

Monitoring Places of Detention

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

1 July 2013 to 30 June 2014

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Contents

Foreword	4
Human Rights Commission	6
Independent Police Conduct Authority	8
Inspector of Service Penal Establishments	11
Office of the Children's Commissioner	14
Office of the Ombudsman	19
Overarching issues	27
Appendix: OPCAT background	31

Foreword

This is the seventh annual report of New Zealand's National Preventive Mechanism (NPM), a monitoring mechanism established under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

OPCAT is based on the premise that regular visits to places of detention are an effective means of preventing torture and other cruel, inhuman or degrading treatment or punishment of people in detention.¹ It also provides an effective way to support detaining agencies to improve conditions of detention.

Five agencies are designated as National Preventive Mechanisms (NPMs): The Independent Police Conduct Authority, the Inspector of Service Penal Establishments, the Office of the Children's Commissioner, the Office of the Ombudsman, and the Human Rights Commission.

Since 2007 NPMs have worked, independently and as part of the OPCAT mechanism, to provide a system of independent monitoring. They make recommendations to detaining agencies to strengthen human rights protections and to improve capability across the sector for managing high and complex needs. NPMs also contribute to developing a culture where the rights of all persons deprived of their liberty are protected and respected.

NPMs are not aware of any torture occurring in New Zealand's detention facilities in the 2013/2014 period. However, ill-treatment in detention can and does still occur, whether intentional or not. The prevention of torture and ill-treatment is a shared responsibility.

Beyond their monitoring mandate NPMs seek to build relationships with detaining agencies and civil society to allow for constructive, cross-sector dialogue, aimed at addressing key areas of concern.

In the 2013-14 reporting period New Zealand's performance in protecting human rights in detention was subjected to scrutiny by several United Nations bodies, including the United Nations Human Rights Council's Universal Periodic Review process and the United Nations Working Group on Arbitrary Detention.

The United Nations Subcommittee on Prevention of Torture (SPT) visited New Zealand for the first time in April 2013. The SPT is the international body overseeing implementation of OPCAT. Its mandate is to develop an innovative, sustained and proactive approach to the prevention of torture and ill-treatment in detention. Its report to the New Zealand Government confirmed a number of issues that NPMs had also identified, including conditions of detention, and health and mental health care in detention. NPMs will seek

1. This report uses the generic term 'ill-treatment' to refer to any form of cruel, inhuman or degrading treatment or punishment.

to make progress on these and other areas in collaboration with detaining agencies and other key stakeholders.

The SPT also made a number of recommendations to government relating to its obligation to provide adequate financial and human resources to the NPMs so they can better fulfil their monitoring responsibilities.

In 2015 the government will be reviewed by the United Nations Committee on Torture. It is due to report to the United Nations Human Rights Committee, the United Nations Committee on the Rights of the Child and the United Nations Committee on the Elimination of Racial Discrimination. These bodies will also review matters relating to people in detention.

New Zealand is acknowledged internationally as a leader in realising, promoting and protecting human rights. NPMs will continue to work towards their vision of a New Zealand that is free from torture and ill-treatment, where places of detention are safe and humane, and where people who are detained are treated fairly and their human rights are respected.



Judge Sir David Carruthers
Chair, Independent Police Conduct Authority



Robert Bywater-Lutman
Inspector of Service Penal Establishments, Office of the Judge Advocate General



Dr. Russell Wills
Children's Commissioner, Office of the Children's Commissioner



Dame Beverly Wakem
Chief Ombudsman, Office of the Ombudsman



David Rutherford
Chief Commissioner, Human Rights Commission

Human Rights Commission

The Crimes of Torture Act 1989 designates the Human Rights Commission (the Commission) as the Central National Preventive Mechanism (CNPM).

This role entails coordinating with NPMs to identify systemic issues, liaison with government and the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT).

The Commission is an independent Crown Entity with a wide range of functions under the Human Rights Act 1993. 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.

The Commission's function includes 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. The Commission also administers a dispute resolution process for complaints about discrimination.

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

OVERVIEW

The Commission's role as CNPM is established under sections 31-32 of the Crimes of Torture Act 1989 (COTA). In the 2012/13 reporting period the Commission worked with NPMs to develop a job description for the CNPM, which includes:

1. Publication of the OPCAT annual report
2. Addressing systemic issues and advocating on issues of common concern
3. Liaising with the UN Subcommittee on Prevention of Torture
4. Coordinating and maintaining NPM policies and procedures
5. Maintaining an online workspace for NPMs to share information
6. Coordinating and facilitating outreach activities, including an annual programme of engagement with civil society
7. Organising training and development activities, such as thematic workshops
8. Convening regular meetings of NPMs
9. Providing expert human rights advice
10. Assisting with NPM monitoring.

SUMMARY OF ACTIVITIES

During the reporting period the Commission convened six roundtable meetings of NPMs. The first of these meetings focused on examining and responding to the draft findings of the SPT during its 2013 visit to New Zealand. The Commission coordinated a joint NPM response to the draft report and to the government's draft response.

The Commission facilitated a meeting of NPMs with the UN Working Group on Arbitrary Detention, where NPMs highlighted issues of concern to the Working Group. The Commission coordinated the submission of further information to assist the Working Group with their visit. The Working Group's initial report was published at the conclusion of their visit in May 2014.

Another meeting convened by the Commission focused on the range of issues relating to health and mental health care in detention. The meeting, which brought together NPMs and representatives of the Ministry of Health as well as the Mental Health Foundation, provided a useful forum to identify and discuss key issues, and to strengthen relationships between NPMs and health professionals.

The Commission has worked with NPMs to further develop and progress the NPM Action Plan developed in 2013. It has worked with NPMs to produce policies to clarify the mechanism's collective vision and approach, and to guide activities. The development of a coordinated communications and engagement strategy continues to be important work in progress for the Commission.

GOING FORWARD

Facilitating engagement with detaining agencies and civil society are a priority for the next reporting period. The reports and recommendations of the SPT, the UN Working Group on Arbitrary Detention and the Universal Periodic Review provide a strong platform for engagement and collaboration.

The completion of a National Plan of Action on Human Rights in 2015, in consultation with government and civil society, will further contribute to these activities.

The Commission intends to undertake further research to clarify issues identified by NPMs relating to the definition of places of detention, and the application of the OPCAT mandate and other oversight mechanisms in contexts where risks of torture and ill-treatment may exist that are not yet covered by OPCAT.

The SPT's recommendations about adequate resourcing will also be progressed.

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 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 seriously bodily harm has occurred. It may investigate those incidents and other matters involving Police policy, practice and procedure where it is satisfied that it is in the public interest to do so.

In addition, the Authority has entered into a Memorandum of Understanding with Police under which the Commissioner of Police may notify the Authority of incidents involving offending or serious misconduct by a Police employee, where that matter is of such significance or public interest that it places or is likely to place the Police reputation at risk. The Authority may act on these notifications in the same manner as a complaint.

