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OPCAT Report

Report on an announced follow up inspection of Matawhāiti Residence under the Crimes of Torture Act 1989

February 2023

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Tari o te Kaitiaki Mana Tangata

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Introduction

The following report has been prepared in my capacity as a National Preventive Mechanism (NPM), as designated under the Crimes of Torture Act 1989 (COTA). The purpose of the COTA is to enable Aotearoa New Zealand to meet its international obligations under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its Optional Protocol (OPCAT).[1]

I am empowered to examine places of detention: where people are unable to leave at will. My designation includes residences established under section 114 of the Public Safety (Public Protection Orders) Act 2014 (the Public Safety Act). Central to this is conducting visits and inspections. This has a preventive purpose, to ensure that safeguards against ill-treatment are in place and that poor practices, or systemic problems, are identified and addressed promptly.

My role is to form an independent opinion as to the conditions and treatment in these places, report my findings and if necessary make recommendations for improvement.

More information

Find out more about the Chief Ombudsman's OPCAT role, and read my reports online: ombudsman.parliament.nz/opcat.

Overview of inspection

Inspection approach

An unannounced visit of the Residence was undertaken in 2018. The first full OPCAT inspection of the Residence took place in February 2020. On 23 February 2022, my Inspectors made an announced one-day inspection to the Residence to follow up on recommendations made in 2020. Two residents were detained in the 12-bed facility at the time of the inspection.

My Inspectors looked for progress in implementing the 2020 recommendations, and identified any additional issues that need addressing. To ensure an evidence-based approach, my Inspectors gathered and assessed a range of information, including:

- information and documents from the Department of Corrections and the Residence, including relevant policies, procedures and performance reports;
- interviews with residents, staff and other relevant stakeholders; and
- observations within the Residence.

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

Consultation on provisional report

A provisional report was provided to the Matawhāiti Residence, the Department of Corrections and the Chairperson of the Public Protection Order Review Panel (PPO Panel) for comment. I received a response from Chair of the PPO Panel and the Department of Corrections. I have considered their feedback when preparing my final report.

Follow-up inspections will be made to monitor the implementation of my recommendations.

Facility facts

Matawhāiti Residence (the Residence) is Aotearoa New Zealand's civil detention facility for people detained under the Public Safety (Public Protection Orders) Act 2014 (the Public Safety Act).[2] The Residence opened in January 2017 and is located on one hectare of land in the grounds of Christchurch Men's Prison.

To be detained under a Public Protection Order (PPO) a person must be aged over 18 and have served a prison sentence for a serious sexual or violent offence, or be subject to the most intensive form of an extended supervision order.[3] Section 13 of the Public Safety Act requires that the person must also pose a very high risk of imminent and serious sexual or violent offending and be assessed as having each of the following characteristics:[4]

- an intense drive or urge to commit a particular form of offending;
- limited self-regulatory capacity, evidenced by general impulsiveness, high emotional reactivity, and inability to cope with, or manage, stress and difficulties;
- absence of understanding or concern for the impact of their offending on actual or potential victims; and
- poor interpersonal relationships or social isolation.

PPOs are granted by the High Court for an indefinite period, but are reviewed annually by a Review Panel.

Key observations and recommendations

I am pleased that there has been positive progress at the Residence on a number of my 2020 recommendations. The follow up inspection found that of the ten 2020 recommendations, six had been achieved, three were not achieved, and one I was unable to definitively assess.

I found that there had been significant progress on my recommendation regarding access to supervised leave for residents for rehabilitative or humanitarian purposes. Since approximately May 2021, residents had markedly more regular and meaningful access to a range of activities

[2] Linda Pullan and Andrew Burger (2019) 'Matawhāiti Residence – Public Protection Orders' *Practice: The New Zealand Corrections Journal*, Vol. 7, Issue 1.

[3] Public Safety (Public Protection Orders) Act 2014, section 7.

[4] Public Safety (Public Protection Orders) Act 2014, section 13.

outside the Residence, including supervised opportunities to develop life skills, individual hobbies and connect with others. My Inspectors observed the positive impacts this shift was having on the well-being, quality of life and re-integration opportunities for residents.

Residents had improved access to their own medications and the Residence was no longer charging residents for the use of the telephone. The Residence had made a number of positive modifications and improvements to the living environment. Residence gardens and grounds had been developed and maintained with involvement of staff and residents. The Residence and the Department of Corrections had also taken proactive steps to develop a potential employment pathway for residents.

