Te Kāhui Tika Tangata
Human Rights Commission

2022/23

Monitoring places of detention

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

1 July 2022 to 30 June 2023

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

National Preventive Mechanism (NPM) agencies under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[1] have a mandate to regularly and independently 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 NPM involves five distinct statutory bodies, which are the Chief Ombudsman, the Independent Police Conduct Authority, the Inspector of Service Penal Establishments and Mana Mokopuna | Children and Young People's Commission.[2] Te Kāhui Tika Tangata | Human Rights Commission is Aotearoa New Zealand's Central National Preventive Mechanism, which involves both a co-ordinating role and acting as a liaison with government and international monitoring bodies.

NPM agencies are responsible for monitoring places of detention, including prisons, police cells, court 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, immigration detention facilities and defence force penal establishments.[3]

This report outlines the activities of the NPM during the reporting period 1 July 2022 to 30 June 2023. A key focus for the NPM during this reporting year was providing a joint submission to the United Nations Committee against Torture in its 7th periodic review of the country's compliance with the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The NPM agencies worked together to identify cross-cutting issues arising in the broad range of detention settings under their monitoring designations.

Thematic issues identified during this reporting period include:

- ongoing non-compliance with minimum standards for the treatment and conditions of people in detention, and over-reliance on restrictive practices;
- the need to address underlying causes of over-representation of Māori across all detention settings, and to focus on ensuring equitable treatment and improving outcomes;
- alarming rates of people in detention experiencing poor mental health, and deficiencies in the provision of support;
- the importance of facilitating contact with whānau while a person is deprived of their liberty;
- mokopuna continuing to experience harm in places where they are deprived of their liberty, and disproportionate impacts on mokopuna Māori;
- ongoing staffing pressures and the need for adequate and specialised staff training;
- concerns about unacceptable material conditions in many detention facilities; and
- the need to strengthen the accessibility and independence of complaints mechanisms for people in detention.

The NPM has made a commitment at governance level to explore further the relationship between OPCAT monitoring functions and the role of Te Tiriti o Waitangi when monitoring places of detention in Aotearoa New Zealand. Looking ahead to the next reporting year, the NPM will seek to consolidate shared understandings and advance relationships with hapū and iwi to further this commitment.

The NPM will also look to continue joint work and submissions, particularly to international human rights mechanisms including during

[1] Referred throughout as either the Optional Protocol to the Convention against Torture or OPCAT.

[2] For the period covered by this annual report the predecessor agency, the Office of the Children's Commissioner, was still in place. Mana Mokopuna was established from 1 July 2023, pursuant to the Children and Young People's Commission Act 2022.

[3] Designation of National Preventive Mechanisms, 2 July 2020, available at https://gazette.govt.nz/notice/id/2020-go2845. This Designation was updated on 22 June 2023, available at https://gazette.govt.nz/notice/id/2023-go2676.

the United Nations Human Rights Council's 4th Universal Periodic Review of New Zealand.

After the close of the current reporting period, Mana Mokopuna farewelled Judge Frances Eivers in October 2023. Judge Eivers took on the role of Children's Commissioner in November 2021, and was then appointed Chief Children's Commissioner from 1 July 2023 under the Children and Young People's Commission Act 2022. She led the transition from the Office of the Children's Commissioner to Mana Mokopuna. The NPM wishes to acknowledge Judge Eivers' advocacy for mokopuna in the care and protection and youth justice systems, calling for the closure of these institutions and a by Māori, for Māori approach. We wish her well for her return to the District Court.

The NPM welcomes the appointment of Dr Claire Achmad as the new Chief Children's Commissioner from 1 November 2023 for a five year term, following her appointment as Deputy Chair of Mana Mokopuna from 1 July 2023. Claire has an extensive background in children's rights, through former roles as the Chief Executive Officer of Social Service Providers Te Pai Ora o Aotearoa, in various children's NGOs and international organisations, and with Te Kāhui Tika Tangata. Claire holds a doctorate in international children's rights law.

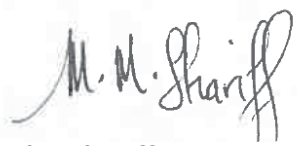
Te Kāhui Tika Tangata also farewelled Te Amokapua Chief Human Rights Commissioner Paul Hunt in January 2024. Over the past five years, Paul chaired NPM hui and led the way for NPM agencies to acknowledge and uphold Te Tiriti o Waitangi through their OPCAT monitoring. In his role as Chief Commissioner, Paul sought to advance the full range of human rights, to hold government and corporate actors to account, and grow awareness about the responsibilities we all have to each other. We wish him well for the future.

Te Kāhui Tika Tangata's Equal Employment Opportunities Commissioner Saunoamaali'i Dr Karanina Sumeo has stepped into the role of Acting Chief Human Rights Commissioner until a new appointment is made. Saunoamaali'i has been a staunch advocate for the rights of women in prison for several years and coordinated the NPM delegation to present to the Committee against Torture in July 2023. The NPM agencies welcome Saunoamaali'i to the role of Chair of the NPM.

Saunoamaali'i Dr Karanina Sumeo
Acting Chief Commissioner
Te Kāhui Tika Tangata Human Rights Commission

Judge Kenneth Johnston KC
Chairperson
Independent Police Conduct Authority

Dr Claire Achmad
Chief Children's Commissioner



Alec Shariff
Inspector of Service Penal Establishments
Office of the Judge Advocate General

Peter Boshier
Chief Ombudsman

Te Kāhui Tika Tangata | Human Rights Commission

Introduction

Te Kāhui Tika Tāngata | 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 the NPM to identify systemic issues arising in places where people are deprived of their liberty. To strengthen protections against torture and ill-treatment, the Commission also liaises regularly with government and the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) – the United Nations body with oversight of OPCAT.

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 NPM agencies have statutory powers to independently monitor places of detention, with or without notice, the Commission's role as CNPM is more focussed on coordinating the activities of the NPM including:

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

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

Activities during reporting period

The Commission organised and hosted two Chairs' meetings with the heads of the NPM agencies. The Chairs shared monitoring developments from within their organisations and discussed common issues faced by the NPM agencies. The Chairs endorsed a paper about how the NPM agencies can explore ways to work better together, through appropriate cooperation, harmonised working methods and enhanced coordination. The Chairs made a commitment for the NPM agencies to prepare a joint submission to the Committee against Torture (CAT Committee) in its 7th periodic review of Aotearoa New Zealand, as discussed further below.

The Commission also organised and hosted two general operational-level meetings with staff members from within the individual NPM agencies. These operations meetings aim to increase collaboration and share experiences between the Aotearoa NPM agencies, as well as identify ways to work together more effectively and progress work requested by the NPM Chairs. International reporting was a significant focus for the NPM operations team over the 2022/2023 reporting period. The Commission hosted three additional operational-level meetings dedicated to preparing the NPM's submission to the CAT Committee.

Committee against Torture 7th periodic review

As noted above, the NPM agencies filed a submission to the CAT Committee on its 7th periodic review of Aotearoa under the United Nations Convention against Torture (UNCAT). The NPM's written submission was filed on 12 June 2023, ahead of the CAT Committee's review in Geneva in July 2023.

The NPM submission opened with observations about Te Tiriti o Waitangi issues across the monitoring estate, including government detaining agencies' obligations to Māori and the NPM's commitment to incorporating Te Tiriti into their assessments of places of detention. The submission then addressed cross-cutting human rights issues in detention settings across Aotearoa, including:

- The impacts of COVID-19 on NPM monitoring practice and jurisdiction, as well as impacts felt by people in detention during the pandemic;
- Resource allocation for the NPM to effectively fulfil OPCAT mandates;
- NPM experiences of reporting and making recommendations, and engagement with detaining agencies;

- Concerns regarding the adequacy of human rights training and education for law enforcement and custodial personnel;
- Insufficient mental health support for persons in detention; and
- Poor material conditions of places of detention.

The NPM made 11 recommendations to the Committee, for inquiries and directions to help the government better meet its obligations under UNCAT. The Commission, the Ombudsman and Mana Mokopuna also filed separate submissions to the CAT Committee ahead of its review.[4]

International engagement

The Commission facilitated increased engagement between the Aotearoa NPM and international bodies during the reporting period.

In June 2022, the Aotearoa NPM attended a joint session between the SPT and other NPMs within the Asia Pacific region (including the Maldives, Cambodia and Lebanon). This was a unique opportunity for NPMs across the region to share their experiences and establish connections for future contact.

In August 2022, the Commission met with representatives from the Association for the Prevention of Torture (APT), an international non-government organisation. During this meeting, the Commission was able to establish new relationships with APT staff and discuss mutually beneficial future projects.

In April 2023, the Commission provided a submission to the SPT for its draft General Comment on the definition of 'places of deprivation of liberty' under Article 4 of OPCAT. The Commission's submission outlined the correlative yet distinctive functions of NPMs who are also accredited as National Human Rights Institutions (NHRIs). In its submission, the Commission expressed support for the SPT's broad interpretation of what constitutes a place of detention, and recommended that the SPT consider obligations to indigenous peoples, expansion to cover private custodial settings, and the need to protect vulnerable detainees.

The Commission also met with other multi-body NPMs from Australia and Scotland, to share experiences and updates on implementation of OPCAT in other jurisdictions.

Engagement with Ara Poutama Aotearoa | Department of Corrections

Ara Poutama Aotearoa | Department of Corrections (Corrections) was a significant focus of the Commission's OPCAT-related advocacy during the reporting period.

The (now former) Amokapua | Chief Human Rights Commissioner Paul Hunt maintained quarterly hui with Corrections CEO, Jeremy Lightfoot.

Kaihautū Ōritenga Mahi | Equal Employment Opportunities Commissioner Saunoamaali'i Dr Karanina Sumeo,[5] also held regular hui with leads for Corrections' *Wāhine – E Rere Ana Ki te Pae Hou Women's Strategy*, which focussed on the management of women in prison. Commissioner Sumeo visited Christchurch Women's Prison in June 2022 and Auckland Region Women's Corrections Facility in May 2023, to speak with women detained in these facilities and to view body imaging technology which has been introduced as an alternative to strip searching.

From September 2022 onward, Commissioners Hunt and Sumeo corresponded with Corrections leadership to raise urgent concerns that ongoing staffing shortages, restrictions on face-to-face visits, extended cell lock-up time, and transfers of prisoners to different sites were failing to comply with minimum entitlements required under the United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules), and the Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules). Corrections leadership provided operational updates to the Commission about strategies to address these concerns.

Following delivery of the High Court judgment *Cripps & Bassett v Attorney-General* [2022] NZHC 1532 in July 2022, Commissioners

[4] The joint submission of the NPM, and the individual submissions of some NPM agencies, are all available here: https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/countries.aspx?CountryCode=NZL&Lang=EN.

[5] We note this work falls within Commissioner Sumeo's Human Rights of Women portfolio, delegated to her by the Chief Human Rights Commissioner under ss 8(1B) and 15(e) of the Human Rights Act 1993.

Hunt and Sumeo and the Chief Ombudsman raised concerns with Corrections that their ongoing regulation and use of pepper spray was inconsistent with the findings in that judgment and, thereby, international human rights standards. The Commission and the Chief Ombudsman's office have been involved in regular dialogue with Corrections' policy team, regarding proposed legislative and regulatory amendments about the use of force. The Commission and Ombudsman's offices continually emphasise the need for Corrections to invest in procedural justice and preventive measures rather than taking a reactive approach to disruptive incidents.

During the reporting period, Commissioners also gave the following presentations:

- In a webinar hosted by the Chief Ombudsman on 31 August 2022, to mark the 15-year anniversary of OPCAT, Commissioner Sumeo spoke about the recent progress Aotearoa has made in recognising the distinct needs of women as a population group among detainees, pressing issues including inequitable outcomes for wāhine Māori in detention and the prevalence of mental health issues among all women in detention, and her hopes for the next 15 years. Commissioner Hunt delivered a closing address for the webinar.
- On 28 June 2023, Commissioner Sumeo gave a presentation to the Office of the Prison Inspectorate regarding "the Value of Oversight". Commissioner Sumeo and the Chief Inspector spoke about correlating kaupapa conducted by their offices, including the need to focus on trauma, gender and culturally informed approaches to women in prison.

Te Tiriti o Waitangi and OPCAT Monitoring

The Aotearoa NPM recognises the need to factor Te Tiriti o Waitangi considerations into monitoring and reporting on the government's treatment of people deprived of their liberty, to demonstrate attention to Te Tiriti obligations in its own practice and methodology, and to ensure Te Tiriti obligations relating to treatment and conditions are reflected in recommendations to detaining agencies.

The NPM agencies have made a commitment at governance level to further explore the relationship between OPCAT monitoring functions and the role of Te Tiriti when monitoring places of detention in Aotearoa. As the CNPM, the Commission is facilitating ongoing discussions between NPM agencies about how this may be implemented in practice. The Aotearoa NPM is 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.

On 30 September 2022, the Commission was granted leave to participate in the Waitangi Tribunal's Wai 3060 Te Rau o te Tika: Justice System Kaupapa Inquiry. The Wai 3060 Inquiry is examining allegations, including in relation to:[6]

- discrimination against Māori in the statutory and institutional framework for the administration of justice in colonial and modern times;
- institutional racism and bias in the policy and practice of justice sector organisations;
- discrimination against Māori in policing policy and practice; and
- prison conditions and the treatment of Māori in prison (both in pre-trial detention and sentenced).

