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OPCAT Report

Report on an announced follow up inspection of Ward 9A, Wakari Hospital, Dunedin under the Crimes of Torture Act 1989

19 October 2023

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Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report on an announced follow up inspection of Ward 9A, Wakari Hospital under the Crimes of Torture Act 1989

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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 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 health and disability facilities. 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 observations 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

From 27 to 30 September 2022, two Inspectors made an announced four-day inspection[2] to Ward 9A at Wakari Hospital, Dunedin to follow up on recommendations made when I inspected in 2019.[3] Therefore, the inspection is referred to as a 'follow up inspection'.

The follow up inspection focussed on progress in implementing the recommendations I made as a result of my 2019 inspection, and whether I consider these recommendations to have been achieved or not. To ensure an evidence-based approach, my Inspectors gathered and assessed a range of information including:

[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.

[2] The follow up inspection was announced on 16 September 2022.

[3] *Report on an unannounced inspection of Ward 9A, Wakari Hospital under the Crimes of Torture Act 1989,* (2019) Wellington.

- Information and documents from the Ward, including clinical records, incident reports and meeting minutes, policies and procedures produced by the Ward and Te Whatu Ora Southern (formerly the Southern District Health Board);
- One-to-one interviews with tāngata whai ora,[4] management, staff and other relevant stakeholders; and
- Observations within the Ward, with a focus on issues impacting on the conditions and treatment of tāngata whai ora.

Health New Zealand - Te Whatu Ora and the Ministry of Health received a copy of my provisional report and were invited to comment. I received responses from Te Whatu Ora Southern and the Ministry of Health and I have considered their feedback when preparing my final report. The Ministry of Health stated they will work with the Director of Area Mental Health Services (DAMHS) and local District Inspectors to monitor the implementation of my final recommendations.

Facility facts

Ward 9A (the Ward) is a 15-bed, medium secure regional forensic inpatient service[5] for tāngata whai ora between the ages of 17 and 65 in Otago and Southland. The Ward is part of the Southern Regional Forensic Psychiatric Service. At the time of the inspection, the Ward could accommodate a maximum of 11 tāngata whai ora, due to staffing levels and the acuity of tāngata whai ora.

On the first day of the inspection, the Ward had a total of 11 tāngata whai ora. The average length of stay on the Ward was 670 days.

References to the District Health Board

At the time of the follow up inspection, the Ward was under the management of Te Whatu Ora Southern.[6] Throughout this report, there are references to the DHB, as the responsible body at the time of the original inspection in 2019. However, where appropriate, recommendations are made to Te Whatu Ora, as the responsible agency at the time of the follow up inspection.

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[4] A person who uses mental health and addiction services. In the report on my 2019 inspection, tāngata whai ora were referred to as 'patients'.

[5] The ward is described as being for '*Otago and Southland consumers who are involved with the justice system and require assessment, treatment and rehabilitation. Clients have either been charged with a criminal offence or alleged to have offended and are known or suspected to have a mental illness, or require assessment and treatment whilst serving a Prison Sentence, or are unable to be managed safely in general mental health services. A full complement of a multidisciplinary team delivers a range of therapeutic services and programmes in this setting. Ward 9A has a strong emphasis on linking consumers with families (whānau) and support persons and reintegration into the wider community*.' www.healthpoint.co.nz/public/mental-health-specialty/forensic-services-southern-te-whatu-ora/?solo=subservices&index=0& [Accessed 4 April 2023].

[6] On 1 July 2022, DHBs were disestablished and replaced by Te Whatu Ora – Health New Zealand (Te Whatu Ora). Te Whatu Ora manages all health services in Aotearoa New Zealand, through a network of regional divisions and district offices, and works in partnership with Te Aka Whai Ora – the Māori Health Authority.

Key observations and recommendations

A central issue of concern during my follow up inspection was that the building was not fit-for-purpose. This was not a new issue, but one identified initially in my predecessor's 2014 report, and again in my 2019 report. A number of the recommendations I make in this follow up report are related to the poor physical state and design of the Ward. I acknowledge there have been some – mainly cosmetic – improvements to the Ward. However, the evidence at the time of this follow up inspection suggests the physical environment remains inadequate and potentially unsafe, as highlighted by an independent assessment report which states that the environment, *'presents a number of health and safety risks'*.

