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[REDACTED]

RE Official information request CDHB 10036

I refer to your email received 5 February 2019, requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

In the Ombudsman's report on Te Whare Manaaki it mentions a 2014 report on the same unit.

- **Does the CDHB have a copy it can provide?**

Please refer to **Appendix 1** (attached) for a copy of the Chief Ombudsman's 2014 report on Te Whare Manaaki Unit.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website after your receipt of this response.

Yours sincerely



Carolyn Gullery
Executive Director
Planning, Funding & Decision Support



Ombudsman

Fairness for all


.....
COTA Report

Report on an announced visit to Te Whare Manaaki Unit Under the Crimes of Torture Act 1989

31 July 2014
.....

Dame Beverley Wakem, DNZM, CBE
Chief Ombudsman
National Preventive Mechanism

.....
Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata



Contents

Executive Summary	5
Background	5
Summary of findings	5
Recommendations	6
Consultation	6
Te Whare Manaaki comments	6
Facility Facts	7
Te Whare Manaaki Unit	7
Region	7
District Health Board (DHB)	7
Operating capacity	7
Last inspection	7
Director Area Mental Health Services	7
Charge Nurse Manager	7
The Visit	8
Visit methodology	8
Recommendations from previous reports	9
Evidence	9
Treatment	9
Torture or cruel, inhuman or degrading treatment	9
Seclusion	9
Restraints	12
Recommendations - treatment	12
Protective measures	12
Complaints process	12
Records	12
Recommendations – protective measures	13
Material conditions	13
Accommodation	13
Recommendations – material conditions	13
Activities and communications	14
Outdoor exercise	14
Leisure activities	14
Access to visitors/external communications	14
Recommendations – activities and communications	15
Acknowledgement	15
Appendix 1. Photographs	16

Appendix 2. Overview of OPCAT – Health and Disability places of detention _____ 18

Tables

Table 1: Seclusion episodes 1 January - 30 June 2014 _____	11
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Figures

Figure 1: Seclusion room _____	10
Figure 2: Low-stimulus/admissions area _____	10
Figure 3: Seclusion room used as bedroom _____	11
Figure 4: De-escalation lounge _____	11

Executive Summary

Background

1. In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA¹), with responsibility for examining and monitoring the general conditions and treatment of patients in New Zealand secure hospitals.
2. On 31 July 2014, Inspector Jacki Jones (to whom I have delegated authority to carry out visits of places of detention under COTA) visited Te Whare Manaaki Unit which is part of Hillmorton Hospital complex.
3. This report will also address **two** recommendations made following a visit in May 2010.

Summary of findings

4. The Inspector's findings may be summarised as follows:
 - The interactions between staff and patients were respectful and appropriate.
 - Patients in the Unit have no problem communicating with family and friends, either during a visit or through the telephone/mail.
 - Patients have access to daily fresh air.
 - There is a comprehensive activities programme for both individuals and groups.
 - There appears to be no issues with the complaints system and clients are able to contact the District Inspectors direct.
 - Accommodation was clean, tidy and well maintained.
 - There are adequate bathroom and laundry facilities in the Unit.
 - All patients had the necessary legal documentation to be detained and treated them in the Unit.
 - Staff leadership was noticeable in the Unit.
 - The two recommendations made following our inspection in 2010 have been implemented.

¹ Acting under delegation of the NPM Chief Ombudsman Dame Beverley Wakem and Ombudsman Professor Ron Paterson.

5. The issue that needed addressing was as follows:
- There was no evidence that any patients had been subject to any action which could be construed as torture in the six months preceding the visit. However, the use of seclusion rooms as bedrooms could potentially amount to cruel or inhuman treatment.

Recommendations

6. I recommend that:
- a. The seclusion rooms should not be used as long term accommodation (bedrooms) for those difficult to manage, or difficult to place patients. The DHB, in conjunction with the Ministry needs to find alternative accommodation for the highly complex individual currently accommodated in seclusion.

Consultation

7. A draft copy of this report was forwarded to Te Whare Manaaki for comment as to fact, finding or omission prior to finalisation and distribution.

Te Whare Manaaki comments

Thank you for the opportunity to comment.

Te Whare Manaaki and SMHS have worked with DSS for nine years and intensively for the past two years on a plan to transition this consumer to a community residential provider. The community provider withdrew due to concerns about the safety and security of the community property.

