a prison is expected to achieve.

These criteria are underpinned by a series of indicators that describe evidence Inspectors look for to determine whether there is anything that could be considered to be torture, or cruel, inhuman or degrading treatment or punishment, or impact adversely on detainees. The list of

² Public Safety (Public Protection Orders) Act 2014, section 7.

³ Public Safety (Public Protection Orders) Act 2014, section 13.

indicators underpinning the criteria is not exhaustive, and does not preclude a prison demonstrating that the expectation has been met in other ways.

I am conscious that the Residence is a civil detention facility and not a prison. However, the facility is run by the Department of Corrections, and the Act contains prison-like administrative powers similar to those in the Corrections Act 2004.

For consistency, I have decided to use same criteria as for prisons, with any necessary modifications to reflect the specific legislative and operational context of the Residence. I propose to update the criteria over time.

The following criteria were examined during the one-day inspection:⁴

Criteria 1: Treatment

Criteria 2: Reception

Criteria 3: Decency, dignity and respect

Criteria 4: Health and wellbeing

Criteria 5: Protective measures

Criteria 6: Purposeful activity and transition to the community.

Evaluation techniques

My Inspectors gathered and assessed a range of information, resulting in the evidence-based findings presented in this report, using a variety of techniques including:

- obtaining information and documents from the Department of Corrections and the Residence;
- interviewing residents, visitors and staff on a one-to-one basis;
- observing the range of services delivered within the facility at the point of delivery;
- inspecting a wide range of facilities impacting on both residents and staff; and
- reviewing policies, procedures and performance reports produced both by the Residence and by the Department of Corrections.

Future follow up inspections will take place as necessary to monitor the implementation of my recommendations.

⁴ Our inspection methodology is informed by, but not limited to, the Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), the Association for the Prevention of Torture's publication 'Monitoring Places of Detention', the New Zealand Bill of Rights Act 1990 (NZBORA), the Corrections Act 2004 and Corrections Regulations 2005.

Criteria 1: Treatment

Expected outcomes–treatment

- The Residence has robust oversight measures and standards in place for preventing torture and other cruel, inhuman or degrading treatment or punishment. Such protection measures are subject to regular review by senior managers to ensure standards are consistently achieved.
- The Residence takes all reasonable steps to ensure the safety of all residents. Residents live in a safe and well-ordered environment where positive behaviour is encouraged and rewarded. Unacceptable behaviour is dealt with in an objective, fair and consistent manner. There is regular and responsive consultation with residents about their safety.

Assessment

Restraint

The restraint of residents ('use of force') is regulated by section 72 of the Act. Under section 72, a residence manager may restrain a resident only to prevent prescribed circumstances.⁵ The person exercising the power of restraint may not use a greater degree of force than is required to achieve the purpose of the restraint. Records of all restraint events must be maintained and be made available to statutory visitors for inspection.⁶

The Residence provided Inspectors with a copy of the use of force register.

There had been one recorded instance of use of force, which took place in 2018. The Residence Manager had undertaken an evaluation of the use of force within 24 hours of the event. The evaluation of the use of force was robust and appropriate actions were taken to prevent future events.

I was pleased to note that the Resident Manager had attended the Residence approximately an hour after the incident to undertake a welfare check of the residents involved. However, records showed that the residents had not been examined by a registered health professional within three hours of the event, which is concerning.

Timely examinations by registered health professionals is Department of Corrections' policy for any use of force in a prison context. It is unclear why that same policy would not apply in the Residence. I consider that residents subjected to a use of force should be seen by a registered health professional within three hours of the event.

⁵ Endangering the health or safety of the resident or others, seriously damaging property, seriously compromising the care and well-being of the resident or of other persons, and escaping from lawful custody.

⁶ [Chief Executive's Guidelines on the Use of Coercive Powers under the Public Safety \(Public Protection Orders\) Act](#) (May 2015).

Seclusion

The Residence had a purpose-built room where residents could be secluded. Seclusion is the placement of a resident without others in a room or other area that provides a safe environment for the resident, but does not allow them to leave without help.⁷ The Residence referred to this room as the 'respite area'.

The respite area was clean and tidy, and had sufficient natural light. It was monitored in the staff control room through CCTV and an observation window. A curtain had been installed so that residents could undertake their ablutions and go to the toilet in privacy.

The Residence provided Inspectors with a copy of the seclusion register. I was pleased to note that no residents had been secluded since the Residence opened in 2017.

Safety and security

There is an expectation that residents feel, and are, safe from bullying and victimisation, including verbal and racial abuse, threats of violence and assaults.

Overall, the residence was safe and secure with low levels of violence and tension.

The Residence provided Inspectors with details of the one resident-on-resident assault, which had occurred in 2018. Information provided by the Residence also indicated that there were sometimes tensions between residents, often as a result of personality clashes and difficulties that the residents had regulating their moods.

No searches of residents or the Residence were reported in the relevant registers.

The minimum staffing level per shift was two Resident Supervisors. The minimum of two Resident Supervisors were rostered on during the inspection, along with the Residence Manager and Deputy Residence Manager. Staff told Inspectors it was rare for a third Resident Supervisor to be rostered.

