Ombudsman

Fairness for all

OPCAT Report

Thematic report on inspections of secure intellectual disability facilities under the Crimes of Torture Act 1989

April 2022

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Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

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Introduction

New Zealand has international human rights obligations under the United Nations Optional Protocol to the Convention against Torture (OPCAT) [1] to prevent torture and other cruel, inhuman or degrading treatment and punishment. As part of OPCAT, there is a requirement for New Zealand to have an independent inspection programme of places of detention (where people are not free to leave at will).

Ombudsmen have been designated by the Minister of Justice to carry out OPCAT inspections of health and disability facilities such as secure residences for people with intellectual disabilities. The preventive purpose of these inspections is to provide independent assurance that the treatment and conditions in these facilities are appropriate, and to provide recommendations for improvement.

In August 2019 my Inspectors began a programme of inspections of 17 secure intellectual disability facilities across six services. I had planned to finish these inspections by early in 2020. However, I reviewed my pre-planned OPCAT programme of inspections and visits in light of COVID-19.[2] As a result, completion of the inspection programme was delayed. Inspections of the residences recommenced at the earliest possible opportunity and were completed in June 2020.

[1] Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. More information about OPCAT and the Chief Ombudsman's National Preventive Mechanism (NPM) function can be found at https://www.ombudsman.parliament.nz/what-we-can-help/monitoring-places-detention/why-ombudsman-monitors-places-detention

[2] See https://uniteforrecovery.govt.nz/assets/resources/legislation-and-key-documents/COVID-19-national-action-plan-2-issued-1-April.pdf for more information about essential services during the Alert Level 4 lockdown.

Executive summary

This report provides a summary of my findings and recommendations in relation to inspections conducted between 14 August 2019 and 4 June 2020 of 17 secure residences where people with intellectual disabilities were detained. At the time of my inspections in June 2020, New Zealand was at COVID-19 Alert Level 2.[3]

Each residence was operated by one of six service providers in locations around Aotearoa New Zealand.

Overall, I found there was significant variation in the treatment and conditions across the residences. I found some positive practices, which I have highlighted in this report, and I made specific recommendations for improvements to five of the six service providers. The service providers and the Ministry of Health were provided with an opportunity to comment on my findings and recommendations.

I emphasise that the issues and recommendations summarised in this report do not apply equally, and in some cases at all, to all the service providers. However, I consider it is important to highlight the practices I found, whether positive or concerning, across the sector. My hope is that this report provides transparency around the issues I consider to be of concern, as well as promoting those positive practices observed, to improve the treatment and conditions for people with intellectual disabilities detained in secure residences.

A note about terminology

I acknowledge the importance of language around disability, and that people have different views on the meaning, accuracy, and effects of particular terms. I have chosen to use the term 'intellectual disability' in this report, and to refer to people living with intellectual disabilities as 'clients and tāngata'.

There is no single definition of 'intellectual disability'. People with intellectual disabilities are a diverse group who may experience challenges understanding new or complex information, learning new skills, and living independently. The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (the IDCCR Act) provides a legal definition[4] and, relevant to this report, a framework for the compulsory care, rehabilitation, and *special rights* of people with intellectual disabilities.

Other terms used to refer to people with intellectual disabilities include 'tāngata whaikaha hinengaro', 'intellectually impaired people', or 'people with a learning disability'.

'Civil clients and tāngata' in this report, means clients or tāngata who have been placed in the facility by the Ministry of Health's Disability Support Services Group, or who have transitioned

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

[4] Section 7.

from a detention order but have not been found suitable alternative accommodation.[5] While those in the second group are not subject to an order made under the IDDCR Act, there are substantial barriers to their ability to leave the facility which, in my view, amounts to their being 'deprived of their liberty' for the purposes of my OPCAT role.

Inspection methodology

To inform my inspection programme of the residences, my Inspectors requested a list of secure residences from the Ministry of Health.

Eight Inspectors, operating in teams of two , conducted 17 inspections between August 2019 and June 2020 of residences in the Northern, Central, Lower North and Southern regions.

The residences were privately owned facilities contracted by the Ministry of Health to provide care and rehabilitative support for people with an intellectual disability who met the criteria under the 'High and Complex Framework' (HCF).

