Canterbury
District Health Board
Te Poari Hauora ō Waitaha

CORPORATE OFFICE

Level 1
32 Oxford Terrace
Christchurch Central
CHRISTCHURCH 8011

Telephone: 0064 3 364 4160
Fax: 0064 3 364 4165
Ralph.lasalle@cdhb.health.nz

16 February 2021

9(2)(a) [redacted]

[redacted]

[redacted]

RE Official information request CDHB 10506

I refer to your email dated 10 December 2020, requesting the following information under the Official Information Act from Canterbury DHB. Specifically:

1. **The name, location and number of beds for each mental health and intellectual disability unit (this includes forensic units) operated by your DHB.**

Please refer to **Table One** below, which lists the name, location and number of beds for each of the mental health and intellectual disability units operated by Canterbury DHB.

Table one

Service	Ward	Beds
Adult Inpatient	East MH Inpatient	16
Adult Inpatient	North MH Inpatient	16
Adult Inpatient	South MH Inpatient	16
Adult Inpatient	West MH Inpatient	16
AOD Detox	Kennedy	6
Child and Adolescent	CAU	16
Forensic	Te Whare Mauriora	13
Forensic	Te Whare Manaaki	15
Forensic	Te Hohou Roko	9
Intellectual Disability	MH ATR	7
Intellectual Disability	Aroha Pai Inpatient	14
Rehab	Seager Clinic	24
Rehab	Tupuna	15
Mothers & Babies - Eating Disorders	C Ward	19

2. **All reports carried out by the Ombudsman in the past five years on any one of these units.**

Please refer to previous Official Information Act response for CDHB 9996 which contains the OPAC reports for 2018 and which is posted on the Canterbury DHB website: https://www.cdhb.health.nz/about-us/document-library/?_sft_document_type=official-information-act-response

Additionally, please refer to **Appendix 1** attached, which contains four Ombudsman reports from the past five years which have not already been released.

3. **For each unit, please provide the occupancy data for the 12 months ending November 30. What I mean by this is the average occupancy (in bed numbers) each month and the number of times the unit was caring for more patients than it had beds.**

Please refer to **Table Two** below, which shows the average occupancy data for each of Canterbury DHB's mental health and intellectual disability units per month for the year November 2019 to November 2020.

Table Two

Service	Ward	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Number of days unit had more patients than beds*
Adult Inpatient	East MH Inpt	106%	88%	88%	74%	54%	57%	81%	82%	77%	82%	86%	82%	91
Adult Inpatient	North MH Inpt	83%	94%	89%	77%	60%	52%	80%	81%	70%	76%	89%	86%	52
Adult Inpatient	South MH Inpt	91%	88%	89%	88%	70%	64%	92%	84%	77%	93%	95%	88%	41
Adult Inpatient	West MH Inpt	88%	84%	85%	72%	41%	45%	75%	79%	80%	89%	85%	85%	27
AOD Detox	Kennedy	88%	72%	84%	64%	0%	53%	106%	81%	95%	82%	83%	81%	13
Child and Adolescent	CAU	24%	33%	47%	49%	36%	53%	65%	45%	58%	67%	56%	60%	0
Forensic	Te Whare Mauriora	63%	68%	77%	73%	73%	52%	82%	80%	77%	65%	51%	46%	0
Forensic	Te Whare Manaaki	98%	95%	89%	85%	82%	91%	92%	90%	78%	82%	80%	87%	0
Forensic	Te Hohou Roko	97%	94%	90%	90%	94%	96%	97%	100%	94%	87%	98%	99%	0
Intellectual Disability	MH ATR	74%	80%	83%	86%	73%	80%	86%	86%	66%	57%	57%	57%	0
Intellectual Disability	Aroha Pai IP	53%	50%	62%	69%	59%	54%	55%	52%	35%	51%	52%	39%	0
Rehab	Seager Clinic	83%	83%	76%	70%	80%	89%	86%	90%	93%	90%	92%	87%	0
Rehab	Tupuna	78%	77%	74%	70%	70%	76%	80%	76%	91%	94%	97%	96%	0
Mothers & Babies - Eating Disorders	C Ward	53%	43%	69%	65%	30%	46%	52%	54%	68%	67%	85%	88%	1

***Please note:** Where there are any instances of units having more patients than beds, Canterbury DHB employs strategies to locate a designated bedroom for these patients in an alternative unit. Additionally, for Forensic and Intellectual Disability units we also negotiate with the Forensic Coordination Service (FCSID) around finding alternative community beds (consumers who come through under court orders).
Canterbury DHB does not accept admissions if we do not have capacity to care for people appropriately. Please also refer to the response for Question 4.

4. **Please describe what strategies your DHB employs to house and care for people in mental health and intellectual disability units if there are too few beds. Does your DHB turn office space/seclusion rooms into bedrooms? If not, how do you manage demand.**

Canterbury DHB only cares for consumers in designated bedrooms. When demand is high we use a number of strategies appropriate to the needs of the individual, for example: providing additional support through the community teams and NGO providers to maintain someone in the community; accommodating consumers, for a short period, in an alternative unit; supporting individuals to go on overnight leave or early discharge with support from our community teams.

For specialist units such as the Forensic and Intellectual Disability Units we will negotiate with the Forensic Coordination Service (FCSID) around finding alternative community beds (consumers who come through under court orders). However, we will decline admissions if we do not have capacity to care for people appropriately.

Please also refer to **Table Three** below, which details the number of patients accommodated in an alternative unit for each month from December 2019 to November 2020. The data shown is from the adult acute inpatient units.

Table Three[1]

	East Inpatient	North Inpatient	South Inpatient	West Inpatient	Total
Dec-19	5	0	1	0	**6**
Jan-20	0	0	0	0	**0**
Feb-20	3	1	1	1	**6**
Mar-20	5	5	11	6	**27**
Apr-20	0	0	0	0	**0**
May-20	0	0	0	0	**0**
Jun-20	2	0	1	0	**3**
Jul-20	1	1	1	2	**5**
Aug-20	7	0	0	0	**7**
Sep-20	1	0	0	2	**3**
Oct-20	18	2	0	2	**22**
Nov-20	6	1	11	7	**25**

[1] This may be due to demand, anticipated demand or clinical situations that require someone to be cared for in an alternative unit.

5. **Please provide the most recent engineering/building report for each of your mental health and intellectual disability units (again, this includes forensic units).**

Please refer to previous Official Information Act responses for CDHB 9930, CDHB 9917 and CDHB 9881 which contain reports on Hillmorton facilities and are posted on the Canterbury DHB website: https://www.cdhb.health.nz/about-us/document-library/document-type/official-information-act-response/?sf_paged=12

Additionally, please refer to **Appendix 2** attached, which contains the two latest building/inspection reports for Canterbury DHB's mental health and intellectual disability facilities.

6. **Please provide the self-assessment data collected by your DHB and submitted to the Ministry of Health for each of your mental health and intellectual disability units.**

The self-assessment data for Canterbury DHB's mental health and intellectual disability units was collected by an online tool and sent directly to the Ministry of Health. The Canterbury DHB does not hold or keep a record of this information. We are therefore declining a response to this part of the request pursuant to 18(g) of the Official Information Act, i.e. "*that the information requested is not held…"*

I trust this satisfies your interest in this matter.

You may, under section 28(3) of the Official Information Act, seek a review of our decision to withhold information by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz; or Freephone 0800 802 602.

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

Ralph La Salle
Acting Executive Director
Planning, Funding & Decision Support

Appendix 1

Ombudsman

Fairness for all

OPCAT COVID-19 Report

Report on Te Awakura Acute Mental Health Inpatient Unit under the Crimes of Torture Act 1989

May 2020

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

Contents

Introduction

New Zealand has international human rights obligations under the United Nations Optional Protocol to the Convention against Torture (OPCAT)[1] to prevent torture and other cruel, inhuman or degrading treatment and punishment. As part of OPCAT, there is a requirement for New Zealand to have an independent inspection programme of places of detention.

Ombudsmen have been designated by the Minister of Justice to carry out OPCAT inspections of health and disability facilities such mental health facilities. The preventive purpose of these inspections is to provide independent assurance that the treatment and conditions in these facilities are appropriate, and to provide recommendations for improvement.

I reviewed my pre-planned programme of inspections and visits in light of COVID-19 and my designation as an essential service for OPCAT inspections. I considered a wide range of information, including that provided by the United Nations. I decided that as well as remote monitoring primarily through information gathering, physical on-site inspections must continue in order for me to provide effective independent oversight. My OPCAT COVID-19 inspections are carried out with full regard for health and safety, and they are short and targeted, using specific COVID-19 relevant assessment criteria.[2]

Independent monitoring is essential during these unprecedented times. Monitoring places of detention remains an essential preventive safeguard for the treatment of people who cannot leave a facility at will. It provides confidence to the New Zealand public that our most vulnerable people are being treated fairly during these times. While firm action to respond to COVID-19 and to keep people safe from the virus is necessary, extraordinary measures must not have an unnecessary or disproportionate impact on people's rights.

Methodology

On 6 May 2020, three Inspectors (the Team) carried out an announced inspection of Te Awakura Acute Mental Health Unit (the Unit). At the time of the inspection New Zealand was at COVID-19 Alert Level 3.[3]

The Unit has 64 beds across four wards, and provides acute mental health services. The Unit is located in the grounds of the Hillmorton Hospital Campus, Christchurch, and is operated by Canterbury District Health Board.

---

1 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

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

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

The Team was informed that, on 6 May 2020, there were 38 consumers in the Unit, so it was operating at approximately 59 percent capacity. An additional seven consumers were on leave from the Unit.

The Team was on site for four hours, inspecting the four wards. During the inspection, my Team spoke with a number of managers, staff, whānau, and consumers.

The Unit was given nine days' notice of the inspection. At the time of announcing the inspection, my Team requested information about the Unit as part of the inspection process.

Key observations

My key observations of the Unit showed a well-resourced, balanced, and efficient response to the COVID-19 pandemic. The Team observed positive and collaborative relationships between the staff and consumers, and robust health and safety processes that were effectively communicated across the Unit.

