Te Kāhui Tika Tangata
Human Rights Commission

2021/22

Monitoring places of detention

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

1 July 2021 to 30 June 2022

IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Office of the Judge Advocate General of the Armed Forces

MANA MOKOPUNA
Children & Young People's Commission

Ombudsman
Fairness for all

Te Kāhui Tika Tangata
Human Rights Commission

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Foreword

Impacts of the COVID-19 pandemic continued to be a key feature of the National Preventive Mechanisms (NPMs) exercising their independent monitoring functions during this reporting period. Lockdown periods lessened for much of Aotearoa New Zealand in the latter half of 2021. The Government then shifted to the COVID-19 Protection Framework from December 2021.

However, while the rest of the country moved away from the lockdown phase of response at the end of 2021, people in detention continued to be subject to significant COVID-19 restrictions. Detaining agencies implemented various measures to prevent the spread of COVID-19 within places of detention including: limiting movements in and out of places of detention; minimising detention numbers; implementing quarantine or isolation protocols; and, in some instances, introducing video calls to whānau and support services.

NPMs under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[1] have a mandate to independently and regularly monitor places where people are deprived of their liberty in order to prevent torture and other cruel, inhuman or degrading treatment or punishment (ill-treatment).

The designated NPMs in Aotearoa New Zealand are the Ombudsman, the Independent Police Conduct Authority, and Inspector of Service Penal Establishments and the Children and Young People's Commission.[2] The Human Rights Commission is designated as Aotearoa New Zealand's Central National Preventative Mechanism (CNPM), which primarily provides a co-ordinating role.

NPMs are responsible for monitoring places of detention, including prisons, police cells, care and protection facilities, youth mental health facilities, youth justice facilities, intellectual disability secure and supported accommodation services, inpatient acute mental health units, aged care facilities, and managed isolation and quarantine facilities.[3]

This report outlines the activities of the NPMs during the reporting period 1 July 2021 – 30 June 2022. A number of thematic issues identified during this reporting period include:

- The need to address the underlying causes of over-representation of Māori across all detention settings, and to focus on achieving equitable treatment and improving outcomes for Māori in detention;
- Impacts of the COVID-19 response interfering with the minimum entitlements of persons in detention;
- Continued concerns around the unnecessary and disproportionate use of force and restrictive measures in some detention settings, including pepper spray, seclusion and restraint;
- The need for appropriate and specialist staff induction and training, including cultural capabilities;
- Concerns around poor mental health outcomes for persons across the majority of detention settings, and the need for appropriate supports;
- The need for independent and accessible complaints processes for detained persons; and
- Concerns around material conditions in places of detention.

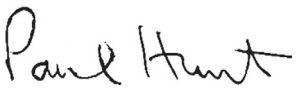
[1] Referred throughout as either the Optional Protocol to the Convention against Torture or OPCAT.
[2] From 1 July 2023, pursuant to the Children and Young People's Commission Act 2022.
[3] Designation of National Preventive Mechanisms, 22 June 2023, publicly available at https://gazette.govt.nz/notice/id/2023-go2676.

The NPMs have made a commitment at governance level to further explore the relationship between their OPCAT monitoring functions and the role of Te Tiriti o Waitangi when monitoring places of detention in Aotearoa New Zealand. The NPMs are comprised of five distinct statutory bodies, meaning they must each consider how Te Tiriti applies to their entities separately and the extent to which they can work together to uphold Te Tiriti within the OPCAT monitoring framework.

Looking ahead to the next reporting year, the NPMs welcome the opportunity to provide submissions and appear before the Committee Against Torture in its 7th periodic review of Aotearoa New Zealand. The NPMs recognise the vital correlation between deprivation of liberty and risk of torture and ill-treatment, and see their monitoring and preventive functions as fundamental for continued, independent public scrutiny of our places of detention.

The Independent Police Conduct Authority farewelled Judge Colin Doherty in May 2023, who served as the Chair of the Authority for five and a half years. The NPMs wish to pay tribute to Judge Doherty who led the organisation through a period of change, overseeing the evolution and expansion of its operational functions. The NPM's acknowledge Judge Doherty's dedication to the role, holding Police to account and developing constructive relationships to help improve outcomes for people held in their custody. We wish him well for the future.

The NPMs welcome the appointment of Judge Kenneth Johnston KC as the new Chair of the Authority, who brings experience from his role as a High Court Judge, former Chair of the Teachers Disciplinary Tribunal and Deputy Chair of the Health Practitioners Disciplinary Tribunal, and as a legal practitioner across both the criminal and civil jurisdictions.



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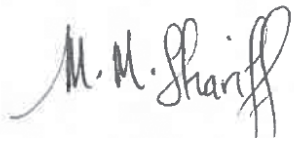
Te Kāhui Tika Tangata | New Zealand Human Rights Commission

Judge Kenneth Johnston KC
Chairperson
Independent Police Conduct Authority

Dr Claire Achmad
Chief Children's Commissioner
Mana Mokopuna | Children & Young People's Commission



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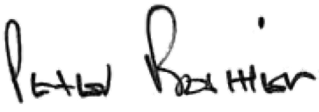

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Te Kāhui Tika Tangata | Human Rights Commission

Introduction

Te Kāhui Tika Tāngata | the Human Rights Commission (the Commission) is the designated Central National Preventive Mechanism (CNPM) under OPCAT and, domestically, the Crimes of Torture Act 1989 (COTA). The CNPM role entails coordinating NPMs to identify systemic issues arising in places where people are deprived of their liberty. The Commission also liaises with government and the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) to strengthen protections against torture and ill-treatment.

The fundamental premise of OPCAT is to prevent violations of the rights of people who are detained by the State. This mechanism recognises the vital correlation between deprivation of liberty and risk of torture and ill-treatment. While NPMs have statutory powers to independently monitor places of detention, with or without notice, the Commission's role is more focussed on coordinating the activities of the NPMs including:

- facilitating annual meetings of the NPMs;
- meeting with international bodies;
- making joint submissions to international treaty bodies; and
- providing communications and reporting/ advocacy opportunities.

The Commission also provides support to the NPMs through expert human rights advice, maintaining effective liaison with the SPT, coordinating submissions to the SPT and Parliament, and facilitating engagements with international human rights bodies.

Activities during reporting period

The COVID-19 pandemic continued to have an impact on the Commission's activities during the reporting period. In the first half of the reporting period the Commission carried out its co-ordination functions with online participation from NPMs. From April 2021, the Commission was able to recommence its hosting of in-person meetings between the NPMs.

The Commission organised and hosted two Chairs' meetings with the head of each NPM agency. The Chairs shared monitoring developments from within their organisations and discussed common issues faced by the NPMs. The NPM Chairs endorsed three papers which NPM staff prepared as guidance for NPMs in their monitoring functions, addressing the following topics:

- Interpretation of what "regular visits"[4] and to examine at "regular intervals"[5] mean for NPMs;
- The role of NPMs in reporting and publishing following visits to places of detention; and
- Exploring how NPMs in Aotearoa New Zealand can better work together.

The Commission also organised and hosted four operational meetings with staff members from within the individual NPMs. The operations meetings aim to increase collaboration and share experiences between NPMs, as well as identify ways to work together more effectively and progress work requested by the NPM Chairs.

First, Do No Harm

In November 2021 the Commission was delighted to release the *First, Do No Harm* report authored by Dr Sharon Shalev as a spotlight on women's prisons in Aotearoa New Zealand. This report was the third in the series in which Dr Shalev has explored the use of solitary confinement and forms of restraint used in New Zealand's closed institutions. Dr Shalev's three reports are available here.

[4] See OPCAT, article 1.

[5] Crimes of Torture Act 1989, s 27.

The Commission hosted a launch event for the *First, Do No Harm* report in November 2021, which generated considerable media around treatment of women in Aotearoa prisons. The launch coincided with a webinar chaired by Kaihautū Ōritenga Mahi | Equal Employment Opportunities Commissioner Saunoamaali'I Dr Karanina Sumeo, with presentations from Dr Shalev, Professor Tracey McIntosh and others. This webinar was attended by over 300 people.

The findings in Dr Shalev's report have informed Commissioner Sumeo's ongoing work under the Human Rights of Women portfolio.[6] Dr Sumeo has advocated for the need to improve the experiences of women in prison, through a gender-responsive, culturally-informed, and mana-enhancing approach. Following the release of Dr Shalev's report, Commissioner Sumeo met with Ara Poutama | Department of Corrections' (Corrections) National Commissioner, to hear about how concerns raised in Dr Shalev's report are being met at an operational level.

Commissioner Sumeo has also established a programme of regular hui with Corrections' leadership involved in the development and implementation of *Wāhine: E Rere Ana Ki te Pae Hou Women's Strategy 2021 – 2025*.

National Human Rights Institution (NHRI) accreditation

The Commission's primary role is that of Aotearoa New Zealand's National Human Rights Institution (NHRI). There is a distinction between the specific, preventative focus of NPMs designated under OPCAT and the more general human rights mandate of the Commission as NHRI.

The Commission has recently gone through its accreditation as NHRI, where the Global Alliance of National Human Rights Institutions (GANHRI) Subcommittee on Accreditation assessed the Commission's performance in line with the Paris Principles. In March 2022, the GANHRI Subcommittee re-accredited the Commission with 'A' status under the Paris Principles. As an 'A' status NHRI, the Commission is able to have standing before the Human Rights Council at the UN.

As part of the accreditation process, the GANHRI Subcommittee observed that the Commission had conducted or contributed to monitoring activities in places of detention both in its capacity as NHRI and CNPM. One of the recommendations from the GANHRI Subcommittee was that, under the Paris Principles, there is an expectation that an NHRI can themselves conduct unannounced visits to places of detention.[7] Notwithstanding the Commission's CNPM status under OPCAT, the Subcommittee recommended that the Commission be able to "access all places of deprivation of liberty in a timely, regular and/or ad-hoc manner in order to effectively monitor, investigate and report on the human rights situations in these places".

International engagement

In January 2022 the Commission met with the Australian Commonwealth Ombudsman, upon their request, to discuss the progress of implementation of the OPCAT in Australia. The Australian Government is intending to establish a federated, multi-body NPM model. During the meeting the Commission shared its knowledge and experience as the CNPM in New Zealand.

In June 2022, the New Zealand NPMs attended a joint session between the Subcommittee for the Prevention of Torture and other NPMs within the Asia Pacific region (including the Maldives, Cambodia and Lebanon). The New Zealand NPMs provided other members with an overview of their structure and functions, as well as sharing their key areas of concern in the OPCAT space. This was a unique opportunity for the NPMs across the region to share their experiences and establish connections for future contact.

[6] As delegated to her by the Chief Human Rights Commissioner under ss 8(1B) and 15(e) of the Human Rights Act 1993.
[7] GANHRI Subcommittee on Accreditation, *2.7 New Zealand: New Zealand Human Rights Commission (NZHRC)*, 25 March 2022.

Engagements with Ara Poutama | Department of Corrections

The Commission has developed a constructive working relationship with Corrections in its role as the Aotearoa CNPM. Te Amokapua | Chief Human Rights Commissioner Paul Hunt established a programme of quarterly hui with the Chief Executive of Corrections, to share feedback about steps the Commission considers are necessary to comply with international obligations regarding the humane treatment of prisoners.

During the reporting period, the Commission provided feedback to Corrections as part of an ongoing consultation about proposed amendments to the Corrections Act 2004 and Corrections Regulations 2005. With reference to Dr Shalev's *First, Do No Harm* report, the Commission recommended that Corrections undertake a broad review of its use of force and pepper spray to Aotearoa prisons, to assess whether its practices are consistent with Te Tiriti o Waitangi and human rights law. In particular, the Commission advocated against the ongoing use of pepper spray:

- dispensed through MK-9 (also known as "cell buster") devices, whereby Corrections officers pump pepper spray into closed cells by means of a fog delivery device;
- in response to passive resistance by prisoners;
- in confined spaces; and
- against individuals who have been identified as high risk (such as those with underlying injuries, mental health issues, respiratory conditions, or pregnancy).

Te Tiriti o Waitangi and OPCAT Monitoring

The Commission remains actively focussed on becoming a Te Tiriti o Waitangi-based organisation.[8] To achieve this, the Commission aims to ensure that all articles of Te Tiriti are embedded within its day-to-day operations across all of the functions it undertakes. The Commission recognises that embedding a Te Tiriti-consistent approach is critically important to uphold the mana and dignity of people through its work.

The Commission is cognisant of the importance Te Tiriti plays in fulfilling the OPCAT monitoring function. In its role as CNPM, the Commission has recognised that Te Tiriti, its principles, and tikanga are a source of obligations in a variety of ways for the Government's detaining agencies and must be factored into the review and monitoring of those agencies by the Aotearoa NPMs.

In 2022 the Commission started a programme of work to better reflect Te Tiriti through OPCAT monitoring. The Commission is facilitating ongoing dialogue between the Aotearoa NPMs about how to include Te Tiriti considerations in their monitoring and reporting on the Government's treatment of people deprived of their liberty, demonstrate attention to this in their own practice and methodology, and ensure this is included in their recommendations.

Looking ahead

The Commission looks forward to further supporting the NPMs to effectively carry out their monitoring responsibilities under OPCAT. In 2022/2023 the Commission is looking forward to:

- Working together with the NPMs to provide submissions for the Committee Against Torture's upcoming 7th periodic review of Aotearoa New Zealand. Submissions from NHRIs and NPMs are due in June 2023, with the review before the Committee taking place in Geneva in July 2023.
- Continuing to work with NPMs to develop our understanding of how Te Tiriti and tikanga inform OPCAT monitoring and how we can give effect to monitoring of places of detention from a uniquely Aotearoa New Zealand perspective.

[8] Further information about the Commission's Te Tiriti Journey is available on our website.

Independent Police Conduct Authority

IPCA
Independent Police Conduct Authority
Mana Whanonga Pirihimana Motuhake

Introduction

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

The Authority is an independent Crown entity established under the Independent Police Conduct Authority Act 1988. It exists to hold New Zealand Police to account, with the aim of maintaining and enhancing public trust and confidence in the Police.

We handle, investigate and resolve complaints about Police. By law, we're also notified of and may investigate incidents where Police have caused death or serious injury.

The use of Police's powers of arrest and detention are a core policing function. In addition to arresting persons suspected of committing criminal offences, Police regularly respond to people experiencing a mental health crisis or intoxicated people needing care and protection. The majority of those detained are taken to Police custody units. It can be a difficult and challenging environment for both staff and detainees. Police staff must safely manage detainees with often complex and competing health needs.

