Our ref 587749

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Ombudsman
Fairness for all

Mr Richard Roil
Senior Solicitor
Abuse in Care Royal Commission of Inquiry

By email: Richard.Roil@abuseincare.org.nz

Dear Mr Roil

I refer to the Notice to Produce No 472, in which the Royal Commission of Inquiry into Abuse in Care (the Royal Commission) has requested information about:

- How I give effect to Te Tiriti o Waitangi / the Treaty of Waitangi in discharging my responsibilities towards people in care.
- The evolution of the Ombudsman's functions over time, including how it relates to particular communities.
- How I and my staff ensure my approach and work:
  - is informed by Māori understandings of whānau and models of care Māori;
  - is informed by Pacific cultural values, norms, practices and understandings including understandings of disability; and
  - complies with the United Nations Convention on the Rights of People with Disabilities (UNCRPD) since its ratification in 2008.
- The current capacity and constraints of the Ombudsman's functions and role including, where possible, details of any specific improvements in the role, responsibilities, powers, resources or funding that I believe would increase its effectiveness for helping those in care.
- The manner in which Ombudsmen may review decisions by the Health and Disability Commissioner, and how the Ombudsman's review function works in practice.
- Information about the Ombudsman's training, education and guidance to public sector agencies on improving how they work with communities including:
  - Māori and Pacific peoples;
  - disabled people; and
  - people from rainbow communities.
- A view on what improvements could be made in future, including improvements within the public sector.

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

L 7, 70 The Terrace, Wellington 6011
PO Box 10 152, Wellington 6143
New Zealand

Tel: 64 4 473 9533 Fax: 64 4 471 2254
Free phone: 0800 802 602
www.ombudsman.parliament.nz

I have provided detailed information in response to the Royal Commission's Notice in **Appendices 1 and 2**, below.

However, it may assist the Royal Commission if I make some introductory remarks.

First, I want to acknowledge the harm suffered by those who have been abused and the complexity of the Royal Commission's task. The issues before the Commission are critical and confronting, and the evidence given by abuse survivors and others to the Royal Commission raise important and complex issues.

Successive Ombudsmen have engaged with many of those issues over time, beginning with—for instance—a 1969 challenge to the committal of 'socially defective' persons under the Mental Health Act 1911, the investigation of a complaint involving the Lake Alice Child and Adolescent Unit in 1977 and, now, with expanded statutory responsibilities and powers, in particular through monitoring of places of detention under the Crimes of Torture Act 1989.[1] I am committed to assisting the Royal Commission in its work as much as I am able.

While Ombudsmen have a unique role as an Officer of Parliament, it should be acknowledged that there are many complementary and sometimes overlapping statutory oversight and human rights bodies which comprise part of the oversight framework for both the public and private sector in New Zealand.

As already noted and as the Royal Commission is aware, Ombudsmen have a long history of dealing with matters relating to the rights of individuals in state care, and continue to do so to the present day. As will be clear from the information provided below:

- The range of functions undertaken by Ombudsmen has expanded significantly since the role's inception, and there are also a range of new specialist bodies which deal with complaints on particular subjects.
- The way Ombudsmen undertake their work has evolved, and continues to evolve, in significant ways. For example, in recent years, Ombudsmen have formally acknowledged the relevance of tikanga, Te Tiriti o Waitangi and Te Ao Māori to their work. Ombudsmen have complainant-centric processes, and will continue to develop this further as expected by the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill.

The evolution of Ombudsman functions and ways of working mean that the Ombudsmen have been able to be more responsive to people in the New Zealand community over time, including those who have suffered abuse in care. This agility demonstrates the ability for the Ombudsman model to progressively develop in response to societal expectations, including through international human rights innovations and corresponding treaty obligations such as those underpinning monitoring of detention under the Crimes of Torture Act.

That said, the Ombudsman model is not able to respond to all the issues raised by abuse in state care: while the model now incorporates several different roles and functions for oversight, monitoring, investigating and reporting, it is not—for instance—a substitute for criminal

[1] See further below and, for details of the early investigations, Julia Maskill "The Ombudsmen and health" (1982) 12 VUW Law Rev 285, 291.

investigation and prosecution. It is necessary to recognise the strengths and limits of my own functions and the need to coordinate and work alongside others.

Over time, other specialist oversight bodies have been created, such as the role of the Health and Disability Commissioner in responding to complaints about health services. The strength of the Ombudsman model is that even where such specialist oversight bodies exist, with a broad overview of the public sector the Ombudsman is able to consider matters which might otherwise 'fall through the cracks', as well as oversight the acts and decisions of most of the specialist mechanisms themselves.

As well discussing the particular roles and functions of the Ombudsman as they are at present, I would welcome further discussion with the Royal Commission as to where they consider the New Zealand Ombudsman's own practices might be enhanced. This may help inform a discussion with Parliament about any reformed or new functions that the Ombudsman might take on once the Royal Commission has completed its inquiries.

I should also mention that a number of my functions involve various degrees of confidentiality: for example, the Ombudsmen Act 1975 prevents disclosure of information obtained in the course of complaints and investigations, as does the Crimes of Torture Act in respect of monitoring.[2]

The premise of those restrictions is that these forms of inquiries are best informed by comprehensive access to information, which can often only be achieved by statutory assurances of confidence. The questions posed by the Commission have not engaged those statutory provisions, but I think it appropriate to mention that I cannot—for instance—go into the content of particular investigations beyond the public reports of those investigations (some of which I have referenced in my answers below).

The Royal Commission has sought my comment on the limitation posed by resourcing. Resourcing presents an inherent limit on the performance of any statutory functions, including my own. As an Officer of Parliament, my funding is agreed annually through Parliament by way of recommendation by parliamentary Select Committees as part of the Budget cycle. During my term as Chief Ombudsman, the funding I have received has been increased to enable me to carry out the new functions the Ombudsman has been given and to meet Parliament's expectations. As an example, I am funded at a level that enables me to undertake inspections of places of detention within my current jurisdiction under the Crimes of Torture Act 1989 at least once every four years – more regular inspections would require more resources.

The Royal Commission has also asked me to comment on what improvements could be made within the public sector. This is clearly a complex topic. However, it may not surprise the Royal Commission that I consider further independent oversight to be an important tool. For example, it appears to me that regular independent oversight and reporting on the measures agencies have in place to identify and prevent abuse in care does assist. This kind of measure is enabled to some extent under the Ombudsman's various statutory functions outlined further below. The Royal

[2] See, for example, Ombudsmen Act 1975 ss 20 and 21 (information not to be disclosed) and Crimes of Torture Act 1989 s 33 (confidentiality to be maintained, including non-identification of individuals).

Commission may wish to consider in what ways the Ombudsman model is best suited to this context, and how other mechanisms may also contribute.

I am aware of the Royal Commission's practice note on witness statements[3] – if it would assist the Royal Commission I would be happy to translate this evidence into a particular format.

I look forward to discussing my evidence with the Royal Commission and considering the remedial actions it sees as necessary to make whole and help restore the mana of the many New Zealanders who have been detrimentally impacted by abuse in care.

Yours sincerely

Peter Boshier
Chief Ombudsman

Encl: Appendix 1 Detailed information
Appendix 2 Te Rōpū Kaiārahi Hauātanga's terms of reference

[3] Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, Practice Note 3 - Witness Statements, available at: https://www.abuseincare.org.nz/our-progress/library/v/119/practice-note-3-witness-statements

Appendix 1. Detailed information

Contents

How I give effect to Te Tiriti o Waitangi / the Treaty of Waitangi in my work

Foundational status of Te Tiriti o Waitangi / the Treaty of Waitangi

I have acknowledged the foundational constitutional status of Te Tiriti o Waitangi / the Treaty of Waitangi (collectively, Te Tiriti) in New Zealand.[4] I also acknowledge the increasing recognition of tikanga as a source of law.[5] Te Tiriti and tikanga must be incorporated into my work in a range of ways.

While Ombudsmen must maintain their institutional independence from the Crown and are not a Crown treaty partner, I am committed to ensuring my processes and decisions are consistent with Te Tiriti, its principles and tikanga, and in looking to Te Tiriti as part of my review of the actions of public bodies. I am taking active steps to further incorporate Te Tiriti and tikanga into my work, but in practical terms will:

- Aim to not make decisions that are inconsistent with Te Tiriti / its principles.
- Engage with Māori to understand their views when determining matters that affect their rights and interests (including through Pūhara Mana Tangata, my Māori Panel, and via my Ropu Māori Hononga Hapori, my Māori and Community Engagement team).

I am taking active steps to further incorporate Te Tiriti and tikanga into the work of the Ombudsmen, including by seeking expert legal advice on how to apply Te Tiriti and tikanga in my investigations.

It is also important to recognise that through my statutory roles, outlined further below, I am able to hold the Crown to account for its compliance with Te Tiriti and tikanga. There are recent examples of my incorporating Te Tiriti into my assessment of agencies subject to my jurisdictions,[6]

[4] I also acknowledge there are two separate texts, with different meanings.

[5] For a helpful overview of these developments, see the discussion at Part V of the High Court's judgment in *Ngāti Whātua Ōrākeri Trust v Attorney-General* [2022] NZHC 843 [28 April 2022].

[6] See, for example, paragraph 32 of the Ombudsman's Report into MCH's construction of a memorial in Auckland: https://www.ombudsman.parliament.nz/resources/chief-ombudsmans-opinion-under-ombudsmen-act-erebus-memorial

and I expect this to become more frequent as my staff and I expand our knowledge of Te Ao Māori.

Giving effect to Te Tiriti in discharging my responsibilities towards people in care

In respect of how this impacts upon people in care specifically, I note, by way of example, my recently published report concerning an inspection of Ward 21 of Palmerston North Hospital (an acute inpatient mental health unit) under the Optional Protocol to the Convention Against Torture (OPCAT).[7] (I speak more about my OPCAT function in the relevant section below, which includes references to other inspections).

In that report, I observed:

> *Of the 20 seclusion events reported, 14 involved seclusion of Māori tāngata whai ora (70 percent of seclusion events), despite the percentage of tāngata whai ora identifying as Māori on the Ward during that period being approximately 38 percent. This indicates that Māori were disproportionately subject to seclusion in comparison to both the rates of seclusion for non-Māori, and to the rates of admission of Māori tāngata whai ora. In their feedback, the DHB noted that while nationally, seclusion rates for Māori are increasing, in the MidCentral DHB rates have been in 'steady decline.'*

I also registered my concerns that:

- young people were subjected to restraint and seclusion;
- voluntary tāngata whai ora were subject to leave restrictions;
- there appears to be a normalisation of the use of security guards in mental health facilities, and security guards were present in 13 of the 30 documented instances where restraint was used on tāngata whai ora;
- there were issues with the complaints process, so that tāngata whai ora could not make a written complaint without staff assistance, and concerns about treatment were sometimes treated as feedback rather than complaints;
- there were insufficient activities and programmes for tāngata whai ora, especially in the evenings and weekends; and
- tāngata whai ora did not have independent access to telephones.

