BEFORE THE UNITED NATIONS HUMAN RIGHTS COMMITTEE

Nathalie Prouvez
Secretary of the Human Rights Committee
Office of the High Commissioner for Human Rights
United Nations Office at Geneva
8-14 Avenue de la Paix,
CH- 1211 Geneva 10
Switzerland

IN THE MATTER OF NEW ZEALAND'S 5TH PERIODIC REPORT

SECOND SET OF ADDITIONAL INFORMATION IN SUPPORT OF LIST OF ISSUES COMPLIED BY THE COMMITTEE AND THE SHADOW REPORT – FILED BY TONY ELLIS, BARRISTER OF THE HIGH COURT OF NEW ZEALAND

AUTHOR: TONY ELLIS
Barrister
Blackstone Chambers
P.O. Box 24347
Wellington
New Zealand
Email: ellist@jhug.co.nz

STATE PARTY: NEW ZEALAND
1. Since preparing the first set of additional information two relevant reports have issued one from the Independent Police Complaints Authority ("IPCA") and the other from The Human Rights Commission in respect of monitoring places of detention under OPCAT.

Question 4 and 23 of List of issues: Article 2—Delayed Investigations

2. In respect of the IPCA the Chairperson Justice Goddard said in a press release (annexed):¹

   "The Authority was notified in June of delays in the Police response to child abuse cases in the Wellington District, in particular the Wairarapa. At that time the Authority opted to oversee a Police investigation. In August, the Authority announced that it was conducting its own investigation.

   "The Authority has established a dedicated team of investigators and lawyers focusing solely on this inquiry. The assigned investigators have extensive international Police experience," said Authority Chair Justice Lowell Goddard.

   "The Authority has received evidence that there have been delays or issues with management of child abuse cases in districts other than the Wairarapa and is therefore treating this as a nationwide enquiry."

   The inquiry is focused on Police conduct, and Police practices, policies and procedures, in relation to child abuse cases.

   It will consider the manner in which child abuse cases are received, prioritised and investigated by Police, and the efficacy of Police practices, policies and procedures, both past and present.

   As part of the inquiry, the Authority is conducting an independent audit of child abuse cases throughout New Zealand, and investigating complaints about Police handling of child abuse cases.

3. It would seem delayed investigations have the potential to be worse than I had first indicated. No doubt the Committee would appreciate a copy of the IPCA report, and the Government's response prior to the next 5 yearly periodic report from the State party.

Question 13 of List of Issues Articles 6, 7 and 10 (Mental Health)

Human Rights Commission Monitoring Places of Detention

4. This second report under OPCAT was released 18 December 2009.²

5. See the report at page 12 (selected pages annexed):

Potential cruel and inhuman treatment (mental health)

The Chief Inspector encountered two cases that caused much concern. One involved a mental health patient who had been in virtually constant restraint and seclusion for nearly six years to prevent the patient from assaulting other patients and staff. Another example was a young mentally disabled patient, held pursuant to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, who had been kept in seclusion for a lengthy period.

In both instances the Chief Ombudsman wrote to the respective Chief Executives of the District Health Boards concerned. As a result, one patient has been moved to a more suitable facility and the other now has a management plan to facilitate a move into a suitable community based facility.

6. Whilst the report contains a number of worrying aspects these two points are singled out.

7. Whilst the Chief Ombudsman has written to the Chief Executive of the Health Boards, The Committee might care to ask, what inquiry (if any) has the State party instigated and/or what steps have the State party taken to ensure that those unlawfully detained receive a personally effective remedy including being advised of their legal rights in a meaningful way relating to the Chief Ombudsman findings, and has any compensation be advised as possibly payable, or paid, and if not, why not?

8. No doubt a a mental health patient detained in seclusion (solitary confinement) for six years would have had little understanding of his/her rights not to treated in such a fashion, and/or a right to a lawyer, and plainly little chance of exercising those rights, and presumably little understanding of what steps to now take to obtain an effective remedy.

9. The Committee is also invited to consider its jurisprudence on solitary confinement, and the recent comment of the Committee Against Torture in respect of Azerbaijan CAT/C/AZE/CO/3, 19 November 2009, at paragraph 13:

...The State party should limit the use of solitary confinement as a measure of last resort, for as short a time as possible under strict supervision and with a possibility of judicial review.

Tony Ellis
Barrister of the High Court of New Zealand
4 January 2010
Inquiry into Police handling of child abuse cases

22 December 2009 - The Independent Police Conduct Authority’s inquiry into Police handling of child abuse cases will cover all of New Zealand, the Authority said today.

The Authority was notified in June of delays in the Police response to child abuse cases in the Wellington District, in particular the Wairarapa. At that time the Authority opted to oversee a Police investigation. In August, the Authority announced that it was conducting its own investigation.

"The Authority has established a dedicated team of investigators and lawyers focusing solely on this inquiry. The assigned investigators have extensive international Police experience," said Authority Chair Justice Lowell Goddard.