The HCF is the framework of support provided to care recipients[6] detained under the IDCCR Act or Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP)), as well as eligible civil clients who have high and complex behavioural needs that cannot be met within mainstream disability support services.[7,8]

The residences ranged in size, with capacity for between one and 10 clients and tāngata. In some instances, the operating capacity of the residences included assessment[9] and respite care beds.[10]

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5 In mental health services, the term 'voluntary' or 'informal' is generally used instead of 'civil'.

6 Individuals with an intellectual disability subject to orders under the IDCCR Act are described as 'care recipients'. See: https://www.health.govt.nz/our-work/disability-services/about-disability-support-services/intellectual-disability-compulsory-care-and-rehabilitation-act-2003

7 Ministry of Health, *A Guidance Document: Care and Rehabilitation under the High and Complex Framework,* May 2016.

8 Residential support services for people (generally under 65 years of age) with a long-term physical, intellectual and/or sensory impairment that will require ongoing support. See: https://www.health.govt.nz/our-work/disability-services/about-disability-support-services

9 Assessment beds are managed through Ministry of Health forensic contracts (FCS (ID) to enable it to respond immediately to court directions for placement for assessment. Assessment beds are funded on a capacity basis in order to ensure that they are available when required by FCS (ID). See: https://www.health.govt.nz/system/files/documents/pages/sevice-spec-ridsas-08.pdf

10 In the context of disability support, respite aims to provide families/whānau or carers with a planned, temporary break from caring for a person with a disability. The primary purpose of respite is to relieve carer stress as a way of supporting them to continue in their caring role. A break can be for a few hours, a day, overnight or longer and may take place in or away from the family home. See: https://www.health.govt.nz/system/files/documents/publications/transforming-respite-dss-respite-strategy-2017-2022_0.pdf

The teams were on site at each facility for short periods, usually between two and four hours. The inspections were a combination of unannounced and announced visits.

The teams reviewed records and spoke to staff and, where possible, clients and tāngata as part of the inspection process. The teams also spoke to whānau.

Feedback

The service providers and the Ministry of Health were invited to comment on a draft of this report before it was finalised.

I thank the service providers and the Ministry of Health for their consideration and feedback, including on my individual reports. I have had regard to all feedback received when preparing my final report.

Key observations

There were a number of key themes and observations that arose from my inspections regarding the treatment and conditions of people in the residences. These themes and observations are discussed below. I also wish to raise an additional issue relating to the identification and recording of secure residences.

Identification and recording of secure residences

As noted above, my Inspectors requested a list of secure residences from the Ministry of Health. When my Inspectors were carrying out inspections, they found that the list was not always accurate in categorising whether a residence was secure or not. My Inspectors were also made aware of further secure residences during the course of the inspections, but which did not appear on the list provided to my Inspectors.

My Inspectors heard from staff in the residences that the designations could change frequently depending on the client and tāngata group. Staff also had a variety of different understandings of what constituted ‘secure’.

I acknowledge that this is a large, dynamic sector with many challenges. The status of residences may therefore regularly change, subject to the specific requirements of clients and tāngata. However, I expect the systems in place to be capable of accurately identifying which residences are secure and, therefore, how many people are detained at any one time.

In response to my provisional report, the Ministry of Health said that:

> *The Ministry holds up-to-date information regarding the placement of all care recipients. While there are usually specific houses within RIDSAS providers that primarily provide secure placements, there will also be other RIDSAS houses that can be designated as secure facilities by the care coordinator where required… Any*

> *change of status will be documented by the forensic coordination service and forwarded to the Ministry to ensure that records are up to date.*

I appreciate the Ministry's response and I expect to closely monitor this process as part of future inspections.

Civil clients and tāngata in secure residences

Over the course of the inspections, my Inspectors observed that 20 civil clients and tāngata were residing across nine of the residences.

The residences were locked and had controlled points of entry. Civil clients and tāngata could not unlock external doors, required staff assistance and accompaniment to leave, and in most residences, would be treated as absent without leave if they decided to leave temporarily without permission. I therefore consider that there were considerable restrictions, which meant civil clients and tāngata were not free to leave the residences at will.

Some civil clients and tāngata had previously transitioned from a detaining order[11] but remained in the residences due to lack of other suitable accommodation.[12] Other civil clients and tāngata had never been detained in a secure residence under a detaining order.

I have significant concerns that some civil clients and tāngata are being held in secure and highly restrictive environments due to the lack of other suitable accommodation.

My concerns about civil clients centre on three key issues:

- Informed consent to remain in a secure residence;
- Restrictive practices imposed on civil clients and tāngata; and
- Transition planning for civil clients and tāngata.