I therefore recommended that, among other things:

1. *Seclusion records are sufficiently detailed, at a minimum, in line with the Seclusion Policy and Seclusion Procedure.*
2. *All necessary steps are taken to reduce the disproportionate seclusion of Māori.*

[7] Chief Ombudsman Peter Boshier, *OPCAT Report: Report on an unannounced inspection of War 21, Palmerston North Hospital, under the Crimes of Torture Act 1989*, May 2022, available at: https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-ward-21-palmerston-north-hospital-under-crimes-torture-act

3. *Robust processes are established to ensure that young people are only secluded or restrained as a last resort, where all other methods have been exhausted and failed, including documentation of all methods attempted.*
4. *Leave restrictions are not placed on voluntary tāngata whai ora.*
5. *A dedicated sensory modulation area is available to tāngata whai ora at all times.*
6. *Tāngata whai ora are able to make a written complaint independently of staff.*
7. *Feedback containing concerns about treatment are categorised as a complaint, and are dealt with accordingly.*
8. *Consent to treatment paperwork is completed for all voluntary tāngata whai ora, and where tāngata whai ora have not signed, the reasons for this are recorded.*

   …

11. *Tāngata whai ora have access to telephones independently of staff, unless individual assessment deems it unsafe.*

I also committed to making further, follow-up inspections at future dates to monitor implementation of my recommendations.

Pūhara Mana Tangata | Chief Ombudsman's Māori Panel

Pūhara Mana Tangata was established in late 2019 to advise me in my work with or relating to Māori, as a means of ensuring I am aware of and more responsive to concerns held by tangata whenua, and to better integrate Te Ao Māori into my office.

Pūhara Mana Tangata is an advisory panel made up of senior and rangatahi leaders from throughout Te Ao Māori. Its membership is publicly available.[8] Its terms of reference also are publicly available.[9]

On 14 June 2022, Pūhara Mana Tangata published its report on the Ombudsman's activities during the first two years of its existence. This inaugural report, *Te Pūrongo nā te Pūhara Mana Tangata ki te Kaitiaki Mana Tangata*,[10] provides an overview of the highlights of the panel's mahi supporting me and my staff between December 2019 and December 2021. Its report states that Pūhara Mana Tangata's specific role is to:

- Champion the work of the Chief Ombudsman and my unique constitutional role as an Officer of Parliament.

[8] Office of the Ombudsman, *Pūhara Mana Tangata*, available at: https://www.ombudsman.parliament.nz/about-ombudsman/puhara-mana-tangata

[9] Office of the Ombudsman, *Pūhara Mana Tangata Terms of Reference*, 6 March 2020, available at: https://www.ombudsman.parliament.nz/resources/puhara-mana-tangata-terms-reference

[10] Office of the Ombudsman – Pūhara Mana Tangata, *Inaugural Pūhara Mana Tangata report for 2020/2021*, 14 June 2022, available at: https://www.ombudsman.parliament.nz/resources/inaugural-puhara-mana-tangata-report-20202021

- Provide Te Ao Māori perspectives on internal capability and cultural competencies.
- Provide advice on Crown and Māori relations, with a focus on Te Tiriti obligations including guidance, interpretation and the application of the principles of Te Tiriti.
- Provide advice on any issues that have an impact on relations between Māori and the Chief Ombudsman and my office and, where necessary, challenging assumptions and perspectives.
- Provide advice and support on managing effective and meaningful communication and engagement with Māori.
- Provide Te Ao Māori perspectives and thoughts on the identification and development of suitable programmes which could enhance the strategic direction of the Chief Ombudsman and promote my relationship and engagement with Māori.

Pūhara Mana Tangata will publish these reports on an ongoing basis, and I expect they will continue to traverse this territory, including by considering the Ombudsman's effectiveness in delivering for and to Māori.

Te Ao Māori transformation programme

I am currently undertaking a Te Ao Māori Transformation Programme, designed to enable Ombudsman staff to work confidently with and beside Māori. The ultimate objective of this programme is to support the development of cultural capability and enable Te Ao Māori to be embedded within the policies, processes and practices of my office. This programme includes:

- A staff cultural competency programme covering tikanga protocols, te reo, and te ao Māori.
- A staff reference group specifically focused on considering Te Tiriti issues.

Māori and community outreach and engagement

Part of my wider strategic work, led by Ropu Māori Hononga Hapori, my Māori and Community Engagement team, focuses on developing my outreach and engagement practices and capability to enable my staff to engage particularly with:

- Māori communities;
- Pacific communities;
- Ethnic communities; and
- Youth communities.

I note that I engage with disabled people through my Disability Rights Team, which I discuss in a following section.

This work is a critical part of my overall intent to embed practices which are informed through evidence-based considerations. Furthermore, the philosophy of 'nothing about us without us' is important. I value and seek the lived and learned experiences and voices of the communities I serve to help inform my practices. This work undertaken by Ropu Māori Hononga Hapori will help

to ensure that my staff have the confidence and competence to engage effectively with our diverse communities. In doing so, I am confident that:

- the mana of the Ombudsman is supported and enhanced;
- my role continues to have the trust and confidence of stakeholders, to enable the vision 'Tuia kia ōrite–Fairness for all' to be achieved; and
- I am recognised as an employer of choice for others to follow.

The voices of the communities

I have recognised the importance of having the voices of the communities I serve as advisors to support my Chief Ombudsman role. These advisors are a means of ensuring that I am aware of, and more responsive to, concerns held by our communities, particularly those who traditionally may not have engaged with the Ombudsmen. Part of my outreach and engagement development is to establish advisory panels, similar to my Pūhara Mana Tangata. Pūhara Mana Tangata has proven its value and provides a blueprint for how an advisory panel can be established and operate to support my role. The establishment of further advisory panels will also be guided by my assessment of the extent to which my effectively engage with diverse communities and how that engagement can be most efficiently supported. As I note below, for example, my work has raised issues relevant to rainbow communities and an advisory panel or other mechanism may become appropriate to ensure effective engagement with those communities.

Living and leading the future

My medium to long term focus is about developing my staff's Te Ao Māori confidence and competence within my workplace practices, enabled through supporting policies and processes. As I grow my staff capability and as the organisation matures in its systems-wide transformation, I intend to share my learnings with interested parties to help them to grow. Furthermore, as I grow my medium to long term capability, I also need to ensure my office is structured appropriately, and that I have the right staff, skills and systems supporting me to discharge my functions. This wider thinking about what growth is necessary and how it is managed is part of my annual strategic planning.

Evolution of the Ombudsman's functions over time & How I ensure my approach and work is appropriately informed by and reflects cultural values

I consider it appropriate to consider these questions together, as the practices of the Ombudsmen have developed alongside and have been informed by the incremental additions to and development of the Ombudsman's remit.

The Ombudsman's status as an Officer of Parliament

As you know, Ombudsmen are Officers of Parliament. This phrase 'Officer of Parliament' was both novel and undefined when the Parliamentary Commissioner (Ombudsman) Act 1962 was

enacted.[11] Nevertheless, New Zealand's first Ombudsman, Sir Guy Powles, clearly understood its import. Upon being sworn in, he stated:

> *The Ombudsman is Parliament's [watchdog], put there for the protection of the individual, and if you protect the individual you protect society ... I shall look for reason, justice, sympathy and honour, and if I don't find them I shall report [to Parliament] accordingly.*

In 1989, the Finance and Expenditure Committee set out criteria to consider when there is a proposal to create a new Officer of Parliament. The Committee concluded that:[12]

- An Officer of Parliament must only be created to provide a check on the arbitrary use of power by the executive.
- An Officer of Parliament must only discharge functions that the House of Representatives itself, if it so wished, might carry out.
- An Officer of Parliament should be created only rarely.
- Each Officer of Parliament should be created in separate legislation principally devoted to that position.

The Social Services Committee subsequently referred to these criteria when considering a proposal to make the Children's Commissioner an Officer of Parliament in 2000.[13] The Committee ultimately concluded that it would be inappropriate to do so because the Children's Commissioner was undertaking an 'executive' (as distinct from Parliamentary) function by, among other things, *'advising the Minister on matters relating to the administration of the Act'.* Instead, the Committee concluded that the Children's Commissioner more properly should remain a statutory Commissioner and independent Crown entity, whose principal function is to be an advocate.[14]

The nature of the Ombudsman's functions

The role and function of an Ombudsman is, at its heart, to investigate and monitor alleged or suspected maladministration, and to report any findings to the House of Representatives. This reporting power to the House helps cement the perception that Ombudsmen, as Officers of Parliament, attract a special constitutional status which helps enhance the independence and moral authority of their opinions.[15]

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[11] Gilling, *The Ombudsman in New Zealand*, 1998, Historical Branch, Department of Internal Affairs, page 38.

[12] Finance and Expenditure Committee, *Inquiry into Officers of Parliament,* 21 March 1989, [1987–1990] AJHR I.4B.

[13] Social Services Committee. *Interim report on the Parliamentary Commissioner for Children Bill*, 25 May 2000, [1999–2002] AJHR I.22A at 893.

[14] Social Services Committee, *Parliamentary Commissioner for Children Bill Interim Report,* 25 May 2000, page 892.

[15] Report to the NALI Ministerial Group on status of Chief Archivist, page 8 at 49.

