OPCAT Report

Report on an unannounced inspection of the Fraser McDonald Unit, Auckland District Health Board, under the Crimes of Torture Act 1989

February 2022

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Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report of an unannounced inspection of Fraser McDonald Unit under the Crimes of Torture Act 1989

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Contents

Contents 5

Executive summary 1
Background 1
Initial feedback to Facility from the physical inspection 1
Recommendations 2
Feedback meeting 2

Facility facts 3
Fraser McDonald Unit, Auckland City Hospital 3
District Health Board 3
Previous inspections 3

The inspection 4
Inspection methodology 4

Safety 5
Detention status 5
Provision for voluntary patients to give informed consent 5
Restrictions 7
Safeguarding 7
Complaints 7
Recommendations – safety 9

Healthcare and treatment 9
Discharge planning and transfer of care 9
Recommendations – healthcare and treatment 10

Decency, dignity and respect 10
Unit environment 10
The main outdoor area 11
Culture 11
Māori cultural services including te reo interpretation 11
Recommendations – decency, dignity and respect 12

Leadership and culture 12
Specialist staffing 12
Recommendations – leadership and culture 12

Acknowledgements 13

Appendix 1. List of documents reviewed by Inspectors 14

Appendix 2. List of people who spoke with Inspectors 15
Appendix 3. Legislative framework 16

Tables

Table 1: List of people who spoke with Inspectors 15

Executive summary

Background

Ombudsmen are designated 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 patients detained in secure units within New Zealand hospitals.

From 21 to 25 June 2021 (inclusive), Inspectors[1] — whom I have authorised to carry out visits to places of detention under COTA on my behalf — made an unannounced inspection of the Fraser McDonald Unit, which is located in the grounds of Auckland City Hospital.

Initial feedback to Facility from the physical inspection

Inspectors provided initial feedback to the Facility immediately after the inspection. This feedback was:

- staff treated patients with dignity and respect, and spoke about the patients in a respectful way;
- interpreters were used in a timely way, as and when required;
- a project was underway to provide access to te reo Māori interpretation and cultural services for patients;
- the Unit proactively planned patient reintegration back into the community;
- the Unit's leadership made a positive contribution to the care of the patients through their culture of continuous improvement.

The issues that need addressing are:

- there was no record indicating that voluntary patients or their authorised representatives[2] had consented to being in a secure unit;
- there was no clear distinction between restrictions placed on patients who were admitted to the Unit on a voluntary basis and those who were admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1992;
- there was no anonymous way for patients and their whānau[3] to make a complaint.

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[1] When the term Inspectors is used, it refers to the inspection team including the OPCAT Manager, Senior Inspectors, and Inspectors.

[2] A patient's authorised representative may be their Enduring Power of Attorney or Welfare Guardian.

[3] This document refers to whānau rather than family. In Te Ao Māori, whānau encompasses family in the fullest meaning. Whānau may include immediate and extended family, whakapapa (genealogy), as well as all persons connected by emotional or spiritual bonds. Any person who has been involved in the care or welfare of a patient may also be considered whānau (kaupapa whānau).

Recommendations

I recommend that:

1. The Unit works with the Auckland District Health Board to develop a policy and procedure to ensure voluntary patients are fully informed about what it means to be in a locked unit, and their informed consent to be in the Unit is sought and recorded.
2. The Unit puts in place processes to enable voluntary patients to leave the Unit freely and safely, and informs voluntary patients and their whānau of these processes.
3. The Unit ensures patients are provided with access to Māori cultural services, including experts in te reo Māori and tikanga Māori.

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 Auckland District Health Board and the Unit’s leadership team, to summarise their initial observations.

Facility facts

Fraser McDonald Unit, Auckland City Hospital

The Fraser McDonald Unit (the Unit) is a 15-bed mental health unit for adults over 65 years of age who live in Auckland City. The Unit offers a 24-hour service that provides specialist assessment and treatment to people experiencing an acute episode of mental illness. The Unit seeks to return its patients to community-based care as soon as possible.