The Unit had taken measures to support consumers in maintaining contact with the outside world, and provided regular, relevant, and up-to-date information about COVID-19. Consumers told my Team they felt supported, safe, and well-informed.

Health and safety

I consider the health and safety arrangements of the Unit were of a high standard at the time of inspection. The Unit operated each of its four wards as a separate 'bubble', and had dedicated staff working on each ward to maintain 'bubbles'.

On all wards consumers had access to hand-washing facilities and hand sanitiser. The cleaning regimes on the wards had been enhanced during COVID-19, with higher strength cleaning products. 'Touch points' throughout the wards were cleaned throughout the day. The Unit had good supplies of cleaning products and personal protective equipment (PPE).

Information regarding COVID-19 and education about hand hygiene was up-to-date, and clearly displayed in each ward and in the shared foyer. Consumers felt that they had been well-informed about the COVID-19 precautions and protocols on the Unit, and staff noted there had been a very high level of compliance with handwashing practices.

Staff and consumers felt well-informed about the Unit's approach to COVID-19. Staff commented that they had been kept well-informed by the DHB and by their Unit management staff.

The Unit had a robust plan for admission and management of consumers with suspected or confirmed COVID-19. Each ward had a designated isolation area in case of confirmed or probable COVID-19 cases, and staff had been trained on the use of PPE.

Management advised that medical appointments and urgent medical assessment and treatment continued during Alert Levels 4 and 3.

All wards opened to secure courtyard areas, and the Team observed consumers using these areas. Consumers with leave were able to walk within the hospital grounds or to the local dairy.

Contact with the outside world

I consider that efforts to maintain contact with the outside world were being managed effectively at the time of inspection.

At Alert Level 4, consumers were unable to have visitors to the Unit. Most consumers had their own phones or tablets, and used these to contact whānau and other supports using Audio Visual Link (AVL) facilities. The Unit had a number of portable devices they supplied on request to consumers who did not have their own device. Wi-Fi was free to consumers. There was a fixed phone and a portable phone on each ward.

At Alert Level 3, consumers were able to have one designated visitor. The Team spoke with one whānau visitor who said that she had been kept well-informed by staff throughout the admission of her son.

I have no concerns about consumers' ability to maintain contact with the outside world.

Dignity and respect

I consider that consumers were being treated with dignity, respect, and compassion at the time of inspection. The Unit was calm and quiet on all wards, and the Team observed positive interactions between staff and consumers.

An Occupational Therapist was assigned to each ward, and an activities programme was continuing throughout Alert Levels 4 and 3. The Team observed nursing staff engaging consumers in activities.

I have no concerns about consumers being treating with dignity and respect.

Protective measures

I consider that the complaints system was functioning effectively at the time of the inspection. The District Health Board complaints procedure was displayed on all wards and there were complaints boxes for consumers throughout the Unit. The Health and Disability Commissioner information was clearly displayed.

Information and updates regarding COVID-19 was made widely available to consumers and communicated in a format that was easy to understand.

District Inspectors' phone numbers were displayed clearly on all wards. District Inspectors had not been visiting the Unit during Alert Levels 4 and 3. However, one had arranged with staff to be 'shown' around the ward using AVL on a tablet with the opportunity to speak to consumers during the 'tour'. I consider this a positive addition to the safeguards currently in place.

I have no concerns about consumers' access to the complaints process.

Staffing

The Unit had a number of vacancies prior to COVID-19, and an additional number of staff were unable to work due to vulnerability, or for a period of stand-down due to COVID-19 precautions. The Unit had been operating at 60–75 percent occupancy during Alert Levels 4 and 3, which had allowed the Unit to maintain safe staffing levels.

Staff spoken with felt that staffing levels had remained safe during the COVID-19 period.

Recommendations

I have no recommendations to make.

The Unit accepted my report, commenting:

> "*We accept the report as a factual and accurate reflection of our service during these unusual times. The service Leadership Team are pleased with your findings and will endeavour to continue to provide a high standard of care for our consumers as we slowly transition back to normal".*

Acknowledgement

I am grateful to the facility staff for supporting my Inspectors in conducting their inspections. I appreciate that this is a difficult time, and am heartened by the helpful approach taken by management and staff.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Ombudsman

Fairness for all

OPCAT Report

Report on an unannounced visit to Te Awakura Inpatient Unit (Canterbury District Health Board) Under the Crimes of Torture Act 1989

5 January 2018

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

Contents

Tables

Figures

Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of service users in New Zealand secure hospitals.

On 1 to 3 November 2017, 9(2)(a) [redacted] (to whom I have delegated authority to carry out visits of places of detention under COTA)[1] visited Te Awakura Inpatient Unit in Hillmorton Hospital grounds. They were assisted by contractor, Sal Faid.

Summary of findings

The Inspectors' findings may be summarised as follows.

- There was no evidence that any service users had been subject to anything that could be construed as torture, or cruel, inhuman or degrading treatment in the six months preceding the visit.
- Generally, service users were complimentary about the staff in the Unit and felt there was someone they could turn to if they had any concerns. Inspectors observed good service user/staff relationships with respectful interaction taking place.
- Files contained the necessary paperwork to detain and treat the service users in the Unit.
- Access to the complaints process was readily available for service users, family/whanau and visitors. The District Inspectors details were accessible to service users.
- Service users had their own bedrooms which they could lock, access to clean bedding and showers daily.
- Service users could easily access fresh air in the external gardens and courtyards.
- There were no complaints about the food, access to the telephone or access to family or friends.
- Cultural support services could be easily accessed by all service users.
- Staff were complimentary about the management. Leadership was visible, supportive and positive.

The issues that needed addressing were as follows.

- Service users requiring a period in seclusion had to be moved through a public area (usually under restraint), which was not appropriate.

[1] Acting under delegation of the NPM Chief Ombudsman Peter Boshier.

- There was no signage in place to explain the process to enter and exit the Unit and wards when the doors were locked.
- When bed occupancy across the service was above capacity, staff moved service users between units and wards to accommodate new admissions.
- Not all service users received a copy of their treatment plan.
- Consent to treatment forms were missing from some files.
- Service users did not routinely attend their multi-disciplinary team (MDT) review.
- There was limited programmes and activities available in the wards.
- The family/whānau room was not fit for purpose.
- Not all nursing staff had a good understanding of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Recommendations

I recommend that:

a. Access to the seclusion area for clients in East, South and West wards should be reviewed.

b. Notices detailing the process for entry and exit into the ward should be displayed in prominent areas when the doors are locked.

c. The service develop a plan to reduce the number of sleepovers.

d. Service users receive a copy of their treatment plan.

e. Consent to treatment forms should be completed and filed appropriately.

f. Service users be invited to attend their MDT meeting.

g. Privacy issues in North ward be addressed.

h. Worn and damaged soft furnishing be replaced.

i. The Unit, in conjunction with service users, should review the activities and programmes on offer in the wards. Service users should be able to access a gym.

j. The Unit should identify a more suitable family/whānau room.

k. The Nurse Coach should work with nursing staff on the application of the Mental Health Act.

Follow-up visits will be made at future dates as necessary to monitor implementation of the recommendations.

Housekeeping issues

The DHB's *Seclusion* and *Restraint* policies and *Complaint Management* policy should have review dates.

Service users in seclusion should be orientated to time and date.

What was working well

The service was working hard to reduce seclusion and restraint.

Good leadership was evident across the service.

Staff were visible on the wards. They were helpful and pleasant.

Clients spent a considerable amount of time off the wards and made use of the extensive hospital grounds.

Advocacy services were actively engaged in the wards.

Multi-disciplinary team meetings were comprehensive and had a positive approach to assessing clinical risk for each service user.

Feedback meeting

A feedback meeting took place prior to the conclusion of the inspection. The Chief Inspector outlined the initial findings of the inspection and provided an early opportunity for the Acting Nursing Director to offer any corrections or clarifications as deemed appropriate.

Consultation

A draft copy of this report was forwarded to Te Awakura Inpatient Unit for comment as to fact, finding or omission prior to finalisation and distribution.

Publication

Under sections 27 and 36 of the Crimes of Torture Act, it is the intention of the Chief Ombudsman to report to Parliament on his analyses of inspections carried out. We advise that such reports will be published in the foreseeable future.

Te Awakura Inpatient Unit Comments

The Acting Nurse Director confirmed the service has accepted all recommendations.

Te Awakura had no specific comments on the report.

Facility Facts

Te Awakura Inpatient Unit

Hillmorton Hospital is the main site for Specialist Mental Health Services in Canterbury. Some mental health services are also based at Princess Margaret Hospital and in the community.

Te Awakura (Adult Acute Inpatient Service) is a four ward complex at Hillmorton Hospital providing assessment and treatment by a multidisciplinary team for adults with acute mental illness when 24 hour nursing care is required. The four wards work in collaboration with the community mental health teams and other agencies.

Te Awakura wards:

- North (16 beds) plus 3 seclusion rooms separate to the main ward
- South (16 beds)
- East (16 beds)
- West (16 beds)

Region

Canterbury

District Health Board (DHB)

Canterbury District Health Board

Operating capacity

64

Unit Manager

North – 9(2)(a) [redacted]

South – 9(2)(a) [redacted]

East – 9(2)(a) [redacted]

West – 9(2)(a) [redacted]

Acting Nursing Director

9(2)(a) [redacted]

DAMHs

9(2)(a) [redacted]

Last inspection

Announced inspection – February 2014

Scoping visit – September 2008

The Visit

The visit of Te Awakura Inpatient Unit took place on 1 to 3 November 2017 and was conducted by 9(2)(a) They were assisted by contractor, 9(2)(a)

Visit methodology

The Acting Nursing Director (adult services) provided the following information during and after the visit.

- a list of service users and the legislative reference under which they were being detained (at the time of the visit);
- policies/procedures on use of mechanical restraint, environmental restraint and seclusion;
- the seclusion and restraint data for the previous six months;
- restraint minimisation committee meeting minutes for the past three months;
- a list of all staff trained in use of restraint and reasons for those not up to date;
- the number of complaints for the previous ten months and the complaints policy;
- average length of stay, admission and discharge numbers for last 12 months;
- staff list including number of vacancies;
- information for service users on admission;
- visits policy;
- activities programme.

