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OPCAT report on an unannounced follow up inspection of Pūrehurehu Forensic Acute Mental Health Unit, Rātonga-Rua-O-Porirua, under the Crimes of Torture Act 1989

22 December 2025

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Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT report on an unannounced follow up inspection of Pūrehurehu Forensic Acute Mental Health Unit, Rātonga-Rua-O-Porirua, 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). 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 24 to 26 June 2024, a team of two inspectors, who were delegated authority to carry out visits to places of detention under the Crimes of Torture Act, 1989 (COTA), made an unannounced three-day visit as part of the follow-up inspection to Pūrehurehu Forensic Acute Inpatient Unit (the Unit), Rātonga-Rua-O-Porirua. Inspectors were guided by our Expectations for conditions and treatment of tāngata whai ora[1] in health and disability places of detention.

The inspection was to follow up on the 16 recommendations made following the previous inspection[2] conducted in 2020[3]. Capital & Coast District Health Board (the DHB), who managed the Unit at the time of this inspection, accepted 11, partially accepted one,[4] and rejected four of these recommendations.

Follow up inspections of Rangipapa and Tāwhirimātea at the Rātonga-Rua-O-Porirua campus were also completed during June and July 2024.

During the 2020 inspection, the Unit was under the management of the DHB. DHBs have since been disestablished and replaced by Health New Zealand | Te Whatu Ora (Health New Zealand). In this report, there are references to the DHB, as the responsible governing body at the time. However, new recommendations are made to Health New Zealand, as the responsible agency for the current inspection.

Inspectors gathered and assessed a range of information, including reviewing documents, interviewing a number of people, and observing facility activities. Before leaving the Unit,

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1 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 'patient' was used to reflect the language used at the Unit at the time.

2 Office of the Ombudsman. *Report on an unannounced inspection of Pūrehurehu Forensic Acute Mental Health Unit, Rātonga-Rua-O-Porirua Campus, under the Crimes of Torture Act 1989.* 2021. Available online at https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-purehurehu-forensic-acute-mental-health-unit-ratonga-rua-o

3 Findings and recommendations from this inspection were published in 2021.

4 It is our usual practice to ask facilities and agencies if they accept the recommendations made in OPCAT reports. In the past, some indicated only partial acceptance. We now ask that recommendations be either accepted or rejected in full.

inspectors met with Unit management and some senior Service management to outline their initial observations.

Consultation

Our provisional report was sent to Health New Zealand and the Facility for comment. We received a response from Health New Zealand, Central region, and have considered this feedback when preparing the final report.

Facility facts

The Unit is located on the Rātonga-Rua-O-Porirua campus in Porirua, north of Wellington. It accommodates tāngata whai ora admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) or the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act).

Services were provided by Te Korowai Whāriki - Central Regional Forensic Adult Inpatient Mental Health Service (the Service) under the umbrella of Health New Zealand. According to their website:

> *[Tāngata whai ora] are either referred from the courts for assessment and/or treatment as part of the judicial process, or they are admitted from prison for psychiatric care and treatment.*

The Unit consisted of two wings: the Rehabilitation Wing (Aronui Wing) and the Tānerore Wing, which provides intensive psychiatric care for tāngata whai ora with more acute needs.

The Unit was funded for 15 beds but had 19 physical beds available at the time of this inspection. On the first day of inspection, there were 20 tāngata whai ora in the Unit. Occupancy data showed that it was routine for the Unit to accommodate around this number of tāngata whai ora, well above the number of beds it was designed and funded for. The average length of stay for tāngata whai ora admitted to the Unit was one year. The longest time a tāngata whai ora had spent on the Unit at the time of the inspection was just over 3 years, and the shortest was 18 days.

Inspection outcome

From this follow up inspection, the Unit has achieved three of the 2021 recommendations. The remaining 13 recommendations were not achieved. This shows a clear lack of progress.

In addition, I consider there are a number of systemic concerns that exist across the three Units inspected on the Rātonga-Rua-O-Porirua Campus. In particular, non-designated bedrooms being used as bedrooms, and restrictive practices (such as environmental restraint and use of blanket restrictions). These practices were, at times, linked to ongoing over-occupancy across the three units, or the design of the facilities.