However, whilst there had been positive improvements in certain practices at the Residence, some of my recommendations require further attention. I also identified new areas of concern. Whilst there has been significant progress on access to supervised leave since my 2020 inspection, the shift in policy and practice required significant and sustained scrutiny and intervention from a number of parties, over a number of years. I remain concerned at the speed at which the implementation of some recommendations is occurring. In response to my provisional report the Department of Corrections advised that an electronic recommendations reviewer is now being used to track and support the implementation of recommendations.

Policies and guidance regarding medication, telephones and complaint processes did not always consistently reflect positive changes in practice at the Residence. To embed these changes, policies need to align and inform the good practice that is occurring. The Department of Corrections, in response to my provisional report, informed me that a review of policies, manuals and relevant documents will be completed by the end of December 2022.

I found that my recommendation regarding the frequency of rehabilitative treatment was not achieved. I acknowledge that factors outside of the Residence and Department's control have impacted the ability to deliver rehabilitative services more frequently. There is also consensus that the nature of and access to independent rehabilitative treatment services that can cater to the individual needs of residents, including those with disabilities, is currently limited. Given its fundamental component of the ongoing justification for limiting a resident's human rights, this area requires significant attention by the Department of Corrections. In response to my provisional report the Department of Corrections informed me that residents are currently receiving weekly to fortnightly psychologist sessions. In addition, Matawhāiti is currently exploring other models of intervention and treatment and funding for these.

Recommendations

I am making one repeat recommendation, one amended recommendation, and three new recommendations based on my 2022 inspection.

Recommendations to the Residence Manager

- The Residence provide facilities with sufficient privacy for confidential meetings and visits, including over Audio Visual Link (AVL). Discussed on page 20 and 21.

Recommendations to the Residence Manager and the Chief Executive of the Department of Corrections

- The Department of Corrections and the Residence implement recommendations made by the Review Panel in a timely manner. This is a repeat recommendation. Discussed on page 13 and 14.
- The Department of Corrections and the Residence ensure that residents are able to access frequent, specialist rehabilitative services that cater to their individual needs. This is an amended recommendation. Discussed on page 15, 16 and 17.
- The Department of Corrections and the Residence implement a workforce plan that ensures staff are suitably trained to provide for the rights and needs of all residents, including people with disabilities. Discussed on page 18 and 19.
- The Department of Corrections and the Residence ensure that policies, manuals and other guidance documents consistently reinforce residents' rights, including access to medications and telephones. Discussed on page 19 and 20.

Implementation of 2020 recommendations

This section of my report focuses on whether my 2020 recommendations were achieved or not achieved. Where additional issues arose during my 2022 follow up visit, these are discussed below under 'New recommendations from the 2022 inspection'.

Treatment

Restraint

2020 recommendation - Residents are seen by a registered health professional within three hours of a use of force.

- The Department of Corrections accepted this recommendation.
- On my follow up inspection I **was unable to fully assess progress** against this recommendation.

Inspectors reviewed the *Matawhāiti Residence Manual* (the Staff Manual), which sets out key policies and procedures for staff at the Residence. The Staff Manual contained guidance for staff in potentially volatile situations. This included an emphasis on de-escalation, the need to consider a resident's health needs prior to initiating any physical restraint as a last resort and various restraint evaluation and reporting obligations. The Staff Manual, however, did not include the requirement for a resident subject to use of force to be seen by a registered health professional within three hours.

I understand that residents are within their rights to refuse medical treatment.

However, respecting the autonomy of residents does not prevent the Residence from setting a clear expectation that residents are seen by a registered health professional within three hours of a use of force. Registered medical professionals are responsible for the informed consent process prior to initiating any medical treatment.[5]

Inspectors were provided with a copy of the use of force register. I was pleased to see that there had been no recorded use of force incidents since my 2020 inspection. Prior to my 2020 inspection, there had only been recorded one use of force. In my view, it is very positive that force has been almost never been used in the five years since the Residence opened in 2017.

Due to the absence of recorded use of force incidents, I will not be making a definitive assessment on the progress status of this particular recommendation. However, I expect the Residence to ensure that the Staff Manual, or other relevant policy, stipulates that residents are seen by a registered health professional within three hours of a use of force. I have also issued a new overarching recommendation that the Residence ensures that all policies, manuals and other guidance reinforce residents' rights (discussed below under 'Residence policies').

Reception

Initial needs assessment

2020 Recommendation - Needs assessments are conducted and recorded separately from other administrative and procedural requirements of the Public Safety (Public Protection Orders) Act 2014.

