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OPCAT Report on an unannounced follow up inspection of Tāwhirimātea Rehabilitation 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 Tāwhirimātea Rehabilitation 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),[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

On 24 June, and from 1 to 3 July 2024,[2] 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 Tāwhirimātea Inpatient Unit (the Unit), Rātonga-Rua-O-Porirua, an acute inpatient mental health unit. Inspectors were guided by our Expectations for conditions and treatment of tāngata whai ora[3] in health and disability places of detention.

The inspection was to follow up on the 11 recommendations made in the 2021 report [4] following the previous inspection conducted in 2020. Capital & Coast District Health Board (the DHB) accepted 10 of these recommendations and rejected one.[5]

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

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 management and some members of the Regional Rehabilitation and Extended Care Inpatient Service's management to outline their initial observations.

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1 More information about the United Nations Optional Protocol to the Convention against Torture ('OPCAT') and 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 On 24 June 2024, it was apparent to inspectors that certain Unit obligations would not reflect the everyday operation of the facility. For this reason, the inspection was paused, and continued from 1 to 3 July 2024.

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

4 Found at: https://www.ombudsman.parliament.nz/resources/report-unannounced-inspection-tawhirimatea-rehabilitation-unit-ratonga-rua-o-porirua

5 At the time of 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.

We have also actively engaged with Management of Regional Forensic and Rehabilitation Inpatient Services regarding concerns identified at the time of the inspection about the care and long-term placement of a tangata whai ora. A letter was sent on 23 January 2025 outlining these concerns. A response was received on 28 February 2025 that provided further information about the situation and outlined some improvements the Service was making. However, we were not assured that there had been significant change to the treatment and conditions for this tangata whai ora. As a result, two inspectors returned to the Unit on 23 June 2025 to conduct an unannounced visit to view what effect the changes had made and relevant observations are included in this report.

Facility facts

The Unit is a specialised inpatient service that focuses on recovery and extended rehabilitation for tāngata whai ora who need a high level of support. It is located on the Rātonga-Rua-O-Porirua campus, north of Wellington.

The Unit is funded for 29 beds; 23 for men and six for women in separate wings. The de-escalation area (Te Whare Watea) has three rooms: two used for de-escalation and one used for seclusion.

On the first day of the inspection, there were 29 tāngata whai ora in the Unit, and occupancy data showed that there were routinely 28 or 29 tāngata whai ora in the Unit. The average length of stay was approximately 4 years and 8 months. The longest time a tāngata whai ora had spent on the Unit at that time was over 13 years and the shortest was six days.

Services were provided by Te Korowai Whāriki - Regional Rehabilitation and Extended Care Inpatient Service management[6] (the Service) under the umbrella of Health New Zealand | Te Whatu Ora Mental Health, Addiction and Intellectual Disability Service (MHAIDS).[7] Tāngata whai ora were referred to the Unit from forensic inpatient units in central New Zealand, and from mental health services in the following regions: Capital, Coast, Hutt Valley, and Wairarapa; Hawke's Bay; Midcentral; Nelson Marlborough; and Tairāwhiti.[8] All were admitted under either the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Criminal Procedure (Mentally Impaired Persons) Act 2003.

6 This includes Tāwhirimātea for recovery and extended rehabilitation, and Tāne Mahuta for intensive rehabilitation. See https://www.mhaids.health.nz/our-services/regional-forensic-and-rehabilitation-services/regional-rehabilitation-and-extended-care/ for more information.

7 MHAIDS stands for Mental Health and Addiction Intellectual Disability Service. See https://www.mhaids.health.nz/our-services/regional-forensic-and-rehabilitation-services/ for more information.

8 See https://www.mhaids.health.nz/our-services/regional-forensic-and-rehabilitation-services/regional-rehabilitation-and-extended-care/

Inspection outcome

From this follow up inspection, two of the 2021 recommendations were achieved in part, but not in full. The remaining nine recommendations were not achieved. This shows a clear lack of progress.

This examination also revealed new issues at the Unit, two of which I consider are serious enough that new recommendations are required. The specific conditions and treatment experienced by one tangata whai ora (Client A) were of particular concern. As outlined above, in addition to making a recommendation in relation to this, there has been ongoing dialogue with the Service regarding these concerns, outside this report.