Voluntary patients could also be accommodated in the Unit. My expectation is that voluntary patients' informed consent forms the basis for their placement in the Unit. However, I found no record in these patients' files of the basis for their detention as a voluntary patient. This included no record that any voluntary patient had been informed of their legal detention status and had given their informed consent to be in a locked ward. These issues raise questions about the lawful authority for voluntary patients to remain in the Unit and receive treatment, and their ability to leave at will. There are substantial barriers to the ability of voluntary patients to leave the facility which amounts to them being 'deprived of their liberty' for the purposes of my OPCAT role. I discuss my concerns in more detail on pages 5 and 6.

District Health Board

Auckland District Health Board

Previous inspections

Announced inspection – December 2008

Unannounced inspection – March 2015

The inspection

Inspectors conducted the inspection of the Unit from 21 to 25 June 2021. On the first day of the inspection, there were 12 patients in the Unit. The average length of stay was 21 days.

Inspection methodology

The physical inspection[4] spanned five days – Monday 21 June to Friday 25 June 2021 (inclusive). It included a tour of the facility, formal interviews, reviewing six patient clinical records; and observing operational meetings, hearings held under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act), and interactions between staff and patients. Interviews were undertaken with the Facility Manager, the Nurse Unit Manager, staff involved with the management of the Unit and patient care, and whānau. Inspectors also spoke with patients.

The inspection also included remote inspection activity reviewing operating policies, plans, and incident data; and conducting interviews with staff and whānau. A full list of the documents reviewed is attached as Appendix 1.[5]

The Unit received a copy of my provisional report and was invited to comment. The Auckland District Health Board (ADHB) has responded to my report, and I appreciate their efforts to address the issues identified during the inspection and documented in my provisional report. I have taken their feedback into consideration when preparing my final report.

4 The physical inspection was conducted on-site at the Unit.

5 For a list of people Inspectors spoke with, see Appendix 2.

Inspection focus

Four main 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 patients.[6] These areas were:

- **Safety**, including detention status, restrictions, and safeguarding (complaints);
- **Healthcare and treatment**, including discharge planning and transfer of care;
- **Decency, dignity and respect**, including the Unit's environment and culture;
- **Leadership and culture**, including specialist staffing.

Safety

My expectation is that residents are safe and their independence is nurtured by the Unit's environment and culture. This includes no person being arbitrarily deprived of their liberty, and thorough assessment and legal processes being followed. I expect patients to be involved in these processes to the fullest extent possible.

Detention status

Inspectors were informed that five of the twelve patients in the Unit at the time of the inspection had been admitted to the Unit on a voluntary basis, which meant they were under no legal compulsion to remain in the Unit and receive treatment. My Inspectors observed no record in these patients' files of the basis for their detention as a voluntary patient. This included no record that any voluntary patient had been informed of their legal detention status and had given their informed consent to be in a locked ward. By comparison, on the files of patients detained under the Mental Health Act Inspectors saw comprehensive paperwork containing the relevant documents.

Inspectors saw only one document that referred to 'voluntary service users', the ADHB document *Detention of Voluntary Service Users PP40/RBP/007 – v07.00*. The document applied to people who had already been admitted voluntarily to hospital under section 111 of the Mental Health Act, where a person is reasonably believed to be mentally disordered.

Provision for voluntary patients to give informed consent

Staff told Inspectors, '[Consent for voluntary patients to be in a locked unit] *may be discussed at the time of admission, but this is not something that is part of a policy and possibly comes down to the practice of the clinician admitting the patient. It may not be recorded formally in*

6 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.

the notes. There is no consent form at present that an informal patient would sign prior to coming to FMU [the Unit] or after arriving at FMU.'

In responding to my provisional report the ADHB accepted the need for consent to be recorded. The ADHB provided their 'Informed consent' policy. They advised that informed consent is discussed with, and obtained from, voluntary patients during the admission process. However, it is concerning that consent does not appear to be documented or recorded for voluntary patients.