Looking ahead

The Commission looks forward to further supporting the NPM to effectively carry out monitoring responsibilities under OPCAT. In 2023/2024 the Commission is looking forward to:

- Coordinating the delegation of NPM agencies to Geneva in July 2023, to attend the CAT Committee's 7th periodic review of Aotearoa.
- Continuing to progress discussions among the Aotearoa NPM agencies about how to uphold Te Tiriti o Waitangi obligations in OPCAT monitoring functions.
- Further involvement in the Waitangi Tribunal's Wai 3060 Justice System Kaupapa Inquiry, particularly as it progresses to hearings looking at criminal justice, including police, criminal courts, and prisons.

[6] Ministry of Justice, Te Rau o Te Tika: Justice System Kaupapa Inquiry (WAI3060) available at https://www.justice.govt.nz/justice-sector-policy/justice-system-kaupapa-inquiry/.

Inspector of Service Penal Establishments

Office of the Judge Advocate General of the Armed Forces

Inspector of Service Penal Establishments

Legal Framework

The Inspector of Service Penal Establishments (ISPE) is the National Preventive Mechanism (NPM) charged with monitoring New Zealand Defence Force (NZDF) detention facilities. The Registrar of the Court Martial is appointed as the ISPE as set out in Section 80 (1) of the Court Martial Act 2007 in respect of Service Penal Establishments (SPE) (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 the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) and the applicable laws of New Zealand.

The Role of Detention

Detention, as one of the sentencing options from a Court Martial or Summary Hearing at the Unit Command level is still used as an effective punishment method for promoting and maintaining discipline within the 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 up-skilling its personnel to be proficient in their respective trades, branches and corps and so the intention is to have the majority of Service detainees return to their Services after serving their period of detention.

However, 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 and regularly monitored against OPCAT principles and NZ law.

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 observed or reported ill treatment of detainees in the Armed Forces to date. In the year ending December 2023, **two** of the eight permitted **no notice** inspections were conducted by the ISPE.

The structure of the inspections generally includes 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 routinely provided after the inspections to the OICs, and formal feedback is provided once annually to the senior leadership of the NZDF. Also, an open invitation has been extended to the three newly appointed Judges of the Court Martial and Court Martial Appeal Court of New Zealand to visit the Services Corrective Establishment (SCE) for their situational awareness.

ISPE Expectation Document

As in previous years the 'Expectations' document: *OPCAT – Expectations for Conditions and Treatment of Detainees in Service Penal Establishments January 2022* continues to serve as a good basis for the ISPE to monitor SCE's programmes of adherence to the elements of each inspection. The idea is that the inspections of these elements would provide effective approach to observe the compliance requirements of the OPCAT as well as some of the key obligations under NZ laws and Te Tiriti o Waitangi. Feedback from the SCE staff is that the document continues to provide 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 10-12 hours is highly unusual.

The NZDF also has holding cell facilities on its Bases and Camps. Improving on previous Reports, the facilities at HMNZS PHILOMEL, Linton, Trentham and Burnham Military Camps and RNZAF Bases OHAKEA and AUCKLAND are the only ones considered as being fit for purpose. The status of the cells elsewhere during this report period is as follows:

- Papakura Military Camp does not have dedicated cells and if required the cells at RNZAF Base AUCKLAND or HMZNS PHILOMEL can be utilised;
- Waiouru Military Camp the cells are closed and if required the cells at RNZAF Base OHAKEA or Linton Military Camp can be utilised;
- As noted in the 2022 Report, RNZAF Base Woodbourne has no dedicated cells. However, plans to install temporary facilities that comply with extant specifications are still under consideration with no fixed completion date in sight.

As in 2022, while remediation plans for various facilities appear to have been signalled or are under consideration, a definitive funded remediation programme is still to be published by the NZDF, or confirmed whether one is even under consideration.

Services Corrective Establishment

As mentioned above SCE is the only purpose-built detention facility within the NZDF. It has 10 unisex cells designed for mainly short-term detainees. Recognising that most of the detainees are destined to return 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 2023, SCE was fully staffed with 15 personnel (4 female and 11 males), which is a positive move by the NZDF. There were 21 detainees at SCE,[7] covering some 780 days of detention over the reporting period. The pertinent breakdown statistics are as follows:

Service		
Royal New Zealand Navy: 1(-1)[8]	New Zealand Army: 18(0)	Royal New Zealand Air Force: 2(+2)

Gender	
Male: 81%	Female: 19%

Ethnicity			
NZDF Military Population:[29]			
European: 44%	Māori: 18%	Pacific People: 6%	Other: 32%
NZDF Detainee:			
European: 38%	Māori: 29%	Pacific People: 24%	Other: 9%
(NZ Prisoner Statistics):[10]			
European: 30%	Māori: 51.9%	Pacific People: 11.9%	Other: 6.2%
NZ Population[11]			
European: 70.2%	Māori: 16.5%	Pacific People: 8.1%	Other: 15.2%

[7] Data provided by Officer In Charge of SCE.

[8] Difference to 2022 figures.

[9] NZDF Annual Report 2022.

[10] Prison Facts and Statistics |December 2023: Department of Corrections NZ.

[11] Massey University EHINZ 2023 Data

Unlike the data from 2022, NZDF detainee demographics data shows a sizeable **21% drop** in Māori detention rate with rises in European and Pacific rates which is not reflective of the data at the national level. While the drop in Māori detention rate is very positive, ISPE has not been able to assess the actual initiative/s implemented by the NZDF in the last year that could have directly affected this outcome. That said, the overall rates per head of NZDF Military personnel is still considered too high for Māori and now for the Pacific People.

Whether or not the national narrative continues about developing strategies that would reduce Māori imprisonment/detention/offending rates across the spectrum of the Justice system,[12] there is still an international onus on NZ[13] to reduce the disproportionate rate of Māori and Pacific Peoples' incarceration. As in previous Reports, it would be very useful for the NZDF – if not party to cross agency effort, then - to at least consider implementing relevant outcomes (if any) from the Ministry of Justice-led *Hāpaitia te Oranga Tangata Safe and Effective Justice* and the Department of Corrections' Hōkai Rangi strategies on reducing Māori imprisonment rates.

> **ISPE has not been able to get any feedback on what, if anything, NZDF has done about this recommendation. However, informal feedback received is that some data on offending is being collected, which is a good start.**

Reduction in Māori and Pacific People Detention Rates Within NZDF

As noted above, 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 Peoples' detention rates within NZDF. Although, in fairness, with this year's numbers for Māori rates of detention having reduced considerably the same cannot be said for Pacific Peoples' rate of detention. While the numbers show promise, ISPE is still unable to state what strategies the NZDF has adopted that has resulted in the reduction in Māori rate of detention.

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

It was further noted **that the publication of such data by the NZDF in its Annual Report would promote transparency and public awareness. To date ISPE has not been able to see if there has been any progress on these recommendations. However as noted above informal feedback indicates that offending data is being collected but whether or not this informs any NZDF position on reducing detention rates for Māori and Pacific people remains to be seen.**

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 re-emphasised, however, that the remit of the ISPE is only confined to the detainee data, which currently is available but only on request from SCE. Currently there does not appear to be any data capture on recidivism rates.

Long Term Detainees

Consistent with previous years, the preferred option by the Court Martial 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. It should be noted that increasing the staff to maximum complement is a very positive start.

[12] Ministry of Justice led Hapaiti te Oranga Tangata- Safe and Effective Justice 2021 and 2019 Department of Corrections Hokai Rangi Strategy.

[13] Paragraphs 31-32, UN Committee Against Torture: Concluding Observations On The 7th Periodic Review , 24 August 2023.

This preference by the Courts for longer sentences is most likely because SCE has a very effective personal development 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 programme without burning out the staff has been identified by the Officer in Charge (OIC) of SCE as the key risk facing the establishment. Therefore, maintaining the full staffing complement will be very important.

Short Term Detainees

By contrast, the aim of the short-term detainee programme is solely on Service personnel 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 and to reduce or eliminate the possibility of recidivism. While no formal data on recidivism is being kept by NZDF, anecdotal evidence suggests that the rate is extremely low.

NZDF should implement a formal data capture for recidivism rates of detention as a measure of its corrective programmes SCE.

Rehabilitation Strategy

Over the last reporting period, the OIC introduced a two-strand rehabilitation 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 with attendant staffing numbers has alleviated 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 has allowed the long-term detainees to take more responsibility for their own development with appropriate supervision from the staff. This should allow the detainees to manage their development project, with the Manager seen more in a coach/mentor role while still being within the rules and expectations of a detainee in a detention facility. Feedback from both the detainee and the staff is that this approach continues to show promising results in charting a more effective pathway for the long-term detainees to prepare for re-integration into civilian life.

The rehabilitation strategy is showing positive results, 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.

At its core the corrective training regime still 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 continue to provide an opportunity for detainees to contribute positively to the local community. Development programmes, which

are designed as much as possible for each detainee and 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. Long term detainees, who are almost always dismissed from His Majesty's service, have found the career transition project extremely valuable in their rehabilitation and subsequent integration into civilian life.

Mental Health

SCE continues to make good progress in establishing robust processes to assist individuals dealing with mental health concerns. Staff have received (with continued access as required) 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 and positively contributes to their rehabilitation.

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. To date all feedback received from affected detainees credit the long-term programme as the critical factor in helping them 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 individual 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 at SCE. The detainees appear to know the internal process very well. This has now been extended to include detainees becoming aware of other avenues of making complaints outside of SCE, which is very positive.

However, the area that still needs further development is for the process of raising the complaints externally outside of SCE to be captured in policy documents. ISPE understood that NZDF was to review this area of current policy, but to date no formal feedback was made available to the ISPE. Informal feedback is that the policy is still being developed.

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 but for short term detainees only. 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 outcomes of a review on whether or not an extension of the facility to accommodate more long-term detainees is warranted. Although to date ISPE has not received any formal feedback on any NZDF position regarding any the extension of SCE.

Te Tiriti o Waitangi

SCE continues its development work in ensuring that its operating model reflects Te Tiriti o Waitangi requirements as applicable to the NZDF. Close working arrangements with the Department of Corrections continue to allow SCE staff to identify and adapt workable ideas pertinent to its programme at the local level. This work is proving to be an important enabler and NZDF should maintain it as a priority by formalising the relation with the Department of Corrections. 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.

The success of this work, however, is dependent on NZDF allocating appropriate resources to SCE particularly with specialist staff. It also needs to formalise the relationship with the Department of Corrections so that the collaborative work already developed endures.

Resourcing of ISPE

The duties of the ISPE is one of the tripartite role of the incumbent whose other duties include the Registrar of the Court Martial of New Zealand and the Executive Office of the Office of the Judge Advocate General of the Armed Forces of New Zealand. All three roles are supported administratively by the NZDF and to date the NZDF has been very supportive of the Office when comes to finance. However the Office is established for two other positions, which have not been filled since August 2020.

If the positions are filled, not only will the Office's outcomes be enhanced but, as importantly, it would provide for better continuity and legacy as staff move. The current situation of having a one person Office is considered a critical vulnerability to the effectiveness of all three roles.

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.

Notable positive results over this report period are the 21% reduction in Māori detention rate from last year and the full staffing compliment at SCE. On the negative side the increase in detention rate per capita of Pacific People is not that good.

However, to maintain this success, the NZDF will need to continue to invest and prioritise resources particularly in reducing Māori and Pacific Peoples' detention rates.

Currently the holding cells at RNZAF Bases WOODBOURNE together with those at Papakura and Waioru Military Camps are the only ones considered not to be compliant. The plan for new facilities for these Camps and Base, as part of the NZDF state infrastructure programme, is still under consideration but no definitive dates for their completion have been stated.

More robust and transparent data capture and availability are still not apparent nor is there any feedback about the recommendations from the Reports.

Overall Assessment

The ISPE remains satisfied from inspections at SCE and feedback received about holding cells on Camps and Bases throughout New Zealand that the culture of the NZDF 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 raised, if addressed and appropriately reported, should only improve the organisation's obligations to meeting the OPCAT protocols.

Chief Ombudsman

Ombudsman
Fairness for all

Chief Ombudsman

I am designated as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989, which gives effect to the *United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT).

As Ombudsman, I am designated to monitor:[14]

- prisons (or those otherwise in the custody of Ara Poutama Aotearoa / Department of Corrections);[15]
- health and disability places of detention, which include mental health, intellectual disability, privately run aged care, and isolation and quarantine facilities;
- places of detention approved or agreed under the Immigration Act 2009;
- residences established under the Public Safety (Public Protection Order) Act 2014;[16] and court facilities.[17]

The purpose of my OPCAT role is preventive, aimed at ensuring safeguards against ill-treatment are in place, and risks, poor practices or systemic problems are identified and addressed promptly. Preventive monitoring also helps ensure New Zealand adheres to international human rights standards, to which all people are entitled, and is seen as a good global citizen.

In this role, I am empowered to undertake various activities, including to:

- carry out regular and unfettered monitoring, through examination of places of detention across the 416[18] facilities under my designation;
- use information and evidence from various sources to assess conditions in places of detention;
- comment on law, policy and procedure that relates to conditions and treatment in places of detention; and
- report on my examinations and make and track recommendations to prevent torture or ill-treatment, and to improve the conditions of detention and treatment of detainees.[19]

Examination through visits and inspections

I visit and examine places of detention on a regular basis. In 2022/23, I carried out a total of 101 visits to places of detention. A list of the places I visited is available at Appendix 1. This brings the total number of visits conducted over the 16-year period of the Ombudsman's operation under OPCAT to 827.

The COVID-19 global pandemic was 'front and centre' in my OPCAT inspection role in the previous two reporting years. After the decommissioning of the last Managed Isolation and Quarantine facilities in June 2022, and the disestablishment of the formal COVID-19 Protection Framework in September 2022, my OPCAT visiting programme was largely able to return to business as usual. My approach included visits and inspections of high-risk sites, shorter targeted inspections focusing on specific areas of interest, and an increased number of drop-in visits, particularly in the aged residential care sector. More information about these examinations, including details of reports published this year, are available at Appendix 1.

