NZ Human Rights.
Human Rights Commission
Te Kāhui Tika Tangata

2016/17

Monitoring Places of Detention

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

1 July 2016 to 30 June 2017

IPCA
Independent Police Conduct Authority
Whaia te pono, kia puawai ko te tika

MANAAKITIA A TĀTOU TAMARIKI
Children's Commissioner

Office of the Judge Advocate General of the New Zealand Armed Forces

Ombudsman
Fairness for all

Contact

Human Rights Commission InfoLine

InfoLine: 0800 496 877 (toll free)
Fax: 09 377 3593 (Attn: InfoLine)
Email: infoline@hrc.co.nz (for general enquiries)

TXT: 0210 236 4253

Language Line, an interpreting service, is available. An appointment with a sign language interpreter is 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 7, AIG Building,
41 Shortland Street, Auckland
PO Box 6751, Wellesley Street
Tāmaki Makaurau Auckland 1141
Phone: 0800 496 877
Fax: (09) 377 3593

Te Whanganui ā Tara – Wellington

Level 8 Vector Building
44-52 The Terrace
PO Box 12411, Thorndon
Te Whanganui ā Tara Wellington 6144
Phone: 0800 496 877
Fax (09) 377 3593

Otautahi – Christchurch

Appointments may be made with Christchurch staff through 0800 496 877
Postal Address: c/- PO Box 6751,
Wellesley St, Auckland 1141
Phone: 0800 496 877
Fax (09) 377 3593 (with Att: Christchurch)

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 June 2018
Auckland, Aotearoa New Zealand

Contents

Foreword

In 1976 Jean-Jacques Gautier proposed a new and, at the time, radical idea. He proposed an international convention that would establish a system of un-announced visits to places of detention. Gautier's idea become a reality with the adoption of the United Nations Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2002, and then its entry into force in 2006. OPCAT emphasises cooperation over condemnation, and prevention rather than reaction.

New Zealand was an early adopter of OPCAT and ratified it in March 2007. We were the first country to have a multi-body National Preventive Mechanism (NPM), with responsibility for inspecting places of detention. The NPMs are:

- the Ombudsman: responsible for prisons, health and disability places of detention, immigration detention facilities, youth justice residences, and care and protection residences
- the Independent Police Conduct Authority: responsible for police custody
- the Children's Commissioner: responsible for youth justice and care and protection residences
- the Inspector of Service Penal Establishments: responsible for Defence Force penal establishments.
- the Human Rights Commission has a coordination role as the Central National Preventive Mechanism (CNPM). The Commission has responsibility for coordinating activities, producing reports, identifying systemic issues and liaising with the United Nations.

Together we play a key role in protecting the human dignity and rights of individuals who are deprived of their liberty in New Zealand. These individuals comprise some of the most marginalised and vulnerable in our society; prisoners, people who experience mental health conditions and intellectual disabilities, and children and young people.

This report is the 10th report of the National Preventive Mechanisms. It summarises the activities of the NPMs and CNPM during the period 1 July 2016 to 30 June 2017. This report also identifies the areas where we would like to see more progress, including specific changes we want to see within the next five years. These areas are;

Mental health

Those who are detained are more likely to experience mental health issues, and being detained can exacerbate these conditions;

- Nintey one per cent of prisoners have been diagnosed with either a mental health or substance use disorder over their lifetime.[1]
- Between 40 and 60 per cent of youth who have offended have mental health and/or alcohol or other drug disorders.[2]
- As at July 2017, every 24 hours Police respond to 90 calls involving a person having a mental health crisis.[3]

These people can end up detained in police cells due to a lack of other suitable facilities and/or because mental health professionals are not available. Those in prison, youth justice residences, or care and protection residences who have serious mental health conditions should be able to access the treatment and support they require. This may include treatment in an inpatient unit when appropriate. Too often people who are detained do not receive the help they need.

The right to health is a fundamental human right. The International Covenant on Economic Social and Cultural Rights (ICESCR) states there is a right to the "enjoyment of the highest attainable standard of physical and mental health". People who experience mental health difficulties should be receiving the support and treatment they require in an appropriate manner and in the appropriate environment.

Māori

Māori make up 15.4 per cent of New Zealand's population,[4] but they make up a greater percentage of those detained in New Zealand;

- As at 30 June 2017, 5,171 of the prison population were Māori out of a total population of 10,260. Māori were 50.4 per cent of the prison population.[5]
- Māori accounted for 26 per cent of mental health service users in New Zealand in 2015.[6]
- 60 per cent of those detained in a care and protection residence, and 70 per cent of those detained in youth justice residences, are Māori.[7]
- Māori are involved in 46 per cent of police apprehensions.[8]

We are concerned that our criminal justice system is not responding to the needs of Māori. The Waitangi Tribunal stated that the Crown has a Treaty responsibility to reduce inequities between Māori and non-Māori reoffending rates to protect Māori interests.[9] This responsibility requires the Crown to work in partnership with Māori, not just simply inform itself of Māori interests. Some detaining agencies are making great strides towards reducing inequities while others have some way to go. There needs to be an overarching kaupapa, bicultural frameworks, and strategies that make a real difference for Māori.

Seclusion and restraint

New Zealand has a high use of seclusion, especially when compared to other countries. For example, New Zealand secludes prisoners at a rate over four times the rate of that in England and Wales.[10] New Zealand also uses mechanical restraints, such as tie-down beds and restraint chairs, which are no longer used in countries like England.[11]

Studies have shown seclusion has adverse consequences. Observed effects include panic attacks, difficulties with thinking, concentration, and memory, paranoia, problems with impulse control including self-mutilation, illusions, and hallucinations, and physiological effects such as insomnia, heart palpitations, back and joint pains, appetite loss, deterioration of eyesight, diarrhoea, and tremulousness. These effects can occur after only a few days in seclusion and the risks increase with each additional day spent in seclusion. The detrimental impacts of seclusion and restraint in New Zealand have been well documented in Dr Shalev's 2017 report *Thinking Outside the Box? – A Review of Seclusion and Restraint Practices in New Zealand*.

Dr Shalev's recommendations should be fully implemented. In particular, the use of equipment such as restraint chairs and restraint beds should be abolished, the use of seclusion should be eliminated in mental health facilities,[12] and minimum standards around decent living conditions and access to fresh air, food and drinking water should always be met.

OPCAT designations

The lack of independent monitoring of aged care and dementia facilities has been an area of particular concern. The people in these facilities often have physical and mental vulnerabilities, and there are growing concerns about the treatment of people in these facilities. Applying the OPCAT framework to aged care and dementia facilities will be beneficial.

The NPMs have supported a designation change to allow the Ombudsman to monitor and inspect locked private sector dementia facilities. We are pleased to note that these designations have recently been approved and inspections should commence in 2019/20 after the Ombudsman has scoped relevant requirements and obtained the necessary resourcing.

The NPMs support specialist monitoring of facilities that hold youth. The Children's Commissioner should be able to monitor youth units in prisons, mothers with babies units in prisons, and child and adolescent mental health units. We will continue advocate for these designation changes.

Funding for NPMs

Article 18(1) of OPCAT states "The States Parties shall guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel."

The NPM's potential remains underutilised as inadequate resourcing continues to constrain some NPMs. As a result, the mechanism is yet to make consolidated progress on a range of key issues of concern and has not been able to implement a more comprehensive monitoring approach that is in line with international best practice. Better resourcing would enable increased frequency of visits and better inspection coverage by all NPMs, as required under OPCAT. More funding would also mean the services of experts could be contracted to assist with visits when and where required. All NPMs should be fully resourced to carry out their OPCAT responsibilities.