SMHS has requested that this consumer be transferred to Wellington's Secure ID unit Haumietiketike but this request has also been unsuccessful.

The CDHB will engage with the Ministry of Health in regard to a long term permanent home for this consumer, most likely this home would be on hospital property.

Facility Facts

Te Whare Manaaki Unit

Was built in 1991 and is one of three secure forensic units at Hillmorton Hospital. The Unit receives referrals from the Courts, Prisons, and other Forensic Services.

The Canterbury Regional Forensic Psychiatric Service (CRFPS) is dedicated to assessing and treating people that have acted violently in the context of mental disorder, or who may be at risk of doing so. It also caters for prisoners that require inpatient treatment².

Region

Canterbury Regional Forensic Psychiatric Service – covers Canterbury, South Canterbury, the West Coast and Nelson Marlborough

District Health Board (DHB)

Canterbury

Operating capacity

15 (plus three seclusion rooms)

Last inspection

Announced inspection - May 2010

Unannounced visit – July 2008

Director Area Mental Health Services

Sue Nightingale

Charge Nurse Manager

Leigh Tabak

² Consumer/Family Whanau Information Kit. Specialist Mental Health Services. Canterbury DHB.

The Visit

8. The visit of Te Whare Manaaki Unit took place on 31 July 2014 and was conducted by Inspector Jacki Jones.

Visit methodology

9. The Manager of the Te Whare Manaaki Unit provided the following information:
 - A list of patients and the legislative reference under which they were being detained (at the time of the visit).
 - The seclusion and restraint data for the previous six months and the seclusion and restraint policy.
 - A copy of the complaints for the previous six months and the complaints policy.
 - Information for patients/family on admission.
 - Weekly activities programme.
 - A list of all staff trained in the use of restraint and reasons for those not up to date.
10. At the commencement of the visit the Inspector met with the Manager before being shown around the Unit. On the day of the visit there were 14 male patients in the Unit (two in seclusion).
11. The following areas were examined on this occasion to determine whether there had been torture or inhuman or degrading treatment or punishment, or any other issues impacting adversely on detainees³.

Treatment

- Torture, or cruel, inhuman or degrading treatment
- Seclusion
- Restraints

Protective measures

- Complaints process
- Records

Material conditions

- Accommodation

³ Our inspection methodology is informed by the Association for the Prevention of Torture's Practical Guide to Monitoring Places of Detention (2004) Geneva, at www.apt.ch.

Activities and communications

- Outdoor exercise
- Leisure activities
- Access to visitors.

Recommendations from previous reports

12. The Inspector followed up on **two** recommendations made following an inspection in May 2010, which were:
 - a. Where a patient subject to an order under section 34(1)(a)(i) of the Criminal Procedure (Mentally Impaired Person) Act is received, the hospital authorities contact the nearest prison.
 - b. In order to facilitate the safety, security and privacy of the patients and members of the public, the perimeter wall (fence) needs to be extended to cover the shortfall around the Unit.
13. These recommendations will be addressed in the body of the report.

Evidence

14. In addition to the documentary evidence provided prior to the visit, the Inspector interviewed the Manager, staff and patients of the Unit, inspected records, was provided additional documents upon request by the staff, and observed the facilities and conditions.

Treatment

Torture or cruel, inhuman or degrading treatment

15. There was no evidence that any patients had been subject to any action which could be construed as torture in the six months preceding the visit. However, the use of seclusion rooms as bedrooms could potentially amount to cruel or inhuman treatment.

Seclusion

Seclusion facilities

16. There are three seclusion rooms (all with toilet facilities) located within the low-stimulus/admissions area. A small de-escalation lounge leads from the low-stimulus area and can also be accessed through the main unit.



Figure 1: Seclusion room



Figure 2: Low-stimulus/admissions area

17. All areas were clean, tidy and well maintained. Seclusion rooms have privacy blinds, drinking water and a means of calling staff (alarm).
18. A small, vehicle access area doubles as an exercise yard for patients being managed in seclusion. While the surroundings are blank concrete walls, there is shelter and seating available.