This year, I made 67 recommendations, of which 63 (94 percent) were accepted. A further breakdown of these recommendations can be found at Appendix 1.

I have now implemented a new OPCAT team structure which aims to ensure that I have sufficient capability and agility to examine the number and range of facilities falling within my designation in a timely and quality manner. In 2022/23, my OPCAT staff merged into a single cohesive unit working flexibly across all designations. I created a new management structure, including establishing the role of Director OPCAT to oversee my OPCAT function – reporting to the Assistant Ombudsman

[14] See https://gazette.govt.nz/notice/id/2023-go2676.

[15] Such as prisoner transport vehicles.

[16] Refer to section 114.

[17] The designation in respect of court facilities is jointly shared with the Independent Police Conduct Authority.

[18] The total number of facilities under my designation in the reporting year.

[19] Including identifying and promoting good practice according to international standards.

Proactive Intervention and Monitoring. Two Principal Inspector roles were added to support the Director OPCAT's work programme. I have also created a new team within OPCAT specialising in reporting and analysis and established an OPCAT inspection team based in Auckland with additional inspection personnel.

People in the custody of the Department of Corrections

I examined 4 of the 19 prisons across New Zealand this year. These visits, alongside other activities, have informed my monitoring of the progress of the Department of Corrections (Corrections) in relation to conditions and treatment of people in custody.

I am particularly concerned about Corrections' acute staffing shortages which are having a significant impact on the rights, safety, and wellbeing of people in custody. I consider that workforce issues continue to result in the infringement of human rights, often for prolonged periods in ways which are not consistent with international human rights standards and may, in certain cases, amount to ill-treatment.

Mental health and disability facilities

There are a range of health and disability facilities, including acute mental health inpatient, forensic mental health inpatient, forensic intellectual disability, and older persons' mental health units. Over the course of the reporting year, I inspected 16 health and disability facilities. Several of the issues I identified through my examinations this year have been ongoing, including:

- inequities experienced by Māori and Pacific people;
- over-occupancy of inpatient mental health services;
- substandard and rundown material conditions in health and disability facilities that do not align with current models of care, wellbeing and recovery;
- a lack of intellectual disability-specific training for staff working in health and disability facilities;
- a high number of staff without current appropriate training on restraint minimisation and safe practice; and
- a lack of safeguards in place to ensure that voluntary service users are not arbitrarily detained in health and disability places of detention.

I also raised concerns that restraint methods which can cause pain are still being used to control people with intellectual disabilities at the Mason Clinic's Pohutukawa Forensic Intellectual Disability Unit in Auckland.

Alternative Isolation Accommodation

I continued to monitor alternative isolation accommodation facilities[20] as part of my OPCAT role's preventive function. I consider these facilities fall under my OPCAT designation as potential places of detention, particularly having observed that guests were not always allowed to leave premises as they were entitled to.

In the reporting year, I examined nine facilities throughout New Zealand and I observed inconsistencies in practice with regards to restrictions imposed on the ability to leave the premises for the purpose of exercise.

Immigration

I conducted a follow up inspection of the Te Āhuru Mōwai o Aotearoa – Mangere Refugee Resettlement Centre in the reporting year.

In this follow up inspection, while the majority of my recommendations from my 2020 inspection had been achieved, I commented on failures in recordkeeping, and inconsistent information as to how many people had been detained since June 2020. I continue to engage with the Ministry of Business, Innovation and Employment and Immigration New Zealand on this matter.

[20] Facilities used by individuals or families that do not have somewhere suitable to self-isolate after testing positive for COVID-19, or as a household contact.

The Chief Ombudsman's submission to the Foreign Affairs, Defence and Trade Committee on the Immigration (Mass Arrivals) Amendment Bill

In April 2023, I made a submission to the Foreign Affairs, Defence and Trade Committee on the Immigration (Mass Arrivals) Amendment Bill (the Amendment Bill). The Amendment Bill proposed to extend the period that a 'mass arrival' (defined as 30 people or more) could be detained without warrant from 96 hours to 28 days.

In my submission, I stated that the potential detention of any person for up to 28 days without a judicial warrant could amount to a serious infringement of their rights. I suggested that the proposed amendments would not be aligned with the right to be brought promptly before a judicial or other independent authority when deprived of liberty. My submission highlighted that there would be few, if any, other circumstances where detention in this manner would be considered appropriate or lawful, and that this demonstrates inconsistency between detention on a collective basis and fundamental human rights.

I outlined my view that the Immigration Amendment Act 2013 should be comprehensively reviewed in line with recommendations made by the international community, including those made during the third cycle of the Universal Periodic Review at the United Nations Human Rights Council. I submitted that appropriate weight must be afforded to New Zealand's obligations under international human rights law as part of that review, including the rights of children and families.

I also noted my expectation that the Chief Executive of the Ministry of Business, Innovation and Employment would keep me informed of any locations considered for the detention of people arriving in New Zealand as members of a 'mass arrival group'. This information would be required in accordance with the Ombudsman's powers under the Crimes of Torture Act 1989 to be provided with information for the purpose of monitoring places that are, or may be, places of deprivation of liberty.

Read the Chief Ombudsman's full submission on Parliament's website

Aged care facilities

In the reporting year, there were 254 aged care facilities providing secure care[21] in New Zealand. I visited 66 of those, both announced and unannounced. 'Drop-in' visits have enabled me to educate and familiarise aged care providers with my role, as well as gather information about key issues impacting on the conditions and treatment of residents living in aged care facilities. I have noted significant dedication to resident wellbeing among the staff providing care, despite limited resources.

However, I have also observed varying levels of understanding, among aged care service providers, medical professionals, whānau and others, of the legal framework for accommodating residents in secure aged care facilities, and of the necessary safeguards against arbitrary detention.

[21] Dementia level care, and specialised hospital (psychogeriatric) level care.

Court facilities

My designation to examine the conditions and treatment of people detained in court facilities is held concurrently with the Independent Police Conduct Authority (IPCA).

In 2022/23 I conducted five visits alongside IPCA to court facilities throughout New Zealand, and discussed my observations with the relevant agencies.

OPCAT engagement

The OPCAT role is broad and flexible, going beyond on-site visits and examinations. I also report to Parliament, engage in constructive dialogue with detaining agencies, and co-operate with other NPM agencies in both New Zealand and in other jurisdictions, and civil society. In 2022/23 such activities included:

- finalising and publishing my expectations for conditions and treatment of people in the custody of Corrections;
- formally submitting on a range of legislation and policy proposals (lists of key submissions are available at Appendix 2);
- presenting and participating in a range of symposiums, webinars and other engagements;
- producing a factsheet on my role in examining and monitoring aged care facilities, with information on how to make a complaint about such facilities; and
- engaging with domestic and international stakeholders.

OPCAT engagement

OPCAT engagement this year included:

- Meeting with the United Nations Subcommittee on the Prevention of Torture on contemporary issues of importance in New Zealand.
- Engaging with key international stakeholders in the Australasia and Pacific region, including visiting the Samoan Corrections Facility and the Samoan Youth Corrections Facility, and collaborating with the Australian Commonwealth Ombudsman, New South Wales Ombudsman and Tasmanian Ombudsman on OPCAT practice.
- Attending a discussion on the impact of staff shortages in prisons with colleagues from the Human Rights Commission and NPMs in the United Kingdom, via a virtual meeting with the Association for the Prevention of Torture.

Appendix 1. OPCAT examinations

The 101 visits and inspections were at the sites set out in the tables below.

Type of facility	Total	Unannounced	Announced
Mental Health	15	3	12
Intellectual Disability	1	1	0
Aged Care	66	37	29
Alternative Isolation Accommodation	9	0	9
Courts	5	0	5
Immigration	1	0	1
Prison	4	1	3
Total	**101**	**42**	**59**

Name of facility
Aged Care
Admatha Dementia Care NZ
Ambridge Rose Cottage
Annaliese Haven Rest Home
Aranui Home and Hospital
Athenree Life
Avon Lifecare
Bainlea House
Ballarat Care Home
Bethlehem Views
Bobs Owens Retirement Village
Bruce McLaren Retirement Village
Burlington Village
Carter House Lifecare & Village
Charles Upham Retirement Village
Cromwell House Hospital
Elderslea Rest Home & Retirement Village
Eltham Care Rest Home
Ernest Rutherford Retirement Village
Foxbridge Retirement Village
Golden View Lifestyle Village

Name of facility
Harbour View Rest Home
Hetherington House
Jacaranda Court Dementia Unit, Whangārei Park Village
Jane Mander Retirement Village
Julia Wallace Retirement Village
Kenwyn Rest Home And Hospital
Keringle Park Residential Care
Lakewood Rest Home
Levin Home for War Veterans
Linda Jones Retirement Village
Lonsdale Total Care Centre
Lyndale Care
Millvale House Levin
Millvale House Waikanae
Millvale Lodge Lindale
Oaks Unit, Arivda Ashwood Park
Olive Tree Palmerston North
Papamoa Beach Village
Parkhaven Care Home
Radius Matua
Ranui Court
Riverstone Care Home
Roseneath Lifecare & Village
Rosewood Lifecare
Rosewood Lifecare
Saint Clair Park Residential Centre
Sevenoaks Lodge
Shelly Beach Dementia
Skyhawk and Corsair Units, Lady Wigram Retirement Village
Southanjer Rest Home
Summerset by the Ranges
Summerset on Cavendish
Summerset Richmond Ranges
Summerset Rototuna
Tamahere Eventide Home & Village
Te Awa Lifecare

Name of facility
The Booms Care Home
Tui and Koromako Units, Eastcare Residential Home
Ultimate Care Palliser House
Ultimate Care Pōneke House
Victoria Care
Victoria Place
Wharerangi Rest Home and Village
Windsorcare
Woburn Home
Woodlands Of Palmerston North
Alternative Isolation Accommodation
Averill Court Motel
Caves Motor Inn
City Suites Tauranga
Cortez Motel
Lake Taupo Motor Inn
Mystery Creek Motel
Pupuke Manor Motel
Rose Apartments
Whangarei Central Holiday Park
Courts
Blenhiem District and High Courts
Christchurch District and High Courts
Greymouth District and High Courts
Nelson District and High Courts
Timaru District and High Courts
Immigration
Te Āhuru Mōwai o Aotearoa – Māngere Refugee Resettlement Centre
Intellectual disability
Manawai National Individualised Service Unit (ISU)
Mental Health
He Puna Wāiora, Northshore Hospital
Kensington Inpatient Unit, Kensington Centre (Timaru Hospital)
Kingsley Mortimer Unit (Ward 12), North Shore Hospital
Manaakitanga Inpatient Unit, Greymouth Hospital
Mental Health Services for Older People, Tauranga Hospital

Name of facility
Southland Inpatient Mental Health Unit, Southland Hospital
STAR 1, STAR Centre (Palmerston North Hospital)
Tamahere Hospital and Healing Centre
Te Whare Oranga Tangata o Whakaue Mental Health Inpatient Unit, Rotorua Hospital
Te Whetu Tāwera, Auckland Hospital
Waiatarau Inpatient Mental Health Unit, Waitakere Hospital
Ward 6C Older Persons Inpatient Unit, Dunedin Hospital
Ward 9A, Wakari Hospital
Ward 9B, Wakari Hospital
Ward OPR1, Waikato Hospital
Prison
Hawke's Bay Regional Prison
Mt Eden Corrections Facility
Prisoners of Extreme Risk Unit
Rimutaka Prison

Final reports published in 2022/23 are set out in the table below.

Report	Date of publication
Pohutukawa Forensic Intellectual Disability Unit, Mason Clinic	01/09/2022
Otago Corrections Facility	22/08/2022

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

Facility Type	Recommendations made	Recommendations accepted
Prisons	25	24
Others (including aged care and mental health facilities)	42	39

Appendix 2: Submissions

Key submissions on legislation and draft Cabinet papers included:

Corrections Amendment Bill

Corrections Regulations (pepper spray)

Immigration (Mass Arrivals) Amendment Bill

Key submissions on policy or administrative proposals included:

Department of Corrections' Long Term Network Configuration Plan

Health and Disability Commissioner Act and Code review

Ministry of Health Guidelines for reducing and eliminating seclusion and restraint under the Mental Health (Compulsory Assessment and Treatment) Act

Transforming mental health law: overview of proposed policy proposals for new mental health legislation

Key international submissions included:

Subcommittee on the Prevention of Torture General Comment on Article 4 OPCAT

United Nations Convention on the Rights of Persons with Disabilities 2022 periodic review

United Nations Committee against Torture 77th session

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 court cells, Police cells and otherwise in the custody of New Zealand Police (Police).

The Authority is an independent body set up by Act of Parliament[22] to keep watch over 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 Authority plays a key role in improving Police practice by ensuring Police are accountable for their actions and lessons are learnt. Our aim is to maintain and enhance the public's trust and confidence in Police.

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.

About Police custody

Police operate approximately 131 custodial management facilities (containing approximately 768 usable cells) nationwide. The majority of these are cell blocks situated in Police stations. There are 12 Police districts and each district has one or more designated custody hub and other larger custody units which are equipped to hold detainees overnight. These are complemented by smaller holding cells in other stations which are intended for holding people who can be processed and released without appearing in court or as temporary holding facilities until detainees can be transferred to a primary custody unit.

Police detention facilities must manage the detention of at-risk people, often with complex physical and psychological health needs. Vulnerable groups include children and young persons, people who are mentally unwell and people with alcohol and drug dependencies. 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.

Police custody is often the first point of contact for persons entering the justice system. Similar to the wider justice system, Māori and Pacific peoples are disproportionately represented in Police detentions.