I also discuss my concerns about restrictive practices imposed upon all clients and tāngata below.

Informed consent to remain in a secure residence

There is clear lawful authority to detain clients and tāngata subject to a court order under the IDCCR Act.

However, the situation is less clear when clients and tāngata are not subject to an order, or have recently transitioned from such an order. As civil clients and tāngata are not subject to a detaining order they are under no legal compulsion to remain in a residence. In these circumstances, informed consent would potentially provide lawful authority for civil clients and tāngata to remain in a secure residence.

[11] A legal order under the IDCCR Act or any other Act.

[12] This was evidenced through conversations with staff and civil clients, and documented in civil clients' '*Care and Rehabilitation Plans*'.

Civil client and tāngata consent must be fully informed and carefully sought. Consent should be obtained prior to a civil client or tangata being detained in a secure residence, whether they are transitioning from a court order or new to the residence. Accurate and timely records of informed consent must be kept and reviewed regularly. In my view, such a review should take place at least every three months. Consent must also be able to be revoked at any time by the civil client and procedures must be in place to allow this to occur.

I found that civil client and tāngata consent was not routinely sought or recorded across the residences. At the time of the inspections, I found no evidence that procedures were in place to allow for consent to be reviewed and revoked.

Furthermore, Inspectors observed that processes to facilitate the ability of civil clients and tāngata to leave were generally informal and were not recorded or documented. Locked internal and/or external doors also restricted civil clients and tāngtata access to their environment at three of the services, which Inspectors identified as environmental restraint.[13] There were not robust processes in place to record and document these restrictions.

I consider that the apparent lack of procedures to allow for civil clients' and tāngata consent to be reviewed and revoked, and the lack of processes to ensure that civil clients and tāngata could leave the residences, presents a risk that they were being arbitrarily detained in some residences.[14]

The underlying purpose of the right not to be arbitrarily detained is to protect human dignity, autonomy and liberty.[15] People with intellectual disabilities have no lesser claim to these rights.

I considered that these issues require urgent attention by the residences, the service providers and the Ministry of Health. I wrote to the Ministry of Health in May 2021 to raise my concerns and seek further information relating to the treatment of civil clients and tāngata.[16] The Ministry of Health said it does not generally support civil clients being housed in secure facilities, but understands that in some instances civil clients and tāngata need an intensive level of support. The Ministry of Health agreed that there need to be robust processes around consent. The Ministry of Health noted it would follow up with the service providers around this issue.

In response to my provisional report, the Ministry again indicated that it agreed with my concerns, saying:

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[13] Environmental restraint is where a service provider intentionally restricts a client's normal access to their environment for example where a client's access to their environment is intentionally restricted by locking a door. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards*. Ministry of Health. 2008.

[14] See *Neilsen v Attorney-General* [2001] 3 NZLR 433; (2001) 5 HRNZ 334 (CA). The Court of Appeal has held that a detention may be "arbitrary if it is capricious, unreasoned, without reasonable cause: if it is made without reference to an adequate determining principle or without following proper procedures".

[15] *R v Briggs* [2009] NZCA 244 at [85] per Arnold J.

[16] The correspondence also related to voluntary service users in the context of secure mental health facilities.

> *The Ministry does not generally support civil clients being housed in secure facilities in a manner that subjects them to overly restrictive practices. We agree that where civil clients are placed in houses with secure clients that there needs to be robust processes to ensure that they are not unnecessarily subjected to restrictive practices. …Issues of consent will be reviewed at regular six-monthly reviews when both specialist assessors and care coordinators talk to individuals about how they feel about living in the service, and their future plans and goals, ensuring that they understand that they are in the service by choice.*
>
> *We also expect that any placement of civil clients in secure facilities is subject to regular review and that individuals are transitioned out of secure services as soon as possible.*

I am encouraged to hear the views expressed by the Ministry and look forward to seeing progress in the Ministry's efforts following up with individual service providers.

Restrictive practices imposed on civil clients and tāngata

My Inspectors identified in a number of the residences that civil clients and tāngata were subject to the same restrictions as people detained under a court order. For example:

- In one residence, my Inspectors saw that civil clients did not have free access to their mobile phones, medication, or cigarettes. If clients wanted to access these items, they needed to seek staff permission, and a staff member would retrieve them from a locked cabinet in the office.
- For one service provider, prescriptive bedtime regimes were placed on tāngata across all its residences (see further discussion below on page 9).

