Ombudsman

Fairness for all

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

22 December 2025

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Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT report on an unannounced follow up inspection of Rangipapa Forensic Acute Mental Health Unit, Rātonga-Rua-O-Porirua, under the Crimes of Torture Act 1989
ISBN: 978-1-0672908-5-6 (Digital)
Published September 2026

Office of the Ombudsman | Wellington, New Zealand | www.ombudsman.parliament.nz

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 27 June 2024, a team of two Inspectors, who were delegated to carry out visits to places of detention on behalf of the Chief Ombudsman, made an unannounced four-day visit as part of the follow-up inspection of Rangipapa Forensic Acute Mental Health 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.[2]

The inspection was to follow up on the 15 recommendations made following the previous inspection[3] conducted in 2020.[4] Capital & Coast District Health Board (the DHB) accepted nine of these recommendations, partially accepted three,[5] and rejected the other three.

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

During the previous 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.

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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 'client' was used to reflect the language used at the Unit at the time.

2 OPCAT Expectations Mental Health Services.

3 Office of the Ombudsman. *Report on an unannounced inspection of Rangipapa 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-rangipapa-forensic-acute-mental-health-unit-ratonga-rua-o

4 Findings and recommendations were published in 2021.

5 We ask facilities and agencies if they accept the recommendations, and in the past some indicated partial acceptance. We now ask that recommendations be either accepted or rejected in full.

Inspectors gathered and assessed a range of information. This included reviewing documents, interviewing a number of people, and observing facility activities. Before leaving the Unit, Inspectors met with Unit and some Service management[6] 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 the 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 is funded for 22-beds. It is a medium secure mixed gender facility, providing assessment and treatment. On the first day of the inspection, there were 24 tāngata whai ora in the Unit. Two of these tāngata whai ora were away from the Unit, on leave, during the inspection.[7] The average length of stay on that date was approximately two years and five months. The longest time a tāngata whai ora had spent on the Unit at that time was approximately eight years and eight months and the shortest time was 26 days.

The Unit consisted of two wings: the men's wing (Uenuku), with nine beds, and the women's wing (Aniwaniwa), with four beds. The Safe Care Area (Rangimārie) had two seclusion rooms. At the time of inspection, both seclusion rooms were being used as bedrooms for women tāngata whai ora, due to lack of other available accommodation. The Unit also comprised two self-contained cottages; Pūkeko House with four beds and Sanders House with five beds, which was incorporated into Rangipapa approximately two years ago. The cottages functioned as a rehabilitative step-down facility.

[6] This included the Team Leader for the Unit, the Director of Area Mental Health Services, and the Group Manager, Mental Health, Addiction and Intellectual Disability Service, Health NZ.

[7] Eighteen tāngata whai ora were identified as men, and six as women in Unit records.

Inspection outcome

From this follow up inspection, the Unit has only achieved one of the 2021 recommendations. Two recommendations were achieved in part — not in full. The remaining 12 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 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 Rangipapa I make the following 10 recommendations, eight of which are repeat or amended repeat 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 its services, including providing accommodation in rooms that are designed and designated as bedrooms for all admitted tāngata whai ora. This is a new recommendation.

Recommendations to Health New Zealand and Te Korowai Whāriki– Central Regional Forensic Adult Inpatient Mental Health Service management

I recommend that Health New Zealand and Service management:

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

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

I recommend that Service management:

- make information about complaint mechanisms, and means to access them, available to tāngata whai ora in all parts of the Unit, independent of staff**.** This is an amended repeat recommendation.
- ensure tāngata whai ora are not accommodated in rooms other than those designed and designated as bedrooms. This is an amended repeat recommendation.
- provide a safe well maintained area with seating and shade in the Rangimārie and Aniwaniwa exercise yards. This is an amended repeat recommendation.

- implement a process to ensure electronic systems reflect current and accurate tāngata whai ora information**.** This is an amended repeat recommendation.
- ensure ongoing maintenance issues are addressed, with particular attention to the variation in temperatures across the Unit**.** This is a repeat recommendation.
- ensure tāngata whai ora can access safe outside areas independently of staff**.** This is an amended repeat recommendation**.**
- ensure all instances of environmental restraint are recorded and reported as such. This is a new recommendation.
- ensure all tāngata whai ora can freely access hot drinks as a default, unless deemed unsafe following individualised, regularly reviewed, risk assessment. This is an amended repeat recommendation.