Many of the overnight custody units are also gazetted as 'Police jails' and regularly hold people who are remanded into custody by the courts.

Police are also responsible for managing most detainees appearing at the District Court. 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 IPCA holds a joint NPM designation alongside the Chief Parliamentary Ombudsman for monitoring court facilities.

[22] An independent Crown entity established under the Independent Police Conduct Authority Act 1988

CHANGES TO OUR OPERATIONS DURING THIS REPORTING PERIOD

During this reporting period the Authority reviewed how we fulfil our NPM role. This review built on the enhanced inspection process the Authority had developed and implemented in the previous 21/22 reporting period.

We looked at the resourcing requirements to undertake the number and regularity of monitoring visits of Police custody facilities to meet international and domestic expectations and to ensure we are effective in conducting our preventive monitoring activities.

We recognised that under our existing operating model it would take us approximately 8 to 10 years to inspect all overnight Police detention facilities nationally. There would have been limited capacity to conduct follow up visits or monitor the implementation of any recommendations.

During this 22/23 reporting period the Authority therefore decided to increase the proportion of our baseline funding we allocate to our OPCAT work and to set up a dedicated OPCAT team. This expanded our resourcing from one FTE to three FTE from March 2023. The new three person team replaced our practice of using staff from the existing complaint resolution and investigation teams to carry out OPCAT work alongside their primary roles.

We recruited the new OPCAT inspectors and established the OPCAT team in March 2023. During much of the 22/23 financial year, we therefore remained constrained in our ability to complete inspection visits under the existing resourcing model and with many Authority staff seconded to the Parliamentary Protest Review. This had an impact on all Authority work and the time our staff had available to conduct custody inspections.

As in previous years, to help mitigate these impacts, we continued to concentrate our efforts on our advisory and engagement activities to improve Police practice and following up on our previous recommendations. In addition, we prioritised completing follow up inspections of Police facilities where we had serious concerns about the care and treatment of the people held in custody.

SUMMARY OF 22/23 MONITORING ACTIVITIES

During the 22/23 financial year we continued to deliver on our programme of monitoring activities:

- conducting inspections to monitor the care and treatment of people in Police custody;
- completing routine audits of custodial records;
- providing an assurance role in Police's Custody Quality Assurance and Improvement Framework;
- reviewing complaint data and evidence gathered from our independent investigations;
- making recommendations for improvements; and
- engaging with Police and other Justice sector partners to encourage best practice custodial management and ensure the implementation of our recommendations.

Given the limitations set out above on resourcing through March 2023, within these activities we prioritised the following:

- follow up inspections of higher risk facilities, where we had serious concerns about the care and treatment of people held in custody;
- monitoring of previous Authority recommendations and providing feedback to Police on their proposed measures to respond to these;
- completing regular audits of Police custodial records; and then transitioning to providing an assurance role for Police's recently introduced Custody Quality Assurance and Improvement Framework;
- reviewing complaint data and evidence gathered from our independent investigations to inform our recommendations and support better custodial management;
- increased engagement with Police to improve policy, practices and procedures for the safe management of people held in custody; and
- increased our co-operation and joint working with our fellow NPMs.

INSPECTIONS

Inspection methodology

We continued to conduct inspections of custody facilities during this period in line with the inspection methodology established during the 21/22 reporting period.

During a full inspection, we monitor how Police staff manage people held in custody 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 person'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 records and risk assessments about the people held in custody.

Whenever possible, we conduct voluntary private interviews with the people held in custody 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 people held in custody 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 people held in custody assist us to identify systemic issues and help inform our recommendations.

During a full inspection visit, we monitor and produce recommendations on:

- leadership, governance and accountability;
- staffing levels and training;
- rights of the individual;
- reception and detention processes, including health and welfare risk assessments; and
- material conditions.

We conduct follow up visits to examine any areas of particular concern from previous inspections and to review progress in implementing any recommendations we made. We may also conduct a focused inspection when we have identified a particular area of interest. This could be in response to specific risk information or to gather information in relation to a thematic issue or to review good practices which could be adopted elsewhere.

Inspections conducted

We conducted a total of 14 monitoring visits in this reporting period: eight visits to Police facilities and six visits to court facilities.

We used some of these inspections to complete induction and training of our new inspectors, where these visits took place in the last quarter of the reporting period.

Police custody facilities

We conducted eight inspections of Police custody facilities during this period:

- Wairarapa Custody Unit, Masterton – Unannounced full inspection
- Timaru Custody Unit – Full inspection
- Blenheim Custody Unit – Follow up visit
- Nelson Custody Unit – Follow up visit
- Greymouth Custody Unit - Follow up visit
- Christchurch Central Custody Unit - Follow up visit
- Levin Custody Unit – Focused visit
- New Plymouth Custody Unit – Focused visit

The three follow up inspections in Blenheim, Nelson and Greymouth were conducted to monitor specific serious concerns we had identified in previous visits. These included the impact of the poor physical environment on the health and wellbeing of people held in custody and risks created by low staff numbers.

We felt it was especially important to monitor the conditions in the Nelson Custody Unit which has mould issues caused by water ingress from a leaking roof and where Police were continuing a regime of mould testing and thermal fogging treatment to reduce mould levels to within safe limits.

The New Plymouth Custody Unit was visited as it includes a small Corrections-operated remand facility on the second floor of the facility. We wished to learn more about this model and assess the conditions of detention for persons held on remand at New Plymouth compared to the conditions in many of the gazetted Police jails used to hold people remanded into custody.

Court cell facilities

We conducted six inspections of court cell facilities during this period, including one unannounced inspection of Masterton District Court cells. As part of our joint monitoring programme with the Office of the Ombudsman, we visited five court cell facilities in:

- Blenheim | Te Waiharakeke District and High Courts;
- Nelson | Whakatū District and High Courts;
- Greymouth | Māwhera District and High Courts;
- Timaru | Te Tihi-o-Maru District and High Courts; and
- Christchurch | Ōtautahi District and High Courts.

The Authority Chair and the Chief Ombudsman jointly wrote to the Secretary for Justice, Police Commissioner and Chief Executive of the Department of Corrections to raise concerns we identified during these inspections. We are engaging with the respective agencies about their plans to address our concerns.

CUSTODY QUALITY ASSURANCE AND IMPROVEMENT FRAMEWORK (QAIF)

During the first quarter of the year, the Authority conducted routine audits of custodial records in line with previous years. This monitoring activity was phased out in the first quarter to allow us to concentrate on the recently introduced Custody Quality Assurance and Improvement Framework (QAIF) which Police implemented to help monitor custodial procedures. The introduction of the QAIF enabled the Authority to provide an assurance role by sitting on the national panel reviewing the district QAIF results and action plans. The Authority will continue to review Police custody records separately, and this will form part of a scheduled inspection programme being introduced in 23/24.

Purpose of the QAIF

Police introduced the Custody QAIF to:

- ensure districts are regularly checking custodial processes and practice;
- ensure national consistency with custodial processes and practice;
- assist district management with risk identification and service delivery in the custodial space;
- ensure district management can put early interventions in place to address identified risks and issues;
- ensure national oversight and visibility; and
- ensure effective training is in place to mitigate risk and consistently deliver best practice.

The Police National Custody Team (NCT) is responsible for the framework. The QAIF involves each district reviewing randomly selected custodial records to see if they meet set standards which align with their 'People in Police Custody' Policy. The 'People in Police Custody' policy was written in consultation with the Authority and sets out national standards for the management of people in Police custody.

District panels are convened to assess the results. The panels consider what is working well and identify any risks, issues, and opportunities. Plans are then implemented to mitigate any identified risks and issues. A summary report is then provided to the NCT including any action plans.

A national panel considers the district summary reports and dip samples records. Trends and themes are monitored and national level plans are developed to address issues. A report is then prepared for the Police Executive.

The reviews take place every quarter and for each cycle they have a particular theme. The themes include assessing the care and treatment provided to certain at-risk groups, such as people detained for a mental health assessment, detentions for the care and protection of intoxicated persons and children and young people.

The Authority's assurance role

The Authority supported the implementation of a QAIF process for custody. Police initially developed the QAIF to raise standards in the management of investigations into sexual offences. It had proven an effective mechanism and they decided it could be adapted to drive improvements in custodial management.

Our routine audits had repeatedly highlighted recurring issues with the quality of Police custodial records. We decided that a Police-led audit process would provide a better mechanism for making improvements to custodial management. Each district is primarily accountable for quality assurance and delivering improvements. We considered it undesirable to have two different and unaligned audit processes and therefore agreed to provide an independent assurance role for the Custody QAIF.

We receive copies of all the individual audit samples from each district and the summaries from the district panels. We dip sample the records and have access to the Police custodial database to review supplementary data. We regularly meet with the NCT to discuss training requirements, technological innovations and other actions to improve outcomes. We are part of the national Custody QAIF panel and our feedback is included in the report to the Police Executive.

QAIFs conducted

During this reporting period four 'QAIFs' were conducted, reviewing the following risk areas:

- detentions made for the care and protection of intoxicated people;
- detentions of persons appearing to be mentally disordered in a public place; and
- detentions of children and young persons.

We also worked in partnership with the NCT to deliver a QAIF that focused on the material conditions in custody. This was a different format and saw districts assess their provision of care to detainees. This QAIF covered areas such as food available and what was provided, access to female sanitary products, access to showers, clothing, phone calls and visits. The QAIF was completed prior to the Christmas holiday period which sees an increase in the number of detainees held in custody, especially for longer periods due to reduced court operating hours over public holidays. This timing helped ensure districts were better equipped to meet the basic needs for those in their care and custody ahead of the holiday period.

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.

We continue to foster constructive working relationships with Police and engage with staff from a variety of workgroups which facilitate the delivery of custody, including the National Custody Team, National Property Office (Custody Infrastructure Team), Fleet Services, Training school, district leadership and critically with many staff working in custody units across the country. Police have been receptive to our NPM role and value OPCAT's focus on prevention.

To support the preventive aims of OPCAT, the Police set up a Police and IPCA (OPCAT) Custody Leaders Group. The Group is chaired by an Assistant Commissioner and meets monthly. Membership includes representatives from the IPCA and senior Police members from the national workgroups with responsibilities for delivery of custodial services.

The role of the Police & IPCA Custody Leaders Group is to:

- provide a platform for the IPCA and Police to openly discuss OPCAT related trends, risks, and recommendations;
- provide a mechanism for the IPCA to monitor Police progress against OPCAT recommendations; and
- provide assurance to the Police Executive and IPCA Chair that OPCAT recommendations and issues are being addressed.

The group has proved to be a valuable forum to highlight key areas of concern and discuss options for making improvements. We have provided the group with a consolidated list of outstanding recommendations. We have also engaged with the various workgroups responsible for addressing the recommendations to ensure that solutions align with our expectations as the NPM.

Custodial Training

The Authority regularly identifies the need for more in-depth and nationally consistent custodial training. During this reporting period we supported Police by presenting at:

- the new national custody supervisors course for sergeants and acting sergeants who are either working full-time in custody units or who cover custody duties alongside other roles. We explain our NPM role, share findings from our monitoring work including regularly seen areas of poor practice and examples of good practice. We discuss how to manage risks for detainees and set out our views on best practice custodial management;
- a series of locally delivered training days that the Central Police District had arranged to provide additional training and guidance for their custody staff; and
- a training day for custody sergeants from the Wellington District Custody Unit.

We also arranged to review training material for and observe the delivery of the Authorised Officers Foundation Training course at the Royal New Zealand Police College.

KEY THEMES FROM OUR MONITORING

We continue to identify many of the same systemic issues in Police custody facilities, such as:

- poor physical conditions in older custodial facilities;
- insufficient custodial training;
- inadequate risk assessments; and
- lack of supervisory oversight.

In addition, we have grown increasing concerned about the poor conditions of detention faced by people who are held in Police custodial facilities, especially during longer periods of detention.

Improvements required to the detention environment

Many older facilities continue not to meet our expectation that people 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 have a detrimental impact on the health and wellbeing of detainees and create additional challenges for staff charged with managing people in detention.

The main reason we conducted follow up visits to Blenheim, Nelson and Greymouth was to monitor the ongoing impact of the poor physical environment on the health and welfare of those held in these facilities, all of which require significant remediation or, preferably, replacement.

The short-term nature of most detentions means that the Police's custodial practices, procedures, facilities and staffing models are aimed at mitigating more acute risks, such as the risk of individuals self-harming or attempting suicide while in custody.

However, they are less well suited to managing the needs of people held for longer periods. We have found that cells are frequently dirty, with inadequate ventilation or heating, often with no natural light and detainees have limited or no access to a dayroom or outside exercise area. People are therefore held alone in a cell for all or nearly all their time in custody. The impact of the oppressive nature of this environment can be exacerbated when Police staff are too busy to accommodate providing showers or facilitate visits, and there is very little to help people held in the facilities to pass the time. The care and treatment of people held in these poor conditions falls well below our expectations.

We acknowledge that substantial capital investment would be required to remediate the poor physical conditions. With the current environment of fiscal restraint, more innovative solutions may be required to address the poor conditions of detention. As most regions currently have no suitable alternative facilities that can be used, we have encouraged Police to engage with their Justice sector partners to pursue options that could reduce the length of time people are held in custody units that are not fit for purpose.

The importance of having suitably trained and supported custody staff

We have formed the view that insufficient training and a lack of supervisory oversight is often the main factor when staff have not conducted an adequate health and welfare risk assessment or failed sufficiently to mitigate risks associated with a person's physical or mental health.

A critical part of a person'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 or had a serious medical event in custody, there were issues with the person's evaluation and the level of monitoring conducted while in custody. We have seen 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 people being booked into custody.