A word of thanks

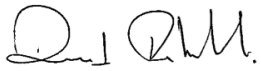
Numerous people and groups have helped us carry out our work during the last decade.

We would like to thank the Association for the Prevention of Torture, the UN Subcommittee for the Prevention of Torture, and the UN Working Group on Arbitrary Detention for their continued support and guidance.

Thank you also to the detaining agencies who continue to cooperate, meet, and discuss issues and changes with us; the Department of Corrections, the Ministry of Health, District Health Boards, Oranga Tamariki, the New Zealand Police, and the Ministry of Justice.

The current chairs of the National Preventive Mechanisms also thank the previous chairs and staff of the National Preventive Mechanisms for all their work establishing and continuing the work of the National Preventive Mechanisms. The performance of today's National Preventive Mechanisms and its achievements are a testament to your hard work.

We will continue to work hard, raise issues, propose changes, and advocate for those marginalised and invisible in our society.

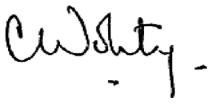


David Rutherford
Human Rights Commissioner,
Human Rights Commission

Judge Andrew Becroft
Children's Commissioner,
Office of the Children's Commissioner

Judge Peter Boshier
Chief Ombudsman,
Office of the Ombudsman

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



Judge Colin Doherty
Chair,
Independent Police Conduct Authority

Human Rights Commission
Te Kāhui Tika Tangata

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

This role entails coordinating with NPMs to identify systemic issues, and liaising 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 functions include 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 fundamental premise of OPCAT is based on international evidence highlighting the deterrent and preventive effect of independent monitoring and oversight. The Commission's role as CNPM is established under sections 31 and 32 of COTA. COTA outlines, in general terms, the coordination role played by the CNPM. The CNPM's responsibilities, as developed by the NPMs and CNPM, include:

- Consulting and liaising with NPMs and coordinating the activities of the NPMs, including:
  - facilitating biannual meetings of the NPMs
  - meeting with international bodies
  - making joint submissions to international treaty bodies, and
  - providing communications and reporting/ advocacy opportunities.
- Providing human rights expert advice
- Maintaining effective liaison with the SPT
- Coordinating the submission of annual reports prepared by NPMs to the SPT
- Reviewing annual reports prepared by NPMs to advise them of any systemic issues arising from those reports and, in consultation with NPMs, making recommendations to government on systemic issues arising from NPMs' reports through media releases and thematic reports or briefing papers, and
- Coordinating and facilitating engagements with international human rights bodies and civil society consistent with the Commission's broader mandate under the Human Rights Act 1993 section 5(1) to "promote respect for, and an understanding and appreciation of, human rights in New Zealand society".

Activities During Reporting Period

The Commission organised and hosted three chair level meetings. The chairs discussed how to ensure a there is comprehensive OPCAT monitoring system and considered what optimum monitoring looked like. They shared monitoring developments within their own organisations. Key issues within detention facilities were discussed including mental health, seclusion and restraint, intellectual disability, youth in police detention, and ensuring appropriate and culturally responsive rehabilitation options for Māori.

The chairs also agreed to formalise regular meetings between officials of the various NPM agencies, in addition to engagement between the respective chairs. The officials meet four times per year to collaborate, share experiences, identify ways to work together more effectively, and progress work requested by the NPM chairs.

A Human Rights Commission advisor joined the

Office of the Ombudsman on their inspection of Christchurch Men's Prison. This provided a valuable experience for the Human Rights Commission to understand on-the-ground monitoring and consider how best to support monitoring staff as the CNPM. The Human Rights Commission would like to thank the Office of the Ombudsman for proving this invaluable experience.

Following the release of the Torture Ambassador Project report, *He Ara Tika – a Pathway Forward*, in the 2015-16 year the Commission continues to advocate for the implementation of its recommendations. The report looked at the role of the Optional Protocol to the Convention Against Torture in the monitoring of aged care facilities and disability residences, and concluded these facilities are in the scope of OPCAT. The Commission continues to advocate and work with the Minister and Ministry of Justice to designate a body under OPCAT to monitor these facilities. We remain optimistic that these facilities will be monitored under OPCAT and were pleased to be informed recently that the required designation changes have been approved by the Minister.

During the reporting period the Commission also participated in several United Nation's specialist Committee reviews. These engagements provide an important foundation for domestic advocacy work and improving adherence with international human rights standards in OPCAT related areas.

The Race Relations Commissioner attended New Zealand's examination by the UN Committee for the Elimination of Racial Discrimination. Concluding observations following this examination included that New Zealand strengthen its efforts to address the root causes leading to disproportionate incarceration rates of Māori.

The Chief Commissioner offered his place at New Zealand's examination by the UN Committee on the Rights of the Child to the Children's Commissioner. The Children's Commissioner attended this examination accompanied by a Human Rights Commission senior advisor. Concluding observations following this examination included that New Zealand strengthen its efforts to improve the cultural capability of care and protection system and its engagement with Māori communities with a view to addressing the overrepresentation of Māori children in State care.

Seclusion and restraint

In late April 2017 the Commission released Dr Shalev's report, *Thinking Outside the Box – A review of seclusion and restraint practices in New Zealand*. This report outlined several serious concerns about New Zealand's seclusion and restraint practices.

The report was completed with funding from the Office of the United Nations High Commissioner for Human Rights, through the Special Fund of the OPCAT. It was commissioned by the Human Rights Commission to provide an independent perspective on seclusion and restraint practices in several different detention contexts and to identify areas of best practice, as well as areas that require improvement.

The report indicated that seclusion and restraint may not always be used as a last resort option, as required by international human rights law, and some of the rooms and units used to seclude people do not provide basic fixtures such as a call-bell to alert staff, a toilet, or fresh running water.

It also highlighted the over-representation of Māori in seclusion and restraint events, a small but persistent number of 'chronic' cases where solitary confinement and restraint were used for a prolonged time, and systemic gaps, particularly in relation to the care of those who are mentally unwell.

Dr Shalev made a number of recommendations including:

- Stopping the use of equipment such as restraint chairs and restraint beds.
- Making sure that rooms and cells are of a reasonable size, are clean, safe, well-ventilated, well-lit and temperature controlled and that basic requirements around access to fresh air and exercise, food and drinking water are always met.
- Decommissioning facilities that are not fit for purpose.
- Ensuring all cells/rooms are equipped with a means for attracting staff attention

- Thorough records and data are kept, indicating start and end times of seclusion and restraint periods and any efforts at less restrictive methods, and regularly analysed for trends in ages, ethnicities and gender.

Going forward

The Commission continues to hone its role as the coordinating NPM. It aims to provide more opportunities for monitoring staff from all NPMs to work together and discuss issues of mutual significance. Specifically, the Commission:

- commits to providing common training for staff of the NPMs
- is eager to prepare and more joint submissions, both domestically and internationally, on issues of relevance to OPCAT activities
- organise public engagements for the NPMs as a group, and
- will continue to raise and advocate for changes on systemic issues across detention settings.

Office of the Children's Commissioner

Manaakitia A Tātou Tamariki

Overview

Since 1989, the Office of the Children's Commissioner (OCC) has had a statutory responsibility to monitor how well Child, Youth and Family (CYF) delivers services for children and young people. When New Zealand ratified the United Nations' Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2007, OCC gained a specific mandate to monitor CYF secure residences. These monitoring responsibilities carried over to the new Ministry, Oranga Tamariki, that replaced CYF on 1st April 2017. There are a total of nine secure Oranga Tamariki residences in New Zealand – five are care and protection residences, and four are youth justice residences.[13] These designations are shared with the Ombudsman, however the Ombudsman and Children's Commissioner have agreed the Children's Commissioner will carry out the inspection of these facilities. The NPMs are working with the Ministry of Justice to have these designations amended.