One Resident Supervisor was required to be in the control room at all times to monitor CCTV footage of the Residence, meaning only one Resident Supervisor would be out with residents at a time. Staff observed that, in practice, having one staff member available would make it difficult to respond to any situation where a resident became violent towards staff or other residents.⁸

Prison detention order

Section 85 of the Act provides that the court may order that a resident be detained in prison if the resident poses such an unacceptably high risk that they cannot be safely detained in the Residence, and all less restrictive options have been considered and appropriate options tried.

No residents had been made subject to a prison detention order since the Residence opened.

⁷ Public Safety (Public Protection Orders) Act 2014, section 71.

⁸ I note that section 74 of the Act allows a residence manager to request assistance from the prison in which the Residence is located in security emergencies.

Recommendations–treatment

1. I recommend that:
 - a. Residents are seen by a registered health professional within three hours of a use of force.

The Department of Corrections accepted recommendation 1a.⁹

⁹ The Department of Corrections' comments on recommendation 1a can be found in Appendix 1.

Criteria 2: Reception

Expected outcomes—reception

On arrival at the Residence, residents are safe and treated with respect. Risks are identified and immediate needs met before residents move to their allocated units.

The Residence complies with administrative and procedural requirements of the law. There is a structured process to provide every resident with all necessary information about their rights, responsibilities and entitlements, the Residence's expectations of them, and the operating and administrative arrangements pertaining to their detention.

Assessment

Induction

The Residence had a comprehensive induction handbook for residents (the Handbook).¹⁰ The Handbook covered a wide range of topics, including the rules and expectations in the Residence, and residents' rights and entitlements.

The Handbook was not available in an alternative format for residents with literacy issues. My Inspectors were informed by staff that a resident's Case Manager will go through each page of the Handbook with the resident to explain the contents. Residents were provided a copy of the Handbook in advance of their arrival, to prepare them for Matawhāiti and to allow an opportunity to discuss it with their family and legal representatives.

Initial needs assessment

Section 41 of the Act requires that, as soon as practicable after a resident first commences their stay in the Residence, the manager of the Residence must assess the needs of the resident in consultation with the resident. The assessment must identify several factors, including any special medical requirements, cultural or religious needs, and any steps to be taken to facilitate the resident's rehabilitation and reintegration.

My Inspectors requested copies of residents' needs assessments. The Residence informed my Inspectors that the needs assessments were not currently distinct from management plans.

I acknowledge the overlap between needs assessments and other requirements of the Act, including information in support of a PPO application and residents' management plans. However, residents' management plans should be informed by the needs assessment. I note that the Act treats these requirements as distinct. I therefore consider that needs assessments should be conducted and recorded separately from other administrative and procedural requirements of the Act.

¹⁰ Matawhāiti Residence, *Handbook for Residents*, 2017.

Recommendations–reception

2. I recommend that:

- a. Needs assessments are conducted and recorded separately from other administrative and procedural requirements of the Public Safety (Public Protection Orders) Act 2014.

The Department of Corrections accepted recommendation 2a.¹¹

¹¹ The Department of Corrections' comments on recommendation 2a can be found in Appendix 1.

Criteria 3: Decency, dignity and respect

Expected outcomes—decency, dignity and respect

The Residence employs fair processes while ensuring it meets the distinct needs of all resident groups irrespective of age, disability, gender and sexual orientation, race, religion and belief. A climate of mutual respect exists between staff and residents.

Residents live in a clean and decent environment, which is in a good state of repair and fit for purpose. Each resident has a bed, bedding and clean suitable clothing, has good access to toilets and washing facilities, is provided with necessary toiletries and cleaning materials, and is properly fed. The Residence supplies the basic requirements of decent life to the residents.

Assessment

Accommodation, clothing and bedding

The communal area of the Residence was open from 7.30am to 9pm. The main communal area comprised a lounge, a toilet, an interview room, a small staff office and a shared kitchen. The staff control room and respite area were also attached to the communal area. The communal area was clean, tidy and well maintained.

Residents were accommodated in individual residential units. Each unit had a bedroom, lounge, kitchenette, and a bathroom with toilet and shower. I consider the units were of an adequate standard and provided reasonable accommodation for disabled people.¹²

I note that at least one resident had asked why they were not accommodated in one of the six new units that became operational in mid-2019. These new units had some improved amenities, including heat pumps and curtains instead of blinds. My Inspectors reviewed correspondence which indicated that residents had not been moved into the new units due to planned upgrades to the original units and concerns about residents' self-regulation.

Residents wore their own clothes and were provided with bedding, which were of an adequate standard and quantity.

¹² Article 1 of the UN Convention on the Rights of Persons with Disabilities provides that people with disabilities includes those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. Impairments can be physical, visual, hearing/speech centred, intellectual or mental. An impairment may be temporary, intermittent or ongoing. People may acquire impairment through an accident or illness, or a person may be born with an impairment.