It deeply concerns me that no significant progress has been made in the nearly 10 years since the need for redevelopment was identified, and that the ability to provide effective care to tāngata whai ora continues to be impacted. I consider this lack of progress, and the consequences for the conditions and treatment of tāngata whai ora, unacceptable.

Recommendations

My 2019 inspection resulted in my making 13 recommendations. The DHB accepted eight of those recommendations, partially accepted three, and rejected two recommendations.

As a result of my 2022 follow up inspection I consider that four of the recommendations were achieved, two were progressing but not yet achieved, and seven were not achieved.

On the basis of my follow up inspection, I make eight recommendations. These are generally amended repeat recommendations from my 2019 inspection.

I make the following recommendations to Te Whatu Ora Southern Interim Lead – Hospital and Specialist Services and management of the Ward as a result of my follow up inspection in 2022:[7]

- I recommend Te Whatu Ora Southern and management of the Ward ensure all relevant staff are up to date with their SPEC training. This is a repeat recommendation. Discussed on pages 6 and 7.
- I recommend Te Whatu Ora Southern and management of the Ward ensure that tāngata whai ora can access hot drinks independent of staff, unless this is considered unsafe based on individual risk assessment. This is an amended repeat recommendation. Discussed on pages 10 and 11.
- I recommend Te Whatu Ora Southern and management of the Ward ensure that all tāngata whai ora have unrestricted access to the outdoor area during the day, unless this is considered inappropriate for individual tāngata whai ora based on a clinical or safety

[7] I am empowered by section 27 of the Crimes of Torture Act 1989 to make recommendations for improving the conditions and treatment of detention applying to detainees and for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

risk assessment. This is an amended repeat recommendation. Discussed on pages 11 and 12.

- I recommend Te Whatu Ora Southern and management of the Ward ensure the reasons for staff turnover are assessed and used to inform remedial action. This is an amended repeat recommendation. Discussed on pages 13 and 14.

I make the following recommendations to Te Whatu Ora Southern Interim District Director:

- I recommend Te Whatu Ora Southern ensure blinds are fitted to the external windows of the seclusion rooms to ensure the privacy of tāngata whai ora and appropriate natural lighting. This is an amended repeat recommendation. Discussed on pages 4 and 5.
- I recommend Te Whatu Ora Southern ensure that reviews of policies and guidelines are undertaken in time to ensure documentation is current, fit for purpose, and reflects best practice. This is a new recommendation. Discussed on pages 5 and 6.
- I recommend Te Whatu Ora Southern ensure the building is upgraded as a matter of urgency. This is a repeat recommendation. Discussed on pages 9 and 10.

I make the following recommendations to management of the Ward:

- I recommend management of the Ward ensure that tāngata whai ora have access to a telephone independent of staff. This is a repeat recommendation. Discussed on pages 12 and 13.

In response to my provisional report Te Whatu Ora Southern advised that recommendations 1, 8, 9, 10, and 12 will be included and addressed in their proposed building refurbishment plan. The environmental conditions of the Ward have been a concern for several years. I previously raised concerns regarding the structure, age, and layout of the Ward and the impact this had on tāngata whai ora in my 2019 report. My predecessor also raised similar concerns in their 2014 report.

At the time of this follow up inspection there had been no change to the layout of the Ward. It is my view the building is not fit-for-purpose. I am aware of the building refurbishment plans and that they were paused at the time of this inspection. However, it is my view that several of my recommendations can be achieved outside of the refurbishment plan that would benefit tāngata whai ora. I point out these recommendations within my report.

Treatment

Recommendation 1 from 2019: Privacy blinds be fitted to the external seclusion room windows.

- This recommendation was accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **not achieved.**

During my 2022 follow up inspection, Inspectors observed there were no blinds on the external windows of the seclusion rooms to provide privacy for tāngata whai ora or allow them to adjust the amount of light entering the rooms. This was also the case at the time of my 2019 inspection.

Service management told Inspectors the Ward's risk assessment prohibited internal blinds, and film on the windows limited the natural light entering the rooms. Service management suggested blinds could be considered as part of the refurbishment of the building.[8] However, Inspectors were not provided with any documentation about whether provision had been made for this.