Introduction

From July 2016 to March 2017, we found that CYF secure residences generally met the standards that are required by OPCAT. Our full 2016-17 findings are described in our publicly available report: *State of Care 2017: A focus on Oranga Tamariki's secure residences*, available on our website.[14] Below is a summary.

Strengths

As far as we could establish, residences appeared to be generally safe for children and young people. In this monitoring period, we found some incremental improvements in residential care at an operational level. Specific areas of improvement included:

- The three care and protection residences we monitored were moving to create more therapeutic environments for children and young people
- There was a trend across more than half the residences for an increased level of training and supervision for residential (care) staff
- An overall improvement in the way residential staff treat young people, including how they respond to challenging behaviour and a reduction in the use of restraints over the previous two-year period.
- An improvement in material conditions across three residences.

Areas for development

However, there is still a long way to go. Secure residences still fall far short of the aspirations of the new agency, Oranga Tamariki. We remain concerned about the variable quality of practice and the fundamental system issues that underpin this variability. These systemic issues have included:

- A lack of understanding of what child-centred practice or systems look like, and how they improve children's experience.
- No nationally consistent articulated vision or purpose for youth justice residences. There is continuing debate as to whether custody or rehabilitation is their primary role.
- No standardised best practice approach to creating a therapeutic environment across residences, including care and protection residences.
- A lack of therapeutic knowledge and skill amongst the staff providing day-to-day care for children and young people in residences, and a lack of training and supervision to build residential staff's capability.
- Insufficient responsiveness to our indigenous Māori children, young people, and their families and whānau (extended families).
- A lack of a suite of suitable community-based facilities to reduce pressure on secure residential placements, especially pressure from remand placements.
- Inadequate transition processes from secure residential care to the community.

Oranga Tamariki response

Encouragingly, in the last couple of years, we have seen evidence of our monitoring findings and recommendations beginning to influence some of

these larger system issues and the design of the new agency, Oranga Tamariki. The new agency itself, including secure residences, is now underpinned by a child-centred operating model, which is something we have long advocated for.

As part of its transformation, Oranga Tamariki is currently working to address each of the above issues. For example, there is now in place a clear vision for youth justice residences, a proposed new structure for residences that should enable residential care staff to receive a higher level of supervision, and new funding to expand the range of care options available to children and young people. Significantly, the new Oranga Tamariki Act 1989 lays the ground work for Oranga Tamariki to find better solutions to improve outcomes for Māori children and young people, their families and whānau, hapū, and iwi.

Evolving the way we monitor

We continue to evolve and improve the way we monitor. In the last year, we have significantly improved how we engage with children and young people during our monitoring visits to Oranga Tamariki residences. For example, we conduct child and youth led tours of residences (where children and young people show us around the residence and point out any areas of the residence they like or dislike), we survey young people, and we conduct in-depth one-to-one interviews with them. These engagements have enabled us to understand young people's experiences and consider young people's views when assessing Oranga Tamariki's performance against the OPCAT domains. This has noticeably enhanced the visibility of children and young people's voices in our reports. Our engagement with children and young people has also led to numerous young people disclosing concerns that we have gone on to investigate and help to resolve.

We are currently testing a new indigenous Māori 'lens', which we have developed to assess the quality of children and young people's experiences. This is important because over 60% of the children and young people in care and protection residences are Māori and over 70% in youth justice residences are Māori. We have named our new monitoring lens Mana Mokopuna. This 'lens' has been designed to ensure that we:

- Consider the cultural values and beliefs that are important to our indigenous children and their families and whānau, hapū, and iwi.
- Focus on children and young people's experiences and outcomes.
- Hold high aspirations for all children and young people.

Mothers with Babies Units (MBUs) in prisons

In this 2016-17 period, we also monitored one MBU, in partnership with the Ombudsman's Office. MBUs are self-care units within each of New Zealand's three women's prisons, managed by the Department of Corrections. Mothers who meet certain criteria may be given the opportunity to live with their babies in an MBU, up until their baby turns two years of age.

Although the MBU we monitored was generally compliant with the OPCAT domains, we found that there had been a significant deterioration in the domain ratings between our latest visit and our previous visit to the same MBU in April 2014. For example, there were inadequate opportunities for babies to socialise and participate in activities outside of the prison and no tailored induction or training in place for MBU staff. We expressed concern to the Department of Corrections about the potential negative implications for babies in the MBU.

Department of Corrections' response

The Department accepted all our recommendations and has made significant progress since our monitoring visit to the MBU. We have been informed that mothers and babies from this MBU are now going on regular external outings. The Department is also in the process of introducing training for all staff who work in the MBUs, which is expected to be completed in June 2018. Encouragingly, the Department now has a Women's Strategy 2017-2021, which includes changes in the treatment and management of women offenders in New Zealand. This strategy should also benefit mothers and babies.

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

Overview

Under the Crimes of Torture Act 1989 (COTA), the Ombudsman is a designated National Preventive Mechanism (NPM) for the OPCAT in New Zealand, with responsibility for monitoring and making recommendations to improve the conditions and treatment of detainees, and to prevent torture, and other cruel, inhuman or degrading treatment or punishment, in:

- 18 prisons
- 80 health and disability places of detention
- three immigration detention facilities[15]
- four child care and protection residences, and
- five youth justice residences.

The designation in respect of child care and protection and youth justice residences is jointly shared with the Children's Commissioner. Work is underway with the Ministry of Justice to review the current NPM designations.

We are funded for three Inspectors and specialist advisors to assist us in carrying out our NPM functions. In 2016/17 we committed to carrying out 32 visits to places of detention. We exceeded this commitment and carried out a total of 57 visits,[16] including 13 formal inspections. Thirty-six visits (63 percent) were unannounced.

For the 2017/18 year onwards we were successful in obtaining new funding from Parliament which will enable us to increase the number of Inspectors on our OPCAT team and expand and intensify our programme of inspections. As part of this more intensive programme, we are committed to progressively publishing our reports, in the interests of transparency and accountability.

Each place of detention we visit contains a wide variety of people, often with complex and competing needs. Some detainees are difficult to deal with and can be demanding and vulnerable, whereas others are more engaging and constructive. All have to be managed within a framework that is consistent and fair to all. While we appreciate the complexity of running such facilities and caring for detainees, our role is to monitor whether appropriate standards are maintained in the facilities and people detained in them are treated in a way that avoids the possibility of torture or other cruel, inhuman or degrading treatment or punishment occurring. In line with our power to make recommendations with the aim of improving the treatment and the conditions of people deprived of their liberty, we also review and comment on proposed policy changes and legislative reforms.

The 13 formal inspections were at the sites set out in the table below.