Police operate approximately 135 custodial management facilities (containing approximately 816 usable cells) nationwide. The majority of these are cell blocks situated at Police stations. There are 12 Police districts and each district has one or more designated custody hub and other larger custody units which hold detainees overnight. These are complemented by holding cells in other stations which are not intended for longer periods of detention. Many of the overnight custody units will also regularly hold detainees who are remanded into custody by the courts.

In addition, Police have a responsibility for those detained at District Courts. There are 59 District Court cell facilities. Police are not responsible for the physical court cell facilities, which are the responsibility of the Ministry of Justice. The Authority has joint jurisdiction with the Ombudsman over the facilities.

As the NPM for Police custody, our focus is to prevent human rights breaches in places of Police detention. We aim to ensure that safeguards against ill treatment are in place and that risks, poor practices, or systemic problems are identified and addressed.

To help achieve this we:

- conduct inspections to monitor the care and treatment of detainees;
- complete regular audits of Police custodial records;
- review complaint data and evidence gathered from our independent investigations;
- make recommendations for improvements; and
- engage with Police and other Justice sector partners to encourage best practice custodial management and ensure the implementation of our recommendations.

During this reporting period the Authority faced additional resourcing challenges. As with many other government agencies the Authority faced significant challenges in the recruitment and retention of staff. Capacity issues meant there was a reduction in the number of inspections visits we were able to conduct during 2021/22.

To help mitigate these impacts, we concentrated our efforts on our advisory and engagement activities to improve Police practice and follow up on our previous recommendations. We also made significant improvements to our inspection methodology to enhance the quality of our monitoring work.

INSPECTIONS

Inspection methodology

We developed and implemented an updated inspection methodology for 'full inspection' visits to custody units used to hold detainees overnight.

During a full inspection, we monitor how Police staff manage detainees from their initial reception into a custody unit until their release or transfer. The inspection involves direct observations of the care and treatment of detainees and is supported by interviews and conversations with the staff involved in all aspects of managing a detainee's time in custody. To ensure we can directly observe as many of the custodial processes as possible, our inspectors work different shifts including evenings and night-time. They also request access to the detainee's custody records and risk assessments.

Whenever possible, we conduct voluntary private interviews with the detainees present during our inspections. We ask about their experiences and understanding of the custody process. We also ask them about their health, wellbeing, and other personal circumstances to help assess whether their needs are being appropriately met.

In addition to following detainees and speaking to the operational staff, we arrange meetings with custody supervisors and managers to discuss custodial policies, practices and procedures and review staffing and training arrangements.

The interviews with staff and detainees assist us to identify systemic issues and help inform our recommendations.

Following a full inspection visit, we provide a report to Police that covers:

- staffing levels and training;
- station governance;
- the custody unit, including physical conditions and detainee monitoring;
- rights of the individual;
- reception and detention processes; and
- recommendations.

Inspections conducted

We conducted three full inspections of Police custodial facilities in this period. These were in Christchurch, Nelson and Blenheim. Four follow-up inspection visits were undertaken to Marton, Whangarei, Henderson and Manukau City. We also completed a visit to the Wellington custody unit.

Christchurch Ōtautahi

Te Omeka Custody Unit (Christchurch Central Custody Unit) is a modern and well-designed facility situated on the ground floor of the Emergency Services building, which is part of Te Omeka, the Justice and Emergency Services Precinct. The precinct is owned and managed by the Ministry of Justice (MoJ). As well as being the Police custody unit for Christchurch city, the custody unit is also the court cells.

The custody unit is primarily staffed by full-time teams of custody officers (Authorised Officers) supplemented by some constables. Each team is led by a Police sergeant and the unit is managed by a senior sergeant. During the day, Corrections staff are also on site to manage Corrections prisoners attending court.

Summary of findings

There were well established governance and assurance arrangements, including processes to review adverse incidents and disseminate lessons learnt to all custodial staff.

Having a full-time senior sergeant in charge of the unit provided strong leadership. We found that they set clear expectations for the unit and staff understood their roles and responsibilities.

We were satisfied that there were sufficient rostered staff to safely manage the detainees, however, at the time of our visit we noted that the unit had three vacancies.

Some staff expressed concerns that there were sometimes not enough custodial staff available to maintain effective safety protocols, such as when escorting detainees within the unit.

Arresting officers spoke to the custody sergeant on arrival to explain the reason(s) for the detention. We observed custody sergeants questioning arresting officers about the circumstances of the arrest or detention and giving appropriate advice and directions. This helped to ensure detentions were lawful and necessary.

We noted that some arresting officers were not passing on all relevant information about a detainee's circumstances (such as any physical injuries, health concerns or behaviour) to the custody staff.

Whilst the custody staff were confident in conducting detainee evaluations (health and welfare assessments), some assessment records lacked detail and not all relevant information was recorded on some records. In particular, we found that many custody records did not record the supervisor's decision-making or set out how identified risks were going to be managed.

We found that detainees identified as having a greater risk of self-harming were appropriately monitored by staff.

A local partnership between Police and Health services meant that a team of mental health practitioners (Duly Authorised Officers) were based in the custody suite and worked shifts to provide as close to 24-hour coverage as possible. This provided custody staff with specialist advice to support the appropriate care and management of detainees presenting with mental health concerns.

We observed many positive interactions between custody officers and detainees. Overall, staff were professional and sensitive to the needs of vulnerable detainees. Detainee interviews supported this assessment.

The custody unit was in good condition, and we were satisfied that it provided a safe and clean environment. There is good CCTV coverage to help monitor detainees and cells have intercoms.

Blenheim

The custody facility is on the ground floor of Blenheim Police station. The station was opened in 1965. At the time of our visit, the custody unit had two full-time custody officers (Authorised Officers) and three Authorised Officers on a casual contract. These staff were supplemented by constables from other work groups on an "*as needed*" basis. In addition to staffing the Police cells, the custody staff transport detainees to court and staffed the court cells in Blenheim and Kaikōura. The station sergeant provides primary supervision and oversight of the custody unit supported by other frontline sergeants when they are not on duty.

Summary of findings

The physical conditions in the custody block do not meet our expected standards. The cells have safety issues and are not well maintained.

The unit does not have a dayroom or other area where detainees can spend time outside their cell.

The cells have no natural light and poor ventilation.

Conditions for detainees are so poor that the unit should not be used to hold detainees for longer than 48 hours.

The safe operation of the unit is reliant on the knowledge and leadership of a small cadre of experienced staff. Whilst this is recognised by managers, we are concerned that it is a constant operational challenge to ensure there are sufficient staff with the necessary experience to manage detainees with often complex and competing needs.

The staff who worked regularly in the custody unit understood their roles and responsibilities and demonstrated a good understanding of custody policies.

Detainees remanded into custody after a first court appearance are held in the Police cells until they can be transferred to Corrections facilities in Christchurch. At the time of our visits there were only two scheduled transfers to prison per week.

Due to the lack of any Corrections facilities in the Marlborough or Tasman regions detainees who are required for subsequent court appearances or trials are held in Police cells.

Many detainees being transferred to and from prison face long journeys in poor conditions. They are transported in small, individual cell compartments inside the custody escort vehicles (cell vans) for approximately nine hours in total (excluding stops). They travel from Blenheim to Nelson then to Greymouth and onto Christchurch.

Nelson

The custody facility is on the ground floor of Nelson Police station. The station was opened in 1961. At the time of our visit, the custody unit was comprised of six custody officers (Authorised Officers) and four constabulary staff. Custody staff are usually on duty between 7 am and 10 pm. Overnight the unit is staffed by officers from the Public Safety Team (frontline response officers). The Authorised Officers are primarily responsible for taking the detainees to Nelson Court and staffing the court cells. They also transfer detainees to Greymouth (en-route to prison) or directly to prison. They are also required to support station support officers with public enquiries at the Police station. The constabulary staff are primarily responsible for receiving people who have been arrested or detained. The station sergeant provides supervision and oversight of the custody unit supported by other frontline sergeants.

Summary of findings

There were extensive mould issues in the facility. Police had closed off some of the cells and other parts of the facility.

Some testing and analysis of the types of mould present had occurred. Areas that had been closed had mould readings above recommended safe levels. The testing identified the presence of mould spores that could have more serious impacts on human health.

Even without the mould issues, the physical conditions in the custody block did not meet our expected standards. The cells have safety issues and are not well maintained.

At the time of our visit, there was no functioning dayroom or an exercise yard where detainees could spend at least one hour of exercise in fresh air.

The cells have no natural light and poor ventilation.

We noted that scheduling arrangements for staff working in the unit appeared very changeable and work patterns varied. Staff explained that without this flexibility they would not be able to operate the unit. We are concerned that this highlights that at times there are not enough experienced custody staff to ensure the safety of both staff and detainees.

Custody staff raised concerns about the lack of access to supervisors on nightshifts. During the night, a frontline sergeant is responsible for supervising officers responding to incidents as well as overseeing any detainees in custody. When supervisors are called out to attend incidents this can mean that detainees are managed by staff without the required knowledge of custody. We believe it is inappropriate to for inexperienced and insufficiently trained staff to be left to manage such a high risk environment as a custody unit.

Detainees remanded into custody after a first court appearance are held in the Police cells until they can be transferred to Corrections facilities in Christchurch. At the time of our visit, there were only two scheduled transfers to prison per week.

Due to the lack of any Corrections facilities in the Tasman region detainees who are required for subsequent court appearances or trails are held in the Police cells.

Many detainees being transferred to and from prison face long journeys in poor conditions. They are transported in small individual cell compartments inside the custody vehicles (cell vans) for approximately seven hours in total (excluding stops). They travel from Nelson then to Greymouth and on to Christchurch.

Subsequent Police Actions

Following our Nelson inspection visit, further extensive mould testing was completed which resulted in the whole custody unit being temporarily closed for specialist treatment. Police implemented a programme of regular testing and further treatment and completed other remedial work to ensure the unit was safe. We continue to monitor the testing outcomes and suitability for the cells to remain operational.

Police are also taking several steps to remediate some of the infrastructure issues in the Nelson custody unit.

Work has been undertaken and the dayroom is now operational. An additional programme of work will see a new roof structure erected over the custodial suite, enabling remediation work to be completed on the external exercise yard and a full upgrade of the heating, ventilation and air conditioning (HVAC) units servicing the custody suite. Access to the exercise yard will enable detainees to access natural light and fresh air.

Furthermore, as part of New Zealand Police's 10-year capital investment plan, new site builds are currently scheduled for Blenheim (approximately 2025/26) and Nelson (2027/28), however these will be subject to funding required to be provided through successful Budget bids.

As a short term solution to help limit the number of detainees spending more than 48 hours in the Blenheim or Nelson Custody units, Police have increased the number of scheduled transfers to prison from two to three times a week.

As a medium term solution, Police have also secured a lease at a Kaikōura site which is to be utilised as a detainee transport transit hub. This will enable the previously used State Highway 1 transport route to be reinstated. This transit hub will provide a safe and secure location for detainees to use the bathroom facilities, eat and drink, and provide a mechanism to transfer custody responsibilities between New Zealand Police and the Department of Corrections.

Police are piloting an in-person custody supervisors' course and have updated their online training modules.

ROUTINE AUDITS OF CUSTODIAL RECORDS

The 'People in Police Custody' policy was written in consultation with the Authority and sets out national standards for the management of detainees in Police custodial facilities.

A programme of rolling audits of custody records from an individual Police district allows us to monitor compliance with the 'People in Police Custody' policy and other applicable Police policies and legislative requirements.

We review and assess a sample of 100 records from the electronic database which records information about a person who has been detained. The sample always includes records of detainees:

- 17 years old or younger;
- solely detained for mental health assessments; and
- solely detained for detoxification.

The sample also includes all records where the person's level of consciousness was recorded as unresponsive or partially responsive.

We look at:

- quality of risk assessments and the appropriateness of selected monitoring regime for the person detained;
- compliance with the requirements of the selected monitoring regime;
- care and management of high-risk detainees;
- length of time in detention;
- compliance with legislative requirements regarding mental health detentions and for the detention of children and young persons;
- type of search conducted and its validity;
- provision of medical care;
- provision of meals and other necessities; and
- quality of record keeping.

This year, five audits were conducted of Waitemata, Waikato, Central and Bay of Plenty Districts.

The results are reported to the Commissioner of Police and the relevant Police district. Where we made recommendations, we discussed the required response with both.

The major issue that we identified through our audits was the lack of detail being recorded in the detainees' custody records and in the Police description of the arrest or event that led to the detention. We have recommended to Police that additional training be provided to ensure all staff are aware of and know how to complete custody records, including adequate detail to support risk assessments and compliance with policy. Police have implemented an updated quality assurance and improvement process which should address this issue.

The Bay of Plenty audit also identified an issue where detainees arrested after 7.00am were often not appearing before the court on the same day. Police explained that the Rotorua District Court did not accept any detainees with arrests made after 7.00am unless a detainee has "*a serious medical condition*", therefore, some detainees from arrests were held overnight. The Authority was concerned such an early cut-off time meant that detainees were held in custody longer than necessary and that this may infringe on individuals' rights not to be arbitrarily detained (section 22 NZ BORA) and to be brought before the court as soon as possible (sections 23-25 NZ BORA). We recommended Police must consult with the Rotorua District Court as a matter of urgency to agree the protocols for arrests being presented before the court.

We continue to monitor the actions taken to implement our recommendations made following these audits and to undertake follow-up visits where appropriate.

COURT FACILITIES

We share the responsibility for inspecting the conditions and treatment of people detained in court facilities with the Chief Ombudsman.

We have agreed a Framework and set of Expectations to guide our court inspections. The Framework seeks to enable us to work together, report on the conditions and treatment of people in detention, and to influence change. The Expectations sets the joint expectations for the conditions and treatment of people detained in court facilities

The programme of inspections commenced in July 2022.

KEY THEMES FROM OUR MONITORING

We continue to identify many of the same systemic issues, such as:

- condition of custodial facilities;
- insufficient custodial training;
- inadequate risk assessment or monitoring of detainees; and
- poor handling of detainees with mental health issues.

Our focus for this reporting period has been to follow up on our recommendations regarding the condition of custodial facilities and the need for more dedicated custodial training.

A critical part of a detainee's 'booking in' process is the completion of a health and welfare risk assessment. This formal evaluation is recorded on the electronic custody module (ECM).

We have found that in almost every case where a detainee has died in custody that there were issues with the detainee evaluation, meaning that key risks were not identified and opportunities to mitigate the risks were missed. We have therefore highlighted to Police that comprehensive training on completing ECM evaluations must be provided to all staff who are required to process detainees.