Vehicle access

Seclusion policies and incidents

19. Patients being admitted into the Unit are not routinely admitted into a seclusion room and can go into the main unit (behaviour dependant) – which was encouraging to see.
20. There were 299 seclusion episodes involving 14 patients and a total seclusion time of just under 4,153 hours for the period 1 January – 30 June 2014. This can be broken down as follows:

Table 1: Seclusion episodes 1 January - 30 June 2014

	Events	People	Hours	Average hours
January	47	5	765.98	16.30
February	35	5	543.90	15.54
March	42	3	616.74	14.68
April	51	5	613.13	12.02
May	44	3	566.37	12.87
June	80	5	1024.45	13.08
Total	299	Actual = 14	4152.57	-

21. One patient sleeps in seclusion on a permanent basis and accounts for 213 seclusion episodes (just over 71 per cent), and just over two thirds of seclusion hours (2857.36). If this person is excluded from the statistics the average number of seclusion events each week would be just over three.
22. The patient who sleeps in seclusion (due to their unpredictable and potentially harmful behaviour) has been living in seclusion since 2009. On average, they are locked in their room between 15 and 16 hours a day. When unlocked, they spend a significant amount of time watching TV in the de-escalation lounge.

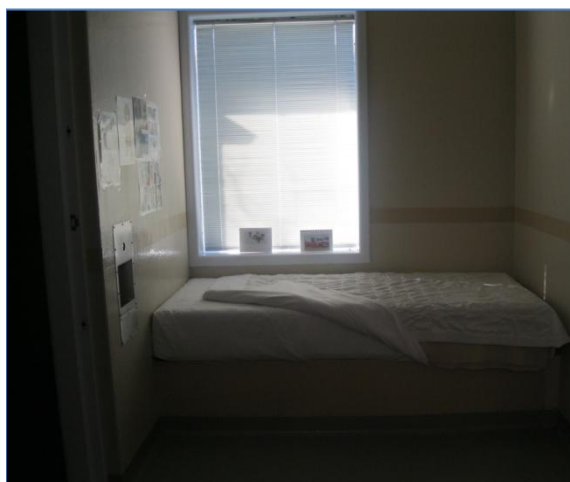


Figure 3: Seclusion room used as bedroom



Figure 4: De-escalation lounge

23. Seclusion, low-stimulus and de-escalation are designed as short term solutions for highly agitated patients who require interventions and actions until a calmer state ensues, these areas are not intended as long term accommodation facilities for patients with challenging and disruptive behaviour.
24. Despite the best efforts of staff, the quality of life for this patient is poor.

Restraints

25. There were 333 restraint incidents involving 14 patients for the period 1 January – 30 June 2014. The patient sleeping in seclusion on a permanent basis accounts for 228 restraint incidents (68.4 per cent). If this person is excluded from the statistics the average number of restraint incidents each week is four.
26. Six members of staff were out of date with their calming and restraint/de-escalation training but were booked to attend in the coming weeks.

Recommendations - treatment

- a. The seclusion rooms should not be used as long term accommodation (bedrooms) for those difficult to manage, or difficult to place patients. The DHB, in conjunction with the Ministry needs to find alternative accommodation for the highly complex individual currently accommodated in seclusion.

Protective measures

Complaints process

27. The complaints process is readily available and can be found in both the consumer and family information kit. Contact details for District Inspectors were displayed in the Unit and in the information kit. Four District Inspectors visit the Unit on a regular basis.
28. The number of complaints in the last six months was eight (five by the same patient). All complaints were responded to appropriately and within the requisite timeframes.
29. Posters and leaflets for the Health and Disability Commissioner's Office and the Patient Advocacy Service are readily available.

Records

30. There were 14 patients in the Unit on the day of the visit and the Inspectors checked all of their files.
31. Ten patients were being detained under the Mental Health (Compulsory Assessment and Treatment) Act and four under the Criminal Proceedings (Mentally Impaired Persons) Act.

32. All files contained the necessary paperwork to detain and treat the patients in the Unit.
33. In 2010 we recommended that a system be put in place with local prisons for patients being detained under section 34(1)(a)(i) of the Criminal Proceedings (Mentally Impaired Persons) Act to ensure parole end dates (PEDs) and sentence release dates (SRDs) were accurate, upon admission into the Unit.
34. The Unit put several checks in place, including checking PEDs and SRDs dates at the first clinical case conference. The Manager said they had not experienced any further problems with ensuring prisoners attend their parole hearing.
35. All patients have a primary nurse and an associate nurse who develop a treatment plan within 24 hours of admission. Patients are given a signed copy of their plan which is updated on a regular basis.

