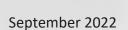


Fairness for all

OPCAT Report

Report on an announced targeted inspection of Manawatu Prison under the Crimes of Torture Act 1989



Peter Boshier

Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman Tari o te Kaitiaki Mana Tangata





OPCAT Report: Report of an announced follow-up inspection of ManawatuPrison under the Crimes of Torture Act 1989

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Introduction

The following report has been prepared in my capacity as a National Preventive Mechanism (NPM), as designated under the Crimes of Torture Act 1989 (COTA). The purpose of the COTA is to enable Aotearoa New Zealand to meet its international obligations under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and its Optional Protocol (OPCAT).¹

I am empowered to examine places of detention: where people are unable to leave at will. My designation includes prisons. Central to this is conducting visits and inspections. This has a preventive purpose, to ensure that safeguards against ill-treatment are in place and that poor practices, or systemic problems, are identified and addressed promptly.

My role is to form an independent opinion as to the conditions and treatment in these places, report my findings and if necessary make recommendations for improvement.

More information

Find out more about the Chief Ombudsman's OPCAT role, and read my reports online: ombudsman.parliament.nz/opcat

Overview of inspection

Inspection approach

Ombudsmen are designated as one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining the treatment of, and conditions applying to, detainees in Aotearoa New Zealand prisons.

From 29 September to 1 October 2021, a team of two Inspectors, whom I have authorised to carry out visits to places of detention under COTA on my behalf, made an announced three-day inspection of the Prison. At the time of this inspection, the Prison was operating at COVID-19 Alert Level 3.² For this reason, the inspection was shorter and more focused than a full inspection, and this is why it is referred to as a 'targeted inspection'.

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. More information about OPCAT and the Chief Ombudsman's National Preventive Mechanism (NPM) function can be found at https://www.ombudsman.parliament.nz/what-we-can-help/monitoring-places-detention/why-ombudsman-monitors-places-detention

See https://covid19.govt.nz/alert-system/covid-19-alert-system/ for more about New Zealand's COVID-19 alert system.

In assessing conditions and treatment for prisoners, my Inspectors focussed on three main areas. Those areas were:

- Treatment;
- Decency, dignity and respect; and
- Health and wellbeing.

To ensure an evidence-based approach, my Inspectors gathered and assessed a range of information, including:

- information and documents from the Department of Corrections and the Prison, including relevant policies and practice guidance;
- interviews with prisoners and staff; and
- observations within the prison, with a focus on service delivery, facilities and relevant meetings.

Consultation on provisional report

A provisional report was provided to the Prison and to the Department of Corrections for comment. I received a response from the Department of Corrections on behalf of Corrections and the Prison. I have had regard to their comments when preparing my final report.

Follow-up inspections will be made to monitor the implementation of my recommendations.

Facility Facts

Manawatu Prison (the Prison) is the smallest prison in the North Island, based in Linton, south of Palmerston North. The Prison has capacity for 252 minimum to high security prisoners, including remand prisoners, and employs 165 full-time equivalent staff. The Prison falls within the Department of Corrections (Corrections) Lower North region.

There were 227 prisoners in the Prison on 29 September 2021, when this inspection started, so it was operating at approximately 90 percent capacity. Of those prisoners, 104 (46 percent) were on remand, with 56 (25 percent) awaiting trial and another 48 (21 percent) awaiting sentencing. Of sentenced prisoners (120, or 53 percent of the prison population), 23 (10 percent of the prison population) were serving sentences up to two years in duration. Corrections data identified 123 prisoners (54 percent) were Māori. This compared with 16.5 percent of the general population of Aotearoa New Zealand.³ At the time of inspection, there were no prisoners aged under 18 at the Prison. A short description of the residential units in the Prison is set out in Appendix 1.

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At the 2018 Census. Statistics New Zealand. *New Zealand's population reflects growing cultural diversity.*Wellington, 2019. Accessed on 18 November 2021 at www.stats.govt.nz/new-zealands-population-reflects-growing-diversity

I last conducted a full inspection of the Prison in 2016,⁴ and a follow-up inspection in 2017.⁵

Key observations and recommendations

The Prison was managing significant complexity at the time of the inspection, with COVID-19 safety requirements in place, a variety of security classifications and categorisations, and construction work. In light of these challenges, I am grateful to the Prison staff and the prisoners for their assistance during the inspection.