Improvements required to the detention environment

The condition of Police cells varies significantly from facility to facility. Conditions in Blenheim and Nelson reflect similar poor conditions found in many provincial centres around the country. Many older facilities do not meet our expectation that detainees are held in a custody unit that is safe, in a good condition and that promotes their security, privacy and dignity. A poor physical environment can impact the health and wellbeing of detainees and create additional challenges for staff charged with managing detainees.

A recurring issue is the lack of 'observation cells' which are designed to make it easier for staff to monitor the safety of detainees at higher risk and intervene quickly. Many cells also lack CCTV, call buttons or intercoms. These technologies are valuable tools that complement regular in-person welfare checks to ensure detainees are safe and their individual needs are met.

There are frequently circumstances that lead to longer periods of detention in unsuitable facilities. At the time of the inspections, remand prisoners were spending as many as five days in Blenheim or Nelson awaiting their trial and/or return to prison. Having no remand centre or prison in the Marlborough or Tasman regions exacerbates this situation.

We acknowledge that the Police National Property Group have set up a Custody Infrastructure Team who are systematically assessing custodial facilities and managing a rolling remediation programme. Whilst we support this programme, we are mindful that that past chronic underinvestment in the custodial estate has left many Police districts with unacceptable facilities that will require substantial capital investment to ensure that custody units are fit for purpose.

The importance of having suitably trained and supported custody staff

We have identified that having staff whose primary role is dedicated to custody duties is advantageous. Dedicated custody staff have frequently demonstrated to the Authority that they have higher levels of knowledge and greater familiarity with custody policy, practices and procedures. The Authority believes this leads to more consistency in the quality of care provided. In particular, we have observed that the quality of evaluations conducted by permanent custody staff are often of higher quality, more detailed and more thorough.

The regular rotation of frontline Public Safety Team staff and the short periods they cover custody roles mean they often do not spend long enough to gain sufficient experience. We found that they do not receive sufficient in-person training and often receive limited induction to the custody unit before they must perform custodial duties.

We have seen that suitably trained and supported Authorised Officers enhance the custodial environment. We recognise that staff hired specifically to work in custody areas are often well motivated, provide consistency and build up expertise.

ADVISORY AND ENGAGEMENT

An important part of our NPM role is to work co-operatively with Police to improve Police custodial policy, practice and procedures and follow up on our previous recommendations.

There are several areas where we have worked with Police to support policy development and operational improvements.

We have been consulted and provided feedback on a range of initiatives and workstreams including:

- new custody training modules for all frontline staff (Assessing risk and monitoring);
- development of a custody supervisors' course;
- updated guidance on manging intoxicated detainees;
- changes to the ECM;
- national infrastructure remediation programme for custodial facilities;
- design of new custodial facilities to ensure facilities meet our NPM expectations; and
- implementation of a Custody Quality Assurance and Improvement Framework (Custody QAIF) and we are also part of the national panel for the QAIF.

We have also been engaging with the National Fleet Services group on improving conditions for detainees being transported in custody escort vehicles (cell vans).

Police set up a National Custody Team (NCT) at Police Headquarters in October 2021, this permanent team replaced the previous Custody Enhancement Programme (CEP).

The purpose of the NCT is to enable and enhance custodial operating capability. The core services and functions the NCT are responsible for are:

- providing assurance to the Police Executive of district compliance with national custody operating practices and policies through an evidence-based framework;
- providing support and guidance to districts, as well as monitoring and reporting on performance, health, safety and risk, nationally within the custody environment; and
- managing internal and external stakeholders to continuously improve custodial operating capabilities.

We recognise the importance of having a permanent national team to develop and implement national custodial polices and practices and provide the tools districts need to improve the delivery of best practice custodial management.

FINAL COMMENT

Custodial management carries significant risk and responsibility. Whilst there are many challenges and more work to be done, we acknowledge the improvements that have already been made and congratulate New Zealand Police on their continued commitment to improving outcomes for detainees in their care.

Mana Mokopuna | Children and Young People's Commission

Introduction

Mana Mokopuna | Children and Young People's Commission (CYPC) is a National Preventive Mechanism (NPM) under the Crimes of Torture Act (1989). Mana Mokopuna's Monitoring Team visits places where children and young people (mokopuna) are deprived of their liberty, to examine living conditions and treatment, identify any improvements required or problems needing to be addressed, and make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing ill treatment.

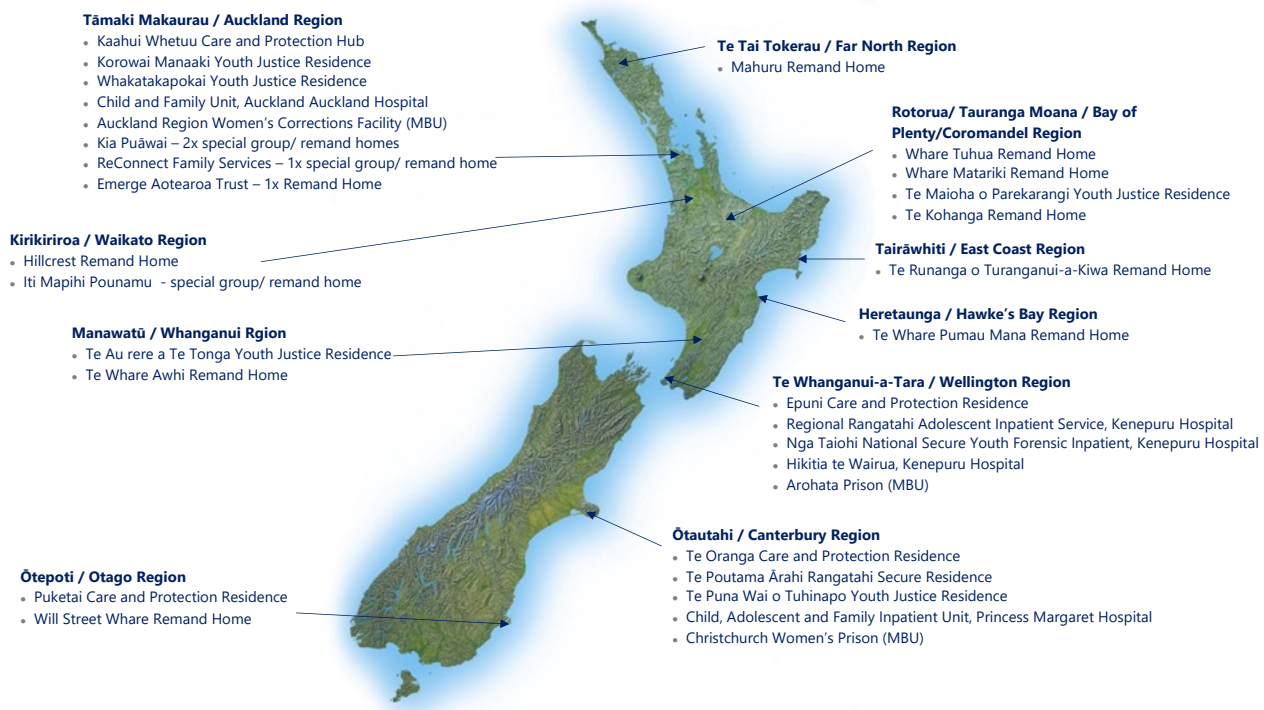
Who Mana Mokopuna monitors

The Team monitors all secure facilities throughout Aotearoa New Zealand. This includes:

- Five Youth Justice Residences for:
  - Young people charged in the Youth Court with an offence who are on remand
  - Young people who have been sentenced to a Supervision with Residence Order by the Youth Court
  - Young people who have been charged with an offence and are on remand whilst their matters are being dealt with by either the District or High Courts
  - Young people who have been sentenced through the District or High Court to a term of imprisonment and, due to their age or other vulnerabilities, are placed in a youth justice facility by agreement between Oranga Tamariki and Ara Poutama – Department of Corrections.
- Four **Care and Protection Residences** (which includes a secure assessment hub - Kaahui Whetuu) for children and young people who are deemed to be at risk of harm to themselves, others, or have significantly high and complex needs.
- Five **Youth Mental Health Facilities** for vulnerable youth with complex mental health needs or intellectual disability. Three of these are in-patient youth facilities and two are youth forensic mental health and intellectual disability units.
- Fourteen **Youth Justice Community Remand Homes** which are small three-to-five-bedroom homes situated across Aotearoa New Zealand and are available to children and young people who are on remand with their matters being dealt with in the youth jurisdiction. They are designed to keep children and young people close to their whānau and within their 'home' community.
- One **Special Purpose Facility:** Oranga Tamariki contracts Barnardos, a non-government organisation, to provide secure care and specialist therapeutic treatment for a small number of children and young people with diagnosed harmful sexual behaviours.

Mana Mokopuna also considers the three Mothers with Babies Units (MBUs) in women's prisons that are managed by Ara Poutama – Department of Corrections. The CYPC's focus in these units is the safety and wellbeing of the babies who are aged under two years old and live in the units with their mothers. We also consider the level of support provided to mothers in caring for their babies.

Locations of Facilities



How Mana Mokopuna monitors

Based on the United Nations Guidelines, the domains that form the basis for the Team's OPCAT monitoring assessments are:

- Treatment
- Protection systems
- Material conditions
- Activities and contact with others
- Medical services and care
- Personnel

In addition to these domains, Mana Mokopuna has added one Aotearoa specific domain:

- Improving outcomes for mokopuna Māori (Māori children and young people) and their whānau (immediate and extended family).

For mokopuna Māori, being supported to have a positive connection to cultural identity is critical to wellbeing. This domain focuses specifically on how secure environments are improving outcomes for mokopuna Māori, who are often over-represented within the population of those under the care of Oranga Tamariki and within secure facilities. This domain is important because the Government has responsibility under the Treaty of Waitangi to partner with, protect, and ensure participation for Māori.

Monitoring 2021 – 2022

Mana Mokopuna conducted twelve onsite NPM monitoring visits to places of detention between July 2021 and June 2022. Five of these visits were unannounced, while the other seven were announced. For youth justice remand homes that Mana Mokopuna had yet to visit, it was agreed with all stakeholders that the Team would announce its first visits before putting the facilities into its regular unannounced schedule.

Facility	Monitoring Description	Designation	Stakeholder
Te Oranga Care and Protection Residence	Unannounced	Care and Protection	Oranga Tamariki
Te Puna Wai o Tuhinapo Youth Justice Residence	Unannounced	Youth Justice	Oranga Tamariki
Te Au rere a te Tonga Youth Justice Residence	Unannounced	Youth Justice	Oranga Tamariki
Regional Rangatahi Adolescent Inpatient Service	Announced	Youth Mental Health	Capital and Coast District Health Board
Whakatakapokai Youth Justice Residence	Unannounced	Youth Justice	Oranga Tamariki
Puketai Care and Protection Youth Justice Residence	Unannounced	Care and Protection	Oranga Tamariki
Epuni Care and Protection Residence	Announced	Care and Protection	Oranga Tamariki
Child, Adolescent and Family Unit	Announced	Youth Mental Health	Canterbury District Health Board
Whare Tuhua Community Remand Home	Announced	Youth Justice	Te Tuinga Whānau Social Services/ Oranga Tamariki
Whare Matariki Community Remand Home	Announced	Youth Justice	Te Tuinga Whānau Social Services/ Oranga Tamariki
Child and Family Unit	Announced	Youth Mental Health	Auckland District Health Board
Auckland Women's Regional Corrections Facility	Announced	Corrections Facility	Ara Poutama – Department of Corrections

COVID-19 and Monitoring

COVID-19 continued to impact upon day-to-day operations in places of detention across the country. Residences across both Care and Protection and Youth Justice remained at reduced capacity for large parts of the year to ensure that the Oranga Tamariki COVID strategy could be enacted if a positive case was to present itself. This included holding whole units within residences vacant, having dedicated isolation wings, and staff having the ability to work in team 'bubbles' to ensure they had the capability keep themselves and mokopuna safe.

The Monitoring Team engaged in full monitoring visits and worked in line with government and facility guidelines and protocols to reduce the risk of spread of COVID-19.

The majority of facilities Mana Mokopuna visited had well-thought out and comprehensive COVID-19 response plans in place which included containment strategies to limit the spread of COVID-19. However, the Team did note that one facility had limited provisions in place and noted this as inconsistent with policy and practice guidelines issued by Oranga Tamariki.

Some of the key COVID-19 related impacts across facilities included:

- Access to independent advocates was reduced, with kanohi ki te kanohi (face-to-face) contact no longer occurring. Access was typically via phone or video conferencing. We hope to see this change as it is important for young people to have unrestricted access to independent advocates and the majority of mokopuna told the Team that they prefer this to be kanohi ki te kanohi.
- The national shortage for workers in places of detention was exacerbated by COVID-19. Staff sickness and vaccination mandates further reduced staffing levels which in many facilities were already low. This had a ripple effect, and in a number of places meant that training and supervision did not occur as there was not sufficient staff available to provide cover.
- Facilities are not fit-for-purpose and did not have enough separate or multi-use spaces. For example, designated de-escalation areas or sensory rooms were being used as isolation zones. This meant that mokopuna were unable to access spaces to regulate or they were being held in secure care areas to self-regulate which were often dark, dreary and far from therapeutic.
- Access to off-site activities was reduced in some facilities and opportunities for external facilitators to run youth focused programmes was limited. This led to facilities offering a reduced activity programme which mokopuna frequently said was boring and did not fit their needs.

Themes from onsite monitoring

Of the facilities monitored in 2021/2022, there were some trends that appeared across all Care and Protection, Youth Justice, and Mental Health facilities.

The key themes for each designation have also been described, with graphs at the end of each section to visually represent collective findings across the domains. These are based on the aggregated findings of strengths and areas for development.

Any quotes from children and young people have been italicised.

Positive Trends

Positive relationships with staff

Consistently, the relationships between mokopuna and staff were highlighted as being positive, supportive and respectful. Overall, staff were very engaged and attentive to mokopuna and their needs, and mokopuna described experiences of having staff they trusted to turn to for any support or help – *"They're here to work with us – not in front of us, not behind us, beside us"*. Staff frequently role-modelled positive, pro-social behaviour which mokopuna said was helpful *"This place makes you change, shows that there's a better way, better path"*.

Good food, mokopuna-centred education and outside areas

Across all facilities the Team heard good things about the food provided and often there were opportunities for mokopuna to partake in preparing food themselves.

The education component in all facilities was a highlight and mokopuna told us that they enjoyed the activities run as part of their structured day. Strength based learning using multiple techniques and mediums were a feature for many facilities. Mokopuna particularly enjoyed occupational and vocationally focused tasks such as CV writing, driver licensing and interview preparation.