As a result of the follow up inspection of Pūrehurehu I have made nine repeat recommendations, and five new recommendations.

Recommendations to Health New Zealand

I recommend that Health New Zealand:

- work with other relevant agencies to ensure that Te Korowai Whāriki - Central Regional Forensic Adult Inpatient Mental Health Service is able to meet the demand for their services, including providing suitable bedrooms for all admitted tāngata whai ora. This is a new recommendation.
- upgrade the Aronui Wing. This is an amended repeat recommendation.

Recommendations to Te Korowai Whāriki - Central Regional Forensic Adult Inpatient Mental Health Service

I recommend that Service management:

- ensure tāngata whai ora are not accommodated in rooms other than those designed and designated as bedrooms. This is an amended repeat recommendation.
- cease locking tāngata whai ora in their bedroom during the day unless deemed necessary following individual risk assessment and consideration of alternatives. This is a new recommendation.
- ensure decisions to restrict tāngata whai ora to their bedrooms overnight are based on an individualised risk assessment which demonstrates that there are exceptional circumstances requiring the use of this restriction. This is an amended repeat recommendation.
- ensure tāngata whai ora are able to access the bathroom independently of staff, unless deemed unsafe based on an individual risk assessment. If tāngata whai ora are not able to access to the bathroom independently, the reasons are recorded and regularly reviewed. This is a repeat recommendation.
- ensure reportable event documentation is completed in full. This is a repeat recommendation.
- ensure all relevant staff members maintain current Safe Practice Effective Communication (SPEC) certification. This is an amended repeat recommendation.
- make sure complaint mechanisms are available and accessible to tāngata whai ora independent of staff, and that tāngata whai ora are aware of how to access these. This is an amended repeat recommendation.
- provide seating, shelter, and shade in the Tānerore courtyards. This is an amended repeat recommendation.

- ensure all tāngata whai ora can freely access drinking water and hot drinks, unless deemed unsafe following individualised, regularly reviewed, risk assessment. This is an amended repeat recommendation.
- ensure tāngata whai ora are not subject to greater restrictions than individually necessary based on risk assessment.
- ensure all practices meeting the definition of environmental restraint are recorded and reported as such. This is a new recommendation.
- make social worker services available to all tāngata whai ora in the unit. This is a new recommendation.

2024 Follow Up Inspection

2021 recommendations achieved

2021 recommendation	Observations
Medical assessment or advice is obtained in a timely manner following any reportable event where there is potential harm to the patient.	The 2021 recommendation was based on a particular restraint event where there was an apparent failure to get immediate medical assessment after a tangata whai ora had sustained a potential injury. Inspectors reviewed data for reportable events for the six months prior to inspection. The data contained information on the physical and mental health assessments carried out post-event. For the events reviewed, there was no evidence of any failures or delays in obtaining this assessment. This aligned with comments from staff about their approach following a reportable event. However, I repeat a recommendation regarding incomplete reportable event documentation, which is outlined in more detail below.
Medical assessment or advice is obtained in a timely manner following medication errors where there is potential harm to the patient.	The 2021 report outlined Unit staff had struggled to contact the on-call Psychiatric Registrar when a medical error led to a tangata whai ora receiving double their prescribed dose of medication. It also appeared that the inability to obtain medical advice following this event had not been considered during the review into the incident. During the current inspection, the documentation reviewed by inspectors indicated that medical assessment and advice had been obtained in a timely manner following all reported medication errors.
Responses to complaints are personalised, and provided within the DHB policy's timeframe.	Records showed three complaints were made regarding the Unit between 1 December 2023 and 31 May 2024. Inspectors reviewed responses to these complaints and saw that they were personalised and timely. We note that, in two instances, the precise date on which the complaint was received was not clear, as the response referenced a different 'date received' than the date marked on the original complaint. We suggest complaints are stamped with the date they are received so that the time taken to address complaints can be more easily verified.