"The Authority has received evidence that there have been delays or issues with management of child abuse cases in districts other than the Wairarapa and is therefore treating this as a nationwide enquiry."

The inquiry is focused on Police conduct, and Police practices, policies and procedures, in relation to child abuse cases.

It will consider the manner in which child abuse cases are received, prioritised and investigated by Police, and the efficacy of Police practices, policies and procedures, both past and present.

As part of the inquiry, the Authority is conducting an independent audit of child abuse cases throughout New Zealand, and investigating complaints about Police handling of child abuse cases.
People with relevant information, such as Police staff, social workers and staff of child welfare agencies, families and other members of the public, can also make submissions, which will be received in confidence – details are available on the Authority’s website www.ipca.govt.nz/Site/Child-Abuse-Inquiry/default.aspx.

“The Authority is concerned about past delays in completing investigations,” said Justice Goddard. “Our inquiry will determine the extent of those delays, and what lessons can be learned to ensure that future investigations are completed effectively and in a timely manner.”

The Authority’s inquiry is being conducted independently of Police, who have been working to address a backlog in child abuse cases in the Wairarapa, and are also conducting internal inquiries.

None of the IPCA investigators assigned to the Authority’s inquiry has been a member of New Zealand Police.

The Authority will publicly report once its inquiry is completed.

Privacy | Accessibility | About this site | newzealand.govt.nz

Inquiry into Police handling of child abuse cases

22 December 2009 - The Independent Police Conduct Authority’s inquiry into Police handling of child abuse cases will cover all of New Zealand, the Authority said today.

The Authority was notified in June of delays in the Police response to child abuse cases in the Wellington District, in particular the Wairarapa. At that time the Authority opted to oversee a Police investigation. In August, the Authority announced that it was conducting its own investigation.

“The Authority has established a dedicated team of investigators and lawyers focusing solely on this inquiry. The assigned investigators have extensive international Police experience,” said Authority Chair Justice Lowell Goddard.

“The Authority has received evidence that there have been delays or issues with management of child abuse cases in districts other than the Wairarapa and is therefore treating this as a nationwide enquiry.”

The inquiry is focused on Police conduct, and Police practices, policies and procedures, in relation to child abuse cases.

It will consider the manner in which child abuse cases are received, prioritised and investigated by Police, and the efficacy of Police practices, policies and procedures, both past and present.

As part of the inquiry, the Authority is conducting an independent audit of child abuse cases throughout New Zealand, and investigating complaints about Police handling of child abuse cases.

People with relevant information, such as Police staff, social workers and staff of child welfare agencies, families and other members of the public, can also make submissions, which will be
Monitoring Places of Detention

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

1 July 2008 to 30 June 2009
SUMMARY OF ACTIVITIES
A significant number of scoping visits have been completed, as have a number of focused visits. Focused visits are inspection-type visits that can vary from a full inspection of a particular unit within a facility to a shorter visit that focuses on specific areas. These areas may or may not have been identified as of potential concern by the Chief Inspector on behalf of the Ombudsmen.

The Chief Inspector and the Chief Ombudsman have had several meetings with various civil society groups, the Department of Corrections and some District Inspectors of Mental Health. These meetings have proven to be a valuable source of information about the facilities over which the Ombudsmen have jurisdiction, as well as providing an opportunity to explain the Ombudsmen’s role under the Crimes of Torture Act and clarify any issues or concerns.

As at 30 June 2009, 89 scoping visits to the following facilities have been completed:

- Immigration: 2
- Mental Health sites: 74
- Care & Protection residences: 1
- Prisons: 11
- Court cells: 1

Eighteen focused visits have been completed for the following facilities:

- Mental Health Units: 15
- Prisons: 2
- Immigration: 1

However, it is estimated that in excess of 120 facilities will need to be visited to fulfill the delegation to monitor and inspect prisons, immigration, health and disability places of detention, child care and protection residences and youth justice residences.

Because of the significant amount of work the OCPAT responsibility will require, the Ombudsmen intend to increase the number of inspectors during the next financial year, subject to resourcing being made available.

ISSUES
There are a number of significant areas of concern that have been identified during both the scoping visits and the focused visits.

Potential cruel and inhuman treatment (mental health)
The Chief Inspector encountered two cases that caused much concern. One involved a mental health patient who had been in virtually constant restraint and seclusion for nearly six years to prevent the patient from assaulting other patients and staff. Another example was a young mentally disabled patient, held pursuant to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, who had been kept in seclusion for a lengthy period.

