



Ombudsman

Fairness for all

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OPCAT Report


Report on an unannounced follow up inspection of Christchurch Men's Prison under the Crimes of Torture Act 1989

June 2021
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OPCAT Report: Report of an unannounced follow up inspection of Christchurch Men's Prison under the Crimes of Torture Act 1989

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Executive summary

Background

Ombudsmen are designated 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.

From 25 to 28 February 2020, my Inspectors (whom I have authorised to carry out visits of places of detention under COTA) visited Christchurch Men's Prison (the Prison) to follow up on 54 recommendations made in my previous OPCAT inspection report (December 2017).¹

There were 919 prisoners in the Prison on the first day of inspection. The Prison had designated capacity for 966 men with security classifications ranging from minimum to high security classification.

Methodology

During this follow up inspection, my Inspectors (the Team) visited all units and spoke with a selection of prisoners, managers and staff across the site. Inspectors also held a focus group with prisoners in one of the low security units. The Team looked for progress in implementing the recommendations made in 2017, and identified any additional issues that needed addressing.

My Inspectors provided verbal feedback to the Prison Director and members of the leadership team on 28 February 2020, outlining initial observations.

Following the inspection, my Team requested further information from the facility and engaged in further analysis of data.

Findings

The follow up inspection found that of the 54 recommendations I made in December 2017, 10 had been achieved, 12 partially achieved and 27 not achieved. My Team were unable to assess or verify the status of a further five recommendations due to inspection time constraints and the subsequent lockdown due to COVID-19. This unannounced follow up inspection took place

¹ A copy of this report can be found on my website, see <https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-christchurch-mens-prison>

some three weeks before the New Zealand Government implemented the 'alert level' system for responding to the COVID-19 pandemic²³ and the nationwide 'lockdown'.

One new and 26 repeat recommendations have been made as a consequence of the follow up inspection in February 2020 (see list of all recommendations in Appendix 2).

My Inspectors made the following positive observations:

- Interactions between staff and prisoners appeared to be largely positive and were improved from my 2017 inspection. Prisoners' verbal feedback to my Inspectors about staff was generally complimentary.
- The Prison Director and Prison Management Team had a number of initiatives they were working on implementing to improve conditions at the Prison;
- The employment of high security prisoners within the Prison had begun to increase;
- There were some improvements in the availability of purposeful activities for sentenced prisoners;
- The pilot Intervention and Support Project Team were beginning to work alongside custodial staff to improve conditions for prisoners with mental health concerns; and
- The Prison entry search procedures were greatly improved.

I continue to remain concerned about:

- The high level of use of force in the Intervention and Support Unit (ISU) and the continued use of unapproved control and restraint techniques;
- The lack of privacy for prisoners undertaking their ablutions in the ISU;
- Minimum entitlements being denied for at least one prisoner; and
- The lack of both time out of cell and meaningful activity for remand prisoners.

² COVID-19 (SARS-CoV-2) is a coronavirus that can affect peoples' lungs and airways. Its existence was confirmed on 9 January 2020 in China and, on 12 March 2020, the World Health Organization declared the virus outbreak to be a global pandemic.

For more about COVID-19 and the New Zealand Government's response, see <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus> and <https://covid19.govt.nz/alert-system/covid-19-alert-system>, retrieved on 16 July 2020.

³ A copy of my report on nine prisons inspected between 29 April and 8 May 2020, at the time New Zealand was at Alert Level 3, is on my website at <https://www.ombudsman.parliament.nz/resources/opcat-covid-19-report-report-inspections-prisons-under-crimes-torture-act-1989>.

Criteria 1: Treatment

In 2017, I recommended:

a. The Prison Director investigates the prevalence of use of force in the ARU.

Findings 2020

The Prison Director had completed a review of the prevalence of the use of force in the Intensive Supervision Unit (ISU), previously known as the At Risk Unit (ARU).

However, despite the increased focus on the use of force, incidents of use of force in the ISU remained high. My Inspectors reviewed the Prison's use of force records and the individual incident paperwork for the period 15 January to 18 February 2020. There were a total of 88 incidents of use of force across the Prison, of which 22 (25 percent) took place in the ISU which comprised of 18 cells. This meant that force was used in the ISU more frequently than in any other unit.

My Inspectors reviewed camera footage from a sample of use of force incidents. Most planned use of force appeared to be well implemented, however my Inspectors had concerns about some incidents of spontaneous use of force. My Inspectors identified four incidents of use of force in the ISU that were of concern. My Inspectors observed footage where multiple staff used force on vulnerable prisoners to gain compliance, despite little risk to staff or the prisoner being evident. Use of force in these instances appeared to be disorganised and disproportionate. Prisoners did not appear to understand why force had been used on them. My Inspectors fed back their concerns at the end of the inspection to the Prison Director, with examples provided.

While I acknowledge that the Prison Director had achieved the recommendation to investigate the prevalence of use of force, I remain concerned regarding the use of force in the ISU.

In conclusion, I found that my recommendation was **achieved**.

However, I have made the repeat amended recommendation that the Prison Director takes action to reduce the incidence of use of force in the ISU.

The Department of Corrections' response to this recommendation is summarised in Appendix 2. Whilst I acknowledge that the Prison had initiatives underway to address use of force, these initiatives had not resulted in a reduction in the use of force used in the ISU.

b. Firm action is taken to ensure the integrity and reliability of records and the reporting systems.

Findings 2020

Files reviewed by my Inspectors showed a variation in standard. Some files were of a good standard. However, other files were of concern, with some signatures missing, particularly signatures of nursing staff. One use of force document was incomplete and did not contain the required Prison Director signature. Additionally, on-body camera (OBC) footage was not consistently saved and the OBCs were not consistently activated.

In conclusion, I found that my recommendation was **partially achieved**.

c. Only approved Control and Restraint techniques are used by staff at the Prison.

Findings 2020

Inspectors reviewed a sample of use of force footage. Custodial staff appeared to use approved techniques in most incidents reviewed. However, my Inspectors identified two incidents of unplanned use of force where appropriate techniques were not used.

In conclusion, I found that my recommendation was **not achieved**.

The Department of Corrections has provided a response to this finding, summarised in Appendix 2.

The control and restraint techniques used in the reviewed incidents were deficient. Prison staff and the Department have acknowledged this. Urgent action is required to address this.

d. The Prison Director ensures that processes for referral and subsequent management of prisoner complaints to the Police are followed.

Findings 2020

Inspectors reviewed documentation that demonstrated there was a clear system in place for referral and management of prisoner complaints to Police. Further, all allegations of staff assault on prisoners were entered on the Department's national database.

In conclusion, I found that my recommendation was **achieved**.

e. Processes to easily identify prisoners in the wings with a recognised health condition should be implemented.

In 2017, this recommendation was rejected by the Department.

Findings 2020

While 'medical alerts' were routinely entered on the Integrated Offender Management System (IOMS), this information was not immediately accessible to custodial staff.

My Inspectors noted that there was no additional process in place to easily inform custodial staff of prisoners who had recognised health conditions, which they may need to be alert to.

Custodial staff spoken with did not know which prisoners had health conditions such as epilepsy or type I diabetes.

In conclusion, I found that my recommendation was **partially achieved**.

f. Prisoners in the ARU are held in cells that meet Corrections' standards for natural light.

Findings 2020

Some prisoners in the ISU were still being held in cells with little to no natural light. While 10 cells in the ISU had sufficient natural light, eight cells did not meet the Department's own standards for natural light, nor did they meet internationally accepted standards.⁴

In conclusion, I found that my recommendation was **not achieved**.

The Department of Corrections has provided a response to this finding, outlining a number of initiatives to improve cell standards. I welcome the initiatives identified, but note that the initiatives do not appear to address the lack of natural light in the ISU.

g. Measures be undertaken to better protect the privacy of prisoners in the ARU when they are naked, partially naked, or undertaking their ablutions.

Findings 2020

Inspectors noted prisoners in the ISU, were still subject to CCTV monitoring, which was displayed in the staff base and master control. The screens could be viewed by anyone entering the staff base, and presented a significant privacy issue.