This nature has been recognised by the courts. In the Supreme Court of Alberta, Canada, Chief Justice Milvain observed:[16]

> *…the basic purpose of an Ombudsman is provision of a 'watchdog' designed to look into the entire workings of administrative cases ... [the Ombudsman] can bring the lamp of scrutiny to otherwise dark places even over the resistance of those who would draw the blinds. If [the Ombudsman's] scrutiny and reservations are well founded, corrective measures can be taken in due democratic process, if not no harm can be done in looking at that which is good.*

The Supreme Court of Canada later cited the above judgment, and went on to observe that:[17]

> *The Ombudsman represents society's response to these problems of potential abuse and of supervision. [The Ombudsman's] unique characteristics render [them] capable of addressing many of the concerns left untouched by the traditional bureaucratic control devices. [The Ombudsman] is impartial. [The Ombudsman's] services are free, and available to all. Because [the Ombudsman] often operates informally, [their] investigations do not impede the normal processes of government. Most importantly, [the Ombudsman's] powers of investigation can bring to light cases of bureaucratic maladministration that would otherwise pass unnoticed. ... On the other hand, [the Ombudsman] may find the complaint groundless, not a rare occurrence, in which case [their] impartial and independent report, absolving the public authority, may well serve to enhance the morale and restore the self-confidence of the public employees impugned.*

Conversely, it is not the role of an Ombudsman, or Officers of Parliament generally, to act as an advocate. When Ombudsmen were made an ex officio member of the Human Rights Commission,[18] it quickly became apparent that the nature and role of an Ombudsman conflicted with some of the functions of the Commission, most notably the function of offering broad public policy advice to government. This ultimately prompted the Ombudsman to withdraw from the role. As Sir Kenneth Keith observed:[19]

> *…the Act made provision for this if it was felt that the Commission's work was incompatible with the function or office of the Ombudsman … the [Ombudsman] was removed from the list of Commissioners when the Commission was reconstituted in 1993.*

The Ombudsmen Act 1975

The Parliamentary Commissioner (Ombudsman) Act 1962 gave authority to the Ombudsman to investigate core central government agencies. The Ombudsman's jurisdiction expanded incrementally from this starting point, eventually drawing in local authorities, hospital boards and other bodies only indirectly responsible to Parliament. These developments were crystallised in

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16 *Re Ombudsman Act (1970),* 72 W.W.R. 176 (Alta. S.C.), per Milvain C.J., at pp. 192-93.

17 *British Columbia Development Corporation and another v Friedman* [1984] 2 SCR 447.

18 Human Rights Commission Act 1977.

19 As above n1, at page 11.

the Ombudsmen Act 1975, with over 4,000 central and local government agencies (including schools) now subject to an Ombudsman's jurisdiction.

The Ombudsmen Act 1975 provides wide and flexible powers of investigation, including:

- the ability to inquire into *any administrative act, decision, omission or recommendation* of a government agency (administrative essentially includes any actions which are not judicial or legislative in nature);[20]
- the ability to carry out an investigation *in any manner* the Ombudsman thinks fit (subject of course to requirements of natural justice);[21]
- the ability to require *any person* to provide the Ombudsman *any information, documents, papers or things* that relate to the investigation (even if that person is bound by a secrecy obligation);[22]
- the power to enter any premises occupied by a relevant public sector agency,[23] subject to an obligation to notify the chief executive beforehand;[24] and
- the ability to *summon any person* and *examine* them on oath.[25]

After investigating, the Ombudsman's role is to form an opinion on whether an agency has behaved in a manner which is, among other things, unreasonable or which appears contrary to law.[26] The Act also empowers an Ombudsman to consider whether the agency has behaved in an '*unjust, oppressive, or improperly discriminatory*' manner, or has behaved '*in accordance with a rule of law or any legislation or a practice that is or may be unreasonable, unjust, oppressive, or improperly discriminatory*'.[27] An Ombudsman might also conclude that an agency's decision was simply '*wrong*'.[28]

The Ombudsman might also consider an agency's exercise of a discretionary power, and form the view that in exercising it, the agency did so '*for an improper purpose or on irrelevant grounds or*

[20] Section 13 of the Ombudsmen Act. See also *British Columbia Development Corporation and another v Friedman* [1984] 2 SCR 447, in which the Supreme Court of Canada held that: '*The phrase "a matter of administration" encompasses everything done by governmental authorities in the implementation of government policy, regardless of whether the implementation of those policies involves matters of proprietary, commercial or business concern. Only the activities of the legislature and the courts are excluded from the Ombudsman's scrutiny'.*

[21] Section 18 of the Ombudsmen Act.

[22] Section 19(1) of the Ombudsmen Act.

[23] Section 27(1) of the Ombudsmen Act.

[24] Section 27(2) of the Ombudsmen Act.

[25] Section 19(2) of the Ombudsmen Act. Note if the person is not an agency official or the complainant, prior approval of the Attorney-General is required.

[26] Section 22(1)(a) and (b) of the Ombudsmen Act.

[27] Section 22(1)(b) of the Ombudsmen Act.

[28] Section 22(1)(d) of the Ombudsmen Act.

on the taking into account of irrelevant considerations', or simply that reasons should have been given for its decision.[29]

After forming an opinion, the Ombudsman may make any recommendations they '*think fit*', and may follow up with the agency about the implementation of those recommendations.[30] The Ombudsman may also report to the relevant Minister or Mayor, and if adequate and appropriate action is not taken in the case of central government, to the Prime Minister and House of Representatives.[31] The Ombudsman may also publish reports on the outcome of his investigation activities.[32]

It is this flexibility which characterises the Ombudsman's role, and which differentiates the Ombudsmen from the courts. This is intentional. Former Chief Ombudsman Sir George Laking said:[33]

> *Any Ombudsman who appears to the public to be a remote and rather godlike figure is not a good Ombudsman … It is a highly personal office. I think the special characteristic of it is that the ordinary citizen can feel there is some individual whom [they] can approach … who's willing to take an interest in things that might seem unimportant to the system, but very important to the person who has a complaint.*

An Ombudsman's willingness to adopt informal, flexible processes[34] permits the Ombudsman to deal effectively with complaints from citizens who may be ill-equipped or unable to explain their grievance in terms of legal obligations, rights or responsibilities, but who nevertheless have a deep sense that they have been wronged by a government act, decision, omission or recommendation.

This is reflected in the ability of an Ombudsman to investigate a matter on receipt of a complaint or of his or her own motion,[35] including where '*the complaint may not appear to relate to that decision, recommendation, act or omission'*. The Ombudsman's ability to investigate is not constrained by the ability or capacity of a complainant to successfully identify the decision that has caused them harm, or their ability to articulate why that decision was wrong. The Ombudsman may consider an investigation even where the complainant cannot quite put their finger on what went wrong, or where the Ombudsman has identified an issue of which the complainant is unaware. In addition, the own motion power is used to conduct systemic investigations into matters identified by the Ombudsman.

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29 Section 22(2) of the Ombudsmen Act.

30 Section 22(3) of the Ombudsmen Act.

31 Section 22(3) and (4) of the Ombudsmen Act.

32 Section 23 of the Ombudsmen Act and Rule 2 of the Ombudsmen Rules 1989.

33 Kenneth Keith, *Development of the role of the Ombudsman with reference to the Pacific*, speech to Australian and Pacific Ombudsman Conference, 9-11 February 2005.

34 See section 18(7) of the Ombudsmen Act, which states an Ombudsman '*may regulate [their] procedure in such a manner as [they think] fit*'.

35 Section 13(3) of the Ombudsmen Act.

An Ombudsman might also investigate:

- A petition referred to the Ombudsman by a Select Committee, or any matter to which that petition relates, to the extent it is within the Ombudsman's jurisdiction.[36]
- A matter referred to the Ombudsman by the Prime Minister, with consent of the Chief Ombudsman.[37]

As noted above, after investigating and forming an opinion that an agency has behaved deficiently, an Ombudsman may make any recommendations they think fit. This might include individual remedies for the complainant, such as that the act, decision or recommendation in question be reconsidered, varied or cancelled, an apology be given, or an ex-gratia payment be made. It could also include more systemic remedies, such as a recommendation that the agency's relevant policy or practice be altered, or that the law on which the decision was based be reconsidered.[38]

Some examples of the wide variety of matters an Ombudsman may consider include:

- Complaints I investigated about the seclusion of children in two primary schools,[39] which resulted in the Secretary of Education writing to all schools prohibiting the use of seclusion.
- My systemic investigation into hospital-level secure services for people with an intellectual disability. I identified inadequate planning, action, monitoring and advice by the Ministry of Health contributed to a situation where capacity pressures meant some people with intellectual disabilities were returned to prison, inappropriately accommodated in mental health units or placed outside their home region, and that seclusion and de-escalation rooms were being used as bedrooms.[40]

Unlike the courts, an Ombudsman makes recommendations. This is an important part of the Ombudsman's identity, as an impartial Officer of Parliament exercising wide powers of inquiry, but balanced with using *moral suasion* to achieve an outcome of good administrative practices within executive government. The onus remains with the agency concerned to respond to and implement an Ombudsman's recommendations. Almost all recommendations made under the Ombudsmen Act are accepted. However, if the agency

[36] Section 13(4) of the Ombudsmen Act. The House has recently convened a standalone Petitions Committee to consider petitions, including any engagements with the Ombudsmen.

[37] Section 13(5) of the Ombudsmen Act. Convention suggests that the Chief Ombudsman would consult the Leader of the Opposition before granting consent, given the need for the Ombudsman to act, and to be seen to act, independently.

[38] Section 22(3) of the Ombudsmen Act.

[39] See case notes on complaints against Miramar Central School and Ruru School, and my Annual Report for 2016/17, at page 3.

[40] Chief Ombudsman Peter Boshier, *Oversight: An investigation into the Ministry of Health's stewardship of hospital-level secure services for people with an intellectual disability*, 28 July 2021, available at: https://www.ombudsman.parliament.nz/resources/oversight-investigation-ministry-healths-stewardship-hospital-level-secure-services

does not take steps to provide what the Ombudsman considers to be a satisfactory remedy within a reasonable time, the Ombudsman may:

- Decide to report the findings to the Prime Minister and then to Parliament.
- Initiate an own motion investigation into the omission of the agency to remedy the matter.[41]
- Draw public attention to the matter, as discussed above.

The addition of functions over time

Given the nature of the Ombudsman's wide role and jurisdictions and inherent flexibility, its extensive experience in overseeing public administration and decision-making, and the impact certain decisions, actions and omissions can have on people, it was unsurprising that, over time, the remit of the Ombudsmen has expanded to include oversight of other important rights and interests. These includes the protection of constitutional rights and freedoms and fundamental human rights expected to be operating in a healthy democracy:

- Reviewing decisions by central and local government agencies on requests for information under the Official Information Act 1982 and the Local Government Official Information and Meetings Act 1987.
- Providing guidance to whistleblowers and organisations under the Protected Disclosures (Protection of Whistleblowers) Act 2022,[42] about reporting serious wrongdoing in the workplace, as well as receiving and investigating protected disclosures.
- Monitoring the rights of disabled people, and working as part of an Independent Monitoring Mechanism, to ensure that New Zealand's obligations under the United Nations Convention on the Rights of Persons with Disabilities are being realised.
- Examining the conditions and treatment of people in places of detention under the Crimes of Torture Act 1989 and the Optional Protocol to the Convention Against Torture (OPCAT), including prisons, intellectual disability and mental health facilities, aged care facilities,[43] court cells,[44] immigration detention centres, and isolation and quarantine facilities.
- Undertaking an enhanced international leadership role, focused on the Pacific and Asia, to promote good government practices, including transparency and anti-corruption. In this role, I both learn from my Pacific and Asian colleagues, and assist to develop international best practice.

