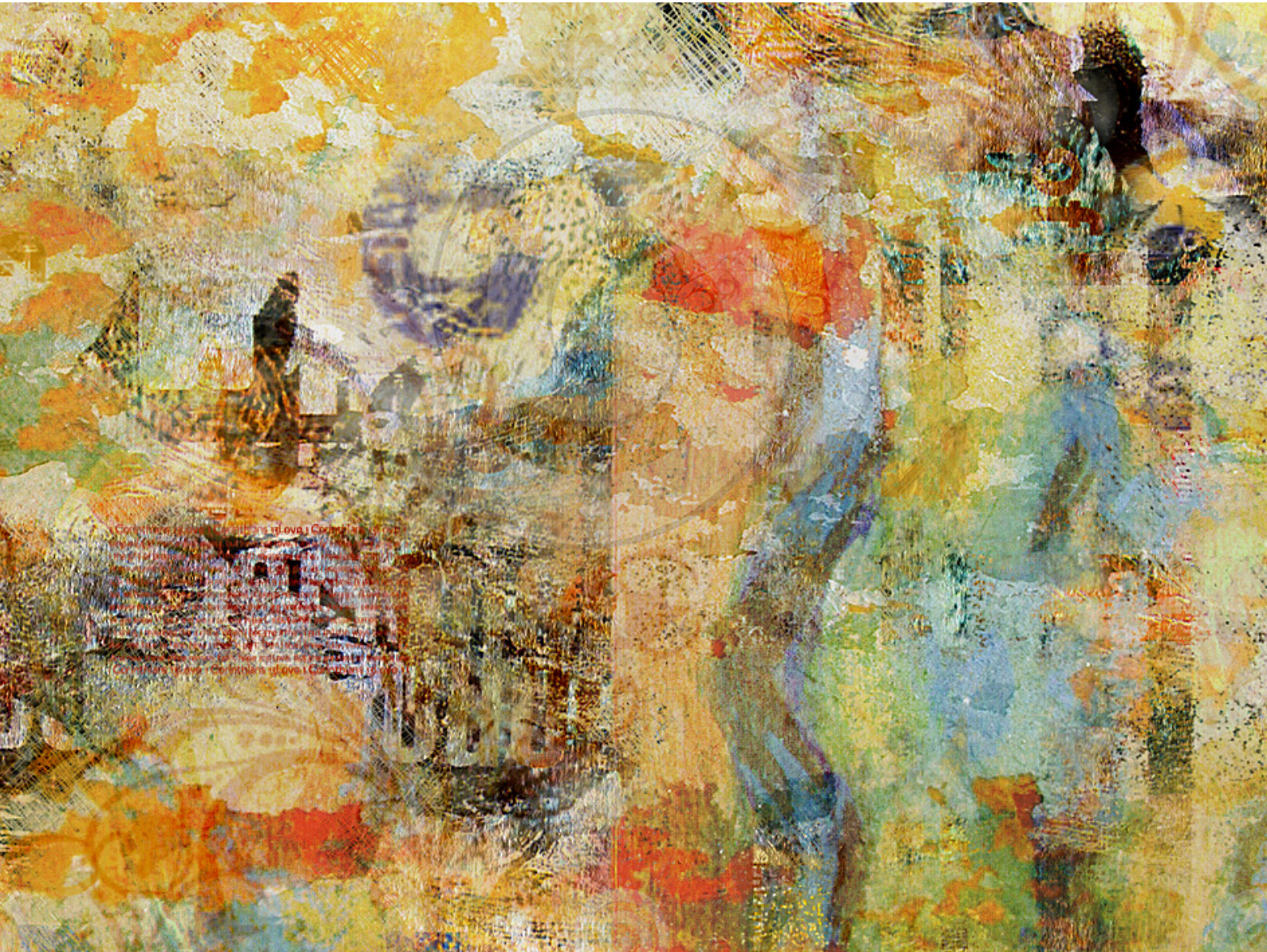


Monitoring Places of Detention

Annual report of activities under the Optional
Protocol to the Convention Against Torture
(OPCAT)

1 July 2011 to 30 June 2012



Contact the Commission

Human Rights Commission InfoLine

0800 496 877 (toll free)

Fax 09 377 3593 (attn: InfoLine)

Email info@hrc.co.nz

TXT 0210 236 4253

www.hrc.co.nz

Language Line and NZ Sign Language interpreters available

If you have a hearing or speech impairment, you can contact the Commission using the New Zealand Relay Service. NZ Relay is a telecommunications service and all calls are confidential. www.nzrelay.co.nz

Tāmaki Makaurau – Auckland

Level 3, 21 Queen Street

PO Box 6751, Wellesley Street

Tāmaki Makaurau Auckland 1141

Waea Telephone 09 309 0874

Waea Whakaahua Fax 09 377 3593

Te Whanganui ā Tara – Wellington

Level 1 Vector Building, 44-52 The Terrace

PO Box 12411, Thorndon

Te Whanganui ā Tara Wellington 6144

Waea Telephone 04 473 9981

Waea Whakaahua Fax 04 471 6759

Ōtautahi – Christchurch

Level 2 Moeraki Suite, Plan B Building

9 Baigent Way, Middleton

PO Box 1578, Ōtautahi Christchurch 8140

Waea Telephone 03 379 2015

Waea Whakaahua Fax 03 353 0959

Office of Human Rights Proceedings

Te Tari Whakatau Take Tika Tangata

Email ohrp@ohrp.org.nz

PO Box 6751, Wellesley Street, Auckland 1141

ISSN: 1179-531X (PRINT)

ISSN: 1179-5328 (ONLINE)

Published December 2012

Auckland, Aotearoa New Zealand



This work is licensed under the Creative Commons Attribution 3.0 New Zealand License.
To view a copy of this license, visit <http://creativecommons.org/licenses/by/3.0/nz/>.

Contents

Foreword	2
Human Rights Commission	3
Office of the Children's Commissioner	5
Independent Police Conduct Authority	8
Inspector of Service Penal Establishments	14
Ombudsman	16
Progress on Standing Issues	21
Appendix	22

Foreword

Accounts of abuse and ill-treatment in detention and care in New Zealand and elsewhere highlight the need for detention facilities to be monitored. State power is at its greatest when citizens or others are detained or placed in care facilities they cannot leave. As highlighted by those who have survived ill-treatment while in detention, people deprived of liberty are extraordinarily vulnerable to abuses of power. It is important therefore that as a country we remain vigilant about protecting the human rights of those who are deprived of their liberty. As Nelson Mandela states - "It is said that no one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones."

The Optional Protocol to the Convention Against Torture (OPCAT) provides a unique, prevention-focussed regime for the regular monitoring of all places where people may be detained. Monitoring occurs through regular visits by independent agencies to places where people are deprived of their liberty. The focus is on preventing torture and other cruel, inhuman or degrading treatment or punishment.¹ In New Zealand, five agencies are designated as National Preventive Mechanisms (NPMs) - the Children's Commissioner, Independent Police Conduct Authority, Inspector of Service Penal Establishments, the Ombudsman and the Human Rights Commission (Central NPM). I acknowledge the important contribution and work undertaken by each of these agencies in monitoring situations of detention in areas spanning health, police custody, corrections, children and young people.