As voluntary patients are under no legal compulsion to remain in the Unit, informed consent provides the lawful authority for a voluntary patient to remain in the Unit and receive treatment. I expect the Unit to ensure each voluntary patient has been provided with the opportunity to give their informed consent[7] to be in a locked unit, and to record this. This means that before giving their consent to stay in the Unit as a voluntary patient, the patient should be provided with information and be able to understand what being a voluntary patient in the Unit means and how they can expect to be treated. This includes understanding any restrictions that may be placed on them while in the Unit, including how they can leave the Unit, communicate with friends and whānau and the wider outside world, and access visitors and their personal items.

Consent may be revoked at any time by a voluntary patient. I expect the Unit to work with the ADHB to develop a policy and procedure to ensure voluntary patients are fully informed about what it means to be in a locked unit, and their informed consent is given and recorded. Appropriate procedures must be in place to allow this to occur. ADHB has responded to my provisional report stating, *'ADHB Mental Health Services agrees with the Ombudsman's recommendation that it develop a policy and procedure to ensure voluntary patients are fully informed about what it means to be in a locked unit, and their informed consent is given and recorded.'* Such procedures are particularly important, as voluntary patients are not protected by the other legal safeguards for patients detained under the Mental Health Act, such as oversight of the District Inspectors.[8]

I expect placement of voluntary patients in locked units to be subject to regular review. Where placement is not appropriate eg, consent has not been obtained from the patient or their authorised representative, this must be addressed. In my view, voluntary patients should not be detained if they haven't consented to being in a locked ward.

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[7] Informed consent requires the patient to have the capacity to consent which means they are provided with information and are able to understand the nature and effects of what is being proposed, its purpose, the likelihood of success, and any possible alternatives. They should also be provided with information about, and be able to understand, the possible consequences for them of consenting to and taking part in what is proposed, and be able to communicate their decision. Informed consent should be voluntary and include reasonable opportunity to deliberate about the information provided.

[8] District Inspectors are lawyers appointed by the Minister to protect the rights of people receiving treatment under the Mental Health Act or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. See: https://www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-legislation/mental-health-compulsory-assessment-and-treatment-act-1992/mental-health-district-inspectors [accessed on 17 June 2021]

ADHB has acknowledged that improvements can and should be made to the practice of recording consent and that a policy regarding this would be helpful.

Restrictions

My expectation is that patients are not subject to greater restrictions than are individually necessary for their safety and that of others.

Information for patients and their whānau was provided verbally by staff on each patient's admission (including for voluntary patients about how to leave the unit), through posters displayed in the Unit, and in a booklet entitled *Fraser McDonald Unit Information for Patients* (the Unit's patient information booklet).

The Unit's patient information booklet outlined the rights of patients detained in the Unit under the Mental Health Act. However, no written information was provided for voluntary patients about their rights, for example, their right to leave the Unit at will; access independent advice, advocacy and support; provide consent or withdraw consent to treatment; and access their personal items. My Inspectors also did not see any signage informing patients and their whānau about a process for voluntary patients to leave the Unit. As noted above, I expect voluntary patients to be fully informed about what it means to be in a locked unit.

Voluntary patients have a fundamentally different legal status to people detained under the Mental Health Act. I expect the Unit to consider how it can work with patients and their whānau to enable patients to leave the Unit freely and safely.

ADHB Mental Health services has accepted there is a need to put in place a clearer process to enable voluntary patients to leave the Unit, and that patients and their whānau should be informed of this process.

Safeguarding

Safeguards include ensuring residents are listened to when they raise concerns or make complaints, and their views are taken seriously and responded to sensitively. With this in mind, my Inspectors were interested in whether complaints processes in the Unit were accessible, well communicated, timely, and effective.

Complaints

Inspectors observed information about how to make a complaint displayed on posters, in pamphlets, and in the Unit's patient information booklet. The Unit's patient information booklet stated that in the first instance any issues should be directed *'to the nurse in charge on duty or in business hours, the Charge Nurse … so that we can try and resolve the matter quickly and to your satisfaction'*. Staff told Inspectors that on receipt of a complaint, they determined whether an issue was a '*formal or informal complaint'*. Formal complaints were forwarded to the Consumer Liaison Team, and staff managed any informal complaints.