Recommendations – protective measures

- I have no recommendations to make.

Material conditions

Accommodation

36. The Unit was clean, tidy and well maintained and has been repainted and had new carpets since our previous visit.
37. Patients have their own bedroom with integral toilet and hand washing facilities, privacy screening, and sufficient storage for personal possessions. New curtain fittings (anti-ligature) were being fitted on the day of the visit.
38. There is no night seclusion in the Unit and patients can enter and exit their bedrooms any time of the day or night – which is commendable.
39. There are a sufficient number of showers within the Unit for the number of patients, and a laundry facility for those wanting to launder their own clothes.
40. The Unit has a reasonable size gymnasium with a small selection of gym equipment, a computer/library room and large communal which doubles as a dining area.
41. In order to facilitate the safety, security and privacy of the patients, we recommended (in 2010) to extend the perimeter fence to cover the shortfall round the Unit. This has now been completed.

Recommendations – material conditions

- I have no recommendations to make.

Activities and communications

Outdoor exercise

42. Patients are able to access a large outdoor area with adequate seating and shade.



43. The Inspector had no concerns with patients' access to outdoor exercise.

Leisure activities

44. A fulltime Occupational Therapist provides a structured programme of daily activities which includes both individual and group work. There is a reasonable sized activity room for such things as art and craft and a small kitchen for cooking sessions.
45. Some patients have walking privileges and are able to leave the Unit to undertake activities (both escorted and unescorted).
46. From the observations of the Inspector and speaking with staff and patients, there are sufficient activities available for patients in the Unit.

Access to visitors/external communications

47. Visits to patients are by arrangement and usually limited to 30 minutes. Supervised visits are from 10am – 3pm, unsupervised visits are from 10am – 8pm. This is explained to patients, family/whanue on admission into the Unit.
48. No visits occur on the Unit, there is a specifically designed visitor room at the entrance to the Unit.
49. There is a patients' telephone in the Unit which was in constant use during the visit.

50. Patients can send and receive mail.

Recommendations – activities and communications

- I have no recommendation to make.

Acknowledgement

51. I appreciate the full co-operation extended by the Manager and staff to the Inspector during her visit to the Unit. I also acknowledge the work involved in collating the information sought by the Inspector.

Dame Beverley Wakem DNZM, CBE
Chief Ombudsman
National Preventive Mechanism

Appendix 1. Photographs



Gymnasium



Sensory modulation room



Activities room

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
(120 → 1145 stop at morning & Edna)		Names on board lunches Thurs by 8:30 Today		Morning tea with item to edit - shopping.
MORNING MEETING				
TEA BREAK				
0930 AM		940 - Work group	940 - work group	930 - Games
	11am - Circuits with Kelly	1030 - VPG (closed group)		1030 - VPG (closed group)
Buy up list & Edna 11:30-12				
LUNCH + BREAK				
1200 PM				
1pm Sport with Kelly	1pm - ward meeting with Matt + Melissa	1230 - lawn mowing	1pm - Sport with Kelly	1pm - kitchen replacement
3pm - music with Mike	2:30 - Education group (Richard from Hagley)			1:30 - drop in
<p>* Friday Buy Up Write on small whiteboard from Thursday 8:55 maximum - 1 done only</p> <p>Food Service requires no less than 24 hours notice of meal cancellations. Therefore all games must be on whiteboard by Breakfast time Thursday for menu planning</p>				

Weekly activities

Appendix 2. Overview of OPCAT – Health and Disability places of detention

1. 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.
2. 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. 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...

 - (d) *a hospital*
 - (e) *a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003...*”
3. Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.
4. Under section 27 of COTA, an NPM’s functions, in respect of places of detention, include:
 - a. to examine the conditions of detention applying to detainees and the treatment of detainees; and
 - b. to make any recommendations it considers appropriate to the person in charge of a place of detention:
 - i. for improving the conditions of detention applying to detainees;
 - ii. for improving the treatment of detainees;
 - iii. for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.
5. To facilitate the exercise of their NPM functions, the Ombudsmen have delegated their powers to inspect places of detention to Inspector’s (COTA). This is to ensure that there is a clear distinction between the Ombudsmen’s preventive monitoring function under OPCAT and the Ombudsmen’s investigation function under the Ombudsmen.