Since my last visit to the Prison in 2017, the Prison had made a number of changes that improved the conditions and treatment of prisoners. In particular, a new model of care provided to young prisoners in the dedicated Tū Mai Unit was an extremely positive initiative, with significant potential to reduce recidivism. I encourage Corrections to explore implementation of this or a similar programme in other prisons. Corrections responded to my provisional report advising that they were considering expanding similar initiatives in other locations.

I welcome the Prison's approach to management of unwell prisoners in the hauora (wellness) focus area in B Block. This was used for prisoners with mental health challenges who needed a higher level of support than was available in the wider Prison. Despite efforts to improve the environment in the safe cells, which were rundown at the time of my 2017 inspection, these were still not suitable for managing unwell prisoners, and I make a recommendation to limit their use. Similarly, the Separates cells were rundown, and the Prison was limiting their use.

Inspectors saw evidence of early revocation of directed segregation orders in some cases, which reflects good practice, despite minor deficiencies in paperwork. Safer Custody Panel meetings were held regularly and were well attended. Significant investment had been made in security measures, improving safety for prisoners and prison staff. A shortage of meaningful activity for prisoners had been identified as contributing to a high number of incidents. ⁶ Corrections responded to my provisional report outlining the work they were undertaking regarding the provision of meaningful activity, and I discuss this below.

Use of force incidents were generally followed up with acceptable paperwork and timely reviews, however, I am concerned at the use of pepper spray. The Department of Corrections have indicated an intention to provide additional training around the use of pepper spray, and I make a recommendation about this. Corrections responded to my provisional report stating, 'Under the five-point Violence and Aggression Action Plan, all training is going to be reviewed in terms of content and methodology.'

⁴ Report on an unannounced inspection of Corrections Service Manawatu Prison Under the Crimes of Torture Act 1989, January 2016.

Report on an unannounced follow-up inspection of Manawatu Prison Under the Crimes of Torture Act 1989, December 2017.

An 'incident' could include a range of events, such a prisoner receiving bad news which indicates some monitoring of their behaviour is appropriate, through to assaults by prisoners or uses of force by Corrections staff.

The Prison was managing challenges presented by aging buildings, and inspectors saw significant effort had been made to improve the Prison environment. Nonetheless, B Block is reaching the end of its useful life, and I make a recommendation to Corrections and the Prison to prioritise the decommissioning of B Block. In responding to my provisional report, Corrections advised that most units at the Prison, including B Block, had been identified as poor quality based on Opus reports of 2015 and 2018. However, 'any decisions about units at the Prison needed to be considered in the context of the long-term prison network configuration plan'. In my report I discuss my concern about the time that has elapsed since 2016 when I recommended B Block be decommissioned and replaced. I also make a recommendation to resolve a problem with the doors to the C Block Programmes Rooms, to allow these rooms to be used for their intended purpose. Corrections have since advised that they were seeking quotes for the design and installation of doors to the Programmes Rooms in Block C to correct the issue.

I was pleased to see an increase in mental health provision since my 2016 inspection. The Prison was also taking steps to address long wait times for dental care, and I note an aging steriliser could create new delays if it breaks down before it is replaced. COVID-19 vaccinations were being rolled out at the Prison, although the high population turnover made tracking vaccinations challenging.

Recommendations

I make the following recommendations for improving the conditions and treatment of those in the Prison:⁷

Recommendations to the Prison

- The Prison only use safe cells for the shortest possible period of time. This is discussed on page 7.
- The Prison undertake remedial work to the doors of the C Block Programmes Rooms as a matter of priority, and the rooms be reinstated for constructive activity. This is discussed on page 12.