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 Tāwhirimātea, I make the following 13 recommendations, nine of which are repeat recommendations.

Recommendations to Health New Zealand

I recommend that Health New Zealand:

- work with other relevant agencies to ensure that Te Korowai Whāriki - Regional Rehabilitation and Extended Care Inpatient 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.
- engage with the Ministry of Health to develop and provide a care environment appropriate for the treatment needs of Client A[9]. This is a new recommendation.

Recommendations to Te Korowai Whāriki - Regional Rehabilitation and Extended Care Inpatient Service management

I recommend that Service management:

- display information about the use and availability of the sensory room in the women's wing. This is an amended repeat recommendation.
- make information about complaint mechanisms, and means to access them, available to tāngata whai ora in all parts of the Unit, including the de-escalation area, independent of staff. This is an amended repeat recommendation.

[9] For more information on the treatment and conditions of Client A, see section on *'Appropriate long-term treatment and accommodation'*.

- ensure tāngata whai ora are not accommodated in rooms that lack adequate privacy, access to fresh air, or sufficient storage. This is an amended repeat recommendation.
- ensure all staff that may be involved in restraining tāngata whai ora are up to date with their SPEC training. This is a repeat recommendation.
- provide training and information on the operation of the 'Possession and Use of Alcohol or Other Prohibited Substances' procedure for staff and tāngata whai ora. This is an amended repeat recommendation.
- ensure tāngata whai ora consent to treatment is obtained and consent forms are completed on admission and any other time consent is sought. Consent is consistently recorded and any refusal of consent is also recorded in their files. This is a repeat recommendation.
- make the women's outdoor courtyard safe and secure to allow tāngata whai ora to access the outside area 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.
- ensure tāngata whai ora can access a telephone independent of staff, unless deemed unsafe based on individual risk assessment. This is a repeat recommendation.
- ensure detaining paperwork is present, up-to-date, and easily accessible on all tāngata whai ora files, whether paper-based or electronic. This is a new recommendation.

2024 Follow Up Inspection

2021 recommendations progressing but not yet achieved

2021 recommendation	Observations	2025 recommendation
Both sensory modulation rooms are operational, advertised, and available to clients throughout the day.	We expect tāngata whai ora to be offered therapeutic interventions, such as psychological, sensory, occupational, and speech-language services, to promote their wellbeing and recovery. Tāngata whai ora should be able to physically access these facilities, and signage and information should be presented in languages, formats, and locations suited to their needs. The Unit previously had three sensory modulation rooms; however, at the time of inspection, one had been repurposed as a bedroom. There was a sensory modulation room available to tāngata whai ora in each wing. In the men's wing, a notice on the door explained the purpose of the room, and inside that room, rules for its use were posted. However, during the inspection there were no such notices for the sensory modulation room in the women's wing. Inspectors did not see the sensory rooms used during the inspection. Staff advised that the rooms were to be used under staff supervision, following an incident where an item in the room was damaged and used for self-harm. Inspectors were told that nursing and occupational therapy staff could provide this supervision. Inspectors were told by staff that it could be challenging at times to facilitate the use of the sensory room due to staffing availability, particularly in the women's wing, which was routinely staffed by two people at a time. This had made it difficult to devote one person's time to supervising sensory modulation.	**I recommend Service management display information about the use and availability of the sensory room in the women's wing.** This is an amended repeat recommendation**.**

2021 recommendation	Observations	2025 recommendation
	We are pleased to hear from Health New Zealand in response to the provisional report, that *'The female sensory room is now operational, and a notice has been placed on sensory modulation room in the women's wing.'* No detail was provided about what information had been displayed.	
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), and be well communicated, culturally safe, confidential, and effective. Inspectors observed that, in most parts of the Unit, complaint forms were available to tāngata whai ora independent of staff. However, in Te Whare Watea, the de-escalation area, there were no complaint forms available to tāngata whai ora. Nor was any information displayed about complaint processes, District Inspectors' details, or the *Code of Health and Disability Services Consumers' Rights.* This is concerning as one tangata whai ora (Client A) had been accommodated in a de-escalation room in Te Whare Watea for several years.[10] Staff in Te Whare Watea told inspectors that they did not know if the tangata whai ora would know how to make a complaint. Displaying information could mean tāngata whai ora in Te Whare Watea, who were under greater restrictions, are aware of protective measures available to them, and help them understand how to access these supports should they wish to do so.	**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, including the de-escalation area, independent of staff.** This is an amended repeat recommendation.

