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OPCAT Report on an announced inspection of Auckland South Corrections Facility under the Crimes of Torture Act 1989

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OPCAT Report: Report on an announced inspection of Auckland South Corrections Facility 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 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).

The OPCAT team is part of the Office of the Ombudsman. OPCAT team members have been delegated powers under COTA to examine the conditions and treatment of detainees in places of detention – where persons are or may be deprived of liberty. 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 of people in custody in these places, report my observations and if necessary make recommendations for improvement.

More information about my OPCAT role, and my reports, are available online at: ombudsman.parliament.nz/opcat

Overview

Inspection approach

From 19 to 30 August 2024, a team of eight inspectors made an announced visit to Auckland South Corrections Facility | Kohuroa (the Prison).

Inspectors were guided by our *Expectations for the conditions and treatment of people in custody of the Department of Corrections (Corrections)*.[1] These are:

1. The rights of people in custody are upheld by people, principles, and practices, at all levels.
2. People in custody are safe and their independence is promoted.
3. People in custody can build towards their future, through remaining connected with the wider community and access to meaningful development opportunities.
4. People in custody are treated with dignity and respect.
5. People in custody enjoy the highest attainable standard of physical and mental health.

[1] Available online at https://www.ombudsman.parliament.nz/resources/expectations-conditions-and-treatment-people-custody-department-corrections

6. People in custody are in an environment that promotes their safety, independence, culture, dignity, and wellbeing.

7. People in custody are supported by skilled, motivated, and engaged people.

Inspectors gathered and assessed a range of information, including reviewing documents, interviewing a number of people, and observing Prison activities. This included visiting the Prison in the evening and during the weekend to observe specific aspects of Prison operations outside of typical business hours.

Before leaving the Prison, inspectors met with senior management to outline their initial observations. As outlined later in this report, we have also corresponded with Corrections and senior Prison management (Serco staff) on several occasions since the inspection, in relation to the most serious and pressing concerns.

A provisional report was provided to Serco (Prison management) and to the Department of Corrections (Corrections) for comment. We received responses from Serco on 5 September 2025 and Corrections on 8 October 2025. We had a meeting with Corrections to discuss the report on 29 October 2025, and following this we received further correspondence from Corrections on 28 November 2025. We have considered their feedback when preparing our final report.

Facility facts

Auckland South Corrections Facility opened in 2015. It is located in Wiri, Auckland.

The Prison accommodates sentenced male prisoners with security classifications ranging from minimum to high and has an operating capacity of 960. There were 957 prisoners in the Prison on the first day of inspection.

The Prison is operated by Serco New Zealand under a Public Private Partnership contract between the consortium SecureFuture and Corrections.[2] The Chief Executive of Corrections retains ultimate responsibility for the treatment and conditions of prisoners in privately operated prisons.[3]

While the Prison must comply with the same legal and regulatory requirements, there are some differences in the way the Prison operates compared to facilities managed by Corrections. For example, custodial staff are called 'Reintegration Officers' rather than Corrections Officers. The Prison also has its own operations manual to guide custodial staff, and its own Custodial Management System (CMS) through which prisoners can make requests and access information using in-cell computers.

[2] The contract is available on Corrections' website: https://www.corrections.govt.nz/about_us/getting_in_touch/our_locations/auckland_south_corrections_facility/contract

[3] Section 8 of the Corrections Act 2004 sets out the powers and functions of the Chief Executive. These include *'ensuring the safe custody and welfare of ensuring the safe custody and welfare of prisoners (other than prisoners detained in Police jails or in institutions that are not corrections prisons).'*

The Prison's residential units are comprised of three House Blocks, each with four wings capable of housing 60 prisoners. Wing 4 of House Block 3 was the Te Whare Ora Wing, a wing dedicated for prisoners who were *'vulnerable'* or assessed as being at-risk of self-harm. The Prison also had 10 Residences (also known as Internal Self-Care Units) which each contained four Units, housing six prisoners per Unit.

At the time of inspection, more than half of the Prison's population (497 out of 957 prisoners) were voluntarily segregated[4] for the purpose of protective custody under section 59 of the Corrections Act 2004 (the Act).

The table below outlines the security classifications of the prisoners at the time of inspection.

Security classification	Number of prisoners
High	274
Low medium	268
Low	159
Minimum	256
Total	**957**

Key observations and recommendations

The Prison was last inspected in 2018. Following that inspection, the previous Chief Ombudsman observed that *'the Prison's potential has yet to be fully realised due to a number of operational issues, which negatively influence prisoners' day-to-day routines and sentence progression.'*[5] Based on our observations during this inspection, this continues to be the case.

There were obvious challenges facing the Prison, and some matters of significant concern are detailed in this report. However, despite these, there were areas of good practice seen during the inspection. The Prison's progression pathway model, where restrictions are progressively removed and opportunities for autonomy increased, continues to be a positive approach to preparing prisoners for reintegration into the community. As part of the model, prisoners were supported to develop practical skills through industrial training in areas such as horticulture, cabin manufacturing, engineering and welding.

It was also pleasing to see that the Prison was supporting prisoners to maintain connections with people that were important to them through regular visiting sessions,[6] and providing a

[4] *'Voluntary segregation'* is defined as a prisoner requesting to be segregated from other prisoners. The Prison Director may approve the request if it is considered to be in the prisoner's best interest, and if the Prison Director is satisfied that the prisoner's safety has been put at risk, and therefore there is no other way to ensure their safety.

[5] The report on the former Chief Ombudsman's August 2018 inspection (published February 2019) can be found at: https://www.ombudsman.parliament.nz/resources/report-announced-inspection-auckland-south-corrections-facility-20-february-2019

[6] Each House Block was allocated three visiting sessions between Wednesday and Sunday.

visiting environment that was comfortable and child friendly.[7] Prisoners had access to weekly 45 minute in-person visits which inspectors observed to be well organised. Prisoners were able to book visits using their in-cell computers and could have up to three adults and an unlimited number of children attend each visit.

Although time out of cell for prisoners in some Wings had been reduced to only 2.5 hours, it was positive that across the six months of data reviewed (1 February 2024 to 27 August 2024), most prisoners had on average 4.6 hours out of their cell each day and were encouraged to use this time constructively. The Prison offered a range of purposeful activities, unit-based employment, education, rehabilitation and cultural programmes available for prisoners to use their time constructively. The Prison also provided spiritual support for a variety of faiths.[8]

We were advised that one of the challenges facing the Prison was that the cohort of prisoners the Prison was now receiving differed from that originally envisioned when the Prison and its prisoner progression model were designed.

As discussed above, just over half of the Prison population was voluntarily segregated, a far greater number than during the previous inspection of the Prison. Requirements to keep voluntarily segregated and mainstream populations separated meant staff had less flexibility when making accommodation decisions.

Prison management advised that in order to make space available in the House Blocks, they had relaxed the Residence Units' admission criteria. These Units, which comprised one quarter of the Prison's accommodation, were designed to prepare prisoners for reintegration into the community by creating a more home-like environment and providing increased opportunities to exercise autonomy.

In addition to a cohort which staff struggled to manage within the constraints of current infrastructure, staff inexperience and poor dynamic security meant the Prison was not consistently meeting our expectations for the conditions and treatment of prisoners. This was most pronounced in the high security areas of the Prison.

Dynamic security (security which comes from the ongoing relationships built between well-trained prison staff and prisoners) was clearly lacking. The inspection identified that there were issues with staff not feeling safe and confident enough to complete some duties; being intimidated by prisoners; and failing to report incidents or 'looking the other way' as a result. Staff members assigned responsibility for building individualised relationships with prisoners were not always doing so. Inspectors also heard that staff fears about working in particular areas of the Prison had contributed to unplanned absences, which in turn contributed to the challenging operating environment.

[7] The visit centre had space for 30 prisoners in each session and included areas for children to play freely.

[8] This included spiritual support for Muslim prisoners and prisoners of various Christian denominations. External providers were able to access the site for spiritual needs that were unable to be facilitated by the Chaplaincy Team.

As of August 2024, 58% of the Prison's Reintegration Officers had less than two years' experience, with over a quarter (28%) of all Reintegration Officers having started in the six months before the inspection.

In the time spent in Wings 1 and 4 of House Block 2, inspectors observed that staff were unable to manage prisoner behaviour, which was volatile and at times violent. They witnessed prisoners directly challenge staff. This included a group of prisoners surrounding a staff member, prisoners attempting to enter areas of the Wing they were not authorised to access, and a prisoner physically grabbing a photo muster board out of a staff member's hands. None of which was addressed while inspectors were on the Wings.

Serious incidents, including assaults, and contraband finds, including drugs, alcohol, and potential weapons, were frequent during the inspection, and data provided by the Prison showed this had been an ongoing challenge. While the identification of contraband may be considered a sign of an effective detection processes, we are concerned the amount of contraband was nevertheless being underreported given comments made by staff that some were not comfortable conducting searches or removing contraband.

As well as concerns about safety in particular areas of the Prison, we are also concerned about prisoners' access to healthcare, including dental care, and the Prison's ability to provide care to prisoners with significant health needs.

Observations about the operation of Te Whare Ora, the Wing dedicated to vulnerable and at-risk prisoners, are discussed in more detail below. At a high level, however, we are concerned that this Wing was not sufficiently resourced to manage the complexity of the prisoners accommodated within it. One staff member went so far as to say the Wing was *'not fit for purpose under any circumstances.'*

A model used in Te Whare Ora at the time of inspection, where some prisoners could act as *'peer supporters'* for prisoners who needed assistance with day-to-day tasks, concerned us as it appeared prisoners were completing intimate personal care tasks more appropriately carried out by professional caregivers. Following the inspection and further engagement on this issue, we have been advised that the Prison has ceased using the peer support model. While we acknowledge this, we consider it important to highlight that the model appeared to have been implemented without adequate safeguards to protect the welfare of both the prisoner receiving and prisoner providing support. It also appeared that some of these prisoners' needs were beyond the capacity of the Prison to meet.

Since the onsite inspection, we have continued to engage with both Prison management and Corrections about some of the most serious concerns we identified. While Prison management and Corrections both appear to have had a level of awareness of the issues highlighted above prior to the inspection, it does not appear that they were adequately escalated or treated with sufficient urgency prior to these concerns being raised during and following the inspection.

In December 2024, Corrections and the Prison entered into a *'Mutual Aid'* arrangement, and we were advised that they worked together on a plan to address some of these matters. Corrections staff were stationed at the Prison for approximately two months to provide training and support to Prison staff. A number of prisoners were also transferred to other

prisons. While we acknowledge these actions, we remain concerned that they have not been sufficient to address the root causes of the challenges facing the Prison and will be looking to see oversight processes improve.

It is also disappointing that a number of the issues identified by the former Chief Ombudsman in 2018 had not been addressed. These included, but were not limited to, actioning recommendations to implement a separate health complaints system; improving monitoring of segregated prisoners; improving access to induction information, particularly for foreign nationals, speakers of other languages, and those with literacy or communication difficulties; and improving governance arrangements in relation to misconducts.

