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OPCAT Report

Report on an unannounced inspection of Wāhi Oranga Mental Health Admission Unit, Nelson Hospital, under the Crimes of Torture Act 1989

February 2022

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Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report on an unannounced inspection of Wāhi Oranga Mental Health Admission Unit, Nelson Hospital, under the Crimes of Torture Act 1989

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Background

Ombudsmen are designated as one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining and monitoring the conditions and treatment of tāngata whai ora[1] detained in secure units within New Zealand hospitals.

Between 29 March and 1 April 2021, Inspectors[2] — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of Wāhi Oranga Mental Health Admission Unit (the Unit), which is located in the grounds of Nelson Hospital, Braemer Campus, Nelson.

Tāngata whai ora receive acute inpatient mental health services provided by Nelson Marlborough District Health Board's (DHB's) Adult Mental Health Services (the Service).

Summary of findings

My findings are:

- There was no evidence that any tangata whai ora had been subject to torture or other cruel, inhuman or degrading treatment or punishment.
- All the necessary paperwork to detain and treat tāngata whai ora on the Unit was on file.
- Tāngata whai ora said they felt safe on the Unit and that staff treated them with dignity and respect.
- The use of seclusion had reduced since my last visit in 2016.[3]
- New admissions were not routinely placed in seclusion on admission, an improvement since my previous visit.
- Multi-Disciplinary Team meetings were professional, constructive and well attended, including by community mental health services.
- The Unit was spacious, clean, tidy, and well maintained.
- Voluntary tāngata whai ora were not accommodated in the Intensive Psychiatric Care unit (the IPC), an improvement since my previous visit.

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1 'Tāngata whai ora' are users of mental health and addiction services. This term is often used interchangeably with 'consumer' or 'service user'.

2 When the term Inspectors is used in this report it refers to the inspection team comprising a Senior Inspector, Assistant Inspector, and two Specialist Advisors.

3 *Office of the Ombudsman report on an unannounced visit to Wahi Oranga Mental Health Inpatient Unit Under the Crimes of Torture Act 1989*, April 2016.

- There was an activities programme (the 'Wellbeing Programme') on the Unit, which had been developed in consultation with tāngata whai ora.
- Cultural and spiritual support was available to tāngata whai ora.
- Tāngata whai ora had access to visitors and external communications.
- Tāngata whai ora had access to primary health care services.
- Staff said they generally felt safe on the Unit, and were complimentary and appreciative of the leadership and management of the Unit.

The issues that needed addressing are:

- The inappropriate long-term placement of tāngata whai ora on the Unit.
- Tāngata whai ora in seclusion did not have access to daily fresh air.
- Seclusion rooms were stark and gloomy.
- During the inspection a tangata whai ora was placed alone in the IPC, which met the definition of seclusion in the '*Health and Disability Services (Restraint Minimisation and Safe Practice) Standards'* (2008).[4] The IPC is not a designated seclusion area and the placement was not recorded as seclusion.
- There was a lack of information detailing the process for voluntary tāngata whai ora to enter and exit the Unit.
- Leave restrictions were in place for some voluntary tāngata whai ora.
- An instance of environmental restraint was not recorded.
- Some staff were not up-to-date with, or had not completed, Safe Practice Effective Communication (SPEC)[5] training.
- Restraint records indicated that non-SPEC trained staff were involved in restraint events.
- Some complaints were not managed in accordance with the DHB's *Complaints Management Process.*
- Tāngata whai ora, and their whānau, were not invited to attend their Multi-Disciplinary Team (MDT) meetings.
- The private information of tāngata whai ora could be viewed on a whiteboard through the nurse's station window.

[4] Seclusion is defined as: '*Where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit*'. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[5] SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques.

- There were no privacy curtains or blinds in the observation windows of the IPC bedrooms.
- There were limited activities available to tāngata whai ora during evenings and weekends.
- There was a large number of medication errors on the Unit.

Recommendations

I recommend that:

1. The Service continues to work with external agencies to reduce the inappropriate long-term placement of tāngata whai ora on the Unit.
2. Tāngata whai ora in seclusion be offered access to fresh air at least daily. **This is an amended repeat recommendation.**
3. Tāngata whai ora are not secluded in non-designated rooms or areas.
4. The Unit ensures that voluntary tāngata whai ora are fully informed of their right to leave the Unit at will, including through information displayed on the Unit and provided in induction material. **This is an amended repeat recommendation.**
5. All instances of environmental restraint are recorded in the Unit's restraint register.
6. If internal doors are locked, the Unit ensures that tāngata whai ora still have timely access to all areas of the Unit they would ordinarily have access to.
7. Leave restrictions are not placed on voluntary tāngata whai ora.
8. All relevant staff complete and remain up-to-date with SPEC training.
9. Only appropriately trained staff are involved in restraint events, especially restraint events for the purpose of delivering treatment.
10. Responses to complaints, and details of their resolution, are provided to complainants in writing.
11. The Service applies and adheres to the DHB's *Complaints Managements Process* for every complaint.
12. Tāngata whai ora, and their whānau, are invited to attend their MDT meetings, where appropriate.
13. The whiteboard in the nurse's station displaying the private information of tāngata whai ora is not visible from the main unit.
14. Privacy blinds or curtains be installed in the observation windows of the IPC bedrooms.
15. The activities programme is extended to evenings and weekends.
16. The Service continues to take action to urgently reduce the number of medication errors on the Unit.

Follow-up inspections will be made at future dates to monitor implementation of my recommendations.

Feedback meeting

On completion of the inspection, my Inspectors met with representatives of the Unit's leadership team to outline their initial observations.

Consultation

The Nelson Marlborough District Health Board (the DHB) and the Ministry of Health received a copy of my provisional report and were invited to comment. The DHB and the Ministry of Health responded, and I have given regard to that feedback when preparing my final report. I am grateful to the DHB and the Ministry for their input, which has contributed positively to my final report.

Facility facts

Wāhi Oranga Mental Health Admission Unit

Wāhi Oranga Mental Health Admission Unit (the Unit) is a 30-bed acute inpatient unit, providing comprehensive assessment and treatment for youth, adults and older adults who require 24-hour oversight to their care.[6]

The Unit is a secure locked facility and accommodates clients of all genders. Tāngata whai ora can be admitted either as a voluntary tangata whai ora[7] or under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA).