Table 1

Name of facility	Type of facility	Recommendations made	Report published
Hawke's Bay Regional Prison	Men's Prison	37	Yes
Ward 35 (Middlemore Hospital) Counties Manukau DHB	Elderly/dementia	6	No
Spring Hill Corrections Facility	Men's Prison	33	Yes
Te Whetu Tawera Inpatient Unit (follow-up visit) Auckland DHB	Adult Mental Health	–	No
Pohutukawa (Mason Clinic) Waitemata DHB	Forensic Intellectual Disability	2	No
New Plymouth Remand Centre (Whanganui)	General Prison	2	No

Name of facility	Type of facility	Recommendations made	Report published
Rolleston Prison (follow-up visit)	Men's Prison	7	Pending
Christchurch Men's Prison	Men's Prison	53	Yes
Wards 34, 35 and 36 Henry Rongomau Bennett Centre Waikato DHB	Adult Mental Health	12	No
Arohata Prison (follow-up visit)	Women's Prison	6	Pending
Ward 21 (follow-up visit) MidCentral DHB	Adult Mental Health	4	No
STAR 1 MidCentral DHB (follow-up visit)	Elderly/dementia	4	No
Manawatu Prison (follow-up visit)	Men's Prison	12	Pending

We reported back to all 13 places of detention within eight weeks of conducting the inspection.[17] This brings the total number of visits conducted over the 10-year period of our operation as an NPM to 438, including 171 formal inspections.

This year, we made 185 recommendations, of which 149 (81 percent) were accepted or partially accepted as set out in the table below.[18]

Table 2

Recommendations	Accepted/ Partially accepted	Not accepted
Prisons	126	31
Health and disability places of detention	23	5

The 44 informal visits were at the sites set out in the table below.

Table 3

Name of facility	Type of facility	Number of visits
Te Roopu Taurima O Manukau Trust	Secure community home for clients with an intellectual disability	3 homes
Community Living	Secure community home for clients with an intellectual disability	1 home
Community Care Trust	Secure community home for clients with an intellectual disability	4 homes
Emerge Aotearoa	Secure community home for clients with an intellectual disability	1 home

IDEA Services	Secure community home for clients with an intellectual disability	10 homes
Arohata Prison	Women's Prison	1
Rimutaka Prison	Men's Prison	3
Wellington District Court	Court Cells	1
Mangere Accommodation Centre	Immigration	1
Auckland International Airport	Immigration	1
Tawhirimatea Capital & Coast DHB	Mental Health	1
Haumietiketike Capital & Coast DHB	Forensic Intellectual Disability	1
Te Whare Ahuru Hutt Valley DHB	Mental Health	1
Christchurch Men's Prison	Men's Prison	1
Christchurch International Airport	Immigration Holding Facility	1
Pohutukawa Waitemata DHB	Forensic Intellectual Disability	1
Kauri Waitemata DHB	Forensic Unit	1
Totara Waitemata DHB	Forensic Unit	1
Rata Waitemata DHB	Forensic Unit	1
Auckland Prison	Men's Prison	1
Auckland South Corrections Facility	Men's Prison	1
Mount Eden Corrections Facility	Men's Prison	1
Auckland Region Women's Corrections Facility	Women's Prison	1
Otago Corrections Facility	Men's Prison	1
Invercargill Prison	Men's Prison	1
Tiaho Mai Counties Manukau DHB	Mental Health	1
Henry Rongomau Bennett (Ward 36) Waikato DHB	Mental Health	1
Rotorua Police Hub	Police Jail	1

Prisons

This year, we trialled new inspection criteria for prisons.[19] The criteria are made up of six core inspection standards, each of which describes the standards of treatment and conditions a prison is expected to achieve. These standards are underpinned by a series of indicators that identify the evidence Inspectors should collect in order to determine whether there is anything that could be considered to be torture, or cruel, inhuman or degrading treatment or punishment, or otherwise impact adversely on detainees. The list of indicators underpinning the standards is not exhaustive and does not prevent an establishment demonstrating that the standard has been met in other ways.

This year, we identified several areas of concern. These relate to:

- the increase in prison population, particularly female and remand prisoners
- levels of violence – particularly prisoner-on-prisoner assaults
- the number of 16 and 17-year olds being detained in non-youth facilities, and
- the effectiveness of the prisoner complaint process.

Increase in prison population

Towards the end of 2016, the prison population in New Zealand hit 10,000 for the first time. Since then it has continued to rise, peaking at 10,308 at the end of June 2017. The remand population has experienced a significant increase of 14.7 per cent from June 2016 to June 2017.[20] Inspectors identified

a significant number of remand prisoners spending extended periods locked in their cells, not involved in purposeful activities.[21]

At the end of June 2017, 752 prisoners were female. The increase in the female population has resulted in the decommissioned top jail at Rimutaka Prison (Wellington) being reopened to accommodate low-security women. We will continue to closely monitor conditions for women and remand prisoners over the coming year.

Corrections has acknowledged the growing prison population and advises extra capacity has been added through double bunking and reopening units, as well as planning new facilities.

Levels of violence

During recent inspections, Prison Directors reported concerns around levels of violence. There was a perception amongst both staff and prisoners that levels of violence had increased, which some staff attributed to the use of new psychoactive substances. Responses from our prisoner questionnaire continue to suggest that a significant number of prisoners do not report assaults.

Corrections acknowledges that violence occurs in prisons and states procedures are in place when assaults are reported, as well as a tool to help officers assess the overall level of tension in units.

Table 4: Prisoner questionnaire results – safety[20]

	Hawke's Bay	Spring Hill	Christchurch Men's Prison
Muster on the day of inspection	676	969	897
Number of questionnaires handed out	646	854	853
Number of questionnaires completed & returned	442 (68%)	562 (66%)	534 (63%)
% of prisoners surveyed who reported being assaulted at that prison	46%	37%	49%
Number of responses:	(204)	(203)	(248)
% of prisoners assaulted who did not report the assault at the time	66%	65%	73%
Number of responses:	(134)	(134)	(174)
% of prisoners surveyed who had felt unsafe in current prison	60%	54%	67%
Number of responses:	(265)	(300)	(504)
% of prisoners surveyed who felt unsafe at the time of inspection	29%	48%	25%
Number of responses:	(133)	(135)	(501)
% of prisoners surveyed who felt they had been victimised in this prison	53%	53%	61%
Number of responses:	(235)	(290)	(308)
% of prisoners surveyed who felt they had a member of staff they can turn to	71%	65%	70%
Number of responses:	(315)	(337)	(498)

Young persons in detention

A significant number of young people aged 16 to 17 have been identified as being held in adult prison units. Inspectors found two 17-year old remand accused prisoners[23] held at Manawatu Prison in conditions deemed unacceptable.[24] They were housed in cells previously identified as not fit for purpose.[25] They were subject to a basic yard-to-cell regime, exercising in small safe cell yards and had no access to the gym, library or any form of constructive activity or regular staff interaction. The Department was notified and the youth were relocated to Hawke's Bay Regional Prison where they could participate in programmes and activities for youth.

The Department provided information advising the number of 16 to 17-year olds held at each facility for the week of 19 May to 26 May 2017. On 19 May, there were twenty-five 17-year olds housed in adult accommodation.[26]

Complaints process

The Department has enhanced its prisoner complaints process and set up a dedicated complaints telephone line. The new system was implemented on 1 December 2016. We are continuing to work with Corrections as the new system is refined, including on teething issues which my Inspectors are identifying, such as some prisoners not knowing how to raise a complaint and experiencing difficulties accessing complaint forms. These issues appear to be occurring at a site level and are reflected in prisoner questionnaire responses.