As a result of this examination, I make a number of recommendations.[9]

I recommend that the Department of Corrections:

- ensure effective mechanisms are in place for overseeing the conditions and treatment of prisoners at the Prison to address risks to prisoner safety and welfare. This should include the prompt identification, escalation and management of risks.

I recommend that Prison Management:

- implement ongoing support, training and monitoring for staff to build effective professional relationships with prisoners.
- develop clear staff rostering and allocation criteria that provides sufficient numbers of experienced staff to maintain a safe environment in all wings.
- improve searching practices to ensure the safety and security of prisoners and the Prison.
- implement a robust process to assess the initial and ongoing suitability of cell-sharing arrangements. This includes monitoring that SACRAs are conducted and documented comprehensively, in consultation with each prisoner in advance of cell placement.
- review their manual door procedures to ensure that the site can guarantee the safety and wellbeing of people in custody in the event of a failure of the electronic doors.
- ensure staff provide prisoners a comprehensive induction which includes information on how to use the Prison's kiosks and in-cell systems.
- review induction arrangements for foreign nationals, speakers of other languages, and those with particular literacy or communication needs, and improve these arrangements to ensure these prisoners are fully briefed on the Prison procedures.

[9] 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.

- implement an organised and transparent hearing schedule, and ensure all prisoners are provided with a proper opportunity to prepare their defence to a misconduct charge.
- ensure all use of force events are recorded, reviewed and reported, at least in line with statutory requirements.
- update the use of force policy to include suitable time frames for use of force reviews.
- ensure recommendations from use of force reviews are implemented to improve practice.
- ensure prisoners are only restricted or denied the opportunity to associate with others in accordance with the Corrections Act 2004.
- implement robust systems to record, review and monitor all directed segregation paperwork.
- ensure that that all prisoners are able to engage with support services privately and in-person.
- ensure that prisoners are not subject to in-cell CCTV surveillance without a clear justification identified through individual risk assessment.
- protect prisoners' privacy when using the toilet or showering.
- ensure that prisoners' health information is kept confidential and they are provided privacy during health appointments
- improve processes for communication between Case Managers and prisoners to support individual management planning, including access to programmes and services, and preparation for parole and transition preparation.
- ensure staff follow the Prison's established procedures for caring for prisoners formally assessed as being at-risk of self-harm.
- review the staffing arrangements in Te Whare Ora and take the necessary actions to ensure prisoners in this wing are safe and receive adequate supervision and interaction from staff who have received specific training in how to meet this cohort's needs.
- urgently address deficiencies in prisoner access to timely healthcare services.
- ensure prisoners are promptly advised of cancellations, and appointments cancelled for reasons outside a prisoner's control are immediately rescheduled.
- review the practice of paracetamol administration and dispensing and implement robust safety and quality assurance measures.
- ensure repairs and maintenance are carried out within reasonable timeframes.

- ensure the Prison's property management function is resourced sufficiently to prevent prisoners experiencing long delays in receiving their property.
- standardise the serving of meals to normal hours, with lunch served between midday and 1.30pm, and dinner served between 5pm and 7pm.

I recommend that the Department of Corrections and Prison Management:

- consider the resources and accommodation available at the prison, and work together to ensure prisoners placed there can be accommodated safely.
- urgently address and improve the integrity of the complaint system and to enable prisoners to make complaints independently of staff
- implement a separate and confidential health complaint process.
- develop and implement individual management plans for prisoners on directed segregation that maximise time outside of cell, access to activities, and opportunities for meaningful human contact.
- ensure disabled prisoners receive care and support from trained practitioners and are accommodated in appropriate physical environments.

Discussion

People, principles, and practice

Leadership, oversight and accountability

We expect leadership at all levels to be committed to, and take responsibility for, promoting human rights and providing safe, responsive and high quality care for the people in their custody. Leaders should have genuine insight into and understanding of the culture and operational reality within the Prison, and be engaged in monitoring and ensuring appropriate conditions and treatment are provided for prisoners.

As outlined above, while the Prison is operated by Serco New Zealand, the Chief Executive of Corrections is responsible for the treatment and conditions of all prisoners, whether they are in a publicly or privately operated prison.

Oversight of the Prison's operations came in various forms. Some of these were statutory obligations, such as performance reports prepared by the Prison and the stationing of three Monitors at the site who reported directly to Corrections.[10] The Office of the Inspectorate also has the ability to inspect the Prison.

The contract between Corrections and SecureFuture set out additional reporting procedures and performance standards the Prison was required to achieve.[11] The Prison was required to develop its own *Policy and Procedures Manual* (PPM), alongside other operational documents, which were submitted to Corrections prior to the Prison's opening. Any material changes to the PPM were required to be reviewed by Corrections. The contract also set out the basis on which Corrections could *'step in'* and temporarily assume total or partial management or control of the Prison.[12]

More day-to-day Corrections oversight came through Key Performance Indicator (KPI) meetings, and monthly relationship management meetings attended by representatives of Corrections, Serco and SecureFuture.

Internally, the Prison had a Performance Team, including an Operations Practice Manager, responsible for monitoring and improving staff practice.

This report goes on to discuss serious concerns regarding prisoner safety and welfare at the time of inspection, and the lack of prompt action to address these before they were raised by

[10] See sections 198 to 199K of the Corrections Act 2004 for more information about Corrections' oversight of private prisons. Under the Act, Special Monitors can also be appointed for particular purposes. Examples of topics Special Monitors had been appointed to review at the Prison included health and psychology.

[11] Under the contract, failure to meet standards in various areas of Prison operations could result in *'abatements'*, reductions in the amount paid out by Corrections. The contract also has provisions for financial incentives where successful outcomes were achieved in particular areas such as reduction in recidivism rates.

[12] Part 18 of the contract.

external agencies. Collectively, these matters raise questions about the effectiveness of these oversight and accountability arrangements.

At the time of inspection, Prison management were aware of ongoing tensions at the site due to muster pressures and population factors, such as managing a large voluntarily segregated population. They were open that the Prison was not able to operate its rehabilitative model as intended (the *'Trusted Accommodation Pathway'*), and that criteria for prisoners to progress to less restrictive locations within the Prison had been relaxed to make space available in the House Blocks. They were also aware that they were not meeting the needs of prisoners with complex health needs, that searches were not being done effectively, and that staff inexperience was creating challenges. Management received regular reports on serious incidents. Recent internal audits had also found that observation of at-risk prisoners was not occurring as required, that security classification processes were not always being followed, and that Reintegration Officers were not building individualised relationships with prisoners in the ways expected of them, and as outlined in the Prison's policies.[13]

All of these are matters which are at the heart of running of an effective prison in which prisoners experience appropriate conditions and treatment. Despite this, those in relevant leadership and oversight roles did not appear to treat these issues with the urgency required.

Relationship Management Group Meeting minutes between February and June 2024 showed that challenges resulting from the Prison's current cohort had been repeatedly raised with Corrections by Prison management. They included references to resulting impacts, such as increased incidents involving violence, reduced unlock time, and difficulties accommodating prisoners with different gang affiliations. However, the severity of the impact of these issues on prisoner safety and security was not evident in these minutes, and Corrections did not appear to have considered an immediate response was required. For example, in June 2024 Corrections responded, '*the prisoner placement team is aware of the cohort challenges at ASCF but is currently unable to assist due to the nature of the wider estate cohort.'*

Reports from the Prison Monitors to Corrections did not give an impression of the Prison being under significant pressure, although they did contain reports that unlock hours had been significantly reduced in House Block 2 due to *'a combination of increases in the muster, violence and Voluntary Protective Segregation cohort.'* We were advised that the Monitors had recently discussed some matters informally with the Prison Director; however, at the time of inspection these matters had not risen to the level of KPI breaches under the contract and were not formal concerns. Notably, as there was no KPI related specifically to staff presence in each Wing, this was not something included in the Monitors' reporting.

Prior to leaving the site, inspectors raised concerns about the immediate safety and welfare of prisoners with Prison management, and subsequently followed up in writing to both Serco and Corrections. Correspondence was entered into in November 2024, and a request was made for information about how the immediate safety of people in custody at the Prison would be ensured, how the prison would meet the needs of particular individuals with complex health

[13] Each of these matters is discussed in further detail later in this report.

concerns, and reassurance that the site was well-placed to ensure prisoner safety in an emergency.

In December 2024, Corrections and the Prison entered into a *'Mutual Aid'* arrangement. This involved Corrections developing an action plan, and temporarily allocating staff to the Prison, who were tasked with identifying training needs and providing Prison staff support, mentoring and coaching. We understand all Corrections staff returned to their usual positions by 31 January 2025. A number of prisoners deemed *'influential'* were also transferred to other prisons.

The formal support arrangements put in place in December 2024 were implemented after we highlighted significant concerns during and after this inspection, and at approximately the same time as concerns were raised by other oversight agencies, such as the Office of the Inspectorate and the Health and Disability Commissioner. While we acknowledge the ongoing engagement on these matters with us by Prison Management and Corrections, we remain concerned that the arrangements put in place after the inspection have been insufficient to address the underlying causes of these concerns.

Staff experience and their ability to manage the current cohort remains an issue. Corrections stated in February 2025, after the conclusion of the *'mutual aid'* arrangements, that '*experience levels seem to remain stubbornly low, due to the exits [resignations] mainly coming from the under two-years cohort*.' Additionally, although various prisoners have been transferred to other sites, the Prison cohort may change at any time, depending on national muster considerations. This may result in the Prison again receiving large numbers of prisoners not able to progress along the Trusted Accommodation Pathway as originally intended. To date, we have not seen evidence of meaningful steps being taken to ensure that the cohort of prisoners at the Prison can be accommodated safely in the longer term.

Given what we have outlined above, we are not reassured about the effectiveness of oversight and accountability arrangements for the Prison's operations. In particular, we are concerned that:

- Despite being aware of some significant challenges faced by the Prison which were causing negative impacts on prisoners, both Corrections and Serco/Prison management failed to act promptly.
- It was not until external agencies, including this Office, raised our concerns that plans were put in place to begin to address matters.
- Corrections' oversight mechanisms – such as the Monitors – did not appear effective at escalating or communicating the full extent and seriousness of concerns related to prisoner safety and welfare.
- The steps taken in response to these issues to date do not appear to have addressed their underlying causes, so that prisoner safety and welfare will be assured in the longer term.

Since the inspection, Corrections have advised us that they are considering how to make the Monitor function more effective, noting that the Monitors' focus on contractual compliance has limited their scope to raise broader concerns. In response to the Provisional Report, Corrections further advised that along with the Monitors' work continuing, the '*strengthened oversight regime'* includes:

- Corrections, Prison management, SecureFuture and Serco Australia/New Zealand attending a monthly meeting to discuss contractual performance and day-to-day operations.
- Corrections chairing a quarterly forum with SecureFuture and Serco Australia.
- The Corrections Pae Ora team attending meetings with the ASCF Health Services Manager as needed.

It is positive that Corrections is taking steps aimed at strengthening its oversight of conditions and treatment at the Prison. However, to date we have not seen evidence that Corrections has implemented effective mechanisms for this purpose. In particular, it remains unclear what changes Corrections plans to make to its monitoring to ensure that potential areas of concern at the Prison are reliably identified, escalated, and addressed.