[10] We discuss this further under 2024 new issues, below.

2021 recommendation	Observations	2025 recommendation
	Inspectors noted during the June 2025 visit that there was still no information in Te Whare Watea about how to make a complaint or method for tāngata whai ora to make a complaint independently of staff. In response to the provisional report Health New Zealand stated that forms would be made *'readily available in various places throughout the unit'*. We hope to see complaint information and forms provided in Te Whare Watea in the future. Health New Zealand also stated that tāngata whai ora can raise concerns verbally with kaimahi and through '*the Advocacy Service or the District Inspectors, who visit the unit regularly.'*	

2021 recommendations not achieved

2021 recommendation	Observations	2025 recommendation
My predecessor made a number of recommendations regarding the Unit's suitable accommodation. I have assessed the Unit's progress in addressing these collectively. • Clients are never accommodated in hallways, sensory modulation rooms, or rooms without natural	We expect that tāngata whai ora accommodation promotes dignity, and privacy. We 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. Inspectors saw that a repurposed sensory modulation room, two interview rooms and the de-escalation room in Te Whare Watea were being used as bedrooms at the time of inspection. Three of these rooms were located in high-traffic areas of the Unit and lacked	**I recommend Service management ensure tāngata whai ora are not accommodated in rooms that lack adequate privacy, access to fresh air, or sufficient storage.** This is an amended repeat recommendation.

2021 recommendation	Observations	2025 recommendation
light or sufficient ventilation. This is an amended repeat recommendation. • Clients' bedrooms have internal privacy blinds installed in the observation panel. • Clients' bedrooms have appropriate storage facilities where clients can store their belongings.	adequate privacy. They did not have internal, and in some cases, privacy blinds.[11] The rooms did not have windows that could be opened to allow in fresh air, and had inappropriate or insufficient storage for personal belongings. In response to the provisional report, Health New Zealand stated that all rooms being used as bedrooms, except the room discussed in the section 'Appropriate treatment and long-term accommodation' now have appropriate storage. Staff said these repurposed rooms were being used as bedrooms due to an inability to decline referrals from the courts and routine over-occupancy of the Unit. Occupancy data provided by the Unit[12] showed consistent occupancy around 100 percent. However, this was calculated on the basis of the Unit holding 28 beds, rather than the 29 beds referred to by Health New Zealand.[13] Even though Unit bed capacity data was based on 28 beds, we are concerned that the rooms converted to bedrooms were being used when the Unit was over-capacity. During the visit in June 2025 the two interview rooms were no longer being used as bedrooms. While we are pleased to hear this, we consider non designated bedrooms are	**I recommend Health New Zealand work with other relevant agencies to ensure that Te Korowai Whāriki - Regional Rehabilitation and Extended Care Inpatient 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.

[11] Both interview rooms lacked internal privacy blinds. One interview room had no privacy curtains on an external window, although there was frosted film applied to part of the window. The repurposed sensory modulation room had an external window facing a car parking area, so curtains had to be drawn at all times for privacy when someone was accommodated there.

[12] Data provided by the Unit showed average midnight bed occupancy (excluding leave) as follows: December 2023, 29.13 or 104%; January 2024, 28.52, or 101.8%; February 2024, 27.24 or 97.3%; March 2024, 27.97 or 99.9%; April 2024 27.8 or 99.3%; May 2024, 28.58 or 102.1%; for an average of 28.22 or 100.8%.

[13] Particularly on the MHAIDS website, which states Tāwhirimātea provides support for *'up to 29 people'*. Health New Zealand | Te Whatu Ora. *Regional Rehabilitation and Extended Care Inpatient Service.* 16 August 2024. Accessed online on 24 January 2025 at https://www.mhaids.health.nz/our-services/regional-forensic-and-rehabilitation-services/regional-rehabilitation-and-extended-care/ we note that in our 2021 report, the Unit was also described as having 29 beds.