Police have been making improvements to the ECM. Alongside the QAIF process, this has led to staff receiving more guidance on making informed decisions on managing a person's care. We acknowledge the importance of the new custody supervisor's course, as an essential element of improving outcomes for people in Police custody. Sergeants play a critical role in identifying and managing risks within custody units and it is crucial that they receive bespoke training.

Given the significant risks and responsibilities associated with manging people in detention, we continue to make recommendations that Police provide further training to ensure all staff who are required to care for detainees have the necessary knowledge and experience.

As many custody units away from the main metropolitan centres do not have dedicated custody supervisors on duty 24/7, we have also proposed that every district should have a trained custody supervisor available who can remotely review detentions and approve health and welfare risk assessments.

FINAL COMMENT

Whilst there continues to be many challenges and more work to be done, we acknowledge the improvements that have been made so far. We recognise the professionalism and resilience of the many Police staff responsible for managing the care of people in custody.

We appreciate that outdated facilities not only affect those in custody but can make the task harder for staff. We will continue to follow up on our recommendations to ensure that staff receive the appropriate training and support to discharge their duty of care and improve outcomes for people in Police custody.

Mana Mokopuna | Children and Young People's Commission

Context

Mana Mokopuna - Children and Young People's Commission (Mana Mokopuna) is a National Preventive Mechanism (NPM) under the Crimes of Torture Act (1989). A specialist OPCAT[23] monitoring team within the Commission 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.

Establishing a Commission and a new Oversight System

A key area of development across the financial year included preparing to transition into both a Commission and establishing the new Oranga Tamariki oversight system.

A new Commission

As of 1 July 2023, The Office of the Children's Commissioner became Mana Mokopuna - Children and Young People's Commission, governed by of a Board of five Commissioners, led by the Chief Children's Commissioner with the Children and Young People's Commission Act 2022 (CYPCA) replacing the previous Children's Commissioner Act 2003.

The NPM designation passed from the Children's Commissioner to Mana Mokopuna.

The purpose of the new Commission is to promote and advance the rights, interests, and participation of children and young people and to improve their well-being within the context of their families, whānau, hapū, iwi and communities.[24] The Commission has increased Te Tiriti o Waitangi obligations[25] and the Children's Commissioner's NPM designation has been passed on to the new Commission.

The Oversight System

The Commission forms part of the Oranga Tamariki oversight system.[26] In 2019, Cabinet agreed to develop legislation aimed to strengthen and resource the oversight system in three areas:

- system-level advocacy for all mokopuna
- complaints oversight and investigations
- independent monitoring of the Oranga Tamariki system.[27]

The new oversight system comprises Aroturuki Tamariki (Independent Children's Monitor),[28] the Office of the Ombudsman (the Ombudsman), and Mana Mokopuna. Monitoring of the Oranga Tamariki system is undertaken by Aroturuki Tamariki, as a departmental agency housed within the Education Review Office.[29]

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[23] Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

[24] Refer s 4 of the CYPCA.

[25] Refer s 6 of the CYPCA.

[26] Oversight of Oranga Tamariki System Act 2022 No 43 (as at 01 May 2023), Public Act Contents – New Zealand Legislation

[27] The Oranga Tamariki system is the system that is responsible for providing services or support to children, young people, and their families and whānau under, or in connection with, the Oranga Tamariki Act 1989. Refer s9(1) of the Oversight of Oranga Tamariki System Act 2022.

[28] Aroturuki Tamariki was formally established on 1 July 2019 to monitor agency compliance with the Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018. See: Who we are | Aroturuki Tamariki | Independent Children's Monitor

[29] Contrary to General Comment No. 2, the Paris Principles, expressed Cabinet intent, and findings of an independent review (2018. Beatie, S. *Strengthening independent oversight of the Oranga Tamariki system and of children's issues in New Zealand*. Ministry of Social Development).

The Ombudsman is now solely responsible for receiving complaints from mokopuna in relation to the operation of Oranga Tamariki or care or custody providers, and for investigating these complaints. Mana Mokopuna is responsible for advocating for, and promoting the interests, rights, and well-being of all mokopuna, (including those in the Oranga Tamariki system) and where needed, help mokopuna and their whānau navigate the system to facilitate the resolution of issues.[30]

All three agencies are required to work together to ensure the law is upheld, that services are being delivered effectively, and those services are improving experiences and outcomes for mokopuna.[31]

As an oversight of Oranga Tamariki system agency, the focus for Mana Mokopuna is on mokopuna and their whānau, working to ensure their rights are upheld, and that their interests and well-being are prioritised.
OPCAT monitoring remains functionally independent of oversight system agency activity.

Rapid Review into Oranga Tamariki Youth Justice Residences and Community Remand Homes

As a result of harmful practice by staff towards mokopuna identified through OPCAT monitoring visits, and negative media attention surrounding Youth Justice residence incidents, Oranga Tamariki launched a review of residences and some remand homes in June 2023. The "Rapid Review" was a direct response to serious allegations relating to staff conduct in Oranga Tamariki Youth Justice and Care and Protection residences and other areas of front-line service delivery. The Review team was led by former Police Commissioner Mike Bush at the request of the Oranga Tamariki Chief Executive and undertaken by a small select team. Whilst the Rapid Review was not a forensic examination of the residences or community-based remand homes, it did result in suggestions being made to improve the experiences of mokopuna living in these facilities.

This Review can be found here.

[30] Refer s 20(c) of the CYPCA.

[31] Refer to s7 of the Oversight of Oranga Tamariki System Act 2022.

Our National Preventive Mechanism designation

Mana Mokopuna visits secure facilities where mokopuna can be deprived of their liberty throughout Aotearoa New Zealand. This includes:

- Five **Youth Justice Residences** operated by Oranga Tamariki 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 Court
  - 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.
- 14 **Youth Justice Community Remand Homes** which are small three-to-five-bedroom homes situated across Aotearoa New Zealand and run by community partners on behalf of Oranga Tamariki. They are available to children and young people who are on remand pending their matters being dealt with in the Youth Court. They are designed to keep children and young people close to their whānau (family) and within their 'home' community.
- Three **Care and Protection Residences** operated by Oranga Tamariki for children and young people who are deemed to be at risk of harm to themselves, others, or have significantly high and complex needs. One Care and Protection residence was decommissioned in 2021 and remains closed.
- Five **Youth Mental Health Facilities** operated under Te Whatu Ora – Health NZ for vulnerable youth with complex mental health needs or intellectual disability. Three are in-patient acute youth mental health facilities, one in-patient youth forensic mental health unit, and one in-patient intellectual disability unit.
- 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 mokopuna with diagnosed harmful sexual behaviours.

Monitoring methodology

Mana Mokopuna collects both qualitative and quantitative information to inform its reporting. Based on the United Nation's OPCAT Guidelines, the domains that form the basis for 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 also includes an additional domain in our OPCAT monitoring:

- 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 well-being. This domain focuses specifically on how secure environments are improving outcomes for mokopuna Māori, who are 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 mokopuna, their whānau, hapu and iwi.

Mana Mokopuna is committed to ongoing cultural competency upskilling of our kaimahi, to support and enable the application of a te ao Māori lens to monitoring.

Lines of Inquiry – Informed by Recommendations of the United Nations

In February 2023, the United Nations Committee on the Rights of the Child ('the UN Committee') released its Concluding Observations[32] for New Zealand's seventh periodic review on its implementation of the Children's Convention[33] and how the Government is protecting and advancing the rights of mokopuna in Aotearoa New Zealand.

There are a number of recommendations in the Concluding Observations that relate to the treatment of mokopuna in places of detention, and these have subsequently been woven into our monitoring practice to help inform the lines of inquiry for visits.

Follow-up visits

Alongside full visits which monitor the domains above, Mana Mokopuna has begun undertaking unannounced follow-up visits. These visits are designed to monitor the progress of recommendations made during previous visits and respond to or highlight any issues or concerns that have been raised at our designated facilities.

[32] Refer CRC/C/NZL/CO/6. To see the Children's Commissioner report to the UN Committee, see: NZ Children's Commissioner's Report to the UN Committee on the Rights of the Child - 2022 | Office of the Children's Commissioner (occ.org.nz)

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

Monitoring 2022 – 2023

Mana Mokopuna conducted 15 on-site NPM monitoring visits to places of detention between 1 July 2022 and 30 June 2023. Six of these visits were announced, while the other nine were unannounced, of which seven were follow-up visits. For facilities Mana Mokopuna has yet to visit, it is agreed with all stakeholders that initial monitoring visits will be announced. Subsequent visits will fall into a regular unannounced schedule.

Facility	Monitoring Description	Designation	Stakeholder
Whare Pumau Mana Remand Home	Announced	Youth Justice	Te Ikaroa Rangatahi Social Services
Korowai Manaaki Youth Justice Residence	Unannounced	Youth Justice	Oranga Tamariki
Te Maioha o Parekarangi Youth Justice Residence	Unannounced	Youth Justice	Oranga Tamariki
Te Puna Wai ō Tuhinapo Youth Justice Residence	Unannounced Follow-up	Youth Justice	Oranga Tamariki
Hikitia te Wairua	Announced	Youth Mental Health	Te Whatu Ora
Epuni Care and Protection Residence	Unannounced Follow-up	Care and Protection	Oranga Tamariki
Te Au rere a te Tonga Youth Justice Residence	Unannounced Follow-up	Youth Justice	Oranga Tamariki
Te Poutama Ārahi Rangatahi	Announced	Special Purpose	Barnardos New Zealand
Whakatakapokai Youth Justice Residence	Unannounced Follow-up	Youth Justice	Oranga Tamariki
Regional Rangatahi Adolescent In-Patient Service	Unannounced Follow-up	Youth Mental Health	Te Whatu Ora
Hillsborough Lighthouse Remand Home	Announced	Youth Justice	Kia Puāwai
Korowai Manaaki Youth Justice Residence	Unannounced Follow-up	Youth Justice	Oranga Tamariki
Nga Taiohi	Announced	Youth Mental Health	Te Whatu Ora
Te Puna Wai ō Tuhinapo Youth Justice Residence	Unannounced Follow-up	Youth Justice	Oranga Tamariki
Glenmore Lighthouse Remand Home	Announced	Youth Justice	Kia Puāwai

Themes from on-site monitoring

There were some trends that appeared across Care and Protection, Youth Justice, Mental Health and Special Purpose facilities monitored during the 2022 – 2023 financial year.
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 mokopuna as expressed in their own words have been ***italicised***.

Positive Trends

Effective models of care create the foundation for positive relationships

A number of facilities demonstrated positive and effective models of care. These had noticeable positive impacts across both mokopuna, whānau and kaimahi experience, and often included a multi-disciplinary approach that fostered holistic practice centred on mokopuna voice and whānau involvement. Due to the solid foundation of kaimahi practice, there was a positive trend of kaimahi role-modelling and displaying empathetic care for the mokopuna they worked with. As a result, many facilities were able to demonstrate positive and mutually reciprocated relationships between kaimahi and mokopuna.

> ***"Staff actually care about us."***

There were a number of instances where kaimahi also went beyond their role to act as advocates for mokopuna and elevate their voice.

> ***"staff care, they advocate for me. Whaea tells me what I am entitled to and always makes sure things are advocated and pushed for."***

Mana Mokopuna encourages all facilities to adopt a model of care which supports holistic and therapeutic practice to uphold mokopuna rights and elevate their care experiences.

Using least restrictive practice is important

Many facilities demonstrated efforts towards moving to least restrictive practice. With the exception of Youth Justice residences, there was an overall decrease in use of seclusion and restraints, with some facilities successfully eradicating the use of these practices in favour of relational, therapeutic, and need-centred de-escalation approaches. Mana Mokopuna commends these efforts and looks forward to seeing this shift toward least restrictive practice continue.

Kaimahi support good admission processes and ensure contact with whānau

A number of facilities demonstrated good practice across their admission process which helped support a positive transition into care for mokopuna. Care and thought were put in to ensure mokopuna were well introduced to the facility and had a good understanding of how things operated. In some units, mokopuna were also involved and openly shared what to expect with mokopuna newly admitted.

Access to whānau was generally well supported across all facilities. Ensuring mokopuna have good access to whānau is critical to ensuring their needs are met and whānau are kept involved in the transition into and out of care.

Mokopuna have good access to health and education

Education was seen as a positive across the majority of visits, with efforts being made to make learning mokopuna-centric and based around needs and interests. A number of facilities had initiatives in place to engage mokopuna in meaningful activity and mokopuna generally engaged well with on-site teachers.

Aside from Youth Justice residences where healthcare access and experience can vary, mokopuna generally had good access to primary healthcare and specialists.

Areas for Development

More needs to be done to improve outcomes for mokopuna Māori

Given the continued over-representation of mokopuna Māori in all places of detention, more needs to be done to appropriately assess and address the need to improve outcomes for this specific group. Aside from community remand homes, there is a general lack of strategic vision and direction to address cultural need and equip kaimahi with the skills and knowledge to support cultural competency across a number of facilities. The presence and operation of tikanga and kawa varies greatly from facility to facility. Often upholding culture falls on the shoulders of the few kaimahi Māori working in facilities. This means that not only are mokopuna not having their cultural needs met, but the way mokopuna are cared for lacks foundation in te ao Māori and the values of mātauranga Māori.

Lack of independent complaints systems and access to advocates

There is a lack of independent complaints processes across all designated facilities. Mokopuna are placed in the position where they must access or address complaints via kaimahi working directly with them. This poses a problem when mokopuna must access the complaint system through kaimahi they may wish to complain about. Complaints are then also managed in-house unless escalated by mokopuna. Mana Mokopuna regularly hears that initiating grievance processes in Youth Justice residences is discouraged by kaimahi and other mokopuna, with complaint forms being labelled as 'snitch forms'.

