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OPCAT Report

Report on an unannounced follow up inspection of Otago Corrections Facility under the Crimes of Torture Act 1989

June 2019

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Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report on an unannounced follow up inspection of Otago Corrections Facility under the Crimes of Torture Act 1989
ISBN: 978-0-473-47822-3 (PRINT)
ISBN: 978-0-473-47823-0 (ONLINE)
Published June 2019

Office of the Ombudsman | Wellington, New Zealand | www.ombudsman.parliament.nz

Contents

Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of detainees in New Zealand prisons.

From 28 January to 1 February 2019 my Inspectors (whom I have authorised to carry out visits of places of detention under COTA) visited Otago Corrections Facility (the Prison) to follow up on recommendations made in a previous OPCAT report (May 2016). There were 480 prisoners in the Prison on the first day of inspection.

Methodology

During the follow up inspection, my Inspectors visited all units and spoke with a selection of managers and staff across the site.

The team looked for progress in implementing the recommendations made in 2016, and identified any additional issues that need addressing.

My Inspectors provided verbal feedback to the Deputy Prison Director on 31 January 2019, outlining initial observations. A provisional report was sent to the Prison Director and Corrections Services National Office for comment.

Findings

Sixteen recommendations were made following the full OPCAT inspection in May 2016. The follow up inspection found of these 16 recommendations, five had been achieved, five partially achieved and six not achieved. Seven repeat and two new recommendations have been made as a consequence of the January 2019 follow up inspection. (See Appendix 1).

My Inspectors made the following positive observations:

- the Prison continued to be well maintained and clean;
- the introduction of Improving Mental Health Clinicians since the 2016 Inspection had a positive impact on prisoners experiencing mental distress. Prisoners reported feeling more supported. The clinicians were professional and experienced;
- significant improvements in record keeping and associated processes had been made; particularly in relation to directed and voluntary segregation. Use of force paperwork was up to date; and
- all prisoners were receiving their minimum entitlement to an hour in fresh air, daily.

However, there are a number of matters that are concerning. In contrast to the 2016 inspection, my Inspectors observed some prison staff displaying a lack of respect for, and

negative attitudes towards, prisoners. The use of profane language with prisoners is, in my opinion, unprofessional.

Also, there was no clear progression for prisoners transitioning out of Unit 35K to lower security units, (which was referred to by prison staff as the 'naughty boys unit').

My Inspectors observed a higher use of pepper spray[1] compared to other prisons and what appeared to be a low threshold for deployment.

Senior management reported that a significant number of prisoners at the facility were from out of region; contact with whānau was comprised as a consequence.

Voluntary segregated prisoners were still experiencing long periods of lock down (some prisoners reported spending up to 23 hours a day in their cell).

All youth were routinely held in the Intervention and Support Unit (ISU), as the Prison did not have a dedicated youth unit. Consequently, all youth were subject to constant in-cell monitoring through CCTV, including coverage of the unscreened toilets, which I consider is an unwarranted and unacceptable invasion of privacy.

The Department of Corrections' comments on my 2019 findings and recommendations are set out in Appendix 2.

[1] The Department of Corrections reported that '*Otago Corrections Facility introduced pepper spray across the site in December 2017; where as some other sites did not have pepper spray until June 2018.*'

Treatment

2016 Recommendations – treatment

a. Cameras should not cover toilet areas. **Not achieved.**

Findings 2019

Inspectors noted prisoners in the Intervention Support Unit (ISU)[2], were still subject to CCTV monitoring, which was displayed in the staff base and master control. The camera could be viewed by anyone entering the staff base and presented a significant privacy issue.

My Inspectors note that some prisons and court cells have recently implemented technology that 'blacks out' the toilet area in camera feeds. Otago Corrections Facility has yet to introduce such technology.

