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OPCAT Report on an unannounced inspection of Waikeria Prison under the Crimes of Torture Act 1989

15 December 2025

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OPCAT Report on an unannounced inspection of Waikeria Prison 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).

I am empowered to examine places of detention: where people are unable to leave at will. 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 prisoners 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 13 to 24 May 2024, a team of ten inspectors,[1] who have been delegated authority to carry out examinations of places of detention under COTA, made an unannounced inspection of Waikeria Prison (the Prison).

Inspectors were guided by the *Expectations for the conditions and treatment of people in the custody of the Department of Corrections.*[2] At a high-level, these are:

1. The rights of people in custody are upheld by people, principles and practice 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] When the term inspectors is used, it refers to the inspection team comprising the OPCAT Director, senior inspectors, inspectors, and other support staff.

[2] Office of the Ombudsman. *Expectations for conditions and treatment of people in the custody of the Department of Corrections*. 23 June 2023. 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 documents, interviews, and observing facility activities.

Before leaving the facility, inspectors met with Prison management to outline their initial observations. Prison management provided a written response to inspectors' initial observations, which we have considered when preparing this report.

A provisional report was provided to the Prison and to the Department of Corrections (Corrections) for comment. We received responses from Corrections on behalf of the Department and the Prison on 4 July 2025 and 28 July 2025. We have considered their feedback when preparing our final report.

Facility facts

Waikeria Prison (the Prison) is a men's prison situated 16 kilometres south of Te Awamutu, in the Waikato region.

The Prison had six low to medium security units occupied at the time of inspection:[3] two mainstream units (Rata and Totara);[4] two voluntary segregation units (Puriri and Nikau); a drug treatment/special treatment unit (Karaka); and a Māori focus unit (Te Ao Mārama). In addition, four of these units had designated 'separates' cells, which were used to accommodate prisoners who had been separated from the wider prison population.[5]

The cells, staff base and shared facilities of each Unit bordered a square outdoor recreation area. Each of the 80 bed Units included a separate 20 bed building known as an 'annex', which was separate to the main Units, but connected by a covered walkway. Prisoner placement in the annexes was managed by Unit staff. Prisoners housed in the main part of the Units were not permitted to enter the annexes.

[3] These were a mix of 60-bed and 80-bed units. All cells were single occupancy.

[4] The prison provided a copy of written approval 'exemption' allowing the mixing of remand accused and remand convicted prisoners. The written approval/exemption was initially granted in September 2021, and has since been renewed annually. The current exemption was sighted as being valid until 12 September 2024.

[5] These were prisoners who were under directed segregation directions or who had been assessed as at-risk of self-harm. The separates cells were in small cinderblock compounds that were fenced off but located near each of the Puriri, Nikau, Totara, and Rata Units.

Population at the time of inspection

At the time of inspection, the Prison had a prisoner population of approximately 450 and had capacity for 460 prisoners.[6] There were 179 prisoners who were voluntarily segregated.

Muster numbers provided by the Prison as at 9 May 2024.

Unit	Capacity	Total Population	Sentenced	Remand
Karaka	80	79	79	
Nikau	80	78	78	
Puriri	80	79	79	
Rata	80	80	80	
Te Ao Mārama	60	60	60	
Totara	80	75		75
TOTAL	**460**	**451**	**376**	**75**

Waikeria Prison's recent history and plans for the site

At the time of the inspection, the Prison was no longer accommodating high security prisoners due to the loss of 284 high security beds as a result of fire damage suffered during a prison riot that occurred between 29 December 2020 and 3 January 2021. The Prison's Intervention and Support Unit was also destroyed.

This loss continued to impact the treatment and conditions of prisoners at the Prison, including prisoners in circumstances that required them to be transferred to other facilities, for example where their security classification is increased or those assessed as at-risk of self-harm.

In the year prior to the riot, both the former Chief Ombudsman[7] and the Office of the Inspectorate made observations and recommendations to Corrections and Prison management regarding the physical conditions and treatment at the Prison, including multiple statements that several units were not fit for purpose.[8] The failure to address these recommendations and the subsequent riots at the Prison were contributing factors to the former Chief Ombudsman completing a systemic investigation into Corrections, which resulted in additional recommendations and monitoring.[9] The Office of the Inspectorate also completed an inquiry

[6] There were small changes in population numbers over the course of the inspection.

[7] In this report, 'the former Chief Ombudsman' refers to previous Chief Ombudsman Peter Boshier, whose term as Chief Ombudsman ended on 28 March 2025.

[8] *OPCAT Report on an unannounced inspection of Waikeria Prison under the Crimes of Torture Act 1989*. August 2020. Found at https://www.ombudsman.parliament.nz/resources/final-report-unannounced-inspection-waikeria-prison-under-crimes-torture-act-1989

[9] *Kia Whaitake | Making a Difference: Investigation into Ara Poutama Aotearoa | Department of Corrections.* Available at: https://www.ombudsman.parliament.nz/sites/default/files/2023-06/Making%20a%20Difference.pdf

into the incident and produced a report with further recommendations for Corrections and the Prison.[10]

Corrections' construction of a new 600 bed prison on the Waikeria site[11] was also ongoing at the time of inspection, and was subsequently opened on 5 June 2025. The new facility includes 500 high security beds and a 96 bed dedicated mental health and addiction facility (Te Wai o Pure).[12]

A further 810 bed expansion is planned, which is due to be completed in 2029. Corrections' Long Term Network Configuration Plan[13] advises that several of the pre-existing units will be retired in 2030-2034 following the opening of the further expansion.

Corrections has also advised that due to the increase in the national prison population, subsequent to the inspection Nikau Unit is being operated as a satellite facility for Auckland Region Women's Corrections Facility, and there are plans for Miro Unit, which had been used for property management at the time of inspection, to also house female prisoners in future.

The focus of this report is on the situation at the Prison at the time of inspection. In carrying out this examination, we were mindful that the impacts of the riot were ongoing and were still affecting both prisoners and staff. We also acknowledge Corrections and the Prison were working towards a transition to the new the facility that was under construction. Our understanding is that the units which we inspected will continue to operate once the new facility is fully operational. Therefore, this report has been prepared on the assumption that they will continue to be used to accommodate prisoners.

Key observations and recommendations

It was pleasing to see positive practices at the Prison. For example, inspectors observed: a collaborative structure within the Senior Leadership Team (SLT), with most staff also feeling supported by their managers; engagement and participation of mana whenua, whose involvement at the prison was seen as part of site culture;[14] and organised and transparent

[10] *Report of the Independent Inquiry into the Waikeria Prison Riot 29 December 2020 - 3 January 2021*| Department of Corrections. Available at: https://inspectorate.corrections.govt.nz/reports/investigations/report_of_waikeria_prison_riot_inquiry

[11] The project site is 21 hectares and adjacent to the existing Prison accommodation units. Construction began in 2020 and was originally expected to be completed by 2023. The rebuild project was impacted by global events (such as COVID-19) and the associated supply chain pressures.

[12] In addition, the new facility will include office space for administrative and custodial staff and staff amenities as well as visiting facilities and audio-visual capacity to increase whānau connectivity and suites to facilitate court hearings.

[13] See https://www.corrections.govt.nz/resources/strategic_reports/long_term_network_configuration_plan

[14] The Kaumatua Roopu provided support to the General Manager and staff in regards to kawa, tikanga and cultural awareness, and worked with the Kaiwhakamana Roopu who focus was on prisoner support.

processes for hearing misconduct charges, both at the initial adjudication stage and at the Visiting Justice stage.[15]

In addition, we were pleased to see most prisoners had approximately 11 hours per day unlocked and outside their cells[16] and that in person contact with whānau could be arranged regularly with weekly visits available on Saturdays and Sundays.[17]

However, we are not satisfied that the conditions and treatment of all prisoners was adequate across a range of areas.