Independent advocacy is also not consistently available across all facilities which is particularly concerning as some mokopuna are left without the appropriate supports to advocate for themselves.

Staffing shortages and a lack of appropriate training creates inconsistent care experiences

Across all facilities, recruitment and inadequate staffing levels remain an on-going issue. Due to nationwide shortages, the recruitment of necessary specialist kaimahi has been difficult which has resulted in facilities employing people with little experience working with vulnerable mokopuna. Staff shortages and lack of experienced kaimahi has a ripple effect in that existing staff need to work long or double shifts and annual leave is declined due to lack of coverage. This in turn leads to burn-out and poor practice amongst kaimahi and mokopuna are then directly impacted with their care compromised.

Typically, practice has been noted as inconsistent and there is a lack of resource to manage escalated behaviours appropriately. The ability for kaimahi to engage in professional and cultural supervision is severely impacted by a lack of staffing cover.

Staff shortages have also had a filtered impact onto induction processes, often leading to them being condensed and cut short. Additionally, there is limited on-going and specialist training offered to kaimahi. Kaimahi constantly highlight a need for specialist training that equips them to work effectively with mokopuna in their care. This generally centres around caring for mokopuna with mental health needs, neurodiversity, and mokopuna with very high and complex behavioural needs. Without this training, kaimahi report they find it difficult to manage mokopuna appropriately, leading to escalated behaviours and distress amongst mokopuna and kaimahi alike.

Mokopuna spend too long on custodial remand

For mokopuna, time on remand is not considered time served when sentenced. Therefore, some mokopuna serve a longer custodial remand period than their eventual sentence.[34] Mokopuna must have their remand status reviewed every fourteen days[35]. Across both Youth Justice residences and Community Remand homes,

[34] Sentenced under s311 Oranga Tamariki Act

[35] S242(1)(A) Oranga Tamariki Act 1989

either reviews are not completed or Oranga Tamariki social workers simply resubmit them with a date change without appropriate rationale as to why the detention in custody is still required. Pre-trial detention for mokopuna should be kept to a minimum.[36]

Status-mixing of mokopuna is also an issue across Youth Justice facilities. During the monitoring period, Mana Mokopuna found mokopuna with community bail[37] being housed with those on a custodial remand status and custodial remand mokopuna in the same facilities as sentenced mokopuna. The issues raised relate to equitable access to programmes and off-site activity and being able to appropriately meet all mokopuna needs.

Need for better transition planning and community placement opportunities

Some mokopuna are living in more restrictive placements over lengthier periods of time than necessary. This is due to either a lack of appropriate community placements to address their needs, or a lack of appropriate and involved transition planning from their social workers. Disengaged practice from Oranga Tamariki allocated social workers due to a lack of accessibility, communication, and presence has led to mokopuna and facilities being unclear on care and transition plans. Incomplete documentation is becoming common practice and mokopuna are missing out services and supports they are entitled to during their placements and when they transition out.

Recommendation progress

Mana Mokopuna makes both systemic and facility recommendations based on findings from monitoring visits. The aim is to prevent harm, inform change and support or highlight good practice in places of detention. Systemic recommendations are addressed to the relevant government department (Oranga Tamariki or Te Whatu Ora – Health New Zealand) or community partner responsible for running the facilities. Facility recommendations are addressed directly to the management team of individual residences, homes or units.

Mana Mokopuna was pleased to see the completion and progression of a number of recommendations across the financial year, particularly regarding facility recommendations. This indicates a dedicated effort from management teams across facilities and sectors to improve the treatment, conditions and well-being for mokopuna in their care. Systemic recommendations have been progressing at a slower rate with some making limited progress.

Of the systemic recommendations showing limited or no progress, there are a number of similarities across sectors and many of these recommendations have been long-standing.

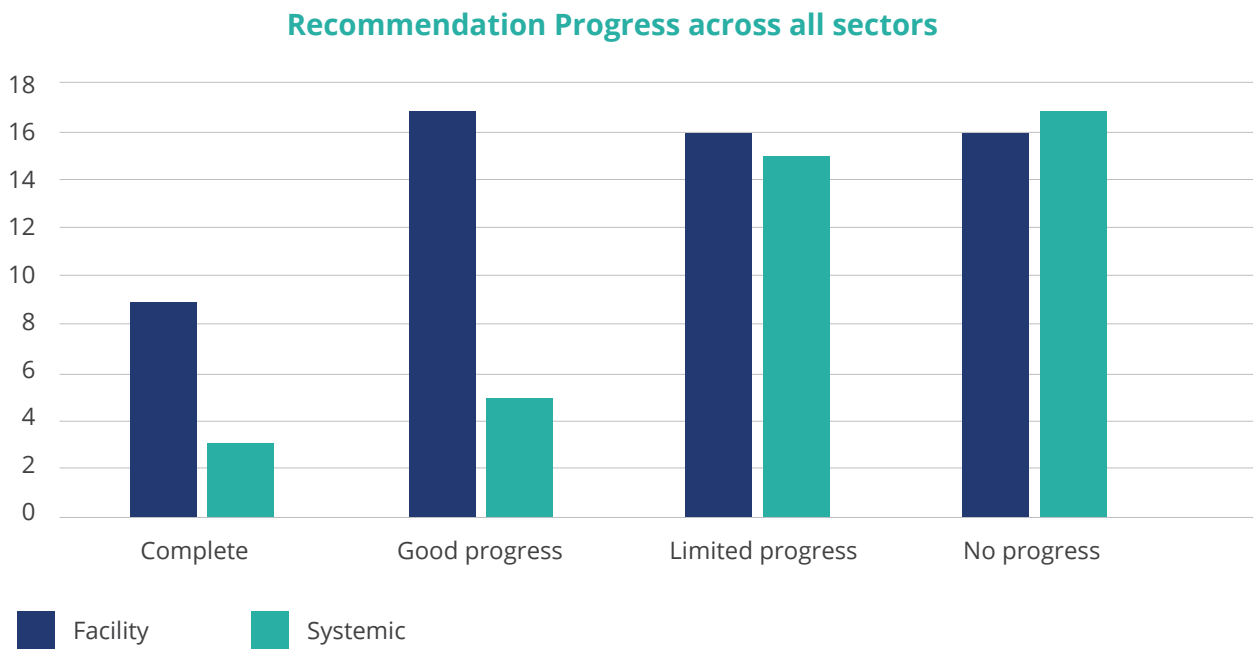
Key areas to address included:

- Low staffing levels
- Lack of independent complaints process
- Lack of access to independent advocates
- Social work practice – including consistent completion of individual care plans and remand status reviews
- The need for comprehensive and fit-for-purpose training packages
- The need for appropriate community-based placement options
- Need for a package of trauma-informed programmes to address criminogenic risk factors, alcohol and drug use, life skills, and cultural development
- A clear strategic direction to improve outcomes for mokopuna Māori

Mana Mokopuna emphasises the importance of addressing these recommendations to ensure the best outcomes for mokopuna.

[36] Convention on the Rights of the Child | OHCHR - Article 37

[37] S238(1)(b) Oranga Tamariki Act 1989



Oranga Tamariki Residences

Mana Mokopuna completed six visits to Oranga Tamariki facilities between July 2022 to June 2023. Korowai Manaaki and Te Puna Wai ō Tuhinapo Youth Justice residences were visited twice within the period due to concerning information received by Mana Mokopuna from members of the public. Both of these residences were found to have harmful practice, and this was directly communicated to the Chief Executive of Oranga Tamariki, leading to the instigation of the aforementioned Rapid Review.

Mana Mokopuna continues to advocate for the closure of large Care and Protection facilities in favour of small, community-based, purpose-built homes, that are well resourced to support mokopuna, their whānau, hapu, and iwi.[38] Positive examples of this model already exist and could be scaled with adequate investment, resourcing, and planning.

Care and Protection

Mana Mokopuna monitored one Care and Protection facility during the 2022 – 2023 period through a follow-up visit. Many of the recommendations showed little or no progress, with one recommendation making good progress and one completed.

Despite a commitment to the phased closure of larger Care and Protection facilities as per the Oranga Tamariki Future Direction Plan,[39] the bed capacity for the Care and Protection facility monitored in 2022-2023 had increased.

At the time of the visit, Oranga Tamariki had implemented a plan for a staggered increase in capacity over a six-month period for one residence. The aim was to provide urgent care for mokopuna with offending behaviours, whilst a tailored intervention plan was developed by the social worker allocated to each mokopuna. The timeframe for these plans to be developed was over the Christmas period, with many mokopuna placed outside of their home area and away from whānau for the holiday period.

[38] OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)

[39] OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)

Concerns were raised directly with the Chief Executive of Oranga Tamariki regarding the treatment of these mokopuna and their ability to have meaningful contact with whānau over this time.

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

Therapeutic practice
Concerns have been raised by Mana Mokopuna that Care and Protection facilities are being used to provide interventions for some young mokopuna who are committing crime. It is important that these facilities are used appropriately and there is careful consideration regarding who is placed in care and protection facilities to ensure all mokopuna have the appropriate means to succeed in a safe environment.

At the time of the visit, Mana Mokopuna saw no evidence that a therapeutic model of care was in place nor did kaimahi demonstrate trauma-informed practice outside of applying Safety Intervention[40] training techniques to manage heightened behaviours. Mokopuna had little input into their care plans and the plans themselves often lack detail, further highlighting the lack of a therapeutic model to address their needs.

Staffing
On-going concerns remain regarding staffing numbers, capabilities, and inconsistent practice employed by kaimahi working directly with mokopuna. Additionally, there was a lack of consistent access to a full induction, appropriate on-going training, and regular, professional supervision to support practice amongst kaimahi. Cultural practice and capability needs to be prioritised in order to meet the needs of mokopuna Māori, who account for a high percentage of mokopuna in the care of the state.

Areas of Strength:

Permanent staff help to build stability
Mana Mokopuna noted there had been a small increase in permanent kaimahi employed at the residence. This has helped support a positive practice and culture shift and this, alongside, positive interactions between staff and leadership that has helped improve kaimahi wellbeing.
Mokopuna enjoy being in the community and connected to whānau
Mokopuna have regular opportunity to leave the residence and engage in activity in the immediate community. Mokopuna had input into where they went and what they participated in. Mokopuna also had good opportunity to share what they had done with whānau by keeping them up to date with regular whānau contact occurring.

Youth Justice

Mana Mokopuna had seven monitoring visits to Youth Justice residences during the 2022 – 2023 period, with two residences being visited twice. There were two full visits and five follow-up visits.

The majority of the recommendations showed limited or no progress, with a few recommendations making good progress and being completed.

Areas of development

Mokopuna safety is compromised
There are regular assaults between mokopuna and instances where kaimahi have not always proactively intervened. Mokopuna aggression is high, injuries from assaults occur frequently, and contraband, such as vapes, is increasingly available. Weapons are being fashioned from everyday items as well as used vape casings. Security equipment such as radios are often broken and kaimahi report they do not always feel safe at work.

[40] Safety Intervention Foundation Training | Crisis Prevention Institute (CPI)

> ***"This is supposed to be a safe place but you never know, someone could come up behind you and punch you, stab you."***

Mokopuna access to timely healthcare does not always occur with some mokopuna waiting long periods of time to have their health concerns addressed. Physical check-ups are not always occurring following use of force incidents and medication is not always appropriately managed or administered.

Age-mixing is occurring across residences and has fostered an environment where younger mokopuna are being negatively influenced by older cohorts. Younger mokopuna are adopting anti-social behaviours to fit in. In one residence older mokopuna refused to engage with education which led to the rest of the unit also refusing to engage. The older cohort had a level of influence over the younger mokopuna and have been 'schooling' them in how to commit crime 'better'.

Mokopuna were also hesitant to utilise complaints processes due to concerns about being labelled as "snitches" and often kaimahi reinforced this belief rather than actively encouraging and supporting mokopuna in their right to complain about things affecting them.

Kaimahi practice is inappropriate and inconsistent

There was inconsistent practice occurring across residences, and there was often a disconnect between leadership teams and those working directly with mokopuna. Many kaimahi were inexperienced and under-trained as recruitment difficulties and low staff numbers did not allow for a full induction period. Additionally, kaimahi were missing out on supervision and did not feel they are being provided with the on-going training needed to address the complex behaviours and needs mokopuna were presenting with. Collectively this had an impact on kaimahi practice, and it was not uncommon across residences for kaimahi to engage in inappropriate practice including disclosing personal information, swearing, not setting appropriate boundaries or role-modelling pro-social behaviours. This was in addition to failing to intervene when mokopuna were heightened or when specific mokopuna were targeted for assault.

> ***"If we have a fight in here or the staff hurt us, it is what it is. We can't do nothing about it, no one's even listening to us anyway."***

Low staffing levels lead to a punitive approach

Due to staffing constraints and an increase in presentations of mokopuna with high and complex needs, there was a largely punitive approach engaged across Youth Justice residences which involved high use of searches and restrictive practices like restraint holds and secure care (seclusion). There were regular applications made to the Youth Court to keep mokopuna in secure care for longer stays.[41] Youth Justice residences lacked therapeutic models of care, and alternative management or de-escalation strategies to manage mokopuna behaviours. There was a feeling from kaimahi across the board that residences were resource poor and were in 'survival mode'.

Mokopuna cultural needs are not always met in residence

There was a general lack of bicultural frameworks across Youth Justice residences which had an impact on mokopuna who whakapapa Māori. Not only are mokopuna not having their cultural needs met, the way mokopuna are cared for also lacks foundation in te ao Māori. Mokopuna said they were eager to learn and engage in te ao and matāuranga Māori but resources are limited and many kaimahi lacked the cultural capability to assist.