2024 Follow Up Inspection

2021 recommendation achieved

2021 recommendation	Observation
The seclusion room window covered in graffiti be replaced.	The window in the seclusion room had been replaced, and there was no new graffiti observed.

2021 recommendations progressing but not yet achieved

2021 recommendation	Observations	2025 recommendation
Complaint forms are available to clients, independent of staff.	We expect that the rights of tāngata whai ora to access complaints processes are respected and realised. Feedback should be actively sought from tāngata whai ora. Complaints systems must be accessible to tāngata whai ora and others (such as authorised representatives, whānau, and advocates) independent of staff, and be well communicated, culturally safe, confidential, and effective. During the previous inspections complaint information was on display in the main Unit, but complaint forms were not available to tāngata whai ora unless requested from staff. In this examination, complaint forms were freely available to tāngata whai ora in	**I recommend the Service make information about complaint mechanisms, and means to access them, available to tāngata whai ora in all parts of the Unit, independent of staff.** This is an amended repeat recommendation.

2021 recommendation	Observations	2025 recommendation
	the main Unit. However, in the cottages, complaint forms were not freely available, and in one cottage, the District Inspector's[8] details were not on display. Health New Zealand advised in response to the provisional report, that *'Complaint forms are available to tāngata whaiora independent of staff'*. However, inspectors did not observe this during their visit. Health New Zealand also advised that a complaints box will be placed in the communal area of the main unit, and the cottages, for tāngata whai ora to submit complaint forms independently.	
The Unit take urgent action to address the high staff turnover.	We expect that sufficient permanent staff, with the appropriate training and knowledge are employed to ensure the facility is safe, and tāngata whai ora needs are met. At the time of inspection, staff retention appeared stable. From the staff who shared their length of service with inspectors, two had been working on the Unit for between three months and one year; four staff between two and four years; and another four had worked on the Unit between 10 to 15 years. Although staff retention had appeared to improve, inspectors were told by staff that current staffing numbers did not, in reality cover what they needed due to the Unit being continually over-capacity along with current vacancies. The vacancies included enrolled and registered nurses, an occupational therapist, and a psychologist.[9] Unit management said they had difficulty filling these vacancies and recruitment was	**I recommend Health New Zealand and the Service ensure the Unit is adequately staffed and resourced.** This is an amended repeat recommendation.

[8] District Inspectors are lawyers appointed by the Minister of Health to protect the rights of people receiving treatment under the Mental Health Act, 1992 or the IDCCR Act, 2003. 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

[9] 2.9 full-time equivalent FTE Enrolled nurses; 2 FTE registered nurses, an occupational therapist, and a 0.5 (FTE) psychologist. In addition, the locum 0.5 FTE psychologist was coming to the end of their three-month contract on the Unit shortly after the inspection.

2021 recommendation	Observations	2025 recommendation
	ongoing. The Director of Area Mental Health Services (DAMHS)[10] quarterly reports also outlined recruiting for these vacancies as an ongoing challenge. However, the Quarterly Report for January 1 to 31 March 2024 stated that *'recruitment and retention was improving'* and *'vacancy rate was dropping since last year'.* Unit management also raised concerns about staff wellbeing and fatigue, as several staff were working a significant number of additional hours due to the over-capacity of the Unit and vacancies. Staff concerns were also seen in incident reports. While we acknowledge the effort from management to try to ensure adequate staffing, inspectors saw 170 incident reports completed by staff in the past year (between June 2023 and July 2024) in relation to unsafe staffing levels. The DAMHS quarterly reports also outlined the number of reportable events related to staffing in units, including Rangipapa, due to over-capacity and high acuity. In response to the provisional report, Health New Zealand acknowledged the difficulties in filling vacancies and the impact of insufficient staffing in forensic mental health units. To alleviate this, Health New Zealand told us they approve all recruitment requests in forensic mental health units. Health New Zealand also acknowledges that *'day-to-day staffing continues to rely heavily on overtime and contracted personnel. This approach, though necessary to ensure safety, places strain on existing resources and is not sustainable long-term'*.	

[10] DAMHS are highly qualified and experienced mental health professionals who also hold senior roles within a mental health service.