New Zealand has a strong human rights reputation internationally and we should strive to strengthen this. Our human rights record affects our ability to trade and to speak and participate credibly in world affairs. After ratifying OPCAT in 2007, New Zealand was one of the first countries to establish a multi-agency NPM body. It has achieved significant success in OPCAT implementation. Six hundred and eighty visits have been conducted over the last five years to places where people are detained and a number of major reports and reviews of various detention issues have been completed.

A key challenge for New Zealand now lies in resourcing NPMs for future OPCAT implementation. There are the "forgotten places" - places where people suffering from dementia for example, and children, are unable to leave. NPMs require sufficient resourcing to effectively monitor these facilities as well as the more obvious places of detention.

The success of the NPMs this year and over the last five years is indicated by the rare occurrence of human rights incidents when people are deprived of liberty. In 2013, New Zealand will face the scrutiny of other countries through the Universal Period Review process. Whilst it can be proud of its OPCAT achievements to date, it will be important that we can assure the world that we remain committed to preventing human rights abuses in places of detention.



David Rutherford
Chief Commissioner, Human Rights Commission
Te Amokapua, Te Kāhui Tika Tangata

¹ OPCAT, Article 1.

Human Rights Commission

The Human Rights Commission (the Commission) is designated as the Central National Preventive Mechanism, which entails coordination and liaison with NPMs, identifying systemic issues, and liaising with the UN Subcommittee.

The Commission is an independent Crown entity with a wide range of functions under the Human Rights Act. One of the Commission's primary functions is to advocate and promote respect for, and an understanding and appreciation of, human rights in New Zealand society.

The Commission's functions may be undertaken through a range of activities, including advocacy, coordination of human rights programmes and activities, carrying out inquiries, making public statements and reporting to the Prime Minister on any matter affecting human rights. This includes the desirability of legislative, administrative or other action to better protect human rights. The Commission also administers a dispute resolution process for complaints about unlawful discrimination.

Commissioners are appointed by the Governor-General, on the advice of the Minister of Justice, for a term of up to five years.

In its role as the Central National Preventive Mechanism, the Commission has this year continued its coordinating role - liaising with NPMs and hosting six roundtable meetings where NPMs had the opportunity to share information, and discuss issues and challenges arising through monitoring work.

The Commission has also coordinated a five-year review of the National Preventive Mechanism. The objectives of this review are to:

- 1 explain New Zealand's monitoring system, and outline its development
- 2 reflect on the progress, challenges and lessons learned, and
- 3 identify ways to strengthen the effectiveness and impact of OPCAT monitoring in New Zealand.

The review lays a foundation for planning future OPCAT implementation. It involved the compilation of self assessments from each of the NPMs; a review of the development of OPCAT and NPMs; and review and reporting on the strengths and challenges for NPMs in five years of operation. The review will be published in early 2013.

A key and enduring challenge for NPMs is to ensure that monitoring visits are undertaken on a sufficiently expert basis given limited or no extra funding for OPCAT work. NPMs provide a breadth of expertise but have identified a need for particular areas of expertise, for example in mental health. To help address this challenge, the Commission this year instigated a review and report on options for NPMs to access experts. The options have been costed and a proposal for going forward will be decided early next year through a strategic planning exercise.

This year the Commission has focused on how it might more effectively facilitate NPMs' engagement with the community and increase public awareness and understanding of OPCAT work. It hosted NPM meetings with members of civil society in the three main centres to provide information on OPCAT activities, and to gather views and information. It has also begun to develop a comprehensive strategy covering engagement with relevant government agencies, community and non-government organisations and public engagement.

The OPCAT mandate is broad and preventative. It encourages collaborative efforts to ensure people who are detained, many of whom are amongst our most vulnerable citizens, are treated with dignity and respect, and that they are protected from ill-treatment or harm. The Commission has accordingly focused on strategies that enhance the joint capacity of the NPMs to have a preventive impact. To this end, it has established online file sharing and proactively identified and pursued opportunities for NPMs to work together on joint projects such as submissions on proposed policy and legislative changes.

This year, the Commission has also continued to maintain and strengthen links with international experts involved in OPCAT. An increasing number of countries have established an NPM under the Optional Protocol, providing rich learning opportunities for New Zealand. Countries new to the OPCAT mechanism are also eager to learn from New Zealand's experience.

Internationally, there is considerable divergence about the scope of NPM monitoring work and the resourcing of NPMs. Scope is determined by NPM designations and their prioritising based on resourcing. This has serious human rights implications given the range of detention facilities that are currently unable to be sufficiently monitored by NPMs because of a lack of funding. It is an issue requiring urgent attention by government given the high vulnerability of people, such as young people and elderly people suffering from dementia, to human rights abuses while in detention or a controlled care environment.

In conclusion, the Commission has continued its coordinating role. It has led a number of initiatives aimed at enhancing the joint capability of NPMs and through the five year review and work on a number of other issues, has helped provide NPMs with a base from which to plan and make decisions about future OPCAT implementation.

Office of the Children's Commissioner

The Office of the Children's Commissioner is an independent Crown entity appointed by the Governor-General and operating under the Children's Commissioner Act. The Commissioner has a range of statutory powers to promote the rights, health, welfare, and well-being of children and young people from birth to 18 years.

The Office of the Children's Commissioner (the Office) monitors activities under the Children, Young Persons and Their Families Act (CYPFA), undertakes systemic advocacy functions and investigates particular issues with potential to threaten the health, safety, or well-being of children and young people.

The Office has joint responsibility with the Ombudsman, to monitor children and young people in residences established under section 364 of the CYPFA. In effect, the Office carries out residence visits and refers reports and findings to the Chief Ombudsman for input, including recommendations they wish to make.

The Office's role as a National Preventive Mechanism (NPM) has some overlap with other statutory responsibilities to monitor the policies and practices of Child, Youth and Family. These responsibilities include visits to residences on a regular basis.

Context

Child, Youth and Family are responsible for nine residences for children and young people, established under s364 of the CYPFA. These are: four care and protection residences; four youth justice residences; and a specialist residence for young men who have displayed sexually inappropriate behaviour.²

A senior advisor from the Office has a particular responsibility to carry out NPM work on behalf of the Children's Commissioner.

Summary of activities

This year, the Office met regularly with Child, Youth and Family's General Manager responsible for Residential and High Needs Services, keeping them informed of the NPM processes, standards and the procedure for preventive monitoring.

A schedule of visits is established at the beginning of each year, ensuring each of the s364 residences is visited once every two years. The Commissioner also has separate responsibilities to visit s364 residences as part of his general monitoring role. Information gathered from these visits can raise issues to be followed up at a later stage during NPM work. During the previous financial year, the Office carried out further unannounced visits, building on the success from this regime in the 2010/2011 financial year. As a result, the Office will be making all of its NPM visits unannounced in the 2012/13 financial year.

While the senior advisor leads all NPM visits, she is now always accompanied by an NPM inspector from another agency. This cross-fertilisation continues to be worthwhile, with benefits extending to a better understanding of the role and improved procedures for collecting information, interviewing, analysis and reporting.

Before an NPM visit is done, the Office checks:

- Child, Youth and Family's annual residential audit of compliance with the Children, Young Persons and Their Families (Residential Care) Regulations (the Regulations); and
- quarterly grievance panel reports.

In the course of residence visits, the Office looks at:

- 1 **Treatment:** identifying any incidents of torture, brutality or inhuman treatment, the use of isolation and/or of force and restraint.

² The day-to-day running of which is undertaken by Barnardos.