Voluntary tāngata whai ora could not exit the Unit without staff assistance and, in some cases, had leave restrictions placed upon them. The expectation was that the informed consent of tāngata whai ora formed the basis for their placement on the Unit. However, informed consent did not change the fact that there were restrictions placed on voluntary tāngata whai ora which meant they were not free to leave the Unit at will. I discuss this issue further on page 19.

Region

Nelson

District Health Board

Nelson Marlborough District Health Board

Operating capacity

30 beds (plus two seclusion beds)

Previous inspections

Unannounced visit – April 2016

Unannounced follow-up visit – November 2012

Unannounced visit – February 2011

Announced visit – June 2008

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6 For more information about Wāhi Oranga Mental Health Admission Unit see the Healthpoint website at https://www.healthpoint.co.nz/mental-health-addictions/mental-health-addictions/nelson-marlborough-health-wahi-oranga-mental/.

7 'Voluntary' means that the tangata whai ora has agreed to have treatment and has the right to suspend that treatment. If the tangata whai ora is being treated in hospital, they have the right to leave at any time.

The Inspection

Four Inspectors conducted the inspection of the Unit between 29 March and 1 April 2021. On the first day of the inspection, there were 25 tāngata whai ora on the Unit, comprising 12 males and 13 females.

At the time of inspection, New Zealand was at COVID-19 Alert Level 1.[8]

Inspection methodology

At the beginning of the inspection, Inspectors met with the Charge Nurse Manager, before being shown around the Unit.

Inspectors requested the following information during and after the inspection:

- a list of tāngata whai ora and the legal authority for their detention (at the time of the inspection);
- the seclusion and restraint data from 1 September 2020 to 28 February 2021, and the seclusion and restraint policies;
- notes from any meetings or reports relating to seclusion minimisation;
- records of staff mandatory training, including Safe Practice Effective Communication training (SPEC);
- tāngata whai ora absent without leave (AWOL) events from 1 September 2020 to 28 February 2021;
- complaints received from 1 September 2020 to 28 February 2021 and responses;
- a copy of the activities programme;
- information provided to tāngata whai ora and their whānau on admission;
- information relating to medication errors from 1 September 2020 to 28 February 2021;
- staff sickness and retention data for the previous three years;
- staff vacancies at time of inspection (role and number); and
- data on staff, categorised by profession.

[8] See https://covid19.govt.nz/alert-system/covid-19-alert-system/ for more about New Zealand's COVID-19 alert system.

Inspection focus

The following areas were examined to determine whether there had been torture or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on tāngata whai ora.[9]

Treatment

- Torture or other cruel, inhuman or degrading treatment or punishment
- Seclusion
- Seclusion policies and events
- Restraint
- Environmental restraint
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Tāngata whai ora views on treatment

Protective measures

- Complaints process
- Records

Material conditions

- Accommodation and sanitary conditions
- Food

Activities and programmes

- Outdoor exercise and leisure activities
- Programmes
- Cultural and spiritual support

Communications

- Access to visitors

[9] My inspection methodology is informed by the Association for the Prevention of Torture's *Practical Guide to Monitoring Places of Detention* (2004) Geneva, available at www.apt.ch.

- Access to external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke with a number of staff and tāngata whai ora.[10]

Inspectors also reviewed tāngata whai ora records, were provided additional documents upon request by the staff, and observed the facilities and conditions.

Recommendations from previous report

Inspectors also followed up on five recommendations made following a visit to the Unit in 2016. These were:

a. Clients[11] undergoing a period of seclusion should be offered access to daily fresh air.

b. Unless warranted, new admissions should not routinely be admitted into a seclusion room.

c. The Unit should develop a locked door policy detailing the process for entry and exit into the Unit for informal (voluntary) clients (and visitors). This should be displayed in prominent areas, including the Unit entrance.

d. Only clients under the Mental Health (Compulsory Assessment and Treatment (MHA)) Act should be managed in the IPC area.

e. The Unit should consider reviewing the weekly activities on offer to clients. This should be done in consultation with clients.

The Unit's adoption, or not, of these prior recommendations is referred to in the relevant sections of this report.

[10] For a complete list of people Inspectors spoke with, see Appendix 1.

[11] In my reports, I use terminology as requested by the Unit. While previously the Unit referred to people staying there as clients, they now use the term tāngata whai ora.

Treatment

Torture or other cruel, inhuman or degrading treatment or punishment

There was no evidence that any tangata whai ora had been subject to torture or other cruel, inhuman or degrading treatment or punishment.

Long-term tāngata whai ora

At the time of inspection, six tāngata whai ora had been on the Unit for over six months. One tangata whai ora had been on the Unit for 1582 days (51.9 months),[12] and another had been on the Unit for 1452 days (47.6 months).[13] Inspectors calculated that the average length of stay for these six tāngata whai ora was 1009.5 days (33.1 months).[14]

Staff told my Inspectors that these long-term tāngata whai ora were unable to be discharged due to a lack of available supported accommodation, or other more appropriate services, in the Nelson region.

A 0.5 FTE consultant position had been created to address the issue of long-term accommodation on the Unit, and unit staff were actively seeking placement for these tāngata whai ora by working with local community service providers and whānau. Inspectors were informed that pathways for discharge were in progress for several long-term tāngata whai ora.

The purpose of an acute mental health inpatient unit is to provide rehabilitation and reintegration for tāngata whai ora experiencing an acute mental illness. I am concerned that tāngata whai ora who were no longer experiencing acute mental illness were being detained in a unit with more restrictive practices than those individuals required. I consider that the Unit is not suitable as long-term accommodation for tāngata whai ora who do not require care in an acute inpatient setting.

Both the DHB and the Ministry of Health acknowledged this issue in their responses to my provisional report. The DHB informed me that, as the 0.5 FTE consultant was leaving the Service, a full-time Clinical Nurse Specialist would be appointed to continue working towards successfully discharging long-term tāngata whai ora. The DHB also said that, since my Inspection, one long-term tangata whai ora had been successfully discharged, and another was on long leave with imminent discharge planned. The Ministry of Health stated that the Mental Health Specialist Services and Disability Directorates had commenced joint work to understand the barriers to discharge across the country and to facilitate a resolution to this issue.