2021 recommendations not achieved

2021 recommendation	Observations	2025 recommendation
The seclusion room is never used as a bedroom.	We expect tāngata whai ora to be provided with a dedicated and comfortable place to sleep, securely store their belongings, and relax in privacy. Tāngata whai ora must be accommodated in designated bedrooms that meet all their health requirements, including adequate floor space, appropriate lighting, temperature, and ventilation/fresh air. The Unit was funded for 15 beds. Data provided at the time of inspection showed there had been approximately 20 tāngata whai ora in the Unit (130% capacity)[5] for the last six months. Reports from the Director Area Mental Health Services (DAHMS) to the Ministry of Health raised this as an ongoing problem for the Unit. At the time of inspection, one tangata whai ora was being accommodated in a seclusion room as no bedrooms were available. Staff stated that, due to capacity pressures, it was common for tāngata whai ora to be accommodated in the seclusion room. In response to the provisional report Health New Zealand acknowledged that *'tāngata whai ora should be accommodated in rooms that are specifically designed and designated as bedrooms'*. Health New Zealand highlighted the *'current crisis-level shortage'* of secure forensic inpatient beds nationwide, attributing this to high demand and the legal obligation to admit individuals from court, with little or no increase in resources to meet demand. Health New Zealand stated they regularly report on, and	**I recommend that the Service 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 Te Korowai Whāriki - Central Regional Forensic Adult Inpatient Mental Health Service is able to meet the demand for their services, including providing suitable bedrooms for all admitted tāngata whai ora.** This is a new recommendation.

[5] Thirteen tāngata whai ora were accommodated in the Aronui Wing and seven in the Tānerore Wing.

2021 recommendation	Observations	2025 recommendation
	escalate, these issues both within Health New Zealand and to the Minister of Health. The practice of accommodating tāngata whai ora in seclusion rooms, despite them not being subject to seclusion, has the potential to cause significant psychological harm, and to compromise tāngata whai ora dignity and wellbeing. Seclusion rooms are inappropriate for use as bedrooms; We are very concerned that this practice continues.	
If a patient is placed in a room or area, for any duration and at any time, from which they cannot freely exit, it is recorded as seclusion.	We expect that in the serious event that practices amounting to seclusion are used, it is only for the immediate safety of tāngata whai ora or others, as a last resort and ends at the earliest opportunity. We identified in the 2021 report that staff regularly locked tāngata whai ora in their bedrooms if they chose to spend time in them during the days or evenings. Tāngata whai ora could alert staff using a call bell if they wanted to leave their bedroom, but they could not freely exit. We were concerned that although this practice met the definition of seclusion,[6] it was not being recorded, or reported on as such. During the 2024 inspection, it was apparent that this practice had not changed. Tāngata whai ora were still routinely locked in their bedrooms and needed to call staff to be let out. This was confirmed by both tāngata whai ora and staff. Staff said that this practice continued due to Unit design, and the ongoing issue of overcapacity, which made it impractical and unsafe to have the doors unlocked.	**I recommend the Service cease locking tāngata whai ora in their bedroom during the day unless deemed necessary following individual risk assessment and consideration of alternatives.** This is a new recommendation**.**

[6] Seclusion, as defined in the Ngā Paerewa Health and Disability Standards, is *'a type of restraint where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.'*

2021 recommendation	Observations	2025 recommendation
	Additionally, these instances were still not being recorded in the Unit's seclusion or restraint registers. Staff told inspectors that there was a focus on restraint minimisation including environmental restraint. There were regular restraint minimisation meetings held at the Unit, but there was 'still a way to go'. When services use highly restrictive practices such as these, it is vital that they have robust recording and reporting processes.[7] There must also be sufficient oversight of their use to ensure safety and security are preserved with no more restriction placed on individuals than is allowed for by the principles of legality, necessity, proportionality, accountability and non-discrimination. Since our last visit, Health New Zealand advised that, '*swipe card access has been installed in the building which means that all tāngata whaiora in Aronui now have free access in and out of their room during the day'.* We look forward to seeing this improvement during our next visit.	
My predecessor made four recommendations in relation to the former restrictive practice known as Night Safety Procedures (NSP). I have assessed	Night Safety Procedures was the name given to the practice of locking tāngata whai ora in their bedrooms overnight for safety reasons. Having recognised that this was a restrictive practice which constituted a use of force, the Ministry of Health issued a transitional guideline in 2018 which required that all mental health services eliminate their use by 30 December 2022.[8]	**I recommend the Service ensure decisions to restrict tāngata whai ora to their bedrooms overnight are based on an individualised risk assessment**

[7] We expect every seclusion incident to be individually authorised, documented and comprehensively reviewed. Any instance of seclusion, and the reason for its use, should be reported to the relevant authorities.