We were disappointed that measures to address the poor conditions in the Separates Units had not been taken since the 2020 inspection. These Units remained run-down, cold, dirty, and unsuitable for human confinement. At the time of inspection, the Separates Units were not staffed to safely and adequately meet prisoners' requirements. Record-keeping was inadequate, and necessary oversight and safeguards to prevent solitary confinement from occurring were not seen to be in place. In addition, we are concerned about the lack of privacy screens for toilets in these cells and the intrusive use of CCTV in some instances.

We are not confident that use of force was only being used by staff when it was legal, proportionate, necessary and with robust oversight. Despite the relatively small number of recorded use of force incidents during the period examined, review of the footage supplied has left us with concerns about some use of force practices at the Prison, such as prisoners being restrained in a prone position, and the way in which force was used on a prisoner assessed as being at-risk of self-harm. Use of force reviews were also taking longer than we would have expected.

Significant findings of contraband are of concern.[18] While we acknowledge the prison grounds provide security challenges, such as multiple entry points, inspectors observed insufficient safety and security measures being taken. We are aware that Prison management were aware of a need to improve security processes, and were seeking to do so. We encourage them to review the processes they have in place to prevent contraband entering the site.

Some prisoners said they did not feel supported or informed during the induction process. Broken kiosks in most units also impeded prisoners' access to necessary information and limited prisoners' ability to make complaints independently of staff. Prisoners with English as a second language had restricted ability to access information and discuss their needs with staff as they were not always provided with adequate interpretation and translation support.

[15] Charges were heard promptly and fairly, with a formal process followed in line with aspects of the Prison Operations Manual (POM) that are designed to ensure fairness and impartiality.

[16] We observed open environments on each of the units, where prisoners were free to move around and associate as they wished. There was a lot of interaction between prisoners while they were unlocked.

[17] Visits during the weekdays had to be arranged via private booking process.

[18] Records of contraband items between November 2023 and March 2024 included: cannabis, vapes, cell phones, phones chargers, prescription medication, obscene material, an improvised ignition device, drug utensils, alcohol, home brew, tobacco and vape oil.

Delays in accessing case managers continued to be an issue across the Prison, as it was during the previous 2020 inspection. We acknowledge that Prison management were aware of the issue and were attempting to address it through recruitment.

In general, prisoners had good access to a variety of activities. However, it appeared that some prisoners had limited access to rehabilitation opportunities and purposeful activity. This particularly impacted prisoners who were segregated voluntarily, and could not attend certain programmes, at times this included programmes on their offender plan, as they were only available in mainstream units.

We have serious concerns about the lack of ventilation and temperature control in cells. Staff and a significant number of prisoners from across the Prison raised their concerns about the temperature of the cells during the summer months. Temperature reading records showed that cell temperatures can reach up to a worrying 34°C.

We continue to expect Prison management and Corrections do all they can to make sure prisoners are safe, and at a minimum, always receive their statutory entitlements. With this in mind, I have made a number of recommendations related but not limited to the concerns we have outlined above. [19]

I recommend that the Department of Corrections and Prison management:

- cease accommodating prisoners in the Separates Units.
- ensure no prisoner experiences solitary confinement.
- review the way prisoners on directed segregation or assessed as at-risk are managed at Waikeria, and take action to ensure these prisoners are safe at all times and their wellbeing is monitored.
- ensure the privacy of prisoners when showering or using the toilet.
- only use CCTV monitoring where it is lawful, necessary, and proportionate on an individual basis
- ensure prisoners have equitable access to the full range of purposeful activity and rehabilitative opportunities offered.
- do not take a more restrictive approach to eligibility for Outside the Wire work than is required by law, unless justified on an individual basis.
- provide appropriate bedding and clothing for all prisoners.

[19] 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.

I recommend that Prison management:

- ensure any use of force adheres to the principles of legality, necessity, proportionality, and is subject to comprehensive and timely review
- ensure staff activate body worn cameras prior to any use of force and that footage is retained**.**
- ensure the use of force register and related paperwork is completed in full**.**
- ensure all safety and security measures are implemented consistently and proportionately.
- implement comprehensive induction processes across all units and ensure prisoners retain access to the information provided during induction.
- ensure all induction information provided to prisoners is up-to-date.
- ensure that all prisoner information kiosks are in working order.
- ensure prisoners have the ability to make complaints independent of staff
- provide prisoners with dedicated, comprehensive and timely case management.
- provide enough working phones in each unit to ensure equitable access to the phones for all prisoners.
- provide private spaces for prisoners to have conversations with legal representatives and other statutory visitors.
- confirm all staff are aware of, and provide, translation and interpretation services to all prisoners who require them.
- ensure cells are well-ventilated and kept at an appropriate temperature.
- develop contingency plans to move prisoners out of cells when temperatures impact on prisoner's health and welfare.

Discussion

Safety and Independence

It is our expectation that people in custody are safe and their independence is promoted. No person should be deprived of their liberty unless in accordance with the law, and with all associated legal protections. Prisoners should be safe from harm, abuse, or neglect (including but not limited to physical, emotional, spiritual, cultural, financial, or sexual). Risks and harm must be identified, recorded, and addressed.

Conditions in the Prison's Separates Units

The Prison had 12 'separates cells' in four small cinder block compounds (hereafter 'Separates Units') that were fenced off but located near each of the Puriri, Nikau, Totara, and Rata Units.

At the time of the inspection, prisoners who were on directed segregation under sections 58 to 60 of the Corrections Act 2004 (the Act) could be housed in any of these Separates Units.[20] In the absence of a specifically designed Intervention and Support Unit (ISU)[21] at the Prison, the Totara Separates Unit was being used to temporarily accommodate prisoners assessed as being at-risk of self-harm before they were transferred to an ISU at another site. Nine prisoners on directed segregation and one at-risk prisoner were housed in the Separates Units during the inspection.

Each of the Separates Units contained three cells, a small yard, and a shower block. The cells had a bed, toilet, and basin with a tap and drinking fountain. Very limited natural light entered the cells from the high windows. The yards were not much bigger than the cells, and had solid concrete walls and a wire mesh roof. The main entrance, yard, and shower block doors in these units were all metal grate doors that let in the cold. The shower blocks were visible from the main corridor through a metal bar door, giving prisoners very little privacy. There were also no privacy screens for any of the toilets in the cells of these units, meaning they were visible through the cell door window.

The units were run-down and dirty. For example, inspectors observed moss growing in the yards, graffiti, dirty basins and toilets, and milk bottles and other rubbish on window sills. The wash-basin in at least one cell was highly pressurized with water coming out with significant force, which meant prisoners could not fill a glass of water from the tap. In one of the units, the heating system was broken, the shower water was cold, and water from the shower block came under the door into a prisoner's cell.

[20] Under these sections of the Act, prisoners may be segregated for the purposes of security, good order, or safety; protective custody; or medical oversight.

[21] ISUs are designated to provide safe management of prisoners with mental health needs and increased self-harm risk. A new ISU is included in the Prison's new build plan.

Inspectors spoke to prisoners who were concerned about mice in their cells, being cold, and not being able to tell the time. Staff also described these units negatively, variously describing them as '*dark, cold*', and '*basically a concrete box*'. A staff member said that they believed that long periods of time in the conditions of the Separates Units' cells would be harmful to a prisoner.

In 2020, the former Chief Ombudsman observed that the Separates Units were not fit for purpose. He recommended that *'measures are taken as a priority to ensure the poor conditions in the Separates Units are addressed. Cells must be clean, free from graffiti, well lit, and well ventilated.'* Despite this, inspectors observed that the conditions in the separates units had not improved at the time of this inspection, and remained unacceptable.