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41 By way of example, I note my investigation into how Department of Corrections has responded to repeated calls for reform and improvements by oversight bodies, including the Ombudsmen, announced on 18 May 2021 here: https://www.ombudsman.parliament.nz/news/chief-ombudsman-investigating-department-corrections

42 And previously under the Protected Disclosures Act 2000.

43 Including aged care facilities in the private sector (which receive public funding).

44 The designation for court cells is shared with the Independent Police Conduct Authority.

- Work relating to the rights of the rainbow community.
- Preparing for a proposed enhanced complaints and oversight role over the New Zealand Oranga Tamariki system, including care and custody providers,[45] which will likely include:
    - statutory obligations on Oranga Tamariki and care and custody providers to notify the Ombudsman of critical and serious incidents;
    - strengthening the powers of the Ombudsmen to proactively seek information from Oranga Tamariki and care and custody providers; and
    - duties for the Ombudsman to engage with children and young people, and their family, whānau, hapū and iwi, as well as to focus on the well-being, interests and rights of children and young people.

I have provided further details about each of these in the section 'More recent functions'.

Alternative complaints-handling or oversight bodies

It is also unsurprising that, as the New Zealand government and the populace of New Zealand developed a more mature culture around complaints-handling, there was a proliferation of new complaints-handling and investigative bodies, often with a view towards increasing specialisation. To varying extents, these bodies have sometimes overlapped with parts of the Ombudsman's jurisdiction. To the extent that there is an appeal, review or adequate alternative remedy available, the Ombudsman would generally not investigate.[46]

Most notably, from the Inquiry's perspective, this framework includes:

- The Health and Disability Commissioner, who became the primary investigative body for complaints made about breaches of the Code of Consumer Rights, issued by the Commissioner under the Health and Disability Act 1994. The Ombudsmen Act was amended to permit the Ombudsman to consult with the Health and Disability Commissioner on any matter relating to the functions of the Commissioner,[47] and, where a matter was within the Commissioner's remit, to refer a complaint to the Commissioner.[48]
- The Children's Commissioner role, enacted in 1989 (as Commissioner for Children) in the Oranga Tamariki Act 1989 / Children's and Young People's Well-being Act 1989. The Children's Commissioner Act 2003 contemplated that, among other things, the Commissioner would have an investigative role in respect of complaints from children. (In practice, however, according to the Minister of Social Development,[49] the Children's Commissioner has not investigated a complaint since 2010, and has instead referred 78

[45] Including care and custody providers in the private sector (and NGO sector).

[46] See sections 13(7)(a) and 17(1)(a) of the Ombudsmen Act.

[47] Section 21B of the Ombudsmen Act.

[48] Section 17B of the Ombudsmen Act.

[49] Radio New Zealand – Nine to Noon, *Children's Commissioner aghast over moves to scrap role*, 15 June 2022, available at: https://www.rnz.co.nz/national/programmes/ninetonoon/audio/2018845916/children-s-commissioner-aghast-over-moves-to-scrap-role

complaints to the Ombudsman pursuant to section 19 of the Act.) Like the Ombudsman, the Children's Commissioner also holds designation as a National Preventive Mechanism under OPCAT. The Children's Commissioner presently holds the designation for inspecting care and protection and youth justice residences established under section 364 of the Oranga Tamariki Act 1989, community based remand care homes, and health and disability places of detention established specifically for the care of children and young people, including youth forensic units and child and adolescent mental health units.[50] I discuss the development of the Ombudsman's OPCAT designations further below.

- The Waitangi Tribunal, to the extent it considers actions or omissions of the Crown in respect of Māori, including Māori in state care.
- The Social Workers Registration Board, to the extent it considers the adequacy of practice performed by social workers employed by the state.
- The Privacy Commissioner, as it relates to complaints arising out of requests by natural persons for personal information about themselves, or certain complaints about mishandling of personal information or privacy interests generally.

Reviewing decisions on official information requests

The Ombudsmen gained the statutory functions of investigating complaints and reviewing decisions by central and local government agencies on requests for official information on 1 July 1983 and 1 March 1988, respectively.[51] This can include requests by whanau for access to their children's files with Oranga Tamariki, health and other agencies, as well as requests for policy and practice information more generally. The access regime for personal information about the individual requesting it was carved off and incorporated within the Privacy Act 1993 (now Privacy Act 2020).[52]

A requester, having had their information request refused, may make a complaint to the Ombudsman seeking a review of the agency's decision on their request. The Ombudsman will then, using the experience and accumulated knowledge which are the Ombudsman's by virtue of the office they hold,[53] form an independent opinion on whether the agency was justified in

[50] Gazette, *Designation of National Preventive Mechanisms*, 2 July 2020, available at: https://gazette.govt.nz/notice/id/2020-go2845

[51] Sections 1(2) and 28 of the Official Information Act 1982 and sections 1(2) and 27 of the Local Government Official Information and Meetings Act 1987.

[52] The OIA and LGOIMA regimes did retain, however, the access regimes for people seeking documents containing internal rules for decisions that affect them (section 22 of the OIA and section 21 of LGOIMA refer) and for seeking reasons for decisions affecting them in their personal capacity (section 23 of the OIA and section 22 of the LGOIMA refer).

[53] *Wyatt Co (NZ) Ltd v Queenstown-Lakes District Council* [1991] 2 NZLR 180, at 191.

refusing that request,[54] or whether the decision complained of was unreasonable or wrong or otherwise subject to maladministration.[55]

If the Ombudsman forms the opinion that the agency's decision was not justified and recommends release of the information, a public duty to observe that recommendation is imposed on the agency from the commencement of the 21st working day after the day on which the recommendation is made unless the Governor-General, by Order in Council, otherwise directs.[56] This 'Cabinet veto', as it became known after its amendment from a 'Ministerial veto' in 1987, has never been exercised. The Acts provide further rights of review and appeal to the courts in respect of the 'veto',[57] which may be exercised by the requester at the agency's expense.

On the rare occasions where an agency has been reluctant to meet the legal duty arising out of an Ombudsman's recommendation by releasing information, successive Ombudsmen have referred the matter to the Solicitor-General to ensure compliance.

Survivors of abuse in care have been able to use the legislation to access information to help them understand government decisions and inform their next steps on seeking restitution. I note one example in my published case note concerning my investigation into the Ministry of Social Development's withholding of its internal guidance entitled *MSD Historic Claims Business Procedure and Guidance – March 2019*.[58]

Whistleblower protections under the Protected Disclosures Act

The Protected Disclosures Act 2000 was recently replaced by the Protected Disclosures (Protection of Whistleblowers) Act 2022. The new Act continues the previous Act's purpose, which is to facilitate the disclosure and investigation of 'serious wrongdoing'[59] in the workplace, and to provide protection for employees and other workers who report concerns.

The 2022 iteration of the Act confirms the Ombudsman's status as an 'appropriate authority' who may receive and investigate allegations of serious wrongdoing. The Ombudsman also continues to provide confidential advice and guidance to disclosers or would-be disclosers about how to make a disclosure and about the statutory protections for disclosers.

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54 Section 30(1)(a) of the Official Information Act and section 30(1)(a) of the Local Government Official Information and Meetings Act.

55 Section 30(1)(b) of the Official Information Act and section 30(1)(b) of the Local Government Official Information and Meetings Act.

56 Section 32(1) of the Official Information Act 1982. This is in contrast to the veto under section 32(1) of the LGOIMA, which may be exercised by resolution made at a meeting of the local authority.

57 Sections 32B and 32C of the OIA and sections 34 and 35 of the LGOIMA refer.

58 Chief Ombudsman Peter Boshier, *Request for MSD historic claims guidebook*, 13 May 2020, available at: https://www.ombudsman.parliament.nz/resources/request-msd-historic-claims-guidebook

59 See section 10 of the PDA 2022 for the full definition of serious wrongdoing. Serious wrongdoing includes an offence, a serious risk to health or safety of the public or an individual, a serious risk to the maintenance of the law, and oppressive or discriminatory conduct or gross negligence or mismanagement by a public official.

However, the 2022 Act makes changes to address identified issues and improvements. The key changes which are specifically relevant to the Ombudsman include:

- Expanding the Ombudsman's advisory role to provide independent information and guidance to anyone. This includes past or present employees who are considering making a disclosure, organisations (both public sector and others) about what to do with a disclosure, and third parties.
- Confirming the ability of an Ombudsman to receive and investigate disclosures without these first having gone to the organisation concerned.

Dedicated funding did not come to the Ombudsman with the protected disclosures role in 2000. However, in line with the passing of the 2022 Act and the expanded Ombudsman functions, Parliament has provided dedicated funding from 1 July 2022 for the protected disclosures role.

I hope that the move to strengthen this regime will further incentivise would-be disclosers to make protected disclosures, as a means to ensure wrongdoing is detected earlier and dealt with appropriately, and without whistleblowers being subjected to retaliatory action.

Monitoring the rights of disabled people

New Zealand is a signatory to and has ratified the United Nations Convention on the Rights of Persons with Disabilities (Disability Convention). Under the Disability Convention, New Zealand is committed to ensuring disabled peoples' full and equal enjoyment of all human rights and fundamental freedoms.

The Ombudsman is one of three equal partners who comprise New Zealand's Independent Monitoring Mechanism (IMM) under the Disability Convention, along with the Human Rights Commission and the Disabled People's Organisations' Coalition.[60] The IMM works together to:

- Promote, protect and monitor implementation of the Disability Convention.
- Report to Parliament, the public and the United Nations on the implementation of the Disability Convention and specific disability issues.[61]
- Provide advice on legislation, policy and practice affecting disabled people.