School facilities were often described as well-resourced and welcoming, with mokopuna describing positive relationships with the teaching staff. There was also ample opportunity for mokopuna to get outdoors, with outside spaces being well-utilised in many of the facilities.

Whānau access

Whānau access and involvement in care was largely highlighted as positive across most of our visits. While face-to-face contact with whānau could be limited, largely due to distance, whānau were encouraged to visit. Many facilities had spaces where whānau could stay onsite or otherwise assisted with providing accommodation if they did not live locally – *"My family put in an effort to come through to, 'cos the place was putting in an effort to get them here"*.

Whānau contact was further supported throughout all facilities by providing daily access to phone-calls. This was particularly helpful for maintaining relationships with whānau not living locally. Some facilities also offered the opportunity to connect via video-calls, which was particularly important when short-term, localised COVID-19 restrictions were in place, and when vaccine mandates were implemented. Mana Mokopuna commends these additional efforts to sustain whānau connection and would like to see it implemented across facilities as a regular option for mokopuna to connect with whānau.

Access to Primary Health Care

Mokopuna had good access to primary health care across all designations. Specialist health care was often also well supported in terms of access and referral pathways although waiting times could vary and be lengthy. However, it was noted that in Youth Justice Residences in particular, there was a lack of access to specialist mental health services and alcohol and drug treatment programmes.

Areas for Development

Low staffing levels and unsafe practice

Staffing levels were raised as a central issue across all designations. Difficulties with recruitment and staff retention alongside COVID-19 related issues (sickness, mandatory isolation periods, and vaccination status) further exacerbated this issue. Consequently, common trends included unsafe staffing practices such as working long or double shifts, limited breaks between shifts, alongside a lack of access to annual leave and supervision due to not having enough staff to cover shifts. This is concerning as it sets staff up for burnout and prevents them from being in the position to provide mokopuna with the best possible care.

Specialised and ongoing training is needed

Staff across multiple facilities highlighted the lack of training they received, whether it be from the very beginning of their time working in a facility, or any on-going training post-induction. In many cases, staff described feeling unequipped to manage the behaviours of mokopuna, particularly those with more complex needs who are regularly placed into care. This is a concern as it places both mokopuna and staff at risk and emphasises the need for adequate and more specialised training to be put in place as a safety and protective measure.

Inappropriate placement and lengthy stays

The Monitoring Team was told of a number of instances where mokopuna were placed in facilities that could not meet their needs. This was more prevalent in Youth Justice facilities where minor offending was secondary to complex care and protection and mental health needs and yet mokopuna found themselves in a custodial justice environment. Leading on from this, mokopuna with high and complex needs were often segregated from their peers in secure care and experienced lengthy (often on remand) custodial stays.

Mana Mokopuna would like to see a co-ordinated effort from multiple agencies that include Oranga Tamariki, the Ministry of Health, iwi and community support agencies so that clear wrap-around plans for mokopuna can be developed. Diagnostic pathways and specialist care should be available to all mokopuna and their whānau to inform placement choice and support transitions home.

Mana Mokopuna does not believe large residences can provide the level of therapeutic care many mokopuna need and continues to call for Oranga Tamariki to close their residences in favour of small, bespoke, well resourced, community-based homes.

Cultural practices and commitment to Mokopuna Māori varies

Whilst some facilities were able to successfully integrate cultural practices, recruit more kaimahi Māori and demonstrate a commitment to improving outcomes for mokopuna Māori, this was not consistent across all facilities. The Youth Justice remand homes that the Team monitored were stand out facilities in the way they had integrated te ao Māori into everyday operations of their whare. Mana Mokopuna commends the efforts made in some larger residences, but as a whole, there needs to be more intentional development in this area given the continued over-representation of mokopuna Māori in places of detention.

In general, the cultural capability amongst staff was limited. Embedding operational practice change, providing cultural expertise, guidance, training and facilitating cultural events such as Pōwhiri or Mihi Whakatau, was often left to a limited few in named cultural roles. To truly improve outcomes for mokopuna Māori, we need to see a collaborative, lived approach shared amongst all staff that collectively places mokopuna Māori, their whānau, hāpu and iwi at the centre of all decision making and truly move to a by Māori, for Māori practice approach. This approach should be guided by the principles of Te Tiriti o Waitangi, Mātauranga and te ao Māori.

Care and Protection and Youth Justice Residences – Oranga Tamariki

Mana Mokopuna visited seven Oranga Tamariki facilities between July 2021 to June 2022 which all met the majority of our standards under OPCAT.
It is important to note that these standards are minimum requirements. They do not fully reflect our aspirations for promoting children's rights or enhancing their wellbeing.

Care and Protection

Following on from a serious incident that occurred in June 2021 at a Care and Protection residence, the decision was made to close the facility due to issues that involved both staff and mokopuna – a move that was fully supported by Mana Mokopuna. While the facility transitioned to closure, Mana Mokopuna undertook a monitoring visit which highlighted the importance of communication to mokopuna about what is happening to them. Mokopuna told us they were not regularly informed with what was happening, why it was happening, and their transition plans were not well communicated.

Mana Mokopuna hopes that lessons can be taken from the mokopuna experience and that future closures are carefully planned and well communicated so as to lessen any negative impact on mokopuna.

Mana Mokopuna does not believe that living in institutional group environments is appropriate for mokopuna, especially for those with high and complex needs who require specialised and on-going support. Mana Mokopuna supports the goal outlined by Oranga Tamariki to phase out the use of large Care and Protection residences in favour of small, bespoke, purpose-built homes.[9] However, progress on this work plan is slow and no other residences were closed during the 2021-2022 period. Mana Mokopuna has been openly critical of Oranga Tamariki and the lack of progress toward actioning the Future Direction Plan.

While mokopuna continue to remain in Care and Protection residences, key areas need to be addressed

Through the findings of Mana Mokopuna's monitoring visits, it was identified that key areas for development for Care and Protection residences, as per the domains we monitor against, were under Treatment, Personnel and Protection Systems. Mana Mokopuna believes that the following issues need to be addressed:

Long-term stays and inappropriate admissions

Across the residences, long-term stays for mokopuna with complex needs was the norm and was regularly raised as an issue by staff, mokopuna, and advocates alike. The main reason given for lengthy stays included difficulties finding placements in the community and being able to wrap the right community-based supports and resources around mokopuna and their whānau.

It was also acknowledged that some mokopuna were inappropriately placed in the first instance, and as a result were stuck in a facility that was not able to thoroughly assess and address their needs or provide adequate care. The Team also heard that some mokopuna were not informed that they were going into residence, and in some cases mislead about where they were going. For example, one mokopuna disclosed to Mana Mokopuna that when they asked where they were being taken, they were told they were going on a camp. This type of practice is not appropriate and mokopuna have the right to be fully informed about their care.[10]

[9] OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)
[10] Convention on the Rights of the Child | OHCHR

Training, professional development and supervision are not adequate

Staff at two of the three care and protection facilities we visited told us that the access to training, professional development and supervision were limited, inconsistent and did not currently support providing safe practice and environments for mokopuna. Mokopuna being placed in these facilities often had complex needs, and staff did not feel they had adequate skills or training to manage behaviours and promote appropriate therapeutic practice. It is also worth noting that avenues for feedback and support regarding these issues were limited and the communication between leadership groups and staff working directly with mokopuna was quite poor in some facilities.

Staffing levels are unsafe and practice is inconsistent

Across all Care and Protection residences, staffing levels were raised as a significant issue. Consequently, staff have been working unsustainable amounts of over-time or double shifts and have not been able to have sufficient amounts of time off between shifts. This has had an impact on staff wellbeing and the ability to meet the requirements of various roles – in some cases leadership teams have been required to work directly with mokopuna in order to make up shift numbers.

Staff practice was also inconsistent, and instances of staff dis-engagement were reported which placed mokopuna safety and wellbeing at risk. This may be a direct impact of the lack of training and low staffing levels and was more apparent in residences that did not have an overreaching therapeutic model of care in place.

The physical environment is not fit-for-purpose

The majority of the Care and Protection residences were described as unwelcoming, dated, cold, dark, and dreary. Considering mokopuna can have lengthy stays in these facilities, and it is essentially the place they call home, it is not appropriate that children in the custody of the state can have substandard living conditions.

Secure care areas were also being used as every-day living areas for mokopuna with high and complex needs, and additionally as de-escalation spaces to manage over-stimulation. This is concerning as the physical condition of some secure care areas were often highlighted as being in poor condition compared to the rest of the facility. The use of secure care in general is not conducive to therapeutic care nor should it be used for respite care.

Areas of strength:

Mokopuna had access to independent advocates

Across all Care and Protection facilities, the Team found that mokopuna had access to independent advocates, however as a consequence of COVID-19, kanohi ki te kanohi contact had been reduced.

Food, outdoors and education

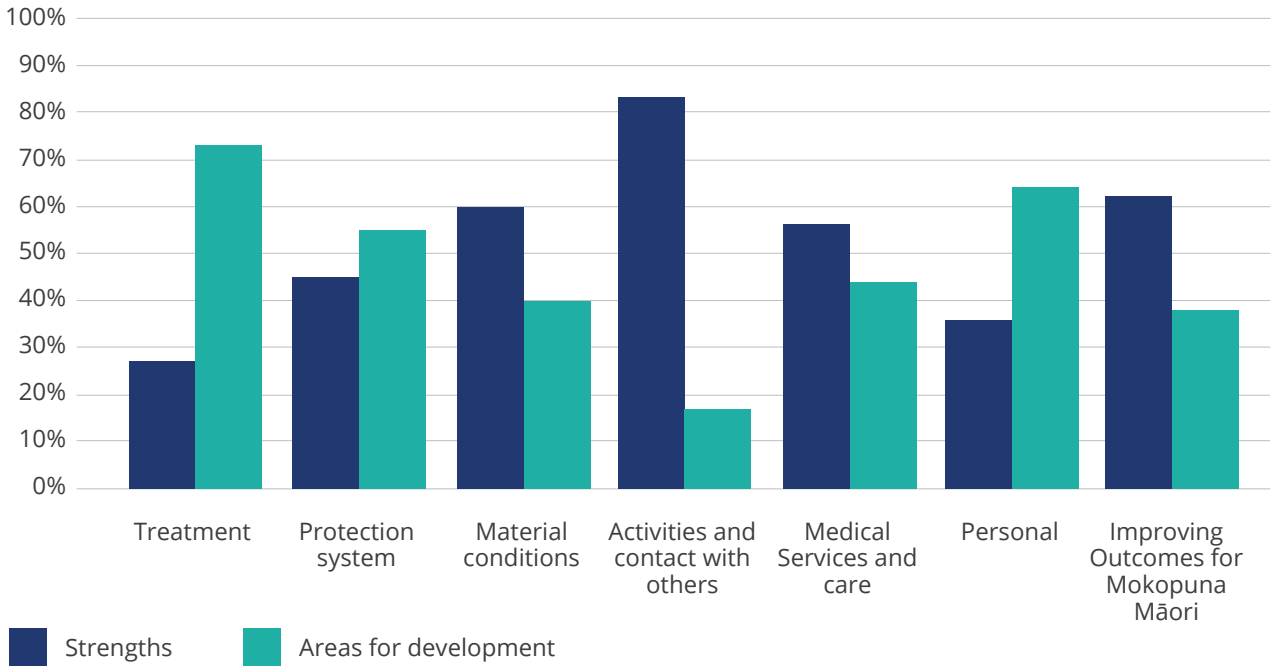
Mokopuna described the food being good and in some residences there was the opportunity to have multiple servings. Most facilities provided mokopuna the opportunity to grow, gather and prepare their own food and this was very well-received. Mana Mokopuna found that across the board outdoor spaces were in good order, well-resourced and widely used. Teaching staff and education were also spoken about positively by mokopuna across residences.

Primary Healthcare

Mokopuna said they had good access to primary and specialist care whilst in residence. However, there is room for development regarding access to mental health services in one facility, and administration of medication was noted as an issue across multiple residences.

An Overall Summary of Findings

Percentage of Strengths vs Areas for Development for Care and Protection



Youth Justice

The key areas for development for Youth Justice residences, as per the domains we monitor against were Personnel, Material Conditions, Improving Outcomes for Mokopuna Māori, and Treatment. Mana Mokopuna believes the following issues need to be addressed:

High and Inappropriate use of Secure Care

In one residence the team noted that admissions to secure care were used as a last resort and were kept short in length and paired with some restorative practices. However, in others it was used frequently alongside restraints and these practices do not align with mokopuna best interests and wellbeing.[11] Mana Mokopuna continues to advocate for Zero Seclusion and Restraint Minimisation in line with international research which highlights the harm that these practices can cause.[12]

Additionally, the team heard of instances where secure care was used as a 'female unit' with one female being isolated in this space. Not only was there a period of time where this mokopuna was the only female in the residence, she was denied access to education and the ability to move about common areas that she normally would be able to do in an 'open' unit because of her gender. Whilst this situation was rectified immediately after Mana Mokopuna highlighted the rights breach, it was disturbing to see that this was an option in the first instance. Secure care spaces were also used for COVID-19 isolation in residences. This is concerning due to the conditions of secure care often being noted as poor and comparatively worse to the main units of residences, and in one facility it was described as damp, with a mouldy smell.

[11] Report of the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment, U.N. Doc. A/63/175 Annex (28 July 2008) (Manfred Nowak).

[12] CRPD/C/NZL/CO/2-3, para 30.

Behaviour Management and Inconsistent Practice

Across the residences a Behavioural Management System that is rewards-based was used. Staff and mokopuna had mixed views about its effectiveness, with the application often being inconsistent from one staff member to another. Mokopuna said that sometimes favouritism or punishment influenced staff decision-making. Mokopuna described its use in terms of a group punishment - *"Everyone gets consequences for one person's actions and I hate that aye... consequences for their actions.... Instead of singling out the ones that are naughty"*.

Whilst most staff engagements were positive, inconsistent practice and acts of favouritism could have negative impacts for mokopuna and contribute to heightened behaviours in the units. Not all staff managed to establish appropriate boundaries when they interacted with mokopuna. The Monitoring Team heard inappropriate conversations that staff did not re-direct, language that was not corrected, and were told about 'play fighting' between staff and mokopuna.

It was noted across residences that access to training and supervision was not consistent, staff resources were stretched, and staff culture varied which may be contributing to the inconsistent and inappropriate practices of staff across youth justice facilities.