Food and meal times

Residents planned meals with staff on a fortnightly basis. All residents received an allowance to order groceries online, which were then delivered to the Residence. Staff encouraged residents to purchase healthy food options.

Staff:resident relationships

My Inspectors observed positive and respectful interactions between staff and residents. Staff spoke respectfully about residents and actively engaged with them on a regular basis. The positive relationships appeared to create a predominantly calm atmosphere in the Residence.

Staff noted, however, that there were occasional tensions with residents. They said they had to be alert to complex behaviours from residents, some of which were subtle or mirrored the dynamics of their offending, and that these behaviours required careful management.

Respect for cultural identity

Section 38 of the Act provides that a resident is entitled to be treated in a manner that respects their cultural and ethnic identity, language, and religious or ethical beliefs.

Religious support was provided by the Chaplain, who visited the Residence regularly. Residents also engaged actively in regular Bible reading groups. Staff had also been working with one resident to explore their indigenous heritage.

I note that although not all residents were Christian, the Chaplain was the only active source of religious and cultural provision in the Residence.

Recommendations—decency, dignity and respect

I have no recommendations to make.

Criteria 4: Health and wellbeing

Expected outcomes—health and wellbeing

The Residence takes all necessary steps to ensure the wellbeing of all residents. Patients are cared for by services that assess and meet their health and substance use needs and promote continuity of care on release. Patients are treated with dignity, respect and compassion and their right to privacy is respected.

Assessment

The minimum standard for the health care of residents is set out under section 35 of the Act. Section 35 provides that a resident is entitled to medical treatment and other health care appropriate to their condition. The standard of health care must be reasonably equivalent to the standard of healthcare available to the public.

Residents were able to attend external medical appointments upon request. Information provided by the Residence indicated that residents had been escorted to five external medical appointments in the six months prior to the inspection.

Residents did not hold any medication, all of which was stored securely in the control room. Staff administered all medications from blister packs. Staff and residents both initialled the signing sheet. I acknowledge that not all residents will have the capacity to responsibly hold and take their own medication. However, I expect residents to be gradually entrusted with more responsibility to manage their own medication to encourage responsibility for their wellbeing. Where this is not possible or desirable, it should be recorded in their management plans. I note that the principles of the Act include promoting residents' autonomy and quality of life.¹³ My recommendation below is consistent with that principle.

Recommendations—health and wellbeing

4. I recommend that:

- a. Residents are allowed to hold their own medications, unless deemed unsafe based on individual risk assessment. If an individual resident is not allowed to hold one or more of their medications, the reasons are recorded and reviewed.

The Department of Corrections accepted recommendation 4a.¹⁴

¹³ Public Safety (Public Protection Orders) Act 2014, section 5.

¹⁴ The Department of Corrections' comments on recommendation 4a can be found in Appendix 1.

Criteria 5: Protective measures

Expected outcomes—protective measures

The Residence performs the duties both to protect the public by detaining residents in custody and to respect the individual circumstances of each resident by maintaining order effectively, with courtesy and humanity. Residents are encouraged to take responsibility for themselves, their environment and their future. Their rights to statutory protections and complaints processes are respected.

The Residence takes appropriate action in response to the findings and recommendations of monitoring, inspectorial, audit or judicial authorities that have reported on the performance of the Residence.

Assessment

Complaints

Under section 80 of the Act, anyone may complain to an inspector about the breach of a resident's rights. The Act also requires that the manager or staff member of a residence who receives a complaint about a breach of rights must refer the complaint to an independent inspector appointed under the Act (PPO Inspector).¹⁵

My Inspectors spoke with staff and residents about the complaints process, and reviewed relevant information in the Handbook and the *Matawhāiti Residence Manual* (the Manual) for staff.

Residents were encouraged to speak with staff or the Resident Manager about any complaint. Formal complaint forms were freely available in the communal area. Formal complaints would go to the Resident Manager or Deputy Resident Manager for response. If the resident was unhappy with the outcome of their complaint, they were informed that they could complain to the PPO Inspector.

Inspectors were also told that if the complaint concerned an alleged breach of human rights and/or the Resident Manager, the complaint would be referred to the PPO Inspector. I consider this is a narrower meaning of 'resident rights' than is expressed in the Act.

There is no requirement in the Act for residents to go through these processes prior to making a complaint to the PPO Inspector. The Manual was clear that complaints could be made to the PPO Inspector at any time. However, it did not direct staff to refer any alleged breach of residents' rights to the PPO Inspector.

¹⁵ PPO Inspectors are lawyers appointed by the Chief Executive of the Department of Corrections under section 127 of the Act. PPO Inspectors have a range of functions and powers under the Act, including accessing documents, receiving complaints, and undertaking inquiries. A PPO Inspector must not be otherwise employed or engaged by the Department of Corrections.

Staff informed my Inspectors that the complaints process also operated as the appeal mechanism for residents in respect of consequences for breaches of communal rules. The Act does not contain a separate mechanism.