While Prison management advised that the cleanliness and maintenance of these cells would be checked more frequently and that records would be kept of this, fundamentally these units are not fit to accommodate prisoners.

In response to our provisional report, Corrections acknowledged our concerns with the conditions in the Separates Units and advised that the new prison facility includes a new management/separates unit with 38 beds and a new 26 bed ISU. They advised when the new ISU was operational at the end of July 2025, all male prisoners identified as at-risk will be assessed and accommodated appropriately, either in the new ISU or at another location which can better meet their needs.

However, we note that parts of the old prison, including Nikau Unit, are now being used to house female prisoners, and this may expand in future. We are concerned that Corrections has not provided any guarantee that the Separates Units will not be used for this population.

Prisoners on directed segregation

Segregation should only be used in accordance with the principles of legality, necessity, proportionality (including shortest period of time), accountability, and non-discrimination. Prisoners' specific needs should be met while on segregation, and segregation should not involve further disadvantages or restrictions on the prisoner. Solitary confinement should not occur – no person should be physically isolated for 22 hours or more in a day without the opportunity for meaningful human contact.[22]

Relevant segregation paperwork showed that the nine prisoners on directed segregation during the inspection spent between three and 14 days in the Separates Units. The average amount of time these prisoners spent in the Separates Units was six days.

Prison management advised that prisoners placed on directed segregation following a violent incident would have their security classification reassessed and be transferred to another

[22] Rule 44 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) defines prolonged solitary confinement as the confinement of prisoners for 22 hours or more a day without meaningful human contact for a time period in excess of 15 consecutive days.

prison as soon as possible. However, they acknowledged that prisoners may spend two weeks in one of the Separates Units.

The Separates Units did not have dedicated staff. Instead, staff from the main units were tasked with conducting periodic checks on prisoners accommodated in these units. Inspectors were told that log books in each of the Separates Units were used to record that prisoners had received their minimum entitlements, as well as to log staff visits and staff interactions. Staff said that more detailed records of interactions between staff and prisoners would be made in the Integrated Offender Management System (IOMS).[23]

However, following the inspectors' review of the relevant log book entries and IOMS records, we consider the record-keeping in relation to these matters to have been completely inadequate. There were days where no information in relation to provision of minimum entitlements was recorded in IOMS for three of the prisoners on directed segregation. Where there were IOMS entries, times were rarely included. IOMS entries which state only *'Prisoner given yard and shower'* are an inadequate record that the prisoner has received their minimum entitlements under the Act. There were similar issues with the hard copy log books in the units, which recorded limited and inconsistent information and were often in poor condition – some consisting of just a loose sheet of paper in the entrance area.

We have concerns about how Prison management were ensuring and monitoring the safety and general wellbeing of prisoners in these units, particularly given the lack of dedicated staffing. There were very few records made on the wellbeing of each prisoner during their time in the Separates Units. Four of the prisoners' records reviewed contained no evidence at all of welfare checks made by custodial staff.

While Prison management advised that *'there have never been any issues in relation to responding to incidents and/or prisoners' needs in the Separates due to staffing levels'*, prisoners' accounts suggest there were safety risks from the lack of dedicated staffing. Two prisoners said that they had been left alone in the shower blocks for an hour, with no way to get staff attention.

All those in the Separates Unit during the inspection were on restricted rather than denied association. Despite this, in practice they were denied the ability to associate with all other prisoners. Interactions inspectors observed between staff and these prisoners were brief, focussing on completing routine tasks such as providing meals, and offering showers or time in the yard. While Corrections advised that phone access and visits are facilitated by staff, none of the prisoners inspectors spoke to had had phone calls or visits.

We consider there to be a high risk that prisoners in these units were experiencing solitary confinement, given the restrictions placed on prisoners' ability to interact with other people; the lack of dedicated staffing in the Units; and the nature of the interactions observed between prisoners and staff. The record-keeping in relation to prisoners on directed segregation provided us little assurance that solitary confinement was not occurring.

[23] IOMS is Corrections' computerised operational database.

In response to the provisional report, Corrections advised that since the inspection, an on-call manager log has been introduced to the site and there are now daily checks of the Separates Unit conducted by a Tier-5 manager. However, management do not appear to have put in place all necessary oversight and safeguards to prevent solitary confinement from occurring and ensure prisoners' wellbeing while segregated.

At-risk prisoners

Our expectation is that the safety of people in custody is provided for at all times. Strategies should be implemented to prevent suicide and self-harm and to provide appropriate, individualised, and specialised support to those vulnerable and/or at-risk.

As outlined above, at the time of inspection, the Prison did not have a designated ISU. Prisoners deemed to be at-risk were assessed by custodial and health staff and transferred to the ISU at Spring Hill Corrections Facility (Spring Hill) as soon as possible.[24] Prior to being transferred, they were often housed temporarily in the Totara Separates Unit.

Inspectors requested and reviewed the records for prisoners who had recently been transferred to Spring Hill after being assessed as at-risk.

- There were no at-risk management plans completed for these prisoners prior to their transfer to Spring Hill. Inspectors were told that at-risk management plans were not completed at Waikeria, as the prisoners were transferred within 24 hours of assessment to Spring Hill ISU, where management plans would be developed.
- It was not clear that the required in-person safety observations of at-risk prisoners were taking place.[25] Inspectors' review of records found that only two of the prisoners had health notes requesting 15 minute observations be carried out until transfer. The Prison was unable to provide observation sheets. They could not account for their absence, nor could they confirm that 15 minute observations were completed.
- Inspectors were told that any observations were recorded in paper form and stored in prisoners' hard-copy files, which were transported between prisons with them. However, staff subsequently confirmed that they had made inquiries with the Corrections facilities these prisoners had been transferred to, and they had also been unable to locate the relevant observation sheets.

We find it concerning that the Prison was not equipped to safely manage, onsite, prisoners who were assessed as being at risk. The prospect of being transferred to a different, unfamiliar prison over 100km away creates a potential negative consequence for these individuals, and risks discouraging disclosures related to mental health and self-harm.

[24] Spring Hill is located approximately 100km north of Waikeria.

[25] To ensure their safety, the *Prison Operations Manual* (POM) stipulates that at-risk prisoners who do not have an at-risk management plan must be observed by way of physical sightings (not by camera) at intervals no longer than 15 minutes, with all observations recorded.

Moreover, the Prison – and Corrections more broadly – have a duty of care to ensure the safety and wellbeing of those in their custody. The lack of clarity about measures in place to monitor the safety and wellbeing of those assessed as at-risk, both before and during transfer, is troubling. This is especially relevant given these prisoners were being housed in the poor conditions of the Separates Units, without permanent staff present to provide ongoing oversight of their wellbeing.

We note Corrections' adoption in 2022 of a Wellbeing Checks policy, involving twice daily checks of all at-risk prisoners by a registered health professional. We understand there will be an audit of this practice at the end of 2025, and we will follow the results of this audit with interest. However, twice daily wellbeing checks do not replace the need for more regular, properly recorded, observations of at-risk prisoners without an at-risk management plan by custodial staff.

Overall, we consider that at the time of inspection there was a lack of accountability for, and oversight of, the safe management of at-risk prisoners.

Given our observations above about the conditions in the Separates Units and the treatment of both segregated and at-risk prisoners, I make the following recommendations.

I recommend the Department of Corrections and Prison management cease accommodating prisoners in the Separates Units.

I recommend the Department of Corrections and Prison management ensure no prisoner experiences solitary confinement.

I recommend the Department of Corrections and Prison management review the way prisoners on directed segregation or assessed as at-risk are managed at Waikeria, and take action to ensure these prisoners are safe at all times and their wellbeing is monitored.

Alongside Corrections' response to our provisional report, Corrections provided us with a response to a number of recent recommendations we have made to Corrections about solitary confinement across several prisons.