I acknowledge the Service's efforts to safely and successfully transition long-term tāngata whai ora out of the Unit, and urge this work to continue. I am grateful to both the DHB and the

[12] As at 29 March 2021.

[13] Ibid.

[14] Ibid.

Ministry of Health for their proactive approach to this issue. I am aware that this issue is not limited to this Unit alone, and I intend to monitor this situation across the country.

Seclusion

Seclusion facilities

The Unit had two seclusion rooms, which were located in the Secure Care Unit (SCU). The SCU also contained a de-escalation lounge and an observation foyer. Access to the SCU was via a long corridor from the IPC.

Both seclusion rooms were stark and gloomy, and graffiti was etched into windows and doors. Each seclusion room contained a mattress on a plinth, and had an en-suite bathroom. Staff could lock the door between the bedroom and the en-suite, and turn the water off, if required. There were integrated drinking water dispensers built into the walls of the seclusion rooms.

Both seclusion rooms had natural light and privacy blinds, and tāngata whai ora were able to maintain orientation to time and date with a clock in the observation foyer.

Large, brightly coloured wall decals had been added to both the observation foyer and the de-escalation lounge in an attempt to improve the therapeutic feel of the SCU. The de-escalation lounge contained a television and soft furniture.

I acknowledge these efforts to improve the therapeutic feel of the SCU through the addition of wall decals and soft furnishings. Overall, however, the SCU was dark and unwelcoming, and not conducive to the mental wellbeing of the tāngata whai ora accommodated there.

In my 2016 report, I recommended that tāngata whai ora in seclusion be offered access to daily fresh air. Disappointingly, this had not been achieved due to the lack of access to an outdoor area from the SCU. In response to my provisional report, the Ministry of Health said that it was working closely with the DHB on progressing a planned reconfiguration of the seclusion area. The DHB stated that an outdoor courtyard accessible to tāngata whai ora in seclusion would be prioritised in these plans. I will monitor the progress of improvements to the SCU.

Seclusion policies and events

The DHB provided my Inspectors with the *Seclusion Policy* and the *Secluding a Consumer Procedure* (dated November 2020). The review date for both the policy and procedure was April 2021.

Data provided by the DHB indicated that, between 1 September 2020 and 28 February 2021, there were 51 seclusion events. In my previous report, data provided for the nine months between 1 July 2015 and 31 March 2016 showed 125 seclusion events.

Table 1: Seclusion events 1 September 2020 – 28 February 2021[15]

Month	Events	Tāngata whai ora	Hours	Average hours
September	19	13	427	22
October	8	5	112	14
November	8	4	237	30
December	4	3	40	10
January	6	5	83	14
February	6	5	60	10
Total:	**51**	**35**	**959**	**18.8**

I am pleased to see an overall reduction in the use of seclusion since my previous visit. Staff told my Inspectors that the Unit had made concerted efforts to reduce the use of seclusion, including regular seclusion reduction meetings, debriefs, and daily discussions about alternatives to seclusion during team meetings. I encourage the Unit to continue work in this area, including actively engaging with tāngata whai ora towards reducing seclusion, and ongoing staff training in de-escalation.

In my 2016 report I recommended that, unless warranted, new admissions should not routinely be admitted directly into a seclusion room. During this inspection I did not see evidence that tāngata whai ora were routinely secluded on admission. A review of seclusion records confirmed this. I therefore consider this recommendation has been achieved.

Seclusion of a tangata whai ora in the Intensive Psychiatric Care unit

During the inspection, my Inspectors observed a tangata whai ora who had been placed in the IPC on their own. The door between the IPC and the main unit was locked. Staff told inspectors that this was to manage Unit dynamics. Staff observed the tangata whai ora through the window from the nurse's station and responded to their requests. Staff said this was not being recorded as seclusion.

The DHB takes its definition of seclusion from the Ministry of Health's *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards* (2008), which describes seclusion as "where a person is placed alone in a room or area, at any time and for any duration, from

[15] Data as provided by the Service.

which they cannot freely exit".[16] This instance of accommodating a tangata whai ora alone in the IPC met this definition of seclusion, however it was not being recorded as such.

Furthermore, Section 71(2)(b) of the MHA states:

> *a patient shall be placed in seclusion only in a room or other area that is designated for the purposes by or with the approval of the Director of Area Mental Health Services.*

In their response to my provisional report, the DHB said that staff were present in the nurse's station, or the IPC, at all times, and would respond to any requests immediately. The DHB also noted that the environment in the IPC was different to a seclusion room, and stated that tāngata whai ora in the IPC had better access to cultural support, visitors, and activities than if they were undergoing a period of seclusion.

I acknowledge that staff were present in the nurse's station adjacent to the IPC at the time of inspection, and responded to the requests of the tangata whai ora. However, placing tāngata whai ora alone in any room or area without safeguards in place, such as documented observations and regular room entries, can risk harmful outcomes for tāngata whai ora.

I also recognise that the IPC is different to the seclusion area in the Unit, and consider that facilities providing greater levels of care and support for tāngata whai ora, such as the IPC, are important to ensure that individual needs are met in a least restrictive environment. However, I am of the view that placing any tangata whai ora alone in an area from which they cannot freely exit, as my Inspectors observed in this case, constitutes seclusion as per the Ministry of Health's definition. I consider that the Unit should ensure that processes are in place to prevent tāngata whai ora from being inadvertently secluded, particularly in non-designated rooms or areas, such as the IPC.

The DHB stated that they would consult with the Ministry of Health as to whether, in its view, the use of the IPC in this way constituted seclusion. I intend to follow up on the outcome of this consultation.

Restraint

The DHB provided my Inspectors with the *Restraint Minimisation and Safe Practice Policy* and the *Using Restraint / Enablers: Safe Practice Procedure* (dated December 2019). The review date for both the policy and procedure was December 2022.

[16] *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

Data provided by the DHB indicated that, between 1 September 2020 and 28 February 2021, there were 33 personal restraint[17] events. In my previous report, data provided for the nine months between 1 July 2015 and 31 March 2016 indicated that there were 38 restraint events.

Inspectors also identified the use of environmental restraint[18] on the Unit, however environmental restraint had only been recorded in one instance. I discuss this further on page 18.