- The Department of Corrections accepted this recommendation.
- On my follow up inspection, I found that my recommendation was **achieved.**

Section 41 of the Public Safety Act requires that, as soon as practicable after a resident first commences their stay in the Residence, the manager of the Residence must assess the needs of the resident in consultation with the resident. The assessment must identify several factors, including any special medical requirements, cultural or religious needs, and any steps to be taken to facilitate the resident's rehabilitation and reintegration.

The Residence's policies and handbooks stipulate that a separate needs assessment should take place as part of a resident's induction process, and that this needs assessment should inform a resident's subsequent management plan/ Good Life Plan.

Since my 2020 inspection, only one resident had been admitted to the Residence. Inspectors reviewed the resident's needs assessment, and related documentation.[6] There was a clear

[5] Medical Council of New Zealand. *Statement on informed* consent: *Helping patients make informed decisions about their care*. June 2021. Accessed 9 June 2022 at https://www.mcnz.org.nz/assets/standards/55f15c65af/Statement-on-informed-consent.pdf.

[6] This included resident's management and safety plans.

distinction between the resident's initial needs assessment, which fed into and informed the subsequent draft management plan. I am pleased that this has been addressed.

Health and wellbeing

Medication

2020 Recommendation - Residents are allowed to hold their own medications, unless deemed unsafe based on individual risk assessment. If an individual resident is not allowed to hold one or more of their medications, the reasons are recorded and reviewed.

- The Department of Corrections accepted this recommendation.
- On my follow up inspection, I found that my recommendation was **achieved.**

At the time of the inspection, both residents at the Residence were managing their own medications. One resident told my Inspectors that they welcomed more autonomy over their medications and that they appreciated being '*treated like adults*.' The Good Life Plans of residents emphasised their autonomy, noted that they could safely self-manage their medications, and were supported to do so.

Inspectors reviewed the Residence's medication policy, the *Matawhāiti Residence Handbook for Residents*, (Resident's Handbook) and the Staff Manual. The Resident's Handbook and the Staff Manual allowed for limited self-management of medications and a supported decision making approach. However, the medication policy still favoured staff control of medications, unless there was prior approval from the manager.

I acknowledge that there may be some residents who cannot safely manage their own medications and individualised risk assessments are necessary to determine this. I also welcome that the current practice has shifted towards a graduated degree of autonomy and supported decision making for residents. I therefore consider this recommendation achieved.

However, the Residence's medication policy does not fully reflect current practice, or the principles in the Public Safety Act relating to residents' autonomy.[7] I expect that the Residence ensure that all medication policies consistently state that Residents are allowed to hold their own medications, unless deemed unsafe based on individual risk assessment, and any individual restrictions are recorded and reviewed. As noted above, I have also issued a new overarching recommendation that the Residence ensures that all policies, manuals and other guidance reinforce residents' rights (discussed below under 'Residence policies').

[7] See section 5(d), which requires that '*persons who are detained in a residence under a public protection order should have as much autonomy and quality of life as possible, while ensuring the orderly functioning and safety within the residence.'*

Protective measures

Complaints - Information for residents

2020 Recommendation - Information is provided to residents that states complaints may be made directly to the PPO Inspector.

- The Department of Corrections accepted this recommendation.
- On my follow up inspection, I found that my recommendation was **achieved**.

Residence Management informed Inspectors that there had been no recorded complaints since the 2020 Inspection.

At the time of the inspection, there was a laminated notice on the noticeboard in the communal living area titled "*Complaints about breaches of rights"* with the following text:

> *Anyone may complain to an inspector about the breach of a resident's rights.*
>
> *The manager or staff member of a residence who receives a complaint about a breach of the resident's rights must refer the complaint to an inspector.*

This laminated notice also included contact details for both residents and staff to call either my office, or the Public Protection Order (PPO) Inspector. Residents told Inspectors that they were familiar with the PPO Inspector and had no issues with contacting them directly.

The Resident's Handbook also contained guidance for residents on raising a concern or making a complaint. It is clear that if a resident has a complaint about staff specifically, they can complain directly to the PPO Inspector. The complaints policy also stipulated that, at any stage in the complaints process, the resident has the right to complain to a PPO residence inspector or other external complaint bodies.