Table 5: Prisoner questionnaire results – complaints process[27]

	Hawke's Bay	Spring Hill	Christchurch Men's Prison
Muster on the day of inspection	676	969	897
Number of questionnaires handed out	646	854	853
Number of questionnaires completed & returned	442 (68%)	562 (66%)	534 (63%)
% of prisoners surveyed who reported not knowing how to raise a complaint	24%	14%	18%
Number of responses:	(107)	(78)	(509)
% of prisoners surveyed who reported it was difficult to access a complaint form	41%	53%	42%
Number of responses:	(181)	(296)	(507)
% of prisoners surveyed who reported they have faith in the complaint system	27%	16%	16%
Number of responses:	(120)	(90)	(471)

What appeared to be working well at the prisons visited

Set out below are examples of good practice that were observed during inspections in the reporting year:

- The Mental Health In-Reach clinician at Christchurch Men's Prison provided an invaluable service. Provision of mental health support for prisoners is being expanded in the region.
- Receiving Office staff and processes at Christchurch Men's Prison were particularly responsive to the individual needs of first-time prisoners.
- Hawke's Bay Regional Prison arranged a job exposition to showcase the range of employment and training opportunities available to sentenced prisoners, and the connections between activities in the Prison and employment opportunities on release. An event to address domestic violence delivered with the assistance of respected community leaders was also provided to prisoners.
- Selected youth are participating in a Duke of Edinburgh's Hillary Award Scheme at Hawke's Bay Regional Prison.

Airport holding areas and immigration detention facilities

Inspectors conducted visits to Christchurch and Auckland International Airports (holding areas) as well as Mangere Refugee Resettlement Centre which also has an immigration detention function. Inspectors were impressed with accommodation standards at the Centre and associated auxiliary areas, as well as the professionalism of staff. Airport holding areas were well-maintained and well-managed, and did not give Inspectors any cause for concern.

Health and disability places of detention

Intellectual Disability (Compulsory Care and Rehabilitation) Act

There are two types of facility that meet the definition of a place of detention for Care Recipients under the Intellectual Disability (Compulsory Care and Rehabilitation) Act (IDCCR). Regional Intellectual Disability Secure Services (RIDSS)[28] and Regional Intellectual Disability Supported Accommodation Services (RIDSAS). RIDSAS services for secure care recipients are delivered in residential homes in the community. There are a number of homes in a region that may be designated secure and meet the definition at any given time.

This year Inspectors visited 19 residential homes in five regions for secure care recipients being detained under the IDCCR.[29] Generally, they observed that staff interacted effectively and positively with clients across all homes, and that efforts were being made to involve clients more in decisions about their own care and treatment. Staff training and supervision, particularly on how to deal with difficult and challenging behaviour, was not well documented and staff retention was a concern for most service providers. On occasion, Inspectors encountered civil clients in secure homes and consequently subject to the same restrictions as secure care recipients.

There was limited evidence at some homes on how clients could make a complaint, including contacting the District Inspector, and not all clients had free access to a telephone.

A number of homes were run down and in need of modernisation. Some bedroom doors potentially compromised clients' privacy and dignity. Observation glass in the doors allowed people outside in the hall/corridor, including other clients, to look into a person's bedroom.

Inspectors observed an increase in the number of cases where the disability sector appears to be unable

to sustain appropriate support for young people with respect to their disability support needs. Inspectors encountered a 15-year-old being managed in an adult secure home due to the lack of appropriate youth facilities. The lack of appropriate youth beds has brought about an inappropriate default to the mental health and criminal justice pathways to find a solution for some youngsters. Inspectors noted several 16 and 17-year olds being managed in acute mental health units due to the lack of secure youth beds. While there were measures put in place to mitigate the risks for the youth (line of sight supervision), the mixing of youth and adults is a breach of the *United Nations Convention on the Rights of the Child*.

As well as raising our concerns at the time of the inspection, ongoing discussions are being held with the National Manager for Intellectual Disability and the Children's Commissioner to find a workable solution.

Mental Health (Compulsory Assessment and Treatment) Act

Similar to last year, Inspectors observed an increase in pressure on acute admission beds with dayrooms, offices, and seclusion rooms routinely being used as bedrooms. The effect of high occupancy levels was having a detrimental effect on the health of staff and service users as well as reducing staff ability to provide optimal nursing care. The risks associated with high occupancy levels has resulted in an increase in restrictions for all service users, including voluntary clients. Service users reported to the Inspectors that the environmental restrictions (locked doors), and lack of autonomy adversely affected their experience of the Service. Inspectors also noted evidence of

A question of restraint

A thematic inspection into the care and management of prisoners at risk of self-harm or suicide found that the use of restraints on five prisoners amounted to cruel, inhuman or degrading treatment.

In March 2017 Chief Ombudsman Peter Boshier published our first thematic OPCAT report *A Question of Restraint*, about the use of seclusion and restraint in five At-Risk Units in New Zealand prisons. Some jurisdictions that have ratified OPCAT have banned the use of tie-down beds.

The Chief Ombudsman found that the Department of Corrections had breached Article 16 of the *United Nations Convention Against Torture* in its use of restraints on five prisoners. One prisoner was tied to a bed for 37 consecutive nights, the period of his restraint coinciding with reduced staffing; another was kept in a waist restraint with his hands cuffed behind his back for 12 weeks, the cuffs being removed every two hours during the day and every four hours at night.

The Chief Ombudsman also found that monitoring At-Risk Units at all times by a live camera feed, including when prisoners were abluting, was degrading treatment under the *Convention Against Torture*. Other concerns included a lack of mental health training for Corrections staff, limited interaction or therapeutic activities for prisoners isolated in At-Risk Units, poor record keeping, and limited staff training. In response to the report, Corrections has started a review of its practice in At-Risk Units and we will monitor progress.

Our OPCAT team also supported international human rights expert Dr Sharon Shalev when she visited New Zealand in late 2016 at the invitation of the Human Rights Commission to consider seclusion and restraint practices in prisons, health and disability units, youth justice and care and protection residences. Dr Shalev's report *Thinking Outside the Box* recommended New Zealand eliminate the use of mechanical restraints altogether.

A Question of Restraint is available at **www.ombudsman.parliament.nz**

Thinking Outside the Box is available at **www.seclusionandrestraint.co.nz**

service users being discharged at short notice because their bed was required for an acute admission.

Due to the high demand for beds, a greater number of service users appeared to be sectioned under the Mental Health (Compulsory Assessment and Treatment) Act in order to secure an inpatient bed. Recommendations to the relevant detaining agency were made with the aim of improving the treatment and conditions of service users. Reports, including recommendations, were sent to the Ministry of Health for follow-up and further discussion.

The Ministry of Health has acknowledged that *'the [Act] has shifted emphasis away from determining whether a person should be detained in hospital to the timely consideration of whether treatment for mental disorder is required'*. The Ministry has advised that services and targeting of funding are under review.

Looking forward

The NPM will be looking to progress some of the key issues detailed below:

Prisons

Safety

There is an obvious and urgent need for the Department to address the levels of violence and intimidation to be found in prisons, particularly in high-security units. Limited staff interaction with high security prisoners, and an insufficient number of constructive activities, result in an atmosphere of boredom and frustration. The Department's gang management strategy is still in development and anti-bullying measures appear to have been largely ineffective to date.

Mental health

Unaddressed, or insufficiently addressed, mental health needs among prisoners is a major issue of concern. The Ombudsman has had occasion to highlight the inadequacy of specialist treatment and support for acutely unwell prisoners. Similarly, a large proportion of prisoners who enter prisons with mild to moderate mental health needs often receive little or no therapeutic intervention. In a stressful custodial environment where violence and intimidation are common features, and where At Risk Units (ARU) can house highly vulnerable prisoners in settings that are inadequate for their needs, mild or moderate mental illness can be exacerbated during incarceration. There is an urgent need to implement a comprehensive prisons programme for the identification and treatment of mental illness at all levels of severity and acuteness.

Prison muster and double bunking

A significant number of single cells across the prison estate are in the process of being double-bunked to accommodate the increase in the prison muster. Placing two people in cells designed to hold one can have a detrimental effect on a prisoner's physical and mental wellbeing, particularly when ancillary services have not been enhanced to deal with the increase.