Table 2: Restraint data (exclusive of seclusion data) 1 September 2020 – 28 February 2021[19]

	September	October	November	December	January	February
Total restraint events	9	5	5	1	11	3
Total tāngata whai ora restrained	7	4	3	1	6	3
Personal restraint	9	5	5	1	10	3
Environmental restraint	0	0	0	0	1	0
Number of males restrained	5	2	3	1	5	2
Number of females restrained	2	2	0	0	1	1
Youngest person restrained (years)	24	43	26	36	19	20
Oldest person restrained (years)	52	72	35	36	63	63
Shortest restraint events (minutes)	0	5	2	5	2	2

[17] Personal restraint is when a service provider(s) uses their own body to limit a service user's normal freedom of movement. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[18] Environmental restraint is where a service provider(s) intentionally restricts a service user's normal access to their environment, for example where a service user's normal access to their environment is intentionally restricted by locking devices on doors or by having their normal means of independent mobility (such as wheelchair) denied. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[19] Data as provided by the Service.

	September	October	November	December	January	February
Longest restraint event (minutes)	20	15	30	5	20	5
Average restraint event (minutes)	8	7	10	5	9	4

Inspectors reviewed the records of 17 restraint events from the DHB's Safety1st[20] database. The 'Evaluation of Restraint' section of the electronic form had not be completed in 13 out of the 17 records. As such, it was unclear to Inspectors what actions had been taken to debrief with staff, tāngata whai ora or whānau, or identify options to avoid restraint in the future.

Environmental restraint

Door locking within the Unit

At the time of inspection, a pair of doors between two sides of the Unit were locked. Staff told my Inspectors that they occasionally did this to manage Unit dynamics and the individual needs of tāngata whai ora. In this instance, the locked door prevented a tangata whai ora from accessing certain parts of the Unit. Staff said they did not record this as environmental restraint.

In response to my provisional report, the DHB stated that they were not convinced that this practice constituted environmental restraint, and that they would solicit advice from the Ministry of Health on its view of the use of the space in this way.

As noted in footnote 18 above, the Ministry of Health defines environmental restraint as where a service provider intentionally restricts a service user's normal access to their environment. I consider that locking the doors between two sides of the Unit meets the Ministry of Health's definition of environmental restraint, as it prevented a tangata whai ora from accessing parts of the Unit they would normally have access to. I consider that this should be recorded as such. I intend to follow up on the outcome of the DHB's consultation with the Ministry of Health on this issue.

The locked internal door also meant that tāngata whai ora could not access areas of the Unit they would normally have access to without staff assistance, including some outside areas. Some tāngata whai ora told Inspectors that the reasons for the locked door had not been clearly explained to them, and that there were delays in staff facilitating access to different parts of the Unit.

Standards New Zealand[21] requires that the service provider must demonstrate that:

[20] Safety1st is the DHB's integrated, electronic system, which collects and reports on safety and risk event data.

[21] *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008.

(d) the use of locking devices on doors does not restrict the normal freedom of movement of consumers for whom restraint is not intended.

I consider that if doors are locked within the Unit, the Unit should ensure there are robust processes in place to provide tāngata whai ora with timely access to areas of the Unit they would ordinarily be able to enjoy.

Leave restrictions on voluntary tāngata whai ora

The Unit was a locked unit, and main entrance/exit doors were operated by a staff member who was stationed in an office next to them during normal business hours. After-hours there was a call bell which displayed on electronic displays across the Unit to alert staff that someone wanted to enter or exit the Unit.

At the time of the inspection, there were six voluntary tāngata whai ora on the Unit. Voluntary tāngata whai ora are under no legal compulsion to remain on the Unit. Informed consent provides the lawful authority for voluntary tāngata whai ora to remain on the Unit and receive treatment. Consent may be revoked at any time by voluntary tāngata whai ora, and they should be able to enter and exit the Unit at will. Appropriate procedures must be in place to allow for this to occur. Such procedures are particularly important as voluntary tāngata whai ora are not protected by the other legal safeguards for tāngata whai ora under the MHA, such as oversight of the District Inspectors (DIs).[22]

There was no information available on the Unit which detailed the process for entry to and exit from the Unit for voluntary tāngata whai ora or visitors. I made a recommendation relating to this matter in 2016 and I am disappointed that this has not been remedied.

On review of the files of tāngata whai ora, there was also evidence that some voluntary tāngata whai ora had leave restrictions placed on them. I therefore do not consider that all voluntary tāngata whai ora were free to leave at will.

I acknowledge that the Unit requires a process to identify and manage absences from the Unit, for example by requesting that voluntary tāngata whai ora notify staff before they leave the Unit. However, voluntary tāngata whai ora have a fundamentally different legal status to people detained under an order. I consider that leave restrictions are incompatible with voluntary status and, as such, should not be placed on voluntary tāngata whai ora.

In response to my provisional report, the Ministry of Health stated that the practice of placing leave restriction on voluntary tāngata whai ora was not appropriate, and that it had reminded all Directors of Area Mental Health Services of this and was monitoring this situation.

The DHB, however, did not appear to share this view. In response to my provisional report, they stated that placing leave restrictions on voluntary tāngata whai ora allowed more tāngata whai ora to progress from compulsory to voluntary treatment, and that leave restrictions provided additional safety benefits. They also stated that leave restrictions were negotiated

[22] District Inspectors are lawyers appointed by the Minister of Health to protect the rights of people receiving treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act).

and agreed to with voluntary tāngata whai ora, and that voluntary tāngata whai ora were aware that they could discharge themselves if they did not agree with leave restrictions.

I am concerned with the position held by the DHB, and note that it is inconsistent with that of the Ministry of Health. I consider it unacceptable that tāngata whai ora would be required to discharge themselves from the Service if they did not agree to the leave restrictions placed upon them. I reiterate my view that leave restrictions are incompatible with voluntary status, and consider that the Unit should cease the practice of placing leave restrictions on voluntary tāngata whai ora immediately.

Restraint training for staff

Inspectors were provided with a copy of the Unit's training register, which indicated that 44 out of the 67 unit staff (65.7 percent) had completed SPEC training. I consider that all relevant staff should have completed, and be up-to-date with, SPEC training as a matter of priority.