I recommend that the Department of Corrections ensure effective mechanisms are in place for overseeing the conditions and treatment of prisoners at the Prison to address risks to prisoner safety and welfare. This should include the prompt identification, escalation and management of risks.

Safety and independence

Safe custody

We expect the safety and security of prisoners, staff, service providers, and visitors to be provided for at all times. Safe custody is a core requisite of the corrections system.[14] National and site-specific strategies and procedures should be in place to support this.

During their time on site, inspectors identified multiple immediate safety concerns related to the day to day running of the Prison which impacted on the personal safety of prisoners and staff. This included:

- incidents of volatile behaviour from prisoners and a failure to appropriately manage these;
- impacts of staff inexperience and unplanned staff leave.
- large amounts of contraband and a reluctance by some staff to confiscate this;

[14] Corrections Act 2004, s5, Purpose of corrections system.

- shared cell ('double bunking') process and practice issues, including incomplete shared cell risk assessments;
- constrained prisoner placement options;
- inadequate complaint processes;
- poor reporting of use of force;
- a failure to follow processes for oversight of prisoners assessed as at-risk of self-harm;
- a lack of specialist training provided to staff working in the Te Whare Ora Wing;
- a lack of staff awareness of emergency procedures; and
- delayed maintenance and repairs.

These issues are all discussed in depth in the sections below.

Management of volatile prisoner behaviour

In Wings 1 and 4 of House Block 2, which were some of the most volatile areas of the prison, inspectors observed several situations that appeared to be unsafe for prisoners and staff, including intimidating and sometimes violent behaviour. For example, prisoners were seen pushing staff away from Wing doors and accessing the central staff area. A staff member was surrounded by prisoners, and a photo muster board was taken from a staff member by a prisoner. Prisoners were also seen approaching other Wings in the House Block. This behaviour went unaddressed by staff. A staff member advised inspectors that such incidents were an almost daily occurrence.

After witnessing these situations, inspectors felt it was unsafe for them to re-enter the Wings and a decision was made that a full examination, including prisoner interviews, of the conditions and treatment of prisoners in these Wings could not be completed. Inspectors did, however, return to observe from within the Wing's staff base.

Staff did not appear to be in full control of these areas, where there appeared to be a lack of staff presence and dynamic security,[15] inadequate cohort management and ineffective safeguarding measures.

Each morning, Prison management held a daily briefing which included a high-level summary of serious events which had taken place the day before. Daily briefing records reviewed by inspectors showed that at least seven of these events occurred across Wings 1 and 4 during the two weeks of inspection. These included violence and assaults, threatening behaviour, and the discovery of improvised weapons and other unauthorised items.

Inspectors heard from several sources that staff working on Wings 1 and 4 were *'scared'* to complete cell searches, remove contraband, were intimidated by prisoners, often 'looked the

[15] *'Dynamic security'* is a term used to describe security which depends on alert staff who interact with prisoners. For more information about prison security, see, for example, United Nations Office on Drugs and Crime (UNODC) *Handbook on Dynamic Security and Prison Intelligence,* December 2015.

other way' during incidents, and intentionally did not report or record these incidents correctly. For example, a staff member said that sometimes staff see the home brew but are too scared to pick it up.

Staff who had worked in these Wings also said that they stayed out of them as much as possible, which inspectors observed occurring during the inspection. This was despite policies outlining that each prisoner should have frequent contact with a *'Nominated Individual Officer'* responsible for *'encouraging and actively supporting prisoners to behave positively'*. Without these interactions, staff cannot develop rapport and understand each prisoner's individual circumstances, or develop an awareness of what is going on in the Prison, both of which are crucial in developing a safe environment. Staff must be alert to what is going on where they work, able to identify concerns and know how to act on or report these.

In response to the provisional report, Prison management advised that it had *'implemented a targeted programme of support, training, and monitoring within House Block 2, Wings 1 and 4'*. They referred to the mutual aid arrangements described above, in which, between December 2024 and February 2025 Corrections staff had been deployed to Wings 1 and 4 of Block 2 to mentor, coach and shadow Prison staff. However, these arrangements ended in early 2025; it is unclear what, if any, ongoing measures have been put in place, or whether the training provided has had a lasting impact on the management of the prisoners in these Wings.

I recommend Prison management implement ongoing support, training and monitoring for staff to build effective professional relationships with prisoners.

While Wings 1 and 4 of House Block 2 were the areas of greatest concern, these were not the only areas of the Prison where prisoners felt and were unsafe. An example of the validity of their safety concerns, and illustration of poor safeguarding practices involved one prisoner, who was eventually put on directed segregation for their safety. The segregation direction outlined that they had been hospitalised after being assaulted in House Block 3. On their return from the hospital, they were returned to mainstream accommodation where they were again seriously assaulted ten days later.

Unplanned absences and staff inexperience

Data provided by the Prison, for the six-month period 1 February 2024 to 27 August 2024, showed a high number of unplanned staff absences across the Prison. Prison management said that staff shortages were covered by casual staff and other staff working over-time. However, daily briefing sheets showed this was not always the case, with some shifts operating with fewer staff than were initially rostered. Anecdotal evidence suggested that some absences in House Block 2 were due to staff fears for their personal safety.

Prison management advised that there were no set staff-prisoner ratios under the contract, but they had recently adjusted staffing rosters to allocate three staff per wing across the Prison. Staffing data, however, appeared to show that in practice staff ratios varied.[16]

[16] *Staff Dispo* 19 to 27 August 2024.

We expect staffing arrangements to be determined based on the purpose, nature and needs of the specific unit or area of custody. Staff resourcing should prioritise prisoner's safety, wellbeing, dignity and rights, alongside the safety of staff working in those units. We are concerned that the staffing allocation criteria was not clear and there were areas in the prison such as House Block 2, Wings 1 and 4, which required additional staffing due to the security and safety concerns. We expect the Prison to have sufficient permanent staff, with the appropriate training, knowledge, and cultural competency to maintain a safe environment.

Several staff told inspectors they considered the main safety issue was an inexperienced workforce which impacted on the safe management of prisoners and the security of the Prison. Data showed just over half (58%) of Reintegration Officers had less than two years' experience, with 33% having less than 12 months of experience.[17]

I recommend Prison management develop clear staff rostering and allocation criteria that provides sufficient numbers of experienced staff to maintain a safe environment in all wings.

In response to the provisional report Prison management advised that a senior custodial role was being established to *'ensure that experienced and capable staff are permanently assigned to each accommodation wing.'* This is a positive step, and we encourage Prison management to continue to find ways to improve staff rostering and allocation to all wings.

Significant presence of contraband

The significant presence of contraband in the Prison was also a factor that both prisoners and staff identified as contributing to their feeling unsafe. Daily briefing sheets for 19 to 30 August 2024 (the time of the inspection) showed significant contraband was found in multiple areas of the Prison. This included findings in the House Blocks, as well as contraband concealed on prisoners, handed to prisoners by visitors, and found outside the visits hall.

Inspectors were told that the majority of contraband was found by the Prison's Site Emergency Response Team[18] (SERT). Inspectors observed SERT complete a random search of a Wing in House Block 2. The search found 13 litres of home brew, mobile phones, shanks, drugs, cables, tobacco and a smoking device. On a different day several packages were thrown over the perimeter fence into the grounds near the Residences. An alarm was triggered and SERT responded and recovered 15 packages of contraband.

SERT staff were not responsible for daily search operations. However, inspectors were told that SERT staff often assisted house block staff with cell searches as some staff in certain House

[17] 28% of Reintegration Officers had 0 – 6 months experience, 5% had 6 – 12 months and 25% had 1 – 2 years' experience.

[18] According to Corrections the overarching aim of SERT is staff safety. Their expectation is that SERT will contribute to the safety of sites by: Taking a preventative approach to safety by working collaboratively with unit staff, security staff, detector dog team members and intelligence staff to pro-actively target the introduction of contraband into prisons to reduce the level of incidents on site; Deliver enhanced tactical options capability in response to incidents and emergency events within the site, to ensure that they are brought to a safe and swift conclusion and minimise the risk to life and the safety of any person and damages to property.

Blocks were scared to carry out this duty. Inspectors were provided with a copy of a Practice Reminder that was sent in May 2024 informing all managers that SERT was not to be used for daily searches, and clarifying the role and duties of the team.

SERT staff also told inspectors that their team were not comfortable working in some House Blocks alone or even in pairs. They said searches in House Block 2 were only completed in a team of more than four staff due to the concerns with the cohort of prisoners and the type of contraband that was often found.

Several staff told inspectors that cell searches were not being completed daily, as outlined in the Prison's policies, and that the way in which these searches were completed varied across House Blocks. For example, staff said SERT would select random cells in each Wing to be searched each day by Wing staff. However, staff said if the House Block was short staffed, the cell searches were not done. Another staff member said they completed random cells searches daily; however, they would only search one Wing and not all of the four Wings on any given day. Other staff said that at least two cells in each Wing in the House Blocks were searched each day.

Prison security was further compromised by inadequate searches of prisoners. Inspectors observed the standard of rub-down searches varied and was generally insufficient to detect contraband. For example, rub-down searches were seen being completed on prisoners returning to a House Block from attending programmes. Prisoners wearing hats and sunglasses were not requested to remove these items, nor did staff search the hats. Staff barely touched the upper half of the prisoner's body and no search was conducted below the prisoners' waist.

The reports of significant findings of contraband are of extreme concern. The presence of drugs, weapons, and other banned items create risks to prisoner safety, security and prospects for rehabilitation. The presence of these items can also contribute to increased influence of organised crime groups within the prison, bullying, intimidation and violence.

I recommend Prison management improve searching practices to ensure the safety and security of prisoners and the Prison.

Large number of voluntarily segregated prisoners impacting placement

We expect there to be a well-designed and managed classification process, which is used effectively to match the risks and needs of individual people in custody with the most suitable placement, regime and resources for them.

At the time of inspection, 497 of the Prison's 957 prisoners were voluntarily segregated. In comparison, at the time of the previous OPCAT inspection in 2018, 178 prisoners were voluntarily segregated. The Prison Director confirmed that since 2022, there had been a significant increase in the number of voluntarily segregated prisoners arriving at the Prison.

The number of prisoners subject to voluntary segregation had impacted on the Prison's ability to place prisoners in a regime and unit suitable for their needs and risk, and Prison management said that as a result they were unable to operate the progression model designed

for the site. Some prisoners stayed in a high security wing for longer than required, while others progressed too quickly into the Residences.

The Prison's progression model, which was an approved prisoner placement system in line with the Corrections Regulations, was designed to support prisoners to progress through House Blocks 1 to 3, then onto the Residences to engage in Release to Work (RTW), and prepare for parole and release into the wider community. As noted above, the Residences accounted for one quarter of the Prison's accommodation.

As prisoners progressed, there were fewer security features and more privileges provided. This was outlined in the Prison's *Trusted Accommodation Pathway* policy which specified that as a prisoner progressed, their Wing/Unit's unlock hours, the extent to which they were required to be escorted within the Prison, the amount and type of property they were permitted, the hobbies and activities available, and the level of additional and specialised support would all change.

