Ombudsman

Fairness for all

OPCAT report on an announced follow up inspection of Te Whare Ahuru Mental Health Inpatient Unit, Hutt Hospital, under the Crimes of Torture Act 1989

15 December 2025

John Allen
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National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT report on an announced follow up inspection of Te Whare Ahuru Mental Health Inpatient Unit, Hutt Hospital, under the Crimes of Torture Act 1989

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Introduction

The following report has been prepared in my capacity as a National Preventive Mechanism (NPM),[1] as designated under the Crimes of Torture Act 1989 (COTA). I am empowered to examine places of detention: where people are unable to leave at will. Central to my role is conducting visits and inspections. My role is to form an independent opinion as to the conditions and treatment in these places, report my observations and if necessary make recommendations for improvement.

Inspection approach

From 29 October to 1 November 2024, a team of four inspectors, who were delegated authority to carry out visits to places of detention under COTA, made an announced four-day visit as part of the follow-up inspection to Te Whare Ahuru,[2] an acute inpatient mental health unit (the Unit). Inspectors were guided by our Expectations for conditions and treatment of tāngata whai ora[3] in health and disability places of detention.[4]

The inspection was to follow up on the 18 recommendations made following the previous inspection in 2020 (report date June 2021).[5] The Unit accepted 12, partially accepted five and rejected one of these recommendations.

Inspectors gathered and assessed a range of information, including reviewing documents, interviewing a number of people, and observing Unit activities. Before leaving the Unit, inspectors met with Unit management to outline their initial observations.

Consultation

A provisional copy of this report was sent to Health New Zealand – Te Whatu Ora (Health New Zealand) on 28 August 2025. On 19 September 2025, we received a response from Health New Zealand on behalf of the Unit. We have considered this feedback when finalising the report.

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1 More information about the United Nations Optional Protocol to the Convention against Torture (OPCAT) and my National Preventive Mechanism (NPM) function can be found at: https://www.ombudsman.parliament.nz/what-we-can-help/monitoring-places-detention/why-ombudsman-monitors-places-detention.

2 Te Whare Ahuru translates from Māori as “a sheltered haven”.

3 A person who uses mental health and addiction services. This term is often used interchangeably with consumer or client. In the 2021 report, the term ‘client’ was used to reflect the language used at the Unit at the time.

4 OPCAT Expectations Mental Health Services

5 OPCAT Report on an unannounced inspection of Te Whare Ahuru Mental Health Inpatient Unit, Hutt Hospital, under the Crimes of Torture Act 1989. June 2021

Facility facts

Te Whare Ahuru is a 24-bed[6] acute adult inpatient unit, providing services for people experiencing an episode of acute mental illness that requires assessment and treatment in a safe hospital setting.[7]

The Unit is a locked facility and accommodates clients of all genders. The Unit consists of two distinct areas, referred to as the acute ward and Te Rangi Marie, which includes the de-escalation area, two de-escalation rooms and four bedrooms. There were 23 tāngata whai ora (15 female and eight male) in the Unit on the first day of inspection.

Tāngata whai ora could be admitted to the Unit under orders made under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), or on a voluntary basis.

At the time of inspection there were four voluntary tāngata whai ora in the Unit. Voluntary tāngata whai ora are under no legal compulsion to remain within a facility to receive mental health services. However, where there is a risk that arrangements in place could effectively mean voluntary consent is not given (including to treatment) or they are not free to leave at will, voluntary tāngata whai ora come within the scope of our OPCAT function.

Inspection outcome

As a result of the follow up inspection of Te Whare Ahuru, the Unit had achieved five of the 2021 recommendations,[8] a further five were progressing but not yet achieved. Therefore, I make 13 repeat or amended repeat recommendations along with one new recommendation. These are set out in the table below.