2021 recommendation	Observations	2025 recommendation
	not appropriate to use as bedrooms, as they lack adequate natural light, ventilation, appropriate storage, and privacy. In response to the provisional report, Health New Zealand acknowledged a nationwide shortage of secure beds and significant waitlist for forensic step-down beds, which delays transitions for tāngata whai ora and further limits the availability of appropriate placements. Health New Zealand also stated the Unit is working with Kelvin House, Manor Park to aide transition of tāngata whai ora ready to step-down into dementia care, with the aim to free up beds within Tāwhirimātea.	
All relevant staff are up to date with their SPEC training.	We expect that restraint, in all its forms, is recognised as a serious intervention with potentially harmful effects on tāngata whai ora. To maintain a safe environment for everyone, we expect staff to receive appropriate training, and have appropriate skills, to manage potentially harmful events or behaviour. This includes use of de-escalation strategies such as *Safe Practice Effective Communication* (SPEC).[14] Records of training must be kept up to date. At the time of inspection, 42 of 61 relevant staff were up-to-date with SPEC training. Of the 19 staff not current with SPEC training, inspectors were told that 11 staff had been exempted for personal reasons. Four newer staff had not received SPEC training, while another five were overdue for refresher training.	**I recommend Service management ensure all staff that may be involved in restraining tāngata whai ora are up to date with their SPEC training.** This is a repeat recommendation.

[14] 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 information.

2021 recommendation	Observations	2025 recommendation
	Data provided by the Unit showed there were only two restraint events recorded between 1 December 2023 and 31 May 2024. Staff said that when restraint was required, this was carried out by SPEC trained staff.	
The Unit clarifies its policy and procedures for stand-down periods, and shares this information with clients.	During the previous inspection, inspectors heard concerns from tāngata whai ora about 'three day stand-down periods',[15] imposed if they were suspected of using drugs or were late returning from leave. During these stand-down periods tāngata whai ora were prevented from leaving the Unit. In response to the 2021 report, the Service advised that the stand-down procedure was being reviewed. During the current inspection, the Unit provided a copy of the MHAIDS Te Korowai-Whāriki *Possession and Use of Alcohol or Other Prohibited Substances* procedure (the procedure).[16] The procedure provided detail on a 'Period of Assessment and Support' (PAS) which was initiated when substance use was suspected or confirmed. The length of time of a PAS could vary depending on the clinical presentation of the tāngata whai ora, their risk profile and legal status, and once a PAS had been initiated changes to tāngata whai ora leave status and attendance at programmes and activities could be made. While it appeared the PAS practice had been clarified in the procedure, inspectors heard a different understanding of this from tāngata whai ora and staff. Some tāngata whai ora still referred to the PAS as a 'stand-down' and described it as a punishment rather than a support tool. Inspectors saw that the procedure was mentioned in induction material, however this did not provide detail about the PAS.	**I recommend Service management provide training and information on the operation of the 'Possession and Use of Alcohol or Other Prohibited Substances' procedure for staff and tāngata whai ora.** This is an amended repeat recommendation.

[15] Also referred to as a 'Period of Assessment' by tāngata whai ora and staff.

[16] The procedure was dated November 2023 with a review date of November 2026. This procedure applied across the Rātonga-Rua-O-Porirua campus.

2021 recommendation	Observations	2025 recommendation
	In response to the provisional report Health New Zealand stated: *'since the OPCAT Team's visit, training has been provided and accessible information is available on the operation of the "Possession and Use of Alcohol or Other Prohibited Substances" procedure for both staff and tāngata whaiora'*. We look forward to seeing these changes during our next visit.	
Clients' consent to treatment forms are completed on admission and any other time consent is sought, and any refusal of consent is recorded in their files. This is an amended repeat recommendation.	We expect consent to treatment from the relevant party is sought, recorded, and adhered to. Senior staff confirmed with inspectors that this was also their expectation. However, inspectors noted that it was difficult to locate consent to treatment forms for each tāngata whai ora, either in paper form or in electronic files. An internal audit was completed by the Unit, during the time of inspection, in response to inspectors' feedback that they could not find consent to treatment documentation on tāngata whai ora files. The audit identified that most tāngata whai ora had 'consent to treat', although, the audit did not state where this consent was recorded. However, there was no record of consent nor legal obligation to accept compulsory treatment for three tāngata whai ora.[17] In addition, three tāngata whai ora in the Unit at the time of the inspection were not included in this audit. Tāngata whai ora consent should always be regularly sought even if a refusal may, according to the law, be overridden. Where informed consent is not deemed possible, there must be robust processes in place to ensure that any treatment is necessary, appropriate and authorised, and that tāngata whai ora have been involved in decision-making to the fullest extent possible.	**I recommend Service management ensure tāngata whai ora consent to treatment is obtained and consent forms are completed on admission and any other time consent is sought. Consent is consistently recorded and any refusal of consent is also recorded in their files.** This is an amended repeat recommendation.