At the commencement of the visit the Inspectors met with the Acting Nursing Director, before being shown around the wards. On the day of the visit there were 61 service users in the four wards comprising of 31 males and 30 females.

The following areas were examined to determine whether there had been anything that could be construed as torture, or cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on detainees.[2]

Treatment

- Torture, or cruel, inhuman or degrading treatment
- Seclusion facilities
- Seclusion policies and incidents

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

- Restraints
- Environmental restraint
- Bed occupancy
- Electro-convulsive therapy (ECT)
- Service users' and visitors views

Protective measures

- Complaints process
- Records
- Cultural services

Material conditions

- Accommodation
- Food

Activities

- Leisure activities
- Outdoor exercise

Communications

- Access to visitors/telephone

Personnel

- Staffing levels

Evidence

In addition to the documentary evidence provided during the visit, Inspectors spoke to the Managers of the wards, service users and staff.[3]

Inspectors also reviewed a sample of health records from across the four wards, were provided with additional documents upon request by the staff, and observed the facilities and conditions.

Service users' visitors were also interviewed during the course of the inspection.

[3] See Appendix 1.

Treatment

Torture, or cruel, inhuman or degrading treatment

There was no evidence that any service users had been subject to anything that could be construed as torture, or cruel, inhuman or degrading treatment in the six months preceding the visit.

Seclusion

Seclusion facilities

Te Awakura had three seclusion rooms and a small de-escalation suite adjacent to North ward. The rooms serviced all four wards. If service users from South, East and West required a period in seclusion they were moved (often while being restrained) through the reception area, a public thoroughfare, to seclusion, which was not appropriate. Staff informed Inspectors that they ensured the corridors and reception area were clear before taking service users though to seclusion.

Seclusion rooms, all with en-suite facilities, were clean and ready for use. Rooms had a drinking fountain, privacy blinds and a means of raising the alarm. There was a clock located in the seclusion area for service users to orientate to time, but not the date.

Figure 1: Seclusion room

Figure 2: Seclusion courtyard

Inspectors noted a small supply of stitched clothing in the linen cupboard. Managers and staff informed Inspectors that stitched clothing[4] was not routinely used for service users although the DHB's *Seclusion Policy* did make provision for its use in rare circumstances. The Restraint Minimisation Committee reviewed all seclusion and restraint incidents and were mindful of the traumatic effect placing someone in stitched clothing could have.[5]

Inspectors spoke to one service user who had experienced a period in seclusion. They reported there was always a nurse outside the seclusion room, they had access to food and water and the

[4] An anti-rip gown used to reduce the risk of suicide.

[5] Minutes from 19 October 2017.

en-suite bathroom facilities were unlocked. They reported it could sometimes get hot in the seclusion room. They had worn their own clothing while in seclusion.

There was a small lounge area and courtyard that could be accessed by service users, when appropriate to do so.

There were no service users in seclusion over the course of the inspection.

Seclusion policies and incidents

An up to date copy of the DHB's *Seclusion Policy* was provided (V16 dated, 28 April 2017; Ref: 23337). There was no written indication of when the seclusion policy would next be reviewed.

For the period November 2016 to October 2017 there was 66 episodes of seclusion involving 54 service users and a total seclusion time of just over 908 hours. The average length of time in seclusion was 16 hours 50 minutes.

Table 1: Seclusion hours (by ward)

	Nov 2016	Dec 16	Jan 2017	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Total hours
North	7.12	0.30	0	0	30.0	0	0	0	0	16.18	121.30	0	175.50
South	0	1.12	1.06	2.12	0	0	4.24	26.18	44.42	0	0	58.48	138.42
East	35.42	21.42	15.12	44.48	42.06	35.54	0	0	0	29.48	55.48	10.24	291.40
West	11.42	3.48	84.30	41.18	7.12	8.30	0	9.0	73.48	27.48	0	36.24	304.00

Staff emphasised that all alternative means to de-escalate and support services users were exhausted before seclusion was considered (least restrictive environment).

Active oversight of seclusion was evident from reviewing the *Restraint Minimisation* minutes. Meetings were well attended and the minutes were comprehensive.

Well-placed sensory modulation rooms were situated in each wing and used to good effect. Rooms were open and accessible.

The service was culturally responsive and mindful of seclusion events involving Māori. Staff were required to consult with Pukenga Atawhai[6] regarding the removal of culturally significant items following a clinical assessment. Cultural items were positioned in places where service users could easily observe them.

The clinical team undertook a full review of the pre-seclusion event and the seclusion episode. The service users' allocated nurse undertook a debrief with the service user when it was safe to do so. Debriefs often involved a peer advocate, peer support or Pukenga Atawhai. The service user's perspective was incorporated into the full evaluation/review and incorporated into the updated treatment plan. This process was audited by the Nurse Coach and fed back to the Restraint Minimisation Committee.

Restraints

A copy of the DHB's *Restraint Minimisation and Safe Practice Policy* was provided (Issue 7, 19 Sept 17; Ref: 231490). There was no written indication of when the restraint policy would next be reviewed

Ward staff carried duress alarms (on their wrist) which could be activated across the service or on individual wards. Responders were allocated on each shift with the shift leader being part of the response team. It was reported to Inspectors that male staff were the first responders for incidents/alarms if they were on the ward. It was also reported by some staff that de-briefs after incidents did not consistently occur. The Inspectors were unable to verify this.

There were five hundred and ten personal restraint incidents involving 140 service users for the period November 2016 to October 2017. Four individual service users accounted for 160 restraint incidents (31 percent). North wing had the highest number of restraint incidents, 182 and South the least, 102. The average number of restraint incidents each month was 42.5.

Table 2: Personal restraint (by wing)

	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Total
North	6	7	3	11	9	27	25	30	16	23	22	3	182
East	11	4	13	4	5	8	5	2	13	31	6	6	108
South	0	11	1	6	2	6	8	28	12	9	8	11	102
West	13	18	12	3	13	1	9	18	9	4	8	10	118
Total	30	40	29	24	29	42	47	78	50	67	44	30	**510**

[6] Pukenga Atawhai - Māori Consumer Advisors.

Over 80 percent of staff were in date with their Safe Practice and Effective Communication (SPEC) training. Training was ongoing and it was hoped that all staff would be fully trained in the foreseeable future.

Environmental restraint

Environmental restraint is when a staff member intentionally restricts a consumer's normal access to their environment. For example, locking devices on doors or denying their normal means or independent mobility (wheelchair).[7]

Generally, Te Awakura was an open unit. The main entrance doors are open between 7am and 8pm in summer and 7am and 6pm in winter. Public entrance and exit from each ward is via the main entrance and is overseen by the reception staff.

To prevent the departure of high risk service users from the Unit, nursing staff could lock the ward doors, for the minimum amount of time necessary to maintain the safety of service users, visitors and staff. Reception staff were made aware of a small number of pre-specified service users; their unescorted approach to the reception led to the front door being locked and the relevant ward contacted.[8] When the entrance to a ward was locked the clinical team were required to assess the situation and ensure any restrictive practice was conducted for the shortest period of time. Alternatives to locking the ward were 1:1 observations or nursing staff observing service users in high care areas (with the doors open). Inspectors noted the doors to North ward were locked when they arrived. There was no information displayed on how to enter or exit the ward for service users (and visitors) not subject to the emergency locking protocol.

Environmental restraint was actively monitored and recorded. Environmental restraint was applied 718 times between November 2016 and October 2017. West wing accounted for 43 percent of all environmental restraints (310 events). South accounted for 15 percent (107 events), North accounted for 20 percent (144 events) and East accounted for 22 percent of environmental restraints (157 events).

Each ward had a high-care area that could be secured and managed separately from the main ward. This was the most common form of environmental restraint reported on each ward. Each high care area had three bedrooms, bathroom facilities, a courtyard and a TV lounge with kitchenette. Once a service user no longer posed a clinical risk the environmental restrictions were removed and the high care area unlocked.

Bed occupancy

The average bed occupancy rate for the service for the period October 2016 to September 2017 was 93 percent. July had the lowest level of occupancy, 87 percent and January the highest, 98 percent.

7 DHB Restraint Minimisation and Safe Practice Policy. Sept 2017

8 Protocol for emergency locking of Te Awakura main entrance doors (undated).

The service worked hard to ensure sufficient beds were available for emergency admissions. Unfortunately, this often resulted in service users having to move to other units to sleep (sleepovers); returning to their ward in the morning.[9] The number of sleepovers per month for the period October 2016 to September 2017 were as follows:

Table 3: Te Awakura (number of sleepovers) - October 2016 to September 2017

	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17
Sleepovers	48	15	24	87	40	43	40	15	26	25	32	22

It was reported to Inspectors that sleepovers were taking place to meet the needs of the service, not the service user. Several service users who had experienced a sleepover stated they found it unsettling and frightening. They reported that moving to a different unit made them feel uncomfortable with the different service users and staff in that ward.

Electro-convulsive therapy (ECT)

There were no service users (in the Unit) undergoing ECT at the time of inspection; clients were community based. The ECT suite was clean and well maintained. Staff were friendly and responsive to client's needs.

Service users' and visitors views on treatment

Service users and family/whānau provided positive feedback in relation to staff and service user interactions. Inspectors observed staff interacting with service users in a positive and respectful manner. Staff routinely knocked on bedroom doors before entering and were seen to ask service users if they would like to speak in a private space. A small number of service users believed they should not have been admitted to the Unit. Others spoke of feeling safe and being listened too. Service users were generally very complimentary about staff and felt they were treated with respect.

Inspectors received varied reports from service users in relation to receiving information packs on admission. Most reported that they had not received one. Not all staff were able to locate an admission pack when asked by Inspectors.

Discussions with service users, carers/family/whānau and staff showed that service users were actively involved in their treatment. Examples were sighted by Inspectors of family inclusion with regard to treatment planning and discharge. Not all services users spoken to by Inspectors reported having a written copy of their treatment/crisis plan.