Inspectors saw evidence in patient files where patients’ whānau raised concerns and complaints about the care and treatment of their whānau member. The issues raised had been managed and resolved informally by staff, in communication with whānau.

Inspectors were provided with the ADHB’s ‘Consumer Complaint Management’ policy which outlined the complaints process. In responding to my provisional report the ADHB stated, *The Consumer Experience team [previously called the Consumer Liaison Team] keeps a record of all complaints and creates complaint files, which contain responses to complaints and documentation of actions taken to address complaints. The complaints process sets out how complaints will be actioned and by whom and the pathway of escalation of complaints within ADHB.*

Ability to raise matters confidentially

Inspectors did not see any complaints forms or a complaints box in the Unit. Staff told Inspectors there had been a complaints box in the Unit, but it had been removed during a renovation and had not been replaced. Staff said they felt a complaints box *‘was not the best way to capture complaints or feedback’* and a project to review the Unit’s complaints process was to get underway.

Additionally, if patients needed to make a phone call about an issue and did not have their own or a whānau member’s mobile phone to use, they had to use a phone that was kept at the nurses’ station, potentially compromising the privacy of the phone call. These aspects limited the ability of patients and their whānau to make a complaint independently of staff. Whānau said they were confident about making a complaint if necessary, although they were unclear of how they could do so independently or anonymously.

I appreciate a project is planned to review the Unit’s complaints process. However, in the meantime, a complaints box would provide a way for patients and their whānau to make anonymous complaints independently of staff. I encourage any review of the Unit’s complaints process to ensure patients and their whānau are informed about how they can make a complaint anonymously and independently of staff, all complaints and the actions taken to address them are recorded, and a clear pathway of escalation is identified.

The ADHB has stated, *‘It is accepted that patients or their whanau may not wish to make complaints directly to FMU staff involved in the patient’s care. This is why the ADHB complaints process provides for complaints to be made directly to the Consumer Liaison team (now called the Consumer Experience team) if the complainant prefers, and for complaints to be made confidentially or anonymously. The noticeboard on the ward in FMU contains advice about contacting the ADHB Consumer Liaison team and their number. A poster about how to make complaints to the Health and Disability Commissioner is also on this noticeboard.*

It is correct there is no complaints form for patients and whānau, however complaints can be accepted in any form, including by email or telephone to ADHB’s Consumer Experience team. Most complaints are transmitted to ADHB’s Consumer Experience team by email, which appears to be the mode accessible to most people. There are also plans to enable patients and

whānau to submit complaints to the ADHB Consumer Experience team via a form on the ADHB website.

ADHB Mental Health Services agrees that the ADHB complaints process should be made more visible to FMU patients and their whanau and this will be addressed.' I am pleased to learn this. I acknowledge ADHB has a detailed policy for managing complaints. I encourage the ADHB to work with the Unit to make it as easy as possible for patients and their whānau to make complaints confidentially. While I am pleased to learn of the additional steps the ADHB is taking, I understand that not all patients will have access to devices to make complaints electronically. Therefore, I consider hard copy complaints forms and a suggestions box in the Unit to be an easily accessible option for patients and their whānau. I am pleased to learn that complaints can be made by phone. However, I understand patients may not have independent access to a phone in private.

Recommendations – safety

I recommend that:

1. The Unit works with the Auckland District Health Board to develop a policy and procedure to ensure voluntary patients are fully informed about what it means to be in a locked unit, and their informed consent to be in the Unit is sought and recorded.
2. The Unit puts in place processes to enable voluntary patients to leave the Unit freely and safely, and informs voluntary patients and their whānau of the processes.

Healthcare and treatment

I expect patients' participation and preferences to be central to the care planning for them. Patients and their whānau (as appropriate) must be given the time and assistance to understand and contribute to their planned care, which includes thinking about and planning for the future.