Corrections advised that they have several projects underway for improving processes relating to solitary confinement including introducing segregation, at risk, and mental health care plans into the IOMS, developing a segregation assurance tool to assess the standard of documentation, decision making, and timeliness of segregation processes, developing an ISU Placement Review Process to ensure that people's placement in the ISU is reviewed daily, and updating the Corrections wide separation and isolation plan.

However, we note with concern Corrections' position that solitary confinement is a legitimate tool of prison management. We do not share this view. While segregation has a clear legislative framework setting out the limited circumstances in which it can be used to ensure security, good order, or safety, this should not constitute solitary confinement. Corrections needs to take all necessary steps to ensure that solitary confinement does not occur, and that all prisoners on directed segregation have their opportunities for meaningful human contact maximised.

CCTV monitoring

The privacy and confidentiality of prisoners should be respected and preserved. Any infringement on privacy should be justified and proportionate, including any use of surveillance technology.

All of the cells in Separates Units had CCTV cameras installed which had a view of the toilets. However, the cameras were only operational in the three separates cells of the Totara Separates Unit (the only Separates Unit being used for prisoners assessed to be at-risk of self-harm).

While the other three Separates Units had some signage which advised that the cameras were not operational, in some cases this signage was not present in the actual cells, where prisoners would be able to see it. Inspectors spoke to prisoners in these Units who were not aware that the cameras were not recording. Even though the cameras were not operational, we are concerned that the presence of the cameras could still have negative effects on some prisoners due to a feeling of being continuously watched, particularly as they have no way to verify the cameras were not functioning.

Inspectors also observed that the toilets of the Totara Separates Unit cells were visible in the CCTV live feed at the staff base. In addition, Corrections staff had not turned a camera off in a Totara Separates Unit cell where a prisoner was housed on directed segregation. This person had not been assessed as at-risk and there was no apparent need for them to be continuously monitored. Inspectors were told that the prisoner had attempted to obstruct the camera using toilet paper; however, inspectors observed that parts of the cell could still be seen on the CCTV footage. We consider this an unacceptable intrusion on this prisoner's right to privacy.

In response to the provisional report, Corrections advised that two of the three cells in the Totara Separates Unit had been modified so they can hold prisoners subject to directed segregation with the CCTV deactivated, and that the remaining cell is used for monitoring at-risk prisoners.

The ability to observe prisoners undressing, showering or using the toilet, either directly or via CCTV, is a serious breach of privacy and dignity. The former Chief Ombudsman was advised by Corrections that they are pursuing regulatory changes to allow them to use privacy screening in cells designated for at-risk prisoners. Nevertheless, we reiterate that intrusive CCTV monitoring should cease as a matter of priority and monitoring solutions which better support the needs of vulnerable prisoners should be implemented.

I recommend the Department of Corrections and Prison management ensure the privacy of prisoners when showering or using the toilet.

I recommend the Department of Corrections and Prison management only use CCTV monitoring where it is lawful, necessary, and proportionate on an individual basis.

Use of force

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.

There were eight recorded uses of force at the Prison during the six months preceding the inspection (1 November 2023 to 30 April 2024). Inspectors requested CCTV and body worn camera (BWC) footage for these incidents, as well as footage of an incident which occurred earlier in 2023 which they were advised was under investigation by the Inspectorate at the time of inspection.

Inspectors were not provided BWC footage for four incidents within the scope of their request, despite use of force review documentation stating that this was available. They were provided BWC footage for one incident although the use of force review stated that no BWC footage was available. The inability to provide footage in relation to these incidents, and the potentially inaccurate record of the availability of BWC footage are concerning.

Footage was provided of other use of force events which occurred in 2023, and were outside the scope of inspectors' request. [26] This footage was reviewed and forms part of the basis of our commentary on use of force practices.

Despite the relatively small number of recorded use of force incidents during the period examined by inspectors, review of the footage supplied has left us with concerns about some use of force practices at the Prison.

Particular aspects of these incidents which concern us include:

- Force being used to remove the trousers of an at-risk prisoner who did not want to change into an anti-rip gown because of the cold in the Totara Separates Units. [27]
- Staff's actions and attitude towards a prisoner who requested an asthma inhaler and complained of being unable to breathe prior to and during a restraint event.
- A staff member involved in the above incident making comments to the prisoner which were disrespectful, unprofessional, and showed a lack of regard for the prisoner's welfare. These comments included telling the prisoner to *'shut the fuck up'* and *'you are talking so you can breathe.'*
- The use of prone restraint on multiple occasions.[28]

[26] The use of force reviews for these additional events were not provided.

[27] Anti-rip gowns are also sometimes referred to as 'stitched gowns'. They are made of reinforced material to reduce the risk of people being able to tear them to make ligatures.

[28] We acknowledge that this is a method of restraint which is permitted by the Department of Corrections, provided the procedures set out in the *Tactical Options Manual* are followed. Our position, however, is that given the risks associated with the position, planned or intentional restraint in a prone position should not occur.

- A ten-minute delay in providing decontamination to a prisoner after pepper-spray was used.

In some instances, footage indicated that had staff listened to and addressed the prisoner's concerns, the degree of force used could have been avoided. We are therefore not confident that force was only being used by staff when it was proportionate and necessary.

Additionally, inspectors identified problems with the Prison's record-keeping in relation to use of force. While on site, inspectors were provided two paper-based registers related to use of force, one used to record completed use of force reviews and one called the *'UOF Register Report.*' There were discrepancies between the two registers, with use of force events recorded in one register but not the other, and different event numbers assigned to particular events in each register.

Following a discussion about this with inspectors, Prison management advised they had created a new electronic register and provided a copy of this shortly after the inspection. However, this register still did not meet the requirements of a Use of Force Register outlined in the Prison Operations Manual (POM). It did not record whether each use of force was spontaneous or planned; the grounds for the use of force; review details; or whether pepper spray or mechanical restraint had been used. Capturing this data is essential for trend analysis.

There also appeared to be errors in the data. For example, there were review dates listed which did not match the dates recorded on the use of force review forms reviewed by inspectors.

Accurate and comprehensive recording of uses of force, as well as retaining evidence (i.e. BWC and CCTV footage), are basic and essential parts of ensuring there is adequate oversight of prisoners' treatment.[29] It is deeply concerning that this was not taking place.

The use of force documentation provided also raised concerns about the Prison's practices for reviewing use of force following its use.

- Two of the reviews contained no description of de-escalation techniques attempted prior to the use of force, and a further review contained poor details.
- Three reviews contained poor details about the grounds for the use of force.
- On occasion, written descriptions of the incident did not align with what was captured on BWC or CCTV footage reviewed by inspectors.
- Only two of the reviews contained recommendations to improve staff practice.
- None of the reviews had been signed by the Prison's General Manager.

[29] Recording the particulars of the use of force is also a legislative requirement: Corrections Act 2004, sec 88 and Corrections Regulations 2005, regs 128 and 129.

- Reviews were taking longer than we would have expected to be completed. Only four of eight reviews were completed within 14 days of the event. Two of the reviews took close to a month to be completed.

The incident identified to inspectors as being under investigation by the Inspectorate had initially been reviewed with no concerns identified or recommendations made by the reviewer. That serious concerns with staff practice were subsequently identified when the Inspectorate investigated, and when Prison staff re-reviewed the force, shows how deficient this initial review was.

Corrections advised all use of force reviews are being completed within 14 days of notification to the Custodial Manager and the Prison has implemented new oversight processes for use of force. These include weekly panel reviews where management will meet to discuss all incidents and use of force from the previous week. In addition, we have been assured all use of force footage will be reviewed to ensure it aligns with the use of force review. These are positive steps, however, given our observations regarding use of force practices, we make the following recommendations.