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

I continue to engage with the Department of Corrections on this issue[3].

b. Alternatives to the use of waist restraints and handcuffs to manage self-harming behaviour should be investigated. **Partially achieved.**

Findings 2019

In the six months prior to this follow up inspection (1 August 2018 -31 January 2019), waist restraints and handcuffs were used on two occasions on two individual prisoners to manage their self-harming behaviour. Inspectors were informed that comprehensive approaches to prisoner management were explored through multi-disciplinary teams, including forensic health, which is good to learn. Periods of restraint did not exceed two hours, during which time prisoners were supervised continuously by staff. All relevant paperwork was completed appropriately.

I am unaware of any comprehensive work undertaken to examine alternatives to the use of waist restraints and handcuffs to manage self-harming behaviour.

[2] Intervention Support Unit (ISU), previously known as the At Risk Unit (ARU).

[3] The Department of Corrections has recently reviewed prisoner privacy and provided me with a copy of their review for comment.

c. A site specific directed segregation register and corresponding segregation paperwork should be easily accessible. **Achieved.**

Findings 2019

Senior prison staff informed my Inspectors that a significant amount of work had been done to improve paperwork and associated systems. The Prison's directed segregation register was easily accessible, as was corresponding segregation paperwork, which was comprehensive and up to date.

d. Punishment cells should not be used to house prisoners on directed segregation. **Not achieved.**

Findings 2019

On the second day of inspection, there were seven prisoners in punishment cells on directed segregation. All separate cells were monitored on CCTV and none of the cell toilets had privacy screening. Therefore, prisoners on directed segregation were still accommodated in cells that did not meet the requirements specified under Corrections Regulation 2005, Schedule 2, Part B, *Items and Features of cells for segregated prisoners*.

e. A site specific voluntary segregation register and corresponding segregation paperwork should be easily accessible. **Achieved.**

Findings 2019

Inspectors noted the Custodial Systems Manager had comprehensive processes and recording systems in place. Voluntary segregation paperwork was easily accessible on the respective prisoner's files.

f. Prisoners on voluntary segregation being managed in the management unit should have access to the same opportunities as all other prisoners on voluntary segregation. **Not achieved.**

Findings 2019

On the second day of the inspection (29 January 2019), there were 13 prisoners in the management unit. My Inspectors were able to speak with three prisoners on voluntary segregation and one prisoner on directed protective custody. All four prisoners reported that they were unable to access programmes or activities, and were locked in their cell for up to 23 hours a day. Prisoners confirmed that they could clean their cells every other day, and use the telephone on request. All four prisoners had been in the management unit for several months.

Staff in the management unit, the Improving Mental Health Clinicians and the Deputy Prison Manager confirmed that prisoners on voluntary segregation in the management unit were subjected to a restrictive regime due to the number of security classifications housed in the unit.

I consider that voluntary segregated prisoners in the management unit still lack access to the same opportunities as other prisoners on voluntary segregation and are, in effect, managed as if on long-term directed segregation.

g. Prisoners being held in the ARU should be given the opportunity to contribute towards their management plan and attend the weekly multidisciplinary meeting. **Not achieved.**

Findings 2019

The ISU Manager, Health Services Team Leader, Forensic Nurse and Improving Mental Health Clinicians informed my Inspectors that prisoners do not get the opportunity to contribute towards their management plan or attend their weekly multidisciplinary team meeting.

h. The ARU should consider implementing some therapeutic interventions which address issues such as coping strategies and mental wellbeing as an alternative to locking prisoners in their cell. **Partially achieved.**

Findings 2019

I am aware that the Department of Corrections is currently undertaking a pilot project at some prisons to increase therapeutic activities in ISUs. However, the ISU Manager, Health Services Team Leader, Forensic Nurse and Improving Mental Health Clinicians confirmed that there were no specific therapeutic interventions for prisoners in the Prison's ISU. Youth prisoners

were also held in the ISU, which reduced the time both ISU prisoners and youth could spend in the ISU dayroom.[4]

My Inspectors also identified that youth held in the ISU were subject to CCTV monitoring, which was displayed in the staff base and master control. The camera could be viewed by anyone entering the staff base and presented a significant privacy issue.