2021 recommendations not achieved

2021 recommendation	Observations	2025 recommendation
My predecessor made four recommendations regarding suitable accommodation. We have assessed the Unit's progress in addressing these collectively. • Seclusion rooms, and other non-designated bedrooms, are never used as bedrooms. • Clients are not kept in seclusion rooms for prolonged periods of time, unless clinically necessary. • Female clients are not admitted into seclusion rooms, unless clinically necessary.	We expect that tāngata whai ora accommodation promotes dignity, and privacy. We also expect that tāngata whai ora have 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 had been continually over occupancy for the six-month period prior to our inspection (Dec 2023 to May 2024), with the average bed occupancy numbers ranging from 118 percent to 130 percent.[11] The Unit had four designated bedrooms for female tāngata whai ora. At the time of this inspection there were six female tāngata whai ora in the Unit. Two tāngata whai ora were being accommodated in rooms not designated as bedrooms, one in a seclusion room, and another in a repurposed office. Staff told inspectors this was to safely accommodate them. Reports from the DAMHS to the Ministry of Health - Manatū Hauora (Ministry of Health) noted repeated capacity issues for women tāngata whai ora resulting in extended stays in repurposed rooms which were not appropriate as bedrooms. In response to the provisional report, Health New Zealand acknowledged *'that tāngata whaiora should be accommodated in rooms that are specifically designed and designated as bedrooms'*.	**I recommend 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 its services, including providing accommodation in rooms that are designed and designated as bedrooms for all admitted tāngata whai ora.**

[11] Percentages calculated including tāngata whai ora admitted to the Unit but on leave.

2021 recommendation	Observations	2025 recommendation
• The use of seclusion rooms without clinical rationale be reviewed, with a particular focus on the equitable treatment of women clients.	As we reported in 2021, male tāngata whai ora were routinely assigned a bedroom on the wing on admission, while female tāngata whai ora were initially accommodated in a seclusion room due to capacity issues. Admission into a seclusion room also meant that female tāngata whai ora first were admitted onto the Unit through the sally port rather than the main entrance, which negatively impacted their experience when arriving at the Unit. It is disappointing that there has been no improvement for accommodating female tāngata whai ora in the Unit. Seclusion rooms are inappropriate for use as bedrooms; we are very concerned that this practice continues. 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 also stated *'We continue to raise and escalate this issue internally within Health New Zealand, and with key stakeholders, including the Ministry of Health, the judiciary, and Ara Poutama New Zealand...'*	This is a new recommendation.

2021 recommendation	Observations	2025 recommendation
My predecessor made two separate recommendations regarding seating and shade. I have assessed the Unit's progress in addressing these collectively. • Seating and shade is provided in the Rangimārie exercise yard. • Shade is provided in the Aniwaniwa exercise yard.	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. As reported in 2021, and was still the case at the time of this inspection, the Rangimārie outdoor area was generally unkempt, there was no shelter or fixed shading and only two plastic chairs were seen in the area. In response to the provisional report, Health New Zealand stated that Rangimārie *'is in fact a sally-port for admissions which at times, is used for exercise. When the sally-port is used, seating is brought out from the unit'*. We appreciate the difficulties of maintaining a dual-purpose space and are happy to hear that portable seating is available to tāngata whai ora when needed. We hope the Unit can find a practical solution to provide shade to tāngata whai ora using Rangimārie for exercise in the future or a suitable alternative exercise yard for these tāngata whai ora. There was also no shelter or fixed shading in the Aniwaniwa courtyard, and furniture consisted of one plastic chair with a worn mattress on top of it. The area appeared in need of upkeep. Since our last visit, Health New Zealand reports that a largely tāngata whai ora led initiative has provided fixed seating and a well maintained garden in Aniwaniwa and that Health New Zealand are currently considering options for shade in this exercise yard.	**I recommend the Service provide a safe well maintained area with seating and shade in the Rangimārie and Aniwaniwa exercise yards.** This is an amended repeat recommendation.

2021 recommendation	Observations	2025 recommendation
My predecessor made two separate recommendations in relation to the restrictive practice formerly referred to as Night Safety Orders. I have assessed the Unit's progress in addressing these collectively. • The use of Night Safety Orders be recorded and reported as seclusion events. • The Service take all necessary steps to ensure comprehensive and accurate collection and reporting on the use of Night Safety Orders.	Night Safety Procedures was the name formerly given to the practice of locking a tāngata whai ora in their bedroom 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.[12] We are pleased to see that since the 2021 report most tāngata whai ora now had swipe cards to open their bedroom doors independently. However, we are concerned that inspector's review of clinical notes showed four tāngata whai ora had been locked in their bedrooms overnight during the six-month period 1 December 2023 and 31 May 2024. Staff advised these occurrences of locking bedroom doors were due to an incident or for safety reasons. 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.[13] However, clinical reviews of the use of environmental restraint did not always find them to be appropriate. Four incident event reports for another tāngata whai ora included comments from the clinical reviewer that environmental restraint should not have been used based on the lack of clinical indicators. In addition, the clinical reviewer highlighted that the recorded event information miss-stated the level of risk posed by the tāngata whai ora. The	**I recommend the Service 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.