However, for concerns or complaints on other issues, the Resident's Handbook still frames the PPO inspector avenue primarily as an appeal mechanism. Residents were encouraged to raise any concerns with staff or the Residence Manager directly in the first instance, and to escalate to the PPO inspector if an issue was not resolved. As I noted in my 2020 report, whilst I recognise the benefit of trying to resolve any complaints as early as possible, there is no requirement in the Public Safety Act for residents to go through these processes prior to making a complaint to the PPO Inspector.[8]

In response to my provisional report, the Department of Corrections provided updated Matawhāiti complaints material, including guidance policies and posters for staff, residents and visitors. This material consistently included a clear articulation that at any stage in the complaints process, a resident has the right to complain to a PPO Inspector about a breach of their rights. I welcome this update to material from the Department and the Residence, and consider that this recommendation is achieved.

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[8] Public Safety (Public Protection Orders) Act 2014, section 80(1).

2020 Recommendation - Staff refer all complaints relating to a breach of residents' rights to the PPO Inspector.

- The Department of Corrections accepted this recommendation.
- On my follow up visit, I found that my recommendation was not achieved. However, in light of actions taken by the Department of Corrections following this visit, I consider that this recommendation is **achieved**.

As I outlined above, I welcome that the information in the communal area is consistent with my recommendation. The Residence Complaints Policy and the Staff Manual were clear that residents can make complaints to the PPO inspector *'at any time'*. However, at the time of my inspection it still did not direct staff to refer any alleged breach of residents' rights to the PPO inspector. Residence policy and guidance, especially the Staff Manual, is an important source of influencing good practice especially for new staff.

As above, in response to my provisional report, the Department of Corrections provided updated Matawhāiti complaints material, including guidance for staff, residents and visitors. The material more clearly stipulates that staff members who receive a complaint about a breach of a resident's rights must refer the complaint to a PPO Inspector so they are aware and can choose to investigate. I therefore consider that this recommendation is achieved.

Mail and telephones

2020 Recommendation - The Residence develop a clear policy on reasonable telephone use and residents are charged only if their usage exceeds that specified in the policy.

- The Department of Corrections partially accepted this recommendation.
- On my follow up inspection, I found that my recommendation was **achieved.**

Staff and residents told Inspectors that residents did not pay for phone calls anymore, provided it was reasonable usage. One resident told my Inspectors that not having to pay for phone calls anymore was "*fantastic*." I welcome the positive impacts of this change in practice on the quality of life and access to an important mode of communication for residents. Use of a telephone is one of the only effective ways residents can maintain contact with others outside the Residence.

Inspectors also reviewed the Residence Telephone policy, Residents Handbook and the Staff Manual. These policies and guidance were not always consistent or reflective of the improved practice. The telephone policy contained the expectation that residents can make phone calls, but '*at their own expense'.* The Resident's Handbook and Staff Manual give some further clarity on when the Residence may charge residents and what usage may be considered unreasonable, such as making long calls on a regular basis.

I am pleased that the practice regarding telephone charges had changed. I consider my recommendation was substantively achieved given the positive outcome for residents. However, I note that the policies do not reflect this positive change and expect that the

allowance for free calls be written into policy, including that any charges for calls outside this allowance are reasonable and clearly specified (see further discussion and new recommendation below under 'Residence policies').

Review Panel

2020 Recommendation - I recommend that the Residence and the Department of Corrections implement recommendations made by the Review Panel in a timely manner.

- The Department of Corrections accepted this recommendation.
- On my follow up inspection, I found that my recommendation was **not achieved.**

The Review Panel is a key safeguard of resident's rights, including in reviewing the continuing justification for a Public Protection Order and making recommendations to the Residence.

As I observed in 2020, the Review Panel had made repeated recommendations on the issue of resident's access to supervised leave for rehabilitation and humanitarian purposes for almost three years. A variety of sources, including the latest decisions from the Review Panel, confirmed that since approximately May 2021, residents had markedly more regular and meaningful access to approved supervised leave (referred to by the Residence as "Supported Outings") outside the Residence for rehabilitative purposes and on humanitarian grounds.

I also observed in 2020 that the Review Panel had repeatedly recommended that the Residence increase the frequency of rehabilitative treatment. I shared the Review Panel's concerns about the frequency of rehabilitative programmes and treatment, and made a recommendation to this effect. As discussed later in this report, I have found limited evidence to suggest that the frequency of rehabilitative treatment sessions offered to residents has increased significantly on a permanent basis compared to 2020 levels. I acknowledge that there are extenuating circumstances that have impacted this progress.