[8] *Night Safety Procedures: Transitional Guideline*. 2018. Wellington: Ministry of Health. https://www.health.govt.nz/publications/night-safety-procedures-transitional-guideline

2021 recommendation	Observations	2025 recommendation
the Unit's progress in addressing these collectively. • The use of NSPs be recorded and reported as seclusion events. • Consent for NSPs is obtained and documented each time they are used. If consent is not obtained the rationale for this is clearly documented and regularly reviewed. • The use of NSPs is based on individual risk assessments and night safety plans are current and fully completed. • Patients subject to night safety procedures NSPs are made aware of their entitlement to leave their rooms during the night upon request, and this is	During the current inspection, the Unit was no longer calling this practice Night Safety Procedures. However, tāngata whai ora were still routinely locked in their bedrooms between 10.30pm and 7.30am. In most cases, individual risk assessments were not occurring. Inspectors were told by staff two tāngata whai ora with mobility impairments would not be locked overnight. However, aside from this, all other tāngata whai ora were included in the blanket approach to overnight bedroom locking. Overnight locking of bedrooms was now being recorded and reported as environmental restraint, consistent with new Ministry of Health guidelines on restraint and seclusion issued in 2023.[9] However, those guidelines also state that overnight locking of bedrooms should be carried out only *'on the basis of an individual assessment and when no other safe and effective intervention is possible.'* A requirement for individualised assessment was also recommended in the 2021 report. We consider it vital that tāngata whai ora understand they are able to leave their room on request. It appeared that tāngata whai ora and staff were not aware of this entitlement at the time of inspection. For example, tāngata whai ora said the only reason the bedroom doors were unlocked was on request to use the bathroom (in bedrooms without ensuites). In response to the 2021 report, the Unit said they were aiming to reduce/ eliminate locking bedrooms overnight once they had made technological	**which demonstrates that there are exceptional circumstances requiring the use of this restriction.** This is an amended repeat recommendation.

[9] Section 7.2.3 of the *Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. 2023. Wellington: Ministry of Health. Available online at https://www.health.govt.nz/publications/guidelines-for-reducing-and-eliminating-seclusion-and-restraint-under-the-mental-health-compulsory

2021 recommendation	Observations	2025 recommendation
documented.	improvements. Inspectors were told at the time of inspection that the Unit was continuing to make changes to the Unit's infrastructure that would enable changes to practice. Health New Zealand, advised that since our last visit '*individualised risk assessments are undertaken daily to determine whether or not overnight environmental restraint in relation to a tangata whaiora is required'.* This has led to individualised decision-making about the use of overnight environmental restraint for tāngata whai ora in Aronui. However, this approach has not yet been adopted in Tānerore where blanket restrictions still apply. We consider a bedroom door should only be locked overnight in exceptional circumstances. As the Ministry of Health's Guidelines state *'It should not occur as part of a routine admission or … be used as a replacement for adequate levels of staff or resources. A "blanket" policy of locking bedroom doors overnight in forensic units is unacceptable.'* While we acknowledge Health New Zealand is actively working towards individualised consideration of environmental restraint in Tānerore, it is disappointing that blanket overnight environmental restraint is still currently practiced.	
Patients are able to access the bathroom independently of staff, unless deemed unsafe based on an individual risk assessment. If a patient is not able to access to the bathroom independently, the	We highlighted concerns in the 2021 report that tāngata whai ora in the three Tānerore bedrooms or in seclusion did not have independent access to bathroom facilities. One tangata whai ora had been given a cardboard receptacle to use when toileting, which was of particular concern as they would have been visible through the observation panel in the room's door. This was considered a serious risk to tāngata whai ora privacy and dignity, and could amount to degrading treatment and a breach of Article 16 of the Convention against Torture.	**I recommend the Service ensure tāngata whai ora are able to access the bathroom independently of staff, unless deemed unsafe based on an individual risk assessment. If tāngata whai ora are not able to**