> ***"I wanted to know my pepeha but no one wants to help me out."***

Meaningful activity is limited or under-resourced

While there were some good initiatives in place in some Youth Justice residences, many of these were not resourced to allow access to all mokopuna or for them to continue past a one-time event. Meaningful activity outside of education can be limited and had been noted as a reason for escalating behaviours and violence in residences.

[41] S371 Oranga Tamariki Act 1989

> *"I'm keen to do sports, [...] but I'm more wanting to get out of the unit."*

A lack of quality time spent with mokopuna to develop their care plans has led to their needs not being identified.

Areas of Strength:

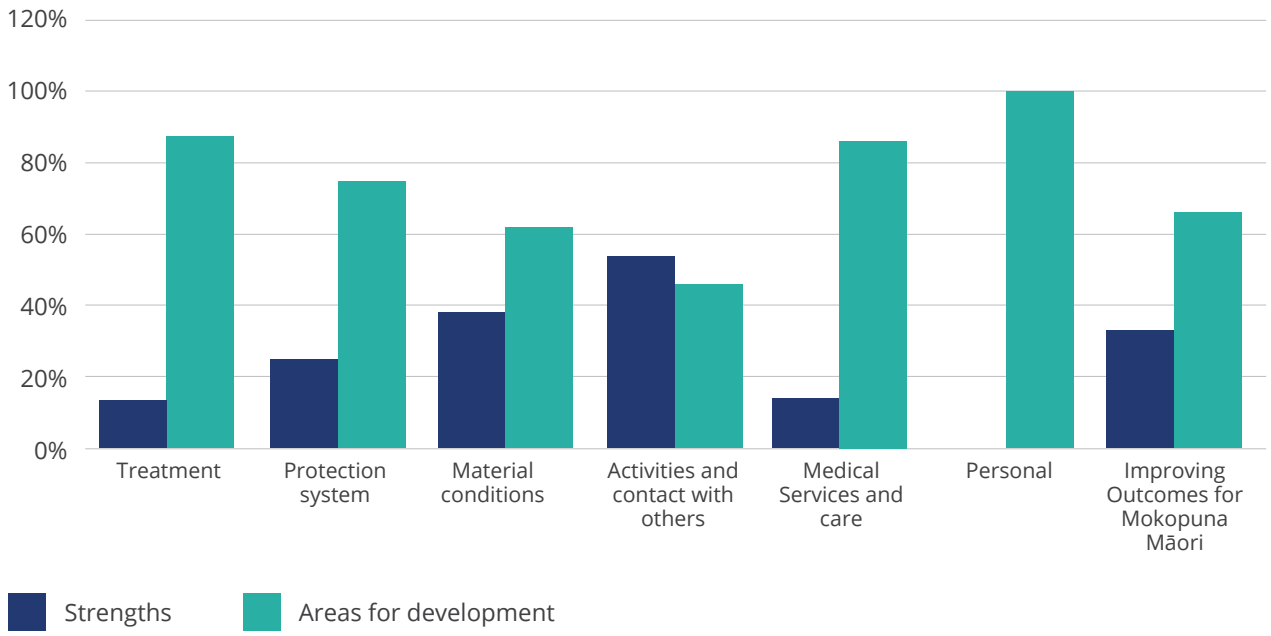
Mokopuna are connected with whānau
Mokopuna were given regular opportunities to connect with their whānau via video or phone calls. Whānau were also welcome to visit mokopuna, although prescribed visiting times were highlighted as a barrier for some mokopuna and their whānau. Some residences also hosted community events which whānau could attend and participate in. This included a variety of cultural events and celebrations during different language weeks.

Kaimahi Māori make a difference
The majority of mokopuna in residences whakapapa Māori. Residences with a higher number of kaimahi Māori demonstrated a notable, positive impact upon residence dynamics for mokopuna. These kaimahi were willing to tap into personal resource and experiences to help mokopuna grow their knowledge of te ao and matāuranga Māori in order to increase their cultural connectedness. However, these kaimahi were not always well-supported by residences to utilise this skill consistently, nor were there frameworks in place to instil cultural capability amongst all kaimahi.

Education is positive when mokopuna engaged
Across residences, there were efforts to include a variety of activities and learning opportunities for mokopuna centred around their interests. Teachers worked hard to make school fun for mokopuna and topics of learning were designed around things relevant to their lives. Learning was celebrated and mokopuna took pride in academic achievement. However, not all mokopuna were choosing to engage in education and this had a 'domino effect' - with mokopuna who had historically engaged in education also then opting out.

Summary of Findings by Domain

Percentage of Strengths vs Areas for Development for Youth Justice Residences



Community Run Remand Homes

Mana Mokopuna monitored three community-based remand homes during the 2022 – 2023 period. These homes were operated by community partners on behalf of Oranga Tamariki.

Community remand homes displayed a higher proportion of strengths across all domains in comparison to the residences within the Youth Justice designation.

There are, however, some areas for development and Mana Mokopuna recommend the following issues are addressed.

Areas of development

Oranga Tamariki practice is inconsistent.
Despite efforts from community partners to engage with Oranga Tamariki sites and social workers, mokopuna plans were often not up-to-date and lacked sufficient detail to inform care. This left kaimahi working in community-based homes without the appropriate knowledge to best support mokopuna needs and account for risks. Kaimahi reported that communication from Oranga Tamariki was inconsistent and there was little evidence of remand reviews or transition planning being completed despite lengthy stays.

Mokopuna access to additional activities, supports and healthcare is reliant on Oranga Tamariki site social workers. If contact with allocated social workers is variable or sporadic, mokopuna may not have the opportunity to progress goals in their care plans or access supports they are entitled to.

Lack of independent advocacy and complaint process.
The community-based remand homes monitored often were not linked with independent advocacy services like VOYCE Whakarongo Mai[42] and kaimahi and mokopuna alike were largely unaware of any advocacy options available to them. Kaimahi did go above and beyond to advocate for mokopuna in their care, but better access to independent advocacy is important.

Additionally, complaints by mokopuna living in community-based remand homes were dealt with in-house which left mokopuna without any advocacy option outside of the home other than their allocated Oranga Tamariki social worker.

Staff constraints have an impact.
Staff numbers are limited. This can easily put a strain on kaimahi, particularly when the homes are at full capacity. Kaimahi said it can be harder to uphold good practice when staffing resource does not reflect mokopuna need. Additionally, the shift work involved with staffing a remand home can make it difficult to access training and professional supervision in a timely manner.

Kaimahi in all facilities said there was a need for more intensive and fit-for-purpose training to equip them with the skills to manage the high and complex needs of mokopuna.

Whānau involvement.
While mokopuna had regular access and contact to whānau via phone calls, whānau involvement in their remand journey could be better facilitated. Whilst some remand homes allowed face-to-face visits, other homes did not. When whānau involvement was high, it had a noticeable positive impact on mokopuna and their engagement with kaimahi and their remand plan.

Areas of strength:

Mokopuna are treated like whānau
The small and close-knit dynamics of community-based remand homes cultivate an environment where mokopuna are treated like whānau and supported to thrive. There is a lot of care demonstrated by kaimahi and this is reciprocated by mokopuna and also shared between mokopuna. Kaimahi work hard to role-model pro-social behaviour and establish healthy boundaries while still creating a fun environment for mokopuna filled with friendly banter.

[42] VOYCE - Whakarongo Mai - advocacy for children with care experience

Kaimahi also share their knowledge and advocate for mokopuna needs, especially on matters related to well-being and care plans.

> ***"I was sick and one of the staff said I had a chest infection and I needed to go to the doctor. The social workers said they would take me next week, but lucky whaea pushed it and [social workers] came as I did have a chest infection".***

Mokopuna needs are at the centre of decision-making

Mokopuna have input into many aspects of the day-to-day running of the homes. They are frequently given the opportunity to exhibit self-determination and input into food menus for the week as well as activities and education which is often centred around their personal interests and abilities and includes lot of variety. Mokopuna are well-connected to the community and have regular contact with whānau, and good access to medical and therapeutic needs. Kaimahi work hard to keep mokopuna connected to the community and utilise resources that can support and engage mokopuna once they leave, providing vital continuity of care.

Community-based homes create a calming environment

The warm and homely design of the community remand homes helped mokopuna to self-regulate. The homes were well-equipped with multiple comfortable spaces that included a variety of entertainment options for mokopuna to use, both inside and outside. Areas like these allowed mokopuna space as and when they needed it which, in turn, helped mokopuna manage their own well-being and self-regulate.

Restrictive practices such as Secure Care (seclusion) and using force to restrain were never used in community-based remand homes as they were not necessary. Instead, relationships between kaimahi and mokopuna were built on a foundation of trust and respect and kaimahi were well-equipped with alternative de-escalation approaches which centred on relational practice and techniques. Mokopuna said they felt safe and valued when living in the homes.

Te Ao Māori was lived and breathed.

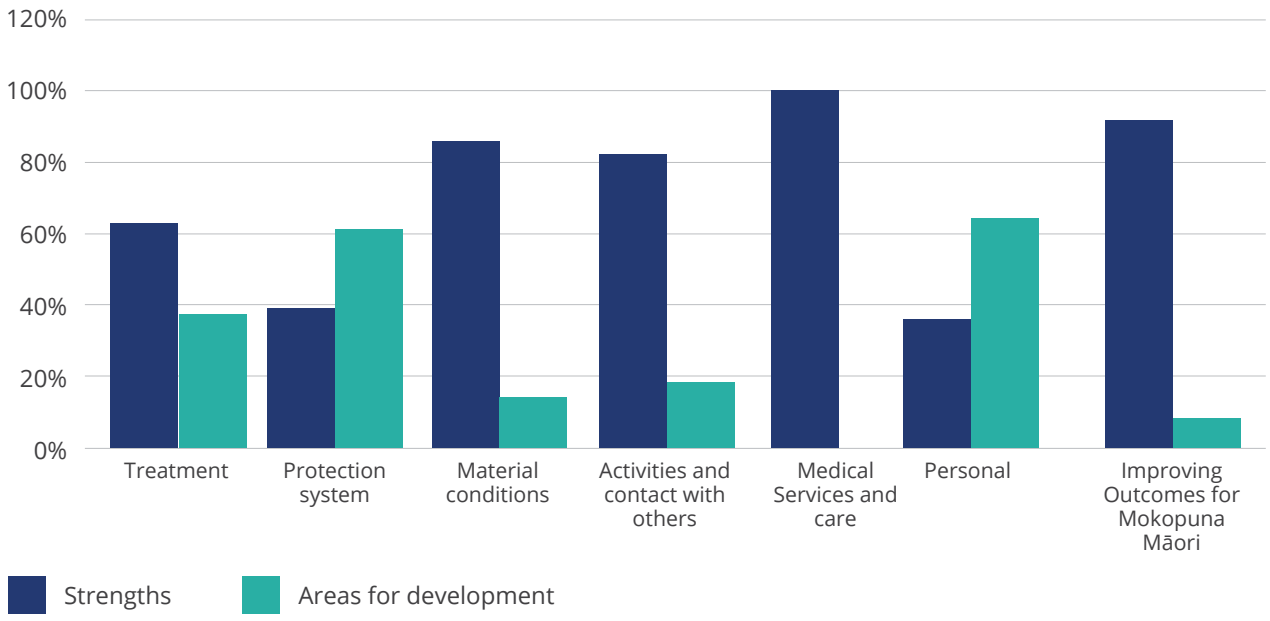
Many kaimahi working in community-based remand homes are Māori. Mana whenua are often well-connected to the homes and in some cases have influence how they operate. There is clear commitment to ensuring both kaimahi and mokopuna cultural needs are being met and realised.

Some of the homes have clear strategic strategies in place to cement Te Ao Māori into all aspects of how they operate, and kaimahi express and uphold Te Ao Māori values in their practice. Kaimahi recognise this as their way of life and want to pass this on to mokopuna. Mokopuna are often welcomed into the homes with a mihi whakatau. The mokopuna are introduced to the kawa and tikanga of the homes right from admission so they have an understanding of how things operate and can integrate accordingly.

> ***"It's choice here. We all Māori here, that's how it should be. Māori looking after Māori, they get us, and it should be our people looking after us".***

Summary of Findings by Domain

Percentage of Strengths vs Areas for Development for Community Remand Homes



Mental health facilities run by Te Whatu Ora

Mana Mokopuna monitored three youth mental health facilities over the 2022 - 2023 period, which included one follow-up visit.
Majority of recommendations showed either good or limited progress with a few being completed or not progressing. Mana Mokopuna recommend the following issues need to be addressed:

Areas of development

A lack of community-based placement options makes transition out of in-patient care difficult
Despite some facilities providing excellent wrap-around transition support, transition timeframes were often extended due to a lack of appropriate community placement and supports for mokopuna. This resulted in mokopuna experiencing stays that were longer than necessary. Some mokopuna described this experience as starting to feel as though they were in prison.

There were also occasions where kaimahi questioned whether mokopuna met the threshold for in-patient treatment, and thought they would be better suited to remain in the community if there were appropriate wrap-around support available.

No appropriate complaints process
Complaints processes across all facilities were often not accessible or appropriate for mokopuna. In one facility, access to complaint forms had to be asked for via kaimahi and were in paper form which did not account for variation in mental presentation and literacy. Other facilities only used general hospital processes which are not designed for mokopuna or those experiencing significant mental distress.

Additionally, there were no independent advocates available to mokopuna, leaving mokopuna reliant on kaimahi and District Inspectors[43] employed by the Ministry of Health to advocate for their needs.

[43] Mental Health District Inspectors | Ministry of Health NZ

Physical setting of some in-patient facilities was not appropriate
In some facilities there was minimal access to natural light, fresh air and green spaces, with windows largely locked and frosted over. Outdoor spaces for mokopuna included small concrete courtyards visible to the public, and mokopuna were limited in how they could access the hospital grounds. In one facility mokopuna noted their bed was not comfortable which made sleeping difficult.