Privacy

ARU cells and Separate cells are subject to CCTV monitoring, with the camera footage being displayed in the staff base and in master control. The footage can be viewed by anyone entering the staff base, which presents a significant privacy issue where toilets are unscreened. The policy of having unscreened toilets in the ARU cells means that prison staff (and anyone entering the staff base) can observe, either directly or through camera footage, prisoners undertaking their ablutions or in various stages of undress. The Ombudsman considers this to amount to degrading treatment or punishment for the purpose of the Convention Against Torture.

Remand prisoners

The regime for remand accused prisoners remains unsatisfactory despite the recommendations made by the United Nations Subcommittee for the Prevention of Torture following its visit to New Zealand in 2013. As such prisoners are not classified, they are by default managed as high security prisoners. Periods of unlock have been reduced and access to constructive activities is limited.

Equality and diversity policy

Awareness, among prison staff, of the needs and vulnerabilities of groups outside established societal norms is low, a circumstance that is not altogether surprising given the absence of a departmental policy

on equality and diversity. As a consequence, religious, gender identity, and physical and intellectual disability needs that fall outside established norms are not being routinely met. While efforts have been made to reduce Māori offending, it is difficult at this stage to measure the effectiveness of these initiatives.

Complaints handling

Prisoner confidence in the effectiveness of prison complaints processes is currently very low. The ability of prisoners to raise concerns effectively, by accessing processes that are clear, robust, responsive, and consistently applied across the prison estate, is vital to maintaining and safeguarding the integrity and accountability of the prison system as a whole. In addition, poor record keeping by prison staff, and an inability at times to readily retrieve complaint-related information in response to information requests, serve to undermine the effectiveness of the complaints processes.

Meal times

Meal times across the prison estate do not reflect standard meal times, with breakfast being served between 8.30 am and 9.00 am, lunch at 11.30 am and the evening meal as early as 3.15 pm in some prisons. The intervals between some meals is not optimal and is in breach of the Mandela Rules.

Health and disability facilities

- Use of long-term seclusion for clients considered to be complex and difficult to manage.
- Lack of step-down beds in both mental health and I.D services resulting in bed blocking and least restrictive practices.
- Use of night safety procedures (locking someone in their room between certain hours i.e. 8pm to 8am. This is not considered seclusion by the Ministry of Health and is being used by some DHB's to reduce their seclusion hours.
- Increase in environmental restraint.
- No minimum entitlements for patients i.e. patients don't automatically have access to daily fresh air and telephones.
- Youth being held in adult services.

Inspector of Service Penal Establishments

The Inspector of Service Penal Establishments (ISPE) is the National Preventive Mechanism (NPM) charged with monitoring New Zealand Defence Force (NZDF) detention facilities. The Registrar of the Court Martial is appointed ISPE as set out in section 80 f the Court Martial Act 1989 in respect of service penal establishments (within the meaning of section 2(1) of the 1971 Armed Forces Discipline Act).

Facilities

The NZDF currently has one facility that caters for the military punishment of detention. The punishment is confined to Navy ratings of able rank, Army privates, and Royal New Zealand Air Force leading aircraftmen, (that is Private soldier equivalents.) The facility is the Services Corrective Establishment (SCE) at Burnham Military Camp, Christchurch. It has the capacity to hold up to 10 detainees at any one time, however no more than two can be female if the male wing is occupied. 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 Military Police Unit. The Southern Region has a medical officer in Burnham Camp on call to SCE and on the rare occasions when detainees require specialist treatment, referral to relevant health professionals in Christchurch is readily arranged.

In addition, each of the more significant NZDF base or camp facilities have a limited number of holding cells, used to briefly confine any members of the Armed Forces for their own protection and/or for the maintenance of good order and military discipline.

Although no detention facilities off-shore are currently available to the NZDF on New Zealand 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.

Inspections

There were 17 detainees in SCE in the 2016/2017 annual year. This is the lowest occupancy ever recorded at SCE.

In the year ending June 2017 the ISPE inspected this facility on two occasions. The inspections were unannounced and included a physical review of the facilities, a discussion with the manager of the facilities, reviewing documentation, and a private interview with those undergoing punishment. Feedback is provided routinely after the inspection to the Officer Commanding of SCE. There was nothing untoward to report from either inspection.

The new management structure at SCE under the Service Police, was reported in the last reporting period and has appeared seamless. The personal development programmes developed for detainees serving at least 14 days detention have been viewed positively by both the staff and detainees.

Issues

SCE opened over 20 years ago. While the facilities remain in fair order it shows signs of wear and tear in places and some more than routine maintenance may well be timely; but not to the extent of raising OPCAT concerns. There was a NZDF works programme in place to update the facilities, but when placed against other priorities for funding, the development was shelved at least for the time being.

The balance of Camp and Base facilities throughout New Zealand are generally old and spartan. They are generally adequate for purpose provided confinement is limited to about 12 hours, because detainees are always closely supervised by service escorts during confinement. These cells may not be too comfortable,

but their treatment is short lived and, given access to toilet and shower facilities, does not approach the threshold of cruel and unusual punishment.

The cell facilities in HMNZS PHILOMEL were closed by Command direction and a temporary arrangement will remain in place in the Devonport Naval Base, using a designated barrack room. This situation will remain until a new purpose-built facility can be delivered.

Going forward

The ISPE will continue "no notice" inspections of SCE in the 2017/18 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.

Independent Police Conduct Authority

Whaia te pono, kia puawai ko te tika

The Independent Police Conduct Authority (the Authority) is the designated NPM in relation to people held in Police cells or 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 entered into a Memorandum of Understanding in 2013 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 acts on these notifications in the same manner as a complaint.

There are two aspects to the Authority's NPM work: firstly, oversight of the nature and quality of Police custodial facilities; and secondly, oversight of the operation and management of both those facilities and other places in which custodial management is the responsibility of the Police.

Police operate 437 custodial management facilities nationwide. The majority of these are cell blocks contained at police stations. In addition, however, Police have responsibility for prisoners in District and Youth Courts. While Police are not responsible for the physical nature of the cell facilities, which are the responsibility of the Ministry of Justice, the Authority nevertheless has jurisdiction over those facilities.

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.

This occurred in a number of places throughout the year, notably Christchurch, Nelson, Rotorua, Manukau, Auckland, Waitakere, Nelson, and Masterton.

The Authority has worked closely with Police to develop National Standards for the management of detainees in Police custodial facilities. A programme of audits of individual districts on a rolling basis to monitor compliance with these Standards has subsequently been established. Resource constraints meant that this programme was not commenced as quickly as planned. However, the first audit, comprising an examination of a random sample of 100 custody records, was undertaken in the first half of 2017. The process has been refined as a result of that audit, and a full programme of audits will be conducted during 2017/18, with a view to ensuring that all Districts are audited every two years.

Complaints and incidents

During the reporting year the Authority received 2,614 complaints and referrals, compared to 2,441 complaints and referrals in the previous year. This increase has put added pressure on the Authority's operational resources. Over the past 12 months it has been increasingly difficult to achieve the outcomes within the time frames that have been set in the Statement of Performance Expectations. The Authority is working with Police to develop more

effective and timely outcomes, and this work will continue.

Of these complaints and notifications 4% were identified to have OPCAT related issues. Where complaints or referrals are identified as having an OPCAT related issue, the Authority categorises them into those that are the most serious and require independent investigation, and those that are suitable for other action including referral back to Police for investigation under the Authority's oversight.