I recommend Prison management ensure any use of force adheres to the principles of legality, necessity, proportionality, and is subject to comprehensive and timely review.

I recommend Prison management ensure staff activate body worn cameras prior to any use of force and that footage is retained.

I recommend Prison management ensure the use of force register and related paperwork is completed in full.

Safe custody

Safety and security of people in custody, staff, service providers and visitors should be provided for at all times. Safety and security should be preserved with no more restrictions than are allowed for by the principles of legality, necessity, proportionality, accountability, and non-discrimination.

Prisoners should be regularly consulted about their safety, and action should be taken to address their concerns. Safety and security measures must be subject to oversight and regular review by senior managers to ensure standards are consistently achieved.

Prison management advised that the Prison being surrounded by a large amount of farmland created security challenges – particularly with controlling contraband.

[Content removed for security reasons]

Inspectors were provided with a data table recording contraband items found by members of the Prison's Detector Dog Team between November 2023 and March 2024. This recorded that there had been findings of cannabis, vapes, cell phones, phones chargers, prescription medication, obscene material, an improvised ignition device, drug utensils, alcohol, home brew, tobacco and vape oil.

The Prison's Safer Custody meeting minutes for 13 December 2023, 14 February 2024, and 13 March 2024 also confirmed that there had been ongoing discussions at the site about the presence of homebrew, cell phones and other contraband. Meeting attendees described the amount of contraband found at that time as *'significant.'* Attendees also identified that the thoroughness of cell searches and rub down searches needed to be improved, and all incidents needed to be recorded in trackers. A reminder was also given to encourage staff to use the Corrections Integrity Line should they need to anonymously report any concerns about staff.

These reports of significant findings of contraband are of concern to us because 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 contribute to increased influence of organised crime groups within the prison, bullying, intimidation and violence.

Some prisoners raised concerns with inspectors about overnight cell searches taking place at the Prison. They said that during these searches, the whole unit would be searched, with all prisoners taken out of their cells. Staff advised that it was current practice to do these night searches before 10pm, but that they may look to do these searches later at night in future, and that they are looking to increase the use of night searches. Staff also said that cell phones had been found during these night searches.

In response to the provisional report, Corrections advised that after hours searches are not routinely carried out, and that any after hours searches are based on information received which supports a targeted search. While night-time searches may be an appropriate and necessary tool in some limited situations, we encourage Prison management to ensure that they consider the necessity and proportionality of each night-time search that is carried out,

given their potential to cause additional impacts on prisoners compared to searches carried out at other times. We also note that Rule 51 of the Mandela Rules states that *'searches shall not be used… to unnecessarily intrude on a prisoner's privacy.'*

Corrections has also advised that a focus has been placed on improving the standard of rub down searches at the Prison, including by the Deputy General Manager issuing guidance to Tier 5 Managers, and the issue being discussed at Safer Custody Panel meetings. Corrections advised that searches of RtW prisoners now take place in the sallyport directly after the prisoner leaves the prison van.

Improving the effectiveness of less intrusive safety and security processes, and making full and effective use of the range of security measures available,[30] may reduce the need to conduct more disruptive or intrusive searches.

I recommend Prison management ensure all safety and security measures are implemented consistently and proportionately.

We would expect every Prison to have localised security policies and procedures which take into account specific risks identified at the prison and provide guidance about how safety and security will be maintained while ensuring no more restrictions than are allowed for by the principles of legality, necessity, proportionality, accountability, and non-discrimination.

Unit inductions

Prisoners should receive comprehensive verbal and written induction information, including information about their entitlements (such as to phone calls, property, showers), and how to access support. Any immediate needs of prisoners should be identified and met.

Inspectors were told by both prisoners and staff that, as part of the unit induction to Te Ao Mārama, all new prisoners were welcomed by the Rūnanga (Welfare Group comprised of prisoners) with a Pōwhiri followed by an induction session with both staff and prisoners. However, this was not representative of all unit inductions. Several prisoners from across the Prison's other Units told inspectors that their unit inductions were vague. At the time of induction, they were given an induction book and a copy of the unit rules to sign, which were both taken back by staff, and told that the unit rules were displayed in the unit (behind cell doors or on notice boards). However, prisoners said the unit rules were not displayed and they '*learn about the unit from other prisoners'.* Staff confirmed that once induction documents were signed they filed them in the prisoners file, and confirmed that rules were displayed in the units.

Inspectors observed that unit rules were not displayed behind cell doors or on notice boards in any of the Units at the time of inspection. A staff member said that the rules get regularly pulled off the wall by prisoners. Corrections have advised that since the inspection, all Units have started to display the prison rules on notice boards and behind cell doors.

[30] In particular, having good physical security, procedural security, and dynamic security.

During the inspection, inspectors noted that several Units' induction documents had not been reviewed for a number of years. For example, documents from the Karaka Unit were last updated on 26 January 2016, the Totara Unit on 6 April 2014, and the Te Ao Mārama Unit on 1 July 2014.

We are concerned that some prisoners were not receiving comprehensive inductions into their units. Induction information is a key way to tell prisoners about their rights, obligations, and entitlements. Without this information, prisoners may not know how to access the support they need**.** Proper induction also contributes to the safe and smooth operation of the Prison, and if done well, can ease pressures on people in custody and staff.

I recommend Prison management implement comprehensive induction processes across all units and ensure prisoners retain access to the information provided during induction.

I recommend Prison management ensure all induction information provided to prisoners is up-to-date.

Access to information and complaints systems

It is our expectation that every prisoner is provided all necessary information about their rights, responsibilities, and entitlements, and the operating and administrative arrangements relating to their detention, in a language and accessible format which they can understand. We also expect that complaints systems are accessible to prisoners, culturally safe, well-communicated, confidential and effective.

Prisoners use kiosks to log electronic complaints, make requests, and find out information. During the inspection, several kiosks were not working, which limited prisoners' ability to make PC01[31] or IR.07[32] complaints. This included one of the two kiosks in the Totara Unit, both kiosks in the Puriri Unit, and one of the two kiosks in the Nikau Unit. Staff in these Units were not always aware that the kiosks were broken, although maintenance requests had been logged for some of these kiosks. Corrections advised that following verbal feedback from inspectors, an urgent review of the functionality of the kiosks was carried out and steps were taken to remedy out of order kiosks.

Several paper-based forms were seen available in unit common areas, however hard-copy complaint forms had to be requested from staff in almost all units (Puriri was the exception). These could only be requested from staff during prescribed times. Having to request complaint forms from staff has the potential to affect prisoners' perception of fairness of the complaint system and willingness to make a complaint.

I recommend Prison management ensure that all prisoner information kiosks are in working order.

[31] The standard process for prisoners to raise complaints to prison management.

[32] Complaints about staff conduct and attitude are addressed through this process.

I recommend Prison management ensure prisoners have the ability to make complaints independent of staff.

Planning for the future

Purposeful activity

From the beginning of their time in custody, there should be a focus on providing individuals with the support, skills and tools they need for the future. All people in custody, including those on remand, should be supported and encouraged to use their time constructively, including through meaningful activities and offence focused rehabilitation opportunities. There should be sufficient and suitable education, cultural, skills, work and programme places to meet the needs of the population, including the needs of particular groups.

Inspectors observed that, in general, prisoners had access to a variety of activities at the time of inspection. Prisoners in all units were generally unlocked between 7.30am and 6.30pm each day which contributed to their ability to access meaningful activity.[33]

Nine programmes were running covering offence-based rehabilitation, cultural engagement, life-skills and problem-solving. In addition, data provided by Corrections showed that 73 percent of the total prison population had employment, were currently attending a programme, and/or were enrolled in an educational activity. The Prison also had a dedicated Te Tirohanga Unit (Te Ao Mārama),[34] which focused on Māori cultural engagement. This included activities such as kapa haka, whakairo, and rakau, as well as support with whānau and iwi relationships, and involvement from kaumātua. Inspectors observed that elements of tikanga and kawa were embedded in this Unit's daily routine.