I remain of the opinion that the ability to observe prisoners, either directly or via CCTV, undertaking their ablutions or in various stages of undress is degrading treatment or punishment and a breach of Article 16 of the CAT.

i. The Prison should carry out its own safety survey to identify where prisoners feel least safe, and address the findings in an arena that includes prisoner representation. **Partially achieved.**

Findings 2019

Since the 2016 inspection, the Prison had undertaken a Well Functioning Service Assessment,[5] which included a survey of prisoners. The final report did not include safety aspects for prisoners but those prisoners surveyed described 'a general feeling of safety' at the Prison.[6]

I am concerned that threatening behaviour and violent incidents towards staff and prisoners showed an upward trend at the Prison from the previous year. There had been 72 incidents of spontaneous use of force between 1 March 2018 and 28 February 2019 compared with 49 for the same period the year prior (47 percent increase). Over the same period, incidents of prisoner-on-prisoner abuse had increased from 19 reported incidents to 34 (79 percent increase), prisoner-on-prisoner assaults had increased from 49 to 58 (18 percent increase) and prisoner on staff assaults from 21 to 34 (62 percent increase). The prison population had increased by approximately six percent from the previous year.[7]

A review of incidents and use of force paperwork suggested that some prisoners from out of the region were assaulting staff to get reclassified and transferred back to their home region. Senior management confirmed my Inspectors' observations on this matter.

I am concerned about the facility's higher use of pepper spray compared to other prisons and what appeared to my Inspectors to be a low threshold for deployment. The Prison has the

[4] There is no designated youth unit at the Prison. Youth must be managed separately from the adult population as per Corrections Regulation 179.

[5] *Tokorima a Māui*. August 2018.

[6] Inspectors were provided with general survey information that was collected for the assessment. Inspectors were not provided with data as to how many prisoners were surveyed for the assessment.

[7] Average muster last year was 464 (between 30 March 2017- 28 February 2018). Average muster this year is 491 (between 31 March 2018 – 28 February 2019).

second highest rate of pepper spray deployment in the country[8] despite it having a comparatively lower muster to the majority of New Zealand prisons. My Inspectors observed footage of three incidents where pepper spray was deployed; on each occasion my Inspectors assessed that alternative responses could have been employed. It did not appear to Inspectors that alternatives along the continuum of force were attempted, or at least considered, before pepper spray was authorised for use.

Protective measures

2016 Recommendations – protective measures

j. The Prison adjudicator should complete all the necessary paperwork, including the punishment book, following each misconduct hearing. **Achieved**.

Findings 2019

During the follow up inspection, my Inspectors observed two adjudication hearings. All the necessary paperwork, including the punishment book, were completed following each misconduct hearing. The punishment book was comprehensive and up to date.

Material Conditions

2016 Recommendations – material conditions

k. Prisoners being processed in the receiving office should be afforded privacy. **Partially achieved.**

Findings 2019

Since the 2016 inspection, CCTV has been installed in a designated interview room in the receiving office. This meant that prisoners could be interviewed and assessed in private. Disappointingly, my Inspectors did not observe the room used as such during the inspection. The majority of assessments continued to be conducted within the hearing of other prisoners and staff in the main receiving office.

[8] As at 14 January 2019. Data provided by the Department of Corrections Organisational Performance and Reporting team.

l. Ideally, the serving of meals needs to be standardised to normal hours, particularly on units that are not running on an 8-5 regime. This would involve lunch being served any time between 12.00pm and 1.30pm, and dinner to be served any time between 5pm and 7pm. **Not achieved.**

Findings 2019

Mealtimes had not been standardised to normal hours. Inspectors observed dinners served to prisoners through their cell meal hatches between 3.30pm and 4.00pm in the high security units on each day of the inspection.