The Residence provided Inspectors with a copy of the complaints register. A total of five complaints had been recorded since the Residence opened in 2017, one of which had been referred to the PPO Inspector. A further complaint, which was not recorded in the register, had been made directly to the PPO Inspector. Copies of the PPO Inspector's reports on the complaints were provided to my Inspectors.

I recognise the benefit of trying to resolve any complaints as early as possible. I also acknowledge that the Residence had been diligent in responding to complaints. However, I consider that all information given to residents must be clear that complaints may be made directly to the PPO Inspector. Likewise, staff must understand, and implement, the requirement to refer all complaints about a breach of rights to the PPO Inspector.

The Handbook acknowledges that residents can seek assistance from other people, including by making a complaint to me and other oversight bodies.¹⁶

Mail and telephones

Section 32 of the Act provides that residents are entitled to be promptly given any written communications and to the prompt dispatch of any written communications put out by the resident for posting.¹⁷

I have no concerns about residents' ability to send and receive mail.

Under section 34 of the Act, residents must be allowed access to a telephone¹⁸ to communicate with persons with whom such communications are permitted. Access to a telephone is subject to sections 50 to 62 of the Act, which specify when residents' phone calls may be monitored.

Residents had access to a telephone independently of staff. Residents were required to cover their telephone costs, with exceptions for calls to certain people including the Ombudsman and the PPO Inspector. The costs for these calls were manually separated out by the Senior Residence Supervisor.

Staff told Inspectors that residents had not originally been charged for phone calls, but that the Residence had instituted charges due to a resident's heavy use of the phone. The issue had

¹⁶ For example, a member of Parliament, the Office of the Privacy Commissioner, the Human Rights Commission or the Health and Disability Commissioner.

¹⁷ Written communications are to be checked if there are reasonable grounds to believe that the communication may contravene the resident's management plan, or be otherwise detrimental to the interests of the resident or other persons. If the residence manager considers the communication contravenes the resident's management plan or is detrimental to a person's interests, the communication may be withheld or not dispatched.

¹⁸ Or other electronic communication device.

also been raised with the PPO Inspector, who was informed that it had been policy under the Manual to require residents to pay for phone calls since the Residence was established.¹⁹

Use of a telephone is one of the only effective ways residents can maintain contact with the outside world. The Act is silent on charging residents for telephone access, unlike the Corrections Act 2004.²⁰ I acknowledge that it may be reasonable to charge for particularly heavy use of the telephone. However, I do not think it is fair and reasonable to have a blanket policy of charging residents to use the telephone.

I consider that the Residence should develop a clear policy on reasonable telephone use and charges should only be applied if usage falls outside the scope of that policy.

The Senior Residence Supervisor had delegated authority for monitoring telephone calls. The independent resident telephone system was held in a secure server room on site. Only the Residence Manager and Senior Residence Supervisor had access to the remote reviewing platform. Certain approved telephone numbers, including to the Ombudsman, were automatically whitelisted and not monitored. All other calls were recorded.

All monitored calls had a pre-recorded warning to both parties to the conversation that calls may be monitored. Written notices were also displayed in prominent places informing the residents that their calls may be monitored.

Review Panel

Section 15 of the Act provides that a Review Panel must review the continuing justification for a PPO annually. If the Review Panel considers there is a continuing justification, they must review the management plan of the resident and make any recommendations to the Residence Manager. The Review Panel consists of six members, including a chairperson and deputy chairperson who must be, or has been, a District Court or High Court Judge.²¹

The Residence provided my Inspectors with Review Panel reports relating to all three residents currently in the Residence.

In respect of the reports themselves, it is not my role to assess the merits of the Review Panel's decisions. However, I found that the reports were comprehensive and contained valuable recommendations for the Residence. Several recommendations had been implemented, such as securing occupational therapy resources and investigating Accident Compensation Corporation (ACC) counselling where residents were eligible.

Review Panel reports also consistently raised concerns about the lack of leave for rehabilitative and humanitarian purposes. The Review Panel expressed a view that the grounds for leave should be read broadly, in keeping with the Act's stated principle of promoting residents' autonomy and quality of life. Each report accordingly recommended more frequent escorted

¹⁹ The Manual states that *“Residents must be allowed to make phone calls at their own expense and at any reasonable hour.”*

²⁰ Corrections Act 2004, section 77(6).

²¹ Public Safety (Public Protection Orders) Act 2014, section 122.

outings for rehabilitative and humanitarian reasons. The PPO Inspector had also noted these recommendations and was monitoring the situation.

Despite these repeated recommendations, residents were not being granted supervised leave in the community for rehabilitative or humanitarian purposes. I discuss my concerns around access to leave below in relation to purposeful activity and transition to the community. However, I am also seriously concerned to note that repeated recommendations of the Review Panel had not been implemented.

The Review Panel is a key safeguard to protect residents' rights. Its members have significant legal and health expertise. However, almost three years after the Review Panel's first report, its recommendations had not been implemented. In this context, the Review Panel considered that their recommendations had been disregarded. I agree. Further, I consider that the failure to implement its recommendations undermines the purpose of the Act and weakens the justification for limiting residents' fundamental human rights.