Mokopuna involvement in therapeutic care

Across all residences, mokopuna had varied, often limited involvement in the planning of their care, as well as their transitions out of care. Involving mokopuna in their care plans is vital in ensuring successful progression and transition to the community and is a fundamental right under Article 12 of the Children's Convention.[13] Additionally, mokopuna often had limited access to therapeutic interventions, specialist mental health care, and not all residences had an over-arching therapeutic model of care in place. Some residences were also lacking in sensory rooms, equipment and resources which are important tools for mokopuna to access in terms of having more adaptable ways to de-escalate and manage their emotions.

Cultural Development

It was highlighted across Youth Justice residences that there was a need for cultural development. Despite the desire and intent from residence leadership, most staff across all residences did not currently have the confidence or competence to engage with mokopuna Māori in a way that reflected te ao Māori values. There were instances when reo Māori was the first language for mokopuna and there were no staff who could communicate with them using their preferred language. Tikanga was also not embedded into day to day practice. Often specific blocks within the school structured day were the only opportunities for mokopuna to immerse themselves in their culture.

Cultural frameworks, which leadership said were in place, were not reflected in practice during our conversations with staff working directly with mokopuna. This showed a disconnect between leadership theory and what was actually happening 'on the ground' with mokopuna.

Areas of Strength:

Mentors for mokopuna

A key strength of the Youth Justice residences was the positive relationships between staff and mokopuna. Across most of the residences we heard mokopuna describe mentor-like relationships and active efforts being made by staff to positively engage with mokopuna or connect them with other staff members identified as trusted adults. We heard from mokopuna the positive impact that these relationships had on them - *"This place makes you change, shows that there's a better way, better path"*. In one residence we heard that residence staff were able to facilitate and repair a relationship between a mokopuna and their father resulting in the father becoming part of the transition plan out of residence, which was just one example of how whānau connection was supported within the residences.

[13] Convention on the Rights of the Child | OHCHR

Good access to advocacy

Across all the Youth Justice residences the team noted that Young People had good access to independent advocacy via VOYCE Whakarongo Mai.[14] Mokopuna also had good knowledge of the grievance process in most residences and told us they had used it during their stays in residences.

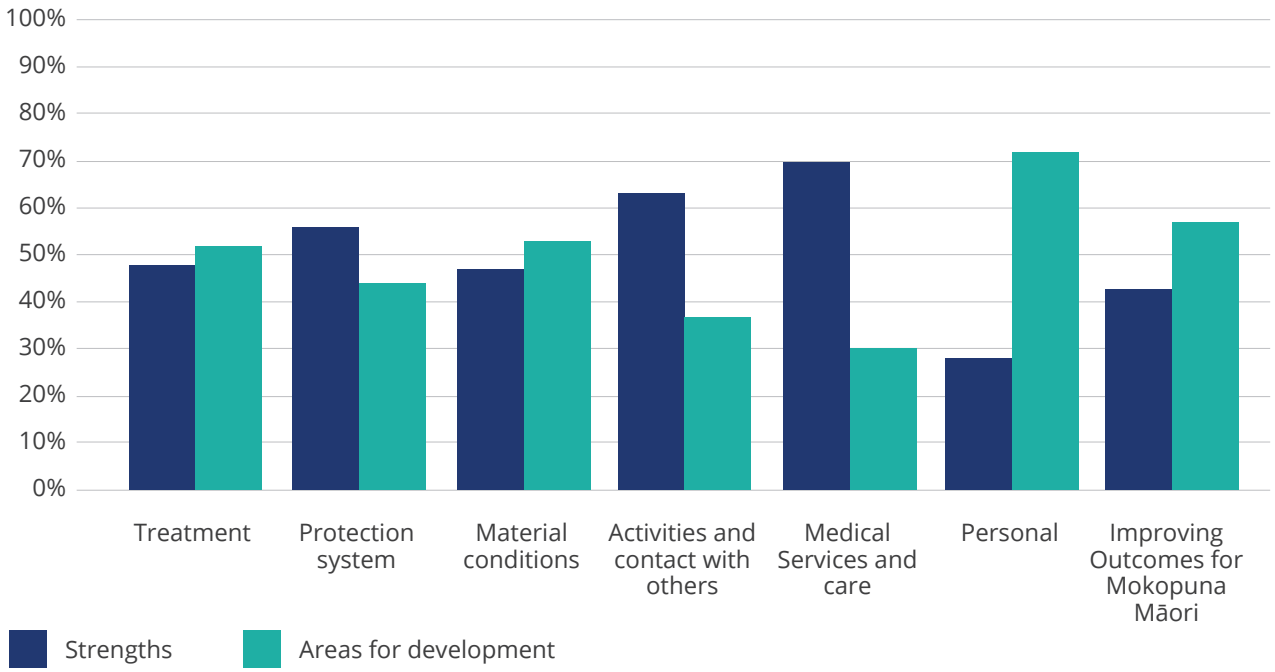
It is worth noting that Mana Mokopuna continues to advocate for an impartial grievance system for residences. Currently the Whāia te Māramatanga[15] grievance process is not independent of the residence and complaints are screened internally by residence staff. Some mokopuna are reluctant to use the grievance system where the complaint is about how facility staff have treated them.

Activities, education and facilities

Mokopuna had good access to indoor and outdoor activities across most of the residences we visited. Furthermore, education was highlighted and enjoyed by mokopuna. In some facilities, the physical environment was highlighted as being in reasonable and clean condition, with access to outside grassed areas. Most facilities also had access to a gym and/ or pool. However, regular maintenance programmes are required to ensure all facilities are of the same standard and damaged infrastructure is repaired or replaced in a timely manner. There is a need for more sensory resources and de-escalation areas that are away from the main units.

An Overall Summary of Findings

Percentage of Strengths vs Areas for Development for Youth Justice Residences



[14] VOYCE - Whakarongo Mai - Your rights when in care
[15] CRPD/C/NZL/CO/2-3, para 30.

Community Run Remand Homes

Mana Mokopuna monitored two remand homes during the 2021 – 2022 period. This was the first opportunity to monitor homes run by NGO partners (as opposed to those run by Oranga Tamariki).

Key areas for development for Remand Homes were under the domains of Personnel and Protection Systems, but as a whole remand homes had a higher percentage of strengths across the domains in comparison to the residences within our Youth Justice designation. Mana Mokopuna believes the following issues need to be addressed:

Personnel

The effects of the COVID-19 pandemic was still being felt by the NGO sector. Vaccination mandates and staff illness resulted in many staff not being available for work.

The knock-on effect has been that staff have needed to work extra shifts or staff who were not employed to work in a remand setting, like back-office staff, cooks or those working in care and protection, have been brought in to provide frontline shift cover in remand homes.

Our monitoring also highlighted the issue of not enough people available to back-fill staff when they needed to take planned annual leave, attend trainings or supervision. This is leading to burn-out, inconsistent practice and a decrease in staff well-being.

Independent advocates and complaints systems

Mokopuna in the remand homes monitored did not have access to independent advocates like VOYCE Whakarongo Mai. Neither staff nor mokopuna the team spoke to knew how to access this service.

Remand homes must employ a high level of trust when dealing with complaints from mokopuna. Being homes rather than residences, there is no CCTV camera footage which means complaint investigations are based on individual interviews with the relevant parties. This places mokopuna in situations where their word is taken into consideration alongside adults and they have to operate within an adult HR system to be heard.

Remand homes did not use the Whāia te Māramatanga process and there is no clear pathway for mokopuna to escalate their complaint if they do not feel it has been adequately addressed.

Independent advocates should be available to all mokopuna in all places of detention and the complaints process should be easy to understand, accessible for youth and be clear when mokopuna or their whānau want to escalate their complaint. This was highlighted to both the NGO and Oranga Tamariki for urgent redress.

Statutory social workers should be more present

The relationship between Oranga Tamariki and NGOs who run remand homes needs to be strengthened. Staff at the remand home frequently went above and beyond their contracted duties, including paving the way for transitions home, escorting and supporting mokopuna in court and pushing for assessments to be completed – all tasks a statutory social worker should be leading. Remand homes cannot become 'dumping grounds' for mokopuna in custody. The remand home model is strong when it can focus on healing and connecting mokopuna to whānau, their whakapapa and living the values of aroha, tika and pono. Statutory social workers need to ensure doors are opened, assessments are resourced and transition plans are comprehensive to address needs.

Areas of strength:

A home-like environment

Mokopuna thrived in small home-like environments with smaller numbers of mokopuna and the ability to build strong, meaningful relationships with each other, staff and their house parents. There were many opportunities for staff to role-model positive and pro-social behaviours and create a safe, stable environment for mokopuna. The model used in remand homes also employs zero use of secure care or restraint.

The remand homes created a sense of belonging for mokopuna *"It's not a residence…It's like a place where you [can] be yourself"*.

Te ao Māori is lived and breathed

In the remand homes the CYPC monitored, te ao Māori was the way of life. Mokopuna show respect because they want to, they show manaaki because it is always role modelled, they show aroha because they are treated with aroha. Learning mātauranga is not classroom based, it is mokopuna experiencing what their tipuna have done before, it is learning how to provide, it is learning how to contribute in a positive way to the group, to your whānau.

This is how the remand homes are run. Staff did not 'show' mokopuna Māori values. It is lived, reo Māori is a given, education is not based on western ideals – it is tailored to individual need and based on practical application of tikanga Māori.

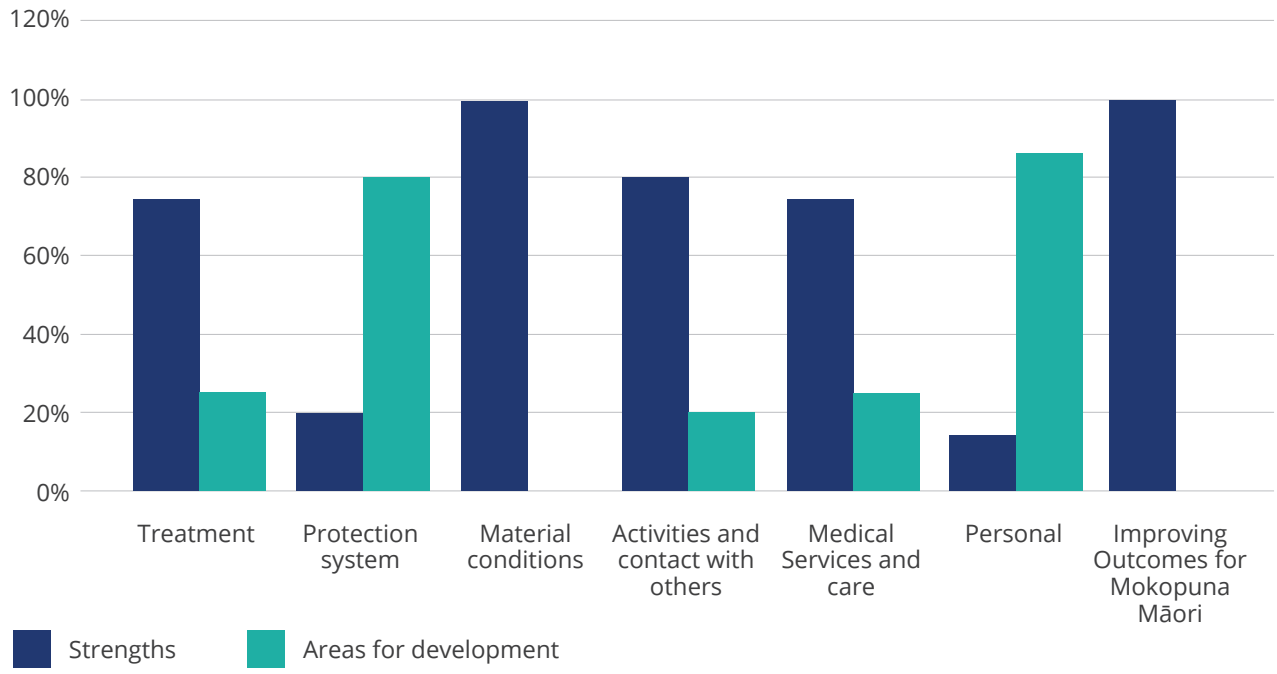
Remand homes use their local resources

Mokopuna described the opportunities they had to engage in various activities including community-based programmes, and how they also used local resources such as beaches, rivers, and local swimming pools. Mokopuna said they liked gathering and preparing their own food in particular. Mokopuna liked how they felt part of the home and the community *"It's like, like they make you fit in, like your actual own house"*. Despite mokopuna being on a custodial remand status, the small number of mokopuna, the highly skilled staff and the ground-rules established within in the home meant that mokopuna had the opportunity to leave the home and engage in normal, every-day activities that are available to all mokopuna. Mokopuna were not constrained by their court status, instead they were able to see what a path away from offending could look like.

This model is something Mana Mokopuna is advocating for. Small, bespoke placements that can cater for individual need. The homes we monitored embodied the principles of Te Tiriti o Waitangi and were a place where mokopuna Māori were thriving. Te ao Māori was celebrated as the way of life, te reo used at every opportunity, and education culturally embedded.

An Overall Summary of Findings

Percentage of Strengths vs Areas for Development for Remand Homes



Mental Health facilities run by the Auckland, Christchurch and Capital and Coast District Health Boards

Mental Health Facilities

The Monitoring Team visited three in-patient youth mental health facilities over the 2021 - 2022 period. Consistent with the other sectors, the Team found that these facilities met the majority of Mana Mokopuna's minimum standards.

Through the findings of the monitoring visits, the team noted that the key areas for development for Youth Mental Health facilities, as per the domains it monitors against, were under Material Conditions, Protection Systems and Personnel. Mana Mokopuna believes the following issues need to be addressed:

Physical facilities are not adequately meeting the needs of mokopuna

Most of the facilities we visited were described as not being fit-for-purpose in terms of their physical condition and therefore did not provide a homely or therapeutic environment for mokopuna in care. Whilst one facility was in the process of constructing a new purpose-built unit, and another had made some improvements, the overall standard across facilities could be improved. Generally, facilities were rundown, cold, dark, and some areas were sparsely decorated with limited access to light and outdoor areas. In one facility the seclusion wing lacked privacy and could be seen into by passing public.

Mokopuna voice and rights

Across the facilities, mokopuna lacked the knowledge and general awareness on how to engage in the complaints process at the facility. There was also limited access to advocates which further prevented the ability for mokopuna to have a thorough understanding or voice around their care and treatment plans.

We also found that mokopuna with more complex needs had a tendency to be kept in some facilities beyond the point of necessity, and this was often in relation to limited social support or adequate placements for mokopuna to transition to within their own community. For mokopuna to thrive, they need to have access to resources in their own communities alongside on-going, post-treatment support in order to have the opportunity to achieve wellbeing beyond a mental health treatment facility.