Te Whatu Ora Southern informed me, *'We are currently liaising with other Forensic Services that have retrofitted blinds with internal controls to understand how we could achieve this without compromising the integrity of the windowpane.'*

This is promising. However, it is clear that the current arrangement does not provide privacy for tāngata whai ora in the seclusion rooms or allow them, or staff, to adjust the amount of light entering. **I recommend Te Whatu Ora Southern ensures blinds are fitted to the external windows of the seclusion rooms to ensure the privacy of tāngata whai ora and appropriate natural lighting.** This is an amended repeat recommendation.

Although Te Whatu Ora Southern advised that they will action my recommendations in the proposed building refurbishment plan, I remain concerned about the privacy of tāngata whai ora in seclusion rooms. In my view, the fitting of privacy blinds at the earliest opportunity would benefit tāngata whai ora and should not wait for the refurbishment plan to be actioned.

Recommendation 2 from 2019: Policies include dates for review.

- This recommendation was accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **not achieved.**

Inspectors reviewed a selection of policies and guidelines to determine whether they each included a date for review. Although the documents included a *'release date'* they did not state a date for review.

Staff told Inspectors that the review date was contained in the metadata for each document rather than on the document itself. Therefore, there was no way to easily see whether the policy or guideline was current, especially when referring to printed copies. In response to my provisional report, Te Whatu Ora advised that *'Printed copies are discouraged and are not to be used for document control purposes (because they are not the master copy and may be out-of-date)'.*

[8] Inspectors were advised that, '*The redevelopment plan is on hold at the request of the Health Infrastructure Unit [HIU] at Te Whatu Ora. The HIU are leading a process to make short to medium improvements to Wakari MHA facilities, and for commencing a business case for new builds. [..]'*

With regard to ensuring policies and guidelines were up-to-date, differing accounts were offered as to how review dates were followed up on. By one account, senior management were automatically alerted on a bi-annual basis when policies within their area of operation were due for review.[9] Conversely, staff said they carried out *'enforced document withdrawals'* annually, advising those responsible that their overdue documents would be withdrawn by a certain date. As at 28 September 2022, a quarter (25 percent) of the documents stored in the MIDAS database[10] were reportedly overdue.

In response to my provisional report, Te Whatu Ora also provided a detailed overview of their electronic document control system and how review dates are highlighted within this system. This included an email to the responsible area when more than 30% of documents are overdue. I appreciate the information provided, however I consider that review dates within the documents are an easy way to allow the reader to be sure the documentation is up-to-date and the most recent version is in use. I expect that including a clearly visible review date on each policy or guideline in electronic or hard copy form is standard practice, and encourage Te Whatu Ora Southern to consider implementing this as a way of reinforcing the practice of document review.

It is concerning that a quarter of the documents stored in the database used by the Ward were overdue. It is also concerning that there was a lack of clarity about how documents due for review were identified. I make a new recommendation that **Te Whatu Ora Southern ensure that reviews of policies and guidelines are undertaken in time to ensure documentation is current, fit for purpose, and reflects best practice.** All relevant staff should be aware of the policy review system.

Recommendation 3 from 2019: All relevant staff are up to date with their SPEC training. This is a repeat recommendation.

- This recommendation was partially accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **progressing but not yet achieved.**

At the time of my follow up inspection, records showed that nine (21 percent) of 44 staff were not up-to-date with their Safe Practice Effective Communication (SPEC) training.[11] This was a slight improvement from my 2019 inspection, when 30 percent of staff were not up-to-date. Of

[9] Inspectors were told that should the date for review be overdue, the policy would be withdrawn and staff would need to draft a new one.

[10] MIDAS is a *'public consultation data warehouse, developed by The Consultation Institute.'* See: MIDAS Database - Explore and Analyse Public Consultations (midasdb.com) [accessed 30/11/2022]

[11] Safe Practice Effective Communication (SPEC) is a training course, 'which supports best and least restrictive practice in mental health inpatient units. This four-day course includes training in restraint minimisation, communication, de-escalation, collaborative ways of working, and the teaching of personal restraint and breakaway techniques. All four days must be completed by participants, with the balance of content being focused on prevention and early effective communication.' See: Safe Practice Effective Communication | SPEC | Te Pou

See https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149

the nine staff who were not up-to-date, six were booked for 'revalidation' training that was to be completed by January 2023. The other three staff did not have revalidation training scheduled.