A twice weekly pharmacy group was held where service users could ask questions or raise concerns regarding medication. Inspectors received favourable service user feedback regarding how they were able to raise and discuss issues in this forum.

[9] Inspectors noted service users moved to the Seager Clinic - a 24 bed extended treatment unit, Tupuna Clinic - a 15 bed extended treatment unit and PSAID – a 15 bed psychiatric unit for adults with an intellectual disability.

A lack of activities on the ward was a common message from service users, and staff.

Recommendation – treatment

I recommend that:

a. Access to the seclusion area for clients in East, South and West wards should be reviewed.

b. Notices detailing the process for entry and exit into the ward should be displayed in prominent areas when the doors are locked.

c. The service develop a plan to reduce the number of sleepovers.

d. Service users receive a copy of their treatment plan.

Protective measures

Complaints process

Inspectors were provided with an out-of-date copy of the DHB's *Complaints Management* policy (Issue date: 25 June 2009. Review date: 25 June 2012). A notation on the documents states that printed copies may not reflect the most recent updates.

At the time of the visit, Inspectors were advised that a new complaints database had just become operational. Complaint forms were readily available in the reception area and on each ward. Complaints were responded to in a timely and comprehensive manner. The Complaints Review Committee, which met weekly, reviewed all complaints.[10]

Service users that were interviewed were aware of how to make complaints. Staff were able to detail the process and explain how the service users were supported to make a complaint. Low level complaints were dealt with at ward level. The Consumer Advisor and Ward Manager's met on a regular basis to discuss complaints that had been raised by service users.

Contact details for District Inspectors were displayed in areas easily accessible to service users. It was reported to Inspectors by both staff and service users that the District Inspector had a regular presence on the Unit.

Records

There were 61 service users (31 females and 30 males) in the Unit on the day of the visit.

Thirty-three service users were being detained under the Mental Health (Compulsory Assessment and Treatment) Act and twenty eight were informal clients.

[10] A sample of minutes from 26 September 2017 to 31 October 2017 was provided.

Inspectors reviewed a sample of files (23) from across the four wards. All files contained the necessary paperwork to detain [and treat] the service users in the Unit.

Service users either reported they could not remember signing consent forms or were unsure about the consent they gave. Staff provided an understanding of consent for voluntary service users, however they were unsure regarding consent for those under the Mental Health Act. Inspectors note consent forms were missing from some files.

There were daily multi-disciplinary team (MDT) meetings in each ward. Service users did not attend their MDT meetings. Follow-up appointments with service users were arranged to discuss any changes to their medication or care plan.

The specialist Māori mental health service - Te Korowi Atawhai was developed in recognition of the need to provide a culturally safe and responsive mental health services for Māori. Pukenga Atawhai worked alongside clinicians to promote a Māori perspective for Māori service users. Their role was specific to providing cultural assessments that sat alongside the clinical assessment and formed the treatment plan and related activities. Te Whare Tapa Whā is the cultural framework that informs their work. Māori Hauora plans were discussed with the service user and their whānau if appropriate. Service users received a copy of their plan.

Records indicated that physical examinations were undertaken and that there was ongoing monitoring of service users' physical health.

With the exception of consent to treatment forms, paperwork was completed to a reasonable standard; up-to-date and stored appropriately. There was good administrative support located in North ward.

Recommendations – protective measures

I recommend that:

e. Consent to treatment forms should be completed and filed appropriately.

f. Service users be invited to their MDT meeting.

Material conditions

Accommodation

The Unit, consisting of four 16 bed wards, was generally clean and free from clutter. Each ward had allocated domestic staff that cleaned the wards on a daily basis. The lay out of the wards did not allow staff to observe all parts of the ward and there were blind spots. Soft furnishing in some wards were worn and shabby; this was particularly noticeable in North ward which also required some redecoration.

Bedrooms (non with en-suite facilities) were reasonably spacious, with adequate storage and natural light. Service users on North ward lacked privacy in their bedrooms because viewing panels on doors were only covered on the outside. Bedroom doors could be locked from the inside. However, service users require staff to unlock their bedroom door to gain access. This was raised as a potential reason for personal property going missing from rooms.

There was adequate bathroom facilities for the number of service users. Each ward had a three bed high care area that could be locked off from the main ward.

There was limited communal space and quiet areas in each wing.

Figure 3: Typical bedroom

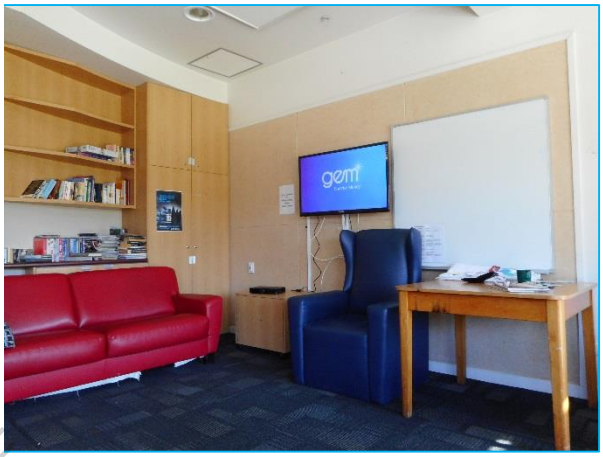

Figure 4: Lounge

Food

Meals were prepared in the main hospital and bought to the wards on a trolley. Service users had a choice of meals from a daily menu. The quantity and quality of the food over the course of the inspection was satisfactory. Special diets, such as vegan meals were provided. There were no formal complaints from service users about food.

Breakfast was scheduled between 7.30 and 8.30am, lunch from 12.45 to 1.30pm and dinner was served at 6.00pm.

There were facilities to make hot food and snacks throughout the day, although, at times, access was observed to be restricted, particularly in North ward.

Service users reported that food was good.

Recommendations – material conditions

I recommend that:

g. Privacy issues in North ward be addressed.

h. Worn and damaged soft furnishings should be replaced.

Activities

Leisure activities

A limited programme of activities was available on each ward, however service user uptake appeared low. Activity rooms, particularly on North ward were not always accessible due to a number of vacancies in the Occupational Therapy team. Inspectors noted the games cupboard in North ward was locked during the course of the inspection. A service user computer with internet access was located in the reception area.

Nursing staff regularly offered and organised activities throughout the week and at weekends. However, at times, escorts and service user observations limited the number of activities that could be offered.

Although not strictly adhered to, there were signs in the TV lounge prohibiting its use between the hours of 9am and 3pm Monday to Friday.

Multi-faith chaplains visited regularly and service users could request specific spiritual advisors. Service users provided examples of being supported to attend church.

A lack of activities and access to a gymnasium was a common message from service users, and staff.

Inspectors noted a considerable number of service users being escorted around the hospital grounds either individually or in small groups.

Figure 5: Art room

Figure 6: Vegetable garden

Outdoor exercise

All wards had open access to outside areas. A small basketball court was available for service users on North and West wards, although the hoop needed to be replaced on West. Service users told Inspectors they enjoyed outdoor activities such as playing football. There was an attractive outside garden space which had recently been established by one of the service users.

Each ward had a courtyard which was open until 6pm; and for 15 minutes every hour until 10pm.

Figure 7: Garden area

Figure 8: Quiet/games room

In line with national requirements the hospital had a smoke-free policy. Nicotine replacement therapy was available to service users. The service took a pragmatic approach to smoking.

I recommend that:

i. The Unit, in conjunction with service users, should review the activities and programmes on offer in the wards. Service users should be able to access a gym.

Communications

Access to visitors/telephone

Visiting hours were from 10am to 8pm daily, including weekends. Te Awakura ran a wellbeing programme during the day and evening that family/whānau and friends could attend. The wards were flexible if people needed to visit outside of the set visiting times.

Inspectors observed, and spoke with, a number of visitors over the course of the inspection. All visitors and service users interviewed reported that family/whanau could visit without any difficulty.

Children were welcome under adult supervision. A small family/whānau room was situated in the reception area. Visitors and service users reported that it was unsuitable for children, particularly during the summer when temperatures became unbearable when the door was closed.

Service users could make telephone calls in private. Hand held telephones were available for service users to use; many had their own mobile device.

Figure 9: Family room

Figure 10: Reception

Recommendations – communications

I recommend that:

j. The Unit should identify a more suitable family/whānau room.

Personnel

Staffing levels

The Unit had a full time equivalent of 108 nurses (registered and enrolled). There were 6.5 nurse vacancies at the time of the inspection; four on South ward.

The Unit had a large number of newly qualified nurses[11] (40 percent). New staff (and student nurses) were orientated in to the Unit and a Nurse Coach was available on the afternoon shift to provide mentoring and support. Clinical Nurse Specialists (CNS) and Clinical Nurse Managers (CNM) were also available for support and guidance.

Most staff Inspectors spoke with had limited understanding of the Mental Health Act. Nurses, including student nurses, reported little training in this area. Many nurses were unsure of the District Inspectors role.

[11] Employed for twelve months or less.

In 2012, Adult Mental Health Services introduced a new in-reach model of care for allied health care staff - *Direction for Change*. Inpatient based Social Workers and Occupational Therapists were relocated to the adult community teams from which an in-reach service was provided to the four wings. There was much discussion with the Inspectors as to the effectiveness of the new in-reach model. Staff raised their concerns with the new model and generally felt service users had been disadvantaged since its implementation. Inspectors were informed that the new model was in the process of being reviewed.

Recommendations – staff

I recommend that:

k. The Nurse Coach should work with nursing staff on the application of the Mental Health Act.

Acknowledgement

I appreciate the full co-operation extended by the manager and staff to the Inspectors during their visit to the Unit. I also acknowledge the work involved in collating the information sought by the Inspectors.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people spoken with by Inspectors

Team Leader

Director of Area Mental Health

Psychiatrist

Director of Nursing

Clinical Director

SPEC Trainer

Māori Consumer Advisor

Allied Health Manager

Occupational Therapist

Social Workers

Customer Services Coordinator and Privacy Officer

Nursing Students

Nurse Coaches

Health Care Assistants

Cleaner

Receptionists

Family/Whānau/Relatives

Registered and Enrolled Nurses

Chaplin

District Inspector

Community case managers

Consumer Representative

Consumer Advocate

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

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. 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…"*

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.