There was, however, evidence that the Residence and the Department of Corrections had taken steps to improve the progression of recommendations made by the Review Panel. For example, the Department advised that it had established the National Intensive Residential Support Advisory Board (IRSA Board) in January 2021. The IRSA Board is comprised of senior Corrections staff and met for the first time in January 2021. I note particularly that the IRSA Board's Terms of Reference stipulate that a purpose and responsibility of the Board is to consider PPO Review Panel decisions to determine if any recommendations may require a change to policies or procedures currently in place.

I welcome the promising internal processes between the Department of Corrections and the Residence, and the strong leadership intention at the Residence to enable the robust and timely progression of Review Panel recommendations. This is reflected in the demonstrable shift on a key recommendation of the Review Panel in relation to supervised leave at the Residence.

In response to my provisional report the PPO Panel reiterated that *'various panel decisions have expressed concern about delay in achieving change'.*

In response to my provisional report the Department of Corrections stated: '*Corrections accepts we should respond to the review panel's recommendations in a timely manner, ensuring that the panel are informed of the approach being taken by Matawhāiti'.* I was informed that '*significant progress has been made in responding to recommendations made by the Review Panel*', including the implementation of the repeated recommendation made by the Review Panel to enable residents to have supervised leave. The Department of Corrections stated that this was now occurring on average twice per week.

The Department of Corrections also advised that future recommendations from the Review Panel will be loaded into the new *'*Recommendations Reviewer*',* an electronic tracker tool launched on 1 June 2022. They stated that the Recommendations Reviewer supports the *'implementation of recommendations from the PPO Review Panel in a timely manner, as we will be able to efficiently track, and hold each other accountable'.*

I am pleased to hear of the progress towards implementing the Review Panel's recommendations, including facilitating supervised leave, and of the creation of the Recommendations Reviewer. However, overall I remain concerned at the speed at which implementation of recommendations has occurred. The implementation of the recommendation relating to access to supervised leave required significant and sustained scrutiny and intervention from a number of parties, over a number of years.

In my view, on balance this is not implementation in a timely manner and the newly developed infrastructure within the Department of Corrections and their Recommendation Reviewer to assist in progressing the Review Panel recommendations are relatively recent. It is not clear yet how these initiatives will assist with timely implementation of recommendations and I **therefore, repeat my recommendation that the Department of Corrections and the Residence implement recommendations made by the Review Panel in a timely manner.** I will continue to monitor progress on this issue.

Purposeful activity and transition to the community

Leave of absence

2020 recommendation - Residents are able to access leave for rehabilitative purposes and on humanitarian grounds, with all necessary precautions taken to manage risk.

- The Department of Corrections partially accepted this recommendation.
- On my follow up inspection, I found that my recommendation was **achieved.**

In my 2020 inspection, I raised concerns about access to leave for rehabilitative and humanitarian purposes for residents. Other parties, including the Review Panel, as discussed

above, raised similar concerns. In March 2022, the High Court made a declaration that the policy in place at the Residence prior to March 2021, which prevented residents from undertaking activities within the community (appropriately supervised), save in exceptional circumstances, was *ultra vires* and therefore without authority.[9] The Department of Corrections accepted that the previous interpretation of section 26 of the Public Safety Act was incorrect.[10]

My Inspectors confirmed from a variety of sources that a significant and positive change since the last inspection had occurred and residents had regular and meaningful access to approved supervised leave outside the Residence for rehabilitative purposes and on humanitarian grounds. Supervised leave was tailored to individual residents and their needs, interests and hobbies. Leave included opportunities for recreation and exercise, shopping, banking, gardening, appointments with support services. The Residence also encouraged supervised connections with some residents and participation in activities at nearby supported accommodation provider, Toruatanga.[11] My Inspectors also observed the significant and positive impacts of these outings on the wellbeing, re-integrative and rehabilitative pathways and opportunities for residents.

I welcome the demonstrable shift in the policy and practice of access to supervised leave for rehabilitative purposes and humanitarian grounds since my 2020 inspection.

Rehabilitation

2020 recommendation - The frequency of rehabilitative treatment sessions offered to residents increase significantly on a permanent basis.

- The Department of Corrections accepted this recommendation.
- On my follow up inspection, I found that my recommendation was **not achieved**.

In my 2020 inspection report, I raised concerns about residents' access to rehabilitative treatment. Rehabilitation is a central protection against arbitrary detention, given that it is a fundamental component of the ongoing justification for limiting a resident's human rights. At the time, the residence indicated that the frequency of rehabilitative treatment sessions had increased from once monthly, to twice monthly. I recommended that the Department of Corrections increase this frequency of rehabilitative treatment sessions significantly on a permanent basis.