Recommendations to the Department of Corrections

- The Department of Corrections provides additional use of force training to all staff authorised to use pepper spray, which includes training on de-escalation techniques and alternatives to pepper spray. This is discussed on page 11.
- The Department of Corrections prioritises the decommissioning and replacement of B Block with a modern, fit for purpose, building. This is discussed on page 11.

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I am empowered by section 27 of the Crimes of Torture Act 1989 to make recommendations for improving the conditions and treatment of detention applying to detainees and for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Recommendations to the Prison and the Department of Corrections

 The Department of Corrections and the Prison cease intrusive CCTV monitoring as a matter of priority, and implement monitoring solutions that ensure the dignity and respect of all prisoners. This is discussed on page 8.

Discussion of key observations

Tū Mai Unit

The Tū Mai Unit is a new initiative for young prisoners aged between 18 and 30. It aims to provide a safe environment for prisoners to focus on rehabilitative programmes. 'Tū Mai' ('stand up') uses the mottos 'I stand on my own two feet' and 'I stand with resilience'. Operation of the Tū Mai Unit is based on te ao Māori. The Unit appears to be well-aligned with Corrections' *Hōkai Rangi* strategy⁸ to address outcomes for Māori.

The Unit includes a communal kitchen and dining area to encourage positive relationships and interactions. Prisoners signed an agreement to adhere to certain 'standards' on entry to the Tū Mai Unit, and the Unit had its own rules ($Ng\bar{a}\ Kawa\ O\ Te\ Whare\ O\ Tu\ Mai$). All prisoners in the Tū Mai Unit had jobs, and were kept busy with programmes and chores on the Unit. Openly displayed star charts were used to 'promote accountability in behaviour'. Prisoners had individualised rehabilitation plans, which included engagement with whānau.

Inspectors observed positive relationships between prisoners and staff in the Unit. The two staff mentors (Tū Mai Pou Arahi) in the Unit did not wear stab resistant vests, to promote engagement with the prisoners. Prisoners spoke of the Unit with pride, and Inspectors observed it to be a warm, welcoming environment, with evident manaakitanga. The Prison advised 'success rates' in the Tū Mai Unit were high, at 72 percent in June 2021, and estimated at 87 percent at the time of inspection. I am very pleased to hear of the success of the Tū Mai Unit in supporting young prisoners and improving their outcomes.

The Prison had piloted Whakatutuki Moemoeā, a 12 week programme, in partnership with Te Tihi O Ruahine Whānau Ora Alliance, in late 2020. All participants had come from the Tū Mai Unit. Whakatutuki Moemoeā means 'to realise one's aspirations' and 'fulfil one's dreams', and explored:

Department of Corrections. Hōkai Rangi: Ara Poutama Aotearoa Strategy 2019-2024. 2019. The strategy document can be viewed online at https://www.corrections.govt.nz/resources/strategic reports/corrections strategic plans/hokai rangi

⁹ Te Aka Māori Dictionary defines manaakitanga as 'hospitality, kindness, generosity, support – the process of showing respect, generosity and care for others.' Accessed online at maoridictionary.co.nz on 23 November 2021.

Success rates were calculated by the Prison. The Prison advised that for prisoners on long sentences, success means ongoing placement in low security areas, while for prisoners with short sentences and remand prisoners, success means not returning to prison after release.

'... how a Whānau Ora approach can be implemented in order to create meaningful pathways for tāne who are transitioning back into the community from prison, and in the process support the reduction of reoffending rates for Māori....'11

Key to this programme was the involvement of a Whānau Ora Navigator, or Kaiwhakaaraara, supporting prisoners and their whānau in the weeks leading up to and following a person's release. Inspectors were provided with a paper evaluating the pilot of Whakatutuki Moemoeā. While success rates in the Tū Mai Unit were high, 'success rates' of 100 percent were achieved by those who went through Whakatutuki Moemoeā. This is extraordinary, and I encourage the Prison to pursue the Whakatutuki Moemoeā programme on an ongoing basis. I also encourage Corrections to look at which aspects of the Tū Mai Unit model, and the Whakatutuki Moemoeā programme, could be implemented more widely.