Judge Sir David Carruthers is the Chair of the Independent Police Conduct Authority, having been appointed for a five-year term in April 2012.

OVERVIEW

In the whole of its work and function the Authority is aiming to shift its general focus from one of 'blame' to prevention. This philosophical shift has informed the Authority's NPM function in the reporting year and will continue to do so.

There are two aspects to the Authority's NPM work. It involves consideration of, first, the quality and nature of Police custodial facilities and, second, the operation and management of those facilities.

Police operate 437 custodial facilities nationwide. The majority of these are cell blocks contained at Police Stations. In addition, Police have responsibility for prisoners, but not the cell facilities, at District Courts.

SUMMARY OF ACTIVITIES

Visits and inspections

Where possible during the reporting year, when the Authority has visited Police facilities in the course of its ordinary work, the opportunity has been taken to conduct an unannounced visit of the attached custodial facility, with a consequent report to Police.

Consistent with the philosophical shift in its focus, the Authority is currently working closely with Police to develop National Standards for Police custodial facilities, as well as Police custodial practices and processes. This work is being undertaken with a view to setting up a model structure of custodial standards against which Police can audit their own compliance nationwide, and develop a capital expenditure plan to gradually close custodial facilities that do not comply with the standards, and upgrade others.

In addition to Police providing to the Authority annual audits of compliance with the National Standards, the Authority plans to continue its periodic visits to Police cells and associated reporting.

The Authority envisages that its new OPCAT model will substantially enhance the supervision, observation and safety of persons in Police custody. This will in turn assist in preventing the suicides and injuries that occur in Police cells.

Oversight of Police custodial management

During the reporting year the Authority received 2,193 complaints from members of the public or notification from the Police. Of these, 9.5 percent were identified to have OPCAT related issues. The Authority categorises these into those which are the most serious and require independent investigation, and those which are suitable for other action, including referral back to Police for investigation or conciliation.

Engagement

New Zealand Police

The Authority engaged with Police during this reporting year through site visits and its consideration of complaints by members of the public, and by referrals from the Police where there has been a death or serious injury occurring in Police custody.

The Authority continues to have a measurable positive effect on Police custodial processes and procedures. This has been achieved through consistent engagement with Police in certain Districts in relation to particular incidents in Police custody, and through engagement with Police National Headquarters and OPCAT site visits. The Authority also applies an OPCAT perspective to its independent investigations and reviews. While independent 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 general oversight role.

NPMs

The Authority continued to work closely with other NPMs. It remains committed to working with NPMs on reviewing its prevention methodologies and identifying avenues for further development going forward.

Issues

In the 2013/2014 reporting year the Authority identified a number of common failings and recurring issues in Police custodial facilities. In response the Authority has conducted a dedicated review of about thirty incidents which occurred in Police custody during the years 2011–2014. These incidents include cases of injury, self-harm and suicide attempts which have come to the attention of the Authority as a result of a complaint, or a referral by the Commissioner of Police.

Issues identified in this review include a lack of alternatives to Police custody for people who are vulnerable due to suspected mental impairment, intoxication or drug use, the Police inability to access appropriate services for vulnerable people in custody, and inadequacies in the custodial management and training of officers in providing required standards of care.

The results of this review will be set out in a generic report by the Authority on Police custodial management.

The Authority has changed its complaints database so that the information it receives on a daily basis now clearly identifies those matters which refer to Police activities in custodial facilities. This change provides more accurate information about what happens in custodial facilities, including patterns of complaints that require more general inquiry.

GOING FORWARD

In the coming year the Authority will continue to work closely with Police to complete and implement its new approach to OPCAT work. This includes developing the National Standards for Police custodial facilities and a robust reporting and auditing process. This will be supplemented by a programme of action to address substandard facilities.

The Authority will continue to identify custodial management issues through its complaints and referrals processes, and independently investigate these matters where it is necessary to do so.

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 sections 79(1) and 80 of the Court Martial Act 2007.

OVERVIEW

The Services Corrective Establishment (SCE) is located in Burnham Military Camp, Christchurch. SCE is currently where all members of the Armed Forces serve out the formal punishment of detention prescribed in the Armed Forces Discipline Act 1971 and available to Naval ratings of able rank, Army privates and Royal New Zealand Air Force leading aircraftmen.

In addition, there are a limited number of holding cells in each of the more significant New Zealand Defence Force base or camp facilities that are used to briefly confine any members of the Armed Forces for their own protection or for the maintenance of good order and military discipline.

While there are no detention facilities off-shore currently available to the NZDF on NZ Navy Ships, they can be arranged relatively readily when required as the Armed Forces Discipline Act section 175(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.

The ISPE has no staff, but has the capacity to second assistance if required in order to meet the OPCAT objectives of ensuring that all members of the Armed Forces deprived of their liberty are treated with humanity and respect and not subjected to torture and ill-treatment.

SCE is a fairly modern but small detention facility that can cater for up to eight male and two female detainees at any one time. It has a professional full time staff of Non Commissioned Officer wardens drawn from all three Armed Services. They are supported by the Commanding Officer of the Southern Regional Support Centre (SRSC) in Burnham Camp, who holds a dual appointment that includes the position of Commandant SCE in his or her job description. The SRSC has a medical officer on call to SCE and on the rare occasions when detainees require specialist treatment, referral to relevant health professionals in Christchurch is readily arranged.

ISPE continues to arrive unannounced at the reception office of SCE and meets with the Chief Warden before reviewing the documentation and inspecting the facilities. Each detainee is interviewed individually and in private. Feedback is provided routinely at the conclusion of the inspection to the Commandant of SCE and to the Chief Warden. Any significant concern identified is reported directly to the Chief of Defence Force in writing without delay.

SUMMARY OF ACTIVITIES

Up to eight inspections are authorised each year.

No members of the Armed Forces were sentenced to the punishment of detention by the Court Martial of NZ during the reporting period. The last service member sentenced by a court to six months detention was in March 2013. As a consequence, all those detained were sentenced by their Commanding Officers at a Summary Proceedings Hearing, where the powers of punishment are limited to a maximum of 28 days detention.

A regular review of occupancy levels by the ISPE throughout the reporting period revealed that there were never more than three detainees undergoing punishment at any one time, and most were serving sentences of less than 20 days detention. More often than not there was just one detainee and for weeks at a time it was not unusual for the correction facility to be free of detainees. As a consequence, given other priorities, just one inspection of SCE was conducted by the ISPE in 2013/14.

The SCE was also independently inspected in March 2014 by the United Nations Arbitrary Detention Working Group (UNADWG) as part of a wider inspection of New Zealand detention facilities. The UNWGAD provided positive feedback to the ISPE that mirrored that of the United Nations Subcommittee on the Prevention of Torture (SPT), who inspected the SCE less than a year earlier. The SPT's comments are expanded below.