Some prisons and court cells have implemented technology that 'blacks out' the toilet area in camera feeds. Christchurch Men's Prison has yet to introduce such technology.

⁴ See Rule 14(a), UN General Assembly, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) : resolution / adopted by the General Assembly, 8 January 2016, A/RES/70/175, available at: <https://undocs.org/A/RES/70/175> .

I remain of the opinion that the ability to observe prisoners, either directly or via CCTV, undertaking their ablutions or in various stages of undress is degrading treatment or punishment and a breach of Article 16 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

I continue to engage with the Department on this issue.

In conclusion, I found that my recommendation was **not achieved**.

h. The Prison Director reviews the treatment of prisoners considered to be at risk of suicide or self-harm. Prisoner-centric management plans should be developed to assist prisoners while they are in the ARU and on their return to mainstream units. The prisoner should receive a copy of their management plan.

Findings 2020

At the time of inspection the Prison was one of three pilot sites trialling the Department's Intervention and Support Project (ISP)⁵. The pilot began in 2018, and was taking place over four years. The ISP model included a new team of clinical specialists employed at each of the three sites to assess and treat prisoners who are vulnerable to self-harm and suicide. The new model of care allows for the possibility of prisoners being managed in their 'home' unit if safe to do so, rather than being moved to the ISU.

At the time of inspection, the ISP team had a complement of seven staff, comprising a Clinical Manager of Mental Health, Clinical Psychologist, Clinical Nurse Specialist, Occupational Therapist, Social Worker, Cultural Support Worker, and Administrator. There was one vacancy for a Clinical Psychologist.

The goal of the ISP team was to increase treatment available to mentally unwell patients, and take preventive action for prisoners there were concerns about. Other than the introduction of the ISP team, however, my Inspectors found that little had changed since 2017 for the treatment of prisoners at risk of suicide and self-harm.

My Inspectors reviewed a selection of management plans for prisoners in the ISU and in mainstream units. The management plans were largely generic and with a focus on complying with unit rules, rather than being prisoner-centric. My Inspectors did note that some of the plans had been tailored to meet individuals' needs, usually where the ISP team had involvement with patient care. At the time of inspection, management plans were being provided to prisoners.

⁵ The Intervention and Support Project: A new approach to preventing self-harm and suicide in prison. March 2018. More detail at: https://www.corrections.govt.nz/resources/newsletters_and_brochures/corrections_works/2018/corrections_works_march_2018/the_intervention_and_support_project_a_new_approach_to_preventing_self-harm_and_suicide_in_prison, retrieved on 16 July 2020.

In conclusion, I found that my recommendation was **partially achieved**.

i. Staff selection processes for the ARU should be improved to ensure staff with the necessary skills and attitude work in the Unit.

In 2017, this recommendation was rejected by the Department.

Findings 2020

Staff working in the ISU appeared to have positive relationships with, and attitudes towards, prisoners in the unit. However, my Inspectors' discussions with staff indicated that there was not a consistent nor robust process for staff selection to work in the ISU. Some staff had expressed an interest in the role, while others had been rostered to work in the Unit despite having no prior knowledge of the ISU.

In conclusion, I found that my recommendation was **partially achieved**.

j. Training, supervision and support of staff in the ARU should be improved.

Findings 2020

All custodial staff received basic mental health training. The Canterbury Regional Forensic Psychiatric Service and Intervention Support Project (ISP) teams had also recently begun providing informal training to ISU staff. However, there was no formal training, supervision or support for staff working in the ISU at the time of the inspection.

In conclusion, I found that my recommendation was **partially achieved**.

k. Meals should be served at normal hours. This would involve lunch being served any time between midday and 1.30pm and dinner to be served any time between 5pm and 7pm.

Findings 2020

My Inspectors observed lunch being served in one unit at 11.10am and dinner being served in the same unit at 3.20pm. This meant that prisoners had to wait approximately 16 hours between dinner and breakfast, which was served at around 7.30am. I consider this practice to

be inconsistent with international standards, which include that food is provided to prisoners by the Prison administration 'at the usual hours'.⁶

I am aware of the proposed national changes in staff rosters which it is anticipated will result in an improvement in the standardisation of meal times. I will continue to monitor progress in these areas on future inspections.

In conclusion, I found that my recommendation was **not achieved**.

Additional findings noted on this inspection

The Department's Integrated Offender Management System (IOMS)⁷ database indicated that one prisoner had not been able to access one hour of exercise in the open air⁸ on five days in February 2020.

Records indicated that the prisoner concerned had assaulted staff on multiple occasions and that denial of minimum entitlements had been made on the grounds that the security of the Prison, or the health and safety of any person, was threatened.⁹ The documentation did not adequately evidence the justification for denying the prisoner his minimum statutory entitlements.

Denial of minimum entitlements on the grounds stated above must be well evidenced, robustly recorded and regularly reviewed.

Incident reports reviewed by my Inspectors also indicated that 'yards' would be denied to this prisoner until '*compliance is shown and proven*'. Minimum entitlements must not be denied to obtain prisoners' compliance.¹⁰

My Inspectors were also told that there was insufficient staff in the unit to facilitate the prisoner's access to the yard to exercise in the fresh air of a minimum of one hour per day, as he was on a 'four-to-one unlock'. There were regularly only three (or fewer) staff assigned to the unit. I remind the Prison that they must take action to ensure all prisoners are able to access at least one hour of exercise in the open air daily.

The Department of Corrections has provided a response to this finding, summarised in Appendix 2. I acknowledge that there were safety concerns in managing the prisoner concerned. The denial of minimum entitlements may therefore have been justifiable in terms of subsection 69(2) of the Corrections Act. However, I consider the documentation did not contain adequate evidence to support that conclusion. The issue of compliance was expressly set out in incident reports viewed by my Inspectors. If there is an issue of clarity and

⁶ See Rule 22, the [Nelson Mandela Rules](#)

⁷ IOMS is the Department's computerised operational database.

⁸ See section 70, Corrections Act 2004, and Rule 23, the [Nelson Mandela Rules](#).

⁹ See section 69(2)(b) and 69(2)(c), [Corrections Act 2004](#).

¹⁰ Ibid

interpretation in this respect, the remedy is to ensure that records are clear and contain evidence to support any denial of minimum entitlements.

Criteria 2: Transition to lawful custody

In 2017, I recommended:

a. Prison management review the procedures for access to property to ensure prisoners can readily access their property.

Findings 2020

Procedures for prisoners' access to property had been reviewed by the Prison Director.

At the time of inspection, access to property however remained an issue with prisoners not able to do so readily. Lack of resourcing was a significant factor. The Prison also stored property for Rolleston Prison, meaning that two civilian staff were responsible for managing the property of approximately 1,200 prisoners. The Prison Director had submitted a business plan to the Department's National Office to increase resourcing, in order to improve prisoner's access to their property.

While access to property remains of concern, I acknowledge that a review of the procedures has taken place, and the Prison Director's commitment to resolving this issue.

In conclusion, I found that my recommendation was **achieved**.

b. The RO improve the accessibility of notices and key information for prisoners.

Findings 2020

There were no notices or key information for prisoners on display in the RO (Receiving Office) at the time of inspection. The holding areas had little written information about available services or prisoners' rights.

In conclusion, I found that my recommendation was **not achieved**.

c. Prison management review induction arrangements for foreign nationals, speakers of other languages and those with literacy issues, and improve these arrangements to ensure these prisoners are fully briefed on Prison procedures.

Findings 2020

Induction material was available in written English only, and access to interpreters was limited. Foreign nationals and speakers of other languages were transferred to the ISU until an interpreter was able to explain the induction arrangements. There were no specific arrangements in place for those with low literacy levels.

While access to an interpreter is an improvement from my 2017 inspection, I remain of the view that further improvements in this area are required.

In conclusion, I found that my recommendation was **partially achieved**.

Criteria 3: Decency, dignity and respect

In 2017, I recommended:

a. There be tailored support for prisoners with cognitive impairments.

In 2017, this recommendation was rejected by the Department.