Discharge planning and transfer of care

My Inspectors observed the Unit's discharge planning to be thorough, timely, and have a patient-centric focus. During multi-disciplinary team meetings, staff involved in a patient's care spoke in a respectful way about the discharge arrangements for each patient. This included discussion of the patient's progress and the different aspects of their treatment, clinical and therapeutic, in which each staff member was involved. Staff appeared to consider the individual preferences of each patient, including their cultural needs, and to consult with patients' whānau frequently.

Inspectors were informed of a patient who was ready to be discharged and wanted to live independently. However, the condition of the patient's home had been assessed as being unsafe for them to live in independently. Inspectors were told that staff were working with

Kāinga Ora – Homes and Communities[9] to consider either preparing the patient's home to be fit for purpose, or exploring the option of a new apartment for the patient. While this was underway, the Unit had arranged and paid for two weeks of respite care for the patient at a privately run rest home.

Inspectors learned that as part of a patient's transition from the Unit, staff would sometimes arrange overnight leave for the patient in the new environment in which they would be living, so they could gradually adjust to the change of environment. A staff member told Inspectors that patients rarely returned to the Unit. They said this was because of the comprehensive discharge planning that included integrating services provided by community mental health providers. I am pleased to learn of the Unit's patient focused approach to discharge planning for each patient that considered clinical and therapeutic aspects.

Recommendations – healthcare and treatment

I have no recommendations to make.

Decency, dignity and respect

Inspectors observed that staff treated patients with dignity and respect and spoke about them in a respectful way. Inspectors were told staff had listened to feedback from patients and their whānau and made improvements to the Unit as a result of this. These improvements included the addition of a Zen garden at the Unit, and a mindfulness space in the occupational therapy room. I commend the staff for this responsive, positive action for the benefit of patients, their whānau, and staff in the Unit.

Unit environment

The Unit is located in the grounds of Auckland City Hospital. Inspectors observed the entrance to the Unit was locked and monitored by CCTV. Entry to the Unit was via a buzzer system and a staff member would unlock the door. Inspectors were informed this entry process had been put in place during the COVID-19 lockdown of March to May 2020. However, it was not clear why the entry door remained locked. Visitors to the Unit could enter the area where patients were being treated by pressing a *'release button'*. Inspectors were informed patients had to approach staff to be able to access the Unit's Zen garden and mindfulness space in the occupational therapy and activity room.

I encourage the Unit to consider how it can ensure patients are able to move around the Unit in a way that promotes their wellbeing, dignity, and independence, and provides ready access to the outdoors. As mentioned earlier in this report, I also expect the Unit to ensure that voluntary patients are able to leave the Unit freely and safely.

[9] Kāinga Ora – Homes and Communities brings together the people, capabilities and resources of the KiwiBuild Unit, Housing New Zealand and its development subsidiary HLC, https://kaingaora.govt.nz/about-us/who-we-are/ [accessed 11 August 2021]

The main outdoor area

The patio leading to the main outdoor area was equipped with an outdoor table and chairs and a barbecue. The patio was surrounded by a high metal fence, and Inspectors were told this was to prevent patients from using the furniture to scale the fence. Inspectors were also told a couch in the high dependency unit could be taken outside for patients to use. The couch was taken on to the patio during the inspection.

Inspectors observed a ramp led down to a grassed area with a walking loop track that patients were using. A staff member was always seen to be with each patient when they were outside, reducing any health and safety risks to the patients, such as falls. Inspectors observed the Unit was adequately staffed for patients to be accompanied by staff in the outdoor area.

Culture

Language is central to a patient's cultural identity and their well-being. My expectation is that professional interpretation services are used as often as needed so each patient can speak in whatever language they choose, or which comes naturally to them.

Māori cultural services including te reo interpretation

Inspectors saw evidence of interpreters being accessed for non-English speaking patients. However, for Māori patients, staff said the Unit relied on the availability of particular staff with expertise in te reo Māori and tikanga Māori. Those staff were employed in the wider ADHB Mental Health and Addictions Services and were not always available to support the Unit's patients. Unit staff told Inspectors they would like to see more designated staff with expertise in te reo Māori and tikanga Māori integrated into the Unit.