[17] Under section 59(2)(b) of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

2021 recommendation	Observations	2025 recommendation
	We are very concerned that despite staff understanding the importance of obtaining consent to treatment, the documentation reviewed at the time of inspection did not clearly indicate if consent had been sought for all tāngata whai ora, or if completion of consent forms was not occurring consistently. In response to the provisional report, Health New Zealand stated that staff will be reminded to use a *'consent flag'* in the Digital Client record anytime they have a discussion regarding consent to treatment, therapy, or information sharing. We hope this improves the transparency of tāngata whai ora consent records.	
The Unit erect fencing around the women's outdoor area to enable clients to freely access the courtyard without staff supervision.	We expect tāngata whai ora have access to safe outside areas without restriction, and are supported to access them as desired. Inspectors observed there was no fencing around the small women's outdoor courtyard area. Unit management told inspectors this had not been done due to a lack of funding. Repeat bids for funding, (including some referenced in the2021 OPCAT report) were declined due to other site priorities. Due to the lack of fencing, the door to the outside area was locked, and women tāngata whai ora were not able to access the outdoor area without staff supervision. Staff told inspectors that an additional reason that women tāngata whai ora could not access the outdoor area freely was because one side of the outside area was beside offices and Doctor's rooms. If the windows to these rooms were open, there was the potential for women in the outdoor area to overhear sensitive conversations. Inspectors were told that a larger outdoor space outside of the Unit, known as the 'Village Green' was accessible to women tāngata whai ora, but only to those who had been approved leave.	**I recommend Service management make the women's outdoor courtyard safe and secure to allow tāngata whai ora to access the outside area independently of staff.** This is an amended repeat recommendation. **I also recommend Service management ensure all instances of environmental restraint are recorded and reported as such.** This is a new recommendation.

2021 recommendation	Observations	2025 recommendation
	In addition, I am concerned that the locked door to the women's courtyard area was not being recorded or reported as environmental restraint. It is my expectation that restraint is authorised, documented, and followed-up appropriately, and reported to the appropriate authority. In response to the provisional report Health New Zealand stated that the *'Building Improvement Group has identified this as a high-priority requirement'* and obtained quotes for the work in 2021. However, the work as not progressed because *'other unit renovations and repairs'* have taken priority and a new request for this work has been submitted for the 2025 financial year. We are concerned that despite this 'high-priority' requirement first being identified in 2017, funding has not yet been allocated to ensure that female tāngata whai ora have safe and secure access to the outdoor area.	
Clients can freely access hot drinks, unless deemed unsafe based on individual risk assessment.	This recommendation was rejected by the DHB in 2021, and inspectors heard that staff were still resistant to the idea of giving tāngata whai ora independent access to hot drinks, based on concerns that they would be thrown at staff. It is my expectation 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 preference to individualised interventions which are subject to discussion and review by all relevant parties. A tea trolley providing hot drinks was available at morning and afternoon tea on the men's wing. This was managed by a tangata whai ora, with staff refilling the hot water jug as required. Inspectors were told a staff member should be present at all times. Some staff advised that this system was also in place in the women's wing. However, other staff	**I recommend Service management 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.