2021 recommendation	Observations	2025 recommendation
reasons are recorded and regularly reviewed.	At the time of inspection, staff said tāngata whai ora in these rooms could ask to use the bathroom. However, if it was deemed too risky to escort them to the bathroom they were provided with a receptacle. The clinical files reviewed by inspectors showed no evidence that staff had undertaken individualised risk assessments regarding bathroom access. As the Ministry of Health guidelines on seclusion and restraint section 8.4 state, *'The use of cardboard receptacles for toileting is degrading and should be avoided wherever possible'.*[10] Health New Zealand have provided feedback that tāngata whai ora housed in Tānerore '*are able to enter and exit the bathroom freely.'* However, inspectors did not observe this during their visit. Bathroom access is discussed further on page 18, in the context of the shared spaces in the Aronui Wing.	**access to the bathroom independently, the reasons are recorded and regularly reviewed.** This is a repeat recommendation.

[10] Ministry of Health. 2023. *Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Wellington: Ministry of Health*.

Reportable event documentation is fully completed.	The 2021 report highlighted that event documentation for episodes of restraint were of variable quality. Some records contained and analysis of the event and recommendations, while other records contained only minimal information about the event with no evidence of a post-event evaluation, resolution, or outcome. Inspectors reviewed reportable event documentation in relation to 11 restraint events and two seclusion events. Some fields in the documentation were consistently completed. For example, the type of restraint used and alternative strategies employed prior to restraint. The *'action taken to prevent recurrence'* field was also consistently completed. However, the *'post-event evaluation of the use of restraint'* section was consistently incomplete, other than noting that a post-event debrief had occurred through a multi-disciplinary team discussion. This section contained questions such as *'Were observations and monitoring adequate and maintained throughout duration of restraint'*; *'What could the team do differently that could avoid restraint in the future'*; and *'Describe the impact the restraint had on the consumer/patient.'* Additionally, records did not contain a complete list of staff involved in the event. This was contrary to the *Restraint Minimisation Safe Practice Policy* in place at the time of inspection, which stated that names and designations of the people involved must be recorded. Health New Zealand said in feedback provided for the provisional report that they acknowledge the importance of complete incident reports and stated *'…to support this, service management will collaborate with the Quality Coordinator to provide targeted training for staff…'* We will continue to monitor this during future visits.	**I recommend the Service ensure reportable event documentation is completed in full.** This is a repeat recommendation.

2021 recommendation	Observations	2025 recommendation
All relevant staff are up-to-date with their Safe Practice Effective Communication (SPEC) training.[11]	At the time of the previous inspection, only 79 percent of relevant staff members were up to date with SPEC training. Based on the information provided by Unit management, this appeared to have improved somewhat since the previous inspection. Unit management were actively tracking the currency of staff members' SPEC training and scheduling refresher training for staff who required it. However, there were still two staff members whose SPEC certification was not current, and a further 23 staff members whose certification would lapse before their re-validation training was scheduled to take place.	**I recommend the Service ensure all relevant staff members maintain current Safe Practice Effective Communication (SPEC) certification.** This is an amended repeat recommendation.
Complaint forms are available to patients on the Unit without needing to ask staff.	We expect tāngata whai ora to have accessible ways to raise concerns and complaints independent of staff, and without repercussions or fear of negative consequences. During our visit staff confirmed that complaint forms remained unavailable to tāngata whai ora unless they asked staff for them. Inspectors also spoke to tāngata whai ora who were unaware of how to make complaints independently of staff. Additionally, tāngata whai ora were unable to contact the District	**I recommend the Service make sure complaint mechanisms are available and accessible to tāngata whai ora independent of staff, and that tāngata whai ora are aware of how to access these.** This is an amended repeat recommendation.

[11] SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraint events. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques. See https://www.tepou.co.nz/initiatives/least-restrictive-practice-2/safe-practice-effective-communication for more detail.