Under section 27 of COTA, an NPM's functions, in respect of places of detention, include:

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

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.

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;

3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the places they want to visit and the persons they want to interview.

Ombudsman

Fairness for all

OPCAT Report

Report on an unannounced inspection of the Child Adolescent & Family Unit (CAF), Princess Margaret Hospital, under the Crimes of Torture Act 1989

Publication date: 15 April 2019

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

Contents

Tables

Figures

Executive Summary

Background

In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act 1989 (COTA), with responsibility for examining and monitoring the conditions and treatment of patients detained in secure units within New Zealand hospitals.

From 26 to 28 November 2018, two Inspectors - whom I have authorised to carry out visits to places of detention under COTA on my behalf – inspected the Child Adolescent and Family Unit, which is located in the grounds of Princess Margaret Hospital.

Summary of findings

My findings are:

- There had been a reduction in the use of seclusion since my predecessor's inspection in 2014.
- Members of the multi-disciplinary team (MDT) worked collaboratively and effectively.
- Interactions between staff and young people were respectful, constructive and appropriate.
- The necessary legal documentation for young people to be detained and treated was on file, where relevant.
- Accommodation was clean and tidy.
- A broad range of therapeutic programmes and education activities were available to young people.
- Young people were able to communicate freely with whānau and friends, either during visits or through the telephone.

The issues that need addressing are:

- The seclusion and de-escalation rooms were unfit for purpose.
- Young peoples' access to the sensory modulation room was limited by inflexible arrangements.
- Information provided to young people on admission does not include details of the complaints process.
- Signed *Consent for use of restraint: Form for parents and guardians* were not completed for the relevant young people in the Unit.
- Some communal areas on the Unit were locked.

- Bedrooms contain potential ligature points.
- Doors to the outdoor areas on both the youth and child wings were locked.
- Evening and weekend leisure activities did not fully meet young peoples' needs or interests for young people.
- Low staff retention.

Recommendations

I recommend that:

1. Young peoples' access to the sensory modulation rooms be improved, starting by monitoring usage to determine if more flexible access arrangements are required.
2. Information about the DHB's complaints process is included in the information booklet given to young people on admission and in the *Information Kit* booklet given to whānau/family.
3. A signed *Consent for use of restraint: Form for parents and guardians* is obtained for all relevant young people in the Unit and kept on file.
4. All young people have unrestricted access to all of the Unit's communal areas.
5. All potential ligature points be removed from bedrooms.
6. Adjust or replace the locks to the toilets in the youth wing to prevent accidental locking.
7. All young people have unrestricted access to the Unit's outdoor areas unless deemed inappropriate for clinical reasons.
8. Evening and weekend leisure activities be reviewed to ensure they meet the needs and interests of the young people.
9. The reasons for staff resignations should be analysed and, where necessary, appropriate remedial action be implemented.

Follow up visits will be made at future dates to monitor implementation of the recommendations.

Feedback meeting

A feedback meeting took place at the end of the inspection, during which my Inspectors outlined Inspectors' initial observations to the Charge Nurse Manager, Consultant Psychiatrist,

Service Manager, Quality Manager, Nurse Consultant, Clinical Nurse Specialist and Occupational Therapist.

Consultation

A provisional report was forwarded to the Child, Adolescent and Family Inpatient Unit for comment as to fact, finding or omission prior to finalisation and distribution.

Facility Facts

Child, Adolescent and Family Inpatient Unit

Located in the grounds of Princess Margaret Hospital, Christchurch, the Child, Adolescent and Family Inpatient Unit (the Unit) provides specialist inpatient care for young people with mental health problems up to the age of 18 years old. Services include assessment, treatment and education for individuals and their families.

The Unit has two separate wings, a child wing (for young people up to the age of 12 years old) and a youth wing (for young people between the ages of 12 and 18 years old). However, older individuals may be accommodated in the child wing based on clinical need.

The Unit also provides mental health consultation services to, and liaises with, general practitioners, schools and allied health and social services to the West Coast and South Canterbury regions.

Region

Canterbury

District Health Board

Canterbury District Health Board

Operating capacity

16 beds, plus one seclusion room and one de-escalation room.

Last inspection

Unannounced visit – July 2014

Informal unannounced visit – August 2012

The Inspection

The inspection of the Child, Adolescent and Family Inpatient Unit (the Unit) took place from 26 to 28 November 2018 and was conducted by two Inspectors. On the first day of the inspection, there were 12 young people on the Unit, comprising 11 females and one male. Five young people were on the child wing and seven on the youth wing.

Inspection methodology

At the beginning of the inspection, Inspectors met with the Charge Nurse Manager (CNM), before being shown around the Unit.

Inspectors were provided with the following information during the inspection:

- a list of young people in the Unit and the legislative reference under which they were being detained (at the time of the inspection);
- the seclusion and restraint data for the previous six months, and the seclusion and restraint policies;
- a list of all staff trained in the use of restraint and reasons for those not being up to date;
- complaints for the previous six months, a sample of responses and associated timeframes, and a copy of the complaints policy;
- information provided to young people on admission;
- activities programme;
- visits policy;
- staff sickness and retention data for the previous three years;
- staff mandatory training records;
- incident reports relating to medication errors for the previous six months; and
- minutes of consumer group meetings for previous three months.

Inspection focus

The following areas were examined to determine whether there had been torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on patients.[1]

[1] My inspection methodology is informed by the Association for the Prevention of Torture's *Practical Guide to Monitoring Places of Detention* (2004) Geneva, available at www.apt.ch.

Treatment

- Torture, or cruel, inhuman or degrading treatment or punishment
- Seclusion and de-escalation
- Restraint
- Restraint training for staff
- Electro-convulsive therapy (ECT)
- Sensory modulation
- Young peoples' and whānau views on treatment

Protective measures

- Complaints process
- Records

Material conditions

- Accommodation and sanitary conditions
- Food

Activities and programmes

- Outdoor exercise and leisure activities
- Programmes and education
- Cultural and spiritual support

Communications

- Access to visitors and external communications

Health care

- Primary health care services

Staff

- Staffing levels and staff retention

Evidence

In addition to the documentary evidence provided at the time of the inspection, Inspectors spoke to the Charge Nurse Manager, staff and nine young people.[2]

Inspectors also reviewed patient records, were provided additional documents upon request by the staff, and observed the facilities and conditions.

Recommendations from previous report

Inspectors followed up on the one recommendation made by my predecessor in 2014, which was:

> *The lack of heating and the unpleasant odour emanating from the drains in the seclusion room are addressed.*

The Unit's adoption, or not, of this prior recommendation is referred to in the relevant section of this report.

Treatment

Torture, or cruel, inhuman or degrading treatment or punishment

There was no evidence that any young people had been subject to torture, or cruel, inhuman or degrading treatment or punishment.

A sensory modulation room was located in both the youth and the child wings. Both were kept locked and could only be accessed with staff supervision. Young people were expected to ask to use the room or staff might suggest to a young person that it would be helpful to them to use the room. During a multi-disciplinary team (MDT) meeting attended by Inspectors, staff discussed the therapeutic benefits of a particular young person using the sensory room.

There was no monitoring of the use of the sensory rooms or their impact on young peoples' mental wellbeing.

Inspectors observed an effective shift handover, during which staff discussed patients' behaviour, risks and care.

Seclusion

Seclusion facilities

The Unit had one seclusion room, with en-suite facilities, located in the youth wing's small high dependency area. The high dependency area also had a small de-escalation room, which had no natural light or bathroom facilities.

[2] For a list of people spoken with by the Inspectors, see Appendix 1.

I was pleased to note that the following recommendation by my predecessor, resulting from the Unit's 2014 inspection, had been implemented:

> *The lack of heating and the unpleasant odour emanating from the drains in the seclusion room are addressed.*

My Inspectors found the seclusion room to be free of any unpleasant odours and was a satisfactory temperature.

Despite this improvement, I am of the opinion that the seclusion and de-escalation rooms are unfit for purpose. The facilities are dark, oppressive and not conducive to the mental wellbeing of the young people accommodated in them.

During the inspection in 2014, the Unit manager informed Inspectors that the Unit would be moving to a new facility in 2016. I am disappointed that the move has not yet materialised. During the 2018 inspection, the DHB provided my Inspectors with a copy of the plans for the new Unit and they learned that the move may not occur for at least another two years.

Figure 1: Seclusion room – youth wing

Figure 2: De-escalation room – youth wing

Figure 3: Head in the Clouds room – child wing

Figure 4:Headspace room – child wing

Seclusion policies and incidents

The Unit provided Inspectors with a copy of the DHB's *Seclusion Policy* (dated 28 April 2017). The policy document does not indicate a review date.

Data supplied by the Unit showed that, for the period 1 May 2018 to 31 October 2018, there were two episodes of seclusion involving two young people. The total seclusion time for the period was 6.2 hours.

Table 1: Seclusion episodes 1 May - 31 October 2018

Month	Events	Patient numbers	Hours	Average hours
May	0	0	0	0
June	2	2	6.2	3.1
July	0	0	0	0
August	0	0	0	0
September	0	0	0	0
October	0	0	0	0
Total	**2**	**2**	**6.2**	**3.1**

The data indicates a significant reduction in the use of seclusion since the inspection in 2014. Comparable data for the period 1 January to 30 June 2015 shows 22 episodes of seclusion, totalling 153.5 hours. I am pleased to see this reduction in the use of seclusion.

No young people were in seclusion at the time of the inspection.

Restraints

The Unit provided Inspectors with a copy of the DHB's *Restraint Minimisation and Safe Practice Policy* (dated 19 June 2018). The policy document does not indicate a review date.

Data supplied by the Unit showed that, for the period 1 May 2018 to 31 October 2018, there were 199 incidents of restraint involving 19 young people. Sixty-five per cent (129) of restraint incidents involved one young person.