Recommendations to Te Whare Ahuru Unit

I recommend the Unit management ensure:

- cultural support for all tāngata whai ora is provided, and actively promoted, in the Unit. This is an amended repeat recommendation
- all Environmental Security Officers (ESOs) are fully inducted to their role and the Unit, including provided with mandatory training**.** This is an amended repeat recommendation.
- tāngata whai ora are able to access the toilet independently of staff at all times, unless deemed unsafe based on an individual risk assessment. This is an amended repeat recommendation.

[6] 23 acute beds and one emergency bed.

[7] *Welcome to Te Whare Ahuru, Acute Inpatient Mental Health and Addiction Services. Information about Te Whare Ahuru for Clients/Tangata Whaiora and Family/Whānau.* Hutt Valley District Health Board.

[8] 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

- tāngata whai ora are not accommodated in rooms other than those designed and designated as bedrooms. This is an amended repeat recommendation.
- leave restrictions are not placed on voluntary tāngata whai ora. This is a repeat recommendation.
- all relevant staff, including ESOs, are up to date with their SPEC training as a priority. This is an amended repeat recommendation**.**
- the sensory modulation room and its use is better advertised and more accessible to tāngata whai ora. This is a repeat recommendation.
- welcome/information packs are provided on admission, and available to tāngata whai ora throughout their admission. This is an amended repeat recommendation.
- information about complaint mechanisms, and means to access them, are available to tāngata whai ora in all parts of the Unit, independent of staff. This is an amended repeat recommendation.
- that all tāngata whai ora have a signed consent to treatment form retained on their file. This is an amended repeat recommendation.
- the Unit is cleaned and maintenance issues are attended to in a timely manner. This is an amended repeat recommendation.

Recommendations to Health New Zealand – Te Whatu Ora

I recommend Health New Zealand:

- ensure improvements to the physical environment are carried out. This is an amended repeat recommendation.
- work with other relevant agencies to ensure that the Service is able to meet the demand for its services, including providing suitable bedrooms for all admitted tāngata whai ora. This is a new recommendation.

Recommendation to Health New Zealand – Te Whatu Ora and Unit management

I recommend Health New Zealand and Unit management:

- ensure the Unit is adequately staffed and resourced. This is an amended repeat recommendation.

2024 Follow Up Inspection

2021 recommendations achieved

2021 recommendation	Observations
Clients are able to conduct telephone calls in private. Clients in de-escalation are able to access a telephone in private.	Inspectors saw that a portable phone was available to tāngata whai ora on request, this could be taken to a private area in the main Unit or to their bedroom. In addition there was a phone in the phone room where private calls could be made. Tāngata whai ora also had access to their own cell phones, unless deemed at risk and/or on a management plan. Tāngata whai ora in the de-escalation area were able to use the portable phone in private, but did not have access to their cell phones. A tangata whai ora who spoke to inspectors said they had good access to the phone and no issues with privacy.
The Unit ensure that voluntary clients are fully informed of their right to leave the Unit at will, including through information displayed on the Unit and provided in induction material.	Inspectors saw the induction pamphlet provided to tāngata whai ora on admission included clear information about voluntary tāngata whai ora leaving the Unit, stating *'If you have been admitted informally/voluntarily you have the right to leave the unit. Please inform staff where you are planning to go and what time you expect to be back.'* Signage about leaving the Unit was seen displayed on the nurses' station window and on the main door of the Unit, this stated *'To exit the ward please see staff at the nursing station'*. However, there was no signage specifically informing voluntary tāngata whai ora of their right to exit the Unit. Voluntary tāngata whai ora confirmed with inspectors that they were provided with information about the process of leaving the Unit and understood they could leave the Unit when they wanted.