ISSUES

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

The ISPE is satisfied with the treatment of detainees and the living conditions at SCE. Provided the control measures remain in place, it continues to be suitably resourced, and the attitude of the management and staff at SCE remains consistent, then torture and ill treatment there looks highly unlikely.

While detention as a punishment is vital to the maintenance of good order and military discipline, it is a punishment for serious offending that is used sparingly by Disciplinary Officers exercising their responsibilities at Summary Proceedings Hearings. This is reflected in the SCE occupancy rate, which is extremely low.

In the 2012/13 OPCAT Report mention was made of the inspection in April – May 2013 by the SPT of SCE and the cells at HMNZS PHILOMEL, within the Naval Base in Devonport. Over the same period the SPT also inspected the camp cells at Burnham Military Camp. The report's findings were not publicly available at the time of the release of the last OPCAT annual report. The SPT's final inspection report was released in August 2014.

The SPT were very impressed by the SCE. They were however critical of the camp cell facilities they inspected. The SPT's principal concern, which as it happens applies to most of the NZDF camp or base cell stock, was the absence of toilet facilities in the cells. As it stands, for a detainee to visit the toilet from a camp or base cell he or she has to call for the assistance of a guard who will provide access to toilet facilities located nearby. This led the SPT to recommend that:

“Deficiencies concerning sanitary infrastructures in camp cells be remedied, giving due consideration to international standards.”

This recommendation fails to recognise that camp or base cell facilities are used by the Armed Forces as a last resort, and when they are, detention for periods over 12 hours is very unusual. Further, Camp and Base Standing Orders direct the closest of supervision for those detained, so a member of the Armed Forces who is detained in a camp or base cell can call for toilet assistance from a guard or escort, who is readily available and close at hand, and the situation is not quite as dire for a detainee as suggested by the SPT in their report.

The SPT recommendation also appears to take no account of Armed Forces Discipline Act section 175(1) on establishment and regulation of service prisons and detention quarters noted above.

GOING FORWARD

The ISPE will continue “no notice” inspections of SCE in the 2014/15 year. The number of inspections will depend to some extent on the numbers detained in the SCE facility and the duration of sentences. There is no value in an inspection of the facility when no members of the Armed Forces are undergoing punishment and limited value when detainees have been detained for the first few days of a sentence of about 14 days detention.

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 wider New Zealand Armed Forces.

While no notice inspections of SCE are required to meet the objectives of OPCAT, there has, throughout the course of OPCAT inspections, been no evidence of torture and ill-treatment meted out to members of the Armed Forces who are detained. Indeed such a concept is anathema to the ethos and values of the Armed Forces.

Office of the Children's Commissioner

The Office of the Children's Commissioner monitors children and young people in residences established under section 364 of the Children, Young Persons, and Their Families Act 1989 (CYPFA).

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 2003.

The Commissioner has a range of statutory powers to promote the rights and well-being of children and young people up to 18 years of age.

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

OVERVIEW

The Office of the Children's Commissioner (the Office) is designated as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989. The Office's role is to visit youth justice residences, care and protection residences, and Mother and Baby Units (MBU) in prisons to ensure compliance with OPCAT.

The Office's NPM designation was originally set up as a joint responsibility with the Office of the Ombudsman. In practice, and with the agreement of the Chief Ombudsman, the Office now carries out its NPM role independently.

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

SUMMARY OF ACTIVITIES

Monitoring approach

Over the past year the Office has developed a new framework to improve monitoring of Child, Youth and Family (CYF) residences and sites under section 13(1) (b) of the Children's Commissioner Act 2003. This new framework aims to achieve a deeper and more systemic understanding of performance and the outcomes being achieved for children and young people.

The Office uses this new approach for its NPM monitoring. This supports the preventive focus that is inherent in the NPM mandate and is a better fit in the New Zealand context. The Office's new approach looks beyond basic safety and care, and takes a systems and performance approach. This performance approach will influence and support CYF to focus on developing their practice so that it positively changes the lives of the young people and children in their care.

In the NPM context the new approach can assess the use of CYF's coercive powers such as placing young people into secure care and into restraints, within a wider assessment of a residence's culture, leadership, staff capability and overall performance. The Office sees value in considering residences' compliance with these OPCAT domains within this wider context as these factors influence the extent to which the treatment of young people is focused on enhancing their wellbeing and rights. The Office believes that moving from a solely audit focus to take a system performance view will allow them to consider how these elements come together to produce better outcomes for children and young people, and drives a culture of improvement that prevents issues of ill-treatment from occurring.

To support this approach the Office has developed a three point assessment scale for the OPCAT domains, with ratings of (1) detrimental, (2) developing, and (3) well placed. 'Detrimental' indicates the residence is non-compliant with an OPCAT domain, while a rating of either 'developing' or 'well-placed' indicates the residence is compliant with the standard required for the relevant domain.

Budget considerations

To date the Office has not been funded to undertake its NPM function and has absorbed the costs by combining the activity with the Office's general monitoring work in residences. The Office was able to undertake a visit to the Auckland Region Women's Corrections Facility alongside an Inspector from the Office of the Ombudsman to assess the Mother and Baby Unit. However, the Office's resources limit its ability to participate as part of multi-disciplinary team to review mental health facilities and adult prisons where people up to the age of 18 are detained. This is a gap and without funding cannot be managed within existing staffing and resourcing levels.

Monitoring visits

During the reporting period the Office conducted three planned and one unannounced NPM visit at four CYF residences. In addition, the Office

made one planned visit to the Mother and Baby Unit (MBU) in the Auckland Region Women's Corrections Facility. It is important to note that for this monitoring visit, the Office assessed the MBU conditions against only the OPCAT domains and not the domains from the Office's broader monitoring framework.

ISSUES

Key findings of monitoring visits

Across the five visits the Office's overall assessment was that all facilities were compliant with OPCAT domains. Using the above-mentioned three-point scale, the assessment of the facilities' overall OPCAT performance was that:

- One residence and the MBU were well placed, indicating there was strong performance, capability and consistent practice evident across both facilities on the six domains
- Two residences were developing, indicating that staff had some awareness of areas needing improvement and had undertaken some actions to address weaknesses but that overall there was inconsistent practice occurring across the two sites
- One residence was developing with some well-placed elements.

Name of facility	Type of facility
Te Au Rere a Te Tonga	Youth Justice residence
Te Puna Wai o Tuhinapo	Youth Justice residence
Te Oranga	Care and Protection residence
Epuni (unannounced)	Care and Protection residence
Auckland Region Women's Corrections Facility	Mother and Baby Unit

These ratings reflect that, in general, children and young people in New Zealand facilities are treated well, their rights are upheld. Children and young people in detention live in relatively pleasant surroundings, eat well and have access to physical and mental health care and a range of programmes to support their personal development. They also usually have opportunities to see or talk to their families and whānau.