Findings 2020

There was no specific tailored support available to prisoners with cognitive impairments. The Prison Director informed my Inspectors that work was occurring nationally on a disability strategy to address this issue. I will follow this up with the Department's National Office.

In conclusion, I found that my recommendation was **not achieved**.

b. Prison management review the Prison entry search procedures with some urgency.

Findings 2020

My Inspectors observed the process of searching visitors entering the Prison. Visitors passed through a walk-through metal detector (WTMD). If the WTMD beeped, gatehouse staff used a hand-held detector to identify more accurately the location of any metal object. Inspectors had no concerns with the process.

In conclusion, I found that my recommendation was **achieved**.

c. The distribution of meals is supervised by custodial staff.

Findings 2020

Inspectors observed meals being distributed across a number of units. There was no consistent approach taken with regards to the supervision of meal distribution. Inspectors observed prisoners on some units handing out meals without supervision. Custodial staff on some units confirmed that this was the usual practice.

In conclusion, I found that my recommendation was **not achieved**.

The Department of Corrections provided a full response to this finding, summarised in Appendix 2.

My Inspectors saw meals being distributed across the Prison, including in High Security Units, without the supervision of custodial staff. I remain of the view that the distribution of meals should be supervised by custodial staff.

d. All prisoners should be able to access adequate clean clothing, footwear and bedding including wet weather gear.

Findings 2020

Store rooms were inspected across a number of units. Inspectors noted them to be well stocked with adequate clean clothing, footwear and bedding.

In conclusion, I found that my recommendation was **achieved**.

e. The Prison makes greater efforts to engage with their local iwi to better support the needs of Māori prisoners.

Findings 2020

The Prison did not have a working relationship with Kāi Tahu. Staff acknowledged that greater effort was still required to build the relationship with mana whenua.

I acknowledge that initial conversations had occurred in the Prison about the implementation of the Department's Hōkai Rangī strategy¹¹. I also recognise that a staff-led rōpū waiata was providing a positive means of exploring te ao Māori in the Prison.

In conclusion, I found that my recommendation was **not achieved**.

¹¹ *Hōkai Rangī 2019-2024* is the Department's strategy to achieve better outcomes with Maori prisoners, and their whānau. See https://www.corrections.govt.nz/resources/strategic_reports/corrections_strategic_plans/hokai_rangi, retrieved on 16 July 2020.

f. A washing machine and dryer are installed in Kotuku Unit.

Findings 2020

Inspectors visited Kotuku Unit and noted a washing machine and dryer had been installed and was in use.

In conclusion, I found that my recommendation was **achieved**.

g. High-security prisoners spend more time out of cells engaged in purposeful activities.

Findings 2020

A small number of high security prisoners were employed in the kitchen and Activity Officers were scheduling time with high security prisoners in the gym. However Inspectors noted that a number of high security prisoners continued to spend extended periods without purposeful activity.

In conclusion, I found that my recommendation was **partially achieved**.

h. Unlock arrangements for high-security prisoners should be consistently applied.

Findings 2020

High security prisoners in all but one unit had consistent unlock regimes. The exception was J Block, which was being used as the management unit at the time of inspection, due to the partial closure of Miro Unit.¹²

In conclusion, I found that my recommendation was **partially achieved**.

i. Unlock times in the DRU should be in line with other low security units.

In 2017, this recommendation was rejected by the Department.

¹² Miro Unit is the Prison's new, designated management unit which was partially closed at the time of inspection as it was damaged by a fire in December 2019.

Findings 2020

Unlock times in the Disaster Recovery Unit (DRU, now called the Recovery Unit) operated within the 8am to 5pm regime. Other low security units were operating unlock times of 7:15am to 8:45pm. The Prison Director informed Inspectors that the unlock times for low security prisoners, including those in the Recovery Unit, were to be reviewed across the site as part of the new staff rostering system being implemented nationally. I welcome this initiative, however at the time of this inspection unlock hours in the Recovery Unit continue to be less than in the other low security units.

In conclusion, I found that my recommendation was **not achieved**.

j. Mould in 'single double' cells is removed as a matter of urgency.

Findings 2020

A number of 'single double' cells¹³ were inspected. All 'single double' cells inspected contained mould.

In conclusion, I found that my recommendation was **not achieved**.

k. 'Single double' cells should revert to single occupancy or time out of cell for prisoners significantly increased.

Findings 2020

Custodial staff, where possible, did not use 'single double' cells for double occupancy. However, when prisoner numbers were high, these cells were used to accommodate two prisoners. At the time of inspection a number of these cells contained two prisoners. Time out of cell for prisoners in these units was generally two-and-a-quarter hours a day.

In conclusion, I found that my recommendation was **not achieved**.

The Department of Corrections has provided a response to this finding, set out in full in Appendix 2.

I acknowledge the significant pressures across the country as a result of the increased prison population. However, I remain of the view that 'single double' cells were wholly unfit to be used for shared accommodation. I consider that prisoners are entitled to a decent standard of accommodation at all times.

¹³ Single-double cells are single cells in the remand unit which have been modified with a bunk bed to accommodate two prisoners.

l. Health and safety issues associated with roosting pigeons are addressed as a matter of urgency.

Findings 2020

The Prison had entered into a partnership with the local council and the Civil Aviation Authority to collectively address the issue of pigeons in the Canterbury region.

The Prison had additionally implemented a broad range of measures to deter pigeons roosting within the Prison grounds. Measures taken included installing netting and reshaping the grills over yards. It is pleasing that the Prison has made such extensive efforts to address the problem of roosting pigeons. At the time of the inspection however, roosting pigeons remained a significant issue at the Prison. However, I will not be making any further recommendations on this matter at this time, due to the efforts being made to control the problem by the Prison.

In conclusion, I found that my recommendation was **not achieved**.

Criteria 4: Personal safety

In 2017, I recommended:

a. The Prison Director conduct a survey of prisoners to establish the circumstances and locations where prisoners feel unsafe, and address the findings in an arena that includes prisoner representation.

In 2017, this recommendation was rejected by the Department.

Findings 2020

The Prison Director had conducted a comprehensive survey of prisoners, broken down by unit, in 2018. At the time of inspection some units had regular meetings, which included prisoner representation, to identify and address issues of prisoner safety in the units.

In conclusion, I found that my recommendation was **achieved**.

b. Drug testing should be extended to include synthetic psychoactive substances.

Findings 2020

There was no ability to test for synthetic psychoactive substances at the Prison at the time of inspection. The Department is working nationally on addressing this complex issue. At this time

I will not be making a repeat recommendation, but I look forward to developments in this area and I will follow up on this in future inspections.

In conclusion, I found that my recommendation was **not achieved**.

Criteria 5: Health and wellbeing

In 2017, I recommended:

a. An annual health needs analysis be carried out to inform the health development plan and funding.

In 2017, this recommendation was rejected by the Department.

Findings 2020

There was no process in place at the Prison for identifying emerging trends in prisoners' healthcare needs that would inform the delivery and development of the health care service. The increase in remand prisoners was noted by health care staff to be having an impact on their workload. I remain of the view that this analysis would assist the Prison health service in identifying the level of resources needed.

In conclusion, I found that my recommendation was **not achieved**.

b. There be a separate health complaint process to ensure patient confidentiality.

In 2017, this recommendation was rejected by the Department.

Findings 2020

While there was a separate health complaint process in place, this was not well advertised. My Inspectors held a focus group with prisoners on one unit. The prisoners who attended were not aware that there was a separate process for health complaints.

My Inspectors noted that IOMS was still being used to lodge health complaints. In the period 1 August 2019 to 30 September 2020, there were 34 complaints recorded in IOMS relating to health concerns. My Inspectors reviewed a number of health complaints and noted responses were timely but not confidential.

In conclusion, I found that my recommendation was **partially achieved**.

c. Nurses have access to clinical supervision.

Findings 2020

Nurses employed at the Prison did not have access to clinical supervision. Nurses spoken with by Inspectors continued to express the need for clinical supervision.