- 2 **Protection measures:** provision of information such as complaint, inspection, and disciplinary procedures and how such incidents are recorded.
- 3 **Material conditions:** accommodation, lighting and ventilation, personal hygiene, sanitary facilities, clothing and bedding, and food.
- 4 **Regime and activities:** contact with family and the outside world, outdoor exercise, education, leisure activities, and religion.
- 5 **Access to medical services:** access to medical care.
- 6 **Personnel:** staff conduct and training.

During the 2011/12 financial year the Office undertook five inspections. The Office visited Puketai (Care and Protection) in September 2011; Lower North (Youth Justice) in November 2011; Te Maioha o Parekarangi (Youth Justice) in February 2012; Te Poutama Ārahi Rangatahi (Specialist Unit) in April 2012; and an unannounced visit to Te Puna Wai o Tuhinapo (Youth Justice) in June 2012.

During the visits, there were discussions with children and young people, staff, management, the grievance panel and external stakeholder agencies. Each visit took three days³ and required extensive verification of processes to ensure children and young people are not exposed to torture, brutality or inhuman treatment. Following each visit a comprehensive report was completed.

Key findings for 2011/2012

The key findings made in this financial year are:

- 1 Within each of the nine residences, processes are in place to ensure that children and young people are not exposed to torture, brutality or inhuman treatment.
- 2 All residences have complied with their obligations under OPCAT to ensure children and young people are not exposed to torture, brutality or inhuman treatment.

Most of these processes are prescribed by the Regulations. Child, Youth and Family audits compliance with these Regulations annually.

- 3 Child, Youth and Family and Barnardos management continue to be helpful in facilitating access to the residential facilities, staff, residents and to written documentation. NPM reports have been well received, with recommendations promptly addressed and responded to.

While it was found that residences are generally complying with the Regulations, there is always room for further improvement and the Office identified a number of areas where improvements could be made. These were reported back to Child, Youth and Family and Barnardos who have given assurances that each is being addressed. This will be monitored during next year's visits.

Strengths

This year has seen an improved focus on the relationship between staff and young people, with all young people being able to identify staff they trusted and could relate to. There was also an improved focus on individualised assessment and planning. Young people have consistent access to their families. The residences present as warm and welcoming environments.

Areas for improvement

Treatment of children and young people

The Office continues to find gaps in the recording of secure care and incident analysis, including the use of restraint and searches. Given that these are the most restrictive interventions that Child, Youth and Family and Barnardos can carry out, this documentation must be able to account for these interventions. All residences could benefit from improving their internal analysis of these events. There are still some inconsistencies with how the Behaviour Management System and Time Out is used.

³ With the exception of the unannounced visit which took the form of a review visit and lasted one day.

Protection measures for children and young people

Child, Youth and Family have been working on improving their cultural assessments and plans for young people, although this still requires some attention. Young people appear to have a reduced engagement with the grievance process, with many, especially in youth justice residences referring to it as a “snitch box”.

Food and facilities

With the exception of one facility, most of the residences have now undergone a refresh, providing bright and friendly spaces. Young people still complain about the comfort of mattresses and the Office understands that Child, Youth and Family are currently reviewing the quality of these. Food has greatly improved with regular nutritional reviews and updates.

Regime and activities

Staff continue to note that it is hard to find time to plan and deliver programmes. Most residences now have dedicated programme coordinators, which has improved the content of programming available.

Access to medical services

Young people have full and consistent access to primary health care. There continue to be gaps in accessing mental health services.

Personnel

Child, Youth and Family have provided a wide range of internal training and development opportunities. There are noticeable links to improved engagement with young people following the training and the Office hopes there will be similar improvement following a recent training initiative to strengthen programme delivery.

Resources

The Office continues to undertake its NPM responsibilities with no additional funding and meet the number of visits suggested in international guidelines.⁴ It finds that the regime in each s364 residence can change quickly depending on the make-up of staff and residents at each facility. If the Office was to receive additional funding, it could undertake more visits and, where necessary, work with a multi-agency reviewing team, to further strengthen the preventive focus of these visits.

Review of the detention of young people in Police cells

The *Joint Thematic Review* of the policies and practices in relation to the care of young people detained in Police cells was completed during this financial year and released in the 2012/13 financial year. The review was carried out in conjunction with staff from the Independent Police Conduct Authority (IPCA) and the Human Rights Commission. Although this is not work the Office is gazetted to do, there was concern that young people in police cells are a vulnerable group who need the specific attention of an NPM. The review made 24 recommendations, mainly to the Police and Child, Youth and Family, with the Office being directly responsible for two. The Office will work with the IPCA to monitor the implementation of these and report on this in next year's annual report.

The coming year

During 2012/13, the Office will continue to undertake all NPM visits in conjunction with other NPM agencies and complete reports. At least four visits are planned for 2012/13, all of which will be unannounced.

⁴ International guidelines suggest that each facility must be visited at least once every four years. It is suggested that facilities that house children and young people are visited more frequently.

Independent Police Conduct Authority

The Independent Police Conduct Authority (the Authority) is the designated NPM in relation to people held in police cells and otherwise in the custody of the police.

The Authority is an independent Crown entity, which exists to ensure and maintain public confidence in the New Zealand Police. The Authority does this by considering and, if it deems necessary, investigating public complaints against police of alleged misconduct or neglect of duty and assessing police compliance with relevant policies, procedures and practices in these instances.

The Authority also receives from the Commissioner of Police notification of all incidents involving police where death or serious bodily harm has occurred. The Authority may undertake an investigation of its own motion, where it is satisfied there are reasonable grounds in the public interest, or in any incident involving death or serious bodily harm.

The Authority evolved from the Police Complaints Authority, which was established in 1998. The enacting in 2007 of the Independent Police Conduct Authority Act marked a major shift in the direction of the Authority. This started with a change of name and change in the composition of the Authority from an individual to a board of up to five members, comprising both legal experts and lay people.

Justice Lowell Goddard, a High Court Judge, was appointed the Police Complaints Authority in February 2007 and thereafter became Chair of the Independent Police Conduct Authority. Following completion of her five-year term, in April 2012 Judge Sir David Carruthers

was appointed Chair of the Authority.

Summary of activities

Visits

In its role as National Preventive Mechanism for Police detention, the Authority conducted 15 site visits during the 2011/12 reporting year. The visits included custody facilities in Police Districts not previously inspected by the OPCAT team and captured both urban and rural sites.

Police custodial environments present unique challenges for both Police and for the Authority's site visit team.

In addition to the large number of sites to be visited, each year more than 150,000 detained people are managed in Police custody and an estimated "70 to 80 per cent have medical and/or psychological issues, including alcohol and drug dependencies".⁵

The Police sites cover rural and urban centres and are geographically dispersed. While other NPMs have significant portfolios in terms of numbers of detainees, they have comparatively fewer sites to visit. The Authority's OPCAT team members are also responsible for delivering on other projects as part of the Authority's role as an investigation and oversight body. No full-time resource is possible with the current budget allocation.

States Parties to OPCAT have an obligation to put in place the necessary legislation, policies, and monitoring bodies to discharge monitoring functions. As explained in the international literature, the obligation does not stop at designation. Implementation requires an ongoing assessment of the needs of NPMs under article 18(3) to ensure that the necessary resources (both human and financial), for both regular visits to custodial sites and other activities that contribute to prevention at the strategic and policy levels, are in place. In light of its experience, the Authority (along with other New Zealand NPMs) invites further dialogue with relevant State representatives on capacity and resourcing as well as

⁵ New Zealand Police, Response to IPCA report on death in custody (Media Statement), 1 July 2011.

cost-effective solutions and partnerships that will enhance the preventive capacities of New Zealand's monitoring bodies.