[12] *Night Safety Procedures: Transitional Guideline*. 2018. Wellington: Ministry of Health. Available at Night Safety Procedures: Transitional Guideline | Ministry of Health NZ

[13] Health. *Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. 2023. Wellington: Ministry of Health. Available 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
	comment included that the rationale for the restraint may have been for keeping the tāngata whai ora away from another tāngata whai ora. [Content removed for privacy reasons] We believe bedroom doors should only be locked overnight in exceptional circumstances and where there is work underway to minimise this practice.	
Complete and correct documentation is kept in respect of all client records.	We expect all appropriate documentation is obtained and held securely. Inspectors were told that tāngata whai ora records were filed between electronic and hard copy filing systems. Staff said that the electronic system did not allow for documents to be scanned which resulted in some information being saved in hard copy files or in a second electronic system, resulting in three different systems being used to manage records. Inspectors reviewed tāngata whai ora records and observed that hard copy records were disorganised, some forms were incomplete, and documents were difficult to find. For example, consent for treatment forms were filed but not completed for all tāngata whai ora.[14] In addition, the original detention order for one tangata whai ora could not be found at the time of inspection. Inspectors were provided with a copy of the detention order one week after the inspection.	**I recommend the Service implement a process to ensure electronic systems reflect current and accurate tāngata whai ora information.** This is an amended repeat recommendation.

[14] While tāngata whai ora in the Unit were not there voluntarily, it is standard to seek consent to treatment wherever possible. Where a tāngata whai ora does not consent to treatment, this should be recorded on their file and in clinical notes.

2021 recommendation	Observations	2025 recommendation
	Health New Zealand provided feedback that the Unit is working to implement *'a clear and consistent process for managing hard copy files'* and that a project is underway to transition hard copy files to electronic health records.	
Ongoing maintenance issues are addressed (with particular attention to the variation in temperatures across the Unit).	We expect that tāngata whai ora experience a safe and healthy physical environment, which is fit-for-purpose. Space, ventilation, temperature, lighting, utilities and fixtures are all conducive to this and are well maintained. Inspectors observed several areas of the Unit had not been maintained or cleaned effectively. This included rusted roof vents, mould on the Sally port glass roof, broken towel rails, as well as mould in the shower and on the shower curtain in the Pūkeko House. There was also a broken towel rail, a mouldy shower curtain, and a broken and mouldy bathroom cabinet in the Saunders House. At the time of inspection there was a considerable variation in temperatures across the Unit. Inspectors noticed the Uenuku Wing was often colder than the rest of the Unit. Tāngata whai ora in the Uenuku Wing told inspectors that even though they had been provided with additional blankets they still '*froze*' during the nights. Inspectors were told by several staff that there was an ongoing issue with the Unit's air conditioning system. There have been continuous requests to contractors to repair the system, however, contractors had said that the system needed replacing. Inspectors met with a member of the management team to raise their concerns about the variation in temperature across the Unit and to establish what was being done to address or mitigate the problem. Inspectors were informed later the same day that an emergency order to purchase heaters and blankets was approved and items had been received and distributed to tāngata whai ora in the Uenuku Wing.	**I recommend the Service ensure ongoing maintenance issues are addressed, with particular attention to the variation in temperatures across the Unit.** This is a repeat recommendation.