Of the 17 restraint events reviewed by Inspectors, records indicated that non-SPEC trained staff were involved in eight events. In the restraint documentation, in all but three of the eight instances,[23] non-SPEC trained staff were listed as having completed restraint training, despite no evidence of this in the training register provided by the Unit. The DHB's *Seclusion Policy* provides that the DHB "undertakes to ensure that its services use restraint only in appropriate circumstances and by appropriately-trained staff members".

In response to my provisional report, the DHB stated that they consider it unacceptable for staff who are not SPEC trained to be involved in restraint events. By way of possible explanation, they said that the training records held by the DHB could be incomplete. However, the DHB did not provide me with any further information to demonstrate that all staff involved in restraint events had completed and were up-to-date with SPEC training.

I do not consider it appropriate that non-SPEC trained staff may have been involved in restraint events, and I am concerned that this information was not captured in the restraint documentation. It is my expectation that only staff who have completed, and are up-to-date with, SPEC training are involved in restraint events. Furthermore, I urge the DHB to ensure that all training records are up-to-date.

Involvement of security staff in restraint events

Security staff (employed by the DHB as 'Patient Support and Security Workers' (PSSWs)) were present on the Unit in the evenings and during weekends. PSSWs were SPEC-trained and were involved in the personal restraint of tāngata whai ora.

Inspectors were provided with a copy of the position description for PSSWs. It was generic to all PSSWs across the DHB and did not detail any limits on the involvement of PSSWs in restraint events. Several clinical staff members said that PSSWs were skilled at de-escalation and were

[23] In these three instances, the section of the form on restraint training was left blank.

considered a positive presence on the Unit due to their ability to positively engage with tāngata whai ora.

Restraint records indicated that PSSWs had been involved in 11 of the 17 restraint records reviewed by Inspectors. Six of the restraint events involving PSSWs had been to '*facilitate essential delivery of treatment'.* Records indicated that PSSWs had been 'hands on' during these restraint events. Records were generally not specific about what 'treatment' had been given, however two records indicated that tāngata whai ora had been given treatment via intramuscular injection (IMI).

I acknowledge that some clinical staff considered PSSWs to be a positive addition to the Unit. However, restraint is an intrusive intervention, and as such, it is important to have safeguards around who may restrain people and how this may be done. As noted above, it is my expectation that only suitably trained people are involved in restraint, particularly for the delivery of treatment. While PSSWs were required to be up-to-date with SPEC training, the DHB position description for PSSWs indicated that they were not required to be clinically or therapeutically trained. As such, the involvement of PSSWs to deliver treatment presented a significant risk to the safety, dignity, and wellbeing of tāngata whai ora.

Overall, I am concerned about what appears to be a normalisation of the use of security staff in mental health facilities, including on the Unit. I appreciate that a range of factors has contributed to this trend. However, the use of security staff in place of more appropriately trained staff is not an ideal solution. In response to my provisional report, the Ministry of Health said that the use of security staff in restraint could be appropriate in some situations, if security staff are suitably trained, and are working under the direction of a registered health professional with clear boundaries on their role. The Ministry of Health noted my concerns about the use of security staff in mental health settings and said it would continue to monitor this issue to ensure security staff are used appropriately.

I am appreciative of the Ministry of Health's response to my concerns, and I acknowledge its view that security staff involvement may be appropriate in some circumstances. However, I emphasise that there must be clear, appropriate limits on their involvement in restraint, and robust oversight processes in place. I also intend to monitor the situation across the country.

Electro-convulsive therapy

There were no tāngata whai ora undergoing Electro-convulsive therapy (ECT)[24] on the Unit at the time of inspection.

[24] Electroconvulsive therapy is used mainly for people experiencing severe depressive episodes. It involves the passage of an electric current across the head of a person to produce a convulsion. See https://www.health.govt.nz/publication/electroconvulsive-therapy-ect for more information.

Sensory modulation

The Unit had one Sensory Modulation[25] room, which contained basic sensory items, including chairs and couches, rugs, beanbags, a weighted soft-toy dog and cat, a Shakti mat, and a piano. There was also a massage chair, which was not functional at the time of inspection. There were additional sensory items stored in the occupational therapy office that patients could ask to use.

Staff told my Inspectors that the Sensory Modulation room was often locked and therefore tāngata whai ora would have to ask staff if they wanted to access the room. Staff and tāngata whai ora told Inspectors that the room was used regularly, however staff did not record when tāngata whai ora accessed the room, or track its use against seclusion and restraint events.

In my view this resource could be more effectively utilised as a means of therapeutic intervention for tāngata whai ora and a tool toward seclusion and restraint reduction.

The Unit's Occupational Therapist (OT) offered one-to-one individualised sensory modulation sessions with tāngata whai ora. Information booklets on sensory modulation were available to tāngata whai ora.

Tāngata whai ora views on treatment

Tāngata whai ora my Inspectors spoke with said they felt safe on the Unit and that staff treated them with dignity and respect. Tāngata whai ora also said they felt they could approach staff if they had any concerns. Inspectors observed positive interactions between tāngata whai ora and staff throughout the inspection.

The Unit held daily morning meetings with tāngata whai ora during weekdays, and a weekly Wānanga community meeting with a Māori cultural focus. Tāngata whai ora were encouraged to participate in these meetings, and to raise any issues, thoughts or ideas about the Unit.

[25] 'Sensory modulation uses a range of tools to help individuals get the right amount of sensory input. In mental health settings, sensory modulation can be used to assist distressed service users to regain a sense of calm'. *Sensory modulation in inpatient mental health: A summary of the evidence.* Te Pou o Te Whakaaro Nui. 2011.

Recommendations – treatment

I recommend that:

1. The Service continues to work with external agencies to reduce the inappropriate long-term placement of tāngata whai ora on the Unit.
2. Tāngata whai ora in seclusion be offered access to fresh air at least daily. **This is an amended repeat recommendation.**
3. Tāngata whai ora are not secluded in non-designated rooms or areas.
4. The Unit ensures that voluntary tāngata whai ora are fully informed of their right to leave the Unit at will, including through information displayed on the Unit and provided in induction material. **This is an amended repeat recommendation.**
5. All instances of environmental restraint are recorded in the Unit's restraint register.
6. If internal doors are locked, the Unit ensures that tāngata whai ora still have timely access to all areas of the Unit they would ordinarily have access to.
7. Leave restrictions are not placed on voluntary tāngata whai ora.
8. All relevant staff complete and remain up-to-date with SPEC training.
9. Only appropriately trained staff are involved in restraint events, especially restraint events for the purpose of delivering treatment.