In one facility, the use of seclusion and restraints were high. Mana Mokopuna also found that in this facility, mokopuna were given cardboard potties to use despite there being bathroom facilities available in the seclusion wing. This was highlighted as a rights breach and action was taken by the facility.

It is worth noting that one facility has successfully eliminated the use of seclusion and restraints and Mana Mokopuna would like this facility used as an exemplar for others. Mana Mokopuna continues to build a relationship with the Ministry of Health and the new entity Te Whatu Ora to establish how we can support a zero seclusion policy for the future.

Opportunities for training were limited

Across some of the facilities there was an absence of ongoing and/or specialist training. In one facility staff were out-of-date with their mandatory restraint training,[16] and Mana Mokopuna noted this as alarming, particularly as it was a facility with a high use of seclusion and restraint practice. Staff shortages across the sector were given as the reason for the lack of up to date training. However, in a setting where mokopuna are acutely unwell, Mana Mokopuna believes that staff who are available to work with mokopuna should be adequately trained to reduce the risk of harm.

Areas of strength:

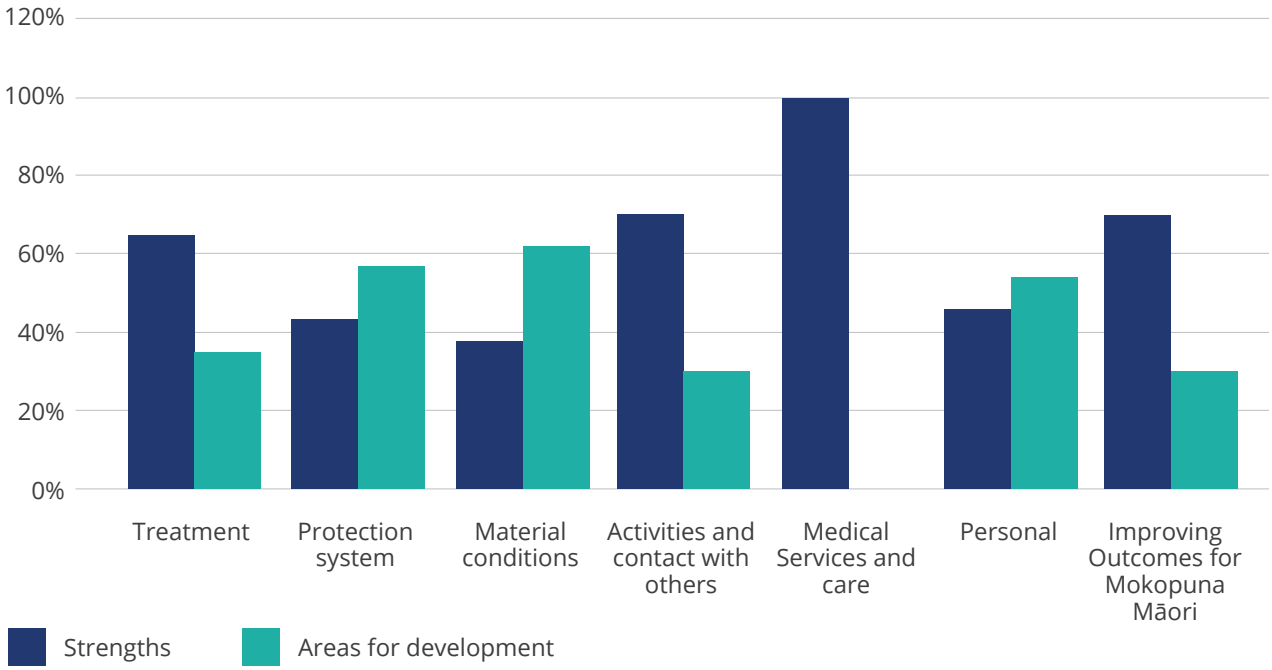
In line with these facilities being based within a hospital setting, we were pleased to see that Medical Services and Care was a strength. We noted excellent therapeutic interventions upheld by good models of care which promoted good staff practices. We saw notable improvements to staff culture and attitudes across the board and this was despite documented staff shortages within the mental health sector.

Mokopuna also had good access to peers and access to their whānau was described as a highlight. Mokopuna were also supported to establish connections within their hāpu and iwi, learn their whakapapa and learn about their world through a te ao Māori lens.

[16] Safe Practice Effective Communication | SPEC |

An Overall Summary of Findings

Percentage of Strengths vs Areas for Development for Mental Health Facilities



Mothers with Babies Units, Ara Poutama – Department of Corrections

Mana Mokopuna visited the MBU at Auckland Women's Regional Corrections Facility.

Mana Mokopuna acknowledges the on-going effect the COVID-19 pandemic had on prisons and that there continues to be a significant shortage in Corrections Officers across all prisons which significantly impacts prison operations.

Mothers with Babies Unit

The Monitoring Team found no evidence that women or babies had been subjected to torture or ill-treatment and observed that babies were safe and living in an environment supported by their mothers.

The key areas for development for MBU, as per the domains monitored against, were under Activities and Contact with Others, Protection Systems and Personnel. Mana Mokopuna believes the following issues need to be addressed:

Mothers were isolated and experienced limited social interactions

Under the COVID-19 Custodial Resilience Operating Framework (CCROF),[17] mothers in the MBU could not mix or interact with other women in the low security self-care units and were restricted to staying within their unit.

[17] Redesigning_the_Ara_Poutama_Complaints_System_-_Report_Jan_2022_Corrections_Response_FINAL.pdf

While mothers had respectful relationships with Corrections officers, their interactions were often quite brief and limited due to staffing shortages and mothers described feeling isolated from the lack of interaction. Mothers were unable to see whānau kanohi ki te kanohi and we noted some babies had never seen any whānau kanohi ki te kanohi.

Staff looking after mothers in the MBU were not specifically trained

Corrections Officers working in MBU had only attended a generalised Correction's Officer induction training and received no additional training in terms of working with mothers and babies. We recommended that all staff working within the MBU received training specific to working with mothers and babies including, but not limited to, baby development and safety and maternal mental health.

Mothers did not have sufficient child-care support and missed opportunities to participate in activities

Mothers did not have adequate access to child-care support and had to rely on each other to baby-mind. This did not always work out when the mothers had appointments at the same time. This led to appointments needing to be re-scheduled or activities being missed. Mothers had very little opportunity to engage in any activity alone or have respite time away from their baby. Generally, activities were limited for mothers and were centred around parenting skills. There were few programmes that focused on the mothers interests outside of being a parent.

The complaints process was generic and not fit for purpose

Mothers only have access to the generic prison complaints system, which is lengthy, not always effective, and offers no operationally independent complaint oversight unless appropriately escalated. It was also noted that it is not aligned with the Hōkai Rangi Strategy,[18] which as a whole aims to lower the proportion of Māori in care.

Mothers also did not have adequate access to independent advocacy or support to navigate any issues they were dealing with. We saw the visiting midwife as a strength and saw how she escalated issues on behalf of mothers despite this being outside the scope of her role.

Areas of strength:

Mothers in the MBU unit actively worked together to support one another across multiple avenues – including baby-minding, providing emotional support, and maintaining their whare. The whare units were home-like, mothers could cook for themselves and their babies and move furniture around to maximise indoor play space.

The Pou Tūhono[19] visit the whare and help mothers explore whakapapa connections, learn te reo and extend knowledge of te ao Māori and this was noted as a highlight amongst mothers. This relationship was seen by mothers as positive, nurturing and supportive and a protective factor for them alongside they relationship they shared with their midwife.

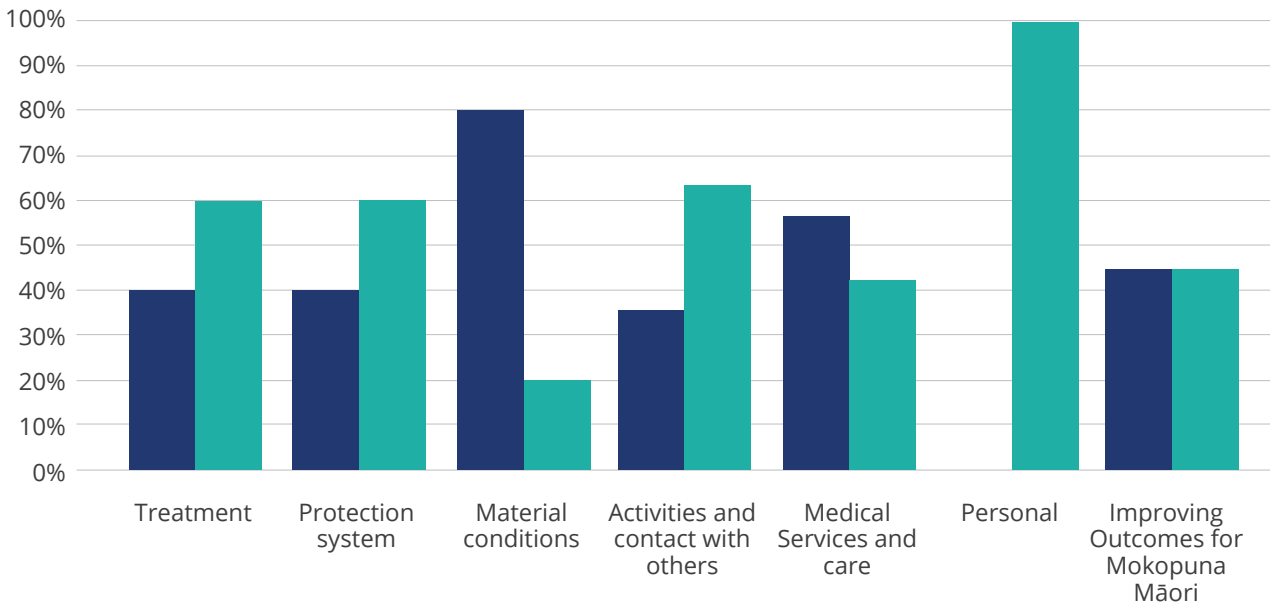
Mothers had good access to medical care and we were pleased to confirm that the handcuffing of women in late stages of pregnancy was not occurring. However, the midwife did note some Corrections Officers had to be reminded of the policy especially when women were escorted off-site for specialist appointments or to give birth.

[18] Hokai_Rangi_Strategy

[19] A role dedicated to helping women in prisons learn about their whakapapa, connect back into Te ao Māori, and practice their reo

An Overall Summary of Findings

Percentage of Strengths vs Areas for Development for Mother's with Babies Units



In Summary

The impacts of COVID-19 remain ongoing across places of detention in terms of stretched staffing levels and reduced kanohi ki te kanohi access to advocates and external providers. This includes extracurricular activity instructors and community-based services and supports.

Some of the key themes we noted across our visits were the positive relationships staff have with mokopuna, which mokopuna told us made them feel supported and that they had safe people to turn to. The majority of the time, mokopuna said that staff really cared about them and wanted to promote their best interests.

Unfortunately, the team did note in some facilities, staff practice and behaviour could be inconsistent, and this is something that needs to be addressed. Mokopuna thrive on consistency and routine and staff behaviour needs to reflect this in order to maintain and develop pro-social behaviours amongst mokopuna. As one mokopuna put it - *"We just treat them how they treat us pretty much. They talk to us like shit, we pretty much talk back to them like shit, yeah"*.

Mana Mokopuna heard on a number of occasions that staffing levels, retention, and recruitment was a significant issue that was leading to unsafe staffing numbers and in turn likely impacting upon the quality of staff practice. In line with this, lack of appropriate training was a regularly reported issue and some staff felt out of their depth and ill-equipped to manage some of the high and complex needs mokopuna had. Supervision in many facilities was not prioritised due to not having enough staff to provide cover, and therefore staff did not have adequate mechanisms in place to help support them through practice or well-being challenges.

Staffing challenges also extended to having the capacity and capability to embed tikanga Māori practice throughout facilities. Mana Mokopuna often found that upholding the cultural needs of mokopuna Māori was left up to one or two staff members. Ensuring appropriate kawa and tikanga was upheld for events such as Pōwhiri or Mihi Whakatau, imparting knowledge of te ao or mātauranga Māori, exploring whakapapa and ensuring someone could speak reo Māori to mokopuna where te reo was their first language, fell on the shoulders of a few. Māori continue to be over-represented in places of detention, however, these same facilities often struggle to ensure cultural needs are met which is not appropriate.

Mana Mokopuna, through its monitoring, continues to observe that that some mokopuna appear to be in places of detention purely because the system has not been able to find them other places in which to live and be cared for. This is highly concerning and calls into question the extent to which the rights of these mokopuna under the Children's Convention are being upheld.

Mana Mokopuna continues to advocate for resources to be devolved to iwi and community groups to establish and fund solutions fit for them. Our team has seen how small, purpose built homes run by iwi or kaupapa Māori organisations, can have positive effects for mokopuna in steering them away from a youth justice pathway or ensuring their care needs are appropriately assessed, planned for, and inclusive of a successful transition back to whānau. Keeping mokopuna in their own community, close to whānau, hāpu and iwi is essential, and these bespoke services embody the principles set out in Te Tiriti o Waitangi.

Mana Mokopuna will continue to advocate for the closure of large care and protection residences and hold Oranga Tamariki accountable for operationalising the commitments it has made in its Future Direction Action Plan.

Inspector of Service Penal Establishments

Office of the Judge Advocate General
of the Armed Forces

Introduction

The Inspector of Service Penal Establishments (ISPE) is the National Preventative Mechanism (NPM) charged with monitoring New Zealand Defence Force (NZDF) detention facilities. The Registrar of the Court Martial is appointed as the ISPE as set out in Section 80 (1) of the Court Martial Act 2007 in respect of Service Penal Establishments (within the meaning of Section 2(1) of the Armed Forces Discipline Act 1971). The remit of the ISPE is to ensure that the SPE comply with the principles of Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The Role of Detention

Detention, as one of the sentencing options from a Court Martial or Summary hearings, is still used as an effective punishment method for promoting and maintaining discipline within the New Zealand Defence Force (NZDF). It is second only to imprisonment and dismissal from His Majesty's Forces at the top end of available punishments within the military justice system.

However, a very important aspect to detention within the NZDF is that its focus is on corrective training. A training that is designed to engender appropriate behaviours and attitudes that align with the values of the NZDF and are conducive to the effectiveness of a disciplined force. This is because the Services invest considerable resources in upskilling its personnel to be proficient in their respective trades and corps and so the intention is to have the majority of Service detainees return to their Services after serving their period of detention.

That said, like their civilian counterparts, Service detainees are also deprived of their liberty and so it remains important that these places of detention in the NZDF are independently monitored against OPCAT principles regularly.