However, across the visits to CYF residences some clear themes emerged that point to areas for improvement and which influence how well CYF residences are placed to positively engage young people, uphold their rights, ensure their access to effective treatment, and their ability to use the protection system in residences. These broader systemic issues impact on the ability of facilities to deliver the preventative care and services children and young people require.

Strengthen management capability and leadership at residences

Good leadership drives the residence's direction and is essential to build capability. Leadership sets the tone, culture, and expectations of the organisation which directly impacts on how staff manage young people. The Office believes that CYF need to invest in developing their leadership capability in residences. This is important as the residence's culture and expectations influence how effectively staff de-escalate difficult behaviour or whether they resort to the use of secure care as the preferred management tool. When Residence management are supported to further develop core management skills, we would expect to see greater modelling of best practice, ability to manage performance issues effectively, and greater drive for practice change.

Strengthen staff capability

There is a strong need for ongoing planning and investment in the skills, both general and specific, that staff need to work effectively and compassionately with the complex and challenging children and young people in residences. Throughout the year we have made recommendations to CYF that they address staff capability and invest in training and development of their residence care teams. When staff capability is improved, we would expect to see the right level of skill to effectively de-escalate difficult behaviour and manage the complex needs of children and young people in residences. This will help to ensure that the treatment and protection activities in residences meet the needs of children, that powers are appropriately used, and that the care delivered is high quality with children's rights at the centre of practice. When staff do not have adequate training and support they struggle to respond in optimal ways to some children and young people.

Increase the quality of supervision for care staff

The environment in residences is a challenging one for staff given the complexity of needs and the behaviours of the children and young people they manage. Related to the point above, excellent social work practice requires regular quality supervision that provides the opportunity for staff to learn from situations that have arisen, reflect on their practice and understand how they could improve their response to children and young people.

The Office believe that CYF need to enhance the quality and level of supervision provided to care staff in residences to ensure skills are developed and maintained, and staff receive the support necessary to work effectively with children and young people.

Build cultural capability and provide quality cultural supervision

Staff need support to integrate culturally appropriate practices into their work with a wide range of children and young people from different cultural backgrounds in residences, particularly Māori and Pasifika children and young people. Approximately 60-65 percent of children and young people in residences are Māori. It is therefore vital that culturally appropriate practice is integral to residence staff's service delivery.

At present there is variable cultural capability in residences, with an over-reliance on Māori staff to support the cultural practices of non-Māori staff in residences. It is the Office's view that the responsibility for ensuring that cultural practice is embedded in residences lies with the Residence Management team.

Māori staff also need to be better supported than they are currently and should be provided with regular quality cultural supervision to support their role and the demands of meeting cultural requirements for other staff. When CYF put investment into this area of practice, the Office would expect to see better integration of tikanga Māori practice across all elements of service delivery, more distributed cultural capability across all staff, including the management team, resulting in a positive flow on impact on the treatment and quality of services provided to Mokopuna Māori in residences.

Develop a more young person/child-centred approach

Residence staff need to treat children and young people with dignity and respect, ensure they have access to the services they need, facilitate regular contact with their family and whānau, allow them opportunities to have input into what happens in the facility, and ensure they have

confidence in the grievance process. Currently the Office's assessment is that most residences have not developed a culture, or the systems and processes, needed to place the needs of children and young people at the centre of their practice.

Putting in place child focused systems and processes will better place residences to meet the needs and uphold the rights of children and young people and ensure that their treatment and protection is appropriate and proportionate. It will also ensure that young people have confidence in the grievance system, which is currently not as high as it should be in some residences.

Increase the effectiveness of collaboration and partnerships with other agencies

Access to many services such as health, education or training opportunities improves when CYF staff build positive and constructive relationships with other agencies. The Office identified variability across residences in their ability to engage effectively with other agencies delivering services to children and young people. Some issues the Office observed in this area do sit outside the control of CYF, as it was clear in some cases that other agencies needed to improve the level of service and engagement they provide to CYF staff. However, the Office would like to see Residence managers prioritise interagency engagement, ensuring communication channels are open, and regular relationship management is in place so that young people and children in residences receive the services that they need in a timely manner.

Good practices at the facilities visited

At one residence, stakeholders and staff indicated there had been a clear shift from a control and containment approach to one that focused on the quality of care. This shift had resulted in numerous positive impacts including improvements in the way young people were treated, their access to activities and contact with others, the quality of the residence's protection system, and training for the residence's personnel.

At this site, the leadership also modelled and encouraged open engagement in tikanga Māori and, as a result, culturally appropriate practices were well integrated throughout service delivery. To support this practice in the residence there is ready access to high quality cultural advice for staff and for young people.

The approach and values of staff at this residence were considered transformational, with relatively low use of secure care, a wide range of culturally appropriate programmes available for young people, and staff willing to go out of their way for the young people so that their outcomes are improved.

The Office's reports and recommendations, and engagement with CYF aims to support CYF to learn from and draw on best practice examples like this to lift performance at other residences.

The required improvements highlighted above indicate that more systemic shifts are required by CYF to ensure that children and young people receive the level of service and care that they need to thrive. These areas will assist in establishing a preventive culture in CYF residences that is sustained and embedded in practice and which delivers better outcomes for young people.

In summary, it is clear that more investment in leadership is required as well as a concerted focus on building the capability and training of staff caring for these children and young people.

There needs to be a clear expectation that tikanga Māori practices are embedded into the day to day activities of residences. For Māori children and young people it is a fundamental right that their cultural wellbeing is prioritised and supported.

At the heart of the Office's findings is the need for CYF to fully embed a child-centred approach in their residences that results in meaningful engagement and participation by children and young people in decisions that affect them. This is an area that the Office will continue to focus on across all of its monitoring activities.

The Office acknowledges that every residence visited develops an action plan that responds to their recommendations and the Office monitors progress in implementing those plans. The Office also recognises that addressing many of our systemic recommendations will require a 'whole system' response and acknowledge that CYF is currently focused on making these strategic shifts through their Modernisation Programme.

GOING FORWARD

The Office's new framework takes an explicit future-focused perspective on performance. In this way the Office's recommendations aim to provide a way forward for CYF to deliver an enhanced level of service for children and young people. Over the next 12 months the Office will continue the development of its monitoring framework. For example, the Office will move to a five point rating scale for NPM monitoring. This will bring the NPM rating scale in line with the general monitoring scale and will allow a more nuanced assessment of OPCAT domains.

Office of the Ombudsman

The Office of 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 Ombudsmen have wide statutory powers to investigate complaints against central and local government agencies. The functions and powers of the Ombudsmen are set out in several pieces of legislation, including the Ombudsmen Act 1975.