Corrections responded to my provisional report advising that Whakatutuki Moemoeā was a pilot programme initially funded until 30 June 2021, and the programme would not be continuing in its entirety because, 'Ongoing funding could not be secured for the external Kaiwhakaaraara role past this date.' However, they stated that, 'many of the beneficial aspects introduced, including the dedicated case managers and Pou Arahi of the unit, will continue to provide support for the men participating in the project.'

Corrections said they were considering expanding similar initiatives in other locations as part of their wider Hōkai Rangi initiatives. They provided a number of examples, including work the Youth Team was beginning 'to explore operating models for the management of young adults under 25 years outside of youth/young adult spaces'. This work would draw on learnings from Tū Mai, the existing youth units, and Te Ara Tauwhaiti at Rimutaka. I will follow the progress of these initiatives with interest.

Mauri Ake hauora area

Mauri Ake, an area of B Block, had been upgraded and renovated to serve as a hauora (wellness) focus area for prisoners with mental health challenges who needed a higher level of support than that available in the wider Prison. At the time of inspection, five cells were available in this area, and work was underway to convert a corridor into a lounge environment. There were also plans to remodel an outside area, to provide a sensory outdoor environment including a grassed area. Prisoners in Mauri Ake were supported with weekly multi-disciplinary team meetings involving health and custodial staff and mental health services. The Mauri Ake area is close to the Unit Manager's office, and Inspectors saw that the Unit Manager regularly engaged with the prisoners. I welcome the Prison's approach to the management of unwell prisoners in this more-tailored environment.

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¹¹ Dr Michelle Levy, Lisa Cherrington. *Whakatutuki Moemoeā: Tāne, Whānau and Key Informant Perspectives.* April 2021. [Please note that this document is not publicly available.]

¹² See footnote 11 which discusses how success rates were calculated by the Prison.

Safe cells for at-risk prisoners

The Prison did not have an Intervention Support Unit for at-risk prisoners. Instead, there were four 'safe cells', 13 including one dry cell 14 located in B Block.

In my 2016 inspection report, I noted the safe cells created 'a detrimental environment for individuals already struggling with significant mental health issues.' Inspectors saw the Prison had made significant efforts to improve the safe cells, painting them in bright colours, providing temporary furniture in the associated yards, upgrading showers and removing mould. Corrections responded to my provisional report stating they are committed to improving support for at-risk people. They advised that as part of 'efforts to create more humanising and healing environments' they had begun refurbishment of the safe cells to create a 'more therapeutic environment'. Since the inspection 'appropriate forensic in-patient furniture' had reportedly been installed to 'create softer and more welcoming common spaces'.

I acknowledge these efforts. However, based on my observations during the inspection, I remain concerned regarding the suitability of these environments for the ongoing management of individuals who are at risk of self-harm. My recommendation later in this report regarding the decommissioning of B Block reflects my agreement with Corrections that the space is not fit for purpose.

The Prison advised that between 1 June and 31 August 2021, there were 16 occasions when atrisk prisoners were assigned to safe cells. The majority of these stays were between one to two days, however six prisoners were held in safe cells for between five and 12 days. Inspectors found no evidence that the dry cell had been used to accommodate at-risk prisoners.

Corrections responded to my provisional report noting that it 'ensures people spend as little time as possible in safe cells' and reflecting agreement that people should not spend long periods in safe cells 'where avoidable'. However, the length of stays in safe cells at the time of my inspection did not, in my view, demonstrate this. Given this, I recommend the Prison only use safe cells for the shortest possible period of time.

I acknowledge information that Corrections provided in response to my provisional report that five adjacent cells were now being used as a 'step-up/step-down unit' to support prisoners if their mental wellbeing was deteriorating, or to transition them back to their home units from the safe cells. I consider this an initiative which may assist in meeting my recommendation.

In responding to my concerns about the length of time some at-risk prisoners were in safe cells Corrections also said that 'moving all people who are at risk of self-harm away from their whānau or local community can have a negative impact on their mental health and compound

¹³ A safe cell is designed to reduce opportunities for self-harm, for example by removing ligature points, and increase observation of prisoners, such as by constant CCTV monitoring.