Inspections

OPCAT success is based on the premise that regular independent visits will prevent torture and other cruel, inhuman or degrading treatment of detainees. So regular OPCAT inspections remain relevant despite the absence of any ill treatment of detainees in the Armed Forces to date. In the year ending December 2022, three of the eight permitted **no notice** inspections were conducted by the ISPE.

The structure of the inspections generally include a physical review of the facilities, discussions with the Officer-In- Charge (OIC) and staff, reviewing various documentation and private interview/s with randomly selected detainees. Feedback is provided routinely after the inspections to the OICs and a formal feedback is provided once annually to the senior leadership of the NZDF. This year the Services Corrective Establishment (SCE) was also visited by newly appointed Judges of the Court Martial of New Zealand. The intention is also to extend the invite to the three newly appointed Judges of the Court Martial Appeal Court of New Zealand.

ISPE Expectation Document

In the Annual Report last year, it was reported that the ISPE produced an 'Expectations' document:

> *OPCAT – Expectations for Conditions and Treatment of Detainees in Service Penal Establishments January 2022. The purpose of the document is to provide a guide to the elements of the inspection. The idea is that the inspections of these elements would provide a basis of the compliance requirements of the OPCAT as well as some of the key obligations under the Te Tiriti o Waitangi.*

Feedback from the SCE staff is that the document has provided a very good foundation and reassurance for the Establishment's corrective training strategy especially in the area of its key obligations under the Te Tiriti o Waitangi.

Detention Facilities

The NZDF continues to have just one dedicated facility that caters for the military punishment of detention. The SCE is based at Burnham Military Camp, Christchurch. Members of the NZDF can also be confined in Ship, Camp and Base facilities when close arrest is ordered. However, these periods of confinement are rarely ordered and confinement exceeding 12 hours is highly unusual.

The NZDF also has holding cell facilities on its Bases and Camps. As was the case in the 2021 Report, the facilities at RNZAF Base OHAKEA, Linton and Trentham Military Camp and RNZAF Base AUCKLAND are the only ones considered as being fit for purpose. The current status of the cells elsewhere are as follows:

- HMNZS PHILOMEL the cells remain closed as they are no longer fit for purpose and if required the cells at RNZAF Base AUCKLAND can be utilised until a new purpose built is facility delivered for the Devonport Naval Base;

Rec 1: **NZDF should consider to permanently close this detention facility;**

- Papakura Military Camp does not have dedicated cells and if required the cells at RNZAF Base AUCKLAND can be utilised;
- Waiouru Military Camp the cells are closed and if required the cells at RNZAF Base OHAKEA can be utilised;
- RNZAF Base Woodbourne has no dedicated cells. Plans are underway to install temporary facilities that comply with extant specifications **but still no fixed completion date has been provided to ISPE**; and
- Burnham Military Camp the cells can be used but are scheduled for remediation although the urgency is somewhat mitigated by the presence of SCE on Camp. However, **still no fixed completion date has been provided to ISPE**.

As in 2021, while remediation plans for various facilities appear to have been signalled, a definitive funded remediation programme is still to be published by the NZDF.

Services Corrective Establishment

As mentioned above SCE is the only purpose-built detention facility within the NZDF. It has 10 unisex cells. Recognising that most of the detainees are destined to return back to the Services, SCE has a twofold purpose, which is to provide:

- corrective Service training for detainees so that those who are to be retained in the Service may return to their units as better members of the Armed Forces; and
- a custodial punishment, which will act as a deterrent to future offending by each detainee and other members of the Armed Forces.

Committal Statistics

During the period January to December 2022, there were 20 detainees at SCE,[20] covering some 760 days of detention over the reporting period. The pertinent breakdown statistics are as follows:

Service		
Royal New Zealand Navy: 2(0)[21]	New Zealand Army: 18(+1)	Royal New Zealand Air Force: 0(-1)

Gender	
Male: 90 %	Female: 10%

Ethnicity			
NZDF Military Population:[22]			
European: 44%	Māori: 18%	Pacific People: 6%	Other: 32%
NZDF Detainee:			
European: 30%	Māori: 50%	Pacific People: 10%	Other: 10%
(NZ Prisoner Statistics):[23]			
European: 30.2%	Māori: 53.2%	Pacific People: 11.5%	Other: 5%
NZ Population[24]			
European: 70.2%	Māori: 17.1%	Pacific People: 9%	Other: 4%

NZDF detainee demographics continue to be similar to those at the national level. Recognising that the national narrative continues about developing strategies that would reduce Māori imprisonment/detention/offending rates across the spectrum of the Justice system,[25] it was recommended in the 2021 Report that it would be appropriate for the NZDF – if not party to cross agency effort then - to at least consider implementing relevant outcomes from the Ministry of Justice-led *Hāpaitia te Oranga Tangata Safe and Effective Justice and the Department of Corrections' Hōkai Rangi* strategy to reduce Māori imprisonment rates.

ISPE has not been able to get any feedback on what, if anything, NZDF has done about this recommendation.

Reduction in Māori and Pacific Detention Rates Within NZDF

To date, there does not appear to be any explicit policy setting and/or strategy within NZDF that targets the reduction of Māori (and Pacific People) detention within NZDF. Although, in fairness, and as noted in the 2021 Report, the NZDF did start a review of the Military Justice System with an initial focus on process review on the appropriateness of detention as a punishment option for Summary hearings. Whether or not the outcomes from this review informed any further work on achieving a reduction in Māori and Pacific detainee numbers still remains to be seen.

As noted last year, given Parliament's acceptance of the special character of the Military Justice System that underpins the effectiveness of a disciplined force, ***that the NZDF should consider a more robust data capture by relevant categories of the various stages of the military justice spectrum including investigations, offending, detainees and recidivism rates.***

It was further noted ***that the publication of such data by the NZDF in its Annual Report for it would promote transparency and public awareness. To date ISPE has not been able to see if there has been any progress on these recommendations.***

[20] Data provided by Officer In Charge of SCE.
[21] Difference to 2021 figures.
[22] NZDF Annual Report 2022.
[23] Prison Facts and Statistics |September 2022: Department of Corrections NZ.
[24] NZ Statistics 2018 Census data
[25] Ministry of Justice led Hapaiti te Oranga Tangata- Safe and Effective Justice 2021 and 2019 Department of Corrections Hokai Rangi Strategy.

ISPE continues to hold the view that such data would be valuable in informing the development of any current or future strategies of effecting discipline within the NZDF.

It should be noted, however, that the remit of the ISPE is only confined to the detainee and recidivism data, which currently is available but only on request from SCE.

Long Term Detainees

Similar to previous years, the preferred option by the Court to send detainees with long sentences (of more than six months) to SCE over imprisonment continues. However, while SCE appears progressively to be getting better placed now to accommodate long term detainees, the establishment is nonetheless facing challenges particularly with resources that will still need to be invested by NZDF.

This preference by the Courts for longer sentences is most likely because SCE has a very effective personal developmental and rehabilitation/reintegration programme, even for those who are going to be dismissed from Service at the end of their detention period. The NZDF is very fortunate to garner the productive outcomes from the SCE programme especially given the considerable resources that are expended to 'grow' effective Service personnel across the many trades, branches and corps. **However, maintaining the effectiveness of this embryonic programme without burning out the staff has been identified by the Officer in Charge (OIC) of SCE as the key risk facing the establishment.**

Short Term Detainees

By contrast, the aim of the short term detainee programme is solely on Service personnel at SCE to become productive and effective members of the NZDF. The programme is focussed on self-reflection on behaviours that led to them being at SCE in the first place.

Interim Strategy

Preliminary indications suggest that the NZDF is exploring ways address the resourcing issue. Until the issue is resolved, the OIC has introduced a two strand mitigation strategy as follows:

- creating two dedicated programmes for long term and short term detainees respectively with dedicated staff, and
- maximum use of technology.

The creation of a dedicated long term programme Manager should alleviate the constant switching and reorientation that the staff have had to do between the two programmes. As the long term detainees are almost always dismissed from the Service they require a programme that is focussed on the reintegration into society, hopefully as good and productive citizens.

Greater use of technology into the programme delivery will allow the long term detainees to take more responsibility for their own development with appropriate supervision from the Manager. This should allow the detainees to manage the development project, with the Manager seen more in a couch/mentor role while still been within the rules and expectations of a detainee in a detention facility. This approach is in its infancy but feedback from both the detainee and the Manager is that this approach is showing promising results in charting a pathway for the long term detainees to prepare for re-integration into civilian life. **Initial indications are that the mitigation strategy will be successful but its continued success is very much dependent on NZDF investing in the required resources**.

Corrective Training

The principal aims of corrective training are to restore detainees' self-confidence, self-respect, and to motivate them to a level where they can adjust to the structure and discipline of a Service environment. As well, for those detainees who are to be dismissed from the Service, to develop personal qualities which will enhance their successful integration into civilian society. The split between the long and short-term detainee programmes will only improve the achievement of these aims.

The current form of corrective training has a personal development focus centred on the maintenance of discipline, through physical training (PT), military drill, work details, complex tasks and equipment husbandry. The work details provide an opportunity for detainees to contribute positively to the local community. Development programmes, which are designed for each detainee, focus on the areas that provide the greatest amount of personal development with specialist outside support utilised in the areas of education in substance misuse and, where appropriate, career transition.

Mental Health

SCE continues to make good progress in establishing robust processes to assist individuals dealing with mental health concerns. Staff have received some professional development in this area through the Mental Health Education and Resource Centre. SCE is also well placed to utilise the full suite of internal and external support network as part of its rehabilitation/reintegration programme. One notable aspect of assisting in this area is the community service work that the detainees do regularly. Helping others freely seems to help the wellbeing of detainees.

Detainee Feedback

As in previous years, detainees report feeling a greater sense of self-worth and confidence at the completion of their sentence and feel motivated to become productive members of either the Service or the community. Individuals continue to state that the safe environment at SCE allows them to concentrate on themselves and become receptive to receiving appropriate counselling and/or treatment. The sole long term detainee credits the long term programme as the critical factor in helping him to focus and plan on a productive future in civilian life.

Productive Projects

As in previous years, SCE Staff continue to train detainees in basic skills in the operation, maintenance and safe use of various power tools particularly for gardening and landscaping. This training then allows the detainees to be regularly employed as manual labour for various self-help projects such as:

- The eradication of seedlings pines, scrub clearance and the management of a newly developed native nursery as part of the Burnham Camp beautification scheme.
- maintaining the Burnham Camp Urban Training Facility Range on the 189 acre paddock in a clean and tidy condition.
- The redesign of Burnham Camps Grants Grove reflective garden. This project provides an opportunity to educate detainees in planning processes, liaison with outside agencies, managing resources, problem solving and formal progress briefings, which exposes them to public speaking.
- Restoration of military headstones as part of the Army restoration project. Detainees report a significant feeling of satisfaction and pride in carrying out this work. Some state that this work was instrumental in the success of their rehabilitation programme at SCE; and
- Growing vegetables for the City Mission and spending time working there periodically provides detainees with greater self-worth.

Discipline

Like last year, there were no breaches of discipline at SCE. Some detainees initially struggled to meet the standards required at SCE and some are still impacted from long term drug use. SCE, however, appear to have the required capability to work with these individuals and keep them safe as they overcome the adverse effects of drugs and /or alcohol abuse.

From detainee interviews, the services of the Career Transition Coaches continue to have positive impact on the rehabilitation of the detainees. The Coaches have assisted individuals leaving the NZDF with preparatory job seeking skills. They have also worked with personnel remaining in the Service by mapping out five year career plans.

Complaints Process

Last year it was noted that the detainees needed to be made fully aware of the formal procedures for lodging a complaint regarding any aspect of their treatment. Currently there is a very mature process for internal complaints to be

raised to the Officer-In-Charge. The detainees appear to know the internal process very well. **However, the area that needed further development was for the process of raising the complaints externally outside of SCE. ISPE understood that NZDF was to review this area of current policy, but to date no formal feedback was avilable to the ISPE**.

SCE State of Buildings/New Works/ Improvements

In its current location, SCE continues to be assessed as being in a good state of repair as well as being fit for purpose. The environment enables it to effectively run the required development programmes in a professional manner. Equally, organising the physical environment down into zones allows the detainees to quickly orientate themselves into the SCE operating model. The ongoing development of the external areas within the SCE area ensures that it is now self-contained which continues to be vital in countering the spread of COVID-19 or similar threats. The building provides staff with good dedicated workspace as well as the ability to effectively induct new staff to the Establishment. **However, as the trend for long term detainees are on the rise, the NZDF appear to be looking at plans for the extension of the facility to accommodate more long term detainees. Although to date ISPE is not aware of any formal plans for the extension of SCE**.

Te Tiriti o Waitangi

SCE continues its development work in ensuring that its operating model reflects the Te Tiriti o Waitangi requirements as applicable to the NZDF. **However, the success of this work is dependent on NZDF allocating appropriate resources to SCE particularly with specialist staff.** Close working arrangements with the Department of Corrections continue to allow SCE to identify and adapt workable ideas pertinent to its programme at the local level. This work is an important enabler and NZDF should maintain it as a priority. An equally important point to note is that SCE appears to have fully embraced the significance of the cultural influences into its correcting training programmes with some very remarkable successes.

Conclusion

The continued focus at the SCE is on personal development for those individuals that are to remain in the Defence Force. The development is founded on corrective training, which is fundamental, immediate and mandatory. Furthermore, the training programme centres on, but is not confined to, the maintenance of discipline through physical training, drill on the parade ground, physical work, equipment husbandry and considerable time for self-reflection on appropriate behaviours.

For those who are to be dismissed from the NZDF, the focus shifts to that of preparing for life in civilian society and positioning for success, in relation to job obtainment and the processes involved in realising this outcome. Overall, the corrective training programme at SCE is considered to be very effective in delivering its stated outcomes. **However, to maintain this success, the NZDF will need to invest and prioritise resources particularly in the area of reducing Māori and Pacific peoples' detention rates**.

Currently the holding cells at RNZAF Bases OHAKEA and AUCKLAND and Trentham Military Camp are the only ones considered to be compliant. While other Camps and Bases are planned for new facilities as part of the NZDF state infrastructure programme, no definitive dates for their completion have been stated.

Overall Assessment

The ISPE remains satisfied from inspections at SCE and visits to Camps and Bases throughout New Zealand that the culture of the New Zealand Defence Force continues to support the promotion of the human rights and humane treatment in its detainee ranks. Recommendations and key issues have been highlighted in this Report to NZDF for its consideration. These recommendations and issues if addressed should only improve the organisation's obligations to meeting the OPCAT protocols.