As identified in last year's OPCAT annual report,⁶ fewer sites were visited as a result of limited resources. The Authority is committed to the principle outlined in Article 1 of OPCAT, which has as its primary objective "a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment." In 2008, the Subcommittee on Prevention of Torture (SPT) noted with respect to its visit to Sweden that the lack of additional resources "might, in the view of the SPT, influence the prospect of comprehensive and effective work",⁷ recommending that "[a]dequate resources should be provided for the specific work of NPMs in accordance with Article 18(3) of OPCAT; these should be ring-fenced, in terms of both budget and human resources".⁸ Sufficient resources and capacity would undoubtedly enable the Authority to conduct visits on a more regular basis, thereby better fulfilling its preventive mandate.

Research and evaluation

In the current reporting year, the Authority enhanced its effectiveness through the completion of two research projects, which are discussed in further detail below.

Joint Thematic Review of Young Persons in Police Detention

The *Joint Thematic Review of Young Persons in Police Detention* (*Joint Thematic Review*) was launched in October 2012 by the Authority, the Office of the Children's Commissioner and the Human Rights Commission as part of each agency's mandate under OPCAT.

The *Joint Thematic Review* was the first of its kind in New Zealand. There has been a positive and constructive engagement with Child Youth and Family (CYF) and the Police during the review and finalising of the report, including regular consultation with a dedicated liaison officer within Police National Headquarters.

The project involved an examination of issues relating to the conditions applicable and treatment of young persons in Police detention, as well as issues of policy, practice, and procedure and inter-agency engagement. It included assessment of: the international and domestic human rights framework; New Zealand's legislation concerning young persons and relevant detention statistics; and the issues raised in staff and public submissions, namely conditions of detention; treatment; de facto detention; and monitoring standards. Importantly, the Review sought to identify solutions to the issues identified, and explored opportunities arising at the pre-arrest stage; the treatment of young persons once detained (age-mixing, cell suitability, specialisation and training of staff); and systemic issues surrounding inter-agency collaboration, data collection and local level monitoring.

The review process involved meetings with key stakeholders, site visits, and a review of submissions received from staff and members of the public (including feedback from young people). The reviewing agencies received and considered comments from an independent advisory group comprising lawyers, members of the judiciary, practitioners, advocates, and academics.

The *Joint Thematic Review* contains 24 comprehensive recommendations for Police and CYF. In a media statement, Assistant Police Commissioner Nick Perry stated that "Policing of children and young people does present unique challenges. We recognise that and our [youth policing] strategy outlines ways that we will

6 Human Rights Commission, *Monitoring Places of Detention: Annual Report of Activities under the Optional Protocol to the Convention against Torture (OPCAT) 1 July 2010 to 30 June 2011*, p 7.

7 Subcommittee on Prevention of Torture, *Report on the Visit of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment to Sweden*, UN Doc CAT/OP/SWE/1 (10 September 2008), para 35.

8 Ibid, para 41(g). In response to this recommendation, the Government of Sweden reported that "[b]udgetary issues will be dealt with within the framework of the future annual budgetary planning processes by the Riksdag and the Government." See Subcommittee on Prevention of Torture, *Replies from Sweden to the Recommendations and Questions of the Subcommittee on Prevention of Torture in its Report on the first periodic visit to Sweden*, UN Doc CAT/OP/SWE/1/Add.1 (30 January 2009), para 3.

9 New Zealand Police, *Prevention key to policing of young people* (Media Statement), 23 October 2012.

ensure we have better training, decision making and auditing processes to make sure we are complying with our own policies and procedures as well as international conventions that New Zealand is part of.”⁹

The Authority will engage with Police to monitor the implementation of the recommendations contained in the Review. The positive nature of this engagement, and the breadth and depth of recommendations made by the reviewing agencies, highlights the potential for future preventive work under the OPCAT mandate.

Deaths in Custody Review

In late 2010, the Authority commenced a review of trends and issues arising from 27 deaths in Police custody during the preceding decade. The Authority examined the circumstances of the deaths and considered whether improvements can be made to Police policies and procedures in order to reduce the likelihood of further deaths. Specifically, it involved assessment of 13 core issues:

- 1 alcohol/drugs
- 2 mental health
- 3 use of force/methods of restraint
- 4 searching of detainees
- 5 risk assessment of detainees
- 6 monitoring of detainees
- 7 dispensing medication to detainees
- 8 National Intelligence Application alerts
- 9 handover procedures
- 10 safety of cells
- 11 medical treatment /mental health assessment
- 12 training of custody staff and
- 13 near miss reporting.

The Authority's review made 20 recommendations for the improvement of the treatment and safeguards surrounding persons detained in Police custody. The report acknowledges the work done in recent years by New Zealand Police to improve custodial policies, systems and processes and identifies opportunities for further development. The report and accompanying media statement were publicly released on 30 June 2012 and received extensive media coverage. The Authority Chair, Judge Carruthers, stated:

“While it is rare in New Zealand for people to die while in Police custody, such deaths can be controversial. There may be issues around the use of force by Police during an arrest, or with the standard of care Police provide to a detainee. When a person dies while he or she is in custody, it has a serious impact on both their family and the Police officers involved. Public confidence in the Police may also be affected. While not all deaths in custody are foreseeable or preventable, in some cases the actions or omissions of Police staff may be a contributing factor.

The main purpose of the review was to examine the circumstances of each death and identify any recurring issues or developing trends. While the investigations into some deaths identified procedural omissions or errors, the purpose of the review is not to attribute blame; rather, to learn useful lessons from these cases.”¹⁰

Police National Headquarters also responded positively and constructively to the report. Assistant Commissioner Nick Perry issued a media statement and engaged in a number of TV and radio interviews. Mr Perry acknowledged the Authority's research and findings and explained the improvements to Police policies, practices and procedures that have occurred and are planned for the future as a result of the Authority's report.

Engagement

New Zealand Police

The Authority has continued to engage with Police during the course of this reporting year, particularly in relation to the Authority's OPCAT research projects. In relation to the *Joint Thematic Review*, the Authority's OPCAT team worked with senior staff to discuss advancements currently underway in the areas of mental health and Police policy and training on the use of force, including briefings on the Police Tactical Options Community Reference Group. The Authority intends to continue this engagement in the next reporting year as priority areas are identified for future project planning.

The Authority's OPCAT expertise continues to have a measurable impact on Police custodial processes and procedures. This is achieved both through engagement with Police National Headquarters and the OPCAT site visit process, as well as through applying an OPCAT perspective to the Authority's investigations and reviews. While investigations and reviews are a separate statutory function of the Authority, the human rights principles and standards applied in the OPCAT context are equally relevant to the Authority's oversight role and are therefore a useful basis for meaningful and forward-looking recommendations.