In conclusion, I found that my recommendation was **not achieved**.

d. Processes and practices for dispensing medication, including controlled drugs and night sedation, comply with Corrections' Health Services Medication Standards.

Findings 2020

Improvements were noted in the administration of non-controlled medications. My Inspectors observed two medication rounds. Identification procedures were followed by nursing staff prior to administering medication from the blister pack.

My Inspectors also observed nurses dispensing controlled drugs and viewed the controlled drug register. There were a large number of second signatures missing from the controlled drug register, and Inspectors noted a practice of the medicines being signed out in advance by two Registered Nurses and then dispensed by one Registered Nurse. Inspectors also noted the controlled drug safe was not secured on two occasions with no staff in the medication room.

In conclusion, I found that my recommendation was **partially achieved**.

e. Areas of unsafe practice such as compromised patient confidentiality and identified inefficiencies in the operation of medication rounds be addressed as a matter of urgency.

Findings 2020

My Inspectors observed patients' privacy and confidentiality, when medications were issued or during nurse consultations, continued to be compromised. Inspectors observed nurses speaking with prisoners about health concerns in busy communal areas with custodial staff present. In the youth unit, medication rounds occurred through the window in the staff base in the foyer, with other prisoners queuing behind them.

Nursing staff informed Inspectors that there were occasions when a prisoner attending a GP consultation would be accompanied by three custodial staff, including into the cubicle.

In conclusion, I found that my recommendation was **not achieved**.

f. Corrections develop a national policy for the treatment of patients with ADHD.

In 2017, this recommendation was rejected by the Department.

Findings 2020

Inspectors were informed that there was no national policy for the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD). My Inspectors were informed of a number of local initiatives being considered for improving the treatment of prisoners with ADHD. As this is a national issue, I will follow this up with the Department's National Office.

In conclusion, I found that my recommendation was **not achieved**.

g. Dental treatment is based on dental need.

Findings 2020

Inspectors were provided with the dental treatment wait list. While the waiting times for dental treatment remain undesirably high, my Team found that priority was given to prisoners with the highest need.

In conclusion, I found that my recommendation was **achieved**.

Criteria 6: Fairness and protective measures

In 2017, I recommended:

a. The Prison Director conducts an analysis of prisoner complaints, and implements improvements that address the underlying reasons why prisoners have such little faith in the complaints process.

In 2017, this recommendation was rejected by the Department.

Findings 2020

My Inspectors were unable to follow up on this recommendation due to time constraints and the subsequent COVID-19 lockdown.

b. Regimes available for prisoners on Voluntary Segregation are further developed.

Findings 2020

Regimes for prisoners on voluntary segregation had been further developed from my 2017 inspection. Prisoners on voluntary segregation were employed in the canteen, laundry and on units as cleaners.

In conclusion, I found that my recommendation was **achieved**.

c. The range of healthy goods available through the P119 be improved.

Findings 2020

Additional healthy items had been added to the prisoner canteen (P119) nationally since my inspection in 2017. Prisoners spoken with were positive about the additional options. They were however dissatisfied with the high prices.

In conclusion, I found that my recommendation was **achieved**.

d. TV rental charges for long serving prisoners should be reviewed.

In 2017, this recommendation was rejected by the Department.

Findings 2020

Long-serving prisoners paid \$2.00 per week for the use of a television, or \$1.00 each a week, if they were in a shared cell. While there is a national policy in place to request consideration of charges in the case of financial hardship, this did not include consideration for long-serving prisoners who were of the view that they had paid for the cost of the television several times over. Prisoners spoken with by my Inspectors continue to raise this as an issue. As this is a national issue, I will follow this up with the Department's National Office.

In conclusion, I found that my recommendation was **not achieved**.

Criteria 7: Purposeful activity and family contact

In 2017, I recommended:

a. The information leaflet for visitors should be reviewed to better reflect the Prison's focus on supporting positive family relationships.

Findings 2020

A copy of the 'Visiting Prisoners at Canterbury Prisons' information leaflet was provided to Inspectors. The leaflet described the visits process and the range of restrictions, prohibitions, and consequences for non-compliance with Department' requirements. The leaflet did not reflect the Prison's focus on supporting positive family relationships.

In conclusion, I found that my recommendation was **not achieved**.

b. Immediate measures need to be taken to eliminate the practice of extortion by gang members for the use of the telephone.

Findings 2020

My Inspectors noted that, in some high security units, there were still instances of prisoners with gang affiliations using the telephone excessively. For the period 1 October to 31 December 2019, a single prisoner in Matai Unit used the telephone for a daily average of 34 minutes. Similarly, in Rawhiti Unit, one prisoner used the telephone for an average of 42 minutes a day from mid-December until the end of December. Given the high demand for the telephone due to limited unlock hours in which prisoners have access to the telephones, it would appear that some prisoners continue to monopolise use of the telephone.

In conclusion, I found that my recommendation was **not achieved**.

c. There should be greater opportunities for constructive activities for remand accused prisoners.

Findings 2020

On the first day of inspection there were 260 remand accused and 162 remand convicted prisoners were held at the Prison. The Prison Director reported the increase in the remand population reflected an increase in the remand population nationally.

Regime opportunities for remand accused prisoners continued to be limited. Data provided by the Prison indicated that, for the period 1 February to 29 February 2020, there were approximately 37 remand prisoners on a short duration programme. These included a programme to address problem gambling, a health and wellbeing programme, and a Te Reo programme. My Inspectors observed a small number of remand prisoners using the Prison library at the time of the inspection.

In 2013, *the United Nations Subcommittee for the Prevention of Torture* (the Subcommittee) visited several New Zealand prisons, including Christchurch Men's Prison, and stated that limited time out of cell and the limited range and provision of constructive activities were issues for remand prisoners that should be addressed.¹⁴

¹⁴ United Nations, Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Visit to New Zealand undertaken from 29 April to 8 May 2013: observations and recommendations addressed to the State party, CAT/OPNZL/1, See https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CAT%2fOP%2fNZL%2f1&Lang=en retrieved on 23 July 2020.

I am concerned that, seven years later, the Prison has not made sufficient progress in relation to the Subcommittee's recommendation.

In conclusion, I found that my recommendation was **not achieved**.

d. Remand prisoners should have longer periods out of their cells on a daily basis.

Findings 2020

Inspectors visited all units which contained remand prisoners across the Prison. A typical remand regime gave prisoners two-and-a-quarter hours out of cell per day.

My Inspectors noted remand prisoners in Wings A to E were locked in their cell for up to 21.5 hours a day. Custodial staff in Wings A to E confirmed that remand prisoners were routinely only unlocked for between two and 2.5 hours a day.

In conclusion, I found that my recommendation was **not achieved**.

e. ITL data collection processes are reviewed and improved for accurate reporting.

Findings 2020

My Inspectors were unable to follow up on this recommendation due to time constraints and the subsequent COVID19 lockdown.

f. Case management remand plan objectives should be specific, measurable, achievable, and realistic and time bound.

Findings 2020

My Inspectors reviewed a sample of case management plans for remand accused prisoners. The plans were lacking in content, and often lacking any tangible outcomes.

While assessment of remand prisoners was occurring, this did not appear to translate into meaningful, timely outcomes for remand prisoners.

In conclusion, I found that my recommendation was **not achieved**.

g. High security prisoners should have access to education, programmes and employment training.

Findings 2020

Data provided by the Prison indicated that, for the period 1 February to 29 February 2020, there were approximately 10 high security prisoners on an education programme. Programmes included art and traffic controller training. Thirty-six high security prisoners from Rawhiti Unit were employed in the Prison kitchen and working towards the New Zealand Certificate in Hospitality. I am pleased to note that there has been some improvement in access to education and programmes for high security prisoners, although these continued to be limited. In conclusion, I found that my recommendation was **partially achieved**.

h. Access to interventions should be better sequenced so prisoners can address their needs prior to their appearance at the Parole Board.

Findings 2020

My Inspectors were unable to follow up on this recommendation due to time constraints and the subsequent COVID-19 lockdown.

i. Toilets and showers in exercise yards should be better maintained.