Protective measures

Complaints process

Copies of the DHB's *Complaints Management Policy* and the *Complaints Management Procedure* were provided to Inspectors. The review date for both the policy and the procedure was May 2024.

Information about the complaints and feedback process was displayed in a number of areas on the Unit. Complaints/feedback forms were available on the Unit, independent of staff. Tāngata whai ora spoken with told Inspectors that they knew how to make a complaint and felt comfortable and supported to do so.

Posters for the Health and Disability Commissioner's *Code of Health and Disability Services Consumers' Rights* were displayed throughout the Unit, including in Easy Read format.

Contact details for the District Inspectors (DIs) were displayed in a number of areas on the Unit. Inspectors noted that in some cases the DIs' contact details were written on whiteboards, which risked being smudged or rubbing off. Information on the role and functions of the DIs was available on the Unit and in tāngata whai ora induction packs. Tāngata whai ora told Inspectors they knew who the DIs were and how to contact them.

There were seven complaints between 1 September 2020 and 28 February 2021. Where a written response to a complaint was provided, these were courteous, personalised, and addressed the issues in detail.

Information provided to Inspectors indicated that some complaints were resolved via in-person meetings, emails, and telephone and video calls. While I recognise that this is appropriate in some instances, I consider it good practice that, even where resolutions are reached verbally, responses to complaints and details of their resolution are provided to complainants in writing.

Inspectors requested further information from the DHB relating to a specific complaint of concern. From the information provided, it was unclear to Inspectors what steps had been taken to investigate the complaint. Furthermore, despite meeting the criteria of a 'major' complaint as per the DHB's *Complaints Management Procedure*, the complaint was not responded to in writing as required by the *Complaints Management Procedure.*

I acknowledge that the information provided indicated that this complaint was resolved via email and telephone and video calls. However, I am concerned by the lack of evidence demonstrating that this complaint was adequately investigated and that appropriate written records do not appear to have been kept. I would expect to see a written record of all investigative steps and communications with the complainant, particularly for complaints that meet the criteria for being a 'major' complaint. I would also expect the complainant to be provided with a written summary of any discussions and details of the resolution of the complaint, as required by the *Complaints Management Procedure.*

A robust complaints resolution system that is consistently followed is imperative to ensure fairness, transparency, and equitable outcomes for complainants. I consider that the Service

should apply and adhere to the DHB's *Complaints Managements Process* for every complaint. I was concerned to find that was not case for this complaint.

Records

Of the 25 tāngata whai ora on the Unit on the first day of inspection, 19 were detained under the MHA. Six tāngata whai ora were voluntary. Inspectors were provided with copies of the necessary paperwork to detain and treat tāngata whai ora on the Unit. The Unit had a *Consent to Treatment (Inpatient Services)* form used for voluntary admissions on the Unit.

Inspectors attended the Unit's weekly Multi-Disciplinary Team (MDT) meeting. The MDT meeting was well attended by representatives of unit staff and a variety of DHB and mental health community services. Discussion was professional and constructive.

However, Inspectors did not see any evidence that tāngata whai ora or their whānau were invited to attend their weekly MDT meetings. Staff told Inspectors that they were working towards this, however it was not in place at the time of inspection.

Effective multi-disciplinary based care in mental health services should enable tāngata whai ora to determine their level of involvement in decision-making and ensure they have a clear understanding of their recovery plan. It is my view that tāngata whai ora and their whānau should be invited to their MDT meetings wherever possible, and kept informed of the outcome of these. In response to my provisional report, the DHB said that involvement of tāngata whai ora and whānau in MDT meetings, where feasible, and collaboration with tāngata whai ora and whānau on MDT treatment plans had been identified as an area to be considered in the Service's MDT improvement project. I look forward to seeing progress on this.

Recommendations – protective measures

I recommend that:

10. Responses to complaints, and details of their resolution, are provided to complainants in writing.
11. The Service applies and adheres to the DHB's *Complaints Managements Process* for all complaints.
12. Tāngata whai ora, and their whānau, are invited to attend their MDT meetings, where appropriate.

Material conditions

Accommodation and sanitary conditions

The Unit was comprised of:

- three accommodation wings, with 23 beds;
- the IPC, with four beds;
- two beds adjacent to the dining area;
- three beds adjacent to the staff wing; and
- five single-bedroom flats separate to the main unit.[26]

The main unit consisted of a large, open combined communal and dining area, a television room, the sensory modulation room, whānau room, a combined occupational therapy kitchen/art room, and several lounge areas. Lounge areas were comfortable and had soft furnishings, however, some furniture was worn.

There was a nurse's station looking out into the communal and dining area. Inspectors observed a whiteboard in the nurse's station that contained private information about tāngata whai ora, which could be viewed through the window from the main unit. This posed a serious risk to the privacy of information of tāngata whai ora. In response to my provisional report, the DHB stated that a proposal had been made to move to an electronic whiteboard system, which would improve privacy of information. This project was on hold until IT programmers became available. The DHB also stated a planned refurbishment of the Unit would move the board to a private area. While I am pleased that the DHB has plans to improve the privacy of information, I consider that this issue should be addressed as a matter of priority.

The Unit was spacious, clean and tidy, and well maintained. Accommodation wings were divided by gender, and each wing contained between six and eight bedrooms. All bedrooms were single occupancy, and were of a reasonable size and had adequate natural light, heating and ventilation.

Tāngata whai ora were able to lock their bedroom doors for privacy and security. Tāngata whai ora could unlock their bedroom doors from the inside, however if they were outside their bedrooms they could not unlock them without staff assistance.

Each wing had shared bathroom facilities, which were clean and in good condition. Two bedrooms contained an en-suite bathroom. The Unit was physically accessible and could be easily altered to meet the physical needs of tāngata whai ora with mobility impairments.

[26] The Unit was funded for 30 beds, however there was a total of 37 beds on the Unit.