At the 2022 inspection, information provided to my Inspectors by the Department of Corrections' Canterbury Area Psychological Services indicated that the frequency of

[9] *Douglas v Chief Executive of the Department of Corrections* [2022] NZHC 600 [29 March 2022], at [37].

[10] *Douglas v Chief Executive of the Department of Corrections* [2022] NZHC 600 [29 March 2022], at [31].

[11] Toruatanga is supported accommodation provided by the Department of Corrections and is located near Christchurch Men's Prison developed to facilitate offenders' integration into the community.

rehabilitative treatment sessions had not increased, with a total of 15 treatment sessions provided to two residents in the six months prior to the 2022 inspection.

The Residence and the Department reported that the frequency of treatment sessions had been impacted by the COVID-19 pandemic, availability of specialised treatment services to meet the particular needs of residents, and that treatment sessions to one resident were not provided concurrently with ACC counselling. Staff also told Inspectors that other sessions and activities, including improved access to supervised leave, and programmes provided by the Occupational Therapist were complementary to rehabilitative treatment and/or counselling.

I acknowledge there are some factors outside the Residence's control in the provision of adequate rehabilitation. However, I consider that the frequency of rehabilitative treatment sessions offered to residents had not increased significantly compared to 2020 levels. On that basis, I consider my 2020 recommendation was not achieved.

However, I also appreciate that frequency is not the only relevant factor when considering the sufficiency of rehabilitation. As staff told my Inspectors, the nature and suitability of the rehabilitative services is also a key consideration. The Review Panel had also raised questions in its recent reports as to the suitability and nature of treatment, especially the lack of tailored treatment to cater to the specific contextual and clinical needs of residents.

In response to my provisional report the Department of Corrections advised that *'A holistic view of the management of individuals on PPO's assists the Residence in providing tailored rehabilitative services. Engagement with a Corrections psychologist continues to be provided to residents. This is scheduled to regularly occur weekly to fortnightly for each resident'*.

The Department of Corrections stated *'There has also been a recent emphasis on educating the Residence staff regarding their interactions with the residents'.* This includes the psychologist meeting with both the resident and staff during a session. '

The Department of Corrections also informed me that Matawhāiti is currently exploring other models of intervention and treatment '*including the potential to access intensive group treatment in a custodial setting (as a day participant)'.*

My Inspectors observed in resident's needs assessments, management plans and review panel decisions that all three of the present and recent residents had a confirmed or probable disability.[12] This included a resident who was transferred to prison in 2021 under an interim

[12] Article 1 of the United Nations Convention on the Rights of Persons with Disabilities provides that '*people with disabilities includes those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others*.' Impairments can be physical, visual, hearing/speech centred, intellectual or mental. An impairment may be temporary, intermittent or ongoing. People may acquire impairment through an accident or illness, or a person may be born with an impairment.

detention order who had a number of health and disability needs that the Residence was not equipped to respond to at the time.[13]

Following the transfer of a former resident to the prison, the Residence advised that they had successfully contracted the services of a specialist trust to develop a transition and support plan in case the resident returns to the Residence from prison. Whilst I acknowledge the efforts of the Residence in its response to these events and the limits that they face, transfer to detention in a prison is a serious intervention, especially in the context of a civil detention regime that is not punitive in nature.[14]

I am pleased to hear of the other interventions and treatment explored by the Residence. However, in my view, there is a clear need to ensure a wider range of specialist rehabilitative services are available to respond to the particular needs of residents. I am therefore making an amended recommendation. **I recommend that the Department of Corrections and the Residence ensure that residents are able to access frequent, specialist rehabilitative services that cater to their individual needs.** I also expect that the Department of Corrections provide adequate funding for these services.

In response to my provisional report the PPO Panel welcomed my recommendation and stated that *'Residence staff and Corrections be obligated to ensure residents can access specialist rehabilitative services as required'.*

In response to my provisional report the Department of Corrections advised that the Intensive Residential Support Advisory Board who oversees the operations of Matawhāiti will review the budget for Matawhāiti at their next meeting, including assessing the current level of funding available for rehabilitative services. I will continue to monitor this.

Employment

2020 recommendation - The Residence takes action to make formal employment opportunities available for residents.

- The Department of Corrections accepted this recommendation.
- On my follow up inspection, I found that my recommendation was **achieved.**

Inspectors reviewed a written briefing of progress regarding a potential employment pathway for one of the residents.