Quality assurance meeting minutes from March and April 2024, noted impacts from the increase in voluntary segregation numbers, the challenges with placement of prisoners and the tension this had created in some areas of the Prison. The March 2024 minutes also stated an additional Wing for prisoners subject to voluntary segregation would be created in an attempt to reduce incidents and other concerns. An obvious consequence of this was, however, that the Prison had reduced placement options for mainstream prisoners, limiting their ability to separate these prisoners when required.

The Residences only accommodated mainstream prisoners; prisoners had to give up voluntarily segregated status to move into them. All prisoners also had to meet eligibility and suitability requirements for placement in the Residences. Prison management advised that at one point, the Residences were *'almost empty'* and as a result, the entry criteria had been relaxed. An example of this was that prisoners had previously been required to be within six months of their parole eligibility date and have completed all Rehabilitative programmes recommended for them. The parole eligibility date requirement was removed, and at time of inspection, prisoners only needed to be assessed as being *'motivated to complete'* these programmes.

In their July 2024 report, the Monitors noted that that month *'there was a concerted effort to fill the vacancies in Residences. This also decreased the muster in House Block 2, which has been running over its normal 240 beds. This is to ensure the site could safely manage the cohort. On 31 July 2024, House Block 2 recorded a muster of 249, this is the lowest occupancy in recent months.'*

Staff who worked in the Residences noted to inspectors that there were currently prisoners in these Units who would not have previously been considered ready for the reduced security features found there.

Additionally, prisoners' time out of cell had been reduced in some parts of the Prison, which was also attributed to managing voluntary segregation numbers. Prisoners in House Block 2 only had approximately 2.5 hours per day out of cell so that multiple regimes could be operated. This was to allow staff to keep specific groups separate, including voluntary segregated and mainstream prisoners, in order to reduce the risk of conflict and ensure

prisoner safety. We do not, however, consider reducing prisoners' time out of cell to be an adequate long-term solution to this issue.

In response to the provisional report, Prison management advised that between March and September 2025, 900 of the 960 prisoners onsite were in voluntary segregation, which meant they were able to safely place prisoners and the progression model was now in operation. We are aware the contract between the Prison and Corrections gives Corrections discretion as to which categories of prisoners are placed at the Prison, with few constraints. Therefore, close ongoing cooperation between both organisations is required to ensure the cohort can continue to be accommodated safely in future.

I recommend Department of Corrections and Prison management consider the resources and accommodation available at the prison, and work together to ensure prisoners placed there can be accommodated safely.

Shared cell risk assessments

Our expectation is that prisoners are not required to share a cell (be 'double bunked') without prior, thorough risk assessment, and confidential consultation between each prisoner and a trusted staff member.

Regulation 66 of the Corrections Regulations 2005, requires that before accommodating a prisoner in a shared cell, the prison manager ensure that the prisoner is assessed to determine whether they are suited for the available shared cell accommodation. According to Corrections' policy and the Prison's procedures, this is done in practice by completing a Shared Accommodation Cell Risk Assessment (SACRA).[19] Prisoners should be involved in the SACRA process as their answers to questions could influence the prisoner's placement.

Inspectors observed a group of prisoners be inducted into one of the House Blocks. A staff member asked the prisoners whether they would like to be double bunked. Prisoners who indicated they were happy to be double bunked were then taken into the Wing to their cells, prior to a SACRA being completed, despite the policies and procedures outlined above. Inspectors also spoke to staff who said that when there were no single cells available for prisoners with '*Not to Double Bunk*' (NTDB) status, they would have to share a cell. Inspectors identified at least one case where this had occurred. In this case, the prisoner expressed concern to inspectors that their NTDB alert had not been checked, or was ignored.

The former Chief Ombudsman, in a number of OPCAT reports and submissions, including to the Committee against Torture, raised concerns about the conditions and treatment of prisoners who are double bunked.[20] In these reports and submissions, prisoners' fears about potential

[19] SACRAs take account of the men's age, offending history, gang afflictions, prison experience, size and strength, mental health, risk of violence and/or self-harm, special needs, security classification, segregation status, sentence status and other factors relevant to safety and good order.

[20] Chief Ombudsman's submission to the 77th session of the Committee against Torture, for consideration of the Seventh periodic report submitted by New Zealand.

Relevant reports include: Spring Hill Corrections Facility (report published in 2017), Whanganui Prison (report published in 2018), Waikeria Prison (report published in 2020), Mount Eden Corrections Facility (2023).

sexual violence were highlighted, as were prisoners' statements that to avoid being double-bunked they would threaten or commit violence. These risks illustrate why it is essential that there are robust processes in place to ensure each cell sharing arrangement is suitable. We continue to be concerned about this practice and expect to see active work to reduce and eliminate *'double bunking'* or multiple occupancy where it occurs.

I recommend Prison management implement a robust process to assess the initial and ongoing suitability of cell-sharing arrangements. This includes monitoring that SACRAs are conducted and documented comprehensively, in consultation with each prisoner in advance of cell placement.

In response to the provisional report, Prison management advised that an induction wing had been established in the prison in June 2025 (discussed further in the section on induction below). Prison management did not advise whether the prisoners in this wing are double bunked, or how this wing is being used to mitigate the risk associated with shared cells.

Processes in the event of electronic doors malfunctioning

During an evening visit by inspectors, all electronic doors across the site malfunctioned, preventing the doors from opening and shutting. Inspectors found themselves locked in the House Blocks for a significant period of time. A staff member had to use a set of master keys to open each door individually. The manual process of finding each door's key was very slow, given the number of keys which needed to be identified and number of doors which needed to be individually unlocked. Staff told inspectors that this was not the first time they had experienced widespread electronic door failures.

When asked about how an emergency would be handled if a door failure occurred, staff responded that this '*would be a problem'.* Staff spoken to were also not aware of how prompt access would be provided in this situation; for example, to facilitate emergency services to access a person requiring urgent care. We are, therefore, concerned that the Prison would not be able to respond in a timely way if the doors needed to be opened manually during an emergency. This is a serious risk to the safety and wellbeing of all those at the Prison.

These concerns were put to Prison management and Corrections on multiple occasions after the inspection. In response, Prison management provided us a copy of a *'Master Key'* Policy, which provided staff guidance on issuing and returning the master key to a secure location. This did not, however, appear to substantially improve the processes for ensuring locked doors could be manually opened in a timely way.

I recommend Prison management review their manual door procedures to ensure that the site can guarantee the safety and wellbeing of people in custody in the event of a failure of the electronic doors.

Reception and induction

The 2018 inspection of the Prison identified issues with reception and induction processes. Prisoners expressed concern about receiving a poor induction and reported having to rely on

the goodwill of other prisoners to learn about procedures and rules. Some prisoners had little understanding of how to use the prisoner kiosks. As a result, several recommendations were made to improve the induction experience; all of which were accepted.

While there had been changes to induction processes since the previous inspection, these do not appear to have improved prisoners' access to information. In some ways, the induction experience may be considered to have worsened. There also continued to be insufficient consideration of the communication needs of individual prisoners, particularly those who could not easily understand written or spoken English.

The Prison no longer had a dedicated induction wing or induction officers. Instead, on arrival, an eight minute video was played to prisoners in a Receiving Office holding cell. This outlined how the Prison operated and behavioural expectations. Inspectors watched the video be played to prisoners. It was only available in English and was not subtitled. Staff did not stay while the video played, the volume on the television was low, and prisoners had no ability to increase it; some prisoners also spoke over the video which impacted others' ability to hear. Prisoners were provided a comprehensive written handbook, but this was only available in English.[21]

Induction to the Wing also appeared to be lacking in some Wings, with prisoners given primary responsibility for supporting new prisoners and teaching them to use the kiosk and CMS systems. Under the prison's policies, each prisoner's *'nominated individual officer'* was responsible for providing information about how the Prison operates, the rules, obligations, entitlements, services and supports available, and advice and guidance on coping with imprisonment. However, inspectors were told that Wing staff were not fulfilling this function at the time of inspection. Inspectors observed Wing staff tell new prisoners that it was instead their peers who would provide them induction and support on their arrival in the Wing. Some staff members also said that they did not know how to use the CMS or kiosks. This was despite the previous Chief Ombudsman recommending that prisoners receive a comprehensive induction on kiosks and in-cell systems.

In response to the provisional report, Prison management advised that in June 2025 an Induction Wing was set up in House Block 1, Wing 4. All newly received prisoners are initially housed here and receive a 20-day induction programme. This induction includes information on how to use the CMS and kiosks, as well as providing an introduction to the Prison environment, expectations, services, and opportunities. We consider this a positive development and look forward to seeing this process embedded in the Prison.

In our 2018 report, Prison management were also recommended to review and improve induction arrangements for foreign nationals, speakers of other languages, and those with particular literacy or communication needs. Despite this, prisoners who were foreign nationals continued to report poor induction experiences and a lack of information about the supports available to them. This induction experience appeared to be consistent with their ongoing experience while at the Prison, with these prisoners having limited access to formal language

[21] The handbook was also available to prisoners through the CMS.

support (such as interpreters) and other prisoners and staff who spoke the same language relied on to assist.

While peer support systems can be helpful, they should not replace a comprehensive induction provided by a staff member. As part of good dynamic security, staff should be encouraged to build effective professional relationships with prisoners. This should start from the moment a prisoner arrives on a Wing.

We are disappointed that the induction processes for foreign nationals, speakers of other languages, and those with particular literacy or communication needs have not improved following the previous Chief Ombudsman's recommendation.

I recommend Prison management ensure staff provide prisoners a comprehensive induction which includes information on how to use the Prison's kiosks and in-cell systems.

I recommend Prison management review induction arrangements for foreign nationals, speakers of other languages, and those with particular literacy or communication needs, and improve these arrangements to ensure these prisoners are fully briefed on the Prison procedures.

Feedback, concerns, complaints

There should be accessible avenues for prisoners to raise concerns and complaints independently of staff. Complaint outcomes should be transparent, fair, well-communicated, and timely.

The Prison's complaints processes were a significant concern during the previous inspection. Despite a recommendation that they be fixed as a matter of urgency, these previously identified deficiencies were unaddressed, and complaints processes continued to be of great concern.

Prisoners again reported having little faith in complaints processes and fearing repercussions for making complaints. They were also heavily reliant on staff to make a complaint. Prisoners had to request hardcopy complaint forms from custodial staff. Overnight, custodial staff would log these complaints into IOMS and the prisoner would receive a complaint number the next day. There was no confidential site process for prisoners to make complaints about staff conduct. For example, there were no applications in CMS or kiosk functions for these complaints.

Both prisoners and staff reported instances of complaints not being loaded into the system, including some staff intentionally discarding complaints. In addition to their concerns going unaddressed, this created challenges for prisoners wishing to escalate matters to oversight agencies (such as the Office of the Inspectorate) as they had no record of the complaint being lodged. This is thoroughly unacceptable.