In the 2011/12 reporting year, for example, the Authority conducted three reviews of incidents in which Police used mechanical restraints on people in custody who had mental illness and drug/alcohol issues. The mechanical restraints referred to specifically in this case were restraint boards;¹¹ and combined rear wrist and ankle restraints, more commonly known as a "hog-tie". In the OPCAT context, the Human Rights Commission has been noted that "any use of force, personal searches, or use of mechanical restraints represents a significant interference with individual rights and freedoms. Accordingly, human rights standards require stringent safeguards and restrictions around their use."¹² It has also cited relevant

guidance from international human rights bodies, including the European Committee for the Prevention of Torture.¹³ Combined rear wrist and ankle restraints can be used under current Police policy, although (as with the use of restraint boards) officers are required to complete a Tactical Options Report for submission to their supervisor. Combined rear wrist and ankle restraints are, however, expressly prohibited when transporting detainees.

Complaints were received from the District Inspector of Mental Health about two separate incidents, related to the actions of Police officers from one district. The Authority was also awaiting a Police investigation into a third such complaint from the same District. An Authority Reviewing Officer conducted the initial reviews of the Police investigation files, and worked in consultation with a member of the Authority's OPCAT team.

Detailed recommendations were made to Police regarding the need to improve the quality of training in both the use of mechanical restraints and the knowledge of staff who deal with individuals who are mentally impaired. In one case, the relevant District Commander responded by (amongst other things) tasking an Inspector to review the systems in place to ensure quality Police investigations into complaints (including further training for investigators), as well as discontinuing the use of restraint boards within the District until there is proper nationally mandated training. The Authority has been advised that an operational trial of restraint chairs at two custodial sites will be extended to three further Police custodial facilities, with the purchase of alternative design chairs. The Authority will in due course be provided with a formal briefing on further improvements underway at the national level with respect to the policy, practice, and procedure surrounding the use of restraint boards, tactical options training, and quality assurance. The work done in this area is a useful example of the impact custodial human rights awareness and

11 A restraint board has chest, arm and leg straps. It restricts the movements of a person behaving violently or where other restraints (e.g. handcuffs) are unable to secure them in order to prevent them harming themselves or others. It is designed to immobilise and is not to be used as a punishment. It is the highest level of Police intervention for restraining prisoners.

12 Human Rights Commission, *Monitoring Places of Detention: Annual Report of Activities under the Optional Protocol to the Convention against Torture (OPCAT) 1 July 2009 to 30 June 2010*, p 3. The Authority has also addressed the importance of sound policies, practices, procedures relating to restraint in its engagement with Police National Headquarters (p 10).

13 Ibid, pp 24 – 25.

expertise can have across the Authority's work streams for the overall improvement of conditions applicable to and treatment of persons detained by Police.

NPMs

The Authority continued to work closely with other NPMs during the reporting period. In particular, the *Joint Thematic Review* has enabled the Authority to work closely with the Office of the Children's Commissioner and the Human Rights Commission. In addition, Authority staff accompanied staff from the Office of the Ombudsman on custodial site visits in Wellington District. The Authority remains committed to working with NPMs on reviewing its prevention methodologies and identifying avenues for further development moving forward.

Civil society

In May the Authority hosted, with the support of the Human Rights Commission, a civil society forum for practitioners, advocates and NGOs in the Wellington region. The forum provided an opportunity for the Authority to explain its mandate, its site visit methodology and work programme and gain feedback on detention issues. It has also attended civil society meetings coordinated by the Human Rights Commission in Auckland and Christchurch.

International

As an NPM, the Authority's commitment to engage with international partner agencies has had, and will continue to have, a significant impact on the quality of the Authority's preventive initiatives and human rights promotion strategies. OPCAT requires a multi-faceted prevention strategy:

"Visits to places of detention should be a central part of any preventive system. However, visits themselves are not enough to prevent torture and other ill-treatment. As recognised in Article 2 of the UNCAT, the

prevention of torture and other ill-treatment requires a range of legislative, administrative, judicial and other measures."¹⁴

In February 2012, a member of the Authority's OPCAT team (Legal Advisor to the Chair) was invited to present a keynote address at a conference at Monash University, *Implementing Human Rights in Closed Environments*. The Monash University Faculty of Law's (Castan Center for Human Rights Law) *Applying Human Rights in Closed Environments* is a three-year collaborative project led and jointly funded by the Australian Research Council, Linkage Project 2008, Monash University, and six partner organisations. The February 2012 conference enabled the Authority to explain the New Zealand OPCAT framework, relevant legislation, the approach adopted by New Zealand NPMs, and key achievements in the first five years following ratification. The Legal Advisor to the Chair was invited to provide a contribution to a special edition of a leading socio-legal journal, *Law in Context* based on the keynote address. The publication, currently titled *Implementing Human Rights in Closed Environments: The OPCAT Framework and the New Zealand Experience* is in the process of being reviewed and assessed for publication. It addresses the history and background to OPCAT; the importance of torture prevention under international law; the applicable standards and principles of the OPCAT framework for international and domestic monitoring bodies; the New Zealand legislative framework; advancements and achievements in the first five years following ratification in 2007; and opportunities for the future.¹⁵

Going forward

As identified previously, March 2012 marked the fifth anniversary of New Zealand's ratification of OPCAT. The Authority is actively contributing to the five-year review of OPCAT in New Zealand via the Human Rights Commission and is considering development opportunities in key work streams such as: site visits and

14 Association for the Prevention of Torture, *OPCAT Implementation Manual 2010* (Rev ed, Imprimerie Courand et associés, Geneva, October 2010), p 20.

15 For further information on *Law in Context*, including a list of previous journal editions, see the *Law in Context* website: <<http://www.federationpress.com.au/journals/journal.asp?issn=08115796>>

recommendations; awareness and outreach; law and policy review, as well as research and evaluation; and capacity building and training.

The Authority considers it useful to consider at this time the SPT's Analytical Self-Assessment Tool for National Prevention Mechanisms,¹⁶ which canvasses the need for NPMs to address:

- 1 strategies
- 2 internal organisation
- 3 planning
- 4 visit methodology
- 5 visit reports
- 6 prevention of reprisals
- 7 issues relating to constitutional and legislative issues
- 8 cooperation and communication (including thematic reports)
- 9 systematisation of experiences
- 10 budget prioritisation
- 11 internal capacity building
- 12 annual reporting.

The Authority will continue to identify ways of increasing the breadth, depth, and quality of its OPCAT work, both now and into the future, in a manner that is sustainable and guided by the applicable standards. It will do so by engaging with government actors, key stakeholders, and in partnership with New Zealand NPMs.

16 Subcommittee on Prevention of Torture, *Analytical Self-Assessment Tool for National Prevention Mechanisms*, UN Doc CAT/OP/1 (6 February 2012).

Inspector of Service Penal Establishments

The Inspector of Service Penal Establishments (ISPE) is the NPM charged with monitoring New Zealand Defence Force detention facilities.

The appointment of the ISPE is tied to the appointment of the Registrar of the Court Martial of New Zealand, an official appointed independently by the Chief Judge of that jurisdiction by the provisions of the Court Martial Act (ss79 (1) and 80).

Context

The Services Corrective Establishment (SCE) is located in Burnham Military Camp just south of Christchurch. In addition, there are a limited number of holding cells in each of the more significant New Zealand Defence Force (NZDF) base or camp facilities that are used to confine members of the Armed Forces for a few days at a time.

While there are no detention facilities off-shore currently available to the NZDF on NZ Navy ships or for the forces on operational deployments, they can be arranged relatively readily when required as the Armed Forces Discipline Act s175(1) permits the Chief of Defence Force from time to time to:

set aside any building or part of a building as a service prison or a detention quarter; or

declare any place or ship, or part of any place or ship, to be a service prison or detention quarter.