The IMM operates in accordance with its agreed terms of reference.[62]

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[60] For more information about the Disabled People's Organisations' Coalition, please see: https://www.odi.govt.nz/united-nations-convention-on-the-rights-of-persons-with-disabilities/nzs-monitoring-framework/monitoring-reports-and-responses/reports-from-convention-coalition/

[61] See the most recent IMM report *Making Disability Rights Real in a Pandemic*, available in English, te reo Māori, Easy Read, Large Print, audio, braille and New Zealand Sign Language at: https://www.ombudsman.parliament.nz/resources/making-disability-rights-real-pandemic

[62] Office of the Ombudsman, *Fair treatment for disabled people*, available in English, te reo Māori, audio (English and te reo Māori), Easy Read, and New Zealand Sign Language at: https://www.ombudsman.parliament.nz/what-ombudsman-can-help/fair-treatment-disabled-people#toc-0

The Ombudsman also works separately to protect and monitor the Government's implementation of the Disability Convention, primarily using its general Ombudsmen Act investigative powers, as well as through advice, training and submissions to parliamentary select committees. This complaint handling and investigative work often contributes to the IMM's monitoring. See for example the recent case note on the lack of a review mechanism for community participation services funding,[63] which was picked up in social media by my IMM partners.

The Disability Convention also helps inform the Ombudsman's work generally, including the enhanced role which will be arise under the expanded oversight regime anticipated by the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill.

As my role and functions grow, and understanding around accessibility increases, I have been working to ensure I am meeting the needs of disabled people wanting to engage with the services I provide, as well as those who may wish to seek employment opportunities within my staff. I am developing an Accessibility Strategy and scoping how to progress its accompanying action plan. Doing this will enable me to lead by example and achieve my vision of being fully accessible to disabled New Zealanders.

I also note issues as they arise in inspections of places of detention. Disability rights continues to be an area of focus for my inspections. I am aware that a significant proportion of detainees have a disability, or have experience of mental health distress, and it is important to ensure these people receive appropriate support, and are able to request reasonable accommodation when necessary.

Disability Rights incorporating a te ao Māori approach

I have sought to ensure a te ao Māori approach in my disability rights work. I have established an internship programme in partnership with Kiingitanga. The aim of the programme is to:

- grow awareness of the work of the Ombudsman among rangatahi Māori; and
- provide corporate work experience for Māori university students.

In 2021, my Disability Rights Team welcomed our first Kiingitanga Intern, who undertook a variety of roles including presenting at my staff conference about tāngata whaikaha Māori (disabled Māori) and updating corporate documents to reflect a te ao Māori and matauranga Māori view.

I continue to engage with Kāpō Māori Aotearoa on key disability rights matters. Kāpō Māori Aotearoa is a member-based society providing support and advice for kāpō (blind, vision impaired, and deafblind) Māori and their whānau. This ongoing relationship is an excellent opportunity to learn more about te ao Māori and its approach to disability rights.

I hosted a hui in Auckland with Ngā Rōpu o Manaaki Tāngata (the youth branch of Kāpō Māori Aotearoa). I was extremely grateful to hear the views of Māori youth with visual impairments, and to discuss recent work they have published highlighting their personal experiences. It is vital that I

[63] Chief Ombudsman Peter Boshier, *Lack of review mechanism for community participation services funding unreasonable*, 29 June 2022, available at: https://www.ombudsman.parliament.nz/resources/lack-review-mechanism-community-participation-services-funding-unreasonable

continue to hear the voices of Māori youth and recognise and, where appropriate, amplify these voices in my work.

Te Rōpū Kaiārahi Hauātanga | The Chief Ombudsman's Disability Advisory Panel

Te Rōpū Kaiārahi Hauātanga[64] was formed in late 2021 to inform my work in the area of disability rights. Te Rōpū Kaiārahi Hauātanga seeks to ensure that I have access to timely and high-quality expert advice from New Zealanders with lived experience of disability, thereby reflecting the mantra of the disability rights movement: 'nothing about us, without us'. Te Rōpū Kaiārahi Hauātanga's terms of reference are not yet published, as I am exploring how to make this publicly available in a number of formats. Please find the terms of reference at Appendix 2.

Te Rōpū Kaiārahi Hauātanga helps the Chief Ombudsman to identify, confront and deconstruct barriers that prevent disabled people from participating fully in society. The panel provides critical perspectives, including from Māori, Pasifika, and youth members to show the intersections of these barriers with other social issues.

Monitoring the treatment of people in detention under OPCAT

Ombudsmen are designated as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA), which was amended in 2006 to enable New Zealand to meet its international obligations under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), and its Optional Protocol (OPCAT).

The NPM role has a **preventive** objective, with a focus on identifying and recommending where change should occur to *prevent* torture and other cruel, inhuman or degrading treatment or punishment and *improve* the conditions of detention and treatment of detainees.

The Ombudsman is one of five NPMs in New Zealand, including the Human Rights Commission, which is the central, and coordinating, NPM.

Extent of OPCAT designation

The Ombudsman presently has OPCAT designation for over 470 separate facilities where people are not able to leave at will, across multiple areas, including:[65]

- in prisons and otherwise in the custody of the Department of Corrections;
- on premises approved or agreed under the Immigration Act 1987;
- in health and disability places of detention, including within privately run aged care facilities;
- in residences established under section 114 of the Public Safety (Public Protection Orders) Act 2014; and

[64] Office of the Ombudsman, *Disability Advisory Panel – Te Rōpū Kaiārahi Hauātanga*, available at: https://www.ombudsman.parliament.nz/about-ombudsman/disabilityadvisorypanel

[65] See the Gazette notice of designation, here: https://www.gazette.govt.nz/notice/id/2020-go2845

- in court facilities.[66]

With respect to the Ombudsman's designation over health and disability places of detention, this includes mental health units, substance addiction (compulsory assessment and treatment) units, intellectual disability facilities, secure aged care facilities (including those run privately), and isolation and quarantine facilities.

Nature of the OPCAT function

Under COTA, the Ombudsman's OPCAT functions are to:[67]

- examine the conditions of detention and treatment of detainees;
- make recommendations for improving the conditions of detention, treatment of detainees and to prevent torture and other cruel, inhuman or degrading treatment or punishment; and
- report to the House of Representatives.

Examination most often takes the form of physical visits and inspections (visits), but can also include such things as consideration of law, policy and procedure, gathering of documentary evidence, interviews and surveys.

Parliament has funded me to visit each place of detention within my designation at least once every four years. Some facilities may be visited more often, depending on the circumstances. Inspectors conduct these visits on my behalf. The visits can be announced or unannounced, and can take place at any time of the day or night. Under the legislation my Inspectors have unrestricted access to any area of a detention facility, can speak to anyone, including staff and detainees, and have access to any information about the treatment of detainees and conditions of detention.[68] This information may be requested at any time, and not merely as part of a visit.

To fulfil my obligations under natural justice, I send draft reports setting out my provisional findings and opinion on the conditions and treatment of people in these places of detention and where relevant, any proposed recommendations to the relevant detaining agencies for feedback. Pursuant to section 33 of COTA, care is taken not to disclose any identifying information in my reports, or any other documentation shared with external agencies, without a person's consent.

Publication of OPCAT reports

I usually publish visit reports. In each case, my decision whether to publish is informed by whether this will assist the preventive objective and establish the grounds for the opinion, conclusions and recommendations I have reached.

[66] The designation for court cells is shared with the Independent Police Conduct Authority.

[67] Section 27 COTA.

[68] Sections 28 and 29 of COTA.

My first OPCAT report to be published was in 2017: *A question of restraint – Care and management for prisoners considered to be at risk of suicide and self-harm*.[69] This report highlighted observations for the period July 2015 – June 2016, arising from inspections of five prison sites. My report focused on the conditions and treatment of prisoners considered at risk of suicide and self-harm, who were managed in prison At-Risk Units. Significant issues that I identified included:

- At-Risk cells constantly monitored by a live camera-feed, including unscreened toilets.
- incidences of At-Risk prisoners being restrained on tie-down beds by their legs, arms and chest over prolonged periods;
- incidences of At-Risk prisoners being restrained in waist restraints with their hands cuffed behind their backs;
- incidences of tie-down beds and possibly waist restraints being used for behaviour modification purposes at some sites; and
- prisons not following their own procedures in respect of the application of mechanical restraints.

I formed the opinion that the use of a tie-down bed and/or waist restraints in the circumstances of five prisoners amounted to cruel, inhuman or degrading treatment or punishment under the Convention against Torture. I also formed the opinion that the ability of prison staff to access footage of prisoners undertaking their ablutions constituted degrading treatment or punishment under the Convention.

Following the publication of my report, tie-down beds were phased out, and are no longer used in prisons. Corrections also reviewed its use of mechanical restraints, and a long-term project is underway by Corrections to use better methods to protect the privacy of prisoners undertaking ablutions.

I have routinely published my individual visit reports for prisons since this report.

I first published visit reports for mental health facilities in 2020. Since then, I have published all visit reports for mental health places of detention, as well as thematic and summary reports, such as the *Thematic report on inspections of secure intellectual disability facilities*,[70] and a series of COVID-19 reports for different areas of inspection, including aged care, mental health, and prisons. Of particular interest to you may be:

- My report on an OPCAT inspection of Ward 21 of Palmerston North, discussed above;

[69] Chief Ombudsman Peter Boshier, *A question of restraint - Care and management for prisoners considered to be at risk of suicide and self-harm*, 1 March 2017, available at: https://www.ombudsman.parliament.nz/resources/question-restraint-care-and-management-prisoners-considered-be-risk-suicide-and-self-harm

[70] Chief Ombudsman Peter Boshier, *OPCAT report: Thematic report on inspections of secure intellectual disability facilities*, 13 April 2022, available at: https://www.ombudsman.parliament.nz/news/opcat-report-thematic-report-inspections-secure-intellectual-disability-facilities

- My report on an unannounced follow-up inspection of Te Toki Maurere Acute Mental Health Inpatient Unit, Whakatāne Hospital, in which I found:[71]
    - The building was not fit-for-purpose and, despite multiple and repeat recommendations in previous OPCAT reports, a number of ongoing issues had not been addressed, including:
        - › The seclusion facility, including the de-escalation and seclusion room, and low stimulus area, did not provide for therapeutic care;
        - › Accommodation facilities did not provide gender separation to ensure privacy and safety needs were met; and
        - › Communal areas and bathroom facilities did not meet the needs of clients for comfort, privacy and personal hygiene.
- My report on an unannounced inspection of Te Awhina, Whanganui Hospital, a 12-bed inpatient acute mental health unit, in which I found, among other things, that:[72]
    - The de-stimulation room in the Kiwi wing was used as a bedroom during the inspection, despite having no natural light.
    - The unit used the seclusion area in Stanford House, an extended term secure rehabilitation unit under the Regional Forensic Service, which was not fit for purpose and should not have been used to seclude tāngata whai ora.
    - Seclusion in the six months prior to my inspection had increased significantly compared to the same period before my previous inspection in 2017.
    - Two-thirds of tāngata whai ora secluded by the unit were Māori, totalling almost 90 percent of the unit's total seclusion hours in the six-month period. Māori made up approximately 46 percent of tāngata whai ora at the unit over the same period.
    - Not all seclusion events were being recorded by the unit.
    - There was evidence that a security guard had been present during a seclusion event and had directly interacted with the tangata whai ora, including verbally directing the tangata whai ora.