I am concerned that civil clients were effectively subject to the same restrictions as those clients and tāngata subject to an order under the IDCCR Act. In my view, civil clients and tāngata have a fundamentally different legal status from those detained under the IDCCR Act, and should not be subject to the same restrictions.

I acknowledge there may be individual civil clients and tāngata who, in particular circumstances, require the same level of restrictions as someone under the IDCCR Act. However, these must be demonstrably justifiable on a case-by-case basis. Any such restrictions should be reviewed regularly to ensure they last for no longer than is reasonably necessary.

I recommended to four service providers that civil clients and tāngata are not subject to the same restrictions as clients and tāngata under court orders, unless it is demonstrably justified and for no longer than reasonably necessary. Three service providers accepted my recommendation and indicated they would take steps to implement it by, for example, ongoing review of clients' and tāngata files to determine if restrictions are justified, as well as reminding clients and tāngata and staff. One of the service providers partially accepted my recommendation, indicating that it is difficult in practice to separate civil clients and tāngata from those under compulsory orders.

The Ministry of Health indicated that it would follow up with the service providers to make sure these issues are addressed. In response to my provisional thematic report, the Ministry also noted that:

> *It is important to note that whilst some clients are not care recipients, they may be subject to a range of other legal orders that require a level of compulsion. It would be worth considering the delineation of those described as civil in future reports.*

I acknowledge the point made by the Ministry of Health and will consider this as part of any future work.

Transition planning for civil clients and tāngata

Some civil clients and tāngata may continue to remain in secure residences as part of their transition process from a detaining order to mainstream disability support services. Where this is the case, there should be a comprehensive transition plan, outlining how the service provider will support the resident to move from secure to mainstream disability support services.

While I acknowledge the complexities in sourcing suitable accommodation for civil clients in mainstream support services, I do not consider this in and of itself to be sufficient justification for civil clients to remain in secure residences.

Restrictive practices in secure residences

As well as restrictive practices placed on civil clients and tāngata, I found evidence of further restrictive practices for all clients and tāngata in some residences. For example, I found that:

- Toiletries were locked away and accessible only on request in some residences.
- Clients and tāngata did not have access to their shoes in one residence.

At one service provider, staff were not able to provide Inspectors a clear rationale for restrictive practices, and stated that *'it's always been like this'*. Another service provider, in response to my provisional report, highlighted security concerns in relation to independent access to toiletries. The service provider stated that:

> *Staff have been threatened with toothbrushes, hair brushes and combs, broken off and used as a weapon. Spray deodorants have been used for huffing. Toothpaste and soap have been used to block key holes. Razors have been taken apart and been used to self-harm and when threatening others. These have been replaced with electric razors, however, these have needed to be checked when handed back as there have been attempts to remove parts to use for other purposes.*

I acknowledge that there may be safety concerns in relation to accessing some items. However, my concern is with blanket approaches taken which disadvantage all clients regardless of their individual circumstances. My expectation is that restrictions are only put in place where strictly necessary on the basis of specific, individual risk, rather than by way of a general rule which must be disproved on a case-by-case basis. I acknowledge that some service

providers were already doing so, for example by having individualised telephone protocols in place.

In response to my provisional thematic report, I was informed by the relevant service provider that my report had given them time to reflect and that they *'… agreed that a blanket approach is not ideal for those living in the secure home and moving forward these restrictions will only be put in place were strictly necessary'.* I am grateful to the service provider for reconsidering its approach and look forward to seeing a risk-based, case-by-case assessment of restrictions in future.

As noted above, I also found that prescriptive bedtime regimes were placed on clients and tāngata across one service provider. Bedtimes varied between the specific residences, ranging from 8:30pm to 9:00pm weekdays and, in some cases, extended to 9:30pm on the weekends. Such bedtime regimes are counter-intuitive to supporting the independence of clients and tāngata and their right to choose for themselves. As such, I consider the blanket prescriptive bedtime regimes were unjustified for clients and tāngata regardless of their legal status.

Standard of accommodation

Residences are homes for clients and tāngata, sometimes for a prolonged period of time. They should, in all ways, feel and look as such. I found that the standard of accommodation varied across the residences.

Generally, I found residences were clean and well-maintained. Further, the accommodation in some residences was of a high standard. The common features of these residences were good levels of natural light, comfortable furnishings, adequate ventilation and an ability to personalise bedrooms.