2021 recommendation	Observations	2025 recommendation
	Inspectors[12] without staff involvement as staff were required to connect all phone calls. Since our visit Health New Zealand have informed us that complaint forms were available to tāngata whai ora in the library during the inspection, but that clearer signage regarding complaint forms has now been installed. Health New Zealand also stated that tāngata whai ora can also make a complaint by *'talking to kaimahi who will convey the issue to management…'* and that information on how to make a complaint has been added to the Service welcome booklet. While these are positive steps forward, inspectors saw that staff had to provide tāngata whai ora access to the library. Providing complaint forms in a location that tāngata whai ora cannot access independently, does not meet our expectation that tāngata whai ora can raise concerns and complaints independent of staff. Nor does raising concerns directly with staff.	
Patients have access to shade and shelter while using the courtyards in Tānerore.	We expect that tāngata whai ora have access to safe outside spaces which provide fresh air and other benefits of the natural environment to the greatest extent possible. We also expect that the facilities and grounds are appropriate for their purpose and well maintained. Inspectors saw there was no seating and no shade or shelter in the Tānerore courtyards. Staff advised there was shade in different parts of the courtyard	**I recommend the Service provide seating, shelter, and shade in the Tānerore courtyards.** This is an amended repeat recommendation**.**

[12] District Inspectors are lawyers appointed by the Minister of Health to protect the rights of people receiving treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act), or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act). They are independent from the Ministry of Health and from health and disability services. For more information about the roles and responsibilities of District Inspectors, see: https://www.health.govt.nz/regulation-legislation/mental-health-and-addiction/mental-health-act/mental-health-district-inspectors

2021 recommendation	Observations	2025 recommendation
	during the day as the sun moves across the sky. However, there was no sheltered areas.	
Patients are able to access drinking water and hot drinks independently of staff, unless this is considered unsafe based on an individual risk assessment. If a patient is not able to access drinking water or hot drinks independently, the reasons are recorded and regularly reviewed.	We expect that tāngata whai ora are not subject to greater restrictions than are assessed as necessary and proportionate for identified and considered reasons. Blanket restrictions should be avoided in favour of individualised interventions which are subject to discussion and review by all relevant parties. There were water coolers in the Aronui Wing allowing independent access to drinking water; however, there were none in Tānerore. Staff told inspectors this was because a water cooler could be used as a weapon. We are concerned to hear this. All tāngata whai ora should have access to drinking water as a basic human requirement. Health New Zealand have provided feedback stating they agree *'tangata whaiora should be able to freely access water'* and are *'actively considering'* how to safely facilitate this in Tānerore. Tāngata whai ora were given hot drinks from a trolley, several times a day. Senior staff told inspectors that the Unit did not carry out individual risk assessments relating to access to hot drinks, and that the Unit did not have the resourcing to staff the hot water urn constantly. Other staff told inspectors they did not understand the rationale for the 2021 recommendation, with the potential for boiling water to be used as a weapon. While we acknowledge feedback from Senior staff and Health New Zealand that there are practical challenges in facilitating access to drinks (hot or cold) for	**I recommend the Service ensure all tāngata whai ora can freely access drinking water and hot drinks, unless deemed unsafe following individualised, regularly reviewed, risk assessment.** This is an amended repeat recommendation.

2021 recommendation	Observations	2025 recommendation
	tāngata whai ora completely independently of staff, we are not satisfied that Unit management had adequately considered all options which might enable this.	
The Rehabilitation Wing (Aronui) be upgraded.	We expect that tāngata whai ora experience a safe and healthy physical environment, which is fit-for-purpose. The accommodation promotes tāngata whai ora wellbeing, dignity, privacy, and independence. In 2021 we found that the Aronui Wing was outdated, in need of refurbishment, and that its layout was not fit for purpose. Consequently, it was recommended that this part of the Unit be upgraded. No upgrades had occurred since the 2021 report. It was a consistent theme in interviews with staff and Unit management that the Wing still needed major renovations or replacement. The Aronui Wing was tired and dated, the flooring was worn-out and stained, and curtains over bedroom observation windows were in poor condition, thin or missing. Given the curtains were controlled only from the outside of the room, tāngata whai ora did not have any independent control over the privacy of their bedrooms. Since our visit Health New Zealand have advised that the carpet has been replaced in Aronui Wing and new furniture has been added. We note business cases have been submitted to upgrade the layout of Aronui Wing and look forward to seeing the outcome of these.	**I recommend Health New Zealand upgrade the Aronui Wing.** This is an amended repeat recommendation.