I expect the Residence and the Department of Corrections to implement the recommendations made by the Review Panel in a timely manner.

Recommendations—protective measures

5. I recommend that:

- a. Information is provided to residents that states complaints may be made directly to the PPO Inspector.
- b. Staff refer all complaints relating to a breach of residents' rights to the PPO Inspector.
- c. The Residence develop a clear policy on reasonable telephone use and residents are charged only if their usage exceeds that specified in the policy.
- d. The Residence and the Department of Corrections implement recommendations made by the Review Panel in a timely manner.

The Department of Corrections accepted recommendations 5a, 5b and 5d.²² In response to recommendation 5d, the Department of Corrections commented as follows:

Section 15(3)(b) of the Public Safety (PPO) Act notes that the review panel may make any recommendations to the manager of the residence in which the resident is required to stay. Matawhāiti accept that they should be responding to the review panel's recommendations in a timely manner, ensuring that the panel are informed of the approach being taken by Matawhāiti regarding recommendations.

²² The Department of Corrections' comments on recommendations 5a and 5b can be found in Appendix 1.

Matawhāiti believe that due consideration is given to each of the recommendations made by the review panel and the panel are acknowledged for the important role that they play in reviewing and enhancing outcomes for the residents. Matawhāiti consider that a majority of the review panel recommendations are implemented. This will be a continual focus for Matawhāiti, who consider that they are in a good position to continue addressing any shortfalls in this area. Whilst we accept your recommendation, we do not consider any further action is required.

I disagree with the Department of Corrections' assessment that no further action is required.

I accept that efforts have been made to implement some PPO Review Panel recommendations. However, essential recommendations made by the PPO Review Panel regarding rehabilitation have only recently been implemented, and repeated recommendations regarding leave of absence still have not been implemented. I also sent my provisional report to PPO Review Panel for comment, and the Panel confirmed that my comments in respect of its reports were accurate. I am therefore not satisfied that the PPO Review Panel recommendations are treated with sufficient importance and urgency. In my view, further action is required to implement my recommendation and I hope to see progress at follow up inspections.

The Department of Corrections partially accepted recommendation 5c and stated:

Matawhāiti support that residents should be contributing to their telephone use. Importantly, unlike prisoners, Matawhāiti residents receive a weekly benefit and a winter energy supplement. At Matawhāiti a system has been set up so that residents can receive incoming telephone calls at any time and are able to call from Matawhāiti, at a reduced charge, compared to individuals in the community.

Matawhāiti consider that the budgeting skills that are learned from paying for telephone usage is a part of the residents' rehabilitation and reintegration plan and is in line with the autonomy and quality of life that Matawhāiti seek to promote with the residents. Some residents may from time to time significantly increase their telephone use, potentially incurring a significant cost. The approach to this situation is not to place residents into a significant level of debt in proportion to their average income. In situations where this occurs residents are made aware of the charges and are supported to plan and manage their telephone use.

I acknowledge the Department of Corrections' response. However, I remain of the view that a blanket policy of charging residents to use the telephone is neither fair nor reasonable. I hope to see progress in implementing my recommendation at follow up inspections.

Criteria 6: Purposeful activity and transition to the community

Expected outcomes—purposeful activity and transition to the community

All residents are encouraged to use their time in the Residence constructively and this is facilitated by the Residence. The Residence supports positive family and community relationships.

Residents' orders are managed appropriately to prepare them for their safe return to their community at the earliest opportunity. The Residence provides a broad range of activities, opportunities and services based on the profile of needs of the resident population. There are sufficient, suitable education, skills, and work and programme places to meet the needs of the residents. Residents are consulted in planning the activities offered.

Residents have the opportunity to participate in recreational, sporting, religious and cultural activities.

Assessment

Leave of absence

Section 26 of the Act provides that the Chief Executive of the Department of Corrections may grant a resident a leave of absence from the residence for several purposes. The purposes listed include to receive medical or dental examinations or treatment, attending hearings in a proceeding, attending a rehabilitation programme, and for humanitarian reasons.

Staff and residents informed my Inspectors that leave was, in practice, only granted for medical appointments and to attend court proceedings. As I have noted above, this issue had also been raised with, and by, the Review Panel.

The Residence provided my Inspectors with a register which confirmed that, prior to 2019, leave had only been granted for medical and court appointments. Since early 2019, numerous instances of leave on humanitarian grounds were recorded in the register. However, on further enquiry, my Inspectors found that this referred to escorted walks to the Residence carpark to purchase goods from a coffee cart that visited once a week. The Residence confirmed that no leave had been granted for escorted visits into the community for rehabilitative or humanitarian grounds.

As noted above, the Review Panel has repeatedly expressed the view that section 26 of the Act should not be read narrowly. In particular, I note the Review Panel's view that humanitarian grounds is a broad concept that should extend to normal public outings, albeit supervised.

Prolonged and potentially indefinite detention in closed settings negatively affects mental health and wellbeing.²³ Active steps need to be taken to reduce the risks of deteriorating mental health, including through supervised rehabilitation and reintegration in the community, wherever possible.