2021 recommendation	Observations
	While information about their right to leave the Unit, and how to do this, was provided to voluntary tāngata whai ora, we suggest the Unit displays this information in the Unit and looks for further opportunities to include this information in other documents provided to voluntary tāngata whai ora and their whānau.
Clients are invited to attend their Multi-Disciplinary Team meeting, wherever possible, and routinely informed of the outcome of their review.	Staff told inspectors that multi-disciplinary team (MDT) meetings was not language used by the Unit anymore. One staff member said that the previous MDT meetings had been redesigned as they were not working well and not well attended. The new meeting structure included a meeting with the tāngata whai ora, their whānau and relevant staff, ensuring the discussion was specific and relevant to the individual. Another staff member confirmed that these meetings were held regularly. Tāngata whai ora who spoke with inspectors confirmed that they had meetings with their whānau and staff to discuss their care planning. A review of paperwork also showed tāngata whai ora presence at meetings, and involvement in their care. We are pleased to hear tāngata whai ora participation in decisions relating to their care was being promoted and facilitated.
Safeguards are implemented to ensure clients' privacy is protected.	During the 2020 inspection it was observed that tāngata whai ora privacy was not being respected or preserved. Staff conversations occurring in the nursing station could be heard in other areas of the Unit by tāngata whai ora. Staff told inspectors that as a result of the previous report staff were more aware that their conversations could be overheard outside of the nursing station. To prevent this from happening several signs were displayed in the nursing station reminding staff to keep their voice down and handover meetings were now held outside the Unit. Inspectors did not overhear any conversations about tāngata whai ora during the time of inspection. Staff were also observed leaving the Unit to complete handover.

2021 recommendations progressing but not yet achieved

2021 recommendation	Observations	2025 recommendation
The building is upgraded as a matter of urgency	It is our expectation that the building, facilities and grounds are appropriate for their purpose, and well maintained. The environment promotes the comfort, health, and wellbeing of tāngata whai ora and their enjoyment of daily life. At the time of inspection, the physical environment continued to be in poor condition, as identified in the 2021 report. The Unit was not fit for purpose. Inspectors were told the plans for the proposed new build had been approved and was due to start during 2025. Unit management said that this may take up to three years to complete. We acknowledge a new build is underway, however, due to the significant timeframe until completion, we expect the current Unit to be maintained to improve the living environment for tāngata whai ora accessing the service during this period. We discuss maintenance concerns in more detail and make a recommendation regarding this on page 18.	**I recommend Health New Zealand ensure improvements to the physical environment are carried out.** This is an amended repeat recommendation.
Senior Management address concerns relating to staffing levels.	We expect that tāngata whai ora are never unsafe due to staffing shortages. Staff shortages should not prevent tāngata whai ora from receiving care or having access to meaningful activities. Data provided at the time of inspection showed staffing vacancies had consistently decreased during 2024, from 30.82 full time equivalent (FTE) vacancies in April 2024 to 18.6 FTE vacancies as at 29 October 2024. Inspectors were told that the vacant positions included four registered nurses, three social workers, an occupational	**I recommend Health New Zealand and Unit management ensure the Unit is adequately staffed and resourced.** This is an amended repeat recommendation.

2021 recommendation	Observations	2025 recommendation
	therapist and a psychologist. They were also actively recruiting for a Kuia to provide cultural support for the women in the Unit. A staff member shared positive feedback on the impact of increased staffing numbers, saying the frequency of overtime has reduced, stress levels have reduced and progress towards reducing vacancies had been made. However another staff member said that although there had been additional staff employed, some staff were still working double shifts and gaps on weekends were filled by community nurses and social workers. Although the number of vacancies had reduced, inspectors' review of staffing rosters showed a significant variance between the number of staff recommended on each shift and the actual staff on each shift. [9] The variances were consistent throughout the roster information provided, with the night shift consistently showing under recommended staffing levels. *Feedback in response to the provisional report* Health New Zealand advised that as of September 2025, the vacancy rate had reduced to 11%. We are encouraged that Health New Zealand appears to be prioritising reducing the vacancy rate, and we look forward to further progress in this area.	
Cultural support and provision is made available to clients on the Unit.	We expect that provisions are made to support the expression of identity, culture, or faith. For example, tāngata whai ora should have access to kaumātua, and others who can provide cultural and/or spiritual support such as pastors and/or chaplains.	**I recommend Unit management ensure cultural support for all tāngata whai**

[9] The number of recommended staff is based on the hospital roster model.