With respect to health complaints, no separate health complaint system had been implemented. Prisoners were still making health complaints through the general complaints

system, with these complaints then referred to the health team.[22] Prisoner complaints reviewed by inspectors included references to sensitive medical issues, for example chronic illnesses, symptoms they were experiencing, and medications they had been prescribed. It is disappointing that no separate health complaint system had been implemented. Prisoners should feel confident that their health information is treated with utmost confidentiality and sensitivity.[23]

In response to the provisional report, Prison management advised that there is an IT project in place to allow prisoners to lodge complaints directly in the CMS. This will include three separate complaints processes: PC.01 complaints, staff related complaints and health related complaints. However, we were not provided with a timeframe for this project. We would like to see this project completed as a priority and prisoners provided with clear and accessible guidance on how to use the new system.

I recommend the Department of Corrections and Prison management urgently address and improve the integrity of the complaint system and to enable prisoners to make complaints independently of staff.

I recommend the Department of Corrections and Prison management implement a separate and confidential health complaint process.

In response to the provisional report, Corrections advised that they are committed to strengthening oversight of the complaints process and monitoring the progress of Prison management's complaints improvement project to ensure these recommendations are met.

Discipline and sanctions

We expect all prisoners to be treated fairly in disciplinary procedures, which includes being given sufficient notice in advance of the disciplinary hearing, due process being followed, and there being appropriate avenues for review and appeal of decisions.

Inspectors were advised that there was no schedule for misconduct adjudication hearings. Instead, the prosecutor worked with the adjudicators (who were House Block Managers) on a daily basis to organise that day's hearings. The lack of schedule, and resulting uncertainty, meant inspectors were unable to observe a misconduct adjudication hearing while on site. This has prevented us from fully assessing the procedural fairness provided to prisoners during hearings.

However, information provided by prisoners and staff, as well as disciplinary records provided, have made us concerned about the procedural fairness provided to prisoners. Our concerns primarily relate to the amount of notice given of when hearings would take place and whether they would be before a hearing adjudicator or Visiting Justice.

[22] All of the health complaints provided as part of the information request had been made as PC01 complaints.

[23] I discuss failures to protect the confidentiality of prisoners' health information in more detail in the Privacy section below.

Serco's procedures allowed the prosecutor to refer *'serious'* charges straight to a Visiting Justice,[24] rather than them being referred by the adjudicator following a hearing attended by the prisoner. Although not defined in the policy, in practice these were typically charges which involved violence. Prisoners interviewed said they were not always informed that the referral to a Visiting Justice had taken place. One prisoner said *'you can show up and the hearing is in front of a Visiting Justice without you knowing.'*

While the Prison supplied misconduct records which included an initial hearing date for all charges that had been referred to a Visiting Justice, there were no hearing notes provided for these procedural hearings. The misconduct records also did not align with the comments from a prosecutions staff member who said that referrals to the Visiting Justice were routinely made by the prosecutor.

There were no indicative timeframes provided to prisoners of when Visiting Justice hearings would take place. While adjudicators are required to conduct hearings within 14 days of the charge being laid, there are no similar timeframes for Visiting Justices. Schedules provided to us indicated that a Visiting Justice attended the Prison approximately once every two to three weeks.

Natural justice requires that prisoners be given an adequate opportunity to prepare for their hearing. We consider it important that prisoners are informed in advance of whether a hearing will be before an adjudicator or Visiting Justice as this may affect their preparation. Under Corrections legislation:

- Visiting Justices have the ability to impose harsher penalties than adjudicators.[25]
- There is no statutory right of appeal of a decision made by a Visiting Justice; the only avenue for appeal is a judicial review of the decision.
- The enforcement of any penalty imposed by a Visiting Justice is not suspended (unless the High Court orders otherwise) while a judicial review progresses.

These factors may affect, for example, whether a prisoner chooses to seek legal advice or request the attendance of their legal advisor at the hearing.

The lack of notice provided to prisoners about when their hearings would take place is also of concern as, in a November 2023 decision, Justice Muir was critical of the Prison's failure to provide a prisoner advanced notice of a Visiting Justice hearing.[26] Justice Muir described the prisoner involved as *'effectively blindsided'* when, without any prior notice, they were brought

[24] *14.02 Misconduct Report at 12.2.3.*

Corrections' Prison Operations Manual has no similar provision allowing a prosecutor to make this referral; only hearing adjudicators are authorised to refer a case to a Visiting Justice (MC.03.09).

[25] Corrections Act 2004, ss 133 and 137. An adjudicator can stop or postpone a prisoner's privileges for up to 28 days, stop their earnings for up to seven days, and/or confine a prisoner to their cell for up to seven days. A Visiting Justice can stop or postpone a prisoner's privileges for up to three months, stop their earnings for up to three months, and/or confine a prisoner to their cell for up to 15 days.

[26] *Fahey v The Visiting Justice at SERCO Auckland South Corrections Facility* [2023] NZHC 3807 (20 November 2023).

from their cell to appear before the Visiting Justice. We would have expected to see significant improvements to hearing processes after Prison management were put on notice that this was unacceptable. It is concerning that this has not happened.

I recommend Prison management implement an organised and transparent hearing schedule, and ensure all prisoners are provided with a proper opportunity to prepare their defence to a misconduct charge. Proper preparation includes (but is not limited to) the opportunity to assemble the material which might be the basis for submissions or cross-examination, seek legal advice, and psychologically prepare for the hearing.

I have recommended above that the Department of Corrections implement effective mechanisms for overseeing the conditions and treatment of prisoners. Misconduct adjudication processes and outcomes are areas in which this increased oversight is important.

Prisoners and prosecutions staff also reported inconsistencies between staff in relation to decisions around laying charges. Both groups said that decisions to charge were affected by the relationship staff had with the prisoner. We encourage Prison management to provide additional guidance to staff and exercise increased oversight of charging decisions to ensure consistent and fair treatment.

Staff also told inspectors that prisoners may be *'regressed'*, meaning be moved to a different House Block or out of the Residences, at the time they were charged with a misconduct.[27] Staff said that if a prisoner was found not guilty at their disciplinary hearing, they would be moved back to their original placement, but this may take some time.[28] Inspectors spoke to two prisoners who had been found not guilty, but had not yet been moved back to the Residences. It appeared that movement out of the Residences was actioned quickly, while in contrast returning back to the Residences was not immediately actioned. Depending on the circumstances, regression may raise natural justice concerns, particularly where a change in placement results in reduced access to rehabilitation opportunities. We encourage Prison management to review this practice.

Coercive powers

Use of force records and review

Coercive powers, including use of force, should be recognised as serious interventions with potentially harmful effects. All use of coercive powers should adhere to the principles of legality, necessity, proportionality, accountability and non-discrimination. We expect

[27] This was also outlined in the Prison's *Trusted Accommodation Pathway* policy, although the policy does not use the term '*regression'*. The policy stated that a prisoner may be immediately relocated if they pose a serious risk to the good order or security of the unit or pose a serious risk to the safety of any other person, including if they have tested positive for use of an unapproved controlled drug, are found in possession of an unauthorised item, or assaults any person or behaves in a threatening manner to any person.

[28] The Trusted Accommodation Pathway only required that staff give *'consideration'* to returning a prisoner to their originating area if the misconduct charge is subsequently withdrawn or found unproven.

appropriate oversight and approval processes to be in place and timely and comprehensive recording, debrief, and review to occur.

There were 46 recorded uses of force during the six months of 1 February to 31 July 2024, 24 of which occurred in House Block 2. The quality of the Prison's use of force record-keeping was of concern, including incident reports that were poorly written and submitted without all legally required information and sign off.[29] This had not been identified as an issue in any of the Monitors reports reviewed.

There were discrepancies between incident reports and what was recorded in the electronic register, such as dates on paperwork that did not correspond with the date in the register. Additionally, the column titled *'CCTV/OBC footage review (date and who)'* was completed with a YES or NO in the register, rather than identifying who completed this review and when it took place. In some cases, the data was also incorrect when cross referenced with use of force documentation. Another discrepancy included the use of force register stating a prisoner was seen by the health team, but the documents reviewed stated that the prisoner had declined to be seen.

Use of force reviews were not being completed in a timely manner, with some taking as long as six months after the incident to be completed. There was a backlog of 22 use of force incidents yet to be reviewed at the time of inspection. There were no timeframes or standards of practice for reviews included in the Prison's Use of Force policy.

The Monitors advised inspectors that they were aware of the backlog, and noted this was not a specific requirement under the contract. The Monitors' July report (prepared in August) noted that there was a concern with overdue use of force review reports and that the Deputy Prison Director had assured them these would be resolved by August.

There were no reflective practice sessions held following review and the implementation of recommendations to improve use of force practices were not tracked. For example, one use of force review found non-approved techniques had been used on a prisoner. The record stated that this was referred to senior management; however, there was no information to show what senior management did as a result.

Inspectors raised this issue with Prison management, and as a result, the Prison provided a copy of a new *ASCF UOF Incident Recommendation Register* after the inspection. This listed the recommendations, required actions, and whether these had been completed yet in relation to 16 use of force reviews. Only six entries had a description of actions taken, and only two entries contained an indication that the recommendations had been fully addressed.

Based on these observations, we have several concerns about the recording and review of use of force incidents and I make the following recommendations.

I recommend Prison management ensure all use of force events are recorded, reviewed and reported, at least in line with statutory requirements.

[29] Corrections Regulations 2005, regs 128 and 129.

I recommend Prison management update the use of force policy to include suitable time frames for use of force reviews.

I also recommend Prison management ensure recommendations from use of force reviews are implemented to improve practice.

In their response to the provisional report, Prison management did not engage with the concerns raised above, and advised that in their view they 'predominantly, met' the Corrections Regulations about reporting uses of force. They advised that they carry out reviews of all uses of force but that 'operational and statutory priorities may delay these from being completed within the preferred timeframes'.

It is disappointing that Prison management did not substantively engage with our concerns, and that the standard of use of force reviews do not appear to be a priority, despite their importance to the treatment of people in custody and the serious deficiencies identified.

Segregation

It is our expectation that segregation is used only in accordance with the principles of legality, necessity, proportionality, accountability, and non-discrimination. The reasons justifying a prisoner's segregation should be regularly reviewed, and communicated to them.

There were eight prisoners on directed segregation who were accommodated in the Prison's Separation and Reintegration Unit (SRU).[30]

The 2018 OPCAT inspection report contained a recommendation to ensure robust systems are in place to record, review and monitor all directed segregation paperwork. This recommendation was accepted by both the Prison and Corrections. However, these systems were not evident at the time of inspection and segregation paperwork reviewed by inspectors was deficient in several ways. Additionally, we have concerns about the use and oversight of 'informal' segregation, where prisoners were separated from others without the use of a segregation direction.

In one case, the direction for a prisoner's directed protective custody appeared to have been expired for a month before an extension was approved. Some of the documentation related to the directed segregation of other prisoners was incomplete or lacked individualised detail. This included the reasoning for denying the prisoner association with other prisoners rather than restricting their association entirely, legislative extension and review timeframes, and records of minimum entitlement denials.

The recording of this information is vital to enable the Prison, Corrections and oversight agencies to be assured that directed segregation has consistently been used in a way that is legal, necessary, proportionate, and that a prisoner's wellbeing has not been unduly impacted

[30] Prisoners who had been segregated could also be accommodated in other parts of the Prison, such as Te Whare Ora.