A dry cell is used for prisoners to prevent the concealment or disposal of unauthorised items (Rule 64(2) of the Corrections Regulations 2005). It contains nothing but a mattress on a concrete plinth. Prisoners do not have free access to toilet facilities or drinking water. Prisoners cannot be placed in a dry cell unless subject to directed segregation under section 60(1)(a) of the Corrections Act 2003 (Corrections Regulations 2005, r 64(1)).

their existing distress', and therefore a case-by-case approach to managing at-risk prisoners was taken. Corrections opined that there may therefore be situations where it is preferable for a person to remain in a safe cell at Manawatu rather than being transferred to a facility with an ISU. I consider this further exemplifies the need for an appropriate environment to be available at the prison.

CCTV monitoring of safe cells

Prisoners in safe cells were subject to constant CCTV monitoring, including while using the toilet. I have repeatedly raised concerns, and made recommendations, regarding the use of intrusive CCTV monitoring in prisons, and my view that this may amount to degrading treatment under Article 16 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Corrections have advised that Senior Leaders were to consider a paper with options in relation to areas such as the ISU.

The Department of Corrections responded to my provisional report, advising that it was considering the potential to implement technology to pixilate CCTV footage and undertaking further work to enhance the privacy of people in prison. I consider that meaningful progress needs to be achieved in this area. I recommend that the Department of Corrections and the Prison cease intrusive CCTV monitoring as a matter of priority, and implement monitoring solutions that ensure the dignity and respect of all prisoners.

Separates Cells

In my 2016 inspection report, I noted the Separates cells in B Block were run down and not fit for purpose and I recommended these cells be decommissioned. The cells are still in operation, and my concerns remain. As with the safe cells discussed above, the Separates cells are subject to intrusive CCTV monitoring.

However, at the time of this inspection, Prison senior management advised that the cells were not being used while COVID-19 restrictions were in place at the Prison, and are not generally used at other times, unless no alternative is available. I acknowledge the Prison's efforts to reduce the use of separates cells, but reiterate my view that these cells should be permanently decommissioned. I discuss this further below on page 9.

Directed segregation

The Prison does not have a Management Unit for prisoners on directed segregation.¹⁵ Instead, prisoners subject to directed segregation are housed in one of three designated cells, located in B Block. These cells were dark, with limited natural light. Inspectors saw that showers and yards had been updated since my 2017 inspection. Despite these updates, the cells were still not of an adequate standard.

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¹⁵ Segregation is the restriction or denial of a prisoner's opportunity to associate with other prisoners. It may be initiated by the Prison Director or at a prisoner's request, under sections 57 to 60 of the Corrections Act 2004.

Information provided by the Prison showed that between 1 June and 31 August 2021, 15 prisoners had been subject to directed segregation. Three were segregated 'for the good order or security of the prison' (section 58(1)(a) of the Corrections Act 2004), 11 were segregated 'to protect the safety of another prisoner or other person' (section 58(1)(b)), and one was segregated 'for medical oversight' (section 60).

Directed segregation paperwork

Inspectors reviewed the Prison's directed segregation register for the same period. Two prisoners had their directed segregation orders extended, and records showed the proper process had been followed, including approval by the Regional Senior Advisor. I am pleased to hear my Inspectors found evidence that, in several cases, directed segregation orders were revoked early. This shows ongoing assessment of the circumstances of individual prisoners, and is essential as a fundamental safeguard against the misuse of directed segregation. The register, however, was not updated with the end date of the order, instead showing the date the order was legally permitted to run to. I expect these records to show the correct dates.

Corrections responded to my provisional report advising that the Prison had started a review of the directed segregation database to see if improvements could be 'immediately identified and flagged'. The Prison identified that knowledge of custodial system management practice sat with one person and 'not all of it is widely known'. They said, 'Succession planning and wider training of the Custodial Systems Manager role will be prioritised.' Work to integrate segregation documentation into IOMS (Corrections' Integrated Offender Management System) was to begin by the end of February 2022.