2021 recommendation	Observations	2025 recommendation
	A Kaumātua had been employed to provide cultural support in the Unit on a part time basis. The Kaumātua stated that cultural support was given within structured activity and a life skills group that ran twice each week, where they provided information on cultural healthcare, food and nutrition. In addition an important part of their work was helping tāngata whai ora re-connect with whānau, learn pepeha and understand who they are. The Kaumātua could also be called into the Unit at other times when necessary. Although the Kaumātua confirmed they could be called in when necessary, Unit staff told inspectors that the availability for this service could be improved through increased availability throughout the week and greater visibility in the Unit. Inspectors noted that the Kaumātua services were not advertised in the information booklet or displayed on the Unit. Inspectors did not observe any other cultural practices taking place during the inspection. *Feedback in response to the provisional report* Health New Zealand advised that information about the Kaumātua is now displayed in the Unit, and will be included in the information booklet going forward. They also advised that the Unit has established links with a Pasifika service in the community who are available to visit the Unit on request. Information about this service is now available in the Unit. They have also arranged access to a chaplain. We acknowledge the positive steps taken by the Unit in this area and encourage Unit Management to embed these practices and expand its focus on meeting the cultural and spiritual needs of each tangata whai ora.	**ora is provided, and actively promoted, in the Unit.** This is an amended repeat recommendation.

2021 recommendation	Observations	2025 recommendation
The Unit develops a policy and job description for security staff, which includes a detailed induction and training specific to mental health care.	We expect staff are conscientiously selected and trained, recognising that the safety and wellbeing of tāngata whai ora depends upon staff members' integrity, humanity, knowledge, skills, and personal suitability. Inspectors observed security staff, referred to by the Unit as Environmental Security Officers (ESOs), on the Unit during the time of inspection. Unit management told inspectors that while the number and use of ESOs in the Unit had decreased they were still required to be rostered on to bolster staff numbers. However, they were working towards not having ESOs routinely working in the Unit. ESOs were contracted by Health New Zealand from Allied Workforce. The ESO job description was provided to inspectors. The job description outlined responsibilities, expectations and training requirements which included Safe Practice Effective Communication (SPEC) and Unit orientation. During the inspection, some staff told inspectors that all ESOs were SPEC trained but the Unit do not have training records to confirm this as these were not provided to the Unit. Inspectors spoke to an ESO who said they did not have SPEC training. One staff member said that they had seen ESOs involved in uses of restraint but believed these staff were not always SPEC trained. Another staff member said they feel like ESOs don't understand their role and do not get a full induction. In 2021, the former Chief Ombudsman recommended that the Unit develop a policy and job description for security staff. We acknowledge that documents have been developed outlining the role and training requirements for ESOs, including a requirement that they be SPEC trained. However, it appeared that in practice the function and training of ESOs in the Unit was inconsistent with the requirements of the role and could result in compromised safety for tāngata whai ora.	**I recommend Unit management ensure all Environmental Security Officers (ESOs) are fully inducted to their role and the Unit, including provided with mandatory training.** This is an amended repeat recommendation.

2021 recommendation	Observations	2025 recommendation
	Feedback in response to provisional report Health New Zealand advised that they are exploring ways of ensuring ESOs are SPEC trained, including requesting confirmation of SPEC training completion for each ESO assigned to the Unit. We encourage Unit management to develop a process that ensures that the Unit is assured that all ESOs have completed all necessary training.	
Clients have unimpeded access to toilets at all times	The 2021 recommendation was based on an incident where one tangata whai ora was unable to use the toilet in Te Rangi Marie.[10] During the 2024 inspection, inspectors did not directly observe any challenges with tāngata whai ora accessing the toilet. Several tāngata whai ora told inspectors they had no issues with access to the toilet and could use the toilet anytime. Staff said the only reason the toilet would not be available was if it was being repaired. However, inspectors saw cardboard receptacles in the seclusion room. When asked about these staff responded that the receptacles were used when someone was in seclusion. These were not seen in use at the time of inspection. We are concerned about the use of cardboard receptacles in seclusion. The use of these is an inappropriate replacement for independent access to the toilet for tāngata whai ora in seclusion. The use of cardboard receptacles in seclusion would also be considered a serious risk to the privacy and dignity of tāngata whai ora.	**I recommend Unit management ensure tāngata whai ora are able to access the toilet independently of staff at all times, unless deemed unsafe based on an individual risk assessment.** This is an amended repeat recommendation.