The SRU was a purpose-built unit where prisoners subject to directed segregation could be located. At other prisons, a unit of this type may be called a 'Management Unit'.

by their segregation. The absence of this information has meant we have not been able to verify this.

Additionally, during the inspection, there were two prisoners we consider to have been informally segregated. One of these prisoners was separated from others while receiving ongoing medical treatment; the other was the only mainstream prisoner on a wing designated for prisoners who were voluntarily segregated. The mainstream prisoner had their own cell and was on what is commonly called a *'single unlock'* regime, where they would be locked in their cell while the rest of the wing was unlocked, spending one hour unlocked each day by themselves. The single unlock arrangement had been in place for 22 days at the time of inspection.[31]

With respect to the prisoner on a single unlock regime, inspectors were advised that this prisoner did not want to sign up for voluntary segregation but was concerned for his safety in a mainstream unit. It is not clear why, in those circumstances, the prisoner was not placed on directed protective custody, which would have afforded him the protections of formal oversight mechanisms.

These two prisoners were not identified in the Prison's response to a request for information about all prisoners on single unlock regimes which raises concerns about the oversight of their treatment.[32] The list of prisoners provided included only prisoners who had segregation directions in place. These two prisoners were also not identified in the unit regime and unlock schedules provided.

IOMS offender notes for these prisoners were made infrequently over the two months reviewed, and did not indicate the prisoners were on single unlock regimes, or provide information about their general wellbeing. There was also no evidence in these notes of efforts to ensure their time out of cell was maximised or they were supported to associate with other prisoners.

Section 57 of the Act states that: *'The opportunity of a prisoner to associate with other prisoners must not be denied or restricted, except in accordance with this Act.'* The use of single unlock regimes for prisoners who have not been issued a segregation direction is not consistent with the Act and alternative arrangements should be made.

The Act contains an explicit requirement that Monitors assess the Prison's compliance with sections 57 to 61 of the Act,[33] which relate to denial or restrictions of ability to associate. In each of the monthly reports reviewed, the Monitors considered the Prison compliant with all of these sections. We encourage Corrections to consider whether there are robust processes in place for monitoring the Prison's compliance with these sections of the Act.

[31] I discuss segregated prisoners' access to meaningful human contact in more detail in the section below.

[32] The specific wording of inspectors' request was: *'The names & locations of all prisoners on cell confinement; directed segregation; subject to single unlocks'.*

[33] Section 199G(1)(d).

I recommend Prison management ensure prisoners are only restricted or denied the opportunity to associate with others in accordance with the Corrections Act 2004.

I recommend Prison management implement robust systems to record, review and monitor all directed segregation paperwork.

Solitary confinement

Solitary confinement should not occur, meaning no person in custody is physically isolated for 22 hours or more a day without the opportunity for meaningful human contact.

As discussed above, we are concerned that prisoners who were informally segregated or on directed segregation were experiencing a regime which potentially amounted to solitary confinement.

Prisoners on directed segregation who were accommodated in the SRU were routinely confined to their cells for 23 hours per day. They were able to spend one hour per day in one of the Unit's two yards, in addition to any scheduled appointments or time spent in the Unit's computer room. Appointments occurred infrequently and irregularly. As all prisoners on directed segregation at the time of inspection were denied association, their only opportunity to interact with other prisoners was by yelling between their cell doors or over the concrete wall between the two yards.[34] The interactions these prisoners had with staff were observed to be brief and transactional. They could not be reasonably considered 'meaningful'.

Some prisoners had also spent long periods of time in these conditions; with one prisoner having spent a month segregated at the time of inspection.

In addition, we have concerns about the opportunities for meaningful human contact provided to the prisoner discussed above, particularly given the number of days they had spent on a single unlock regime (22 days at the time of inspection).

There is a risk that, where solitary confinement continues for longer than 15 consecutive days, it becomes 'prolonged' solitary confinement. Isolation for prolonged periods of time can cause people long-lasting harm. For this reason, the Mandela Rules place prolonged solitary confinement in the category of cruel, inhuman or degrading treatment.

I recommend the Department of Corrections and Prison management develop and implement individual management plans for prisoners on directed segregation that maximise time outside of cell, access to activities, and opportunities for meaningful human contact.

[34] Under the Act, segregated prisoners can have their ability to associate with other prisoners 'restricted', where they can have limited contact with other prisoners, or 'denied' where they cannot have any contact with other prisoners. Decision-makers should clearly record why the prisoner has been granted a particular association status and how this status mitigates any risk posed to or from the prisoner.

Privacy and confidentiality

The privacy and confidentiality of prisoners should be respected and preserved. We expect that any infringement on prisoner privacy be justified and proportionate, including regarding the use of surveillance technology.

We consider the Prison could have been doing more to protect prisoner privacy.

The SRU did not have facilities for non-contact engagement between prisoners and support services staff who attended the Unit. Although only some of the prisoners segregated in the SRU were deemed to be a high risk of harm to others, all prisoners in the SRU were required to have custodial staff present for what may be highly sensitive discussions with support services (e.g. case management, education, chaplains, cultural engagement, or mental health and psychological support). [35]

All of the prisoner cells in the SRU had active CCTV cameras. This CCTV footage played on a live feed in the SRU staff base. There did not appear to be any consideration of the necessity or proportionality of each of these prisoners being under constant observation. In response to the provisional report, Prison management advised that CCTV coverage of the SRU cells would cease in September 2025.

CCTV feed from toilets in the Te Whare Ora at-risk cells, in one of the SRU cells and the Receiving Office holding cells were visible to staff. No pixilation technology was in place. Although privacy screens had been installed in the at-risk cells, these did not prevent prisoners being visible on CCTV footage.[36] A staff member responsible for monitoring the at-risk cell CCTV feed said *'it's clear as day when the prisoner is on the toilet'.*

General cells, across the prison, also provided prisoners inadequate privacy when using the toilet or shower. Each cell door had an observation flap which, when opened, looked directly into the toilet and shower. Some prisoners had covered these observation flaps with material to protect their privacy. This was, however, explicitly against the Prison's rules.

Ombudsmen have long held the position that the ability to observe prisoners undressing, showering or using the toilet, either directly or via CCTV, is a serious breach of privacy and dignity. There is opportunity for significant improvement in relation to this at the Prison.

I recommend Prison management ensure that that all prisoners are able to engage with support services privately and in-person.

In response to the provisional report, Prison management advised that they are '*investigating the viability of establishing a "Non-Contact Booth" in the SRU*'. Should this not be viable, we expect Prison management to find a suitable alternative to ensure this recommendation is met. Any proposed solution needs to be individualised and adopt the least restrictive approach necessary for each prisoner.

[35] Meetings with these staff could also be held via AVL.

[36] Privacy screening had been installed in the remaining SRU cells which were effective in preventing a person using the toilet from being visible on camera.

I recommend Prison management ensure that prisoners are not subject to in-cell CCTV surveillance without a clear justification identified through individual risk assessment.

I recommend Prison management protect prisoners' privacy when using the toilet or showering.

Inspectors also observed a number of occasions where prisoners' private health information was not protected by staff. This included a custodial staff member speaking openly about a prisoner's mental health and suicidal ideation in a wing where other prisoners could hear. Inspectors also observed doors being left open during health appointments and a multi-disciplinary team (MDT) meeting when other prisoners or staff were close enough to hear the conversation. Medical staff said they left these doors open during appointments for their safety but prisoners could request that the door be closed. However, inspectors did not observe staff offering this to prisoners.

I recommend Prison management ensure that prisoners' health information is kept confidential and they are provided privacy during health appointments.

Planning for the future

Release planning

We expect planning to take place with enough time, support, communication, and information for prisoners and their whānau to be, and feel, prepared for release. The needs and concerns of prisoners in relation to transition out of prison, or arrangements for their release, should be considered and discussed with them.

Although at the time of inspection the Prison had no case management vacancies, and all prisoners appeared to be allocated a case manager, prisoners said that engagement with their case manager was low unless their Parole Eligibility Date or a parole hearing was approaching.

Prisoners from across the Prison told inspectors they did not feel prepared for Parole Board hearings or know what the requirements were for them to prepare for release. Multiple prisoners said they had limited contact with their case managers and only met them just before parole where '*they speak about in [you] at parole like they know you when they don't….Just feel like a number.'*

We were told that the Prison prepared the largest number of parole reports in the country. Case management staff said that due to pressures around Parole Board reports they did not have as much time for contact with prisoners.

Prisoners could receive and respond to emails from Case Managers through the kiosk or CMS; however, this was only possible if the Case Manager had enabled this communication method.

When prisoners were not able to contact their Case Managers directly, they relied on Reintegration Officers to pass on messages. Inspectors heard from a number of prisoners and staff, that there were challenges with this process. They gave an example of a book used for communication between prisoners and Case Managers being found tucked away unused in

House Block 3. Prison management also shared that at times regimes in some House Blocks could make it challenging for Case Managers to see prisoners in person.

Inspectors heard of several examples where requests made to Case Managers to access treatment programmes had not been actioned. One prisoner said that they were soon to be released but had not been able to complete programmes recommended for them by the Parole Board. They reported being told by their Case Manager to *'sit tight'* and that the Case Manager would make the necessary arrangements. However, this had not happened and they said they felt that *'in this place drugs are more accessible'*.

Multiple prisoners said they could not remember the last time they had seen their Case Manager. One prisoner said '*I've had a Case Manager but you don't see anyone until you get to parole';* with another stating: *'I want to find out from my Case Manager what the Judge thinks I need to do [for parole]. But I never seen my Case Manager.'*

Review of IOMS files for prisoners who raised this concern with inspectors confirmed delayed and minimal contact with Case Managers. In some instances, prisoners hadn't had contact with their Case Manager for as many as 18 months. IOMS entries for one prisoner noted they had last seen their Case Manager on 25 July 2024, prior to that was 9 December 2022. Another example showed a Case Manager had sent an introductory message to a prisoner on 4 March 2023 but there was no further engagement from the Case Manager on file at time of inspection.

The Prison had recently set up a 'help-desk' to address communication difficulties between prisoners and case management. A Case Manager would be available in each House Block or Residence for one hour per week *'depending on restrictions'* to answer case management related questions. Posters were seen displayed on noticeboards in the Wings and Residences to inform prisoners about this service and the House Block 3 log book showed that six prisoners had used it between 14 and 26 August 2024.

A recommendation regarding timely case management was made as a result of the 2018 OPCAT inspection; however it appears little improvement had been made, based on prisoners' comments and IOMS records of prisoner contact with their Case Manager. The help desk appears to be a sensible way to provide an additional avenue for prisoners to express their concerns or ask questions about progression, rehabilitation and release planning. However, we also note that while the poster advertised no appointment was necessary, prisoners were still required to write their name in a log book to be seen.

As noted in the Prison's *Case Management* Policy, on-going contact between the Case Manager and prisoner is important throughout a prisoner's time in custody to ensure their individual management plan remains responsive to their needs.[37]

[37] The policy states: *'The effectiveness of the Individual Prison Management Plan is dependent on its alignment with the prisoner's assessed risks, needs, responsivity and circumstances. It is important that the Individual Prisoner Management Plan is monitored to ensure that interventions are being delivered as planned and objectives met. On-going contact between the Case Manager and the prisoner during their custodial stay is equally important to ensure that risk assessment remains dynamic.'*

I recommend Prison management improve processes for communication between Case Managers and prisoners to support individual management planning, including access to programmes and services, and preparation for parole and transition preparation.