In both instances the Chief Ombudsman wrote to the respective Chief Executives of the District Health Boards concerned. As a result, one patient has been moved to a more suitable facility and the other now has a management plan to facilitate a move into a suitable community-based facility.
The Chief Inspector has advised:

- There are not enough forensic beds to cater for the "ballooning" number of offenders with mental health problems.
- Some offender/patients returned to prison were transferred to District Health Board jurisdiction without notice to the hospital by the Department of Corrections and while the offender was still undergoing treatment by the forensic team. This potentially compromised the patient's ongoing treatment.
- Some patients are being held in secure care longer than necessary because of a shortage of suitable community-based accommodation.

Various mental health personnel spoken to by the Chief Inspector have confirmed these concerns.

**Invalid legal paperwork (mental health)**

The Chief Inspector discovered patients being held in mental health facilities, and whose treatment included the use of seclusion and restraint, where there was no valid documentation authorising their detention. Authorisation includes:

- court orders
- Power-of-attorney documents
- Protection of Personal and Property Rights Act documentation
- signed patient consent forms.

In one instance a patient had been treated for some years without any apparent consent of any kind. Once these issues were drawn to the attention of the respective managers and District Health Board Chief Executives, the necessary paperwork was obtained and the treatment validated.

The issue of what constitutes "informed consent" has also been identified by the Ombudsmen as an area of concern, especially in the case of elderly persons. An elderly person may well have been mentally capable of giving informed consent when first admitted to a hospital. However, a question arises as to whether (and if so when) that informed consent ceases to be informed with the onset of dementia, Alzheimer's or other debilitating illness. The Chief Ombudsmen has asked the Chief Inspector to explore this issue further with relevant agencies.

**Unlawful detention (prisons) — hybrid orders**

There was one instance of unlawful imprisonment uncovered on inspection by the Chief Inspector, following a complaint to the Ombudsmen from a prisoner's mother.

The situation revolved around those offenders who are considered fit to plead and fit to stand trial and be convicted, but are not considered fit by the court to serve any term of imprisonment in a prison. These people become subject to an order made under the Criminal Procedure (Criminal Impaired Persons) Act 2003, which requires they be detained in a hospital. These orders are sometimes known as hybrid orders.
The offender was brought before the Parole Board (several months after his eligibility for parole) and was released back into the care of the hospital. The Parole Board imposed release conditions, including the possibility of recall to prison. When the offender subsequently (and supposedly) breached his parole conditions while still an in-patient, he was recalled to prison for a month. When it was established that, pursuant to the provisions of the Parole Act 2002, he should not have been recalled to prison — as the release conditions did not commence until he was released from hospital — he was returned to the mental health facility. The month spent in prison was then clearly unlawful detention.

As a result of further enquiries, the Ombudsmen understand there were over 20 such offenders in the New Zealand prison system. At least one other offender had been denied their lawful appearance before the NZ Parole Board “as soon as practicable after the expiration of the non-parole period of their sentences”. This appeared to be due to little information being collectively available to the Department of Corrections, Ministry of Justice, Courts, the NZ Parole Board and Mental Health Services, as to who these offenders were, what their legal entitlements were in regards to parole eligibility, where they were located, or whose responsibility they were.

As a result of the Ombudsmen’s enquiries under the Crimes of Torture Act, this situation has now largely been resolved. However, the Ombudsmen will continue to incorporate such enquiries as part of their monitoring role.

Non-smoking policies (mental health sites)

Various District Health Boards have introduced, or are in the process of introducing, no-smoking policies at campuses across the country. This is having an impact on patients who smoke.

As an NPM, the Ombudsmen have no set view on this issue and note that it may be tested through the courts. The Ombudsmen may consider investigating specific complaints about such a policy where warranted under the Ombudsmen Act.

Prisons – fans in prisoner cells

In 2007, the Department of Corrections assured the Ombudsmen:

“...where temperatures exceed policy guidelines and there is no other option for temperature control and/ventilation in that cell, Prison Services will provide prisoners with individual fans, subject to safety and security considerations and availability of electrical facilities.”

The Ombudsmen understand this was never implemented, as individual prisons were not notified of that instruction. Since then, Prison Services has removed the ability for prisoners to purchase their own fans with their own funds. There are prisoners who are without family and friends to provide funds for the purchase of an individual fan. Taking into account all circumstances of a prisoner’s detention (including the increase of “lock-down” time, and doubling up of prisoners in cells designed for one prisoner), the Ombudsmen are concerned that excessive
temperatures could amount to cruel or inhuman treatment under the Crimes of Torture Act. They will continue to monitor this issue. The Chief Inspector raised this issue at a recent meeting with Assistant Regional Managers of the Department of Corrections and was assured that the ability for prisoners to purchase their own fans had been reinstated, and prisoners without sufficient funds would have fans provided to them.

On-site reaction from staff and local hospital and prison management

The Ombudsmen are pleased to report that the Chief Inspector has generally received co-operation from staff and management at the various sites visited. Feedback has indicated that the visits are seen as worthwhile. The Chief Inspector has been able to allay misgivings or concerns about what the OPCAT visits are about and provide practical assistance in addressing issues relating to the humane treatment of those in detention.