In practice, residents were detained indefinitely and essentially in isolation from the community. The lack of recorded escorted leave for rehabilitative and humanitarian grounds, and my Inspectors' conversations with staff, indicated that an excessively restrictive approach to leave was in place.

I also note that two of the three residents are currently subject to an interim PPO. In my view, this adds to the need to ensure residents are able to access leave for rehabilitative and humanitarian purposes.

I recognise that in order for a resident to be detained, they must pose a very high risk of imminent serious sexual or violent offending. The imposition of a PPO also requires evidence of other factors, including a high level of limited self-regulatory capacity, inability to cope with stress, and poor interpersonal relations and/or social isolation.²⁴ Necessary precautions and supervision will no doubt be needed for community outings. That is not, however, a good reason for such outings not to be considered at all.

In my view, residents must be able to access leave for rehabilitative purposes and on humanitarian grounds, with all necessary precautions taken to manage risk.

Library and information services

The Residence had a good supply of books. Staff informed my Inspectors that the Residence also had access to the Christchurch Men's Prison library service, if required. Residents were actively involved in the management of the library.

Every resident had a laptop loaded with programmes of interest to them, such as games, educational programmes, and budgeting software. Laptops were not connected to the internet. The facility also had a secure internet suite where residents could be supervised.

I have no concerns about residents' access to library and information services.

Visits

Under the Act, residents may receive visits from people permitted by the manager to visit the Residence.²⁵

Visiting hours were from 10am to 12pm and 1pm to 4pm every day. Inspectors were told that family visits occurred infrequently. The reasons for the relatively low number of visits included

²³ United Nations, General Assembly, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/38/36 (10 April 2018).

²⁴ Public Safety (Public Protection Orders) Act 2014, section 13(2).

²⁵ Public Safety (Public Protection Orders) Act 2014, section 34.

residents' offending history, complex family dynamics, the location of the Residence, and the cost associated with travel, which residents or their family had to meet. The interview room attached to the communal area also had AVL facilities that could be used to maintain contact with family.

Legal visits took place in the interview room attached to the communal area. There was evidence that legal visits were occurring.

Programmes and activities

Under section 36 of the Act, residents are entitled to receive rehabilitative treatment if the treatment has a reasonable prospect of reducing their risk to public safety. The treatment and programmes that residents participate in must be included in their management plans.²⁶

The Residence provided my Inspectors with copies of residents' management plans. Management plans were oriented around the Good Lives Model of Offender Rehabilitation (GLM). The GLM is focussed on individuals' ability to formulate and select goals in various areas, including medical, interests and hobbies, inner peace, spirituality, and rehabilitation and reintegration. Residents formulated goals in these areas, with assistance from staff.

The Residence had employed an Occupational Therapist (OT) for 15 hours a week since September 2019. The OT worked with residents to conduct cognitive assessments, identify residents' interests, assess the environment, and plan for leisure and self-care. Staff were positive about the impact of the OT, and my Inspectors observed that the OT appeared to have respectful and constructive interactions with residents.

The Residence provided my Inspectors with a copy of its fortnightly activity schedule. I was pleased that the Residence had increased the level of activities and resources available, and that volunteers appeared to be visiting the Residence frequently. At the time of the inspection, the activity schedule included a number of regular events, including exercise, Bible studies, arts and crafts, music, and a quiz. The Residence also had a social night once a week.

A Department of Corrections Psychologist visited the Residence once a week for four hours. The Psychologist's time was divided between one-on-one treatment sessions with residents and training staff to implement residents' management plans. Staff told my Inspectors that the intention was to provide residents with approximately three to four treatment sessions each quarter. ACC counselling had also been secured for an eligible resident. One resident had in effect refused to participate in rehabilitative interventions.

In several of its reviews, the Review Panel had recommended that the Residence increase the frequency of rehabilitative treatment. The Review Panel noted that the high level of risk posed by residents necessitated more intensive rehabilitation, perhaps as frequently as fortnightly or weekly. Despite these recommendations, the Review Panel noted that treatment for a resident had actually decreased from nine sessions in 2017/18 to five sessions in 2018/19. I share the Review Panel's concerns about the level of rehabilitative programmes and treatment.

²⁶ Public Safety (Public Protection Orders) Act 2014, section 42.

Information provided by Matawhāiti indicated that rehabilitative treatment had increased in the last year for two of the residents, from an average of approximately one session per month in the first half of 2019 to two sessions per month in 2019/20. However, Inspectors were informed by staff that the increase in sessions was temporary and that it might not continue.

The recent increase in the number of rehabilitative sessions was promising. However, I consider that further significant increases are required on a permanent basis. In doing so, I acknowledge that not all residents will consent to participate in rehabilitative treatment, and that the Residence cannot, and should not, force them to do so.

I note that the High Court recently observed that detention on prison grounds without rehabilitation might mean that a PPO operated like a penalty.²⁷ I agree. In my view, rehabilitation is a fundamental component of the ongoing justification for limiting residents' human rights. A failure to provide further rehabilitation would therefore create a risk of arbitrary detention and could amount to cruel, inhuman or degrading treatment under Article 16 of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment.