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

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

OVERVIEW

Under the Crimes of Torture Act (COTA) 1989, the Office of the Ombudsman is the designated National Preventive Mechanism (NPM) with responsibility for monitoring and making recommendations to improve the conditions and treatment of detainees, and to prevent torture and ill-treatment in:

- 17 prisons
- 70 health and disability places of detention
- 1 immigration detention facility
- 4 child care and protection residences
- 5 youth justice residences

The designation in respect of child care and protection and youth justice residences is jointly shared with the Office of the Children's Commissioner, and this year the Ombudsman's Office undertook a first joint visit with the Children's Commission to the Mother and Baby Unit (MBU) at Auckland Women's Prison.

The Ombudsman's Office is assisted in carrying out its NPM functions under COTA by two Inspectors. In 2013/14 the Ombudsman's Office committed to carrying out 32 visits to places of detention, which it exceeded by carrying out a total of 37 visits, including 22 formal inspections. Seventeen visits were unannounced.

Each place of detention visited contains a wide variety of people, often with complex and competing needs. Some detainees can be demanding or vulnerable and difficult to deal with, others are more engaging and constructive. All have to be managed within a framework that is consistent and fair to all. While the Ombudsman's Office appreciates the complexity of running such facilities and caring for detainees, its obligation is to prevent torture and ill-treatment.

SUMMARY OF ACTIVITIES

Monitoring visits

The 22 formal inspections were at the sites set out in the table on the following page.

Name of facility	Type of facility	Recommendations made
Christchurch Men's Prison (Youth Unit)	Prison	1
Mount Eden Corrections Facility (ARU/Transit Unit)	Prison	2
Te Awhina Inpatient Unit, Whanganui DHB	Acute Mental Health	–
Stanford House, Whanganui DHB	Extended Secure Regional Forensic	1
Manawatu Prison (B block) (follow-up)	Prison	4
Rimutaka (Upper Prison) (follow-up)	Prison	2
Mason Clinic (Kauri Unit), Waitamata DHB	Forensic Unit	–
Northland Region Corrections Facility (Separates, ARU & Kea Unit)	Prison	7
Auckland Region Women's Corrections Facility (ARU & Management Unit)	Prison	8
Haumietekiteki Unit, Capital & Coast DHB	Forensic Intellectual Disability Unit	2
Arohata Women's Prison (follow-up)	Prison	–
Waikeria Prison (Youth Unit) (follow-up)	Prison	19
Psychiatric Service for Adults with an Intellectual Disability (PSAID), Canterbury DHB	Intellectual Disability	–
Te Awakura Inpatient Unit (North), Canterbury DHB	Acute Mental Health	–
Te Whare Maiangi Inpatient Unit, Bay of Plenty DHB	Acute Mental Health	2
Mental Health Services Older People (MHSOP), Bay of Plenty DHB	Aged Care	–
Te Toki Maurere Inpatient Unit, Bay of Plenty DHB	Acute Mental Health	4
Auckland Region Women's Corrections Facility (Young People)	Prison	8
Mount Eden Corrections Facility (follow-up)	Prison	11
Hawkes Bay Inpatient Unit	Acute Mental Health	1
Hawkes Bay Regional Prison (Youth Unit)	Prison	3
Rangatahi Inpatient Unit, Capital & Coast DHB	Adolescent Unit	2

The Ombudsman's Office reported back to 22 places of detention (100%) within three months of conducting an inspection and made 80 recommendations, of which 65 were accepted or partially accepted (as set out in the table below).

Recommendations	Accepted	Not accepted
Prisons	54	15
Health and disability places of detention	11	0

Of the 15 recommendations not accepted by the Department of Corrections (Corrections), eleven concerned three common matters that were repeated across several sites, namely:

- The standardising of meal times (four recommendations)
- The use of cameras and prisoners' right to privacy (four recommendations)
- Segregated prisoners being placed in non-compliant cells (three recommendations)

This brings the total number of visits conducted over the seven year period of the Ombudsman's Office's operation as an NPM under OPCAT to 299, including 115 formal inspections.

ASSOCIATION FOR THE PREVENTION OF TORTURE

In June 2014, one Inspector was invited to attend the Association for the Prevention of Torture symposium in Geneva on *Addressing children's vulnerabilities in detention*. This was a good opportunity for the Ombudsman's Office to share learning and best practice in inspecting and monitoring children's facilities and to form working relationships with other NPMs from around the world.

ISSUES

Prisons

In last year's annual report three key areas were identified which raised concerns following inspections:

- Segregation facilities
- Prisoner meal times
- The use of force and restraint

Two of these matters continued to be of particular concern in the 2013/14 reporting year.

Segregation facilities

For the third consecutive year, segregation facilities remain a cause for significant concern with further evidence of variances in the way directed segregation is being applied to prisoners pursuant to section 58(1)(a) or (b) of the Corrections Act 2004. There still remains considerable disparity in the accuracy of segregation paperwork and the amount of time prisoners are allowed out of their cells, particularly in the open air.

While it was pleasing to see progress being made on the development of a new Management Unit at Auckland Prison during the reporting year prisoners were still being housed in the two stainless steel cells highlighted in the 2012/13 annual report. Corrections has assured inspectors that these cells are not currently in use and will only be used as a last resort (upon the completion of the Management Unit). Corrections also advised that the cells were developed in response to a range of security breaches and have been effective from a security point of view. However, the Ombudsman's Office still considers these cells are a cruel and inhuman way to detain individuals and has asked that they be decommissioned.

Corrections advised stage two of the Management Unit work will be completed by December 2014. Meanwhile, segregated prisoners located in the Separates Unit are effectively living on a building site. At the time of the inspector's visit in May 2014, one prisoner was in his cell during the day whilst construction work was underway. However, Corrections advised that prisoners are currently being removed each day prior to the arrival of construction staff and placed elsewhere.

Northland Prison and Waikeria Prison have no Management Unit. Therefore, on the evidence available to the Ombudsman's Office, prisoners

on directed segregation are sometimes located in the Separates Unit. Separates facilities are designed for prisoners undertaking a period of cell confinement and have none of the design features legally required for prisoners subject to a segregation directive such as a power outlet and privacy screening. Furthermore, Waikeria Separates Cells, which can only be described as deplorable, have no windows and therefore prisoners have no access to natural light or fresh air for 23 hours a day.

The Ombudsman's Office has been informed that the Separates Unit at Northland Prison will be upgraded to Correction's Management Unit standard towards the end of 2014. Corrections further advised that some remedial work has been undertaken to upgrade the Separates Unit at Waikeria.

Meal times

Last year the Ombudsman's Office reported that the 08.00 to 17.00 unlock regime has condensed the working day for many prisoners, including meal times, with some dinners being routinely served as early as 15.30, leaving prisoners for lengthy periods without meals. While the Ombudsmen were hopeful that Corrections would address this concern, inspectors discovered three more units where the period between dinner and breakfast appears to be too long. Corrections advised it will shortly be commencing a review of the national prisoner menu.