Findings 2020

My Inspectors visited all high security exercise yards and found the toilets and showers to be in a generally poor state of repair.

In conclusion, I found that my recommendation was **not achieved**.

The Department of Corrections has provided a response to this finding, set out in Appendix 2.

I am pleased that a programme of general maintenance and cleaning is in place. However, at the time of inspection toilets and showers were noted to be in a poor state of hygiene, and the privacy screening still did not offer sufficient privacy.

Criteria 8: Preparation for successful return to the community

In 2017, I recommended:

a. Prisoners and their whānau be consulted about the development of a progression system that acknowledges achievements and supports 'new behaviours'.

Findings 2020

My Inspectors were unable to follow up on this recommendation due to time constraints and the subsequent COVID-19 lockdown.

b. Re-integrative services are further developed.

Findings 2020

My Inspectors were informed that no Out of Gate or guided release programmes (also known as 're-integrative services') were in operation at the time of inspection.

In conclusion, I found that my recommendation was **not achieved**.

The Department of Corrections has provided a full response to this finding, summarised in Appendix 2.

The Department's response focussed on a limited number of eligible candidates amongst the prison population. At the time of inspection, however, staff told my Inspectors that guided release was not being offered due to staffing pressures. Inspectors also spoke to the Provider, who confirmed they worked only in the one small self-care unit, and were unable to provide services beyond this due to resourcing constraints.

Youth Unit

In 2017, I recommended:

a. Funding for furnishings and recreational equipment should be provided.

Findings 2020

My Inspectors observed that furnishings and recreational equipment in the Youth Unit were limited, and what was in the Unit was generally of a poor standard.

Communal areas in the Unit's Tui and Kiwi blocks continued to be featureless, and were in a poor state of cleanliness and maintenance on the day of the inspection. Sofas were ripped and the kitchen areas required cleaning.

Recreational equipment included a pool table (in a state of disrepair) in Kiwi block, and a foosball table and a table tennis table in Tui block. My Inspectors were informed that the foosball table and table tennis table could be used if a prisoner requested equipment from a member of staff. While there was a gym in the unit, it had limited equipment available.

In conclusion, I found that my recommendation was **not achieved**.

b. The issue of excessive tagging is addressed.

Findings 2020

Extensive tagging continued to exist across all areas of the Youth Unit.

In conclusion, I found that my recommendation was **not achieved**.

c. The dispensation for youth to mix should be reviewed to ensure it has legal effect.

Findings 2020

The Prison Director understood there to be a nation-wide dispensation to mix accused and sentenced youth. Evidence of this dispensation was requested. My Team was told that the Department's National Office would provide a copy of the dispensation but, at the time of writing this report, the document had not been provided nor had a time frame been set due to the Department's focus on COVID-19 responses.

d. Notices about the complaints process are displayed in the unit.

Findings 2020

My Inspectors observed that while some notices had been put up around the Unit, they were insufficient for the purposes of ensuring that all prisoners are aware of, and understood, the complaints process. Notices were located in a foyer area that was not readily accessible. My Inspectors were pleased to note, however, that the 'Prisoner Information' booklet contained information on how to lodge a formal complaint.

In conclusion, I found that my recommendation was **partially achieved**.

Additional findings noted on this inspection

My Inspectors heard concerns from staff members regarding youth arriving at the Unit from other areas of the country in order to complete the Mauri Tu, Mauri Ora (MTMO)¹⁵ programme which is not offered in other prisons. Staff noted that prisoners from outside the Christchurch region often engaged in harmful behaviour which disrupted the functioning of the Unit, including using stand over tactics, bullying, and intimidation.

¹⁵ The programme caters for youth with index violence or non-sexual offending. See https://www.corrections.govt.nz/resources/newsletters_and_brochures/journal/volume_4_issue_1_august_2016/mauri_tu_mauri_ora_an_offence_focussed_programme_for_high_risk_youth, retrieved 28/07/2020.

Recommendations 2020

As a result of my 2020 follow up inspection, I recommend:

Treatment

1. The Prison Director takes action to reduce the incidence of use of force in the ISU. **This is an amended repeat recommendation (refer 2017 1a)**
2. Only approved Control and Restraint techniques are used by staff at the Prison. **This is a repeat recommendation (refer 2017 1c)**
3. Prisoners in the ISU are held in cells that meet the Department's standards for natural light. **This is an amended repeat recommendation (refer 2017 1f)**
4. Measures be undertaken to better protect the privacy of prisoners in the ISU when they are naked, partially naked, or undertaking their ablutions. **This is an amended repeat recommendation (refer 2017 1g)**
5. Meals should be served at normal hours. This would involve lunch being served any time between midday and 1.30pm and dinner to be served any time between 5pm and 7pm. **This is a repeat recommendation (refer 2017 1k)**
6. Action is taken to ensure all prisoners are able to access at least one hour of exercise in the open air daily.

Transition to lawful custody

7. The RO improve the accessibility of notices and key information for prisoners. **This is a repeat recommendation (refer 2017 2b)**
8. Prison management review induction arrangements for those with literacy issues and improve these arrangements to ensure these prisoners are fully briefed on Prison procedures. **This is an amended repeat recommendation (refer 2017 2c)**

Decency, dignity and respect

9. The distribution of meals is supervised by custodial staff. **This is a repeat recommendation (refer 2017 2c)**
10. The Prison makes greater efforts to engage with local iwi to better support the needs of Māori prisoners. **This is a repeat recommendation (refer 2017 2e)**
11. High-security prisoners spend more time out of cells engaged in purposeful activities. **This is a repeat recommendation (refer 2017 2g)**
12. Mould in 'single double' cells is removed as a matter of urgency. **This is a repeat recommendation (refer 2017 2j)**

13. 'Single double' cells should revert to single occupancy. **This is an amended repeat recommendation (refer 2017 2k)**

Personal safety

I have no recommendations to make.

Health and wellbeing

14. An annual health needs analysis be carried out to inform the health development plan and funding. **This is a repeat recommendation (refer 2017 5a)**
15. Prisoners be made aware that there is a separate health complaint process to ensure patient confidentiality. **This is an amended repeat recommendation (refer 2017 5b)**
16. Nurses have access to clinical supervision. **This is a repeat recommendation (refer 2017 5c)**
17. Processes and practices for storing and administering controlled medication, comply with Corrections' Health Services Medication Standards. **This is an amended repeat recommendation (refer 2017 5d)**

Fairness and protective measures

I have no recommendations to make.

Purposeful activity and family contact

18. The information leaflet for visitors should be reviewed to better reflect the Prison's focus on supporting positive family relationships. **This is a repeat recommendation (refer 2017 7a)**
19. Measures be taken to ensure that all prisoners can access the telephone. **This is an amended repeat recommendation (refer 2017 7b)**
20. There should be greater opportunities for constructive activities for remand accused prisoners. **This is a repeat recommendation (refer 2017 7c)**
21. Remand prisoners should have longer periods out of their cells on a daily basis. **This is a repeat recommendation (refer 2017 7d)**
22. Toilets and showers in exercise yards should be better maintained. **This is a repeat recommendation (refer 2017 7i)**

Preparation for successful return to the community

23. Re-integrative services are further developed. **This is a repeat recommendation (refer 2017 8b)**

Youth Unit

24. Funding for furnishings and recreational equipment should be provided. **This is a repeat recommendation (refer 2017 Youth Unit a)**
25. The issue of excessive tagging is addressed. **This is a repeat recommendation (refer 2017 Youth Unit b)**
26. The dispensation for youth to mix should be reviewed to ensure it has legal effect. **This is a repeat recommendation (refer 2017 Youth Unit c)**
27. Notices about the complaints process are displayed in the unit. **This is a repeat recommendation (refer 2017 Youth Unit d)**

Acknowledgements

I appreciate the full co-operation extended by the managers and staff to my Inspectors during their visit to the Prison. I also acknowledge the work that would have been involved in collating the information sought by the Inspectors.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. Summary of 2017 recommendations and 2020 follow up findings