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[13] Section 74 of the Public Safety (Public Protection Orders) Act 2014 Act provides that if there is a security emergency in a residence, a corrections officer may be directed to detain and take to a prison any resident who appears to pose such an unacceptably high risk to the resident or to others, or to both, that the resident cannot be safely managed in the residence. After 24 hours, a court may order that a resident be detained in prison if the resident poses such an unacceptably high risk that they cannot be safely detained in the Residence, and all less restrictive options have been considered and appropriate options tried.

[14] Section 4(b) of the Public Safety (Public Protection Orders) Act 2014 provides that it is not an objective of the Act to punish persons against whom orders are made.

Documentation provided by the Department of Corrections also recorded formal discussions at governance level within the Department of Corrections in late 2021, on next steps for a possible opportunity to use an existing contractual relationship with a local business. Residence Management told Inspectors they expect that once an employment agreement is formalised, this will create a pathway to employ residents in jobs that match their skills and abilities.

I welcome the steps taken by the Residence and the Department of Corrections to create opportunities for formal employment for residents. I encourage the Residence and the Department of Corrections to continue to take action to ensure, and where possible, expedite formal employment opportunities are available for residents.

New recommendations from the 2022 inspection

Staffing

Following my 2020 inspection, I did not make any recommendations in relation to staffing. However, I noted that, staffing levels at the time could potentially make it difficult to respond to a volatile situation.

During the follow-up inspection to the Residence, my Inspectors observed and heard that the Residence was operating a similar staffing ratio to 2020, and had vacancies that they were looking to fill. Whilst staff told Inspectors that they did not have concerns, given the access to casual staffing pools, ideally, higher staffing levels would enable more flexibility in case of an incident at the Residence and to take residents for supervised leave. Residence Management emphasised that they were actively recruiting.

As I noted earlier, concerning the provision of rehabilitation, all of the present and recent residents had a confirmed or suspected disability. Residence Management told Inspectors that training for staff in working with people with disabilities is generally on a case-by-case basis due to the small number of residents. I welcome that there has been some training and support provided to staff at the residence. However, in my view, this has been relatively limited to date.

I note that under New Zealand's obligations under the Convention on the Rights of Persons with Disabilities, the Committee has also addressed the need to promote training mechanisms for officials working in the criminal justice system that reflect the rights-based framework under the Convention.[15] It is essential that all staff are able to both identify and support the individual needs of disabled people in detention to ensure their enjoyment or exercise of their

[15] United Nations, Committee on the Rights of Persons with Disabilities. *Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities.* September 2015, at [17]. Accessed 9 June 2022 at https://www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc.

rights on an equal basis with others. Well-trained staff also complement the provision of appropriately individualised rehabilitation and support.

In response to my provisional report the Department of Corrections stated that '*We accept that ongoing training is necessary to ensure a resident's rights are protected'.* They provided an outline of the training plan for Matawhāiti staff, which included that all Residence staff would complete Human Rights training and Disability Responsiveness Training (provided by the Office for Disability Issues) by the end of 2022.

The Department of Corrections acknowledged that the Residence does not currently have a specific Disability Action Plan, or any regular Health input at governance or site level. However, it also advised that this was a gap that would be addressed in the Department's draft Disability Action Plan, which was soon to be finalised. The Department of Corrections stated that this plan would ensure that *'disability awareness training is part of mandatory training for all new frontline staff',* and that *'By mid-2023 Corrections staff will have the resourcing for and access to learning New Zealand Sign Language (NZSL), and a disability awareness module will be a part of all nurse's orientation to Ara Poutama'.* In addition they stated that:

> *Once the plan is endorsed, wider internal consultation will take place to establish new relationships for consultation with Tāngata whaikaha, whānau and iwi disability service providers to appropriately operationalise specific outcomes and actions*.

I welcome the updates on the training plans for Matawhāiti staff and the Department's wider draft Disability Action Plan. In order for these initiatives to become embedded in the Residence in the long term. **I recommend the Department of Corrections and the Residence implement a workforce plan that ensures staff are suitably trained to provide for the rights and needs of all residents, including people with disabilities**.

Residence policies

As I discussed earlier in my report, there have been a number of positive improvements at the Residence following my 2020 recommendations.

However, my Inspectors also observed that a number of Residence policies and guidance were not always consistent and did not always reflect the positive changes in practice that had taken place at the Residence. In particular, policies and guidelines on access to medications, telephone usage and complaints processes were not fully consistent or up-to-date.

Residence policy and guidance is an important source of information for residents and staff. Information contained in those policies and guidance should therefore be consistent with operational practice. Further, to embed the positive changes I observed in the long term, the Residence's policies should codify the good practice that was occurring. Scheduled reviews of all policies also enable reflections on good practice or need for improvement.