However, I found two residences were not appropriate for their purpose. Despite natural light in some areas, these two residences felt dark due to their narrow layout and, in one residence, the presence of large dark panels covering the walls. The furnishings in one of these residences were not comfortable, and the courtyard was uninviting, concreted, and had no plants or seating.

In another residence, the standard of hygiene was poor in the bedrooms, living areas and hallways. Carpets were badly stained, and there was a considerable amount of cobwebs in the communal dining area, lounge and hallways. The furniture and furnishings were also in a poor state of hygiene and repair. Mattresses were old and soiled, some beds had no legs and the base of the bed lay directly on the floor.

All people detained in secure residences should experience a high standard of accommodation. I was disappointed to see this was not the case at all the residences I inspected and, where necessary, I recommended action to ensure accommodation was well-maintained, appropriate and fit for purpose. I expect to see a consistently high standard of accommodation across the country. The three service providers to whom I made relevant recommendations for improvement accepted my recommendations.

Cultural and spiritual support

Cultural and spiritual support were available in some way in all residences. at one service provider, clients and tāngata were offered cultural and spiritual support at each stage of their journey. That service provider made an effort to maintain or reinstate the connection between clients and tāngata and their whānau, hapū and iwi.

However, in residences run by two service providers, I found that the assessment of the cultural or spiritual support needs of clients and tāngata was minimal. In another residence I found that, while cultural advisors were available to clients and tāngata, it was not always clear to clients and tāngata what services cultural advisors could provide.

I welcome and encourage cultural engagement and support for all clients and tāngata. In particular, participation in whānau and wider Māori communities is central to enhanced well-being for clients and tāngata with whakapapa Māori.[17]

In response to the provisional thematic report the Ministry of Health advised:

> *We are engaging in ongoing work and development regarding our model of care under the HCF. The meeting of cultural needs will be a key component to this ongoing work*

I am encouraged to hear this and look forward to seeing how this progresses.

Health costs for compulsorily detained clients and tāngata

For two of the service providers, my Inspectors were told that compulsorily detained clients and tāngata were required to pay for the costs of GP visits and their medication.

I am disappointed that clients and tāngata subject to a detaining order were expected to cover the costs of primary health care services, particularly for GP appointments and prescription medication.

I acknowledge that service-level agreements indicate that generally, GP visits should be paid for by the resident.[18] However, the agreements also indicate that this should usually be varied when a person is compulsorily detained. In my view, people who are compulsorily detained should not be expected to meet the costs of basic healthcare provision.

I recognise that this is not necessarily an issue that the two service providers can resolve on their own. However, I expect the service providers to work with the Ministry of Health to ensure funding levels enable healthcare costs to be met and that the service-level agreements reflect the expectation that they will be.

The Ministry of Health agreed that GP visits should not be paid for by clients and tāngata and indicated they would follow up with the service providers about this issue. The Ministry

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[17] See, for example, *Māori Experience of Disability and Disability Support Services*. See: https://www.otago.ac.nz/wellington/otago067751.pdf

[18] Ministry of Health, Disability Support Services Tier Two Service Specification, Regional Intellectual Disability Supported Accommodation Service (RIDSAS), clause 12.2.

reiterated this position in response to my provisional report. I look forward to seeing progress in this area.

Staffing levels and training

The residences operated a minimum of 1:1 staffing to support clients and tāngata, except in some cases where civil clients and tāngata could be unaccompanied. Staff and kaimahi in the residences worked to three-shift rosters. In most residences, the morning shift ran from 7am to 3pm, the afternoon shift from 3pm to 11pm, and a 'wake-over'[19] or 'sleepover' staff member managed the residence between 11pm and 7am.

Generally, I found that the residences were adequately staffed at the time of my inspections. As such, I did not make any recommendations relating to staffing levels and training.

However, I did find some evidence of pressures on staffing during my inspections. For example:

- At one service provider, shift times varied significantly in the residences and each residence had between two and four vacancies;
- At another service provider, staff said it was difficult to cover staff sickness at the residence, and this was compounded by staff from other residences being reluctant to cover shifts due to the location of the residence;
- Staff in another service provider said retaining suitable staff could be problematic, as new staff often did not fully understand the complexity of the role before starting and therefore did not remain in the role for long.

The Ministry of Health, in response to my provisional report, noted that workforce pressures are being experienced across the health and disability sector. The Ministry noted that COVID-19 had a significant impact in this respect. The Ministry also indicated that, in response to my investigation into the HCF, the Ministry would be further developing its workforce development strategy and would report against this as the work progresses.[20]

I look forward to seeing evidence of the Ministry's progress. I also expect to closely monitor staffing pressures in the future.