Safety

Inspectors saw records showing that Safer Custody Panel meetings were held weekly, apart from a break when COVID-19 Alert Levels 3 and 4¹⁷ were in place. Records showed these meetings were well attended, with comprehensive minutes.

There had been significant security upgrades at the Prison since my 2017 inspection. Inspectors told me a single point of entry, thermal camera imaging, and improved cell phone detection technology, have all been implemented. At the time of inspection there were no double-bunking arrangements in place. Inspectors also noticed there was no graffiti in the Prison.

However, there was a high number of incidents at the Prison, at 64 incidents per 100 prisoners noted in Safer Custody meeting minutes for September 2021. The reported causes for the high

Rule 43 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the 'Nelson Mandela Rules') prohibits the use of prolonged solitary confinement, which is defined as periods in excess of 15 consecutive days. Directed segregation orders under sections 58 and 59 of the Corrections Act 2004 expire after 14 days unless extended by the chief executive or a visiting justice, so extensions to directed segregation orders will generally result in a period of solitary confinement in excess of 15 days, therefore amounting to prolonged solitary confinement.

¹⁷ See https://covid19.govt.nz/alert-system/covid-19-alert-system/ for more about New Zealand's COVID-19 alert system.

incidents included high reporting levels, layout of facilities, and lack of programmes for prisoners. I am pleased the Prison is assessing the root causes of incidents. I encourage the Prison and Corrections to explore opportunities to occupy prisoners' time, including programmes, activities, and work, as part of the solution.

Corrections responded to my provisional report stating they are, 'considering access to interventions nationwide as part of our wider enterprise planning programme', with a Service Delivery Plan due to be presented to the Investment Committee in April 2022. The Chief Psychologist was also to present a paper to the Investment Committee in June 2022 outlining how new services could further address the needs of the remand population. These are both important initiatives, and I will follow their progress with interest.

Corrections also advised that more meaningful activities would become available once the programmes room was operational. I discuss this further in the 'Building issues' section of this report.

Use of force, including pepper spray

Information provided by the Prison showed there had been 20 use of force incidents between 1 June and 1 October 2021. Use of force paperwork was completed to an acceptable standard, and reviews of use of force incidents were generally timely.

Four of the incidents included the use of pepper spray, and one of those included use of Mark 9 Pepper Spray (Cell Buster) in a planned cell extraction. One pepper spray deployment occurred during the inspection.

Inspectors reviewed video footage of all four pepper spray incidents. Inspectors assessed that on at least one occasion, verbal warnings were not given, and alternatives along the continuum of force were not adequately attempted before pepper spray was deployed.

I have raised concerns in other OPCAT reports about the increasing use of pepper spray and some of the circumstances in which it has been used in Aotearoa New Zealand prisons. ¹⁸ I am concerned about the use of pepper spray in prisons, in particular what appears to be a low threshold for deployment. I also consider that the use of pepper spray in confined spaces and in cases of passive resistance may be in breach of New Zealand's international human rights obligations.

I am aware that Corrections provided advice to the Minister on the regulations and the training provided around the use of force, including pepper spray. The new regulations came into force on 1 April 2022 but do not address my concerns with its use. At minimum, I expect staff to consider and attempt other interventions before deploying pepper spray. In responding to my provisional report, Corrections agreed that, 'non-forceful alternatives for managing an incident are always preferable'. They acknowledged there is room for improvement in terms of the skilful use of these alternatives, and advised that where a use of force review finds alternative

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¹⁸ See, for example, Final report on an unannounced inspection of Auckland Prison under the Crimes of Torture Act 1989, December 2020; Report on an unannounced follow up inspection of Otago Corrections Facility under the Crimes of Torture Act 1989, June 2019.

actions could have been used to de-escalate an incident, recommendations for refresher training in Tactical Options will be mandatory for the staff involved.

Regarding training, Corrections advised, 'Under the five-point Violence and Aggression Action Plan, all training is going to be reviewed in terms of content and methodology. This will be a wide-ranging piece of work and will include our Tactical Options training.' With that in mind, I recommend Corrections provides additional use of force training to all staff authorised to use pepper spray, including training on de-escalation techniques and alternatives to pepper spray.