In response to my provisional report Te Whatu Ora Southern advised that, at the time of their response, '*14.58%'* of staff were not revalidated but had been booked to complete *'revalidation'* in the next three months'. Delays in attendance had reportedly been caused by sickness and trainer capacity.

The Ministry of Health has informed me that they are aware of the delays in SPEC training and will continue to monitor this issue.

Although there has been a decrease in the amount of staff requiring 'revalidation' training I repeat my recommendation that **Te Whatu Ora Southern and management of the Ward ensure all relevant staff are up to date with their SPEC training.**

It was also of concern that one of the three staff who was not up-to-date with their SPEC training at the time of the follow up inspection and was not booked for revalidation training was the assigned Primary Nurse for a tangata whai ora who was frequently restrained. I expect that only staff who are up-to-date with their SPEC training are involved in restraint practices.

Recommendation 4 from 2019: Options for a local 'step-down' facility for patients transitioning to the community be explored.

- This recommendation was accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **achieved.**

Since my 2019 inspection, Āhuru Mōwai Forensic Step-Down Service (Āhuru Mōwai) had been created as a partnership between the Southern Regional Forensic Psychiatric Service and an NGO, 'Pact'. It had four beds for male tāngata whai ora.

A Southern Regional Forensic Psychiatric Service document[12] stated that Āhuru Mōwai supported '*consumers/tāngata whai ora to return to the community in a positive and structured way'.* The Pact website[13] stated:

> *Special patients can transition from the forensic ward into this service. […] Our support staff coach and support them to ensure they have what they need to live in the community. This can include practical things like ID, bank accounts and a CV. The team also works in partnership with the SDHB community forensics team. We expect clients will be in Āhuru Mōwai for up to two years. The aim is for them to have genuine choices and opportunities as they move toward independence.*

[12] The document was entitled *'Āhuru Mōwai Adult Community Forensic Step-Down Supported Accommodation – Southern Regional Forensic Psychiatric Service (District)'.*

[13] See: Mental Health and Reintegration (Corrections, SDHB, Oranga Tamariki) | Pact Group [accessed 5/12/22]

I am pleased to hear a local step-down facility for patients transitioning to the community is in place.

Protective measures

Recommendation 5 from 2019: The Ward ensure patients who are entitled to escorted leave receive it.

- This recommendation was partially accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **achieved.**

Ward management told Inspectors that although the Ward was operating at safe staffing levels rather than core staffing levels,[14] escorted leave for tāngata whai ora was taking place. See recommendation 13 from 2019 for further discussion of staffing.

Inspectors were informed that leave could be rescheduled, but would not be missed altogether. Inspectors saw that leave data tables, leave information, and escorted leave forms[15] showed all eligible tāngata whai ora had taken various periods of leave. Inspectors also observed tāngata whai ora taking escorted leave throughout the inspection.

As a secondary measure, information received post-inspection stated that the Ward had educated staff to ensure that should leave be unable to be facilitated, for a variety of reasons including tāngata whai ora acuity, those instances were documented in a Safety 1st incident form.

Material conditions

Recommendation 6 from 2019: The Sensory Modulation Room not be used as a bedroom when the Ward is over capacity.

- This recommendation was accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **achieved.**

During my follow up inspection, Inspectors were told by Ward management and observed that the sensory modulation room was not being used as a bedroom. Occupancy rates also supported this observation. They showed that there were between 10.8 and 11.3 tāngata whai ora accommodated on the Ward for the period March to August 2022.[16]

[14] Ward management stated, '*We have staffing as per agreed minimum numbers and Care Capacity Demand Management (CCDM) requires these numbers are agreed to by the unions.'* The shortfall in staff (between safe staffing and core staffing levels) was bolstered by casual mental health assistants.

[15] For the period March to August 2022.

[16] The Ward's ordinary capacity (when not capped) had increased by two beds since the previous inspection.

Recommendation 7 from 2019: Patients' bedrooms have integral privacy blinds installed in the observation panel.

- This recommendation was accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **achieved.**

Inspectors observed that integral blinds[17] were installed in each bedroom door. At the time of the inspection some blinds were unable to be tilted, and so remained closed.[18] Ward management said they were seeking a solution from the installer to address the issue.