I recommend the Residence and the Department of Corrections ensure that policies, manuals and other guidance documents consistently reinforce residents' rights, including access to medications, and telephones. I also expect the Residence to regularly review all policies and guidance to ensure they are up-to-date, consistent and fit for purpose.

In response to my recommendation, the Department of Corrections stated '*The Chief Probation Officer will review the policies, manuals, and other relevant documents from Matawhāiti by the end of December 2022… It will also review how the manuals and policies are applied in practice'*. They also advised that the Chief Nurse visited Matawhāiti and supported the Residence Manager with updating the medication policy to ensure its accuracy. I acknowledge the update provided by the Department of Corrections and will monitor the progress of the policy review.

Accommodation

The Residence had made a number of positive improvements to the living environment since my last visit. The environment was clean and welcoming, and there had been continued efforts to make shared spaces such as the living room, outside patio and sensory room comfortable.

My Inspectors observed that care was taken in tending to the outside spaces, including an orchard and lush vegetable gardens. Staff also showed my Inspectors a new construction workshop that would provide opportunities for residents to develop carpentry skills when it opened.

In my 2020 report, I noted that there was discontent from one of the two residents about not being accommodated in the newer units with improved amenities, which included heat pumps and curtains instead of blinds. I am pleased that the Residence had since installed heat pumps and curtains in all units and that there was a plan for re-painting the units. At least one resident had had the opportunity to be involved in picking the new colour scheme for their unit.

Privacy

An interview room with Audio Visual Link (AVL) capability was next to the main communal area at the Residence. Staff and residents used this interview room for in-person meetings that required privacy, or AVL calls. The AVL function was particularly crucial when physical visits were not possible due to COVID-19, as it provided residents' access to their psychologist, lawyer or friends and whānau through video calls.

However, staff and residents told Inspectors that the interview room was not fully soundproof. There were concerns that anyone in the shared living space could overhear discussions in this room. Staff told Inspectors that they turned up the television in the shared living space next to the interview room or staff altered their movements to help respect the privacy of residents.

Both international human rights standards and the Public Safety Act protect the right to communicate privately with legal counsel and with people outside detention, subject to reasonable conditions and restrictions.[16]

[16] For more, see Principles 18 and 19 of the *Body of Principles for the Protection of All Persons under Any Form of Detention or* Imprisonment, 9 December 1988. Accessed 9 June 2022 at https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/bodyprinciples.pdf and the Public Safety (Public Protection Orders) Act 2014, sections 29 and 34.

Therefore, whilst I acknowledge the efforts of staff to respect the privacy of residents within the context of the physical limitations of the residence, the current arrangement is not acceptable.

Following a subsequent enquiry from my Inspectors, Residence Management advised that they were investigating alternative solutions, including renovations to provide better soundproofing for the interview room. The Department of Corrections, in response to my provisional report, informed me that renovations had been started on the interview room, including the installation *'of acoustic wall panels and ceiling tiles to reduce noise transmission between these two spaces'*. The renovations are expected to be completed by the end of 2022. I am pleased to hear that renovations to provide residents' privacy in this space are in progress, and I consider that this will help achieve my recommendation that **the Residence provide facilities with sufficient privacy for confidential meetings and visits, including over AVL.**

Acknowledgement

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

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. Legislative framework

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

The objective of OPCAT is to establish a system of regular 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 – Public Protection Order residences

Section 16 of COTA defines a "place of detention" as:

> *"…any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in…*
>
> *(fa) a residence established under section 114 of the Public Safety (Public Protection Orders) Act 2014…*

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including prisons and residences established under section 114 of the Public Safety (Public Protection Orders) Act 2014.

Under section 27 of COTA, an NPM's functions include:

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

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

- access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
- unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
- interview any person, without witnesses, either personally or through an interpreter; and

- choose the places they want to visit and the people they want to interview.

Section 34 of COTA provides that when carrying out their OPCAT function, Ombudsmen can use their Ombudsmen Act (OA) powers to require the production of any information, documents, papers or things (even where there may be a statutory obligation of secrecy or non-disclosure) (sections 19(1), 19(3) and 19(4) OA). To facilitate his OPCAT role, the Chief Ombudsman has authorised Inspectors to exercise these powers on his behalf

More information

Find out more about the Chief Ombudsman's OPCAT role, and read his reports online: ombudsman.parliament.nz/opcat.