Inspectors were informed by senior managers that the Department is undertaking a review of shift patterns, which will include a review of prisoner meal times.

I consider the serving of evening meals at 3.30pm contravenes Rule 22 of the Nelson Mandela Rules, namely:

> *Every prisoner shall be provided by the prison administration at the usual hours with food of nutritional value adequate for health and strength, of wholesome quality and well prepared and served.*

Activities and communications

2016 Recommendations – activities and communications

m. All prisoners should be able to access fresh air. **Achieved**.

Findings 2019

Prisoners were able to access their minimum entitlement of one hour's fresh air in all units, including the ISU and Management Unit.

Health care services

2016 Recommendations – health care services

n. Complaints relating to health services should not be logged on the internal complaint system (P.C.O.1). Complaints should be responded to in a timely manner. **Not achieved.**

Findings 2019

The Prison had not established a separate health complaints system. The Team Leader, Health Services informed my Inspector of the measures they were taking to provide better confidentiality regarding prisoners' health complaints.

My Inspectors reviewed a number of health complaints on the Integrated Offender Management System (IOMS) and noted responses were timely but not confidential.

o. There should be adequate supervision of all medication administration to ensure safe practice. This should include the safe and secure transportation of medication around the site and correctly identifying the prisoner (using the medication sheet) before dispensing medication. **Partially achieved.**

Findings 2019

My Inspectors observed a number of unsafe practices including nursing staff issuing medication to prisoners in doorways and communal areas, and a lack of privacy or confidentiality for patients in any of the units when medications were administered. However, nursing staff confirmed a patient's identity before issuing medication, and custodial staff escorted nursing staff with their medication boxes.

Over-the-counter medication (paracetamol) was poorly managed and open to abuse. Inspectors observed custodial staff dispensing large quantities of paracetamol with no written record of the event.

p. All policies, service level agreements and contracts should be up to date. **Achieved.**

Findings 2019

My Inspectors were provided with signed, up-to-date copies of the service level agreement between the Department of Corrections and Southern District Health Board's Regional Forensic Service; the contract for the provision of Improving Mental Health Clinicians; and the contract for the provision of Pharmaceutical Services.

2019 follow up recommendations

Treatment

I recommend that:

a. CCTV should not cover the toilet area.
This is a repeat recommendation.

b. Alternatives to the use of waist restraints and handcuffs to manage self-harming behaviour should be investigated.
This is a repeat recommendation.

c. Punishment cells not be used to house prisoners on directed segregation.
This is a repeat recommendation.

d. Prisoners on voluntary segregation located in the management unit have access to the same opportunities as all other prisoners on voluntary segregation.
This is a repeat recommendation.

e. Prisoners located in the ISU be given the opportunity to contribute towards their management plan and attend the weekly multidisciplinary team meeting.
This is a repeat recommendation.

f. The ISU implement therapeutic interventions which address issues such as coping strategies and mental wellbeing as an alternative to locking prisoners in their cell.
This is a new recommendation.

Material conditions

g. Serving times of meals are standardised to normal hours. This would involve lunch being served any time between midday and 1.30pm, and dinner to be served any time between 5pm and 7pm.
This is a repeat recommendation.

Health care services

h. Complaints relating to health services are not logged on the internal complaint system (P.C.O.1).
This is a repeat recommendation.

i. Arrangements for dispensing and supervising taking of medication should be improved to ensure privacy and clinical confidentiality.
This is a new recommendation.

Acknowledgements

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

Publication

Under Section 27 and 36 of the Crimes of Torture Act 1989, the Chief Ombudsman will present a copy of his final report to Parliament before publication on the Ombudsman website.