Access to handwashing facilities in the main unit was limited for both staff and tāngata whai ora, which staff noted posed challenges for infection control. Linen was available on the Unit and tāngata whai ora could access laundry facilities to wash their own clothing.

The IPC, adjacent to the main unit, was used to accommodate tāngata whai ora requiring high levels of support and de-escalation. The IPC contained four bedrooms with en-suites, two shared bathrooms, a combined lounge/dining area, and a separate lounge that was used for visits. There was a secure courtyard accessible from the lounge area, the door to which was unlocked during the inspection. There was a kitchenette in the IPC, however it had been permanently locked behind a sliding panel after an incident involving hot water.

There were no privacy curtains or blinds on the observation windows in bedroom doors in the IPC. I urge the Unit to install suitable privacy blinds or curtains to these doors as a matter of priority. In response to my provision report, the DHB stated that a maintenance request had been made to address this. I am pleased to hear this, and look forward to monitoring this improvement.

In my 2016 report, I recommended that voluntary tāngata whai ora not be accommodated in the IPC area due to the restrictive nature of this environment. I was pleased to note that this recommendation had been achieved.

The Unit also had five single-bedroom flats that were separate to the main unit and included in the Unit's total funded beds. The flats were located through a locked fence approximately 50 metres from the main unit, and were staffed from the main unit. Each flat had a call bell back to the main unit.

The flats were used to accommodate tāngata whai ora for whom the environment on the main unit may not have been appropriate, and as 'step down' accommodation for some tāngata whai ora transitioning into the community. Inspectors viewed a vacant flat, which was clean and ordered, however furnishings were dated, tired, and generally in a poor state of repair. The flat contained a small fully equipped kitchen, separate laundry with a washing machine, a small bathroom, and a separate bedroom.

Food

Tāngata whai ora selected their meals from a menu that rotated fortnightly. Meals were served at appropriate hours, and there was a range of snacks and fresh fruit available to tāngata whai ora between meal times. Staff told Inspectors that there was dietician input on the Unit as some tāngata whai ora had complex dietary requirements. Special dietary requirements were catered for, however I encourage the Unit to ensure that all tāngata whai ora are aware of their ability to access meals suitable to their dietary requirements.

Tāngata whai ora were generally positive about meals. Inspectors observed a meal being served, and the quality and quantity of the food appeared to be of a good standard.

Tāngata whai ora, with the exception of those in the IPC, were able to freely access hot and cold drinks throughout the day. Tāngata whai ora in the IPC did not have access to hot water and therefore hot drinks were provided by staff on request.

Recommendations – material conditions

I recommend that:

13. The whiteboard in the nurse's station displaying the private information of tāngata whai ora is not visible from the main unit.
14. Privacy blinds or curtains be installed in the observation windows of the IPC bedrooms.

Activities and programmes

Outdoor exercise and leisure activities

The Unit had a large, main outdoor area and several smaller outdoor gardens and courtyards, all of which were generally unlocked during the day. At times, however, access to outdoor areas was restricted, as detailed in my comments on page 18.

The main outdoor area was well maintained and had an open courtyard area with a basketball hoop, a grassed area with a volleyball net, raised gardens, and a water feature. Other outdoor areas contained seating and furniture, and Inspectors observed these areas regularly being used by tāngata whai ora.

A range of activities was available to tāngata whai ora. The Unit had a pool table, table tennis, a collection of books, games, and televisions. There was a small gym on the Unit consisting of a rowing machine and an exercise bike. Staff told my Inspectors that tāngata whai ora had access to the hospital gym and hydrotherapy pool, however some tāngata whai ora said that they would like more opportunities for physical exercise.

The Unit had one full-time equivalent (FTE) Occupational Therapist (OT) who was responsible for coordinating the Unit's activity programme (the 'Wellbeing Programme'), and was supported by two Health Care Assistants (HCAs). The Wellbeing Programme was based on the '*Te Whare Tapa Whā'* model of care,[27] and had been developed with input from tāngata whai ora.

Staff said that activities were well attended, and Inspectors saw evidence of tāngata whai ora making decisions about their daily activities, and being supported to do so where necessary.

The Wellbeing Programme was available Monday to Friday during business hours, and the OT and HCAs left activity kits for evening and weekend staff to coordinate additional activities. However, the provision of activities during evenings and weekends was limited.

The Unit also had two FTE Social Workers (SWs). Weekly 'Community links' outings were facilitated by a SW, where tāngata whai ora were supported to visit a wide range of community services and agencies. The Unit also had a 'Great Hall of Information', which was a corridor containing extensive information for tāngata whai ora and whānau on a variety of issues, including employment, financial services, housing, and cultural and spiritual support. I consider that these two initiatives to improve community engagement and support for tāngata whai ora were a positive addition to the programmes provided on the Unit.

In my 2016 report I recommended the Unit consider reviewing the weekly activities on offer to tāngata whai ora, and that this should be done in consultation with tāngata whai ora. I

[27] See https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha.

consider that this recommendation has been achieved, however more options for activities should be provided during evening and weekends.

Programmes

The OT and two SWs also undertook one-to-one assessments and individual work with tāngata whai ora. OT provision included, for example, distress tolerance assessments and OT screening on admission, full functional assessments, and community assessments to assist with discharge planning. SWs undertook psychosocial assessments and supported links to community services to assist with discharge planning.

The Unit also employed a 0.5 FTE Clinical Psychologist who primarily worked one-to-one with tāngata whai ora and conducted cognitive assessments, brief interventions, and worked with community psychology teams to help transition tāngata whai ora to the community.

Cultural and spiritual support

Cultural and spiritual support was available to tāngata whai ora on the Unit.

Tāngata whai ora who identified as Māori could access DHB Māori Health Services called Te Waka Hauora,[28] which supported both tāngata whai ora and whānau. Te Piki Oranga[29] also supported some tāngata whai ora on the Unit, and representatives attended MDTs where required.

The Unit had a Poumanaaki Cultural Support worker, who supported tāngata whai ora and whānau, and provided cultural input during MDTs. They also provided cultural training for staff and contributed to activities on the Unit. The Unit had previously had a Kaumātua who had retired the week prior to the inspection. This role was waiting to be filled at the time of inspection.