Training, employment and education

Section 28 of the Act provides that a resident who is working in the Residence or in a prison may retain any money earned from that work. Residents may also participate in recreational, educational, and cultural activities within the residence.²⁸

There were no formal employment opportunities available for residents at the time of the inspection. Residents undertook various tasks in the maintenance of the facility, such as gardening, assisting with office work, and taking minutes of resident meetings. While not all residents were willing or able to undertake paid employment, formal employment opportunities should be available where possible to assist with rehabilitation.

Educational opportunities were available onsite and with external providers, such as the Open Polytechnic.

²⁷ *Chief Executive of the Department of the Corrections v Chisnall* [2019] NZHC 3126 at [142].

²⁸ Public Safety (Public Protection Orders) Act 2014, section 31.

Recommendations—purposeful activity and transition to the community

6. I recommend that:

- a. Residents are able to access leave for rehabilitative purposes and on humanitarian grounds, with all necessary precautions taken to manage risk.
- b. The frequency of rehabilitative treatment sessions offered to residents increase significantly on a permanent basis.
- c. The Residence takes action to make formal employment opportunities available for residents.

The Department of Corrections accepted recommendations 6b and 6c.²⁹

The Department of Corrections partially accepted recommendation 6a and stated:

We consider that residents leaving the facility for rehabilitative purposes and on humanitarian grounds, should be assessed on a case by case basis, taking into account each individuals' risk and corresponding management plan.

As part of wider work being undertaken regarding residents accessing leave at Matawhāiti, a process to allow residents greater access to leave for rehabilitative and humanitarian purposes will be developed. It is anticipated that this work will take six months to develop and implement.

I am pleased to hear that work is underway to ensure that residents are able to access leave for humanitarian and rehabilitative purposes. As my comments above indicate, I agree that assessments regarding leave should be made on a case-by-case basis, including a focus on individual risk. My concern, however, is that other considerations also need to be given appropriate weight, including the promotion of residents' autonomy and quality of life. The ability to mitigate risk through supervision of residents, which is required under the Act, must also be given due consideration. In my view, this work is urgent.

²⁹ The Department of Corrections' comments on recommendations 6b and 6c can be found in Appendix 1.

Appendix 1. Department of Corrections' comments on recommendations that were accepted

Recommendations– treatment

1. I recommend that:

- a. Residents are seen by a registered health professional within three hours of a use of force.

The Department of Corrections accepted recommendation 1a and commented as follows:

In line with the Public Safety (PPO) Act 2014, Matawhāiti Residence (Matawhāiti) takes a civil approach when managing residents' medical practitioners and medical visits. Each resident has a community-based General Practitioner (GP) of their choice. It is important to note that residents are encouraged to be active participants in their health care and if they choose not to engage with medical assistance, this must be respected by Matawhāiti.

As referenced in your draft report, there was one incident involving use of force where you note that the resident was not seen by a health practitioner following the event. In this instance, Matawhāiti offered the resident medical assistance following the use of force incident, but the resident refused medical assistance at the time. The resident's choice was respected by staff on the basis that minimal force was applied and that it is their right to make this decision. Matawhāiti consider that this was consistent with their statutory right to medical treatment which was appropriate to their condition; and that the standard of health care available to them as a resident be reasonably equivalent to the standard of health care available to the public (section 35 Public Safety (PPO) Act 2014).

Matawhāiti consider that a resident should first be asked whether they wish to receive medical attention (including after an incident). Their decisions support any future actions from staff and is consistent with Matawhāiti's focus on providing resident's autonomy. However, where there is significant injury or staff are concerned about the resident, an ambulance will be called, or the resident will be transported to the hospital or to their own medical practitioner for further review.

Importantly, Corrections' Health Services staff are employed under the Corrections Act 2004, and cannot perform functions for persons at Matawhāiti (pursuant to section 116 of the Public Safety (PPO) Act 2014).

Recommendations – reception

2. I recommend that:

- a. Needs assessments are conducted and recorded separately from other administrative and procedural requirements of the Public Safety (Public Protection Orders) Act 2014.

The Department of Corrections accepted recommendation 2a and commented as follows:

Matawhāiti consider that the requirements of section 41 of the Public Safety (PPO) Act 2014 have consistently been met. Matawhāiti are currently in the process of establishing a 'stand-alone' needs assessment and appropriate procedures which will require careful consideration and consultation with relevant individuals. It is expected that this work will take around six months to develop and implement in its entirety.

Recommendations – decency, dignity and respect

I have no recommendations to make.

Recommendations – health and wellbeing

4. I recommend that:

- a. Residents are allowed to hold their own medications, unless deemed unsafe based on individual risk assessment. If an individual resident is not allowed to hold one or more of their medications, the reasons are recorded and reviewed.