Peter Boshier
Chief Ombudsman, National Preventive Mechanism

Appendix 1. Summary of 2016 recommendations and 2019 follow up findings

2016 recommendations	Prison response	Follow up finding 2019
a. Cameras should not cover toilet areas	Rejected	Not achieved
b. Alternatives to the use of waist restraints and handcuffs to manage self-harming behaviour should be investigated.	Partially accepted	Partially achieved
c. A site specific directed segregation register and corresponding segregation paperwork should be easily accessible.	Accepted	Achieved
d. Punishment cells should not be used to house prisoners on directed segregation.	Partially accepted	Not achieved
e. A site specific voluntary segregation register and corresponding segregation paperwork should be easily accessible.	Accepted	Achieved
f. Prisoners on voluntary segregation being managed in the management unit should have access to the same opportunities as all other prisoners	Accepted	Not achieved
g. Prisoners being held in the At Risk Unit (ARU) should be given the opportunity to contribute towards their management plan and attend the weekly multidisciplinary meeting. **This recommendation was first made in 2014**.	Accepted	Not achieved
h. The ARU should consider implementing some therapeutic interventions which address issues such as coping strategies and mental wellbeing as an alternative to locking prisoners in their cell. **This recommendation was first made in 2014.**	Accepted	Partially achieved
i. The Prison should carry out its own safety survey to identify where prisoners feel least safe, and address the findings in an arena that includes prisoner representation.	Accepted	Partially achieved
j. The Prison adjudicator should complete all the necessary paperwork, including the punishment book, following each misconduct hearing.	Accepted	Achieved
k. Prisoners being processed in the receiving office should be afforded privacy	Accepted	Partially achieved

2016 recommendations	Prison response	Follow up finding 2019
l. Ideally, the serving of meals needs to be standardised to normal hours, particularly on units that are not running an 8-5 regime. This would involve lunch being served any time between 12.00 pm and 1.30 pm, and dinner to be served any time between 5pm and 7pm	Partially accepted	Not achieved
m. All prisoners should be able to access fresh air daily.	Accepted	Achieved
n. Complaints relating to health services should not be logged on the internally complaint system (P.C.O.1). Complaints should be responded to in a timely manner. **This recommendation was first made in 2014**.	Partially accepted	Not achieved
o. There should be adequate supervision of all medication administration to ensure safe practice. This should include the safe and secure transportation of medication around the site and correctly identifying the prisoner (using the medication sheet) before dispensing medication. **This recommendation was first made in 2014**.	Accepted	Partially achieved
p. All policies, service level agreements and contracts should be up to date. **This recommendation was first made in 2014**.	Accepted	Achieved

Appendix 2. Department of Corrections' response to 2019 follow up findings and recommendations

Follow-up recommendations

a. **CCTV should not cover the toilet area.**

The Department of Corrections partially accepted this recommendation, and commented:

> *Corrections acknowledge that balancing the dignity and privacy of prisoners in Intervention and Support Units (ISUs) with the preservation of life presents a unique challenge. As acknowledged by your office, a piece of work is underway in this area, which has been led by the Chief Custodial Officer. This work has looked at research and international practices to support future actions and includes consideration of international practices, legislative instruments and identifying potential options for enhancing privacy for prisoners in ISUs. We have provided your office with a copy of the completed review regarding this work, for consultation.*
>
> *A cross-organisation group is scheduled to meet later this month to determine a plan to progress the review findings. It is expected that initial plans will be established by the end of July 2019. Once received, any feedback from your office will be considered as part of the planning process. I would like to note your inspector's comments regarding the pixilating or 'blacking out' of footage, particularly footage of the toilet. Please be aware that there is no nationwide Corrections initiative in and of itself regarding implementing technology that pixilates CCTV footage. Any options for enhancing privacy in ISUs across the prison network will be considered as part of the above piece of work mentioned and any site based initiatives should be treated in isolation from the wider prison network.*

b. **Alternatives to the use of waist restraints and handcuffs to manage self-harming behaviour should be investigated.**

The Department of Corrections partially accepted this recommendation, and commented:

> *Otago Corrections Facility notes that the use of waist restraints and handcuffs to manage at risk prisoners is used in extreme cases as a last option for ensuring a prisoner's safety. In both instances you mention in your findings, the prisoners were managed in a number of different ways prior to the use of waist restraints. For instance, with one of these prisoners, the cell door was left open with a Corrections Officer stationed outside the cell on a chair so as to be able to talk to the prisoner if needed and gain easy access to the cell in case of any self harming behaviour. In this instance, the prisoner ran at the Corrections Officer who was knocked over and badly injured. Two staff members were injured in the management of this prisoner.*
>
> *Management plans, daily discussions around appropriate interventions and safety for both prisoners and afterhours care options were consistently updated depending on both prisoners' daily presentations. I am advised that the care plans and management plans*

evidencing this could have been provided to your inspectors; however we are happy to facilitate this information being provided to your office, at your request.

Where the use of waist restraints and handcuffs has been implemented, consultation with the Chief Custodial Officer, Multi-Disciplinary teams and mental health clinicians were done to ensure that the option is considered and the safest and most appropriate choice is made.

Waist restraints and handcuffs are also removed at the earliest opportunity to allow for more therapeutic interventions to be implemented.

In response to the Department of Corrections' comments, I suggest a comprehensive piece of work to examine alternatives to waist restraint and handcuffs is undertaken rather than reviewing prisoners on a case by case basis.

c. **Punishment cells not be used to house prisoners on directed segregation.**

The Department of Corrections partially accepted this recommendation, and commented:

Otago Corrections Facility has eight punishment cells that have been fitted with power points to allow use of these cells for other categories of prisoners when the need arises. The Management unit houses a mix of directed segregation, directed protective custody, prisoners on misconducts or subject to restrictions, and a small number of vulnerable voluntary protective custody prisoners (who regularly move back and forth from the ISU). Often among this group, staff must maintain separation between groups of prisoners due to the potential risk and disruption. This includes instances where gang tensions can mean that certain factions cannot be housed on the same side of the unit or there is a serious non-association need to adhere to.

Prisoners on directed segregation accommodated in punishment cells are not on punishment and are provided with the same amenities as all other prisoners on directed segregation. In this case, the fitting of power points in punishment cells to meet the requirements set out in Schedule 2, Part A of the Corrections Regulations 2005, allows for these cells to be used to accommodate prisoners on directed segregation.

Your office has noted that all separate cells were monitored on CCTV and none of the cell toilets had privacy screening obscuring the camera footage. You note that this does not meet the requirements specified under Corrections Regulations 2005, Schedule 2, Part B, Items and Features of cells for segregated prisoners. As you are aware, there is ongoing dialogue between our agencies with regard to the presence of privacy screens in cells. We understand that you are currently further consulting on the information we provided. We look forward to hearing from you following this consultation and working with you further in this area.

d. **Prisoners on voluntary segregation located in the management unit have access to the same opportunities as all other prisoners on voluntary segregation.**

The Department of Corrections accepted this recommendation, and commented:

Otago Corrections Facility acknowledges that all prisoners on voluntary segregation should have the same access to opportunities to enable them to progress. This is an important element of an individual's rehabilitation and reintegration management. Notwithstanding this, Otago Corrections Facility has noted that prisoners on voluntary segregation in the management unit have a higher dependency on staff, with many of these individuals having complex mental health histories. Many of these prisoners do not necessarily cope well mixing with a large number of other prisoners. These prisoners therefore receive greater one on one time with staff, including with the Multi-Disciplinary team and the Prison Forensic Service.