Staff told Inspectors a project was underway to connect the ADHB inpatient mental health services so experts in te reo Māori and tikanga Māori would be more accessible to the Unit and other units. I am pleased that some consideration is being given to enabling patients to access Māori cultural and language services. I expect patients to have access to staff who can converse in te reo Māori and staff who have an understanding of how to incorporate tikanga Māori practice into a patient's care and treatment.

Recommendations – decency, dignity and respect

I recommend that:

4. The Unit ensures patients are provided with access to Māori cultural services, including experts in te reo Māori and tikanga Māori.

Leadership and culture

Inspectors observed staff working as a team, with respectful and collaborative discussions informing the planning and implementation of patient care and treatment. All staff, including physiotherapy and occupational therapy staff, contributed to the development of care plans and discharge plans for patients.

The Unit had a culture of continuous improvement. This was evidenced by the Unit tracking progress in particular areas on a board entitled, *'Knowing how we are doing'*. As mentioned elsewhere in this report, feedback from patients and whānau had led to improvements being made at the Unit, including the creation of a Zen garden and a mindfulness space in the occupational therapy room.

Specialist staffing

Management at the ADHB were aware of, and seeking to address, the lack of access to te reo Māori speakers and tikanga Māori experts (covered elsewhere in this report) for patients. The ADHB's document *Te Tiriti O Waitangi (Treaty of Waitangi)* outlines the *'Te Tiriti o Waitangi (Treaty of Waitangi) obligations and responsibilities of the Auckland District Health Board (ADHB)'* including the provision of *'services that are responsive to Maori needs and interests'.* Based on the information gathered, I consider these services are not being adequately provided to this Unit. I expect progress to be made in this area and I have made a recommendation about this elsewhere in my report.

Recommendations – leadership and culture

I have no recommendations to make.

Acknowledgements

I appreciate the full co-operation extended by the Facility Manager and staff to the Inspectors during their inspection of the Unit. I am also grateful to the patients at the time of the inspection and their whānau, in particular those who took the time to speak to my Inspectors. I also acknowledge the work involved in collating the information requested.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of documents reviewed by Inspectors

Inspectors reviewed the following information during the inspection:

- Absent Without Leave (AWOL) or Absence Causing Concern (ACC) Policy
- ADHB Website - Manawanui Oranga Hinengaro
- Clinical Record Management Policy
- Code Orange Policy
- Complaints to the Police Policy
- Consumer Complaint Management Policy
- Consumer Participation Policy
- Covert Administration of Medication – Fraser McDonald Unit Policy
- Detention of Voluntary Service Users Policy
- Family/ Whānau Consultation & information Sharing Requirements Policy
- Family – Whānau Participation Policy
- Fraser McDonald Unit – Information for Patients Pamphlet
- Patient Demographic List
- Patient files
- Restraint Minimisation and Safe Practice in Mental Health Policy
- Seclusion in Mental Health Policy
- Service Level Agreement Between Auckland City Policy District and Mental Health and Addictions Directorate – ADHB
- Te Tiriti O Waitangi (Treaty of Waitangi) Policy
- Valuables Safe Custody and Management Clinical Guideline
- Valuables, Property and Taonga – Te Whetu Tawera (TWT) Policy
- Your Rights Pamphlet (ADHB)

Appendix 2. List of people who spoke with Inspectors

Table 1: List of people who spoke with Inspectors

Managers	Ward staff	Key people
Operations Manager	Charge Nurse	Patients
Nurse Unit Manager	Director Mental Health Services	Whānau
Nurse Director Mental Health	Director of Mental Health and Addictions Services (Māori)	
	District Inspector	
	Mental Health Assistant	
	Occupational Therapist	
	Psychogeriatrician	
	Psychiatrist	
	Physiotherapist	
	Registered Nurse	
	Social Worker	

Appendix 3. 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…*
>
> *(d) a hospital*
>
> *(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.