Despite the functionality of some blinds having been limited, they had been installed as per my recommendation. I encourage the Ward to rectify the operational issues as soon as possible.

Recommendation 8 from 2019: Ventilation in the Ward is improved to address excessive temperatures.

- This recommendation was accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **progressing but not yet achieved.**

Since my original inspection in 2019, ventilation and air conditioning units in Ward 9A had been replaced to improve ventilation and address excessive temperatures. Despite this, staff reported that areas of the Ward remained hot (the community lounge) or cold (the seclusion area) and there were multiple orders for work to address ongoing temperature concerns. Unfortunately, the ventilation and air conditioning systems were not operational at the time of the follow up inspection. This was because the Ward was being run on generator power while the mains power system was upgraded and the original generator replaced.

It is positive that action has been taken to address concerns about the Ward's ventilation and temperature. However, it is disappointing that issues concerning temperature continue to arise. In response to my provisional report, Te Whatu Ora have advised that ventilation and temperature will be reviewed with proposed building refurbishment. In the interim management of the Ward should continue to monitor the situation and seek improvement. This should not wait for the refurbishment plan to be actioned.

Recommendation 9 from 2019: The building is upgraded as a matter of urgency.

This is an amended repeat recommendation.

- This recommendation was accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **not achieved.**

In the report on my 2019 inspection I stated, *'[…] the structure, age and layout of the Ward is not conducive to the optimal treatment of acutely unwell patients. I am concerned that the*

[17] Integral blinds are contained in a sealed unit between two panes of glass.

[18] The operation of the blinds was impaired if the dial was 'over-turned'.

environment has a detrimental effect on patients' wellbeing' and expressed my view that the building was no longer fit for purpose.

In April 2021, Purple Consulting Limited produced a report entitled, *'Health and Safety Assessment of Wakari Mental Health Services'.* Recommendation 62C of the report concerned violence and aggression and identified the need to *'provide facilities that are fit for purpose and well maintained'.* The report also commented that,

> *There are a number of health and safety risks presented by […] the physical condition and layout of the hospital site and properties. […] Violence and aggression occurred in all wards, and always related to the following common issues: facilities which are not set out to enable safe movement, quiet reflection or de-escalation. Staff were experiencing elements of work-related stress in many roles across Wakari. […] The facilities were not enabling effective care to be provided, which increased staff demand.*

During my follow up inspection, Inspectors received an email from management with concept plans for alterations to the Ward. However, Inspectors were told the project to alter the Ward had been paused as the Health Infrastructure Unit at Te Whatu Ora intended to submit a request for proposal (RFP) for an architect to develop a campus-wide improvement plan.

A CAPEX (capital expenditure) request was reported to have been approved on 18 May 2022 for non-clinical equipment to enhance the comfort of tāngata whai ora and maintain their physical wellbeing. This included gym equipment, air hockey and table tennis tables, computer tablets, a massage chair, a recessed TV in the seclusion lounge, a basketball court in the seclusion courtyard and main courtyard, swipe card access and self-locking door lock conversions, and a carving or artwork for Āhuru Mōwai. Despite being approved, Inspectors observed that none of the listed items were in the Ward at the time of inspection.

Inspectors observed that there had been some improvements made since my previous inspection. These included the installation of sunshades in the main courtyard, new curtains, new furnishings, and storage in bedrooms. However, the building remained fundamentally unfit for purpose. I repeat my recommendation that **Te Whatu Ora Southern ensure the building is upgraded as a matter of urgency.**

As of May 2023, I am advised that '*Te Whatu Ora Southern are planning refurbishments for Ward 9A and are in the process of finalising proposed plans for building works*'. I expect to be regularly updated on the progress of this.

Recommendation 10 from 2019: Patients need to be able to freely access hot drinks any time of the day or night.

- This recommendation was rejected by the DHB.
- On my follow up inspection I considered that the recommendation was **not achieved.**

At the time of the follow up inspection, tāngata whai ora were unable to independently access hot drinks and were supervised by staff when doing so. The kitchen was otherwise locked. Inspectors were informed that no individual risk assessments were undertaken in regard to

kitchen access for tāngata whai ora. Records showed that over five years there had been five incidents involving hot water, with the last incident occurring three years ago.