Health, care, and wellbeing

Safety of prisoners in Te Whare Ora

Prisoners should receive effective and compassionate mental health care and support from appropriately trained and supported staff. We expect strategies to be implemented to provide appropriate, individualised and specialised support to prisoners who need it, including those at risk of self-harm. Suicide and self-harm risk should be assessed and managed in an effective, person centred, and trauma informed way.

The Prison had established a multidisciplinary approach[38] to supporting vulnerable and at-risk prisoners which was clearly aimed at ensuring that they received the individualised and specialised care they needed. However, we are concerned that the safe management of these prisoners was undermined by staffing numbers, a lack of specialised staff training, and a failure to follow processes.

Prisoners who had been identified as being vulnerable or at-risk were accommodated in a dedicated wing within House Block 3, known as Te Whare Ora. Prisoners could be approved for admission if they were *'mentally unwell patients both with Axis I and II diagnoses who are not able to cope in the residential areas';*[39] *'patients requiring additional support during drug detoxification'*; *'those at risk due to social stresses'*; or prisoners who had *'vulnerability due to extreme health issues'* or *'cognitive challenges'*.[40]

Te Whare Ora had 60 cells. There were eight designated at-risk cells, with the remainder for vulnerable prisoners.[41] The unlock regime could vary depending on the acuity of prisoners accommodated in the Wing and whether any prisoners had been segregated from others.

Te Whare Ora was considered a *'transitional unit'* with each prisoner reviewed at least every four weeks, and a maximum stay of three months unless the Head of Healthcare and House Block supervisor approved an extension. The Prison's Mental Health Nursing Team were

[38] The multi-disciplinary team comprised mental health nurses, healthcare assistants, psychologists, forensic mental health staff, general practitioners, case managers, reintegration officers and operations managers.

[39] *'Axis I and II diagnoses'* is terminology which comes from the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (commonly called the DSM) published by the American Psychiatric Association. Axis I refers to Mental Health and Substance Abuse Disorders and Axis II refers to Personality Disorders and Intellectual Development Disorders.

[40] *Whare Ora Wing Operations* version 2.07, section 4.

[41] There were also designated at-risk cells in the Prison's Health Centre. However, inspectors were advised these had not ever been used and were likely to be decommissioned.

responsible for assessing a prisoner's suitability for admission and determining the support required, following input from the multi-disciplinary team.[42]

Inspectors spoke to staff and prisoners who had serious concerns about the operation of Te Whare Ora. Staff commented on the diversity of the acuity and needs of the prisoners in Te Whare Ora. One staff member said that some of the prisoners in the Wing *'attack vulnerable ones there for health and mental health.'* Another said Te Whare Ora *'is not fit for purpose under any circumstances'.* Inspectors also spoke to prisoners who described assaults which had occurred in Te Whare Ora and had significant ongoing concerns for their safety. These prisoners said they constantly felt nervous and fearful, and tried to always be aware of their surroundings.

Despite the complex needs of those in Te Whare Ora, there was no additional training provided to custodial staff who worked there.[43] Several custodial staff commented about feeling unprepared for the work required of them. Comments included:

> *It's hard to apply our operational training in there*
>
> *We're not qualified for their needs, their mental health, their stability. We're not trained in that field.*
>
> *There's no training for looking after the At-Risk Unit or filling out the observation forms.*

During the inspection, health staff had little presence in Te Whare Ora beyond medication rounds,[44] with the 60-cell wing supervised by only two custodial staff at all times. Custodial staff told inspectors that they felt that to effectively supervise and attend to prisoners' needs, more staff were required.

Inspectors observed glass from a broken kiosk screen had not been attended to for several days during the inspection, which was a significant safety risk for prisoners and staff in the Wing. Staff reported the maintenance request to address this had been made two weeks before the inspection took place.[45]

Prisoner safety, and early detection of potential incidents, also appeared to be risked by observation processes not being consistently followed. These observation processes were outlined in the Prison's *Prevention of Self Harm and Monitoring At-Risk Policy* and the *Whare Ora Wing Observations Policy*.

Daily briefing documents identified prisoners designated as at-risk and the frequency with which staff were to carry out physical observations of them. Inspectors identified instances where observations were carried out once an hour rather than the 15-minute period recorded on the briefing sheet. Inspectors also observed staff members fill out the observation sheets

[42] According to the prisoner's social, physical, cultural, psychological, and mental health needs.

[43] As part of their core training, all custodial staff received training in suicide prevention.

[44] Inspectors' observations of the lack of health staff presence aligned with the Wing's Visitor Register for the inspection period.

[45] On the fourth day of inspection, cardboard was taped over the broken kiosk screen.

for all at-risk prisoners at once and make retrospective observation entries. Examples of incomplete observation sheets were also seen, with one containing no recorded observations between 5am and 8am and another containing only an indication that the prisoner was asleep. Recorded observations often lacked the level of detail required, such as the prisoner's position at the time they were observed.

Staff were responsible for undertaking physical observations of at-risk prisoners in addition to other tasks in Te Whare Ora. They told inspectors that they placed a lot of trust in those monitoring CCTV feeds to identify concerns in the times between physical observation of the prisoners. This made it concerning that inspectors were told that in-cell CCTV cameras were frequently obscured, and that not all staff members responsible for monitoring the CCTV who inspectors spoke to knew which prisoners were accommodated in the at-risk cells and whether they had been assessed as being at-risk.

An internal quality assurance audit had taken place shortly before the inspection (13 August) which assessed compliance with section 11 of Schedule 14 of the contract, which relates to self-harm and suicide prevention. The auditor reviewed *'incidents and components related to At-Risk and self-Harm events from 1 January 2023 to 30 July 2023',* particularly focussed on reviewing the management plans of four prisoners who were still at the prison at the time of review.[46]

The auditor noted there were *'serious inconsistencies'* in the completion and recording of observation forms and in data from the electronic wands used to log staff presence at a particular cell. The audit identified a need for further training for staff who worked in this Wing, particularly in relation to identifying signs of distress, communication with at-risk individuals and documentation of observations.

All prisoners must have their safety ensured, but particular care should be taken to ensure the safety of prisoners who have already been identified as vulnerable. There can be advantages to housing at-risk prisoners in a way which allows them to continue to interact with peers and maintain daily routines; however, at the time of inspection, it did not appear that Te Whare Ora was well situated to manage the competing and diverse needs of the prisoners admitted to the Wing.

I recommend Prison management ensure staff follow the Prison's established procedures for caring for prisoners formally assessed as being at-risk of self-harm.

I recommend Prison management review the staffing arrangements in Te Whare Ora and take the necessary actions to ensure prisoners in this wing are safe and receive adequate supervision and interaction from staff who have received specific training in how to meet this cohort's needs.

In response to the provisional report, Prison management advised that the area in front of the at risk cells in Te Whare Ora has been demarcated with yellow lines, to prevent other prisoners

[46] The auditor did not review prisoners who had since been transferred or released.

from accessing the areas in front of the at risk cells. Anti fishing traps[47] have also been added to the bottom of at risk cell doors. We do not consider these measures address our concerns about the safety, care and support available to at-risk prisoners and others in Te Whare Ora. Rather, we consider they risk reinforcing the separation – and potentially stigmatisation – of those designated at-risk.

Access to timely health care

We expect prisoners to receive timely care and support from appropriately trained practitioners, and have access to the range of services and supports they need.

Both prisoners and staff raised concerns about cancelled health appointments and long wait times to access all health services, including general health, mental health, and dental care.

Access to primary and mental health care

The Prison's *Managing Health Requests* policy outlined the request process prisoners used to make a healthcare appointment.[48] The policy stated that all requests would be reviewed at least once a day. Prisoners were then triaged by a registered nurse to be seen for initial assessment based on urgency of their condition. Following this, the prisoner would be referred to see the relevant healthcare professional (Doctor, RN, Dentist, Physiotherapist). The policy noted that a lower priority appointment may be rescheduled or postponed to accommodate a higher priority case. All prisoners were to be notified of the outcome of their health request through CMS, including if an appointment was required or if an appointment was postponed.

Inspectors were told by staff that health appointments would be cancelled if the wings were running restricted regimes. This was observed happening during the inspection. Health staff also said that if a prisoner did not attend their scheduled appointment twice without an explanation their appointment would be cancelled and they would have to go through the triage process again.

Several prisoners raised their frustrations about health and dental appointments being cancelled or postponed. Complaints data showed prisoners had frequently formally complained about general health appointments being cancelled without an explanation. For example:

> *Over the last 3 months I have had 3 doctors' appointments cancelled with no explanations now I have real concerns with and about my health…*

[47] 'Fishing' involves a prisoner throwing one end of a weighted string from their cell under the door of another cell, and passing notes or small items between cells. Anti fishing traps are heavy draught excluders placed at cell doors so that material cannot be passed between cells this way.

[48] Prisoners can request a health appointment by submitting a request on CMS, completing a hard copy request form (F19.18.02), through custodial staff or through a referral from another health professional (e.g a follow up appointment).

> *I have been waiting to be seen by the Doctor for over 3 months for a chronic [condition]. My appointment was for today [date and time] this morning and was cancelled…*

Health management told inspectors that they did not record cancellations or the reasons for these. The Prison could also not provide information on actual wait times to be seen by a health professional as they were not recorded. The *Health Monitor Report - July 2024* stated that there is currently no robust process for capturing acute care and referral volumes and that for the purposes of the monitoring report these figures had been estimated.

Prisoners described long wait times for access to mental health services, in addition to those for general health services. A prisoner shared they had been waiting 15 months to see the mental health team. They described feeling isolated and lonely. Another prisoner said that they were waiting to see the mental health team, after last having seen them in December 2023. A number of staff also said that increased mental health services would be welcomed at the site.

Waitlist data for mental health/psychological services was able to be provided by the Prison.[49] There were 49 prisoners on the waitlist at the time of inspection. We were, however, advised that there could be as many as 20 prisoners that still needed to be added to the waitlist. Although this waitlist was acknowledged to be lengthy, its length was partially attributed to prisoners being transferred to the Prison who had not yet undergone treatment.

Access to dental care

We expect prisoners to have timely access to quality dental services based on clinical need, including oral health promotion. Staff and prisoners all raised the prevalence of dental issues and the extreme wait times to access treatment.

The Prison had a dentist who worked onsite three days a week. They told inspectors they saw approximately eight prisoners each day. There was no dental hygienist at the time of inspection.

As seen during the 2018 inspection, there were long waitlists for dental services. The Prison's data showed there were 446 prisoners with dental requests in 2024. Of these, 69 were categorised as *'seen';* 11 were listed as '*booked in'* for an appointment. The remainder had not been categorised. Dental requests were organised into three priority categories. It appeared 81 *'priority one'* dental requests from 2024 had not been seen or booked in to be seen by a dentist.[50]

A staff member stated they had seen prisoners experiencing severe symptoms from rotten teeth. They said: *'There's only one dentist here, which is a huge problem.'* Inspectors also heard

[49] Waitlist information for primary mental health care was documented by the Reintegration and Rehabilitation Services Team.