The hospital chaplain visited the Unit several times a week, and was also available to meet with tāngata whai ora on request.

Recommendations – activities and programmes

I recommend that:

15. The activities programme is extended to evenings and weekends.

[28] For information on Te Waka Hauora see https://www.nmdhb.govt.nz/health-services/maori-health-services/te-waka-hauora-hospital-service/.

[29] Te Piki Oranga is a kaupapa Māori primary health provider for Te Tau Ihu o Te Waka-a-Māui (the top of the South Island). For more information, see https://www.tpo.org.nz/.

Communications

Access to visitors

Visits to the Unit could take place seven days a week. Visiting hours were between 3pm and 8.30pm Monday to Friday, and 10.30am and 8.30pm Saturday, Sunday and public holidays. Visits outside of normal visiting hours could be facilitated. Visits took place on the Unit, and tāngata whai ora could make use of a number of spaces, for example, the whānau room, Sensory Modulation room, lounges, and outdoor areas.

Inspectors observed whānau visiting tāngata whai ora throughout the inspection, and noted positive interactions between whānau and unit staff.

Access to external communication

Tāngata whai ora in the main unit had independent access to telephones, which were located in two small booths. One of the booths had a glass door, while the door to the other booth had been removed. Tāngata whai ora were therefore not afforded sufficient privacy while using this phone. I encourage the Unit to address this issue. Tāngata whai ora were able to keep their cell phones in their possession, unless there was a specific clinical or safety reason not to allow this.

Tāngata whai ora accommodated in the IPC did not have access to a fixed telephone, however they could use a cordless phone which was stored in the nurse's station.

There was Wi-Fi on the Unit, and staff supported tāngata whai ora to access the internet if they did not have their own devices.

Tāngata whai ora did not raise any concerns with Inspectors about access to external communications.

Recommendations – communications

I have no recommendations to make.

Health care

Primary health care services

Tāngata whai ora received a physical assessment following their admission, and Inspectors saw evidence in files that tāngata whai ora had access to primary health services.

A House Officer was based on the Unit from Monday to Friday and after-hours medical cover was provided.

There was a treatment room on the Unit for physical examinations. This contained basic medical equipment and was clean, tidy and well ordered. Tāngata whai ora did not raise any concerns with Inspectors regarding access to primary health care.

There were 27 documented medication errors between 1 September 2020 and 28 February 2021. The majority of these were errors in administering medication, including wrong dose, frequency, or time.

I am concerned at the high number of medication errors on the Unit. Data provided by the Unit indicated that in September 2020 there were four medication errors, four in October, eight in November, two in December, five in January 2021, and four in February. In August 2020 unit staff convened a meeting to discuss strategies to reduce the number of medication errors. They had subsequently implemented several actions, such as facilitating information sessions, further education, and establishing Performance Improvement Plans for unit staff.

I acknowledge that the Unit had taken steps to address the issue, however the number of medication errors between September 2020 and February 2021 (after the staff meeting to address the issues) did not appear to be decreasing. I expect to see this urgently addressed as a matter of priority.

In response to my provisional report, the DHB stated their commitment to achieving one-hundred percent accuracy in medication administration, and that a Multidisciplinary Mental Health Medication Safety Group was being formed. I look forward to seeing progress in this area.

Recommendations – health care

I recommend that:

16. The Service continues to take action to urgently reduce the number of medication errors on the Unit.

Staff

Staffing levels and staff retention

Data provided by the Unit showed a multi-disciplinary staff complement (excluding medical staff) of 49 Registered Nurses (RNs), seven HCAs, two Enrolled Nurses (ENs), two SWs, an OT, a 0.5 FTE Psychologist, a Poumanaaki Cultural Support worker, two Clinical Nurse Coordinators, a Clinical Nurse Specialist, and a Charge Nurse Manager. The Unit had vacancies for two RNs and two HCAs.

Nursing staff worked a three-shift roster, with a designated staffing level on each shift. The morning shift ran from 7am to 4pm with nine staff, the afternoon shift from 2.30pm to 11.35pm also with nine staff, and the night shift from 10.40pm to 7.05am with five staff.[30]

Data provided by the Unit showed that between 2019/20 and 2020/2021, nursing staff turnover had increased from zero to 4.9 percent. Data showed that 51 percent of RNs had worked on the Unit for more than five years and the average RN sickness rate for the Unit for the 2020/2021 period was 7.4 percent.

Staff told my Inspectors that the Unit had not had a permanent consultant for a considerable period of time. Some staff said the lack of a permanent consultant made it difficult to ensure continuity of care for tāngata whai ora. Inspectors were informed that a permanent consultant had been recruited, and I look forward to seeing the impact of this on the care and recovery of tāngata whai ora.

Staff my Inspectors spoke with said they generally felt safe on the Unit, and some said there had been an improvement on the Unit with regard to staff safety, particularly during the six-month period prior to my inspection. Many staff attributed this to strong leadership on the Unit, a supportive culture among staff on the Unit, and a shift towards more reflective practice.

Between 1 September 2020 and 28 February 2021, there were seven physical assaults on staff members on the Unit. Although any assault on staff is concerning, I am pleased to hear that staff generally felt supported and safe.

Staff were complimentary and appreciative of the leadership and management of the Unit.

Recommendations – staff

I have no recommendations to make.

[30] Staff rostered on each shift were a mixture of RNs, ENs and HCAs.

Acknowledgements

I appreciate the full co-operation extended by the Unit and staff to the Inspectors during their inspection of the Unit, and I acknowledge the work involved in collating the information requested.

I also thank the tāngata whai ora on the Unit during the inspection for their participation and assistance.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 3: List of people who spoke with Inspectors

Managers	Unit staff	Others
Charge Nurse Manager General Manager, Mental Health, Addictions and Disability Support Services	Clinical Nurse Specialist Clinical Nurse Coordinator Registered Nurses Medical Officer Special Scale Occupational Therapist Social Workers Consultant Psychiatrist Health Care Assistants Registrar Patient Safety and Security Worker Clinical Psychologist Poumanaaki Cultural Support Worker	Tāngata whai ora District Inspector

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 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 – health and disability facilities

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…*
>
> *(e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003…"*

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including hospitals and the secure facilities identified above.

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