2017 recommendations	Prison response	Follow up finding 2020
1a. The Prison Director investigates the prevalence of use of force in the ARU.	Accepted	Achieved
1b. Firm action is taken to ensure the integrity and reliability of records and the reporting systems.	Accepted	Partially achieved
1c. Only approved Control and Restraint techniques are used by staff at the Prison.	Accepted	Not achieved
1d. The Prison Director ensures that processes for referral and subsequent management of prisoner complaints to the Police are followed.	Accepted	Achieved
1e. Processes to easily identify prisoners in the wings with a recognised health condition should be implemented.	Rejected	Partially achieved
1f. Prisoners in the ARU are held in cells that meet Corrections' standards for natural light.	Accepted	Not achieved
1g. Measures be undertaken to better protect the privacy of prisoners in the ARU when they are naked, partially naked, or undertaking their ablutions.	Accepted	Not achieved
1h. The Prison Director reviews the treatment of prisoners considered to be at risk of suicide or self-harm. Prisoner-centric management plans should be developed to assist prisoners while they are in the ARU and on their return to mainstream units. The prisoner should receive a copy of their management plan.	Accepted	Partially achieved
1i. Staff selection processes for the ARU should be improved to ensure staff with the necessary skills and attitude work in the Unit.	Rejected	Partially achieved
1j. Training, supervision and support of staff in the ARU should be improved.	Accepted	Partially achieved
1k. Meals should be served at normal hours. This would involve lunch being served any time between midday and 1.30pm and dinner to be served any time between 5pm and 7pm.	Accepted	Not achieved
2a. Prison management review the procedures for access to property to ensure prisoners can readily access their property.	Accepted	Achieved

2017 recommendations	Prison response	Follow up finding 2020
2b. The RO improve the accessibility of notices and key information for prisoners.	Accepted	Not achieved
2c. Prison management review induction arrangements for foreign nationals, speakers of other languages and those with literacy issues, and improve these arrangements to ensure these prisoners are fully briefed on Prison procedures.	Accepted	Partially achieved
3a. There be tailored support for prisoners with cognitive impairments.	Rejected	Not achieved
3b. Prison management review the Prison entry search procedures with some urgency.	Accepted	Achieved
3c. The distribution of meals is supervised by custodial staff.	Accepted	Not achieved
3d. All prisoners should be able to access adequate clean clothing, footwear and bedding including wet weather gear.	Accepted	Achieved
3e. The Prison makes greater efforts to engage with their local iwi to better support the needs of Māori prisoners.	Accepted	Not achieved
3f. A washing machine and dryer are installed in Kotuku Unit.	Accepted	Achieved
3g. High-security prisoners spend more time out of cells engaged in purposeful activities.	Accepted	Partially achieved
3h. Unlock arrangements for high-security prisoners should be consistently applied.	Accepted	Partially achieved
3i. Unlock times in the DRU should be in line with other low-security units.	Rejected	Not achieved
3j. Mould in 'single double' cells is removed as a matter of urgency.	Accepted	Not achieved
3k. 'Single double' cells should revert to single occupancy or time out of cell for prisoners significantly increased.	Accepted	Not achieved
3l. Health and safety issues associated with roosting pigeons are addressed as a matter of urgency.	Accepted	Not achieved
4a. The Prison Director conduct a survey of prisoners to establish the circumstances and locations where prisoners feel unsafe, and address the findings in an arena that includes prisoner representation.	Rejected	Achieved
4b. Drug testing should be extended to include synthetic psychoactive substances.	Accepted	Not achieved

2017 recommendations	Prison response	Follow up finding 2020
5a. An annual health needs analysis be carried out to inform the health development plan and funding.	Rejected	Not achieved
5b. There be a separate health complaint process to ensure patient confidentiality.	Rejected	Partially achieved
5c. Nurses have access to clinical supervision.	Accepted	Not achieved
5d. Processes and practices for dispensing medication, including controlled drugs and night sedation, comply with Corrections' Health Services Medication Standards.	Accepted	Partially achieved
5e. Areas of unsafe practice such as compromised patient confidentiality and identified inefficiencies in the operation of medication rounds be addressed as a matter of urgency.	Accepted	Not achieved
5f. Corrections develop a national policy for the treatment of patients with ADHD.	Rejected	Not achieved
5g. Dental treatment is based on dental need.	Accepted	Achieved
6a. The Prison Director conducts an analysis of prisoner complaints, and implements improvements that address the underlying reasons why prisoners have such little faith in the complaints process.	Rejected	Not inspected
6b. Regimes available for prisoners on voluntary segregation are further developed.	Accepted	Achieved
6c. The range of healthy goods available through the P119 be improved.	Accepted	Achieved
6d. TV rental charges for long serving prisoners should be reviewed.	Rejected	Not achieved
7a. The information leaflet for visitors should be reviewed to better reflect the Prison's focus on supporting positive family relationships.	Accepted	Not achieved
7b. Immediate measures need to be taken to eliminate the practice of extortion by gang members for the use of the telephone.	Accepted	Not achieved
7c. There should be greater opportunities for constructive activities for remand accused prisoners.	Accepted	Not achieved
7d. Remand prisoners should have longer periods out of their cells on a daily basis.	Accepted	Not achieved
7e. ITL data collection processes are reviewed and improved for accurate reporting.	Accepted	Not inspected

2017 recommendations	Prison response	Follow up finding 2020
7f. Case management remand plan objectives should be specific, measurable, achievable, and realistic and time bound.	Accepted	Not achieved
7g. High security prisoners should have access to education, programmes and employment training.	Accepted	Partially achieved
7h. Access to interventions should be better sequenced so prisoners can address their needs prior to their appearance at the Parole Board.	Accepted	Not inspected
7i. Toilets and showers in exercise yards should be better maintained.	Accepted	Not achieved
8a. Prisoners and their whānau be consulted about the development of a progression system that acknowledges achievements and supports 'new behaviours'.	Accepted	Not inspected
8b. Re-integrative services are further developed.	Accepted	Not achieved
Youth a. Funding for furnishings and recreational equipment should be provided.	Accepted	Not achieved
Youth b. The issue of excessive tagging is addressed.	Accepted	Not achieved
Youth c. The dispensation for youth to mix should be reviewed to ensure it has legal effect.	Accepted	Not inspected
Youth d. Notices about the complaints process are displayed in the unit.	Accepted	Partially achieved

Appendix 2. Department of Corrections' response to 2020 follow up findings and recommendations

Recommendations 2020

1. The Prison Director takes action to reduce the incidence of use of force in the ISU.

This is an amended repeat recommendation (refer 2017 1a).

The Department of Corrections accepted this recommendation.

The Department provided lengthy submissions setting out their policies and practices addressing the use of force, which noted that:

- Staff receive training on use of force, *'... which includes accepted control and restraint practices and tactical communications. Tactical communications work to provide staff with the skills required to successfully de-escalate high pressure situations and incidents.'*
- Mental health training, staff support and use of sensory modulation are used to encourage staff to reflect on incidents, employ de-escalation techniques and reduce instances of use of force. This includes a good working relationship with nearby Hillmorton Hospital and a Safety Custody Panel reviewing safety and use of force incidents across CMP.

2. Only approved Control and Restraint techniques are used by staff at the Prison.

This is a repeat recommendation (refer 2017 1c)

The Department of Corrections accepted this recommendation.

The Department's response set out their practice for reviewing use of force incidents. They also discussed specifics relating to two incidents involving one prisoner, which have been redacted to protect the privacy of those involved.