Approach

The ISPE has no staff, but has the capacity to second if required to assist meeting OPCAT objectives to ensure that all members of the Armed Forces deprived of their liberty are treated with humanity and respect and not subjected to torture or to cruel, inhuman or degrading

treatment or punishment.

ISPE continues to arrive unannounced at the reception office of the SCE and after presenting credentials meets with the Chief Warden before reviewing the documentation, inspecting the facilities and interviewing each detainee individually and in private. Feedback is provided routinely at the conclusion of the inspection to the Commandant of the SCE and to the Chief Warden. Any significant concern identified is reported directly to the Chief of Defence Force.

Summary of activities

While up to eight inspections are authorised, just two inspections of the SCE were completed in 2011/12.

Issues

The ISPE continues to receive cooperation at all levels in the NZDF. The Armed Forces comply with its obligations to OPCAT.

The SCE is a fairly modern but small detention facility that can cater for up to eight detainees at any one time. It has a professional staff of Non Commissioned Officer wardens drawn from all three Armed Services. They are supported by a senior officer from Headquarters 3 Land Force Group who holds a dual appointment that includes the position of Commandant SCE in his or her job description. The ISPE's inspections were kept to a minimum this year as there were a limited number of detainees sentenced to lengthy terms by Court Martial.

The ISPE is satisfied with the treatment and conditions of detention and with the measures in place there, and given the attitude of the management and staff at SCE, torture and ill treatment in the future looks improbable.

Detention is a punishment for serious offending and is vital to the maintenance on good order and military

discipline. It is sparingly assigned by Disciplinary Officers exercising their responsibilities at Summary Proceedings Hearings.

It was reported last year that the SCE will move from Burnham Military Camp to the central North Island where it is more readily available to the vast majority of the Service clientele. This now looks unlikely, at least in the foreseeable future, as there remains no funding available for the capital works for this project.

With the exception of the cell block in HMNZS PHILOMEL, the standard of detention accommodation available in the Camps and bases is suitable for the purpose to which it is put; which is to maintain good order and military discipline by detaining members of the Armed Forces for short periods (usually less than 48 hours). As reported previously, the cells in PHILOMEL are universally recognised as substandard and are earmarked for replacement. Again, this is unlikely to occur in the near future given fiscal restraints.

If the SCE remains resourced and managed at current levels the ISPE is confident that the SCE is unlikely to generate OPCAT issues regardless of its location.

Going forward

It is intended to complete up to eight OPCAT inspections of SCE in the 2012/13 year.

Further visits to camp and base holding cells will also be arranged to ensure that the facilities meet minimum requirements and that the management of detainees is robust enough to ensure that OPCAT objectives continue to be met by the New Zealand Armed Forces.

Ombudsman

The Ombudsman has been designated as the NPM for prisons, immigration detention facilities, health and disability places of detention, and child and youth residences.

The Ombudsman has wide statutory powers to investigate complaints against central and local government agencies. The functions and powers of the Ombudsman are set out in several pieces of legislation, including the Ombudsman Act.

The Ombudsman's role includes providing an external and independent review process for individual prisoners' grievances, as well as the ability to conduct investigations on their own motion.

The Ombudsman is responsible to Parliament but is independent of the government of the day. Ombudsmen are appointed by the Governor-General on the recommendation of the House of Representatives.

The Office of the Ombudsman is the NPM with responsibility for monitoring and making recommendations to improve the conditions and treatment of detainees in:

- 1 17 prisons
- 2 75 health and disability places of detention
- 3 one immigration detention facility
- 4 four child care and protection residences and
- 5 five youth justice residences.

There are also an additional 161 aged care facilities with dementia units that may fall within the Ombudsman's designation in respect of health and disability places of detention. The Ombudsman is seeking additional funding

in order to conduct regular inspections of these facilities.

The designation in respect of child care and protection and youth justice residences is jointly shared with the Children's Commissioner.

The Ombudsman is assisted in carrying out their NPM functions under the Crimes of Torture Act (COTA) by two Inspectors. In 2011/12, the Ombudsman planned to carry out 50 visits to places of detention. A total of 70 visits

Name of facility	Type of facility	Recommendations made
Purehurehu, Ratonga Rua-o-Porirua, Capital & Coast DHB	Forensic unit	Yes
Rangipapa, Ratonga Rua-o-Porirua, Capital & Coast DHB	Forensic unit	Yes
Tawhirimatea, Ratonga Rua-o-Porirua, Capital & Coast DHB	Forensic unit	Yes
Auckland East (follow-up inspection)	Prison	Yes
Auckland East (follow-up inspection)	Prison	Yes
Waikeria (follow-up inspection)	Prison	Yes
Whitinga, Te Whetu Tawera, Auckland DHB	Adult Mental Health	No
Kakenga, Te Whetu Tawera, Auckland DHB	Adult Mental Health	No
Tumanako, Te Whetu Tawera, Auckland DHB	Adult Mental Health	No
Kuaka, Tiaho Mai, Counties Manukau DHB	Adult Mental Health	No
Huia, Tiaho Mai, Counties Manukau DHB	Adult Mental Health	No
Tui, Tiaho Mai, Counties Manukau DHB	Adult Mental Health	No
Arohata	Prison (women)	Yes
Hawkes Bay	Prison	Yes
Rolleston	Prison	No
Te Puna Waiora, Taranaki DHB	Adult Mental Health	Yes
Pohutukawa, Waitemata DHB	Adult Forensic Intellectual Disability	No
Te Whare Ahuru, Hutt Valley DHB	Adult Mental Health	Yes
Ward 21, MidCentral DHB	Adult Mental Health	Yes
STAR 1, MidCentral DHB	Aged care	Yes
Te Aruhe, Ratonga Rua-o-Porirua, Capital & Coast DHB	Forensic Youth Intellectual Disability	No
Purehurehu, Ratonga Rua-o-Porirua, Capital & Coast DHB (follow-up inspection)	Forensic unit	No
Rangipapa, Ratonga Rua-o-Porirua, Capital & Coast DHB (follow-up inspection)	Forensic unit	No
Tawhirimatea, Ratonga Rua-o-Porirua, Capital & Coast DHB (follow-up inspection)	Forensic unit	No

were actually carried out, including 24 formal inspections.

The 24 formal inspections were at the following sites:

The Ombudsman reported back to all places of detention within three months of conducting an inspection, exceeding their target of doing so in 95 per cent of all cases. Thirty six recommendations were made, 33 of

- Prisons: 18 accepted, two not accepted.
- Health and disability places of detention: 15 accepted, one not accepted.

	2007/08	2008/09	2009/10	2010/11	2011/12
Formal inspections announced	0	17	10	7	6
Formal inspections unannounced	0	0	0	13	18
Informal visits announced	43	46	6	2	12
Informal visits unannounced	0	1	1	1	34
Totals	43	64	17	23	70

opposite):

This brings the total number of visits conducted over the five-year period of operation as an NPM to 217, including 71 formal inspections. Ombudsman and the other NPMs have a reciprocal arrangement whereby they accompany each other, where appropriate, on visits to places of detention. These collaborative working arrangements, which will continue for the foreseeable future, help to ensure that all the NPMs benefit from each others' experiences and broaden the knowledge/skill base across organisations.