In respect of access to recreational activities, each Unit had a gym, recreation room, grass field, and courts with basketball hoops. Some Units also provided prisoners with table tennis or art facilities. Inspectors observed that these were frequently in use. Sports, games and exercise also took place in the Units frequently.

However, we note that at the time of the inspection, the Prison's two Activities Officers had been redeployed away from providing prisoners activities.[35] Instead, they were called on to act as prisoner escorts or perform other tasks required by Prison management or Principal Corrections Officers. This meant prisoners did not get the benefit of the wellbeing services and facilitated physical activity that would otherwise have been provided by these staff.

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[33] Fridays were an exception to this, with prisoners being locked between 12pm and 3pm to allow for staff training to take place.

[34] For more information about Te Tirohanga Units, see https://www.corrections.govt.nz/resources/research/journal/volume_4_issue_2_december_2016/the_department_of_corrections_tikanga-based_programmes

[35] The Activities Officers' *Schedule of Work* provided by the Prison stated that usual activities provided by Activities Officers include group gym workouts, games, competitions, weigh-ins and general health, fitness and wellbeing support.

We also have concerns about the access some prisoners had to rehabilitation opportunities and purposeful activity more generally. Prisoners in Puriri and Nikau Units, who were segregated voluntarily, faced particular challenges.

There was a MIRP (medium intensity rehabilitation programme) running in Puriri at the time of inspection, along with a planned follow-up/'maintenance' course for this group. However, there were no rehabilitative programmes running in Nikau, and no further programmes of this nature planned for Nikau or Puriri in 2024.[36] Only five prisoners in the Nikau Unit were engaged in a programme at the time of inspection.

Staff members advised inspectors that because certain programmes were only available in 'mainstream units' prisoners segregated voluntarily needed to either give up this status to attend, or transfer to a different prison to complete these. Corrections has since confirmed that more intensive rehabilitation programmes for violent and sexual offending, which are delivered through Special Treatment Units (STUs), are only available to mainstream prisoners.

Inspectors spoke to a prisoner who had chosen to give up their voluntarily segregated status to attend a programme only offered in a mainstream unit. This prisoner said that as the programme had been included on his offender plan, he felt he had no choice about doing so. He also said that he felt vulnerable and very anxious about being in a mainstream unit.

In response to our provisional report, Corrections advised that a review was carried out in 2019 which found that six out of 149 people on the list for a placement in the Special Treatment Units (STUs) for violence and adult sexual offending indicated they did not want to attend due to having to sign off their segregation direction. This was deemed too small a pool to warrant creating an STU in a segregated unit. It is not clear how this data was gathered and whether it accounted for peoples' incentive to agree to attend even when they felt unsafe.

The 2019 review does not provide us reassurance that prisoners are able to access appropriate programmes, or that they feel safe while doing so. Prisoners may feel pressured to give up their segregated status in order to attend programmes, including those on their offender plan, despite feeling unsafe in doing so. Further, we note that the numbers of voluntarily segregated prisoners at Waikeria and across the prison network has increased significantly since 2019, and it is important that Corrections ensures the adequate provision of programmes for this cohort.

Similarly, the location and availability of the computers used by prisoners to complete secure online learning courses limited access. The computers were primarily located in Rata Unit, with a smaller computer room in Nikau. This meant that prisoners who could not mix with those units' prisoners could not access these learning resources. While Corrections advised that they would facilitate prisoners' movement between Puriri and Nikau Unit, they also acknowledged that there were only four computers in the Nikau Unit, making it difficult for voluntarily segregated prisoners to access them. This figure does not seem sufficient for the number of voluntarily segregated prisoners at the site.

[36] Corrections advised, in response to our provisional report, that MIRP programmes will continue to be delivered in Puriri for the foreseeable future.

Eligibility for work outside the wire

Broadly, there were two types of external employment available to prisoners:[37] Release to Work (RtW)[38], and Outside the Wire[39] (OTW) work. OTW work opportunities included working on the Prison's dairy and dry stock farms, working in the external grounds, horticulture, and working in a kitchen or canteen. Prisoners were supervised and received instruction from Corrections staff members while undertaking this work.

A staff member involved in this area advised that they would like to see more prisoners able to take up OTW work and that there were spaces available.[40] Inspectors heard from prisoners who said that this was work they would like to do in order to demonstrate progress to the Parole Board. Inspectors were also told by staff and management who worked in this area that there were a lot of prisoners they considered suitable for these opportunities but who did not meet the Prison's eligibility requirements. Prison management advised that eligibility for OTW work was determined by legislation and policy.

There are two areas of the Corrections Regulations 2005 which may apply in this situation – Regulation 26, and Regulations 28 and 29. Regulation 26 states that for a prisoner to be able to be '*temporarily released from custody'* they must have the lowest level of security classification and they must be sentenced to less than two years imprisonment, or eligible for parole in less than two years.

Regulations 28 and 29 state that every sentenced and remand prisoner can be '*temporarily removed from a prison'* to undertake rehabilitative or reintegrative activities.

Prison management advised that Regulation 26 is applicable for prisoners to work OTW inside the prison site. It was not clear to us why the Prison was using the stricter eligibility criteria set out in Regulation 26, as prisoners in OTW work were supervised by Corrections staff at all times and remained in custody.

Corrections' response to the provisional report advised that this approach is 'governed by policy and applied in accordance with the specific settings at the site'. However, no further rationale was provided as to why this approach was necessary and proportionate in relation to Waikeria.

We note that at other prisons many of these OTW activities would fall into the category of prison industries and be provided 'inside the wire' – without any need for prisoners to meet any of the requirements governing temporary removal from prison or temporary release from

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37 Unit-based employment was also available.

38 RtW provides people in prison who are near release the opportunity to develop or re-establish work skills and habits necessary for stable employment by temporarily releasing them during the day to work.

39 'The Wire' refers a prison's secure perimeter fence. OTW is rehabilitative work outside the secure perimeter, but within the wider prison site. It provides opportunities for people in prison to engage in community-focussed work, education, or employment.

40 For example, there were 12 prisoners engaged in dairy or dry stock farming. Corrections advertises that there is capacity for 89 people. https://www.corrections.govt.nz/about_us/getting_in_touch/our_locations/waikeria_prison

custody. This raises the potential that prisoners at Waikeria were disadvantaged in their access to these vital rehabilitative opportunities.

We note that the Special Rapporteur on Torture has written about the importance of vocational training and work in providing *'prisoners with valuable skills, confidence and improved self-esteem that reduces the risks of recidivism.'* She also noted the importance of eliminating discrimination in the provision of rehabilitation services and discussed in particular the risk that *'those who have been in the system for extended periods, face the bias that they cannot be rehabilitated or reintegrated, or that they are not worthy of the expenditure of resources to do so.'*[41]

I recommend the Department of Corrections and Prison management ensure prisoners have equitable access to the full range of purposeful activity and rehabilitative opportunities offered.

I recommend the Department of Corrections and Prison management do not take a more restrictive approach to eligibility for Outside the Wire work than is required by law, unless justified on an individual basis.

Case management

Case managers are responsible for working with prisoners to develop a comprehensive phased rehabilitation and reintegration plan. We expect prisoners to receive regular, timely and comprehensive case management. Prisoners' voices should be sought and heard during these processes.