3. Prisoners in the ISU are held in cells that meet the Department' standards for natural light. This is an amended repeat recommendation (refer 2017 1f)

The Department of Corrections accepted this recommendation. Their comments included:

- *'Corrections acknowledge that it is disappointing that we were unable to progress a new, modern ISU build, as discussed in our response to your office in 2017.'*
- *'The 2021/22 Financial Year Capital Planning process is currently underway. The need for resource to further improve the CMP ISU environment has been raised as part of this process.'*
- *'... the Corrections' National Office Mental Health Team have published guidelines to support enhanced physical environments of ISUs. This includes noise, lighting, colour and designs of the ISUs.'*

4. Measures be undertaken to better protect the privacy of prisoners in the ISU when they are naked, partially naked, or undertaking their ablutions. This is an amended repeat recommendation (refer 2017 1g)

The Department of Corrections partially accepted this recommendation. The Department's comments included:

- *'CMP take steps to ensure the highest levels of privacy for those residing in the ISU. This includes the appropriate male to female staffing ratio, the careful positioning of the cameras in the cells and maintaining the dignity of people in our care whilst they are showering or are in a state of undress. In addition to this, CMP are currently exploring options for new ISU doors which will in part, offer further privacy to prisoners in the ISU.'*
- The Department also discussed a research paper produced, around enhancing privacy for prisoners in the ISU. No timeframes for implementation were provided.

5. Meals should be served at normal hours. This would involve lunch being served any time between midday and 1.30pm and dinner to be served any time between 5pm and 7pm. This is a repeat recommendation (refer 2017 1k)

The Department of Corrections partially accepted this recommendation. Their comments included that:

- *'As your office is aware, the current staffing levels per shift and shift patterns do not allow the serving of meals at any other times. Corrections have acknowledged in past responses to your office that there are certain limitations to the current eight-hour shift structure in issuing meals to prisoners...'*
- Serving dinner at 3.20pm *'is not expected practice'*. Dinner is now being served at 4pm.
- *'As your office is aware, Making Shifts Work has been an ongoing project that will influence the timing of prisoner meals... As part of the project Corrections have established a standard of normalised meals, with no more than 14 hours between dinner and breakfast, seven days a week.'* Longer shifts for custodial staff will be implemented *'in a structured roll-out over the next few years.'*

6. Action is taken to ensure all prisoners are able to access at least one hour of exercise in the open air daily.

The Department of Corrections accepted this recommendation. The Department commented that:

'CMP takes its obligations under section 70 of the Corrections Act seriously ... Initial practice discussions occurred with staff at the time of your inspectors visit to CMP, and expectations around minimum entitlements and the recording of minimum entitlements were reiterated during the COVID-19 pandemic response ... Whilst work in this area is ongoing, as it is more focused on continual improvement, we do not consider that any further action is required in response to your recommendation.'

7. The RO improve the accessibility of notices and key information for prisoners.

This is a repeat recommendation (refer 2017 2b)

The Department accepted this recommendation, and commented:

- *'Following the initial feedback from your inspectors, Receiving Office staff have displayed additional information notices in the Receiving Office. These notices include key information about the Receiving Office and their processes with prisoners. We consider that this recommendation has been actioned and is complete.'*

8. Prison management review induction arrangements for those with literacy issues and improve these arrangements to ensure these prisoners are fully briefed on Prison procedures. This is an amended repeat recommendation (refer 2017 2c)

The Department accepted this recommendation.

The Department provided general information on plans to provide additional support for prisoner induction. In respect of prisoners who speak languages other than English, the Department commented:

- *'... Corrections have been working with Translation Services at the Department of Internal Affairs with the view to have key documents relating to the reception and induction process of prisoners (including at risk assessments) translated into other languages. This work is ongoing... We are not yet able to propose an expected timeframe for completion of this work...*

Once implemented, this resource will, as with Ezispeak assist staff in their duties and people in Corrections' care.'

9. The distribution of meals is supervised by custodial staff. This is a repeat recommendation (refer 2017 2c)

The Department accepted this recommendation, and commented:

- *'CMP see value in this recommendation and acknowledge that there should be an increased level of supervision from staff when meals are being distributed.*

However, we do not necessarily agree that a consistent approach should be applied to all units across the site.'

- The Department preferred a flexible approach with an emphasis on *'higher trust activities'* in a lower security environment.
- In respect of CMP specifically, the Department stated that distribution of all evening meals is supervised by staff, and management is working towards staff oversight of all meals.

10. The Prison makes greater efforts to engage with local iwi to better support the needs of Māori prisoners. This is a repeat recommendation (refer 2017 2e)

The Department of Corrections accepted this recommendation. In summary, they advised that:

- CMP recognise that more can be done to engage local iwi to better support the needs of Māori prisoners. There are initiatives that are currently being implemented which aim to improve local relationships.
- These initiatives include having the CMP Prison Director sitting on the Otautahi Māori Leadership Board, working with local iwi in the community and at other prison sites, and having representatives from He Waaka Tapu (a kaupapa Māori health and wellbeing service) work with prisoners.

11. High-security prisoners spend more time out of cells engaged in purposeful activities. This is a repeat recommendation (refer 2017 2g)

The Department of Corrections accepted this recommendation, and commented:

- *'In July 2020, some changes were made to the composition of the High Security units. Prisoners were moved to units that align more with their respective behaviours which means that their routines are more aligned and are more supportive of safer, longer unlock hours. This change means that high security prisoners are spending more time out of their cells, and during this time, they have access to programmes, education opportunities, the gymnasium and recreational activities. Further activities include three visits a week with family and friends for prisoners in the remand units, library and chapel visits.*

With the existing physical space in the units that these prisoner movements have freed up, the high security units are also looking at introducing more 'hobby' type classes for prisoners to engage with during their unlock time.'

12. Mould in 'single double' cells is removed as a matter of urgency. This is a repeat recommendation (refer 2017 2j)

The Department of Corrections accepted this recommendation, and commented:

- *'CMP note your inspectors' finding and have an ongoing programme of maintenance to ensure that facilities are up to standard. Further robust cleaning routines have been implemented which include daily cleaning and weekly assurance checks.*

In addition to this, contact has been made with our maintenance contractor to assess the mould and replace all of the grout in the shower areas that is showing signs of mould. This is part of the ongoing maintenance schedule, however given the ongoing uncertainty around COVID-19 alert levels, we are unable to provide a specific timeframe that the maintenance contractor will be able to access the site. Despite this uncertainty, priority will be given to ensuring that this occurs.'

13. 'Single double' cells should revert to single occupancy. This is an amended repeat recommendation (refer 2017 2k)

The Department of Corrections rejected this recommendation, and commented:

- *'Every effort is made to retain these cells as single occupancy, and they are only used as a last resort, to accommodate prisoners when the prison population demands.*

Corrections do not have a straightforward option to replace the beds that would be lost, if these cells were reduced solely to single occupancy. This is important as CMP have to be in a position to accommodate remand accused individuals as they arrive on site. Whilst we are unable to foresee future prison population numbers, it is critical that we take a cautious approach to beds to ensure that if numbers of arrivals increase again, we are able to safely accommodate individuals.'

14. An annual health needs analysis be carried out to inform the health development plan and funding. This is a repeat recommendation (refer 2017 5a)

The Department of Corrections accepted this recommendation, and commented:

- *'Ongoing work that looks to strengthen the current Health Services work plan (through the development of a work programme) will include two critical pieces of work. This works considers the alignment of Hōkai Rangī to Hōkai Nuku implementation plans (July 2020 to 2022):*
 - *Revisiting our Health Services vision and purpose and the development of a Health Services and Wellbeing plan (HSWP)*
 - *A key building block of the HSWP will be the enabling of a health needs analysis (for all people in our care).'*
- The Department also advised that additional work is being done on capturing health data, and strengthening health services capability in Corrections National Office and Regional teams, including appointing a Deputy Chief Executive Health.

15. Prisoners be made aware that there is a separate health complaint process to ensure patient confidentiality. This is an amended repeat recommendation (refer 2017 5b)

The Department of Corrections accepted this recommendation. In summary, their response noted:

- There had been some confusion for patients following a recent review of the Patient Complaints Policy. As a result the policy was reviewed again, and a new interim policy is to be released, with appropriate communication to prisoners and health services staff.

16. Nurses have access to clinical supervision. This is a repeat recommendation (refer 2017 5c)

The Department of Corrections accepted this recommendation, and commented:

- *'Earlier this year a new policy, 'Supervision for Nurses' was developed by the Corrections Health Leadership Team, in consultation with the New Zealand Nurses Organisation. Regional Operations Directors Health are responsible for establishing supervision arrangements in their respective regions.*

In the Southern Region, a contract for one-on-one Professional Supervision for Health Centre Managers and Clinical Team Leaders has been in place since June 2020. Further work to secure a provider to offer group supervision for nurses is

ongoing. Potential providers have been contacted to offer expressions of interest with a closing date of 27 August 2020. It is anticipated that nurses will be able to engage in group supervision by November 2020, along with the capacity for one to one supervision as required.'