Particular areas of focus

Three particular areas have been the focus of the Authority's work over the financial year: the way in which mentally impaired persons in Police custody are dealt with: the physical state of Court cells and the number of young people in Police cells.

Mental Health and Police Custodial Management

A central theme of this report has been the inadequacies in the way in which mental health issues are addressed when people end up in custody. Police detention is no exception in this respect. Those who are detained are more likely to have a mental health issue and being detained can exacerbate these issues.

Police are often the first point of call when someone is experiencing mental distress. During the 2016-2017 financial year (1 July 2016 until 30 June 2017) Police received 48,837 mental health related calls and attended 35,726 of these.[30] Call and attendance rates have increased by approximately 9% per annum over the past 10 years and this is forecast to continue.[31] In addition, Police respond to many offences (such as family violence) where mental health is a factor. Approximately 46,000 people or 35% of people proceeded against by Police have used mental health or addiction services in the 12 months on either side of their justice interaction.[32]

Police are not the appropriate agency to deal with those in mental distress. Often these people end up detained in a police cell due to a lack of other suitable facilities and mental health professionals not being available. They may then be detained in a police cell awaiting a mental health assessment. As stated by the IPCA in an earlier report:

> "[t]he police custodial environment to which [mentally impaired persons] are taken is designed and constructed to facilitate the effective management of those who pose a risk to others and is an entirely inappropriate environment in which to hold a person in mental distress. It is high sensory, uninviting and frequently noisy. The problems arising from a lack of training and skills of custody officers in dealing with at-risk detainees are accentuated when people are mentally distressed. As a result, while officers strive to deal with such people patiently and professionally, their mental distress is often exacerbated".[33]

The right to health is a fundamental human right. The International Covenant on Economic Social and Cultural Rights (ICESCR) states there is a right to the "enjoyment of the highest attainable standard of physical and mental health". People with mental health needs and experiencing mental health should receive the treatment they require in an appropriate facility that will not exacerbate their illness. Places of Police detention are not generally appropriate facilities.

The Authority has therefore continued to work with Police to improve the way in which Police and Mental Health Services respond to those experiencing a mental health crisis. In particular, in the exercise of its OPCAT function, the Authority has been engaging with Police, Mental Health Services, and Ambulance to ensure that as far as practicable those who are mentally impaired but have not committed an offence are not detained in Police cells awaiting a mental health assessment unless they present an immediate risk to the safety of others.

During 2016 and 2017, the Authority has facilitated a number of workshops between Police and Mental Health Services throughout the country to identify actions that would improve the interagency response to mental health crisis calls. Police themselves have also taken the initiative to work with other agencies to find ways in which those in a mental health crisis can be safely assessed without taking them to the

cells. This has included making greater use of, and providing more suitable facilities within, hospital emergency departments.

This work has had a major impact on practice throughout the country. The number of non-offenders detained in Police cells for a mental health assessment has fallen from 4,995 in 2014 to 2,756 in 2016, and this is forecast to drop further to 2,324 in 2017. That represents a 53.5% reduction in three years.

Over the last 12 months there has been one welcome development which should result in further improvements to practice. The Ministry of Health has funded the development and implementation of a Mental Health Response Triage Line to take non-critical mental health calls from Police and Ambulance communication centres that connects the caller to registered nurses with specialist health knowledge who can provide assistance. This service should reduce the need for attendance at incidents involving mentally impaired persons where no emergency response is required.

Court cells

The Authority has continued to monitor progress in addressing the substandard physical conditions of Court cells throughout the country. These pose a significant risk to prisoner safety, and often also pose hazardous working conditions for staff.

Over the course of the year the Ministry of Justice has been working through the implementation of a remediation programme that has been prioritised according to areas of greatest need. This is designed to modernise cell conditions to the extent that resources allow and to remove obvious areas of risk such as ligature points that provide opportunities for self-harm.

Progress in implementing the remediation programme has been slow. The Authority recognises that the remediation programme requires the investment of substantial resources and will therefore take some time to complete. However, it has had discussions with the Ministry of Justice to seek more rapid progress and is pleased to report that the remediation programme is being expedited.

Youth in police cells

In the year to April 2017, 168 children and youths were remanded in police custody. Of those, 127 spent more than 24 hours in police cells.[34] In some cases, these remands were for prolonged periods. In June 2017 it was reported that a 16-year-old boy spent his third night in an Auckland police cell.[35] In the same month a 14-year-old spent four days in police cells in Christchurch. The Judge was so concerned she visited the cell and informed authorities that they needed to find appropriate accommodation.[36]

These young people (aged 17 and under) are vulnerable. Police cells are not an appropriate environment for them. Young people in these circumstances have reported being treated as an adult rather than a young person, being treated unfairly, having force used on them, feeling discriminated against, and not having their medical and/or mental health needs met.[37] Police cells are unlikely to provide adequate hygiene facilities, appropriate support, adequate food, fresh air, and natural light. Because these young people are being held in a police cell and are legally unable to be held with adults, they are effectively in solitary confinement. This can lead to physical, mental, and emotional harm.[38] The experiences of young people in Police detention are inconsistent with the right to be protected from cruel, inhuman, or degrading treatment.

As a general rule, if a young person needs to be detained they should be held in accommodation appropriate for young people.

The Authority has had discussions with other agencies about this issue and will continue to monitor whether appropriate steps are being taken to minimise the number of young people in Police cells.

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.

Ministry of Justice

The Authority has had a series of discussions with Ministry personnel resulting in an accelerated programme of remediation of court cells across the whole of New Zealand.

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.

Goals for the next 5 years

1 The need to ensure that the funding provided for this work is maintained at a level that meets international expectations of New Zealand

2 That the government should continue to work towards ensuring that there are adequate processes and facilities for non-offenders who experiencing a mental health crisis and that they are not detained in Police cells for monitoring or assessment unless they present a risk to the safety of others.

3 That the government should develop policies and facilities and transport arrangements so as to ensure that defendants remanded in custody by the courts are not kept in Police cells, and that such cells are not used as a means of coping with prison overcrowding.

4 That the government should work to ensure that the number of children and young persons detained in Police cells is kept to a minimum, and never on an overnight basis.

5 That additional funding is provided to improve the condition of Court cells throughout the country so that they meet international minimum standards.

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".[39]

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."[40]

Prevention is a fundamental obligation under international law, and a critical element in combating torture and ill-treatment.[41] 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).

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."[42]

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 National Preventive Mechanisms.

New Zealand's designated National Preventive Mechanisms 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, youth justice residences, and care and protection residences
5. the Human Rights Commission has a coordination role as the designated Central National Preventive Mechanism.

Functions and powers of National Preventive Mechanisms

By ratifying OPCAT, States agree to designate one or more National Preventive Mechanisms 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 National Preventive Mechanisms 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.

National Preventive Mechanisms 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. National Preventive Mechanisms have the right to choose the places they want to visit and the persons they want to interview (Article 20). National Preventive Mechanisms 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 National Preventive Mechanism and discuss their implementation.

The amended Crimes of Torture Act enables the Minister of Justice to designate one or more National Preventive Mechanisms as well as a Central National Preventive Mechanism and sets out the functions and powers of these bodies. Under section 27 of the Act, the functions of a National Preventive Mechanism 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 National Preventive Mechanisms, 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.[43] The designation of a central mechanism aims to ensure there is coordination and consistency among multiple National Preventive Mechanisms 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 are set out in section 32 of the Crimes of Torture Act, and are to coordinate the activities of the National Preventive Mechanisms and maintain effective liaison with the SPT. In carrying out these functions, the Central National Preventive Mechanism is to:

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

Monitoring process

While OPCAT sets out the requirements, functions and powers of National Preventive Mechanisms, it does not prescribe in detail how preventive monitoring is to be carried out. New Zealand's National Preventive Mechanisms 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 National Preventive Mechanism 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 National Preventive Mechanism's findings and providing an opportunity for an initial response

4 A report to the relevant authorities of the National Preventive Mechanism's findings and recommendations, which forms the basis of ongoing dialogue to address identified issues.