Table 2: Restraint incidents 1 May - 31 October 2018

Patients	Total restraint numbers	Locked doors	Full restraint	Partial restraint
Patient 1	1	1	0	0

Patients	Total restraint numbers	Locked doors	Full restraint	Partial restraint
Patient 2	17	5	2	10
Patient 3	4	2	0	2
Patient 4	3	1	1	1
Patient 5	1	1	0	0
Patient 6	5	1	2	2
Patient 7	6	1	2	3
Patient 8	1	1	0	0
Patient 9	2	2	0	0
Patient 10	1	1	0	0
Patient 11	1	1	0	0
Patient 12	4	3	1	0
Patient 13	10	1	4	5
Patient 14	3	1	0	2
Patient 16	1	0	0	1
Patient 17	1	0	0	1
Patient 18	8	2	0	6
Patient 19	129	5	35	89

This data indicates an increase in the use of restraint since the time of the 2014 inspection. Comparable data for the period 1 January to 30 June 2014 showed 172 incidents of restraint involving 14 young people.

Restraint training for staff

All Unit staff were up-to-date with Safe Practice Effective Communication (SPEC) training, with the exception of three staff for whom refresher training was scheduled for December 2018.

However, the SPEC restraint techniques are designed for adults, not young people (some as young as nine or ten years old). In the opinion of the CNM, SPEC is not an appropriate method when restraining young children. My Inspectors were told that the SPEC trainer for the Unit had developed new restraint techniques for the Unit's staff to use that did not involve flexion of the wrist or tension of a young person's skeletal growth plates.

Electro-convulsive therapy

No young people were receiving electro-convulsive therapy (ECT) at the time of the inspection.

Sensory modulation

The DHB provided Inspectors with a copy of its *Sensory Modulation Protocol* (review date July 2021)

A sensory modulation room was located in both the youth and the child wings. Both were kept locked and could only be accessed with staff supervision. Young people were expected to ask to use the room or staff might suggest to a young person that it would be helpful to them to use the room. During an MDT meeting attended by Inspectors, staff discussed the therapeutic benefits of a particular young person using the sensory room.

There was no monitoring of the use of the sensory modulation rooms or their impact on young peoples' mental wellbeing.

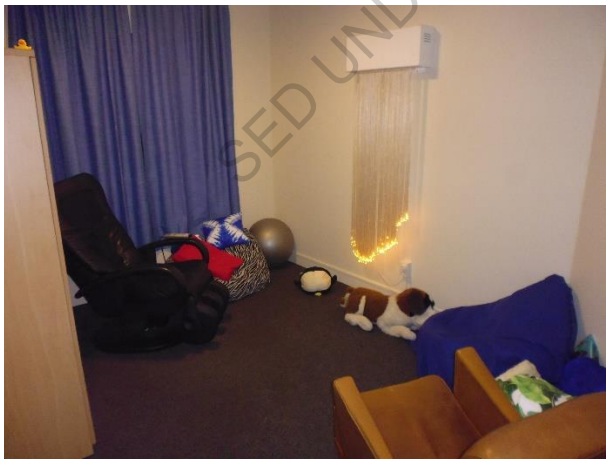

Figure 5: Sensory modulation room – youth wing

Figure 6: Sensory modulation room – child wing

Patients' and whānau views on treatment

Young people told Inspectors that they felt safe on the Unit and staff treated them with kindness. They said that they felt comfortable talking to staff and that the staff were always willing to listen to them.

On discharge, young people and their parents/guardian are invited to complete a satisfaction survey. The information from the survey is collated by the Research Officer six-monthly and a poster-sized infographic of the results is displayed in the Unit. Feedback is also sent to the CNM by email. Inspectors reviewed a random sample of the emails, which included the following comments from young people:

> *The nurses were very kind*
>
> *More consistency with nurses, it can be frustrating having to have new people all the time, and makes it difficult to be open with them*

Comments from parents included:

> *The staff are caring and knowledgeable*
>
> *They listened to…… were very caring and kind.*
>
> *You guys do a fantastic job with your patients and you have been possibly life saving for…… Thank you.*
>
> *Lovely nurse on first admission was so kind and understanding.*
>
> *There was a lack of service at times. No communication. Not knowing what was happening. Some of the nurses were quite disrespectful to daughter and her boyfriend.*

The Youth Consumer advisor (YCA) facilitates a weekly consumer group meeting and Inspectors reviewed a selection of minutes from previous meetings. The minutes indicate a broad range of topics discussed, including building maintenance issues, mealtime menus, use of telephones and activities. The YCA sends copies of the minutes to the CNM and Occupational Therapist (OT). However, it is unclear from the minutes what, if any, feedback the young people receive in relation to the issues they raise at the consumer meetings.

Recommendations – treatment

I recommend that:

1. Young peoples' access to the sensory modulation rooms be improved, starting by monitoring usage to determine if more flexible access arrangements are required.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 1

Recommendation 1 response:

We will review how to maximise use of the room, while ensuring safety.

Protective measures

Complaints process

The DHB provided Inspectors with an out-of-date copy of its *Complaints Management Policy* (review date 25 June 2012).

Information about the DHB's complaints process was displayed in the Unit, along with copies of the customer response form, *Suggestions, Compliments and Complaints.* These were located alongside the complaints boxes and easily accessible by the young people.

However, information about the complaints process was not contained in either the information booklet given to young people on admission nor the *Information Kit* for whānau and other support people. I consider that it would be helpful to both the young people and whānau for information about the complaints process to be included in the information booklets.

The Unit had received one complaint in the six months preceding the inspection. However, as the complainant chose not to use the formal complaints process, while the complaint itself was recorded, any response to it was not. It was therefore not possible for my Inspectors to identify the outcome of the complaint, nor establish any timescale within which the complaint was resolved.

Young people told Inspectors that they were familiar with the complaints process, and they would feel comfortable approaching staff if they wished to raise any concerns.

Contact details for District Inspectors were on display in the Unit, as were posters of the Health and Disability Commission's *Code of Rights.*

Records

Of the 12 young people in the Unit at the time of the inspection, one was detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) and the remainder of the young people had voluntary/informal status. Inspectors reviewed the files of all the young people on the Unit.

The file for the young person detained under the MHA contained the necessary paperwork for detention and treatment. The quality of the paperwork in the files for all the young people was of a high standard, with files structured in an ordered manner and all documentation signed and dated as appropriate. Treatment plans for young people were up to date and progress

notes indicated the young peoples' involvement in their treatment management and planning process.

However, my Inspectors noted that one file contained information pertaining to another young person. Staff corrected this error when it was brought to their attention by Inspectors.

None of the files for voluntary young people in the child wing contained consent forms signed by their parent or guardian, in respect of the use of restraint.[3]

Recommendations – protective measures

I recommend that:

2. Information about the DHB's complaints process is included in the information booklet given to young people on admission and in the *Information Kit* booklet given to whānau/family.

3. A signed *Consent for use of restraint: Form for parents and guardians* is obtained for all relevant young people in the Unit and kept on file.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 2

Accepted recommendation 3

Material conditions

Accommodation and sanitary conditions

The Unit has two wings; the child wing and the youth wing. Both wings are mixed-sex facilities.

My Inspectors noted that the Unit, while clean and relatively tidy, was somewhat tired and dreary in appearance. Staff had endeavoured to improve the ambience of the Unit by the addition of artwork and colourful posters on the walls, but the layout of the building makes any significant improvements difficult. The building contained poor lines of sight and the youth wing, in particular, was dark.

Both wings had combined kitchen/dining/lounge areas and a number of smaller communal areas, which provide quiet space for the young people. However, Inspectors observed the communal areas in the youth wing to be locked on several occasions during the inspection.

[3] *Consent for use of restraint: Form for parents and guardians*. This form is for consent to the use of restraint when necessary for a minor aged 12 years and under, who are not under the MHA.

In each wing, each young person had their own bedroom which, although basic, has curtains for privacy and sufficient storage space for personal belongings. Young people were able to enter and exit their bedrooms freely during the day and night. Bedrooms for male and female young people were located together in the same corridor.

I am concerned that a number of the bedrooms in the Unit contained potential ligature points. The Nurse Consultant told my Inspectors that some young people demonstrated suicidal ideation and behaviour and the ligature points in some of the bedrooms will be removed so those rooms could be used for high-risk individuals. In my opinion, it is not possible to predict accurately who might or might not attempt suicide and, therefore, it would be beneficial to remove potential ligature points from all bedrooms.

Young people share bathroom facilities, with those for males and females located close to one another in each wing. I consider that the lack of separate male and female areas for bedrooms and bathrooms has the potential to impact on the privacy and safety of the young people.

Inspectors observed the toilets in the youth wing to be locked on several occasions during the inspection. Staff demonstrated how the lock mechanism can remain locked if the person leaving the toilet does not turn the latch back to the unlock position, resulting in the door remaining locked and the toilet inaccessible to others.

I consider that, despite the best efforts of staff, the structure and layout of the Unit is not conducive to the optimal management of young people or to their mental wellbeing. I am pleased to note that the DHB intends to build a new Unit at Hillmorton Hospital, and my Inspectors have seen plans for the new facility. However, I am concerned that the building of the new Unit is unlikely to start for at least two years.