[10] Te Rangi Marie includes the de-escalation area and seclusion rooms.

2021 recommendation	Observations	2025 recommendation
	Guidelines from the Ministry of Health state that *'the use of cardboard receptacles for toileting is degrading and should be avoided wherever possible.'*[11]	

2021 recommendations not yet achieved

2021 recommendation	Observations	2025 recommendation
The issue of over occupancy is addressed as a matter of urgency. Seclusion rooms and other non-designated bedrooms are never used as bedrooms.	We expect tāngata whai ora to be provided a dedicated and comfortable place to sleep, securely store their belongings, and relax in privacy. Inspectors were told that over occupancy had improved since the previous inspection, and tāngata whai ora were no longer sleeping in the lounge or phone rooms. The Unit was funded for 24 beds. Data provided at the time of inspection showed there had been approximately 22 to 23 tāngata whai ora in the Unit[12] between April and November 2024. Unit management explained the occupancy had improved with the introduction of 'bed-capping' in the region. The Unit now had a maximum number of tāngata whai ora they could admit. Prior to the bed capping the Unit was accommodating up to 27 to 28 tāngata whai ora. However, Unit management explained that there had been occasions when the de-escalation and seclusion rooms in Te Rangi Marie had been used as bedrooms. This happened when Te Rangi Marie was at capacity and they had to manage an additional	**I recommend that Unit management ensure tāngata whai ora are not accommodated in rooms other than those designed and designated as bedrooms.** This is an amended repeat recommendation. **I recommend Health New Zealand work with other relevant agencies to ensure that the Service is able to meet the demand for its services, including providing**

[11] Ministry of Health. 2023. Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992. At page 48.

[12] Excluding tāngata whai ora on leave.

2021 recommendation	Observations	2025 recommendation
	tangata whai ora from the Acute side of the Unit, or when other units in the region were at capacity. Some staff told inspectors that this was not a common occurrence. Tāngata whai ora who spoke with inspectors also said that they had not used these areas for sleeping, or had not heard of these spaces being used as bedrooms. As outlined in the 2021 report, seclusion rooms are inappropriate to use as bedrooms; we are very concerned that this practice continues.	**suitable bedrooms for all admitted tāngata whai ora.** This is a new recommendation.
Leave restrictions are not placed on voluntary clients.	Voluntary tāngata whai ora are under no compulsion to receive treatment, nor to remain in the Unit should they wish to leave. As a consequence, no leave restrictions should be placed on voluntary tāngata whai ora. As discussed above, the Unit had adequate information for voluntary tāngata whai ora about their right to leave the Unit. Despite this information, in practice leave restrictions were being placed on tāngata whai ora. Several staff told inspectors that there were leave restrictions placed on some voluntary tāngata whai ora. Restrictions included the requirement of escort, limited leave or even leave being declined due to identified risk factors. Review of clinical records showed leave restrictions were documented in the clinical records of voluntary tāngata whai ora. While it seems sensible for staff to support tāngata whai ora to understand the consequences of their decision to leave the Unit, any discussion should not impede tāngata whai ora from leaving. We also expect staff to make clear the decision belongs to tāngata whai ora.	**I recommend Unit management ensure leave restrictions are not placed on voluntary tāngata whai ora.** This is a repeat recommendation.