The assessments undertaken by the National Preventive Mechanisms take relevant international human rights standards into account and, and involve looking at the 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.

Endnotes

1 Indig, D., Gear, C., Wilhelm, K. (2016) *Comorbid substance use disorders and mental health disorders among New Zealand prisoners*. New Zealand Department of Corrections, Wellington.

2 See Ministry of Health, 2011, Youth Forensic Services Development: Guidance for the health and disability sector on the development of specialist forensic mental health, alcohol and other drug, and intellectual disability services for young people involved in New Zealand's justice system

3 NZ Police (2017) Mental health – driver of demand, Available: http://www.police.govt.nz/news/ten-one-magazine/mental-health-%E2%80%93-driver-demand

4 Statistics New Zealand (2016) Māori Population Estimates: Mean year ended 31 December 2016. Available at http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/MaoriPopulationEstimates_HOTPMYe31Dec16.aspx

5 http://www.corrections.govt.nz/resources/research_and_statistics/quarterly_prison_statistics/prison_stats_june_2017.html

6 NZ Police (2017) Mental health – driver of demand, Available: http://www.police.govt.nz/news/ten-one-magazine/mental-health-%E2%80%93-driver-demand

7 Children's Commissioner (2017) State of Care 2017

8 Department of Corrections (2017) Prison facts and statistics - June 2017. Available at http://www.newshub.co.nz/home/new-zealand/2015/11/commissioner-police-addressing-bias-in-maori-relations.html

9 Waitangi Tribunal (2017) *Tū Mai te Rangi: Waitangi Report on Disproportionate Re-offending* Available: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_135986487/Tu%20Mai%20te%20Rangi%20W.pdf

10 Shalev, S. (2017) *Thinking Outside the Box? A review of seclusion and restraint practices in New Zealand* (Available at www.seclusionandrestraint.co.nz)

11 ibid

12 The Government target is for seclusion in mental health facilities to be eliminated by 2020.

13 Oranga Tamariki contracts the management of one care and protection residence to a non-government organisation, Barnardos.

14 See: http://www.occ.org.nz/publications/reports/state-of-care-2017-a-focus-on-oranga-tamarikis-secure-residences/

15 After visits to Auckland and Christchurch International Airports, it was established both facilities are places of detention.This brings the total number of immigration detention facilities to three. Wellington airport has one police cell which does not fall within the Ombudsman's designation.

16 Nineteen visits were undertaken to secure community homes. Between two and three homes were visited at a time due to their close proximity.

17 All 13 reports were provided to detention facilities within eight weeks of the inspection for their comment. However, of the 13 reports, six were not finalised and published within three months due to an extended comment process. A protocol with the Department of Corrections is currently being developed, which should streamline the publication process for our OPCAT reports.

18 Eleven recommendations were accepted by the Department of Corrections, but the accompanying commentary suggests they should be read as rejected. For reporting purposes these have been recorded as not accepted.

19 Criteria trialled at Hawke's Bay Regional Prison and Spring Hill Corrections.

20 Figures provided by the Ministry of Justice.

21 From OPCAT inspection reports for Hawke's Bay Regional Prison, Spring Hill Corrections Facility and Christchurch Men's Prison.

22 Hawke's Bay survey conducted on 28 November 2016, Spring Hill survey conducted on 20 February 2017.

23 Inspectors short interactions with the youth indicated that one 17-year old appeared to have a learning disability and his cognitive functioning appeared to be that of a much younger boy.

24 Corrections advises that the youth did not interact with mainstream adult prisoners while being held at Manawatu Prison.

25 Manawatu Inspection report—January 2016.

26 There were also 107 eighteen-year olds housed in adult accommodation on 19 May 2017, who are not deemed '*young persons*' under the Oranga Tamariki Act 1989. However, the Department assesses prisoners aged 18 to 20 to determine where they should be held in light of their potential vulnerability. *A Test of Best Interest Assessment* is completed to determine whether they should be held separately from the adult prison population or whether they are able to safely mix with them.

27 Above, n 46.

28 Wakari Hospital, Dunedin; Hillmorton Hospital, Christchurch; Ratonga Rua Porirua, Wellington; Henry Bennett Centre, Hamilton and the Mason Clinic, Auckland.

29 At the time of writing there were six service providers (Te Roopu Taurima O Manukau Trust, IDEA Services, Community Living, Community Care Trust, Navigate and Emerge Aotearoa) providing care across 26 secure residential homes for people detained under a secure care order or supervised care order.

30 New Zealand Police categorises its calls as either 1M (general mental health related) or 1X (threatens or attempts suicide). This categorisation does not match Ministry of Health mental health categorisation.

31 New Zealand Police SAS Analytics Data for mental health (1M) and threatens/attempts suicide (1X) events. These codes do not necessarily indicate that a person has a diagnosable mental health condition or that they meet the criteria for a mental disorder as defined in the Mental Health (Compulsory Assessment and Treatment Act) 1992.

32 Ministry of Justice Crime and Justice Insights Sector Analysis and Modelling, 15 December 2015. This research did not specify the ethnic break-down of the people with an indicator of mental illness proceeded against by Police.

33 IPCA, 2015, Review of Police Custodial Management.

34 https://www.stuff.co.nz/national/crime/93968611/Holding-youths-in-police-cells-a-continued-embarrassment-for-NZ-Childrens-Commissioner

35 http://www.radionz.co.nz/news/national/332993/lives-at-risk-by-keeping-youths-in-cells-overnight

36 https://www.stuff.co.nz/national/crime/93951804/still-no-bed-for-christchurch-14yearold-held-in-desolate-police-cell

37 https://www.hrc.co.nz/files/5914/2550/8314/HRC_IPCA_OOC_2012_-_Joint_thematic_review_of_young_persons_in_prisons.pdf

38 https://www.hrc.co.nz/files/8514/9255/4659/FINAL_Onepager_Police_cells31_March_2017.pdf

39 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.

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

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

42 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.

43 OPCAT, Article 1.

NPM contacts

Independent Police Conduct Authority

0800 503 728 (toll free)
Language Line available
Telephone 04 499 2050
Email enquiries@ipca.govt.nz
Website www.ipca.govt.nz
Level 10, 1 Grey Street, PO Box 5025,
Lambton Quay Wellington 6011

Inspector of Service Penal Establishments

Office of the Judge Advocate General
Headquarters New Zealand
Defence Force
Private Bag, Wellington

Office of the Children's Commissioner

0800 224 453 (toll free)
Telephone 04 471 1410
Email children@occ.org.nz
Website www.occ.org.nz
Level 7, 110 Featherston St PO Box 5610,
Lambton Quay Wellington 6145

Office of the Ombudsman

0800 802 602 (toll free)
Email info@ombudsman.parliament.nz
Website www.ombudsman.govt.nz

Auckland

Level 10, 55-65 Shortland Street
PO Box 1960, Shortland Street
Auckland 1140
Telephone 09 379 6102

Wellington

Level 7, 70 The Terrace
PO Box 10 152
Wellington 6143
Telephone 04 473 9533

Christchurch

Level 1, 545 Wairakei Road
Harewood
Christchurch 8053
Telephone 03 357 4555

Human Rights Commission
Te Kāhui Tika Tangata