Measuring prevention

Because the Ombudsman measures prevention by the uptake of their recommendations, they have modified the way in which they report issues of concern to various agencies. They now only make recommendations where remedial action is clearly required. These are distinguished from "housekeeping points", where action is desirable but not essential, and needs to be considered in light of available implementation funds and competing priorities. "Good practices" are also separately recorded, not only to commend the relevant agency and its staff, but to establish a record of learnings that can be disseminated more widely across the sector. In 2011/12 the Ombudsman identified 12 housekeeping matters; 11 in mental health and one in prisons. Ten areas of good practice were also identified, all in mental health.

Issues arising

Prisons

Segregation

At two sites the Inspectors identified variances within the regimes being applied to prisoners placed on directed segregation pursuant to section 58(1)(a) or (b) of the Corrections Act. The amount of time prisoners were allowed out of their cells, particularly in the open air, varied significantly. However, once the issue was drawn to the managers' attention, measures were put in place to rectify the problem. The Inspectors did an unannounced follow-up visit six months later to one of the two sites and were pleased to see that prisoners placed on directed segregation were receiving more than their minimum entitlements.

Smoking ban

The Inspectors have not identified any serious concerns arising from the ban on smoking in prisons, which has now been in place for over 12 months.

Prison closures

During 2011/12 the Chief Executive of Corrections announced that a number of facilities would be closed and some would be upgraded as they were no longer fit for purpose. The Ombudsman had previously visited these sites, and identified a number of areas of concern. The closures and upgrades will significantly improve the quality and suitability of New Zealand's prison facilities, and will eliminate many of our earlier concerns. The Department of Corrections (Corrections) is to be commended for this initiative.

Questionnaires

This year the Ombudsman introduced a questionnaire

for prisoners, and this was used at four sites. As it is impossible for the Inspectors to interview all prisoners, the questionnaire was designed provide a good indication of how the prisoners consider they are being treated. The Inspectors hand out the questionnaires to the prisoners individually or in groups, explain its purpose, and then collect the responses before the end of their visit. Prisoners are encouraged to elaborate on any of their responses or make additional comments if they

Involving patients in their care is a key factor in promoting their recovery. In this reporting year, the Inspectors saw some good examples of patients having significant input into planning their care, as well as patients being actively involved in how their unit is run. However, a lack of patient involvement continues to be an area of concern for the Inspectors.

There have also been a number of examples of good practice in relation to patients' consent to treatment

Places of detention	Muster on the day of the visit	Number of questionnaires given out	Number of questionnaires returned
Christchurch Women's prison	82	82	53 (65%)
Rolleston Men's prison	310	310	141 (45%)
Christchurch Men's prison	818	770	347 (45%)
Hawke's Bay prison	651	538	363 (67%)
Total	1,861	1,700	904 (53%)

wish. Those prisoners who are not able to complete the questionnaire in time are able to post their responses back in a confidential envelope. To date, the response rate has been good.

The Ombudsman is currently analysing the results of the survey and intend to continue using the questionnaire in 2012/13.

Health and disability places of detention

Intellectual Disability (Compulsory Care and Rehabilitation) Act

The Ombudsman visited secure, community care facilities in 14 Regional Intellectual Disability Supported Accommodation Services. All 14 visits were unannounced. The Inspectors had no concerns with the standard of care being given and were pleased to see such positive interactions between care recipients and support workers during the visits.

Mental Health (Compulsory Assessment and Treatment) Act

forms being completed, but there is still room for improvement.

Good practices

The Ombudsman is pleased to report a number of good practices around the country in health and disability places of detention, especially in the areas of seclusion reduction and restraint minimisation. Many units have introduced, or are in the process of introducing, sensory modulation rooms, which are utilised by patients/care recipients exhibiting signs of agitation and stress, with a view to calming and relaxing them without the need for physical intervention (restraint), and seclusion.

Auckland District Health Board's Te Whetu Tawera Mental Health Unit has introduced a system called *Releasing Time to Care*, which contributes to the ward team improving processes that allow staff to spend more time with service users and their families. Furthermore, upon entering the ward, notice boards display a range of reports, on the use of restraint and seclusion data for example, which

demonstrates a commitment to operating an open and transparent facility which keeps service users, staff and visitors informed.

Other activities

In July 2011, the Chief Inspector was invited to speak on the implementation of the OPCAT at a seminar titled *Oversight of Correctional Facilities* hosted by the Queensland Ombudsman.

The Chief Inspector was also invited to make a presentation at the 5th Anniversary Global Forum on the OPCAT, in Geneva in November 2011. The presentation, *Particularities of the Preventive Approach*, was based on how NPMs operate in New Zealand. The Chief Inspector was one of 32 invited speakers at the Forum, which included over 350 delegates from around the world.

The Ombudsman continues to meet with civil society groups to raise awareness of COTA, and also meet regularly with officials from the Ministry of Health, Ministry of Justice and Corrections.

Looking forward

In 2012/13, the Inspectors are committed to carrying out 32 visits to places of detention, at least a third of which will be unannounced. They will continue to send finalised reports out to places of detention within three months of

Progress on standing issues

the visit.

Material conditions

In previous reports, NPMs have raised concerns about the physical state of some detention facilities and the need to upgrade them to meet human rights standards. NPMs recognise that the current environment of fiscal restraint and the costs of renovation or replacement of older facilities are challenging.

A number of significant developments this year are therefore particularly welcome. Two of the oldest prisons and a number of prison units that are no longer fit for purpose, are being decommissioned or upgraded. This will address some of the concerns that the Ombudsman had previously raised about conditions and will significantly improve the prison estate. Likewise, the refresh of almost all Child, Youth and Family residences is another positive development in ensuring that facilities are of a high standard.

Mental health

The high prevalence of mental health issues amongst people in detention, and their access to care and treatment in detention are longstanding issues. This year, the Ombudsman completed an investigation into prison healthcare. This identified deficiencies in the management of mentally unwell prisoners, and found that aspects of the management of prisoners at risk of self harm could be detrimental to their long term mental health. The Ombudsman began scoping an investigation into the identification, management and treatment of mentally unwell prisoners.

The IPCA carried out a review of deaths in Police custody, highlighting the effect of alcohol, drugs and mental health issues on people in Police custody as areas requiring attention. The 20 recommendations made by the IPCA included the establishment of detoxification centres to provide appropriate care for heavily intoxicated people, and expansion of the watch-house nurse programme to

help identify and manage detainees with mental health, alcohol or other drug issues.

Resources

Since NPM roles were undertaken with little or no additional funding, resource issues have been an ongoing challenge. NPMs have taken a pragmatic approach to implementing their roles as effectively as possible within the resources available, and using funds from other work programmes. This approach has enabled the OPCAT monitoring system to be established and operational, but has affected NPMs' capacity to carry out monitoring to the full extent required by OPCAT.

NPMs continue to collaborate where possible and assist in each other's visits in order to augment the small teams. However, one of the most pressing needs is for additional staff in the OCC, IPCA and Office of the Ombudsman, in order to enable them to expand the frequency and coverage of their monitoring visits. For these NPMs, resource pressures are significant, and inhibit the full performance of their OPCAT function.