Specialist staff are hard to find
Despite extensive recruitment drives, staffing levels were not always optimal, which at times led to kaimahi working extended or double shifts. Kaimahi could also be rostered across other services within the hospital which contributed to reduced resource and the inability to work with small mokopuna to kaimahi ratios. Not having adequate staffing resource creates safety risks, as well as the ability to positively contribute to care plans and multi-disciplinary team (MDT) meetings, facilitate contact with whānau, and supervise leave from the unit with mokopuna. Not being able to complete basic nursing requirements for mokopuna who are acutely unwell negatively impacts upon mokopuna journey to wellness.

Cultural capacity and capability varied across sites.
Whilst some facilities go above and beyond to support the cultural needs of mokopuna and create an environment committed to increasing cultural capability, other facilities were greatly lacking in any cultural vision or practice.

Across the board there was a lack of kaimahi Māori. Often responsibilities to uphold kawa and tikanga fell on named roles that were spread across many different services, which could impact on availability with resource being so minimal and stretched.

Areas of strength

Minimal restrictive practice
Restrictive practices such as restraint holds and seclusion were only used as a last resort, where there was escalated behaviours and concern for mokopuna harming themselves or others. Across all facilities there had been a decrease in the use of restraints and minimal use of seclusion.

Eliminating the use of seclusion and minimising restraint holds is achievable and currently being practiced in some in-patient mental health facilities in Aotearoa New Zealand.

Mana Mokopuna encourages these practices to be adopted across the sector, in line with international human rights and children's rights standards.

Caring relationships between kaimahi and mokopuna
Efforts were made to build rapport with mokopuna to gain a more holistic understanding of their care needs. In some facilities mokopuna had assigned workers that worked closely with them to facilitate a positive and needs-centred treatment experience. Mokopuna demonstrated they felt comfortable asking kaimahi for help and displayed the same care and consideration for one another that had been role-modelled to them.

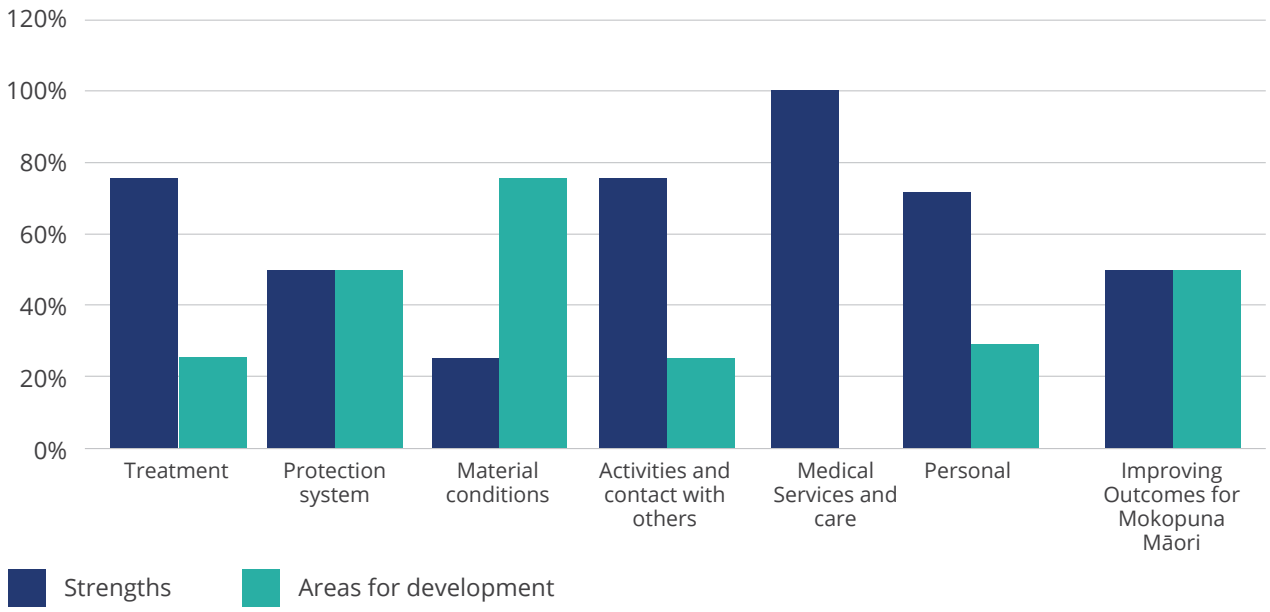
Mokopuna have a voice in their stay
Mokopuna and their whānau were involved in care planning and were encouraged to contribute to treatment plans. Efforts were made to ensure mokopuna were involved in decision-making through inclusion in MDT and community meetings, which allowed them to have autonomy in their care experiences. Admissions to the wards were also often tailored around the need and presentations of mokopuna, and mokopuna were made aware of their rights through informational booklets and verbally. Whānau are actively encouraged to visit mokopuna on the ward. Many whānau said they felt well-informed with what was happening for their mokopuna.

Mokopuna also had good access to a variety of activities across all facilities, with kaimahi keeping mokopuna engaged, and structuring programmes around their interests and goals. Education was also largely built around mokopuna presentations and interests, with kaimahi role-modelling positive engagement and one-on-one lessons provided as necessary.

Strong leadership underpins a positive workplace culture.
Across facilities, leadership teams fostered environments where there was a lack of hierarchy and all kaimahi felt valued and were treated equally. Teamwork and mutual respect were a significant part of daily practice and MDT meetings were inclusive of all. Collectively this approach had a positive impact upon staff culture and subsequently staff practice, which fed into strong external relationships. Kaimahi felt that opportunities to attend supervision and training were adequate.

Summary of Findings by Domain

Percentage of Strengths vs Areas for Development for Mental Health Facilities



Special Purpose Facility run by Barnardos

Mana Mokopuna undertook a visit to the special purpose facility for children with harmful sexual behaviour over the 2022-2023 period. This service is operated by Barnardos behalf of Oranga Tamariki.

The standard of care provided by this facility was exceptional and there were only a few areas requiring development.

Areas of development

Property maintenance needs to be swift
Property maintenance requests can be lengthy processes and take a long time to be signed off and actioned. During the visit the main kitchen was not operational due to a fire, and make-shift facilities were not appropriate. Likewise, mokopuna highlighted the importance of having access to dedicated spaces for self-regulation, and quiet spaces away from others as being important to them. The sensory room was run-down and not fit-for-purpose. Mokopuna noted it would be useful if this space was better equipped with sensory modulation 'toys' and equipment.

Relationships between kaimahi and mokopuna are influential and require careful management Mokopuna can be placed in the special purpose facility for a considerable period of time. Due to the length of stay, mokopuna build strong relationships with the kaimahi. In testament to this, mokopuna noted the impact when kaimahi had left the home and they did not get to say goodbye, which caused periods of dysregulation and anxiety. For some mokopuna, it put their treatment plans on hold while they took time to adjust to new kaimahi. It is critical that every staff transition is well planned to avoid setbacks in mokopuna treatment progress.

Areas of strength:

Mokopuna voice is elevated and their needs are central to decision making.
Mokopuna were given multiple avenues to exercise their voice, provide feedback or put complaints forward, and had good access to independent advocates. Mokopuna could raise issues with staff directly, were supported to submit grievance forms or write letters to management, and to fill in forms for smaller issues or requests. Mokopuna could also put forward nominations for a staff member of the month, were actively involved in assessment and treatment processes, and had platforms to communicate their thoughts and feelings during regular community meetings. Having multiple avenues for mokopuna to exercise their right to have a say had a notable positive impact in care experiences for mokopuna. Mokopuna needs and interests were also consistently centred across their access to activities, education, and healthcare with support from kaimahi.

Strong relationships between kaimahi and mokopuna.
Mokopuna are assigned key workers who have aligned interests and with whom they easily connect and engage. It was evident this matching helped foster strong and supportive relationships and mokopuna were able to identify adults they trusted and could confide in. Kaimahi understood the importance of upholding the therapeutic model of care and consistently role-modelled pro-social behaviours. The impact of maintaining strong, healthy relationships was clear in how mokopuna engaged with one another and handled dysregulation.

Comprehensive assessment supports successful admissions and transitions.
Assessments and treatment plans were excellent, with clear treatment pathways and rationales and plans were updated regularly. Transition pathways are key to ensuring that mokopuna are able to thrive outside of the residential environment and there were a number of success stories. Factors which supported a solid transition out of the residence were: placement options are identified early; and the way all kaimahi work intensely and collaboratively with mokopuna, their whānau, community organisations, and specialists to fully support a placement.

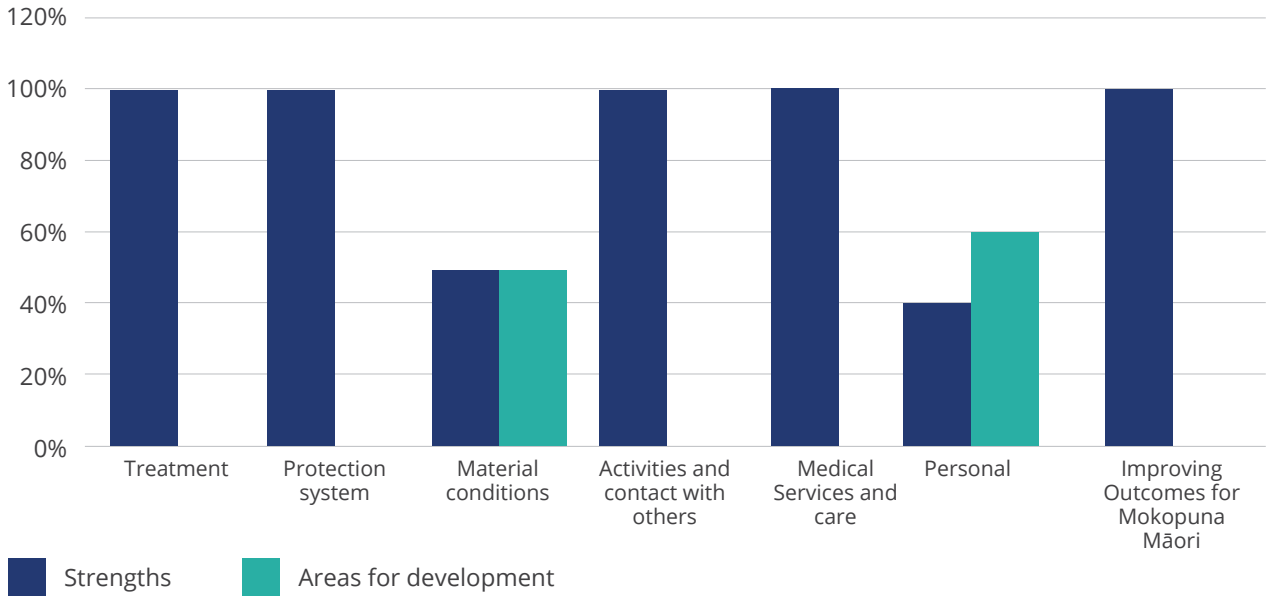
However, it is worth noting that there is a lack of quality community placement options for mokopuna when they cannot return to whānau. This can lead to lengthier stays at the facility even if they have successfully completed their treatment.

A tidy, clean and well-resourced facility.
The facility was very tidy and clean with beautiful cultural artwork throughout, and numerous windows to let in light. Mokopuna bedrooms were well-resourced with en suites and the opportunity to be personalised. There was a wide array of equipment available to mokopuna to entertain themselves both inside and outside within the grounds of the residence. Fences were painted with artwork, and trees were being planted on the outer side of the fence to disguise it without compromising community safety.

There is a commitment to uphold cultural practice.
The facility had developed a cultural framework to improve cultural competency and embed mātauranga Māori concepts into practice and everyday operations, with a focus on supporting the needs of mokopuna, their whānau, and developing the cultural capacity of kaimahi. There was a general approach towards honouring every culture, and a dedicated effort in assisting mokopuna to understand their identity and their link to whānau.

Summary of Findings by Domain

Percentage of Strengths vs Areas for Development for Special Purpose Facility



In Summary

National staffing shortages across sectors remain an ongoing and prominent issue which has wide-ranging impact on how facilities operate. The influence on kaimahi is immense. This unfortunately has a knock-on impact upon practice and the care experienced by mokopuna. It is important that kaimahi have good access to appropriate induction, training, supervision, and work schedules. Without these in place, mokopuna care and safety is compromised. Youth Justice residences demonstrated the impacts of operating in 'survival mode' with limited resource, which led to harm for mokopuna.

Community remand homes consistently demonstrate positive findings, which contrasts with that of Youth Justice residences. These findings provide good evidence that community models work. Mana Mokopuna continue to advocate for the expansion of this resource. Key areas to highlight across sectors include good whānau contact, some positive relationships between kaimahi and mokopuna, and shifts toward holistic therapeutic models of practice. 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[45]. Education is a strength in spaces of detention and mokopuna centric approaches help foster good engagement.

Across sectors, mokopuna are needing more meaningful activities, better living conditions, consistent engagement from their social workers, access to independent complaints processes and advocates, and more community placement and transition opportunities.

There is still a lot of work to be done across sectors when it comes to creating a foundation for mokopuna Māori to thrive, as cultural models, capability and practice varies across facilities. What is clear is that facilities with more kaimahi Māori, have successfully implemented models to uphold cultural capability and as a result are fostering environments where mokopuna are flourishing.

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

NPM contacts

Independent Police Conduct Authority

0800 503 728 (toll free)
Language Line available
Telephone 04 499 2050
Email enquiries@ipca.govt.nz
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Inspector of Service Penal Establishments

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

Mana Mokopuna | Children and Young People's Commission

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