At the start of this report, I wrote that the Ward accommodates tāngata whai ora who require assessment, treatment, and rehabilitation. I consider that blanket practices that deprive tāngata whai ora of freedom of choice are not consistent with recovery-based and rights-based approaches to treatment and rehabilitation, as outlined in the '*Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992 guidelines'.*[19] These guidelines state, *'care and treatment are proportionate and tailored to the person's circumstances (least restrictive approach)'.*

As the only forensic mental health unit at the hospital, the Ward provided care and treatment for tāngata whai ora from acute, sub-acute and a rehabilitative level of need. It concerns me that all tāngata whai ora were nevertheless subject to the same restrictions, and security in the ward was set at the highest level. In my view, this disadvantaged those who would benefit from further independence, such as access to the kitchen.

Blanket restrictions are not conducive to tāngata whai ora having independence, quality of life, or autonomy over their living environment. I make an amended repeat recommendation that **Te Whatu Ora Southern and management of the Ward ensure that tāngata whai ora can access hot drinks independent of staff, unless this is considered unsafe based on individual risk assessment.** If a tangata whai ora is not permitted to access hot drinks independently, the reasons are recorded and reviewed regularly.

The Ministry of Health shared my concern of tāngata whai ora not having access to hot drinks. In their response to my provisional report they commented '*that there are now modern solutions that can be plumbed into the unit with a heat-tempered tap to ensure safer use for tāngata [whai ora].'*

Although Te Whatu Ora advised that they will action my recommendation in the proposed building refurbishment plan. In my view, providing access to hot drinks should not wait for the refurbishment plan to be actioned, and suggest they explore the solutions advised by the Ministry of Health.

Activities and programmes

Recommendation 11 from 2019: All patients are able to access the outdoor area for at least one hour per day.

- This recommendation was partially accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **not achieved.**

Limits on access to the outdoor area remained unchanged since my 2019 inspection – the area could only be accessed when staff were available to supervise tāngata whai ora. Staff told

[19] See Human Rights and the Mental Health (Compulsory Assessment and Treatment) Act 1992 | Ministry of Health NZ [accessed 7/12/2022]

Inspectors this was because fencing around the courtyard posed a ligature risk. While Inspectors observed tāngata whai ora in the courtyard under the supervision of staff on a small number of occasions during the follow up inspection, the requirement for this supervision without commensurate increase to staffing meant that, in my view, access to the courtyard for tāngata whai ora remained inadequate.

Post my follow up inspection, Te Whatu Ora Southern stated that Ward 9A had reviewed the Ward's activity programme to include the times when the courtyard would be regularly open, *'in addition to individual access'*.[20]

I acknowledge that unrestricted access to the courtyard may not be safe for all tāngata whai ora in all circumstances. However, the blanket restriction disadvantages all tāngata whai ora regardless of their individual circumstances. I expect that restrictions are only put in place where strictly necessary based on individual risk assessment. This is particularly important concerning access to basic needs, such as fresh air. I make an amended repeat recommendation that **Te Whatu Ora Southern and management of the Ward ensure that all tāngata whai ora have unrestricted access to the outdoor area during the day, unless this is considered inappropriate for individual tāngata whai ora based on a clinical or safety risk assessment.** This should be documented and reviewed regularly. Safety features of the outdoor area, such as ligature risks, must be addressed.

Communications

Recommendation 12 from 2019: Patients have access to a telephone independent of staff.

- This recommendation was rejected by the DHB.
- On my follow up inspection I considered that the recommendation was **not achieved.**

Restrictions on access to a telephone had not changed since my previous inspection. Tāngata whai ora had to ask to use the Ward's portable telephone, which was located at the nurses' station. This enabled staff to vet calls to ensure non-association orders were not breached, or victims contacted. Calls were usually made in the quiet lounge close to the nurses' station.

A corded landline telephone, stored in a drawer at the nurses' station, was also available on request. It could be plugged into a jack on the stairs in front of the nurses' station. However, this did not provide tāngata whai ora with privacy when making a call. When on leave, tāngata whai ora who had approval could use one of the mobile phones stored at the Control Centre.[21]

[20] The Ward Programme provided showed the courtyard was scheduled to be open daily from 10-11am, and 3-4pm.