2021 recommendation	Observations	2025 recommendation
	said this was not the case. Inspectors observed that all hot drinks were provided by staff on the women's wing during the inspection. Inspectors reviewed clinical notes and found no evidence of individual risk assessments in relation to hot drinks. We understand there can be concerns around risk management; however, we expect these to be managed on an individualised basis, and not by imposing blanket restrictions on a group of tāngata whai ora. Given the rehabilitative focus of the Unit, ongoing review and reconsideration of restrictions, in this case an individual's ability to safely access hot drinks, should be completed to make sure the restrictions remain necessary and proportionate.	
All clients have access to a telephone, independent of staff, 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. Practices such as restricting independent access to phones should be reflected in individual care plans and supported by relevant assessment and evidence. Inspectors saw two phone booths on the Unit, one on the men's wing and one on the women's wing. Inspectors were told that a portable phone was available in Te Whare Watea (the de-escalation area) on request. Staff told inspectors that both phone booths were kept locked as they presented ligature and fire risks; for example, the phone jack access point was previously used to light cigarettes. The booths were unlocked on request; however, the phones in the booths did not have keypads. Staff dialled and connected all calls for tāngata whai ora, including calls to their lawyers, the Health and Disability Commissioner's Office, District Inspectors, and advocacy services.	**I recommend Service management ensure tāngata whai ora can access a telephone independent of staff, unless deemed unsafe based on individual risk assessment.** This is a repeat recommendation.

2021 recommendation	Observations	2025 recommendation
	Some tāngata whai ora had access to their own mobile phones. They paid for cellular services from their own personal money. Access to a mobile phone was individually assessed, with these assessments recorded in tāngata whai ora Comprehensive Plans.[18] Mobile phones had to be returned to staff by 9pm to promote sleep hygiene. We are disappointed to hear that tāngata whai ora who did not have access to their own mobile phone (including those who had no available credit to make outgoing calls) could not access a phone, or dial a number, without staff assistance. While we appreciate that some restrictions may need to be in place regarding phone use for some tāngata whai ora we are not satisfied that Unit Management have explored all available options to support independent phone use where appropriate.	

2024 new issues

Observations	2025 recommendation
Appropriate long-term treatment and accommodation We expect that tāngata whai ora experience treatment and conditions that are conducive to their wellbeing and recovery and are subject to the least restrictive environment possible. As outlined earlier in this report, one tangata whai ora (Client A) had been accommodated in Te Whare Watea for [a considerable period].	**I recommend Health New Zealand engage with the Ministry of Health to develop and provide a care environment appropriate for the treatment needs of Client A.** This is a new recommendation.

[18] Inspectors reviewed 17 Comprehensive Plans and saw that three tāngata whai ora of these 17 had phone plans.

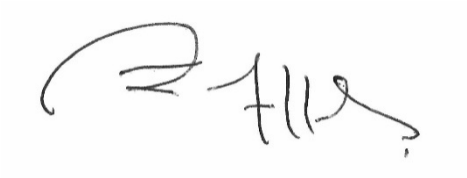
Observations	2025 recommendation
[Redacted for privacy reasons]	

Observations	2025 recommendation
[Redacted for privacy reasons] While we appreciate that there has been an ongoing focus, over several years, to find suitable individual solutions for this tangata whai ora, we expect Health New Zealand and the Ministry of Health to support all efforts made to find suitable accommodation as soon as possible.	
Detaining paperwork As was the case for consent to treatment paperwork, outlined above, inspectors had difficulty locating detaining paperwork for tāngata whai ora, whether in paper-based or electronic form. While senior staff told inspectors this paperwork should be present on all files, inspectors did not find such documentation when carrying out file reviews. When inspectors asked to see examples of detaining paperwork, relevant staff could not easily locate this. It was suggested this may be due to expired orders or orders nearing expiry having been removed from a file to facilitate obtaining updated orders, which themselves may not yet be uploaded. The reasons for tāngata whai ora being in a secure environment must be clear and recorded, with all appropriate documentation obtained and filed securely. All relevant staff should be aware of, and understand, the importance of this processes.	**I recommend Service management ensure detaining paperwork is present, up-to-date, and easily accessible on all tāngata whai ora files, whether paper-based or electronic.** This is a new recommendation.

Observations	2025 recommendation
In response to the provisional report Health New Zealand stated that *'…each tāngata whaiora has a current electronic file and a paper file. All current legal documentation is recorded and accessible on one or both of these files'*. However, this was not what inspectors observed during the visit.	

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 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