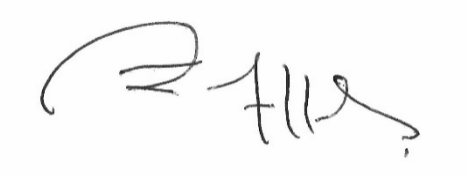
2021 recommendation	Observations	2025 recommendation
	In response to the provisional report, Health New Zealand stated *'temperature variations will always occur and maintenance issues are addressed as they arise. Sometimes the issue is not so much a maintenance issue but different opinions among tāngata whaiora as to what constitutes a comfortable temperature throughout the different parts of the unit'*. Health New Zealand's feedback is not consistent with what inspectors heard from staff and tāngata whai ora during the visit and is at odds with approval of an emergency order to purchase heaters and blankets. This view also contradicts advice from independent contractors that the air conditioning system needs replacing. It is concerning that Health New Zealand does not appear to be taking this issue seriously.	
All clients have unrestricted access to courtyards during the day, unless deemed inappropriate for individual clients on a clinical or safety basis.	We expect tāngata whai ora have access to safe outside areas without restriction and are supported to do so as desired. The Unit had three courtyards, doors to access these were locked throughout the inspection. When asked by inspectors, tāngata whai ora and staff said that access to the courtyards was dependent on staff supervision. This practice appeared to be consistent with the *MHAIDS Te Korowai-Whāriki Courtyard use* procedure which states *'Tāngata whai ora only have access to the courtyard for recreation and therapy under the direct supervision of staff. Access to the courtyard is generally in the form of group time with appropriate staff ratios to maintain the safety of all.'* We agree that staff supervision for safety reasons is crucial. However, tāngata whai ora should still be able to access a safe courtyard independently of staff when appropriate. For example, at the time of inspection there were six tāngata whai ora with unescorted leave approved. The procedure and practice for accessing the courtyards did not appear to take unescorted leave into consideration.	**I recommend the Service ensure tāngata whai ora can access safe outside areas independently of staff.** This is an amended repeat recommendation. **I also recommend the Service ensure all instances of environmental restraint are recorded and reported as such.** This is a new recommendation.

2021 recommendation	Observations	2025 recommendation
	Independent access to the courtyard is an opportunity to increase and encourage the autonomy of tāngata whai ora. In response to the provisional report, Health New Zealand provided feedback that '*In the interest of managing risk, courtyard is granted on individual terms. Some tāngata whaiora have unrestricted unsupervised access to the courtyards which is based on assessment of their risk…'* This is not consistent with the *MHAIDS Te Korowai-Whāriki Courtyard use* procedure, what staff told inspectors during the visit, or what inspectors observed while at the Unit. Staff also told inspectors that the upkeep of the courtyard was poor and there were potential safety risks in the courtyard, for example a hose. Inspectors saw that the courtyards were not well maintained and there were hazards, such as visible moss and algae, drain covers that were covered with leaves, and broken chairs. We are pleased to hear Health New Zealand's report of a large decrease in the number of environmental restraints in the Unit (13 in the 6 months ending in July 2025 compared to 23 recorded in the 6-month period reviewed as part of the OPCAT inspection). However, we are concerned that the locked doors to courtyards was not being recorded or reported as environmental restraint. We expect that restraint is authorised, documented, followed-up appropriately, and reported to the appropriate authority.	
Clients are able to freely access hot drinks, unless deemed unsafe based on individual risk assessment.	We expect that tāngata whai ora are not subject to greater restrictions than are assessed as necessary and proportionate for identified and considered reasons. Some tāngata whai ora and staff told inspectors they could only access hot drinks at four allocated times (around breakfast, morning tea, afternoon tea, and dinner). Whereas other staff and tāngata whai ora said that staff were accommodating if	**I recommend the Service ensure all tāngata whai ora can freely access hot drinks as a default, unless deemed unsafe following individualised,**

2021 recommendation	Observations	2025 recommendation
	tāngata whai ora asked for hot drinks outside of these times but tāngata whai ora could not independently access hot drinks. However, tāngata whai ora in the cottages could make hot drinks at any time without staff involvement. A staff member said there was one rule for all tāngata whai ora in the Unit regarding access to hot drinks. This was due to the mixed cohort who were at various stages of wellness and free access to hot drinks could be dangerous. We consider blanket restrictions should be avoided in preference to individualised interventions which are subject to discussion and review by all relevant parties. Health New Zealand reported *'Due to the design/layout of the kitchen and this being a medium-secure unit, access to the kitchen is only possible with staff supervision. It is a safety risk for tāngata whai ora to be able to freely access elements to boil water/urns with boiling water as the risk of injury is too high…'* While we acknowledge the practical challenges in tāngata whai ora independently accessing hot drinks, we are not satisfied the Service had adequately explored all options available to enable this.	**regularly reviewed, risk assessment.** This is an amended repeat recommendation.

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 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 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