Young persons

The three male Youth Units in New Zealand are located in Waikeria, Hawke's Bay and Christchurch Prisons. Although Mount Eden does not have a Youth Unit, the Ombudsman's Office believes Mount Eden Prison receives sufficient numbers of young people to justify the

establishment of one. The three Youth Units are of similar design and hold between 30 and 40 prisoners. All three units were under capacity at the time of the inspections due to a decline in the youth population subject to juvenile justice nationally.

Although managed separately from adults, young females are located in one of the three women's prisons and do not receive the same level of attention as their male counterparts.

Christchurch and Hawkes Bay Youth Units were orderly, well maintained and generally relaxed. The majority of young people were purposefully engaged in education or work-based learning throughout the day and given the opportunity to participate in a wide range of leisure activities in the evening. Observations suggest positive relationships between staff and young people, and youngsters were generally complimentary about most of the staff. Due to the extended unlock hours at Christchurch and Hawkes Bay Youth Units, meal times are able to be standardised to normal meal times.

Waikeria Youth Unit was less orderly and some staff seemed disengaged with the young people. There was a scarcity of education and leisure activities and no employment opportunities. Some cells were in a disgraceful state of cleanliness with dirty floors and walls and excessive amounts of graffiti. There was an expectation that prisoners should pay weekly contributions into a welfare fund to supply food, prizes and some sporting equipment for family days and sports days. On the weekends, youth were locked in their cells during the afternoon in order for staff to facilitate visits. Inspectors made twelve recommendations to improve conditions for the young people in this unit. The Ombudsman's Office has been informed by

Corrections that some remedial work has been undertaken to improve the environment and increase the activities available to youth.

Mount Eden is not set up to manage young people long term. However, Serco2 has developed, implemented and resourced a dedicated programme for those young people who are temporarily managed there. Youth are generally managed in the induction wing (but separately from adults). Accommodation is of an acceptable standard and staff/prisoner relationships seemed positive. While the prison has improved unlock hours for youth prisoners since the inspectors' visit in August 2013, they were still subject to 19 plus hours lock down a day with limited access to fresh air.

At Auckland Women's Prison young persons are managed in the same unit as adult prisoners (on a separate unlock regime). The multiple unlock routines and lack of appropriate facilities undermines the full implementation of juvenile justice and penalises female youth significantly. While accommodation was exceptionally clean and tidy there were very few opportunities for education, programmes and leisure activities. Corrections has agreed to review the current regime for young females, including the implementation of a Youth Strategy project focusing on improving the management of the young people in its care.

The average time out of cell for youth on a week day is set out in the table below.

Because of the small number of youth facilities and their geographical location, young people tend to be located further from their homes than adult prisoners, in spite of their particular need to maintain family ties. This situation impacts on their ability to receive visits and resettle back into the community. Video conferencing goes some way to facilitating/maintaining family contact but does not replace face-to-face interaction.

Privacy issues

By their very nature, prisons house difficult to manage, sometimes dangerous and often vulnerable prisoners who can push boundaries and challenge the system. In coercive environments such as prisons, there is a danger that security is overemphasised to the detriment of the dignity of prisoners. This year inspectors found examples that suggest order and security prevailed too easily over dignity and fairness.

In Youth Units, double cells are monitored on camera and have limited privacy screening around the toilet/shower area. In Waikeria East, seven cells (the old At Risk cells) are monitored on camera but house mainstream prisoners.

In Northland Prison, prisoners in Separates Cells are required to shower in an external yard which is monitored on camera.

As well as being monitored on camera, women in the Separates Cells at Auckland Women's Prison can be observed by prisoners and staff from both the corridor and the cell opposite using the toilet and shower.

Christchurch	Hawkes Bay	Waikeria	Mount Eden	Auckland Women's
14 hours	11-12 hours	6-7 hours	4-5 hours	1-2 hours

2. Mount Eden Corrections Facility is managed by Serco, under contract to the Department of Corrections.

In the At Risk Unit, cells are monitored by cameras, including the unscreened toilet area. Cameras in both units are monitored by staff in the office and in *'Master Control'* including by officers of the opposite sex in the course of their work when female staff are unavailable. At Auckland Women's Prison just over 41% of officers are male.

The ability to view naked female prisoners in the shower and undertaking their ablutions is of great concern. The Ombudsman's Office considers this to be significantly degrading treatment or punishment under COTA and the OPCAT. The ability to view male prisoners in the shower is similarly degrading. The Ombudsman's Office recommended that cameras should not cover toilets and shower areas. This was not accepted by Corrections.

Corrections are currently considering the use of privacy screening in Separates Cells, but maintain that privacy screens should not be used in At Risk Cells as Corrections believes there is an overriding need for staff to be able to safeguard prisoner well being.

Corrections has acknowledged that showers in external yards in Northland Prison are not ideal and advised that significant remedial work will be undertaken in 2014 to upgrade the Separates Unit at Northland Prison, including a new indoor shower block.

Good practices at the prisons visited

Arohata Women's Prison: In 2012 the Ombudsman's Office made a recommendation to cease using outdoor shower facilities in secure cells because they were monitored on camera. It was pleasing to note during our follow-up visit (January 2014) that a new shower block had been installed in the Secure Unit. Furthermore privacy screens had been installed around toilets/showers in double bunked cells.

Rimutaka Prison: Inspectors took the opportunity to revisit the High Dependency Unit at Rimutaka Prison and found a well-run facility that brings together health and custodial staff to provide care in a safe and secure environment for prisoners with age-related conditions.

Auckland Women's Prison and Northland Prison: The At Risk Units at both sites have made positive changes to the overall running of the units by introducing a much more therapeutic approach to the management of detainees.

Northland Prison: Kea Unit is a 24 bed facility for younger persons (not to be confused with Youth Units) who are considered vulnerable. This unit was well run and had purposeful work and leisure opportunities for the detainees.

HEALTH AND DISABILITY PLACES OF DETENTION

Mental Health (Compulsory Assessment and Treatment) Act 1992

In the 2012/13 annual report the Ombudsman's Office reported on two forensic sites using outdated "*night safety procedures*" to justify locking patients in their bedrooms overnight – Totara Unit in the Mason clinic (Waitemata DHB), and Purehurehu Unit at Te Korowai-Whariki Forensic Mental Health Service (Capital and Coast DHB). Inspectors returned to both sites and found that the "blanket" policy has now been replaced with individualised night safety plans. However, the number of patients on night safety plans remains high. In contrast, both Midland and Canterbury Regional Forensic Psychiatric Services have no night seclusion and patients are free to leave their bedrooms any time of night or day.

The Ministry of Health has published guidance on the use of seclusion and night safety procedures in mental health inpatient services. The Ministry also advises that further guidelines on the use of restraint and seclusion practices are planned for 2015, which will have an increased emphasis on a human rights approach to the provision of treatment and the continued reduction of restrictive practices such as seclusion and restraint. Transitional guidelines, specific to the phasing out of the use of Night Safety Procedures, will be published in the coming months.