Building issues

B Block

In my 2016 inspection report, I recommended the accommodation in B Block be decommissioned and replaced with cells that were fit for purpose. In 2017, Corrections advised that an upgrade of B Block was to be considered in future planning. The Prison has since carried out significant remedial work. Walls and doors had been repainted in bright colours, mould issues had been addressed, and showers and yards had been upgraded. I was pleased to see these improvements and acknowledge the efforts made. However, this work could not address fundamental issues with the B Block layout, which limits clear lines of sight and restricts the use of space.

Corrections responded to my provisional report and agreed that B Block is not fit for purpose. However, they said any decisions about B Block needed to be considered in the context of the long-term prison network configuration plan. This plan was due to be finalised by the end of March 2022. However, at the time of finalising my report this had been extended to the end of December 2022.¹⁹

I am deeply concerned about the time that has elapsed since 2016 when I recommended B Block be decommissioned and replaced. Corrections have informed me that the 'poor quality' of units at the Prison, including B Block, was identified in 2015. While I appreciate the planning, investment and time required to make changes to infrastructure, I consider it unacceptable that despite awareness of the deficiencies inherent in the building, decisions are still unable to be made about the future of B Block seven years later. I also consider that any remedial work should not be an alternative to, or reason to delay, addressing the fact that B Block is not fit for purpose. Management of prisoners is increasingly difficult in the environment Block B presents, as it is not consistent with modern prison standards. I recommend Corrections prioritises the decommissioning and replacement of B Block with a modern, fit for purpose, building.

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¹⁹ Corrections provided this information in their response to the Arohata Prison provisional report.

Programmes Rooms in C Block

The Programmes Rooms in C Block had been identified as posing a security risk, due to the rooms' doors opening inwards, not outwards, making it harder for staff to maintain control over movements through the door. As a result the Prison had stopped using these rooms for prisoner activities.

The Prison had previously identified challenges finding appropriate spaces to run programmes (discussed earlier in this report in relation to 'safety'), which limited prisoners' access to meaningful activities, and the unavailability of these rooms compounded this. Corrections responded to my provisional report advising they were seeking quotes for the design and installation of doors to the Block C Programmes Rooms that would open outwards. I recommend the Prison undertake remedial work to the doors of the C Block Programmes Rooms as a matter of priority, and the rooms be reinstated for constructive activity.

Access to hot water

Inspectors were told by some prisoners they had difficulty accessing hot water in the low security areas before around 10am each morning. This included one prisoner who needed hot water at 4am for spiritual reasons. I encouraged the Prison to investigate this issue, and make any improvements required, in my provisional report.

Corrections responded by advising that the Prison investigated this issue but had been unable to substantiate it. I appreciate the Prison following up on this potentially significant concern, and the assurances from Corrections that prisoners can access hot water at all times.

Health services

Health care services at the Prison appeared to have improved since my 2016 inspection. However, Inspectors were told there had been no Clinical Governance meeting in the 12 months prior to the inspection, due to the impacts of COVID-19. I consider that these meetings are important to maintain and improve health services during a pandemic, and encourage the Prison to explore alternative ways of holding these meetings, such as meeting remotely. Following the inspection, Corrections informed me that a clinical governance meeting was to be held by 31 March 2022. However, this meeting was subsequently rescheduled to 26 July 2022, due to COVID-19 related staff shortages. I reiterate my encouragement for these meetings to take place regularly.

Primary health care services

The Health Care Centre was well-maintained, clean and tidy, and appeared to be functioning well. Inspectors were told there were good relationships between Health Care and custodial staff. While there were vacancies for two nursing staff at the time of inspection, recruitment was underway.

Dental services

It was positive to note that Inspectors saw the dentist on-site during the inspection. However, the average wait for dental care at the time of inspection was 34 days for urgent treatment, or 49 days for non-urgent care. Inspectors were told there were three prisoners who had been waiting over 100 days each for non-urgent dental care. In my view, these wait times for dental treatment are unacceptable. I acknowledge, however, that the Prison was taking steps to reduce the waiting list, including holding regular dental clinics. I consider it important that improvements are made to ensure timely access to dental services.