Otago Corrections Facility acknowledges the importance of allowing these prisoners to access the same opportunities as other prisoners on voluntary segregation. The following opportunities are made available to these prisoners:

- *Intensive Literacy and Numeracy*
- *Secure Online Learning*
- *Core Credits Programme (NCEA)*
- *Seasons for growth*
- *Workplace First Aid*
- *Self Directed Learning – supported by Corrections' Education Tutors*
- *Polytechnic courses*
- *Weekly visits to the gym for physical activity.*
- *Access to colouring books, puzzles, Sudoku and reading material.*
- *The Otago Corrections Facility Cultural Officer, the Chaplain and the Island Support Network visit the unit regularly and are available for further support on request.*

When a prisoner is progressing well, he is relocated to the Voluntary Protective Custody unit at the earliest opportunity.

e. **Prisoners located in the ISU be given the opportunity to contribute towards their management plan and attend the weekly multidisciplinary team meeting.**

The Department of Corrections accepted this recommendation, and commented:

Where appropriate, Corrections agree that prisoners in the ISU are offered the opportunity to have greater involvement in their management, which can also mean attending the weekly Multi-Disciplinary team meeting. However, there are cases where prisoners have been deemed too unwell by mental health professionals, to be engaged in their management plans. The aim is to remove this barrier through appropriate treatment of the prisoner to allow them more autonomy in their management.

Prisoner involvement is considered on a case by case basis and is an ongoing priority for staff in the ISU.

f. **The ISU implement therapeutic interventions which address issues such as coping strategies and mental wellbeing as an alternative to locking prisoners in their cell.**

The Department of Corrections accepted this recommendation, and commented:

> *As part of the Intervention and Support project, in mid 2018, a Supported Decision Making Framework (SDF) was rolled out to prison staff to support the development of management plans for individuals in ISUs. Specifically, when reviewing decisions about exercise, unlock hours, communal eating, property, meals and mixing with other prisoners. The SDF prioritises safety of the individual and staff whilst balancing humane treatment. It focuses on including input from custodial staff, health services and the individual to develop the management plan. A main focus of the SDF is to support decision making that provides the least restrictive environment possible whilst providing rationales if restrictions are put in place.*
>
> *At the time of your visit, Otago Corrections Facility had work planned or underway with regard to introducing therapeutic interventions and strategies for prisoners in the ISU. This work is ongoing and is a priority for the site. Any further work will be supported by the roll out of the Intervention and Support project once it has been completed in its pilot sites.*

g. **Serving times of meals are standardised to normal hours. This would involve lunch being served any time between midday and 1.30pm, and dinner to be served any time between 5pm and 7pm.**

The Department of Corrections accepted this recommendation, and commented:

> *The importance of aligning meal times to standardised hours is currently being addressed as part of our ongoing 'Making Shifts Work' project. Corrections have acknowledged that there are certain limitations to the current eight hour shift structure in issuing meals to prisoners, conducting muster checks and the lock up times. The 'Making Shifts Work' project team will provide foundational infrastructure to enable flexible work practices and a modern rehabilitation-focused prison system, supported by up-to-date and effective technology.*
>
> *As your office is aware, the Healthy Products Canteen Review was completed in 2018. The aim of this review was to offer healthier and more substantial choices to prisoners through a review of the options sold at the P119 store. Given the completion of this review and the provision of a sufficient quantity of nutritional food, alongside the ability for prisoners to purchase additional food items, we consider this mitigates immediate concerns.*

h. **Complaints relating to health services are not logged on the internal complaint system (PC.O1).**

The Department of Corrections accepted this recommendation, and commented:

> *The process for PC.01 complaints relating to health complaints has been altered to prompt prisoners not to include medical information on their PC.01 form and to remind*

staff not to enter this into prisoners profiles. This is to provide for greater privacy for the individual and their medical information. This change was communicated to all staff in October 2018.

The Deputy Prison Director at Otago Corrections Facility sent a reminder to staff on 6 May 2019, not to record confidential health information in prisoner's profiles when lodging PC.01 complaints and to prompt prisoners not to include this information when filling out PC.01 forms.