In the 2012/13 annual report the Ombudsman's Office also reported on a patient in Tawhirimatea Unit (Capital & Coast DHB) who was being managed in seclusion/de-escalation on a semi-permanent basis. The DHB, with the involvement of the staff of this Office, has been actively seeking resolution of this situation. While

progress has been slow, the DHB is committed to finding suitable, alternative accommodation and the Ombudsman's Office is encouraged by recent developments for the patient concerned. The Ombudsman's Office will continue to liaise with all parties until a satisfactory resolution can be found.

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

Haumietikitiki Unit (Capital & Coast DHB) is one of two national secure facilities that provide services for people with an intellectual disability. It also provides the only inpatient service for women. As the national secure facility for care recipients, the unit receives people with some of the most challenging and difficult to manage behaviours from around the country.

Care recipients may, from time to time, be required to spend a period of time in the seclusion/de-escalation area. This year, the Ombudsman's Office met two clients who were permanently sleeping in seclusion rooms and who had spent a significant amount of time in the de-escalation area (well over twelve months). Although one client has since been moved to a more appropriate facility, the second client remains in seclusion/de-escalation with no prospect of exiting in the short to medium term.

The Ombudsman's Office has been informed that discussions are taking place with the Ministry of Health to build a number of secure, individualised units to accommodate patients with high and complex needs. However, this is a long term project, and immediate, alternative accommodation needs to be sourced for this client and others in a similar position.

The Ministry of Health has advised that intensive service planning is currently occurring around this individual. Whilst there is a medium term plan in place involving the development of a step down facility, current discussions involve the provision of a more immediate solution.

Good practices at the facilities visited

Kauri Unit (Waitemata DHB) has a good system for documenting the use of seclusion and in particular recording the amount of time each service user on seclusion spends unlocked whilst in the seclusion area.

Te Whare Maiangi Inpatient Service (Bay of Plenty DHB) has a reportable seclusion event form that is easy to follow and which covers all the necessary key points that should be asked before deciding to seclude a service user.

Te Awhina Unit (Whanganui DHB) has introduced a swipe card access system to improve safety and security for service users and staff.

Stanford House (Whanganui DHB) uses de-escalation techniques which have resulted in the elimination of patient restraints over the last two years.

GOING FORWARD

In 2014/15, 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 the visit.

OVERARCHING ISSUES

REPORT OF THE UN SUBCOMMITTEE ON PREVENTION OF TORTURE

In April – May 2013 the United Nations Subcommittee on Prevention of Torture (SPT), the international monitoring body established under the OPCAT, carried out its first visit to New Zealand. The delegation visited 36 places of detention across the country, including police and court cells, prisons, Defence Force facilities, immigration facilities, and residences for children and young people. It also met with relevant government agencies, representatives of civil society and with members of the NPM.

Under the provisions of OPCAT, the SPT's visit and reporting process is confidential, with publication of the report largely at the discretion of State authorities. In early 2014 the government provided NPMs with the opportunity to view and comment on the SPT's confidential draft report and on the government's draft response. The final report was released, with the government's agreement, in August 2014.

NPMs acknowledge the opportunity to view and provide comments on the SPT's report and the government's draft response, and welcome the government's decision to make the SPT report public. As well as demonstrating a commitment to transparency and to the OPCAT itself, the report's findings and recommendations can now be openly discussed and used to best effect to address the issues raised.

The SPT identified areas where improvements are required in order that human rights standards are met and adequate safeguards are in place to prevent human rights violations. The recommendations deal with issues concerning:

- Resourcing and effectiveness of the NPM monitoring bodies and the OPCAT system in New Zealand
- Alignment of domestic legislation with human rights standards
- Review of the institutional framework, including regime conditions, access to Parole and pre-trial detention
- Fundamental safeguards, such as access to information and complaint mechanisms
- Māori over-representation in the criminal justice system and availability of programmes aimed at reducing Māori recidivism
- Juvenile justice, including the currently low legal age of criminal responsibility and access to organised activities
- Health and mental health care in detention, noting, among others, the high rates of often chronic and acute mental disorders within the prison population, and access to timely and adequate health and mental health care services
- Conditions of detention, including adequacy of facilities, access to exercise and outdoor activities, nutrition, the right to privacy and the use of segregation and restraint

These issues and concerns have also been identified by the NPMs in their monitoring activities, including during the reporting period. Some of these are further discussed on the next page.

The government's response to the SPT report indicates areas where relevant policies or practices are in place already, where initiatives are underway to address the concerns raised by the SPT, and where challenges remain.

The SPT's findings highlight the gap that can exist between policies and their implementation and operation. This can be for a range of reasons and is an issue common to jurisdictions around the world. It is also one of the reasons why OPCAT places such importance on regular, monitoring.

NPMs look forward to discuss in more detail the issues raised by the SPT. Their report and the government's response provide a clear framework for implementing and monitoring progressive improvements.

DIGNITY IN DETENTION

When people are detained, their rights to liberty and freedom of movement are affected. However, they retain the majority of their human rights. In particular, people in detention have the right to be treated with humanity and respect for their inherent dignity. This positive obligation complements the prohibition against torture and ill-treatment. Detention conditions or the misuse of intrusive practices such as force, restraint, searches or seclusion may constitute torture and ill-treatment in certain circumstances.

The need for security and order is a clear and legitimate concern in a detention context. However, an over-emphasis on security can infringe the human rights of detainees.

NPMs sometimes encounter situations where the standard of facilities or treatment may compromise the dignity of detainees. NPMs continue to work with relevant agencies to address these identified instances and areas where changes to policy or practice can prevent this from occurring.

NPMs recognise the challenges faced by detaining agencies in balancing the requirements of security and safety of all staff and detainees alongside the need to uphold detainees' rights. However, NPMs are concerned at the evidence of over-reliance on security at the expense of human dignity.

NPMs recommend that detaining agencies continue to engage in dialogue on standards of facilities and treatment in order to achieve a better balance of security and dignity.

Seclusion and secure care

NPMs recognise that within a detention context it may be necessary to temporarily separate a person from other detainees for their own or others' safety.

Human rights standards require that the use of segregation, seclusion or other conditions amounting to isolation must be limited and accompanied by safeguards, such as monitoring, review and appeal processes. Because of the potentially harmful effects on a person's physical and mental health, human rights minimum standards are premised on the notion that conditions amounting to 'isolation' should be a measure of last resort and used for as short a time as possible.

In certain circumstances, solitary confinement can amount to a breach of human rights standards. The reason for its use, the conditions, length, effects, and individual circumstances are all factors that are considered when determining whether solitary confinement reaches this threshold.

In a mental health context there have been improvements in reporting and transparency around the use of seclusion, including closer monitoring and regular publication of data. Ministry of Health guidelines are part of ongoing efforts to reduce the use of seclusion.