Positive practices

I wish to also highlight a selection of the positive findings I made during my inspections, for example:

[19] A 'wake-over' is when a staff member is required to remain awake at the residence overnight because of the particular needs of those they are supporting. Refer to: *Idea Services Ltd v Dickson* (2009) 9 NZELC 93,305 at [10] and [26].

[20] See Chief Ombudsman's report *Oversight: An investigation into the Ministry of Health's stewardship of hospital-level secure services for people with an intellectual disability* (July 2021). See: https://www.ombudsman.parliament.nz/resources/oversight-investigation-ministry-healths-stewardship-hospital-level-secure-services

- Positive and respectful interactions between staff and clients and tāngata, with staff treating clients and tāngata with dignity and respect.
- Monthly community meetings, which were well-attended, constructive and presented in an accessible format.
- In one residence, I found the client was well-informed and had a good knowledge of their care plan and entitlements. I also found clients and tāngata in other residences were aware of their rights and were supported to make decisions regarding their care and support.
- A good range of activities, courses and employment opportunities.
    - For example, in one residence staff were proactive in looking for and facilitating new activities and there were opportunities to socialise in public spaces (eg. go out to a bar for dinner and a drink, visit other residences etc.)
    - In another residence, there were regular external activities such as Friday night discos, swimming, basketball, skate parks, car shows and shopping, among a variety of other activities.

In my view, positive practices such as these are critical to ensuring that clients and tāngata are treated with dignity and respect. I was pleased to see such practices in place and look forward to seeing further evidence of the good work done by the service providers in future inspections.

Summary of recommendations

I made a total of 42 recommendations across five of the six service providers I inspected. While recommendations were not relevant to all residences or service providers, some of the recommendations I made across multiple reports can be summarised as follows:

- Civil clients' informed consent is sought, recorded, reviewed at least every three months, and able to be revoked by the civil client at any time.
- Civil clients are not subjected to the same restrictions as residents under court orders unless it is demonstrably justified and for no longer than reasonably necessary.
- Discussions with care recipients about the role of the District Inspector and how to access them are documented in care recipients' care and rehabilitation plans.
- Information on the complaints process is easily visible and accessible to all clients and tāngata.
- Whānau visits are able to take place in the residence unless deemed unsafe based on individual risk assessment.

- The service provider engages with the Ministry of Health to ensure clients and tāngata who are compulsorily detained under a court order are not required to pay for GP appointments and prescription medication.
- Staff and kaimahi are always up-to-date with mandatory training requirements.

In total, the service providers accepted 36 of my 42 recommendations. Two of the service providers indicated to me that they accepted all my recommendations. For the remaining three service providers:

1. Three recommendations were accepted and two recommendations were rejected. The recommendations rejected by the service provider were:

    Care recipients have access to their shoes in the residence.

    Care recipients have privacy for telephone calls, unless deemed unsafe based on individual risk assessment.

    - Initially, the service provider said shoes would remain locked away due to risks of self-harm and assault. The service provider also said phone calls were monitored from a distance to maintain privacy, that people sometimes make non-emergency calls, and that clients and tāngata had become elevated and abusive on the phone, requiring staff intervention. As noted above, however, the service provider subsequently stated that they '*agreed that a blanket approach is not ideal for those living in the secure home and moving forward these restrictions will only be put in place were strictly necessary*'

2. Ten recommendations were accepted, one recommendation was partially accepted and one recommendation was rejected. The recommendation rejected by the service provider was:

    Kaimahi are provided a private office, and sleepover kaimahi have a dedicated private area in which to sleep.

    - In response, the service provider told me that the recommendation was not practicable due to constraints on housing, but that they would review the type of office set up and sleepover beds in use.

3. Six recommendations were accepted and two recommendations were partially accepted.

In my view, it is essential that not only are my recommendations accepted, but that there are clear action plans in place to ensure the desired outcomes occur. As such, I have requested plans from the service providers indicating how they intend to implement my recommendations. The service providers have given me these plans and I will monitor progress on their implementation.

Acknowledgements

I am grateful to residence staff for supporting my Inspectors in conducting their inspections. I also acknowledge the work that would have been involved in collating the information sought by my Inspectors.

Also, thank you to the clients and tāngata, and whānau, who have discussed difficult and personal information with my Inspectors.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. 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.