Prisoners from across the Prison frequently raised concerns with inspectors about delays in accessing their case managers. Some prisoners told inspectors that they had had no contact with their assigned case manager since arriving at the prison, or had only seen their case manager once. One prisoner stated '*my case manager is currently on long term leave.*'

This was also evident in prisoner complaints data for the six month period prior to the inspection (1 November 2023 to 30 April 2024). Several complaints, 54 of 471 (11 percent) related to case management, including prisoners trying to make appointments with their case manager for months with no response. For example, one complaint stated *'I really need to see my case manager to sort my licence before I leave. I have asked repeatedly for help with this for the last 4-5 weeks now, via message and/or meeting request and have had no luck…'*

Prison management advised that there were three case manager vacancies and two staff on leave at the time of the inspection, and as a result case managers' caseloads were high, although they were actively recruiting. At the time of inspection there were approximately 28-32 prisoners assigned to each case manager. Staff said that high workloads due to the vacancies, staff leave and sickness meant some case managers were working longer than rostered hours. There were also impacts on the prisoners such as prisoners not being assigned

[41] Alice J Edwards *Current issues and good practices in prison management: Report of the Special Rapporteur on torture and other cruel inhuman or degrading treatment or punishment* UN Doc A/HRC/55/52 (20 February 2024) https://documents.un.org/doc/undoc/gen/g24/011/85/pdf/g2401185.pdf [46] – [52].

a case manager[42] and remand prisoners and prisoners with shorter sentences not seeing their case managers when they need too. Inspectors were told that, due to the limited number of available case managers, they had been triaging work based on urgency. For example, legal requirements such as offender plans were being prioritised, along with ensuring prisoners who are close to release are met with to confirm their release plan and what they need.

We acknowledge Prison management's awareness of the issue and their attempts to address it through recruitment. However, we also note that appropriate and timely case management has been a concern for some time at the Prison, with the former Chief Ombudsman making a recommendation on this issue in his 2020 report.

In response to the provisional report, Corrections advised that the Prison's case management team is now fully staffed and as of May 2025 most new prisoners had an initial consultation with a case manager within 10 days and most prisoners had an offender plan in place.[43] We are pleased to hear of this progress.

Case managers play a crucial role in supporting prisoners on their rehabilitation journey and helping prisoners plan the necessary steps before their release. **I recommend Prison management provide prisoners with dedicated, comprehensive and timely case management.**

Dignity and respect

Telephone calls

It is our expectation that the importance of loved ones in the life of prisoners is acknowledged and valued. Prisoners should be encouraged and supported in developing and/or maintaining positive relationships with whānau, especially tamariki and rangatahi, and the wider community.

Four of the five 80 bed units with an annex had three telephone (phones), with two phones located in the main part of the unit and one in the annex. The Nikau Unit, also an 80 bed unit, had four phones and the Te Ao Mārama Unit, a 60 bed unit, had two phones.

Prisoners and staff from across the Prison told inspectors the number of phones in each unit was not sufficient to provide equal access for all prisoners. Inspectors saw that phones were in high demand with three or more prisoner's queueing to use phones during the inspection.

Both prisoners and staff told Inspectors that prisoners in the 80 bed units with an annex often felt frustrated that the one phone in the annex was allocated just to the prisoners housed

[42] Prison documents provided to inspectors showed 18 prisoners had not been allocated a case manager at the time of inspection.

[43] Corrections advised that at the time of the inspection, 75% of prisoners were seen by a case manager for an initial consultation within 10 days. This compares to 87% in May 2025. At the time of the inspection only 27% of prisoners had an offender plan in place. In May 2025 this was 89%.

there. For example, in the Totara Unit the two phones in the Unit were allocated to 60 prisoners and the one phone in the annex being allocated to just 15 prisoners.

Inspectors were also told that one of the phones in the Totara Unit was often broken. A prisoner shared that recently the phone had been broken for five days and prisoners were not allowed to use the phone in the annex, even though this wasn't being used.[44]

Prisoners on RtW told inspectors that they sometimes finished at 5:30pm – 6:00pm and could not always get time to use the phone. Staff confirmed this, saying that RtW prisoners have limited time to use the phone once they get back to the unit from work, and often there is already a queue. In response to the provisional report, Corrections advised that arrangements are made on a case-by-case basis for prisoners on RtW to access the phones. We are concerned that this may mean that access is on an exceptions basis for RtW prisoners, and that they may have reduced access compared to other prisoners.

Prisoners and staff also raised the issue of some groups of prisoners in some units spending more time on the phone than others, stating '*you get a lot of double clutching'* - when a prisoner makes repeated 15 minute calls instead of going to the end of the queue after each call. This was occurring as there was no limit for the number of phone calls made, just the 15 minute time limit per call.

We are aware that, in January 2025, Corrections reduced the daily time limit for prisoners' access to phones from three hours to 30 minutes, except in exceptional circumstances. Corrections has advised that this change is intended to make access to phones more equitable. While recognising the issues with fairness in phone usage, as described above, we are concerned that a blanket response reducing phone time for all prisoners may be a disproportionate response to what Corrections has referred to as *'a small group of people'* using the phone in a way that disadvantaged others. It also does not address the limited number of working phones available to prisoners, and the time available for prisoners to access phones.

We encourage Corrections to consider how it will ensure that access to phones for all prisoners is not only fair and transparent, but also maximises prisoners' ability to maintain meaningful contact with whānau and manage aspects of life which continue outside of prison.

Engagement with Corrections on the impact of the reduction in daily personal phone call time limits will continue, and access to phones will continue to be an area of interest in examinations.

I recommend Prison management provide enough working phones in each unit to ensure equitable access to the phones for all prisoners.

Inspectors were also told by prisoners that they had little to no privacy when using the phone,[45] including when using them for legal calls. Private facilities for prisoners to call their

[44] Permission to use the annex phone was, however, reportedly granted on Mother's Day as frustration and tensions between prisoners over phone access was particularly high.

[45] These phones were generally corded phones located in the units' shared outdoor areas, near staff bases.

lawyers were not readily available, prisoners highlighted the lack of privacy that resulted from having to make calls using the unit phones – staff and other prisoners were often within hearing distance during calls. Staff in one unit told inspectors that they tried to facilitate some prisoners' lawyer calls in the visits room, but said that the room often had to be used for other purposes. We expect that prisoners have unobstructed and confidential access to independent advocates and services, including legal representatives. [46]

I recommend Prison management provide private spaces for prisoners to have conversations with legal representatives and other statutory visitors.

Communication and language

Communication used in prisons should be responsive to individual needs. Speech, language, and communication needs should be well understood and accommodated. Language interpretation and translation services[47] and tools should be used, and should be tailored to the individual and the situation.

Telephone interpretation services were available for all staff to use to communicate with prisoners with English as a second language. Information about these services was seen on the Prison's intranet. Correspondence from the Clinical Quality Assurance team also directed all staff to use interpretation services to manage the wellbeing and needs of foreign nationals, speakers of other languages and those with literacy issues.

However, it appeared that interpretation and translation services were not used consistently. Inspectors were told by one prisoner that they interpreted for two other prisoners for whom English was their second language. Another prisoner pointed to prisoners nearby, when trying to communicate with inspectors, to tell them that they use these prisoners to help translate and complete forms. Another prisoner shared that they required translation services for written documents, but there was no translation application available on computers in the learning suite.

Prison management were also unable to provide a list of all Foreign National prisoners and prisoners with English as a second language when this was requested by inspectors, who were told by staff this information was difficult to retrieve from IOMS.

Inspectors reviewed the electronic records for three prisoners identified during the inspection as speaking limited English. There were no alerts loaded to indicate language barriers or a need for communication support, despite individual file entries showing instances where the support of interpreters would be of assistance, or where other prisoners had provided assistance with interpretation. One entry detailed a conversation which had been successful due to the use of an interpretation service.

[46] Rule 61 of the Mandela Rules states that prisoners are to be provided with adequate opportunity and facilities to communicate and consult with a legal advisor in *'full confidentiality'*. Consultation can be within in sight, but cannot be within hearing of prison staff.