Figure 7: Bedroom – youth wing

Figure 8: Bedroom – child wing

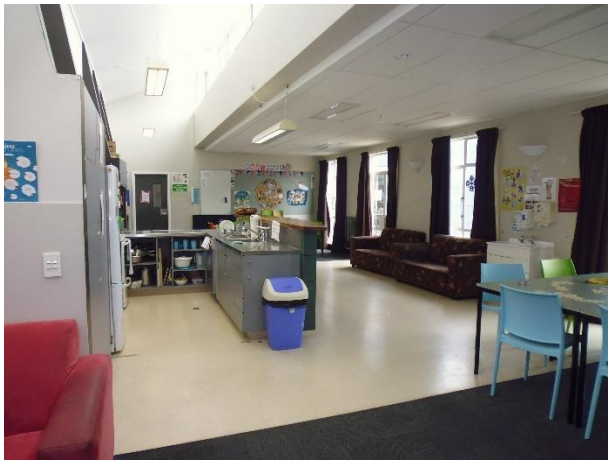

Figure 9: Communal area – child wing

Figure 10: Communal area – youth wing

Food

Assisted by nurses, the young people prepared their own breakfast at 8.00am, comprising cereals, toast and other items such as poached eggs. A similar arrangement existed for lunch at 12.30pm, when young people prepared sandwiches, wraps and salad. The evening meals at 5.30pm (child wing) and 6.00pm (youth wing) were prepared in the hospital kitchen and transported to the unit in a heated trolley. The young people were also able to prepare their own meals at this time – for example, pizza and cauliflower cheese.

Inspectors observed that the quality and quantity of the food over the course of the inspection was satisfactory, and no young people raised with Inspectors any concerns about the food. However, minutes of the weekly consumer meeting showed that young people had requested more healthy options at mealtimes such as more fruit and vegetarian/vegan options.

Recommendations – material conditions

I recommend that:

4. All young people have unrestricted access to all of the Unit's communal areas.
5. All potential ligature points be removed from bedrooms.
6. Adjust or replace the locks to the toilets in the youth wing to prevent accidental locking.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 4

Partially accepted recommendation 5

Recommendation 5 response:

Removal of every ligature point in this facility is impractical. The new facility will ensure there are no ligature points.

NPM response:

While I appreciate that it would be difficult to remove ligature points throughout the entire facility, my recommendation relates specifically to the removal of ligature points in all bedrooms. As work is being undertaken to remove ligature points in some bedrooms, I do not consider it impractical to extend this work to include all bedrooms, especially as the new facility will not be built for at least two years.

Accepted recommendation 6

Activities and communications

Outdoor exercise and leisure activities

The Unit provided outdoor areas on both the youth and child wings but Inspectors observed the doors to these areas were locked throughout the inspection. This restricted young peoples' access to the areas and required them to ask a staff member to unlock the doors. Inspectors did not observe any young people in the outdoor areas during the inspection. The one exception to this was the outdoor play area in the child wing, which was used by young people during breaks in their school activities.

A number of leisure activities are available to young people including: MP3 players; Playstation/Xbox; leave from the Unit; cycle rides; walks; brain games, colouring activities; and, craft activities. The youth wing has an activities room, 'The Zone', which contains craft materials and exercise equipment. However, this room was locked during the inspection and Inspectors did not observe any young people using the room.

Young people told inspectors that there was little for them to do in the evenings and at weekends and would welcome a greater range of activities during these periods. During an evening visit to the Unit, my Inspectors observed that all the young people on the youth wing were out on leave with their families. On the child wing, one young person was using the telephone, two young people were playing a board game and the remaining young people were in their bedrooms.

Figure 11: Play area – child wing

Figure 12: The Zone – youth wing

Programmes and education

Young people engaged in a range of therapeutic programmes or education between 9.00am and 3.00pm, Monday to Friday.

Therapeutic programmes included both individual and group sessions designed to meet the clinical needs of each young person. Group sessions focussed on areas such as social skills, relationships, cultural groups, managing stress and regulating emotions. An OT or Clinical Psychologist, supported by a nurse, facilitated most of the groups.

All young people of school age are able to attend the Unit's schoolroom, operated by Southern Health School, which is responsible for providing education to those students who are unable to attend mainstream schools owing to health reasons.

All young people attending the school had an Individual Learning Plan, with subjects based on the national curriculum. Young people are able to sit NCEA examinations and teachers told Inspectors that at the time of the inspection eight young people were scheduled to sit examinations.

Figure 13: Classroom

Figure 14: Occupational Therapy room

Access to visitors and external communication

Visits take place between 3.00pm and 8.00pm, Monday to Friday and at any time during the weekend. Young people meet with their visitors in the communal areas of the Unit or may use the Whānau/family room, which primarily functions as a waiting and information room for whānau.

The Unit provided two parents rooms for those occasions when, for domestic or clinical reasons, it was necessary for a young person's parent(s)/guardian to stay at the Unit.

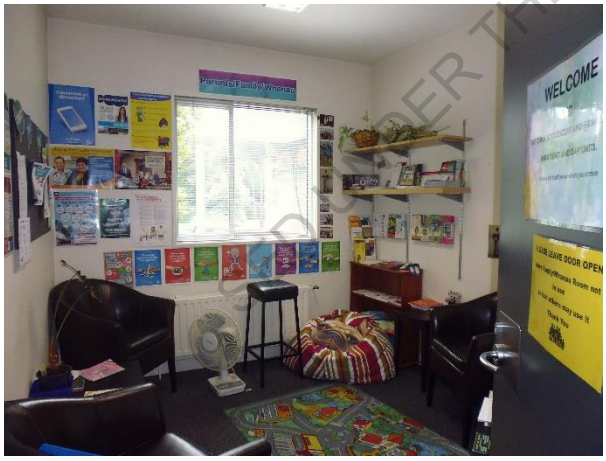

Figure 15: Whānau/family room

Figure 16: Parents room

A telephone for use by the young people was located on each wing. Whilst the telephone on the youth wing provided some degree of privacy, the one on the child wing was located close to the entrance to the wing and so privacy was limited. However, during an evening visit, Inspectors observed staff allow a young person on the wing to use a cordless telephone to make her telephone call in a more private area.

The Unit regulated young peoples' use of their mobile telephones by restricting use between 6.30pm and 8.30pm weekdays and from 10.00am to 12.00pm at weekends. The CNM told Inspectors that the use of mobile telephones was restricted so that it did not interfere with young peoples' programmes and education and to facilitate good sleep hygiene. Young people who spoke with Inspectors expressed mixed opinions on the restrictions on mobile telephone use with some supporting the policy as it gave them time *to do other stuff* and helped them to get to sleep at night.

Cultural and spiritual support

The hospital chaplain visited the youth wing weekly for approximately two hours and engaged with the young people in whatever they were doing at the time. The Chaplain also met with young people individually upon request. Contact details for the hospital chaplains were displayed in the Unit.

At the time of the inspection, the Chaplain did not visit the child wing but he told Inspectors that he planned to discuss with the CNM the possibility of attending the child wing on a weekly basis also.

The Pukenga Atawhai provides cultural support to young people on the Unit and advocates for whānau when requested to do so. A weekly cultural group is co-facilitated by the Pukenga Atawhai and a nurse during which young people can participate in a variety of cultural activities such as tikanga.[4]

Recommendations – activities and communications

I recommend that:

7. All young people have unrestricted access to the Unit's outdoor areas unless deemed inappropriate for clinical reasons.

8. Evening and weekend leisure activities be reviewed to ensure they meet the needs and interests of the young people.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 7

Accepted recommendation 8

[4] Tikanga: Culture, custom, lore, the customary system of values and practices that have developed over time and are deeply embedded in the social context. Downloaded from the Māori Dictionary https://maoridictionary.co.nz/search?keywords=tikanga

Health care

Primary health care services

The Consultant Psychiatrist explained that, on admission, all young people receive a physical examination by the Unit's Medical Officer Special Scale (MOSS) or by the House Surgeon. Routine blood tests are also carried out at this stage. Doctors also explore the young person's use of drugs and alcohol and sexual health issues; appropriate advice and support is provided, as required.

Those young people requiring dental treatment are referred to the community dental service at Hillmorton Hospital or they may use the school dental services.

The Unit's pharmacist works closely with medical staff in designing appropriate medication plans and attends the weekly clinical review meeting. She also facilitates education sessions with nurses to enhance their knowledge of medicines. I am pleased to note the proactive approach of the pharmacist in facilitating weekly sessions with the young people, either in a group or individually, to discuss the medication they are receiving and to answer any questions they may have. I consider this a good example of actively engaging individuals in their treatment.

The temperature in the medicines fridge was recorded daily, and Inspectors observed that temperatures were within the Ministry of Health's guidelines of between 2°C and 8°C.[5]

Data provided to Inspectors by the DHB indicated that in the six months prior to the inspection, the Unit experienced six medication events including failure to administer prescribed medication and the administration of incorrect medication. The Medication Events schedule indicated that no harm or injury was experienced by young people because of the events.

Both the youth and child wings had a designated clinic room for physical examinations and minor medical procedures. The shared emergency trolley, containing oxygen and the defibrillator, was located in the youth wing clinic.

Recommendations – health care

I have no recommendations to make.

[5] *National Guidelines for Vaccine Storage and Distribution*. Wellington: Ministry of Health, 2012.

Staff

Staffing levels and staff retention

Data provided by the CNM showed the Unit to have a multi-disciplinary staff complement (excluding medical staff) of 40.4 full time equivalent (FTE). The CNM told Inspectors that at the time of the inspection there were three FTE nursing vacancies.

Nursing staff worked to a three-shift roster with a designated staffing level on each shift. The CNM told Inspectors that there was a range of experience among the registered nurses, six of whom had recently completed the New Entry to Specialist Practice (NESP). These nurses required ongoing support from their more experienced colleagues.

Several managers and staff told Inspectors that the turnover among nursing staff was a concern. Data provided by the DHB showed that between 2015/16 and 2017/18 staff turnover increased from 10 per cent to 24 per cent. The CNM told Inspectors that nurses resigned for a variety of reasons, including to undertake further training, new jobs, personal reasons and to go travelling. However, no systematic evaluation of the reasons for the increase in turnover had been undertaken.

All new nurses received an orientation to the Unit, which included the allocation of a 'buddy' or, for new graduates, a preceptor.[6] New staff who Inspectors spoke with spoke positively about the orientation process and the support they had received from colleagues.

Clinical supervision is available to nurses but the Nurse Consultant told Inspectors that a shortage of supervisors meant that there was a waiting list for supervision.

My Inspectors reviewed the training records of staff, which indicated that the majority of staff had undertaken the core mandatory training or had it scheduled in the new future. Nurses told Inspectors that professional development was encouraged on the Unit by means of post-graduate courses and regular in-house training sessions.