In addition, some prisoners were receiving mental health care from the Mason Clinic's Forensic Prison Team rather than the Prison's Mental Health Team.

[50] Priority one dental request were often listed as swollen gums or jaws, broken or impacted teeth, or pain, including severe tooth pain.

from multiple prisoners that dental care was their major concern.
[content removed for privacy reasons] .

There were 23 complaints recorded regarding dental services for the 6 month period between February 2024 and July 2024 that included similar themes to what staff and prisoners told inspectors. For example:

> Complaint dated 2/2/2024: *I have been trying to get a dentist appointment for about 10 months or more. I have a bad absess tooth and guess my tooth needs attention a.s.a.p. I have tryed asking the staff as the kiosk says I have also tryed pulling it out myself as the pain is so bad.*
>
> Complaint dated 24/03/2024*: I waited a very long time to see the dentist and have been trying to get dental treatment in multiple prisons it has taken roughly 8 months to get my first appointment only for it to be cancelled and having to wait for another month …*
>
> Complaint dated 30/07/2024: *I've been waiting for over a year for my broken tooth to be pulled. I am over the pain. The Dentist said it would be pulled in December.*

Provision of timely dental care is an important aspect of providing healthcare equivalent to what is available in the community, which is our expectation. We are deeply concerned about the adequacy of access to dental care, and the impact of this on prisoner's health, wellbeing and dignity.

I recommend Prison management urgently address deficiencies in prisoner access to timely healthcare services.

I recommend Prison management ensure prisoners are promptly advised of cancellations, and appointments cancelled for reasons outside a prisoner's control are immediately rescheduled.

Provision and recording of paracetamol tablets

We expect medications to be dispensed safely, in accordance with evidence-based practice, and the dispensing of medication to be documented.

The administration of over the counter medication (paracetamol) continued to be problematic, as observed during the 2018 inspection. Poor and inconsistent practice of providing safe doses and documentation of these were observed across the prison, but particularly in the Te Whare Ora where vulnerable prisoners were accommodated.

The *Prisoner Information Handbook*[51] stated '*Paracetamol is available from the officers in your House Block if you have minor pain. You must sign for this. If your pain persists, please make a request on CMS to see a doctor.'* Despite this, inspectors observed staff handing prisoners entire blister packs of paracetamol without prisoners signing for it.

[51] I08.03.01 Prisoner Information Handbook v3.0 Serco Business

Inspectors asked a number of staff about the process for providing paracetamol safely to prisoners. Staff were not always able to describe this process. One staff member stated '*we don't have time to go through the paperwork'.* A senior staff member in one House Block told inspectors that one tablet sheet is given to staff per shift and all dispending should be logged. They highlighted that there is a focus on this process for new staff, but they were aware that staff practice *'often deteriorates'*.

Logs to record the provision of paracetamol were unable to be found in House Block 3. In the Residences' staff hub, the log was difficult to locate; once found, inspectors saw it contained no entries.

One log reviewed contained two entries of prisoners signing for paracetamol; however, while the dose was recorded as being two each time, the total tablets provided were six and eight respectively. The current provision and recording of paracetamol tablets creates a risk of overdose.

I recommend Prison management review the practice of paracetamol administration and dispensing and implement robust safety and quality assurance measures.

In response to the provisional report, Prison management advised that Reintegration Officers no longer dispense paracetamol, and all dispensing is undertaken exclusively by qualified health clinicians. We look forward to seeing improved practice on future visits.

Support and accommodation provided to prisoners with complex health needs

We expect disabled people in custody to have their health, disability and wellbeing needs effectively identified and addressed. They should receive care and support from appropriately trained practitioners, and have access to the range of services and supports they need.

The arrangements in place for the care of prisoners with complex health needs were inadequate at the time of inspection. One prisoner who was receiving ongoing medical treatment was living in a room without natural light. For access to the outdoors and fresh air, they were taken to an alleyway between buildings which had litter in it at the time of inspection.

Other prisoners, who had significant health needs, received support from prisoners who were *'peer support'* workers. The *Te Whare Ora Wing Operations* Policy stated that *'Prisoners who fit the role of peer supporters may be admitted to support men in the Whare Ora. The criteria for peer supporter is contained in a position description which will be discussed with the prisoner at the time of admission.'*

There were [ ] prisoners receiving *'peer support'* during the inspection. The scope of the support arrangements were queried by inspectors. Prison management advised that the peer supporters would provide [ ] prisoners *'prompting and support',* and supervise, do laundry and prepare meals [Content removed for privacy reasons

]

[Content removed for privacy reasons]

In summary, we saw no evidence of the Prison having robust processes to ensure:

- The peer support role was well-defined and understood with clear boundaries on the tasks peer support workers were expected to complete.
- Prisoners who were peer support workers were and remained suitable for the role.
- [ ] prisoners were able to raise concerns about the arrangement or have changes made.
- Adequate oversight of the arrangement and its impacts [ ].

Given the potential for detrimental effects on [ ] prisoners involved in the arrangement, and the risks of abuse and neglect created, we would have considered these to be minimum considerations before the peer support role was implemented.

Peer support is an expansive concept, and prisoners may find benefits in both providing and receiving support. It appears, however, that at the time of the inspection, prisoners in Te Whare Ora were being expected to perform tasks which went far beyond 'peer support' and should have been completed by professionals.

We raised concerns about the arrangements with Prison management and Corrections immediately after the inspection. [Content removed for privacy reasons]. In June 2025, we were informed that the Prison is no longer using the peer support model.

While this has addressed some of our immediate concerns for the welfare of these prisoners, we remain concerned that the peer support role was introduced with very few safeguards for ensuring the welfare of both the prisoner receiving and prisoner providing peer support.

While Prison management have told us they do not intend to use the peer support model in future, **I recommend the Department of Corrections and Prison management ensure disabled prisoners receive care and support from trained practitioners and are accommodated in appropriate physical environments.**

In response to the provisional report, Corrections advised that it recognises the importance of ensuring that all people are cared for appropriately, and that this may require Corrections to strengthen its oversight and support of ASCF. Corrections' Pae Ora team is assessing what strategies can be implemented to balance reporting and oversight with Prison management's operational management on-site.

Living environment

Physical environment

Prisoners should have a safe and healthy physical environment, which is fit for purpose. Material conditions, including the space, ventilation, temperature, lighting, utilities and fixtures should be conducive to this, and be well-maintained.

Overall, the physical environment of the House Blocks was substandard. While the buildings and grounds were for the most-part well-kept, there were cleanliness issues and maintenance and repairs were required.

Many prisoners had created makeshift barriers at the bottom of their cell doors to prevent mice entering their cells. Graffiti was present on glass windows in the House Blocks. In many of the Wings, prisoner laundry was draped over hand-rails in common areas, despite this being against the Prison rules. There were also water-fountains, hand-basins and empty cells in the House Blocks which required cleaning. One cell was without power, requiring an extension cord from another cell to be used.

The state of mattresses was also poor, with a number seen which were thin, worn and in need of replacement. Inspectors saw large supplies of new mattresses available in stores. When this was raised with a staff member, they said they would look into replacing the old mattresses.

Inspectors were told that cell fabric checks were not occurring as required by the Prison's operating procedures. These are checks carried out by staff to ensure any repairs and maintenance issues are reported and remedied. Checks were meant to be carried out daily throughout the wings, with each individual cell checked at least weekly.

Inspectors were told that one prisoner had been waiting approximately 10 days for the broken phone in their cell to be repaired. Staff also advised that the waitlist for repairs to broken in-cell computers could be months long. Approximately 15 prisoners did not have access to their in-cell computer at the time of inspection. Inspectors were told that repairs and maintenance could be delayed due to a lack of staff to escort contractors responsible for the repairs.

I recommend Prison management ensure repairs and maintenance are carried out within reasonable timeframes.

Property and personal possessions

It is our expectation that prisoners have timely access to their possessions. There should be clear, timely and effective processes in place for the storage, transfer and distribution of property.

It was previously recommended that delays to property distribution be addressed by Prison management.

During the inspection, many staff and prisoners commented that distribution of property continued to be slow. Estimates of how long it took prisoners to receive property once it arrived at the prison typically ranged from between one and three months.

Inspectors heard consistently that the Property Office was under-resourced for the number of prisoners and volume of property at the site, and that property management was a challenge. At the time of inspection, there were two staff members responsible for property, a permanent full-time staff member and their fixed-term assistant. In response to the provisional report, Prison management advised that the assistant property staff member role has been made permanent.

Some staff also felt that the Prison's security processes could also at times contribute to the time taken for prisoners to receive their property. They said that the security team often had to prioritise other tasks ahead of conducting security checks of incoming property.

Prisoners were having to wait too long to be provided their property. **I recommend Prison management ensure the Prison's property management function is resourced sufficiently to prevent prisoners experiencing long delays in receiving their property.**

Meal times

We expect meals to be well prepared and served at appropriate times.

At the time of inspection, prisoners in the House Blocks were not receiving meals at appropriate times.[52] Meals were prepared in the Prison's main kitchen and then would be distributed to the House Blocks. Staff advised that on weekdays the evening meal and next morning's breakfast typically arrived at the Wing between 2.30 and 3.30pm, with prisoners eating dinner shortly after this. Staff said that meals could be delivered earlier on weekends and inspectors observed the evening meal leaving the kitchen at 2pm on a Saturday.

Serving dinner in the mid-afternoon and expecting prisoners to save the food provided for their breakfast until the next day falls below our expectations. Having dinner this early can mean prisoners have to wait significant lengths of time between meals, and is something

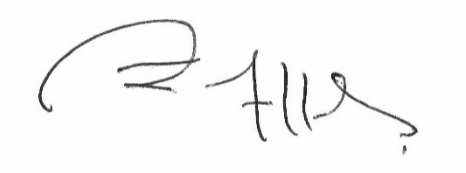
[52] Prisoners in the Residences prepared their own meals.

previous Ombudsmen have criticised on numerous occasions.[53] We acknowledge that, unlike at other prisons, prisoners had some degree of control over meals, as they could choose when to have their breakfast.

I recommend that Prison management standardise the serving of meals to normal hours, with lunch served between midday and 1.30pm, and dinner served between 5pm and 7pm.

Acknowledgements

We appreciate the co-operation extended by the Prison Manager and staff. We are also grateful to the prisoners and to those people who took the time to speak with inspectors. We also acknowledge the work involved in collating the information requested.



John Allen
Chief Ombudsman
National Preventive Mechanism

[53] See for example: For example Manawatū Prison Report (published 2017), Arohata Prison Report (published 2017), Invercargill Prison Report (published 2019), Northland Prison Report (published 2019), Auckland Prison Report (published 2020), Whanganui Prison Report (published 2021), Christchurch Men's Prison Report (published 2021).

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

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…*
>
> *(a) a prison*
>
> *…*

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 the OPCAT role, the Chief Ombudsman has authorised inspectors to exercise these powers on their behalf.

More information

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