2024 new issues

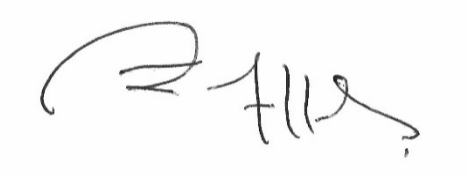
Observations	2025 recommendation
Environmental restriction and restraint We expect that restraint, in all its forms, is recognised as a serious intervention with potentially harmful effects on tāngata whai ora and is only used as a last resort, when strictly necessary for the immediate safety of tāngata whai ora or others. Where restraint is used, it is authorised on a case-by-case basis, documented, reviewed, and followed-up appropriately. During the day, tāngata whai ora could choose whether to be in their bedroom or in shared spaces of the Unit. However, whichever space they were in, the doors were locked, and they were confined in the room. Inspectors observed that, when tāngata whai ora occupied indoor communal spaces during the day (usually the recreation room), the doors were kept locked, preventing them from freely leaving the room. Tāngata whai ora had to ask staff to unlock the door so they could be taken to the bathroom in the main corridor. If there were not sufficient staff ratios at that time, tāngata whai ora had to wait to access the bathroom. Independent access to the bathroom was discussed in detail earlier in the report. Doors to the library were also locked. Because complaints forms were provided in the library, locking of doors also restricted independent access to complaints forms, we discussed this earlier in the report. Some tāngata whai ora told inspectors that they felt 'cooped up' as they were unable to move around freely in the Wing. Management and staff said that this practice had been implemented by Unit management to ensure staff safety following assaults that had occurred in corridor areas. They also advised that it allowed increased engagement between staff and tāngata whai ora. Staff told inspectors that the Wing's design, along with overcapacity issues, made it impractical and unsafe to have a more open environment. These restrictions appeared to apply to all tāngata whai ora in the Wing and were not recorded as environmental restraint. Health New Zealand provided feedback to the provisional report stating they *'acknowledge and support the principle that tāngata whāiora should receive care in the least restrictive environment appropriate to their individual needs'.*	**I recommend the Service management ensure tāngata whai ora are not subject to greater restrictions than individually necessary based on risk assessment**. **I also recommend that Service management ensure all practices meeting the definition of environmental restraint are recorded and reported as such**.

Observations	2025 recommendation
We acknowledge the capacity and resource constraints the Service was operating under, which appear to have impacted its ability to meet this obligation. However, we are disappointed that tāngata whai ora were living with significant, and recently increased, restrictions placed on them, due to design, overcapacity, and staffing issues, that amounted to environmental restraint. It is particularly concerning that tāngata whai ora confined to communal spaces could not independently access the bathroom.	
Access to Social Workers We expect that tāngata whai ora are connected with services that will support their transition out of secure services and back to the wider community at the earliest opportunity. At the time of inspection, the Unit had a Social Worker employed to support tāngata whai ora Māori. The Unit had a 1.0 FTE vacancy for a general Social Worker position to support non-Māori. Ethnicity data provided by the Unit at the time of the inspection showed that nine tāngata whai ora in the Unit were listed as ethnicities other than Māori.[13] Inspectors were told that there had previously been general social workers employed in the Unit, however the Unit had struggled to retain staff in this position. Staff told inspectors that social work is an important aspect of supporting tāngata whai ora to retain community links and transition out of secure services at the earliest opportunity. We are pleased to hear from Health New Zealand that since our visit a new Social Worker had been employed to support tāngata whai ora on the Unit.	**I recommend Service management make social worker services available to all tāngata whai ora in the unit.**

[13] Ethnicity data showed 11 tāngata whai ora were Māori, while the remaining nine were listed as 'Pacific' or 'Other'.

Acknowledgements

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

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