[21] This was set out in the 'Patient and Family Information Booklet'. Among other things, the Control Centre managed incoming and outgoing calls; monitored CCTV; held keys, mobile phones, cigarettes, and leave records; and managed access and visitors.

The 'Patient and Family Information Booklet' and the 'Telephone Use' notice (dated 28 January 2020) stated that the Ward would pay for one 10 minute call outside the local area per day, and local calls should be limited to 30 minutes. Ward management said there was no restriction on local calls or calls made with a prepaid calling card. Risk assessments concerning individual phone use were not conducted.

One tangata whai ora told Inspectors they had been told to *'get off the phone'* before, and staff reportedly sometimes considered calls that did not connect[22] as *'counting towards the daily limit'.* The tangata whai ora said how limits on the number of calls per day were enforced, depended on the staff member involved.

It is clear that tāngata whai ora were unable to independently access a telephone, including for calls to their lawyer, a District Inspector, their bank, health and disability advocacy services, and the Ombudsman. Without individual risk assessments, blanket restrictions disadvantage all tāngata whai ora regardless of individual circumstances, including in terms of recovery and rehabilitation. **I recommend management of the Ward ensure that tāngata whai ora have access to a telephone independent of staff.** This is a repeat recommendation.

In response to my provisional report Te Whatu Ora said a telephone booth would be included in the refurbishment plans for Ward 9A. I encourage Ward management to consider options to immediately address my recommendation and not wait for the refurbishment plan to be actioned.

Staff

Recommendation 13 from 2019: The reason for staff resignations should be analysed and, where necessary, appropriate remedial action implemented.

- This recommendation was accepted by the DHB.
- On my follow up inspection I considered that the recommendation was **not achieved.**

Staff were provided with an opportunity to complete an exit interview as part of the off-boarding process. Inspectors sought, but were not provided with any analysis of the reasons for staff resignations, including from exit interviews that took place. I am concerned that this analysis did not appear to have occurred.

The April 2021 *'Health and Safety Assessment of Wakari Mental Health Services'* produced by Purple Consulting Limited stated:

> *Staff were experiencing elements of work-related stress in many roles and locations across Wakari […]*
>
> - *Staff (front line and managers) were visibly upset and emotional during interviews because the demands placed upon them did not match the resources available to meet those demands.*

[22] Calls that were unanswered, engaged, or went to voicemail.

- *Turnover on some wards was high.*
- *Staff expressed fear at coming to work and concern that they were having to provide emergency assistance to other wards when there were assaults – but that they were not resourced to do this.*

Almost 50 percent of the Ward's registered nurse positions were vacant at the time of the follow up inspection.[23] Additionally, a number of staff members were on ACC.

The Ward was operating at safe staffing levels, rather than core staffing levels, aided by casual mental health assistants. Inspectors were told that a number of staff had come to the Ward with no prior experience in a forensic setting, particularly working with more acute tāngata whai ora with complex presentation.

When discussing staffing with Inspectors, Ward management said 2022 had been a *'really, really tough year'.* They described morale as *'better, but not good'*, saying, *'the team is really coming together'.*

It is disappointing that although exit interviews were taking place, there was no evidence of analysis having been conducted and remedial measures implemented. In response to my provisional report, Te Whatu Ora stated '*[t]he People and Capability team member provides an anonymised summary of the exit interviews which is used to plan and improve on the feedback'.* However, I did not receive evidence of the summary information or how this had informed planning or improvements. In light of this, and the staffing challenges faced by the Ward at the time of my previous inspection and this follow up inspection, **I recommend Te Whatu Ora Southern and management of the Ward ensure the reasons for staff turnover are assessed and used to inform remedial action.** This is an amended repeat recommendation.

Acknowledgement

I appreciate the co-operation extended by management and staff to the Inspectors during my inspection of the Ward. I acknowledge the work involved in collating the information requested. My thanks to the tāngata whai ora for their participation and assistance.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

[23] At the time of the inspection, Ward management provided data showing there were 13 registered nurse roles vacant.

Appendix 1. Legislative framework

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

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

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

Places of detention – health and disability facilities

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

> *"…any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in…*
>
> *(d) a hospital …"*

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including hospitals and the secure facilities identified above.

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

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

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

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

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

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

More information

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