APPENDIX 1: OPCAT background

Introduction to OPCAT

The Optional Protocol to the Convention Against Torture (OPCAT) is an international human rights treaty that New Zealand ratified in 2007. It is designed to assist States to meet their obligations to prevent torture and ill treatment in places where people are deprived of their liberty. Unlike other human rights treaty processes that deal with violations of rights after the fact, the OPCAT is primarily concerned with preventing violations. It is based on the premise, supported by practical experience, that regular visits to places of detention are an effective means of preventing ill treatment and improving conditions of detention. This preventive approach aims to ensure that sufficient safeguards against ill treatment are in place and that any problems or risks are identified and addressed.

OPCAT establishes a dual system of preventive monitoring, undertaken by international and national monitoring bodies. The international body, the UN Subcommittee for the Prevention of Torture, will periodically visit each State Party to inspect places of detention and make recommendations to the State. At the national level, independent monitoring bodies called National Preventive Mechanisms (NPMs) are empowered under OPCAT to regularly visit places of detention, and make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing torture or ill treatment.

Preventive approach

The Association for Prevention of Torture (APT) highlights the fact that “prevention is based on the premise that the risk of torture and ill-treatment can exist or develop anywhere, including in countries that are considered to be free or almost free from tortures at a given time”.¹

“Whether or not torture or other cruel, inhuman or degrading treatment or punishment occurs in practice, there is always a need for States to be vigilant in order to prevent ill-treatment. The scope of preventive work is large, encompassing any form of abuse of people deprived of their liberty which, if unchecked, could grow into torture or other cruel, inhuman or degrading treatment or punishment. Preventive visiting looks at legal and system features and current practice, including conditions, in order to identify where the gaps in protection exist and which safeguards require strengthening.”²

Prevention is a fundamental obligation under international law, and a critical element in combating torture and cruel, inhuman or degrading treatment and punishment.³ The preventive approach of OPCAT encompasses direct prevention (identifying and mitigating or eliminating risk factors before violations can occur); and indirect prevention (the deterrence that can be achieved through regular external scrutiny of what are, by nature, very closed environments).

“The very fact that national or international experts have the power to inspect every place of detention at any time without prior announcement, have access to prison registers and other documents, [and] are entitled to speak with every detainee in private ... has a strong deterrent effect. At the same time, such visits create the opportunity for independent experts to examine, at first hand, the treatment of prisoners and detainees and the general conditions of detention ... Many problems stem from inadequate systems which can easily be improved through regular monitoring. By carrying out regular visits to places of detention, the visiting experts usually establish a constructive dialogue with the authorities concerned in order to help them resolve problems observed.”⁴

1 APT (March 2011) *Questionnaire to members states, national human rights institutions, civil society and other relevant stakeholders on the role of prevention in the promotion and protection of human rights*, p. 10.

2 Subcommittee on Prevention of Torture (May 2008). *First Annual Report of the Subcommittee on Prevention of Torture*, CAT/C/40/2, para 12.

3 It sits alongside the obligations to criminalise torture, ensure impartial investigation and protection, and provide rehabilitation for victims.

4 UN Special Rapporteur on Torture, Report of the Special Rapporteur on torture to the 61st session of the UN General Assembly, A/61/259 (14 August, 2006), para 72.

Implementation in New Zealand

New Zealand ratified OPCAT in March 2007, following the enactment of amendments to the Crimes of Torture Act, to provide for visits by the UN Subcommittee and the establishment of NPMs.

New Zealand's designated NPMs are:

- 1 the Office of the Ombudsman – in relation to prisons, immigration detention facilities, health and disability places of detention, and Child, Youth and Family residences
- 2 the Independent Police Conduct Authority – in relation to people held in police cells and otherwise in the custody of the police
- 3 the Office of the Children's Commissioner – in relation to children and young persons in Child, Youth and Family residences
- 4 the Inspector of Service Penal Establishments of the Office of the Judge Advocate General – in relation to Defence Force Service Custody and Service Corrective Establishments
- 5 the Human Rights Commission has a coordination role as the designated Central NPM.

Functions and powers of National Preventive Mechanisms

By ratifying OPCAT, States agree to designate one or more NPM for the prevention of torture (Article 17) and to ensure that these mechanisms are independent, have the necessary capability and expertise, and are adequately resourced to fulfil their function (Article 18).

The minimum powers NPMs must have are set out in Article 19. These include the power to regularly examine the treatment of people in detention; to make recommendations to relevant authorities; and submit proposals or observations regarding existing or proposed legislation.

NPMs are entitled to access all relevant information on the treatment of detainees and the conditions of detention; to access all places of detention and conduct private interviews with people who are detained or who may have relevant information. The NPMs have the right to choose the places they want to visit and the persons they want to interview (Article 20). NPMs must also be able to have contact with the international Subcommittee and publish annual reports (Articles 20, 23).

The State authorities are obliged, under Article 22, to examine the recommendations made by the NPM and discuss their implementation.

The amended Crimes of Torture Act enables the Minister of Justice to designate one or more NPMs as well as a Central NPM and sets out the functions and powers of these bodies. Under section 27 of the Act, the functions of an NPM include examining the conditions of detention and treatment of detainees, and making recommendations to improve conditions and treatment and prevent torture or other forms of ill treatment. Sections 28-30 set out the powers of NPMs, ensuring they have all powers of access required under OPCAT.

Central National Preventive Mechanism

OPCAT envisions a system of regular visits to all places of detention.⁵ The designation of a central mechanism aims to ensure there is coordination and consistency among multiple NPMs so they operate as a cohesive system. Central coordination can also help to ensure any gaps in coverage are identified and that the monitoring system operates effectively across all places of detention.

The functions of the Central National Preventive Mechanism (CNPM) are set out in section 32 of the Crimes of Torture Act, and are to coordinate the activities of the NPMs and maintain effective liaison with the UN Subcommittee on Prevention of Torture. In carrying out these functions, the CNPM is to:

- 1 consult and liaise with NPMs
- 2 review their reports and advise of any systemic issues

⁵ OPCAT, Article 1.

- 3 coordinate the submission of reports to the Subcommittee
- 4 in consultation with NPMs, make recommendations on any matters concerning the prevention of torture and ill treatment in places of detention.

Monitoring processes

While the OPCAT sets out the requirements, functions and powers of NPMs, it does not prescribe in detail how preventive monitoring is to be carried out. New Zealand's OPCAT organisations have developed procedures applicable to each detention context.

The general approach to preventive visits, based on international guidelines, involves:

- 1 Preparatory work, including information collection and identifying specific objectives, before a visit takes place.
- 2 The visit itself, during which the NPM visitors speak with management and staff, inspect the institution's facilities and documentation, and speak with people who are detained.
- 3 Upon completion of the visit, discussions with the relevant staff, summarising the NPM's findings and providing an opportunity for an initial response.
- 4 A report to the relevant authorities of the NPM's findings and recommendations, which forms the basis of ongoing dialogue to address identified issues.

NPMs' assessment of the conditions and treatment of detention facilities takes account of international human rights standards, and involves looking at:

- 1 Treatment: any allegations of torture or ill treatment; the use of isolation, force and restraint.
- 2 Protection measures: registers, provision of information, complaint and inspection procedures, disciplinary procedures.

- 3 Material conditions: accommodation, lighting and ventilation, personal hygiene, sanitary facilities, clothing and bedding, food.
- 4 Activities and access to others: contact with family and the outside world, outdoor exercise, education, leisure activities, religion.
- 5 Health services: access to medical care.
- 6 Staff: conduct and training.



Human Rights
Commission

Te Kāhui Tika Tangata