Chief Ombudsman

Ombudsman
Fairness for all

Introduction

I am designated as a National Preventive Mechanism (NPM) under the *United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT). The purpose of the OPCAT role is to prevent torture and other cruel, inhuman or degrading treatment or punishment of persons who are detained. In carrying out this role, I undertake various activities including examining the treatment and conditions of persons in up to 491 facilities over the 2021/22 year.[26]

Improve the conditions and treatment of people in detention

My role as an NPM has a preventive purpose to:

- carry out regular and unfettered monitoring, including examination of places of detention;
- use information and evidence from various sources to assess conditions in places of detention;
- comment on law, policy, and procedure that encourages the improvement of conditions and treatment;
- make and track recommendations to prevent torture or ill-treatment, and to improve the conditions of detention and treatment of detainees, including identifying and promoting good practice according to international standards.

Visits and inspections

A key activity as an NPM is visiting and examining places of detention on a regular basis. In addition to being a primary function of my OPCAT role, it also ensures Aotearoa New Zealand is seen as a good global citizen, adhering to agreed international human rights conventions. In 2021/22, I carried out a total of 62 visits to places of detention, details of these visits are available at the end of this section. This brings the total number of visits conducted over the 15-year period of the Ombudsman's operation under OPCAT to 725.

The COVID-19 global pandemic has been 'front and centre' in my OPCAT role. The frequently changing circumstances and government advice required that I continuously review the operational approach to conducting OPCAT examinations and made sure that on-site visits were safe and aligned with public health measures. My approach during this time included announcing visits to these high-risk sites, undertaking shorter targeted inspections (focusing on specific areas of interest, such as impact of COVID-19 on treatment and healthcare in prisons), and an increased number of drop-in visits. I updated my internal policies to demonstrate my commitment to consult, cooperate, and co-ordinate with each place of detention when health and safety duties are shared.

The ongoing flow-on effects of COVID-19 and my targeted inspection programme are such that I must find the correct balance in where I direct my resources. In 2021/22, I made it a priority to provide agencies with reports on pre-pandemic examinations. The completion of these deferred reports means that only 58 percent of inspection reports were provided to agencies within target time frames. I have taken steps to address the enduring impacts. The measures I have put in place should be fully realised in the coming years.

Each place of detention contains a wide variety of people, often with complex and competing needs. All have to be managed within a framework that is consistent and fair to all. While I appreciate the complexity of running such facilities and caring for detainees, my role is to monitor whether conditions and treatment are appropriate and set up in a way that prevents the possibility of torture or other cruel, inhuman or degrading treatment, or

[26] Comprising 19 prisons; 373 health and disability places of detention (including 33 managed isolation and quarantine facilities, 254 privately run aged care facilities, and four substance addiction units); one immigration detention facility; one remand facility; one Public Protection Order (PPO) residence; and 22 court facilities (under joint designation with the Independent Police Conduct Authority).

punishment CYPCurring. This year, I made 185 recommendations, of which 161 (87 percent) were accepted.

Prisons and PPO

I examined nine of the 19 prisons across Aotearoa New Zealand. These targeted and drop-in visits allowed for a view of ongoing and emerging issues across the prison systems. The Department of Corrections had progressed some issues previously identified in my inspections, and I noted positive and innovative practice in discrete areas at a number of prisons. However, I identified a few common themes of concern, including:

- poor physical environments, including the use of segregation;
- lack of robust oversight of use of force, including pepper spray; and
- limited access to rehabilitation and reintegration activities, in part due to managing the risk of COVID-19.

I am particularly concerned about the use of force as it relates to the recent amendments to the Corrections Regulations 2005[27] regarding the use of pepper spray. Specifically, I am concerned, and have advised Corrections and Parliament, that in my view the regulations permit the use of pepper spray in enclosed spaces and in cases of 'passive resistance,' which may be a breach of international human rights standards. A number of my OPCAT reports have raised serious concerns around the use of pepper spray.[28]

Isolation and quarantine facilities

I had established an inspection programme for Managed Isolation and Quarantine (MIQ) facilities to provide the public and Parliament assurance that the basic human rights of people isolated for health reasons are being respected. With the change in government policy, this work programme was adapted to include alternative accommodation where people had to isolate due to COVID-19.

These COVID-19 specific examinations were carried out with full regard for health and safety based on the experience gained in the targeted COVID-19 specific examinations[29] of 2019/20. I was mindful of the '*do no harm*' principle and of the need to enter facilities and carry out examinations in a way that was safe, effective, and supportive in this environment. My inspections were all announced and required robust health and safety procedures. In total, I completed 26 COVID-19 specific examinations, and made 27 recommendations for improvement. My activities in this context were world-leading as many other countries' NPM's did not inspect facilities during the pandemic.

The majority of MIQ facilities were decommissioned following two significant announcements in March 2022, re-opening of borders and no further need for unvaccinated New Zealand citizens, and those eligible to travel to New Zealand, to enter MIQ or self-isolate. The last MIQ facilities were closed in June 2022. Overall, it was pleasing to see that the services offered by MIQ improved from the time the facilities were stood up until they were decommissioned, and that the Ministry of Business, Innovation, and Employment (MBIE) was responsive to the majority of my findings and recommendations.

After the Government policy change, the Ministry of Health took over responsibility for the day to day operation of 'Alternative Isolation Accommodation' when individuals or families did not have somewhere suitable to self-isolate after testing positive for COVID-19, or as a household contact, funded by MBIE. Monitoring these 'facilities' involved intelligence gathering to understand the conditions and treatment

[27] Regulatory Impact Statement: Use of pepper spray in custodial settings.

[28] See, for example, Final report on an unannounced inspection of Auckland Prison under the Crimes of Torture Act 1989, December 2020; Report on an unannounced follow up inspection of Otago Corrections Facility under the Crimes of Torture Act 1989, June 2019.

[28] See inspection purpose and criteria: https://www.ombudsman.parliament.nz/resources/criteria-opcat-covid-19-inspections.

of persons who are isolating and develop an informed approach. This reinforced my decision to take a risk-based approach about what constitutes a 'place of detention' and how I give effect to the preventive purpose of my role as an NPM.

Through the examination of these accommodations, I have identified some emerging themes, including:

- inconsistencies in the information provided to people staying in the facilities, particularly in relation to their legal rights;
- unlawful restrictions imposed on the ability to leave the premises for the purpose of exercise;[30]
- inconsistent and disproportionate monitoring of facilities by security staff;
- challenges with a consistent means to provide food to people staying in the facilities; and
- significant variation in the quality of accommodation across regions.

Health and disability facilities

There are a range of health and disability facilities or units which are publicly funded or operated, including acute mental health inpatient, forensic mental health inpatient, forensic intellectual disability, and older persons mental health units. Many of the issues I identified through my examinations this year have been ongoing, despite my previous recommendations that related to:

- incomplete recording of consent for treatment;
- use of seclusion rooms, and other non-designated rooms, as bedrooms;
- lack of privacy (for ablutions) in seclusion rooms; and
- up-to-date restraint training for staff.

I also raised concerns about the treatment of voluntary residents and have begun self-initiated action to resolve this issue under the Ombudsmen Act 1975.

Aged Residential Care Facilities

In this year I undertook inspections of aged residential care facilities in line with the programme of work started in 2019/20. I completed 10 full examinations and two visits specifically to focus on the restrictions in place under the red 'traffic light' letting of the COVID-19 Protection Framework.[31] I am beginning to build a picture of some of the issues impacting on the conditions and treatment of residents living in secure care. Themes I identified in my examinations include:

- significant dedication to resident wellbeing among the staff providing care, despite limited resources;
- a negative impact on residents due to staff shortages and COVID-19 restrictions;
- low awareness of processes for establishing authority for residents to be detained in secure care;
- inconsistent ability for residents to freely access outdoor areas that are suitable for exercise, social interaction, and engagement with the natural environment; and
- impacts on residents' living environments due to required maintenance or upgrades.

This programme of work has already influenced facility-level change in several private aged care facilities. A particularly good result was that I saw one facility shift its focus towards the human rights of the residents as opposed to an audit health lens. From a preventative perspective, it is important for staff and residents' whanau to understand that although the residents are detained in a secure dementia facility, all their human rights remain.

[30] COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022.
[31] https://covid19.govt.nz/traffic-lights/history-of-the-covid-19-protection-framework-traffic-lights/.

Other OPCAT activities

The OPCAT role is broad and goes beyond on-site visits and examinations. I also report to Parliament, engage in constructive dialogue with detaining agencies, and co-operate with other NPMs and civil society. In 2021/22 I engaged with agencies on a number of issues, including:

- engagement with key agencies regarding COVID-19 measures, including home isolation and practices in prisons;
- finalised and published my expectations for the conditions and treatment in aged care facilities;
- consultation on expectations for the conditions and treatment in prisons, mental health facilities, and intellectual disability secure services;
- provided comment on the Department of Corrections' proposal to amend the Corrections Regulations 2005 regarding the use of pepper spray;
- finalised a framework with the Independent Police Conduct Authority to conduct inspections of court facilities, including draft expectations; and
- participated in webinars and conferences organised by civil society and international partners, including the Nga Tūmanakotanga Symposium.

OPCAT examinations

The 62 visits and inspections were at the sites set out in the table below.

Name of facility	Type of visit	
Aged Care		
Aspiring Enliven Care Centre, Hawea Dementia Unit	Full	Announced
Bradford Manor (Dunedin)	Full	Announced
Charles Fleming	Drop In	Announced
Colwyn House Napier	Full	Announced
Norfolk Lodge	Full	Announced
Okere House (Whanganui)	Full	Announced
Star Centre, Palmerston North Hospital, STAR1 Ward	Follow-up	Unannounced
Stokeswood Rest Home, Rotary Dementia Unit	Targeted	Announced
Takanini Lodge	Full	Announced
Te Wiremu House Lifecare and Village	Full	Announced
Ultimate Care Palliser, Wairarapa	Full	Announced
Winara Care Home, Windsor Court Community	Full	Announced
Public Protection Order		
Christchurch Public Protection Order	Follow-up	Announced

Community / Intellectual Disability		
Kenepuru Hospital, Haumietiketike Unit	Drop In	Unannounced
Kenepuru Hospital, Haumietiketike Unit	Drop In	Announced
Mental Health		
Whakatāne Hospital, Te Toki Maurere	Follow-up	Unannounced
Gisborne Hospital, Te Whare Awhiora	Targeted	Announced
Hawke's Bay Fallen Soldier's Memorial Hospital, Ngā Ra Rākau	Targeted	Announced
Henry Rongomau Bennett Centre	Drop In	Announced
Henry Rongomau Bennett Centre, Maatai (Ward 33)	Follow-up	Announced
Henry Rongomau Bennett Centre, Puna Awhi-Ruarua (Ward 32)	Follow-up	Announced
Henry Rongomau Bennett Centre, Puna Poi Poi (Ward 31)	Follow-up	Announced
Hilmorton Hospital, Te Awakura	Drop In	Announced
Rotorua Hospital, Te Whare Oranga Tangata o Whakaue	Follow-up	Announced
Taranaki Hospital, Te Puna Waiora	Targeted	Announced
Tauranga Hospital, Te Whare Maiangiangi	Follow-up	Unannounced
Prison		
Arohata Prison	Targeted	Announced
Auckland Region Women's Corrections Facility	Drop In	Announced
Christchurch Women's Prison	Targeted	Announced
Hawke's Bay Prison	Targeted	Announced
Manawatu Prison	Targeted	Announced
Rimutaka Prison	Targeted	Announced
Rolleston Prison	Drop In	Announced
Spring Hill Corrections Facility	Drop In	Announced
Whanganui Prison	Drop In	Announced
Managed Isolation and Quarantine		
Arena Court Motel	Drop In	Announced
Bella Vista Motel	Drop In	Unannounced
Century Park Motor Lodge	Drop In	Unannounced
Chateau on the Park	Full	Announced
Crowne Plaza Christchurch	Full	Announced
Distinction Hotel Christchurch	Full	Announced
Four Points by Sheraton	Drop In	Announced
Grand Mercure	Full	Unannounced

Grand Millennium Hotel Auckland	Full	Announced
Holiday Inn Auckland Airport	Full	Announced
Jet Park Hotel Auckland Airport	Drop In	Announced
Kennedy Park Resort	Drop In	Announced
MidCentral District Health Board accommodation	Drop In	Announced
Novotel Christchurch Airport	Follow-up	Announced
Ossies Motel	Drop In	Announced
Paraparaumu Motel	Drop In	Announced
Pickwick House	Drop In	Announced
Pullman Hotel	Full	Announced
Quality Hotel Elms	Full	Unannounced
Ramada	Drop In	Announced
SAC(AT), Nova Star	Drop In	Announced
So Hotel	Drop In	Announced
Sudima Christchurch Airport	Full	Announced
Taihape Motel	Briefing note	Announced
Tatum Park Campground	Briefing note	Unannounced
Tuscany Gardens Motor Lodge	Briefing note	Unannounced
Whanganui District Health Board Housing	Briefing note	Announced

Final reports published in 2021/22 are set out in the table below.

Report	Date of publication
Health and disability	
Ward 21, Palmerston North Hospital	02/05/2022
Te Whare Maiangiangi Unit, Tauranga Hospital Primary tabs	28/04/2022
Te Toki Maurere Unit, Whakatāne Hospital	28/04/2022
Thematic report on inspections of secure intellectual disability facilities	13/04/2022
Ward 10a and Helensburgh Cottage, Wakari Hospital Dunedin	02/02/2022
Wāhi Oranga Mental Health Admission Unit, Nelson Hospital	02/02/2022
Ward 6C, Dunedin Hospital	02/02/2022
Fraser McDonald Unit, Auckland District Health Board	02/02/2022
Manaakitanga Inpatient Unit, Te Nīkau Grey Base Hospital	02/02/2022
Haumietiketike Unit, Rātonga-Rua-O-Porirua Campus	28/10/2021
Tāwhirimātea Rehabilitation Unit, Rātonga-Rua-O-Porirua Campus	28/10/2021
Rangipapa Forensic Acute Mental Health Unit, Rātonga-Rua-O-Porirua Campus	28/10/2021

Pūrehurehu Forensic Acute Mental Health Unit, Rātonga-Rua-O-Porirua Campus	28/10/2021
Stanford House, Whanganui Hospital	05/08/2021
Te Awhina, Whanganui Hospital	05/08/2021
COVID-19 specific	
Thematic report on inspections of Managed Isolation and Quarantine Facilities	17/08/2021

The recommendations made in final inspection reports are set out in the table below.

Facility Type	Recommendations made	Recommendations accepted
Prisons	18	18
COVID-19 specific places of detention	27	26
Others (including aged care and mental health facilities)	131	108

NPM contacts

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