Reports that I have published over the last year on inspections of mental health and intellectual disability facilities have identified many issues of concern, including:

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[71] Chief Ombudsman Peter Boshier, *OPCAT report: Report on an unannounced follow up inspection of Te Toki Maurere Unit, Whakatāne Hospital, under the Crimes of Torture Act 1989*, 28 April 2022, available at: https://www.ombudsman.parliament.nz/resources/report-unannounced-follow-inspection-te-toki-maurere-unit-whakatane-hospital-under-0

[72] Chief Ombudsman Peter Boshier, *OPCAT report: Report on an unannounced inspection of Te Awhina, Whanganui Hospital, under the Crimes of Torture Act 1989*, 5 August 2021, available at: https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-te-awhina-whanganui-hospital-under-crimes-torture-act-1989

- buildings that are outdated and not fit for purpose;
- over-occupation, with impacts on safe management of facilities and the resultant use of seclusion rooms as bedrooms,[73] sharing of bedrooms,[74] and sleeping in hallways;[75]
- a mixing of forensic and non-forensic patients with intellectual disabilities in one facility;[76]
- a lack of gender separation in one facility, affecting patient privacy and safety;[77]
- involvement of security personnel in restraint events;[78] and
- a client living in a seclusion room on a permanent basis for over five years.[79]

While these reports may not necessarily speak to the issues specifically being considered by the Royal Commission, it nonetheless shows that the regulatory and oversight framework in place today is vastly improved from decades past.

[73] Chief Ombudsman Peter Boshier, *OPCAT report: Report on an unannounced inspection of Pūrehurehu Forensic Acute Mental Health Unit, Rātonga-Rua-O-Porirua Campus, under the Crimes of Torture Act 1989*, 28 October 2021, available at: https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-purehurehu-forensic-acute-mental-health-unit-ratonga-rua-o; and https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-rangipapa-forensic-acute-mental-health-unit-ratonga-rua-o

[74] Chief Ombudsman Peter Boshier, *OPCAT report: Report on an announced inspection of Manaakitanga Inpatient Unit, Te Nīkau Grey Base Hospital, under the Crimes of Torture Act 1989*, 2 February 2022, available at: https://www.ombudsman.parliament.nz/resources/report-announced-inspection-manaakitanga-inpatient-unit-te-nikau-grey-base-hospital-under

[75] Chief Ombudsman Peter Boshier, OPCAT report: Report on an announced inspection of Tāwhirimātea Rehabilitation Unit, Rātonga-Rua-O-Porirua Campus, under the Crimes of Torture Act 1989, 28 October 2021, available at: https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-tawhirimatea-rehabilitation-unit-ratonga-rua-o-porirua

[76] Chief Ombudsman Peter Boshier, *OPCAT report: Report on an unannounced inspection of Ward 10a and Helensburgh Cottage, Wakari Hospital Dunedin, under the Crimes of Torture Act 1989*, 2 February 2022, available at: https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-ward-10a-and-helensburgh-cottage-wakari-hospital-dunedin

[77] Chief Ombudsman Peter Boshier, *OPCAT report: Report on an unannounced follow up inspection of Te Toki Maurere Unit, Whakatāne Hospital, under the Crimes of Torture Act 1989*, 28 April 2022, available at: https://www.ombudsman.parliament.nz/resources/report-unannounced-follow-inspection-te-toki-maurere-unit-whakatane-hospital-under-0

[78] Chief Ombudsman Peter Boshier, *OPCAT report: Report on an announced inspection of Manaakitanga Inpatient Unit, Te Nīkau Grey Base Hospital, under the Crimes of Torture Act 1989,* 2 February 2022, available at: https://www.ombudsman.parliament.nz/resources/report-announced-inspection-manaakitanga-inpatient-unit-te-nikau-grey-base-hospital-under

[79] Chief Ombudsman Peter Boshier, *OPCAT report: Report on an unannounced inspection of Haumietiketike Unit, Rātonga-Rua-O-Porirua Campus, under the Crimes of Torture Act 1989*, 28 October 2021, available at: https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-haumietiketike-unit-ratonga-rua-o-porirua-campus-under The patient has now moved to new accommodation.

International development and engagement

I have received support and resourcing from Parliament to enhance my work to both learn from, and assist to develop, international best practice.

I am currently Second Vice President of the International Ombudsman Institute,[80] through my role as a Board member of the Asia Pacific Ombudsman Region. I also worked for a period training judges in Samoa, and through that work I have been bestowed with the chiefly title of Matai.

The Ombudsman model developed in New Zealand has been widely copied throughout the world and my advice and experience is sought out by other countries. The systems and processes I employ are widely viewed as international best practice. In the past year, I have engaged with Ombudsmen and their staff from around the Pacific, including the Cook Islands, Vanuatu, Samoa, Tonga, Tuvalu, Papua New Guinea, Solomon Islands and Timor-Leste.

I also derive great value in learning from my international Ombudsman colleagues. With a clear focus on my international development and engagement programme in the Pacific and Asia,[81] I have been able to gain significant understandings to ensure my functions overall are informed by Pacific cultural values, norms, practices and understandings (including understandings of disability).

With the borders now opening up, I have been able to resume in–person visits to my Pacific colleagues, and they are also now able to come to New Zealand. I recently hosted a delegation from the Tongan Ombudsman, who were in New Zealand to raise awareness of the Ombudsman role in the Tongan community.

Work relating to the rainbow community

In undertaking all my functions, I consider the rights of those in the rainbow community.

One example is an OPCAT inspection into the treatment and conditions of prisoners at Whanganui Prison. Following the inspection, I made a recommendation that prisons staff awareness of Rainbow issues could be improved.

In my June 2021 follow-up inspection and report, I noted that senior management had attended an '*LGBTQI Diversity Workshop on 19 July and 23 July 2018'*, and that on 30 July 2018, the Department of Corrections had established an Inclusion and Diversity Council to drive its Inclusion and Diversity Strategy. However, I identified unacceptable behaviour by prison staff who spoke to my Inspectors about a transgender detainee during that inspection. My report observed that:[82]

> *…derogatory language was used by some staff when speaking to my Inspectors in relation to a transgender detainee. Misgendering, deadnaming and any other forms of dehumanising and derogatory language in relation to transgender people is*

[80] The International Ombudsman Institute is the only global organisation of Ombudsman institutions, and includes more than 200 independent Ombudsman member institutions from over 100 countries.

[81] See my International and Engagement Strategy: https://www.ombudsman.parliament.nz/resources/international-development-and-engagement-strategy-july-2020-june-2023

[82] Office of the Ombudsman, *Report on an unannounced follow up inspection of Whanganui Prison under the Crimes of Torture Act 1989*, June 2021, https://www.ombudsman.parliament.nz/resources/report-announced-follow-inspection-whanganui-prison-under-crimes-torture-act-1989, at page 16.

unacceptable. My Inspectors raised their concerns at the time of inspection with senior management.

I consider more work and awareness of LGBTIQ+ issues is needed.

Proposed enhanced oversight role for children in care

Ombudsmen have long had authority to investigate complaints against Oranga Tamariki (and its previous incarnations) under the Ombudsmen Act, as well as undertake systemic investigations.

The Oversight of Oranga Tamariki System and Children and Young People's Commission Bill proposes to, among other things, strengthen the Ombudsman's oversight for children in care by:

- expanding my jurisdiction to include care and custody providers;
- providing me with additional powers to gather and share information;
- including an additional function for me to provide guidance on complaints handling; and
- including duties for me to engage with children and young people, and their family, whānau, hapū and iwi, as well as to focus on the well-being, interests and rights of children and young people.

The Bill has been reported back from Select Committee and is currently with the Committee of the whole House. If passed, the Act will come into force on or before 1 July 2023.

However, I have been working steadily over the last three years to build the capacity and capability I will need to carry out this enhanced role. Further development work is continuing, with this timed to coincide with the Act coming into force.[83]

Proposed additional jurisdiction

Clause 396 of the Bill proposes that 'custody and care providers' will be added to the Ombudsman's jurisdiction under the Bill, being three providers who hold custody over tamariki, and approximately 60 other care providers including iwi and cultural social services, and whanau providers.

Proposed additional powers to gather and share information

As I have noted above, Ombudsmen already have wide-ranging powers under the Ombudsmen Act to conduct investigations, including the ability to require Oranga Tamariki to provide information for the purposes of an investigation.

The Bill proposes to extend these powers to the pre-investigation or 'preliminary inquiry' stage of the process.[84] This means that on receipt of a complaint I would be able to require Oranga Tamariki and care and custody providers to provide information to determine whether an investigation or resolution is appropriate.

[83] See the discussion below.

[84] Clause 40 of the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill.

This is complemented by a provision which excludes, from the Official Information Act, communications between an Ombudsman, and Oranga Tamariki and care and custody providers, made in the course of these preliminary inquiries.[85] This is to ensure that agencies can be candid when engaging with me and my staff in pre-investigation inquiries, and are not constrained in their willingness to discuss or broker resolutions of complaints.

The Bill requires Oranga Tamariki and care and custody providers to give me broad access to information relating to critical or serious incidents, complaints, and trends and data about complaints.[86]

The Bill also enables me to share information and refer matters to other oversight bodies, in order to minimise the burden on agencies, and assist to promote a 'no wrong door' approach.[87]

Finally, the Bill empowers me to disclose information to an appropriate agency or person if it is necessary to mitigate a serious risk of harm to a child, overriding the secrecy obligations under the Ombudsmen Act.[88]

Proposed additional function to provide guidance on complaint handling

Under the Bill, it is proposed that the Ombudsman has a specific new function of providing guidance to Oranga Tamariki and care or custody providers to design their complaints processes and to support their continuous improvement.[89] While this function is couched as discretionary, such guidance is necessary and my office has significant experience in the consequences of poor administrative practice and decision-making. I therefore think it likely that it will be provided.

Proposed additional duties relating to children and young people

Under the principles in clause 5 of the Bill, the Ombudsman must have regard to:

- the wellbeing, interests and voices of children and young people, and their families and whanau;
- the need to respect the domestic and international legal rights of children (including under the Convention on the Rights of the Child and the Disability Convention); and
- the importance of connections of children and young people with their families, whanau, hapu, iwi and communities.