[47] Translators work with written language. Interpreters work with spoken or signed language.

Inspectors noted a particular gap in relation to the provision of health care. Only one of the medical files[48] for the three prisoners discussed above identified that they required interpretation and translation support. Records showed the three prisoners had seen health staff about a range of health issues that would require consent for treatment, self-advocacy and a degree of health literacy.[49] In some instances, there were references to reliance on other prisoners to help translate during health appointments. We are concerned that prisoners do not appear to have been consistently provided with adequate interpretation and translation support during health appointments, both to protect their privacy and to ensure they fully understand the information provided.

In response to the provisional report, Corrections acknowledged the importance of translation and interpretation services being available to prisoners, and advised the site was taking steps to ensure staff are regularly reminded of this.

Without adequate support, language barriers can negatively impact prisoners' access to essential information. We expect that prisoners are able to make decisions about the medication and treatment they receive. They should be helped to understand the clinical actions and effects, limitations, and potential side effects of the medication or treatment prescribed.

I recommend Prison management confirm all staff are aware of, and provide, translation and interpretation services to all prisoners who require them.

Living environment

Temperature

Our expectation is that prisoners are accommodated in cells or rooms that meet their health requirements, including adequate floor space, and appropriate lighting, temperature, ventilation, and fresh air.

A significant number of prisoners from across the Prison raised their concerns about the temperature of the cells during the summer months. One prisoner stated: '*In the summer, the cells are a sauna. You can crack the windows, but not enough for a good draught. It gets to 36° in the summer'.* Review of Rūnanga meeting minutes showed cell temperature was a common issue that was mentioned frequently.

Staff also raised their concerns about the conditions of the cells in summer. A staff member said the temperatures can border on dangerous. Another staff member said that investment in cooling systems to regulate temperature in the cells was required. Inspectors were also told that prisoners' behaviour can escalate when temperatures are extreme and incidents, such as prisoners smashing out windows, have occurred due to frustration.

[48] Provided by the Prison.

[49] Health literacy refers to understanding and using health-related information.

The Prison provided inspectors with temperature reading records taken across each unit over the summer months of 2023 – 2024. Multiple readings were taken each day although not at consistent times across all units, so a true comparison could not be taken.[50] However, the data showed that cell temperature ranged from 18° Celsius to 34° Celsius. 68 of the 174 temperature readings (39 percent) were 30° Celsius or higher.

Prisoners in some units had been given desk fans in order to cool down cells; however, prisoners said that the fans just pushed hot air around the cell.

In response to the provisional report, Corrections advised that appropriate clothing is available to prisoners in summer, along with sunblock, refrigerated cold water and ice blocks. Corrections also provided a copy of their Long Term Network Configuration Plan[51] (the Plan) and advised that temperature and ventilation regulation is an increasingly common issue across many prison sites due to aging infrastructure. Although the Plan includes a further 810 bed expansion opening at Waikeria in 2029, it only includes provision for the '*potential*' closure of the current units in 2030-2034. Given this, we are concerned that these units may continue to operate in their current states for the foreseeable future. Corrections also provided Waikeria's Heat Management Plan. However, the plan focuses on managing periods of heat in the short term. Given that the Units are no longer planned to close in the near future, longer term initiatives are necessary for addressing the temperature issues in these Units.

Corrections is obligated to manage prisoners in a *'safe, secure, humane and effective manner'*.[52] A recent report of the Special Rapporteur on Torture noted that States have an obligation to protect prisoners, including helping them to avoid temperature-related illnesses during particularly hot or cold weather.[53] Keeping cells at a comfortable temperature is important for prisoners, especially given the amount of time that they often spend in their cells. **I recommend Prison management ensure cells are well-ventilated and kept at an appropriate temperature.**

I also recommend Prison management develop contingency plans to move prisoners out of cells when temperatures impact on prisoner's health and welfare.

Kit provisions

It is our expectation that all prisoners have the basic requirements of a decent life met. This includes access to suitable bedding and clothing. Items that need to be washed, such as bedding and clothing must be kept clean and in good condition.

[50] For example, in the Rata Unit temperature readings were taken at 9am, 1pm and 5pm. Whereas in the Nikau Unit, temperature readings were undertaken six times per day, at 7am, 5pm, 6pm, 7pm, 8pm, and 9pm.

[51] See https://www.corrections.govt.nz/resources/strategic_reports/long_term_network_configuration_plan

[52] Section 5(1)(a) of the Corrections Act 2004.

[53] Alice J Edwards *Current issues and good practices in prison management: Report of the Special Rapporteur on torture and other cruel inhuman or degrading treatment or punishment* UN Doc A/HRC/55/52 (20 February 2024) https://documents.un.org/doc/undoc/gen/g24/011/85/pdf/g2401185.pdf

At the time of inspection prisoners across every unit consistently commented about their mattresses and bedding not being fit for purpose. Prisoners said pillows were stained and the duvets and blankets did not provide enough warmth. Comments on how often bedding was changed differed across units, ranging from monthly to over two months. Prisoner remarks on mattresses included that they were smelly, mouldy, very thin, hard and uncomfortable. In addition, some mattresses did not fit bedframes, and some prisoners said they could feel the bed frame through the mattress, resulting in them choosing to move mattresses to the floor to sleep; inspectors saw multiple prisoners had their mattresses on the floor of their cell. Inspectors also heard from prisoners that the thin mattresses particularly impacted prisoners with disabilities, injuries, and limited mobility.

Inspectors observed mattresses that were thin, stained and in poor condition. They also saw bedding in several units that was in poor condition – for example, prisoners in the Puriri and Totara Units showed inspectors their pillows, which were stained yellow. Inspectors also noted that some prisoners had double mattresses, extra blankets and pillows as they had a disability, while other prisoners said that they had been denied an extra mattress when requested.

Access to good quality bedding is a basic necessity, and fundamental to prisoners' dignity. We consider that mattresses should be replaced regularly to maintain their quality. The former Chief Ombudsman was recently told by Corrections that they have awarded new contracts for the supply of mattresses to all prisons and these new mattresses are a little thicker than those in use at the time of inspection.[54] Corrections has advised that since the inspection, the mattresses at the Prison have been replaced. We are pleased to hear that Corrections have taken steps towards addressing issues with bedding, we will maintain an interest in this matter.

Inspectors were also told that the provision of clothing appeared to be inconsistent across the Prison. Prisoners and staff said that clothing was a *'problem'* in the Totara Unit and that '*there are also kit issues'* in the Karaka Unit,[55] while kit changes occurred every day in the Nikau Unit. Inspectors saw documentation between staff identifying inconstant management of kit entitlements. Inspectors also observed that the Puriri Unit kit locker was empty in contrast to the Nikau Unit, which was well stocked and organised.

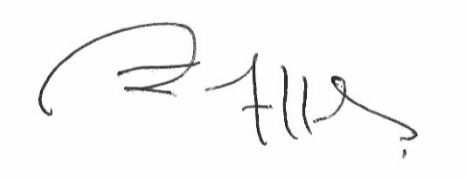
I recommend the Department of Corrections and Prison management provide appropriate bedding and clothing for all prisoners.

[54] The new mattresses are 150mm deep. Mattresses previously were 100mm deep.

[55] A custodial staff member told inspectors it was their understanding that prisoners hoard kit as they do not feel they can rely on getting regular kit change.

Acknowledgements

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



John Allen
Chief Ombudsman
National Preventive Mechanism

Appendix 1. Legislative Framework

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

The objective of OPCAT is to establish a system of regular 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).[56]

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;

[56] "Designation of National Preventive Mechanisms" (22 June 2023) *New Zealand Gazette* No 2023-go2676.

- 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