This has also been raised in morning briefings and Principal Corrections Officer meetings to remind staff of the importance of this process being adhered to. Secondary assurance checks to ensure that this process is embedded in practice, are scheduled over the coming months.

i. **Arrangements for dispensing and supervising taking of medication should be improved to ensure privacy and clinical confidentiality.**

The Department of Corrections accepted this recommendation, and commented:

Nursing staff are aware that medication rounds are exclusively for administering medication and no other medical matters (except true emergencies) are discussed. At shift handover, nursing staff consistently discuss and are made aware of the importance of not raising confidential clinical information with prisoners on medication rounds.

We have found that prisoners may see medication rounds as an opportunity to initiate conversations with health services staff regarding health concerns or requests. They may share clinical information with staff and unfortunately they may do so in front of cell mates. Nurses are aware that they are not to engage in this discussion with prisoners. In an effort to provide a safeguard against this, Otago Corrections Facility have set up weekly unit based health assessments which allow prisoners to be seen (upon submitting a request for health services) by nursing staff without having to be escorted to the Health clinic in the Health Centre. This is guided by the use of a triage system by nursing staff where less serious or routine conditions can be allocated to the unit based health assessments whilst the more serious conditions can be seen in the Health clinic.

This system has many benefits for prisoners and nursing staff, one of them being that it encourages prisoners not to raise concerns on medication rounds as they are aware that they can be seen in unit based assessments. Nursing staff are therefore also able to focus solely on the accurate and safe administration of medication on rounds. This system was in place at the time of your office's inspection however has been strengthened recently through further engagement with custodial staff to support these unit based assessments.

With regard to your finding about the provision of Panadol to prisoners by custodial staff, management have reminded staff at morning briefings and in Principal Corrections Officer meetings that any provision of Panadol to prisoners must be recorded in the register. Each unit has a hard copy register to note the provision of Panadol to prisoners. This practice has been reinforced with staff following your office's findings.

Appendix 3. Legislative framework

In 2007, the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The objective of OPCAT is to establish a system of regular inspections undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention

Section 16 of COTA identifies a '*place of detention*' as:

> *…any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in…*
>
> *(a) a prison …*
>
> *(c) a court cell.*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 (Ombudsmen Act) was designated a National Preventive Mechanism (NPM) for certain places of detention, including prisons and court cells.

Carrying out the NPM's functions

Under section 27 of COTA, an NPM's functions, in respect of places of detention, include:

- to examine, at regular intervals and at any other times the NPM may decide, the conditions of detention applying to detainees and the treatment of detainees; and
    - to make any recommendations it considers appropriate to the person in charge of a place of detention:
    - for improving the conditions of detention applying to detainees;
    - for improving the treatment of detainees;
    - for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Under COTA, NPMs are entitled to:

- access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
- unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;

- interview any person, without witnesses, either personally or through an interpreter; and
- choose the places they want to visit and the persons they want to interview.

Section 34 of the COTA, confers the same powers on NPMs that NPMs have under any other legislation when carrying out their function as an NPM. These powers include those given by the Ombudsmen Act to:

- require the production of any information, documents, papers or things that, in the Ombudsmen's opinion, relates to the matter that is being investigated, even where there may be a statutory obligation of secrecy or non-disclosure (refer sections 19(1), 19(3) and 19(4) of the Ombudsmen Act); and
- at any time enter and inspect any premises occupied by any departments or organisation listed in Schedule 1 of the Ombudsmen Act (refer section 27(1) of the Ombudsmen Act).

To facilitate the exercise of the NPM function, the Chief Ombudsman has authorised inspectors to exercise the powers given to him as an NPM under COTA, which includes those powers in the Ombudsmen Act for the purpose of carrying out the NPM function.

More information

Find out more about the Chief Ombudsman's NPM function, inspector powers, and read his reports online: www.ombudsman.govt.nz under What we do > Protecting your rights > Monitoring places of detention.