Clauses 7 and 102 require the Ombudsman, Independent Children's Monitor and Children's Commission to work in a comprehensive, cohesive and efficient way to reduce the burden on agencies and ensure effective oversight.

Clause 38 of the Bill requires the Ombudsman, when dealing with a complaint or investigation, to:

[85] Clauses 58 and 59 of the Bill.

[86] Clause 41 of the Bill.

[87] Clauses 51, 54 and 113 of the Bill.

[88] Clause 51A of the Bill.

[89] Clause 39 of the Bill.

- recognise the importance of a child or young person's family, whānau, hapū and iwi and culture;
- involve children and young people, and their family, whanau, hapu and iwi in complaints and investigations as appropriate; and
- ensure processes are visible and accessible to children, young people and their family, whānau, hapū, iwi, and incorporate a tikanga Māori approach.

Clause 42 of the Bill requires me to make reasonable efforts to develop arrangements with hapu, iwi and Māori organisations, to support me in this work.

Children in Care team

In 2019/20, with funding approved by Parliament, I created a dedicated Children in Care Complaints Team, to assist me to deal with complaints made against Oranga Tamariki (and eventually care and custody providers).

The team provides early assistance advice, resolves complaints, and undertakes investigations. The team is led by a Manager with extensive experience in child care and protection and Te Ao Māori, and the team has received training in interviewing children and taking a trauma informed approach. The team operates flexibly, matching their communication methods to that preferred by the complainants, and incorporating tikanga and te ao Māori practices such as kanohi ki te kanohi.

Over the past three years, the team has dealt with almost 1,000 complaints and other contacts,[90] including complaints received from children and young people, and whanau. Over 140 remedies have been obtained, ranging from changed or reconsidered decisions, apologies and ex gratia payments for individual complainants, to systemic actions to review or change policy, practice or procedure and the provision of guidance and training to Oranga Tamariki staff.

The team currently comprises 8FTE, with funding available to build to a team of 9FTE. The first reports published arising out of the complaints handled by this team are publicly available on my website.[91]

Other teams handling children in care matters

There are also eight other teams which, as part of their role, are able to assist me with my enhanced children in care work:

- The Systemic Improvement Monitoring and Resolution Team are tasked with identifying and resolving systemic issues, including in the Oranga Tamariki system.
- The Systemic Improvement Investigations Team undertake proactive investigations into issues where I have concerns and decide to initiate an investigation myself. One such investigation

[90] 566 complaints and 419 other contacts. Other contacts are enquiries which are responded to, but which do not progress to a formal complaint.

[91] Chief Ombudsman Peter Boshier, *First children in care case notes published*, 16 June 2020, available at: https://www.ombudsman.parliament.nz/news/first-children-care-case-notes-published

was my review of Oranga Tamariki's processes and practices relating to the uplift of newborns.[92]

- The Learning and Agency Development Team are tasked with providing training and guidance to government agencies, including agencies who deal with children in care, on good practices and decision-making.
- The Strategic Advice Team provide guidance to agencies on complaints handling policies and procedures, including agencies responsible for children in care.
- Rōpū Māori Hononga Hapori (Māori and Community Engagement Team) provide specialist input to support a te ao Māori approach and outreach to iwi and other Māori organisations.
- The Disability Rights Team provides specialist input for issues relating to children and whanau with disabilities.
- The Legal Team and Executive Advisor provide legal advice and expert input where needed.
- The Communications Team are tasked with designing my communications programme including printed material and a microsite for children in care complaints on my website. To inform this work, I commissioned specialist research to seek the voices of children and young people on how they would like to engage with me and my staff.

Altogether, Parliament has funded an additional 20FTE across these teams to support the Ombudsman's children in care work programme.

Comments on limitations posed by resourcing

The Royal Commission has sought my comment on the limitation posed by resourcing. Resourcing presents an inherent limit on the performance of any statutory functions, including my own. As an Officer of Parliament, my funding is agreed annually through Parliament by way of recommendation by parliamentary Select Committees as part of the Budget cycle. During my term as Chief Ombudsman, the funding I have received has been increased to enable me to carry out the new functions the Ombudsman has been given and to meet Parliament's expectations. As an example, I am funded at a level that enables me to undertake inspections of places of detention within my current jurisdiction under the Crimes of Torture Act 1989 at least once every four years – more regular inspections would require more resources.

Complaints about the Health and Disability Commissioner

The Royal Commission has noted that the Ministry of Health made a submission to the Health Select Committee in 2021 which said that healthcare consumers have a '*right of appeal*' to the Ombudsman if they are dissatisfied with how the Health and Disability Commissioner determined their complaint about a healthcare provider.

I would not characterise an Ombudsman's ability to investigate acts, decisions, omissions and recommendations of the Health and Disability Commissioner under the Ombudsmen Act as '*a*

[92] Chief Ombudsman Peter Boshier, *He Take Kōhukihuki | A Matter of Urgency*, 6 August 2020, available at: https://www.ombudsman.parliament.nz/resources/he-take-kohukihuki-matter-urgency

right of appeal'. An Ombudsman cannot substitute their views for that of the Health and Disability Commissioner in a legal sense.[93] Instead, an Ombudsman's statutory functions in this regard are to undertake an investigation, form an opinion, and make recommendations.[94]

In respect of the Health and Disability Commissioner making determinations on claimed breaches of the Code of Health and Disability Services Consumers' Rights, an Ombudsman can investigate both the substance of the decision taken and the process by which that decision was arrived at.

Upon receipt of a complaint, the Ombudsman may elect to make preliminary inquiries or notify an investigation to the Health and Disability Commissioner. Alternatively, the Ombudsman might suggest the complainant first raise the matter directly with the Commissioner, particularly if the complainant has to hand information not already considered by the Commissioner.[95] If the complainant has not provided sufficient information to allow the Ombudsman to determine the best course for progressing the matter, the Ombudsman's investigators typically would make inquiries of the complainant and/or the Commissioner.

An Ombudsman's investigation is an inquisitorial process, where the Ombudsman decides the relevant matters to investigate and the evidence required to enable an opinion to be formed. When the Ombudsman commences an investigation, the Ombudsman formally notifies the matter to the Commissioner and requires any relevant information and/or a report from the Commissioner to be produced on the issues raised by the complainant and any issues identified by the Ombudsman. The Ombudsman may also seek further information from the complainant and/or third parties.

It is a statutory requirement to provide any evidence the Ombudsman seeks during the course of his investigation. As noted above, An Ombudsman may enter agency premises and may summon before him and examine on oath officials from agencies under his oversight jurisdiction.

At any point in the process, the Commissioner may offer a resolution that satisfies the complainant and the Ombudsman. If so, the matter would likely be discontinued.

Once the Ombudsman has gathered sufficient information, they form an opinion as to whether the act, decision, omission or recommendation under investigation was subject to maladministration as described within the Act.[96]

The Ombudsman will provide their provisional opinion to any adversely affected party or parties in order to provide them with the opportunity to be heard. The Ombudsman would consider any comments should that opportunity to taken up, review their opinion if necessary, and once satisfied, form a final opinion on the issue (and, if they uphold the complaint, make any recommendations they see fit). The Ombudsman may also put their preliminary thinking to the

[93] Although an Ombudsman can form the opinion that the decision was 'wrong'.

[94] As discussed in detail, above.

[95] The Ombudsman may decline to investigate a complaint for the reasons set out in section 17 of the Ombudsmen Act.

[96] Section 22(1) and (2) of the Ombudsmen Act refer. See also my discussion of the Ombudsmen Act remedies.

parties about what an appropriate recommendation would look like, to provide the opportunity for that affected party to comment as to whether it would be a meaningful and/or achievable remedy in the circumstances.

An example of a recent investigation

In a recent investigation that I have published,[97] I considered that the former Health and Disability Commissioner's handling of three complaints was unreasonable. I considered the Commissioner's preliminary assessment processes in these cases stepped beyond what Parliament envisaged a 'preliminary' assessment should entail under section 33 of the Health and Disability Commissioner Act 1994.

In particular, I did not consider that Parliament intended the Commissioner to collect extensive information from health providers, expert advisors, and complainants and carry out a comprehensive analysis of the matter as part of the 'preliminary assessment'. Rather these are the types of steps I would expect to be taken in the context of an investigation, once a preliminary assessment as to how the complaint should be handled has been promptly completed.

Taking these steps had an undue negative impact on those involved. In one case, the Commissioner took three years and nine months to inform a complainant that he was declining to investigate her case. In each of the cases, the complainants and the healthcare providers were left in limbo for a significant time, causing them unwarranted stress and uncertainty.

It was also my opinion that in two of these cases, the Commissioner's decision to conclude the preliminary assessment by taking no further action was unreasonable. I was not satisfied the Commissioner had turned his mind to all the relevant factors when reaching this decision. I also considered the Commissioner made these decisions in the absence of an adequate complaint-handling policy.

I recommended the Commissioner apologise to the complainants. I also recommended that the Commissioner reconsider the decision to take no further action in two of the cases, and develop a more comprehensive complaint-handling policy.

The current Health and Disability Commissioner accepted my recommendations, apologised to the complainants, and undertook to reconsider two of the complaints. The Commissioner also began a review of her internal complaint-handling policies with assistance from my staff.

This case helps illustrate the kind of oversight an Ombudsman provides for the Health and Disability Commissioner (and, for that matter, other complaints-handling bodies including the Privacy Commissioner, Human Rights Commission, etc).

In reviewing the nature and process taken by the Commissioner during his consideration of these complaints, I identified procedural and decision-making errors which, in my opinion, made the decisions reached unfair. It is important to emphasise that while this case focused on procedural

[97] Chief Ombudsman Peter Boshier, *Investigation into the Health and Disability Commissioner's assessment of three complaints*, 1 December 2020, available at: https://www.ombudsman.parliament.nz/resources/investigation-health-and-disability-commissioners-assessment-three-complaints

issues, an Ombudsman is also able to form an opinion that a decision reached by the Commissioner was unreasonable, unjust, oppressive, improperly discriminatory, or wrong.

Training, advice and guidance to public sector agencies

Through my Learning and Agency Development, Strategic Advice, Ropu Māori Hononga Hapori, and Disability Rights teams, I provide advice, training and guidance to public sector agencies.

Successive Ombudsmen have offered training, advice and guidance to public sector agencies on that basis that it aligns with the Ombudsman's values of fostering good administrative practice. It is invaluable for agencies to be able to learn from or to test their thinking against the collective experience of successive Ombudsmen, derived from previous cases.