Corrections responded to my provisional report advising that additional funding had been sourced to address the dental waiting list. Extra clinics were being organised by the Regional Operations Director, Health. They stated that the clinics were to begin as soon as possible and go through to June 2022.

Inspectors were informed that while the dental suite had been upgraded, the steriliser was due for replacement. I encourage the Prison to ensure this equipment be replaced before it stops working, as a delay in provision of dental care while a replacement is sourced could undo the good work undertaken to address wait times.

Mental health provision

At the time of inspection, 10 prisoners were under forensic mental health care. The Prison had a forensic mental health nurse (the Clinical Nurse Specialist) on-site, who acted as a single point of contact between the mental health and custodial staff. The timely and accurate sharing of information between custodial and health staff is critical, and I am pleased to hear this role has been established to support this.

A forensic psychiatrist held a fortnightly clinic at the Prison. Weekly multi-disciplinary team meetings were being held for prisoners with moderate mental health needs.

COVID-19 vaccinations

COVID-19 vaccinations were being rolled out at the Prison. At the time of inspection, 154 prisoners (64 percent of the population) had received their first dose. It is pleasing to hear that ongoing vaccination arrangements are in place, particularly considering approximately 46 percent of the prison population were remand prisoners at the time of inspection (108 of 227 prisoners), which contributes to population turnover and challenges tracking vaccination.

Acknowledgement

I appreciate the full co-operation extended by the Prison Director and staff to the Inspectors during their inspection of the Prison. I acknowledge the work involved in collating the information requested. My thanks to the prisoners for their participation and assistance.

Peter Boshier

Chief Ombudsman
National Preventive Mechanism

Appendix 1. Short description of residential units

Building	Unit	Unit description	Capacity
B Block	Remand 1	High security remand unit	10 double cells and 2 single cells
B Block	Tu Mai	Specialist programme holding young prisoners	12 single cells
B Block	Multi A	High security remand unit	12 double cells
B Block	Multi B	High security remand unit	16 single cells
	Safe cells	Non-residential	4 cells
	Isolation	Non residential	3 cells
CA Block	Wing 1	Cells 1-15 Sentenced/ CAS prisoners Cells 16-30 Remand Accused segregation prisoners	30 single cells
CA Block	Wing 2	CAS/ Sentenced segregation prisoners	32 single cells
CB Block	Wing 3	High security mainstream and CAS prisoners	30 single cells
CB Block	Wing 4	High security mainstream and CAS prisoners	38 single cells
TKW - Te Kaitiaki Wairua		Low security segregated unit	60 single cells
TWM – Te Whare Mahi		Low security working unit	20 single cells

Appendix 2. Legislative framework

In 2007 the New Zealand Government ratified the *United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT).

The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention – prisons

Section 16 of COTA defines a "place of detention" as:

"...any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in...

(a) a prison ...

Ombudsmen are designated by the Minister of Justice as a National Preventive Mechanism (NPM) to inspect certain places of detention under OPCAT, including prisons.

Under section 27 of COTA, an NPM's functions include:

- to examine the conditions of detention applying to detainees and the treatment of detainees; and
- to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - for improving the conditions of detention applying to detainees;
 - for improving the treatment of detainees; and
 - for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Carrying out the OPCAT function

Under COTA, Ombudsmen are entitled to:

- access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
- unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
- interview any person, without witnesses, either personally or through an interpreter; and

choose the places they want to visit and the people they want to interview.

Section 34 of COTA provides that when carrying out their OPCAT function, Ombudsmen can use their Ombudsmen Act (OA) powers to require the production of any information, documents, papers or things (even where there may be a statutory obligation of secrecy or non-disclosure) (sections 19(1), 19(3) and 19(4) OA). To facilitate his OPCAT role, the Chief Ombudsman has authorised inspectors to exercise these powers on his behalf.

More information

Find out more about the Chief Ombudsman's OPCAT role, and read his reports online: ombudsman.parliament.nz/opcat.