2021 recommendation	Observations	2025 recommendation
	Feedback in response to provisional report Health New Zealand advised that they are developing clearer guidance and documentation to support staff to ensure that voluntary tāngata whai ora are informed of their rights, and that any discussions regarding risk are advisory rather than restrictive. We look forward to viewing the updated guidance and documentation when this is available.	
All relevant staff are up to date with their SPEC training.	It is our expectation that staff are supported and equipped to provide the highest attainable standard of care. The number of staff not up to date with training in best practice for use of restraint was raised in the 2021 report when 38.7 percent of relevant staff were not up to date with their Safe Practice Effective Communication (SPEC) training. Information provided by the Unit showed that of the 37 staff eligible for SPEC training, eight staff were out of date. This data did not include ESOs. As discussed earlier in this report, it is unclear how many ESOs had completed SPEC training. In response to the provisional report, Health New Zealand advised that only three staff were now out of date with SPEC training, and all three had a refresher training booked. Unit management said having more staff had made it easier to get staff into training and *'training has to take priority'*. Inspectors were told that It was much less common for staff to miss training due to very low staff levels. It remains vital that all staff are properly trained on how to restrain tāngata whai ora in the safest, least restrictive and trauma-informed way. Staff practice must be informed by up to date guidance.	**I recommend Unit management ensure all relevant staff, including ESOs, are up to date with their SPEC training as a priority.** This is an amended repeat recommendation**.**

2021 recommendation	Observations	2025 recommendation
The sensory modulation room and its use is better advertised and more accessible to clients.	We expect that a range of psychological, sensory, and other therapeutic interventions are available to promote tāngata whai ora wellbeing and recovery. At the time of inspection the sensory modulation room was routinely locked and was not freely accessible to tāngata whai ora. Unit staff and management advised that tāngata whai ora had to be supervised when using the sensory modulation room due to past property damage. Information about the sensory modulation room was seen by inspectors displayed on the notice board outside the nurses station (in the main communal area) and directly outside the sensory modulation room. Staff said tāngata whai ora were also told about the sensory modulation room during orientation to the Unit on admission. However, staff and tāngata whai ora said the orientation walk around the Unit was not always provided, or at times, provided too early after admission so not all information was remembered by tāngata whai ora. This was confirmed by some tāngata whai ora who told inspectors that they did not know where the sensory modulation room was or when this was available. Other tāngata whai ora appeared not to understand what sensory modulation activities were when asked about the use of the room by inspectors. While information about the sensory modulation room is available in the Unit, from inspectors' interactions with tāngata whai ora it appears that some tāngata whai ora did not have any understanding of the sensory modulation room. We encourage Unit Management to promote the sensory modulation room to tāngata whai ora.	**I recommend Unit management ensure the sensory modulation room and its use is better advertised and more accessible to tāngata whai ora.** This is a repeat recommendation.

2021 recommendation	Observations	2025 recommendation
Client welcome/information packs are provided on admission.	We expect that tāngata whai ora are provided with information in an appropriate language and accessible format as part of a comprehensive induction on admission. Some tāngata whai ora told inspectors they had received the Unit induction pack that included an information booklet and two pamphlets on arrival to the Unit as part of orientation. But some staff and tāngata whai ora said the information could sometimes be provided too early after admission, making it hard for tāngata whai ora to remember it. Inspectors saw the information booklet and pamphlets were freely available in the Acute Ward. However, these were seen stored in the staff base in Te Rangi Marie, which tāngata whai ora could not freely access. We encourage Unit management to explore ways to ensure that all tāngata whai ora, including those in Te Rangi Marie, are aware of the welcome information available, and have access to it throughout their admission. This may include ensuring staff remind tāngata whai ora that information is available, rather than waiting for tāngata whai ora to request it.	**I recommend Unit management ensure welcome/information packs are provided on admission, and available to tāngata whai ora throughout their admission.** This is an amended repeat recommendation.
Information on the complaints process is easily visible and accessible to all clients, including information on the role of the District Inspectors.	We expect that there are accessible avenues for tāngata whai ora to raise concerns and complaints independent of staff. Inspectors saw information was visible in the Unit regarding complaints process and information on the role of the District Inspector. However, when asked some tāngata whai ora were unclear about how to make complaints and/or how to contact the District Inspector.	**I recommend Unit management ensure information about complaint mechanisms, and means to access them, are available to tāngata whai ora in all parts of the Unit, independent of staff.**