Training has traditionally been developed and delivered on request, and so it typically reflects the needs of the particular agency. Many of these training sessions have related to the operation of the OIA and LGOIMA. Ombudsmen have also provided training, advice and guidance on matters of good administration,[98] including good decision making, effective complaints handling, and dealing with unreasonable complainant conduct. My Disability Rights team also regularly assists agencies to improve their awareness of, and capacity and capability for meeting, the rights of disabled people.

I am currently developing an e-learning system, which will enable me to more effectively reach all of the more than 4,000 agencies under my jurisdiction. The first modules will be publically available for agencies' use in the current reporting year. This will be balanced with continued in-person sessions, focused as needed for the agency concerned.

Assistance rendered to public sector agencies

There have been some examples where public sector agencies have specifically sought advice from me on how to engage with particular parts of the population. In one example, my OPCAT staff conducted an unannounced inspection of Māngere Refugee Resettlement Centre – Te Āhuru Mōwai o Aotearoa. Te Āhuru Mōwai has an ethnically diverse clientele, many of whom may be of the rainbow community, disabled, and almost invariably have experienced trauma.

I subsequently published my report on the inspection.[99] My report observed that residents had a '*varied understanding of the formal complaints process'* and recommended that:

> *The Centre provide residents with comprehensive and understandable information about the complaints process, including on the role of the Ombudsman.*

I was pleased that Te Āhuru Mōwai staff later approached my staff to seek advice and guidance on a draft complaints policy that it had produced, and that it intended to make available to

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98 Office of the Ombudsman, *Resources and publications – Guides (Good administration),* available at: https://www.ombudsman.parliament.nz/resources?f%5B0%5D=category%3A1984

99 Chief Ombudsman Peter Boshier, *Report on an announced inspection of Māngere Refugee Resettlement Centre under the Crimes of Torture Act 1989*, 13 May 2021, available at: https://www.ombudsman.parliament.nz/resources/report-announced-inspection-mangere-refugee-resettlement-centre-under-crimes-torture-act

residents within the facility. This draft policy had clearly taken elements of my generic guide on making complaints, which I consider a good starting point for development of such material.

In engaging with the Te Āhuru Mōwai, my staff observed that the website for the Mangere Clinical Team says:[100]

> *The Mangere Clinical Team is based at the Te Āhuru Mōwai o Aotearoa, where all newly-arrived UN Quota refugees acclimatise for 5 weeks upon arrival to New Zealand.*
>
> *Trauma, family separation, cultural differences, and ongoing struggles in countries of origin are examples of stressors which often impact many former refugees. These dynamic and contextual struggles can thwart adjustment to settlement.*
>
> *RASNZ offers culturally-sensitive, trauma informed mental health services to all incoming refugees to meet individual needs.*

I drew on staff from my Strategic Advice Team, Ropu Māori Hononga Hapori, Disability Rights Team, Children in Care Team, and International Development and Engagement Team, among others, to assist me to determine how my feedback to Te Āhuru Mōwai could best cater to the needs of the intended users of the material.

My staff ultimately were able to provide Te Āhuru Mōwai with advice on how it may best tailor its internal complaints-handling guidance into a client-focused, culturally-aware and disability and child-friendly document that suits the particular needs of its clientele.

Possible improvements within the public sector

The Royal Commission has also asked me to comment on what improvements could be made within the public sector. This is clearly a complex topic. However, it may not surprise the Royal Commission that I consider further independent oversight to be an important tool. For example, it appears to me that regular independent oversight and reporting on the measures agencies have in place to identify and prevent abuse in care does assist. This kind of measure is enabled to some extent under the Ombudsman's various statutory functions outlined further below. The Royal Commission may wish to consider in what ways the Ombudsman model is best suited to this context, and how other mechanisms may also contribute.

[100] Refugees as Survivors New Zealand, *Mangere Clinical Team*, available at: https://rasnz.co.nz/what-we-do/clinical-teams/

Appendix 2. Te Rōpū Kaiārahi Hauātanga's terms of reference

Disability Advisory Panel – Terms of Reference

Background

1. One of the Chief Ombudsman's strategic priorities is to **break** down barriers that prevent disabled people from participating equally in society.

2. The Chief Ombudsman acknowledges Article 4.3 of the Disability Convention, the *'nothing about us, without us'* provision, which provides:

> *In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.*

Purpose

3. The Chief Ombudsman is committed to developing mutually beneficial relationships with disabled New Zealanders that are built on trust and understanding, and are long-term, collaborative and sustainable.

4. To achieve this objective, and to reflect Article 4.3 of the Disability Convention, the Chief Ombudsman has established the Disability Advisory Panel. The Panel will:

   - comprise a cohort of leaders with a range of lived experiences of disability,[101] including representation of tāngata whaikaha Māori (Māori disabled people) and representation from a range of age groups; and
   - meet the needs of the Chief Ombudsman with the provision of broad, wide-ranging expert disability and accessibility advice, support and guidance to support their disability rights work programme.

Role

5. The Panel's objectives are to provide a disability rights perspective, as well as advice and support, in relation to:

   a. the accessibility of the Ombudsman to disabled New Zealanders

   b. disability issues within the Chief Ombudsman's jurisdiction;

   c. ensuring effective and meaningful communication and engagement with disabled New Zealanders, including tāngata whaikaha Māori;

[101] Lived experience of disability in this context is broadly defined, especially from a te ao Māori perspective. From this world view, this includes the experiences of whānau.

d. the identification and development of new work programmes that support the strategic direction of the Chief Ombudsman in the area of disability.

6. The Panel will not provide advice on matters concerning our role within the IMM or work undertaken jointly with IMM partners.

Membership

7. There will be no more than eight members of the Panel. The membership of the panel will include leaders with diverse lived experiences of disability, including tāngata whaikaha Māori, and representatives from a range of age groups and genders.

8. Also:

- membership is generally by invitation of the Chief Ombudsman, with the potential exception of a youth member where there may be an EOI;
- the Chief Ombudsman is the Chair of the Panel (or appoints an Acting Chair in their absence);
- the Chief Ombudsman will draw upon the expertise of the members where most appropriate;
- the Chief Ombudsman may engage separately with individual members as necessary;
- the Chief Ombudsman may call on staff to attend and provide advice to the Panel; and
- other experts and experienced people may be invited to work with the panel at the invitation of the Chief Ombudsman.

9. Any appointed member may resign at any time by giving written notice to that effect to the Chief Ombudsman.

Conflict of interest

10. Members of the Panel will be asked to complete a conflicts of interest register. Further, any member proactively considering any new possible conflicts are trusted to identify them and bring them to the attention of the Chief Ombudsman. The Chief Ombudsman is committed to addressing all disclosures of possible conflicts of interest in a sensitive and reasonable manner.

Confidentiality

11. Members of the Panel may be privy to confidential information. Panel members will be required to take an oath of secrecy to the Chief Ombudsman under section 21(3) of the Ombudsmen Act 1975.

Term of participation

12. The usual term of an individual's membership of the Panel will be 12 months. However, the period of this is at the discretion of the Chief Ombudsman.

The Chair

13. The Chair will preside at all meetings of the Panel at which they are present. The Chair may request another member of the Ombudsman's staff chair any meeting at which the Chair is not present.

14. It will be the duty of the Chair, or person acting in the position of the Chair as the case may be, to approve the agenda for the meeting and any minutes for review and circulation and ensure the agenda, relevant papers and minutes are circulated in a timely manner. The Chair is also responsible for the efficient and orderly conduct of meetings and of the business of the Panel.

Operation

Meetings

15. Panel meetings will be chaired by the Chief Ombudsman (or they will appoint an Acting Chair in their absence).

16. There will be alternating virtual and in-person meetings. Two meetings per year will be convened at the Ombudsman's Wellington or Auckland premises, and two meetings will be convened virtually. Where possible, members will attend the in-person meetings for the promotion of collegiality.

17. Meetings should be conducted on a formal basis, including a record of meeting minutes.

18. The Chief Ombudsman will facilitate meetings with the following in mind:

    - the accessibility needs of all members will be accommodated;
    - the Panel will approach its work from a disability rights perspective;
    - agenda items and work of the panel will be approved by the Chief Ombudsman;
    - all views and opinions provided by members will be received and treated respectfully and in confidence;
    - members will be encouraged to bring different thinking to these meetings. These views may be challenging, but will be received with respect;
    - all public statements relevant to the Panel's work, whether from the Office of the Chief Ombudsman or from Panel members and their own organisations, will be approved by the Panel before being released;
    - members will proactively disclose any perceived conflicts of interests as a standing item at the start of each meeting;
    - Panel members will support open and honest discussions and work in an inclusive and accessible way; and
    - Panel members agree to provide responses in a timely manner and ensure they have reviewed meeting papers prior to attending meetings.

Frequency

19. It is envisaged that the Panel will meet four times per year. The Chief Ombudsman may require additional meetings where a particular need arises.

20. From time to time, the Panel or individual members may be asked by the Chief Ombudsman to provide advice on particular issues or outside of the scheduled meeting times.

Reporting

21. A member of the Office of the Ombudsman's Disability Rights Team will liaise with the Chief Ombudsman and the Panel on emerging issues or follow up on agreed matters.

22. The minutes of these meetings will be circulated to the Office's Senior Management Team, Strategic Advice Team and other staff at the discretion of the Chief Ombudsman.

Administrative support

23. The Office of the Ombudsman's Disability Rights Team will:

- ensure that members receive all available and relevant information at least seven days in advance, to fully prepare for meetings;
- ensure that members receive the necessary time and resources to actively participate in meetings;
- coordinate meeting agendas, distribution of papers and recording minutes for each meeting;
- manage the attendance of any individual or group that may be required to provide further information; and
- manage logistics and expenses for every meeting.

Remuneration

24. The daily fee for all members will be determined by the Chief Ombudsman in accordance with their own policy.

25. The daily fee is for any reading or other preparation required in advance of, attending and participating at meetings.

Costs and expenses

26. The following costs and expenses will be met, upon appropriate invoicing:

- travel costs of one-day, roundtrip airfare, and other travel costs to and from meetings in accordance with Ombudsman policy;
- taxis to and from airports, including parking costs incurred on meeting days; and
- lunch, morning and afternoon teas will be provided on meeting days.

27. The cost or purchase of additional expertise, material or reports will be met at the discretion of the Chief Ombudsman.

Review

28. This document is reviewable at the end of the first year of the term and at the beginning of each new term.

June 2021

[Document ends]