However, there are still indications that a small number of patients are secluded for lengthy periods. The Ombudsman Office's section of this report highlights situations of particular concern. The Ombudsman's Office has worked with the relevant authorities to find appropriate accommodation for individuals involved. In view of the gaps in monitoring further detailed below, NPMs maintain strong concerns that other cases may exist.

NPMs recommend that the government develops a cross-agency plan to improve capability for the appropriate management of individuals with high and complex needs.

REVIEW OF THE SCOPE OF THE OPCAT MANDATE

A substantial number of areas where people are deprived of their liberty are not currently monitored by NPMs. This includes facilities where people reside subject to a legal substitute decision-making process, such as locked aged care facilities, dementia units, compulsory care facilities, community-based homes and residences for disabled persons, boarding schools and other situations where children and young people are placed under temporary state care or supervision. People detained in these facilities potentially are vulnerable to ill-treatment that can remain largely invisible.

NPMs strongly argue that persons in such facilities or situations can effectively be in a state of detention, which means these places should be subject to preventive monitoring under OPCAT.

These facilities are all subject to New Zealand's international obligations in the ICCPR³ and CAT⁴ and may be subject to various types of general monitoring under the auspices of different government agencies. However, the lack of rigorous oversight from an OPCAT specific perspective is concerning.

Currently, an estimated 138 aged care providers with locked facilities potentially fall within the scope of OPCAT. Care agencies note that with a rapidly ageing population the health system is already under pressure as the sector is reaching capacity. These and other factors potentially impact on the quality of care provided to the elderly and increase the risk of ill-treatment, including over-medication and pharmaceutical restraint.⁵

3 ICCPR Article 7.

4 CAT Article 16.

5 See *Elder abuse and neglect*, Families Commission (2008), p.16.

The Committee on the Rights of Persons with Disabilities in April 2014 identified the detention of persons with disabilities, whose legal capacity has been denied, in institutions against their will either without their consent or with the consent of a substitute decision-maker, as an issue open to risks of ill-treatment, including the exercise of seclusion and restraint and unconsented medical treatment.⁶

A 2013 study highlighted the hidden nature of ill-treatment directed against disabled persons within the community.⁷ People in home-care/ live-in support situations may have limited ability to verbalise or communicate what is happening to them, or may be reliant on the abuser for day-to-day support and assistance.

The OPCAT mechanism would become relevant in situations where some degree of substituted decision making or other forms of state control is exercised in removing a person's legal capacity and liberty.

NPMs have also identified places where young people may be directed to attend programmes under Supervision with Activity orders as another gap in monitoring. These settings do not have the same degree of monitoring and external oversight as other residences. Supervision with Activity programmes can be held in relatively isolated places, such as camps located in remote forest settings, and accordingly this entails some significant risk factors.

There is also sporadic and anecdotal evidence of ill-treatment in group homes and boarding schools, including indecent assault, sexual violation and solitary confinement.

It would further be desirable to pay particular attention to the treatment of minors and juvenile offenders in police custody, immigration or penitentiary institutions.

The actual scale of ill-treatment of these population groups is unknown as these issues continue to be under-reported also due to the vulnerability of these groups and their limited awareness of, and access to, complaints and oversight mechanisms.

There need to be systems in place to respond effectively and in a manner appropriate to the needs of the persons concerned to prevent any forms of ill-treatment in these situations. The deterrent and preventive nature of independent monitoring and oversight would go towards identifying and addressing these gaps in a sustainable manner.

In order to make progress on addressing this concern the Human Rights Commission will pursue a research project between November 2014 and June 2016 to consider the definition of "places of detention" and its application in the New Zealand context. This project seeks to review and examine those less traditional places of detention noted above and identify areas of concern where persons deprived of their liberty are vulnerable to ill-treatment.

NPMs recommend that the government prioritises reviewing the scope of the OPCAT mandate in New Zealand and identifying ways to address the gaps in monitoring places of detention.

6 See CRPD General Comments No.1 (2014), p.10. New Zealand ratified the Convention on the Rights of Persons with Disabilities (CRPD) in 2008.

7 *The Hidden Abuse of Disabled People Residing in the Community: An Exploratory Study*, Roguski, M (18 June 2013). <http://www.communityresearch.org.nz/wp-content/uploads/formidable/Final-Tairawhiti-Voice-report-18-June-2013.pdf>.

APPENDIX: OPCAT background

INTRODUCTION TO OPCAT

The Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty that 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, 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 torture and ill-treatment and improving conditions of detention. This preventive approach aims to ensure that sufficient safeguards 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 United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), 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 and ill-treatment.

PREVENTIVE APPROACH

The Association for the Prevention of Torture (APT) highlights the fact that “prevention is based on the premise that the risk of torture and cruel, inhuman or degrading treatment or punishment can exist or develop anywhere, including in countries that are considered to be free or almost free from torture at a given time”.⁸

On the principle of prevention, the SPT noted that:

“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.”⁹

Prevention is a fundamental obligation under international law, and a critical element in combating torture and ill-treatment.¹⁰ 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, closed environments).

8 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.

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

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

The UN Special Rapporteur on Torture remarked that:

“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.”¹¹

IMPLEMENTATION IN NEW ZEALAND

New Zealand ratified OPCAT in March 2007, following the enactment of amendments to the Crimes of Torture Act 1989, to provide for visits by the SPT and the establishment of NPMs.

New Zealand's designated NPMs are:

- 1 the Independent Police Conduct Authority – in relation to people held in police cells and otherwise in the custody of the police
- 2 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
- 3 the Office of the Children's Commissioner – in relation to children and young persons in Child, Youth and Family residences
- 4 the Office of the Ombudsman – in relation to prisons, immigration detention facilities, health and disability places of detention, and Child, Youth and Family residences
- 5 the Human Rights Commission has a coordination role as the designated Central National Preventive Mechanism (CNPM)

¹¹ 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.

FUNCTIONS AND POWERS OF NATIONAL PREVENTIVE MECHANISMS

By ratifying OPCAT, States agree to designate one or more NPMs for the prevention of torture and ill-treatment (Article 17) and to ensure that these mechanisms are independent, have the necessary capability and expertise, and are adequately resourced to fulfil their functions (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. 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 SPT 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.¹² 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 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 SPT. In carrying out these functions, the CNPM is to:

- consult and liaise with NPMs
- review their reports and advise of any systemic issues
- coordinate the submission of reports to the SPT
- in consultation with NPMs, make recommendations on any matters concerning the prevention of torture and ill-treatment in places of detention.

¹² OPCAT, Article 1.

MONITORING PROCESS

While 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 NPMs have developed procedures applicable to each detention context.

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

- 1 Preparatory work, including the collection of information and identification of specific objectives, before a visit takes place
- 2 The visit itself, during which the NPM monitoring team speaks with management and staff, inspects the institution's facilities and documentation, and speaks 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 following **six domains**:

- 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 and disability care
- 6 Staff: conduct and training.

NPM Contacts

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