2021 recommendation	Observations	2025 recommendation
	While complaint forms were seen to be accessible independently of staff in the Acute Ward, tāngata whai ora in Te Rangi Marie required staff assistance to access complaint forms. There were no complaints boxes seen in the Unit. Staff assistance was required to post complaint forms on behalf of tāngata whai ora.	This is an amended repeat recommendation.
Client consent to treatment forms are completed.	We expect consent to treatment from the relevant party is sought, recorded and adhered to. Tāngata whai ora consent should always be regularly sought even if a refusal may, according to the law, be overridden. Inspectors reviewed files for all 23 tāngata whai ora in the Unit at the time of the inspection and saw only five files had consent forms completed correctly, some forms did not have names and/or signatures of the responsible clinician or nominee. There were also no consent forms on file for six tāngata whai ora. We were also concerned to see that most consent forms were dated either 27 or 28 October 2024 - the weekend before the announced inspection. When asked about consent forms by inspectors, staff had different understandings of when these forms were completed. Some staff said that if a client was under the MHA they were often too unwell initially to complete the form, so they were completed when the tāngata whai ora was well. Another member of staff said that there was an expectation that consent forms are completed, but this was technically not a legal requirement.	**I recommend Unit management ensure that all tāngata whai ora have a signed consent to treatment form retained on their file.** This is an amended repeat recommendation.

2021 recommendation	Observations	2025 recommendation
	The MHA states that after the first month of a Compulsory Treatment Order, written consent to treatment is required (unless specific circumstances are met).[13] It also states that a patient's consent should be obtained wherever practical, even if treatment is authorised under the Act without the patient's consent. A Consent to Treatment form, retained on the files of tāngata whai ora, provides an easily accessible document demonstrating that a consent process has been adhered to.[14] *Feedback in response to provisional report* Health New Zealand advised that they are working across the service to implement a consistent process and standardised documentation for consent to treatment. We look forward to seeing these updated processes and finalised documents.	
Cleanliness and facilities maintenance issues are attended to as a matter of priority.	It is our expectation that the building, facilities and grounds are appropriate for their purpose, and well maintained. The environment promotes the comfort, health, and wellbeing of tāngata whai ora and their enjoyment of daily life. Inspectors observed there were several outstanding maintenance concerns. These included a number of ripped seat covers, graffiti on walls, windows and outdoor tables, broken light sockets, worn furniture, a build-up of dead leaves in outdoor areas and a general degree of uncleanliness. Maintenance records were provided to inspectors subsequent to the inspection for the period 1 January to 30 October 2024. This showed a majority of ad-hoc maintenance was completed. However, a number of requests did not have a completed date, we	**I recommend Unit management ensure the Unit is cleaned and maintenance issues are attended to in a timely manner.** This is an amended repeat recommendation.

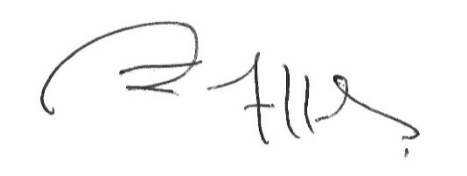
[13] If, after the first month of the order, a tangata whai ora does not consent to treatment, treatment can only be provided where it is considered to be in their best interests by an independent approved psychiatrist.

[14] Consent to treatment must also be regularly reviewed with tāngata whai ora, with these reviews recorded.

2021 recommendation	Observations	2025 recommendation
	could not confirm if this was due to incomplete maintenance or if the date had not been recorded. As discussed earlier in this report, we acknowledge a new build is underway. Despite this, we expect the current Unit to be maintained to improve the living environment on an ongoing basis.	

Acknowledgements

We appreciate the co-operation extended by the Unit Manager and staff to inspectors. We are also grateful to the tāngata whai ora and their whānau, 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

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…*
>
> *(d) a hospital:*

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

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

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

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

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

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

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