The Department of Corrections accepted recommendation 4a and commented as follows:

Matawhāiti acknowledge that issuing medication to residents to manage themselves will afford residents a greater level of autonomy. In accordance with risk assessment frameworks, Matawhāiti will commence consideration of allowing residents to manage their own stocks of medication. This consideration will include the safety of the resident who would be responsible for managing their own medication (i.e. ensuring medication is administered correctly), and will also assess the potential risks that other residents pose, and whether there is any opportunity for stand-over tactics to ensue.

Starting now, this initiative will be implemented gradually, in accordance with the residents' demonstrated responsibilities. Where this is not considered an option for

certain residents, this will be recorded in their management plans and any change in this decision will be clearly recorded.

Recommendations – protective measures

5. I recommend that:

- a. Information is provided to residents that states complaints may be made directly to the PPO Inspector.
- b. Staff refer all complaints relating to a breach of residents' rights to the PPO Inspector.
- c. The Residence develop a clear policy on reasonable telephone use and residents are charged only if their usage exceeds that specified in the policy.
- d. The Residence and the Department of Corrections implement recommendations made by the Review Panel in a timely manner.

The Department of Corrections accepted recommendation 5a and commented as follows:

A laminated notice has been placed on the communal noticeboard and a separate notice has been given to each resident to support further communication. These have been phrased in simple and easily understood language to clarify that complaints can be made directly to the PPO Inspector.

The Department of Corrections accepted recommendation 5b and commented as follows:

Matawhāiti consider that there has been an ongoing focus with staff to ensure that complaints relating to a breach of residents' rights, are consistently referred to the PPO Inspector. We are disappointed that perhaps this was not articulated to your inspectors during their visit. Regardless of this, a notice that staff are to refer all complaints relating to a breach of residents' rights to the PPO Inspector has been provided to residents and staff. Individually, staff have been reminded again that this is an obligation under section 80(2) of the Public Safety (PPO) Act 2014.

Recommendations – purposeful activity and transition to the community

6. I recommend that:

- a. Residents are able to access leave for rehabilitative purposes and on humanitarian grounds, with all necessary precautions taken to manage risk.
- b. The frequency of rehabilitative treatment sessions offered to residents increase significantly on a permanent basis.
- c. The Residence takes action to make formal employment opportunities available for residents.

The Department of Corrections accepted recommendation 6b and commented as follows:

Generally, individuals are placed on PPO's when treatment and interventions have been unsuccessful previously. This lack of success can be for several reasons, including individuals denying their offending, not engaging with the treatments or refusing to participate in treatments altogether.

We agree that residents should have the opportunity to engage in rehabilitation programmes, however we do not necessarily consider that a one-dimensional view of merely increasing the frequency of rehabilitative treatments will provide better outcomes. Instead, a holistic view of the management of individuals on PPO's that offers tailored rehabilitative and employment opportunities, as well as appropriate humanitarian outings and psychological interventions, will work to progress the resident's management plan.

Matawhāiti deliver unique, individually tailored interventions to residents. This includes engaging external agencies and making appropriate referrals to inform treatment pathways.

We note in your report that you mention staff have informed your inspectors that the increase in (rehabilitation) sessions was temporary and that it might not continue. We can confirm there is no intent to reduce rehabilitation sessions for residents and treatments will continue to be offered as and when appropriate. This will be based on individual need.

The Department of Corrections accepted recommendation 6c and commented as follows:

Occupational therapist assessments are undertaken on all residents, to confirm their suitability for employment. Those who are deemed suitable to undertake employment are supported to identify opportunities by Matawhāiti staff and relevant government agencies.

It is an ongoing challenge to find jobs that are aligned to resident's interests, and which they can successfully sustain. Notwithstanding this, as part of the work being undertaken to look at providing resident's with greater access to leave

opportunities, employment options will be reviewed as well. Job opportunities inside the wire at prisons will be explored, as well as external options. Legislative commitments will need to be reviewed as well as ensuring appropriate pay and it is anticipated that a separate policy for this work may be necessary. This will be explored over the next six months.

Appendix 2. Legislative framework

In 2007, the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The objective of OPCAT is to establish a system of regular inspections undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention – Public Protection Order residences

Section 16 of COTA defines a “place of detention” as:

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

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

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including prisons and residences established under section 114 of the Public Safety (Public Protection Orders) Act 2014.

Under section 27 of COTA, an NPM’s functions include:

- to examine the conditions of detention applying to detainees and the treatment of detainees; and
- to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - for improving the conditions of detention applying to detainees;
 - for improving the treatment of detainees; and

for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

- access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
- unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;

- interview any person, without witnesses, either personally or through an interpreter; and
- choose the places they want to visit and the people they want to interview.

Section 34 of COTA provides that when carrying out their OPCAT function, Ombudsmen can use their Ombudsmen Act (OA) powers to require the production of any information, documents, papers or things (even where there may be a statutory obligation of secrecy or non-disclosure) (sections 19(1), 19(3) and 19(4) OA). To facilitate his OPCAT role, the Chief Ombudsman has authorised inspectors to exercise these powers on his behalf

More information

Find out more about the Chief Ombudsman's OPCAT role, and read his reports online: ombudsman.parliament.nz/opcat.