17. Processes and practices for storing and administering controlled medication, comply with Corrections' Health Services Medication Standards. This is an amended repeat recommendation (refer 2017 5d)

The Department of Corrections accepted this recommendation. Their response included:

- Explanation of the Department's practice for storing controlled medicine.
- The Medicines Management Policy, and some potential improvements being explored.
- *'CMP accept that the controlled medication safe must be secured at all times outside of controlled drug preparation, even if staff are working in the area. To remind nurses of the importance of this, a practice reminder was issued to all nursing staff on 6 and 7 August 2020. Further, education led by the contracted pharmacy, relating to controlled drugs occurs with CMP nursing staff every six months. The next session is scheduled for early September 2020.'*

18. The information leaflet for visitors should be reviewed to better reflect the Prison's focus on supporting positive family relationships. This is a repeat recommendation (refer 2017 7a)

The Department of Corrections accepted this recommendation, and commented:

- *'CMP are pleased to note your mention of their focus on fostering positive relationships with prisoners' [families]. CMP are currently reviewing the visits area to identify enhancements. The visitor's booklet will be included in this review.*

Recently, CMP received some positive feedback from family of a youth prisoner, on the information brochure for visitors to the Youth unit. This leaflet will be adapted to ensure it is appropriate for the whole site and will include information regarding visits. It is expected that this leaflet will be completed by December 2020.'

19. Measures be taken to ensure that all prisoners can access the telephone. This is an amended repeat recommendation (refer 2017 7b)

The Department of Corrections accepted this recommendation, and commented:

- *'... We agree that all prisoners should be able to access the telephones when they need to. Staff are vigilant in monitoring this sort of behaviour from prisoners and any misuse of the prisoner telephone system is reviewed and followed up on in a variety of ways, for instance, through misconducts or formal warnings.*

We do not consider that this issue is systemic, and staff will take appropriate action with individuals when this behaviour presents itself.

In an effort to further enhance prisoners' contact with family and friends, CMP have rolled out video visits to all prisoners, to increase their opportunity to speak with individuals external to the prison.'

20. There should be greater opportunities for constructive activities for remand accused prisoners. This is a repeat recommendation (refer 2017 7c)

The Department of Corrections accepted this recommendation, and commented:

- *'The provision of further activities for remand accused prisoners is an ongoing focus for CMP. CMP have recently changed the composition of individuals in the remand units. Individuals were placed in units that align more with their respective behaviours which means that their routines are more aligned and are more supportive of safer, longer unlock hours.'*

Further, all prisoners, including Remand and High Security prisoners, can have access to [an extensive range of] interventions if there is a programme running in the unit they reside in.'

- More detail was also provided about additional programmes being planned for the future.

21. Remand prisoners should have longer periods out of their cells on a daily basis.

This is a repeat recommendation (refer 2017 7d)

The Department of Corrections accepted this recommendation, and commented:

- *'As noted in the response to recommendation 11, in July 2020, a number of prisoners of varying classifications (both sentenced and individuals on remand) were moved to align the units in a way that provides prisoners greater time out of cells and in the units/yards. This has been achieved by grouping smaller numbers of prisoners together (in accordance with managing prisoner dynamics and gang connections) or in some cases, having larger numbers of prisoners mixing in a unit where it has been deemed appropriate. This has resulted in all prisoners (including individuals on remand) having longer periods of time out of their cells, as it is safer and more operationally viable to do so. We therefore consider that this recommendation has already been achieved.'*

22. Toilets and showers in exercise yards should be better maintained. This is a repeat recommendation (refer 2017 7i)

The Department of Corrections partially accepted this recommendation, and their comments included that:

- *'Good cleaning and hygiene practices at prisons are crucially important, and CMP consider the showers and toilets were in good working order at the time of your inspectors' visit. They also consider that the facilities were clean and tidy when your inspectors were visiting, and the privacy screen upgrade had been completed just prior to the visit.'*

23. Re-integrative services are further developed. This is a repeat recommendation (refer 2017 8b)

The Department of Corrections accepted this recommendation and commented:

- *We note your inspectors' finding that both Release to Work and Out of Gate were not in operation at the time of your inspectors visit. We consider this statement to misrepresent the nature of these programmes. There are times where Release to Work uptake is limited due to candidates not meeting the eligibility criteria, or there being limited employment opportunities. However, Corrections employ Release to Work brokers across the country to ensure that opportunities for employment are sought out and are available to suitable candidates. Out of Gate is always available (regardless of the provider), with the case management team referring individuals as appropriate. Whilst prisoner uptake of these programmes may not have been reflected during your inspectors' visit to CMP, these programmes have always been available and are currently being offered to suitable prisoners at CMP.'*
- The Department also provided detail about the Navigate programme run in self-care units, a new Out of Gate programme provider, Guided Release eligibility criteria, supported accommodation for released prisoners and Matapuna, a Special Treatment Unit at CMP with its own 're-integration representative' to assist with transition out of prison.

24. Funding for furnishings and recreational equipment should be provided. This is a repeat recommendation (refer 2017 Youth Unit a)

The Department of Corrections accepted this recommendation, and commented:

- *'CMP are focused on developing a system for maintaining the current facilities and equipment in the Youth unit. This will also include (where appropriate) the replacement of furniture and equipment, however this is more about staff remaining vigilant about maintenance of the current facilities to ensure prisoners are not causing damage to furniture and equipment.*

There is a renewed focus on the cleanliness and usability of the youth unit, as well as supporting youth prisoners to look after their own cell. Staff in youth units are particularly focused on encouraging prisoners to take pride in maintaining their cell and the larger youth unit as a whole (including furniture and equipment); this is an ongoing focus for CMP.'

25. The issue of excessive tagging is addressed. This is a repeat recommendation (refer 2017 Youth Unit b)

The Department of Corrections accepted this recommendation, and commented:

- *'CMP continue to work to ensure that facilities are clean and free of graffiti, however, at its core, this is an ongoing issue of prisoners damaging prison property. As a result, CMP are exploring options for enforcing sanctions with prisoners who are found to be*

damaging prison property. Options being considered include the enforcement of a misconduct.

Notwithstanding this, tagging in the Youth unit will be removed. Timeframes for completion of this work are dependent on the arrival of paint and materials required to remove the tagging, however, the National Office property team have completed an onsite review of the Youth unit and this work will be progressed at pace.'

26. The dispensation for youth to mix should be reviewed to ensure it has legal effect. This is a repeat recommendation (refer 2017 Youth Unit c)

The Department of Corrections accepted this recommendation, and commented:

- *'As advised in our response to your OPCAT inspection report for Hawkes Bay Regional Prison, Corrections accept that there is no formal exemption document in place for both youth units. There is operational instruction in the Prison Operations Manual (POM) which supports current practice at both sites operating youth units.*

In response to your recommendation at Hawkes Bay Regional Prison we initially undertook to consider an exemption for each unit. We subsequently determined a broader approach that allows consideration of any future unit operating for youth was more appropriate and this work is underway. We look forward to providing your office with a copy of the completed work in a month.'

27. Notices about the complaints process are displayed in the unit. This is a repeat recommendation (refer 2017 Youth Unit d)

The Department of Corrections accepted this recommendation, and commented:

- *'CMP have made a significant effort to ensure that notices about the complaints process are displayed in the Youth Unit. Unfortunately, prisoners often remove posters from around the units and despite efforts to stop prisoners from doing this, it can still occur. Youth unit staff are vigilant at replacing notices in the unit and will continue to do so. Youth unit staff are aware of your inspectors' findings and were reminded of the importance of keeping up with replacing notices and posters in the Youth Unit.'*

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 visits 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 – prisons

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...

(a) a prison ...

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including prisons.

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.