Data provided by the DHB showed that the average staff sickness rate for the Unit for the period 2015/16 to 2017/18 was 3.7 per cent.

Recommendations – staff

I recommend that:

9. The reasons for staff resignations should be analysed and, where necessary, appropriate remedial action be implemented.

[6] Preceptor: An experienced and competent nurse who provides support and learning experiences for a new graduate nurse.

Child, Adolescent and Family Inpatient Unit comments

Accepted recommendation 9

Acknowledgement

I appreciate the full co-operation extended by the Charge Nurse Manager and staff to the Inspectors during their inspection to the Unit. I also acknowledge the work involved in collating the information requested.

Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. List of people who spoke with Inspectors

Table 3: List of people who spoke with Inspectors

Senior Managers	Unit staff	Others
Service Manager	Charge Nurse Manager	Young people
Nurse Consultant	Clinical Nurse Specialist	Research Officer
	Registered nurses	Chaplain
	Enrolled nurses	
	Consultant Psychiatrist	
	Clinical Psychologist	
	Occupational Therapist	
	Pharmacist	
	Social Worker	
	Teacher	
	Youth Consumer Advisor	
	Family/Whānau Advisor	
	Pukenga Atawhai	

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 – health and disability facilities

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…"*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 (Ombudsmen Act) was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

The *New Zealand Gazette* of 6 June 2018 sets out in further detail the relevant places of detention:

> *"…in health and disability places of detention including within privately run aged care facilities; …"*

Carrying out the NPM's functions

Under section 27 of COTA, an NPM's functions, in respect of places of detention, include:

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

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the designated places they want to visit and the people they want to interview.

Section 34 of the COTA, confers the same powers on NPMs that NPMs have under any other legislation when carrying out their function as an NPM. These powers include those given by the Ombudsmen Act to:

1. require the production of any information, documents, papers or things that, in the Ombudsmen's opinion, relates to the matter that is being investigated, even where there may be a statutory obligation of secrecy or non-disclosure (refer sections 19(1), 19(3) and 19(4) of the Ombudsmen Act); and
2. at any time enter and inspect any premises occupied by any departments or organisation listed in Schedule 1 of the Ombudsmen Act (refer section 27(1) of the Ombudsmen Act).

To facilitate the exercise of the NPM function, the Chief Ombudsman has authorised inspectors to exercise the powers given to him as an NPM under COTA, which includes those powers in the Ombudsmen Act for the purpose of carrying out the NPM function.

More information

Find out more about the Chief Ombudsman's NPM function, and read his monitoring reports, online: www.ombudsman.govt.nz under *What we do > Protecting your rights > Monitoring places of detention*.

Ombudsman

Fairness for all

COTA Report

Report on an unannounced visit to Te Whare Hohou Roko (Extended Care Secure Unit) Under the Crimes of Torture Act 1989

1 May 2016

Judge Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

Contents

Figures

Executive Summary

Background

1. In 2007, the Ombudsmen were designated one of the National Preventive Mechanisms (NPMs) under the Crimes of Torture Act (COTA), with responsibility for examining and monitoring the general conditions and treatment of clients in New Zealand secure hospitals.

2. On 5 to 6 April 2016, Inspectors 9(2)(a) [redacted] (to whom I have delegated authority to carry out visits of places of detention under COTA[1]) visited Te Whare Hohou Roko (Extended Care Secure Unit) (the Unit) which is located in Hillmorton Hospital grounds.

Summary of findings

3. The Inspectors' findings may be summarised as follows:

- Generally, clients were complimentary about the staff in the Unit and felt there was someone they could turn to if they had any concerns.
- Inspectors observed good client/staff relationships with respectful interaction taking place.
- Clients stated that they had their own bedroom which they could lock, if they chose to and access to clean bedding and showers daily.
- Clients said they could access fresh air in the external garden/courtyard throughout the day.
- There were no complaints about the food, access to the telephone or access to family or friends.
- Although looking tired in places, the Unit was clean, tidy and reasonably well maintained.
- There is a large selection of programmes/activities on offer to clients.
- Clients were very positive about the occupational therapist (who also delivered programmes and took clients off the Unit to undertake activities).
- Clients are invited to attend weekly resident's meetings to discuss unit issues.
- Clients receive a copy of their multi-disciplinary team (MDT) minutes.

[1] Acting under delegation of the NPM Judge Peter Boshier and Ombudsman Professor Ron Paterson.

4. The issues that need addressing were as follows:

- Contact details for the District Inspectors were not easily accessible to clients.
- The DHB complaints management policy was out of date.
- Carpet was looking tired and worn in places. The air-conditioning didn't appear to be working effectively.
- Clients do not have ready access to refreshments.
- Clients are not afforded privacy when using the telephone.

Recommendations

5. I recommend that:

a. Contact details for the District Inspector should be displayed in an area easily accessible to clients.

b. The DHB should consider reviewing its complaints management policy to include a review date.

c. Worn and frayed carpet should be replaced (this was a suggestion for improvement following our visit in 2012). The air-conditioning system needs to be overhauled.

d. Clients should be able to access refreshments (minimum of water) throughout the day.

e. Clients should be offered privacy when accessing the telephone.

6. Follow up visits will be made at future dates as necessary to monitor implementation of the recommendations.

Consultation

7. A draft copy of this report was forwarded to Te Whare Hohou Roko (Extended Care Secure Unit) for comment as to fact, finding or omission prior to finalisation and distribution. Their comments have been included throughout the report.

8. Under sections 27 and 36 of the Crimes of Torture Act, it is the intention of the Chief Ombudsman to report to Parliament on his analyses of inspections carried out. Of course such reports will be published. It seems fair and proper to advise you that this will occur as of 1 July 2016.

Facility Facts

Te Whare Hohou Roko (Extended Care Secure Unit)

The Unit is one of three Regional Forensic Psychiatric Service Mental Health Inpatient Units on the Hillmorton Hospital campus. The service 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 treatment.

Te Whare Hohou Roko provides specialist ongoing treatment for clients who have a diagnosed severe and enduring mental illness. The Unit provided rehabilitation opportunities depending on clinical, legal and individual assessment for consumers to develop skills that promote positive life change[2].

This is a locked unit. The average length of stay is 3-4 years.

Region

Canterbury – referrals coming from across Canterbury, Timaru, West Coast, Nelson/Marlborough, and Dunedin.

District Health Board (DHB)

Canterbury

Operating capacity

9

Clinical Nurse Manager (CNM)

9(2)(a) [redacted]

Director Area Mental Health Services (DAMHS)

9(2)(a) [redacted]

Last inspection

Unannounced inspection – August 2012

Announced visit – May 2008

[2] Te Whare Hohou Roko - Service Provision Framework.

The Visit

9. The visit of Te Whare Hohou Roko (Extended Care Secure Unit) took place on 5 to 6 April 2016 and was conducted by 9(2)(a) [redacted]

Visit methodology

10. The manager of the Unit provided the following information at the time of the visit:

- A list of clients and the legislative reference under which they were being detained (at the time of the visit).
- The seclusion and restraint data for the previous twelve months and the seclusion and restraint policy.
- The number of complaints for the previous six months and the complaints policy.
- Information for clients on admission.
- Visits policy.
- Activities programme.
- A list of all staff trained in use of restraint and reasons for those not up to date.
- Community meeting minutes for the past three months.

11. At the commencement of the visit the Inspectors met with the Manager, Te Whare Hohou Roko (Extended Care Secure Unit), before being shown around the Unit. On the day of the visit there were eight clients in the Unit comprising five males and three females.

12. The following areas were examined on this occasion to determine whether there had been torture, or other cruel, inhuman or degrading treatment or punishment, or any other issues impacting adversely on detainees. [3]

- **Treatment**

  Torture, or other cruel, inhuman or degrading treatment

  Seclusion

  Restraints

  Electro-convulsive therapy (ECT)

  Clients' views

- **Protective measures**

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

Complaints process

Records

- **Material conditions**

  Accommodation

  Food

- **Activities and communications**

  Outdoor exercise

  Leisure activities/programmes

  Access to visitors

Evidence

13. In addition to the documentary evidence provided during the visit, Inspectors spoke to the manager of the Unit, the manager of Te Whare Manaaki, occupational therapists, service manager, social worker, psychiatrist, staff and three service users.

14. Inspectors also inspected records, were 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 clients had been subject to anything that could be construed as torture, and other cruel, inhuman or degrading treatment or punishment in the six months preceding the visit.

Seclusion

Seclusion facilities

16. The Unit does not have a seclusion facility. If a client requires seclusion they are moved to a seclusion room in Te Whare Manaaki (which is located next door). There has been one occasion in the last twelve months which required a client to be placed in seclusion.

Restraints

17. There was one incident of restraint for the twelve months preceding the visit. The client was moved to Te Whare Manaaki.

18. It appeared from the information provided at the time of the inspection that all staff in the Unit (including the occupational therapists and manager) were in date with their safe practice and effective communications training (SPEC).

Electro-convulsive therapy (ECT)

19. There was one client undergoing a course of ECT treatment (without consent) in the Unit at the time of the inspection. Second opinion paperwork had been completed.

Clients' views on treatment

20. Generally, clients were complimentary about the staff in the Unit and felt there was someone they could turn to if they had any concerns. Inspectors observed good client/staff relationships with respectful interaction taking place. Clients stated that they had their own bedroom which they could lock, if they chose to and access to clean bedding and showers daily.

21. Clients said they could access fresh air in the external garden/courtyard. There were no complaints about the food, access to the telephone or access to family or friends. Clients were very positive about the programmes/leisure activities available to them.

22. Clients are invited to attend monthly resident's meetings to discuss unit issues (minutes were provided to the Inspectors). Meetings cover a range of issues from new arrivals, food quality and activities available.

23. Clients have access to both the consumer advisor and family advisor and are able to raise issues at the weekly consumer meetings.

24. The Unit is also part of the "women in secure care" initiative. Developed in 2009 to review the standards of care for women in secure mental health services.

Recommendations – treatment

25. I recommend that:

    - I have no recommendations to make.

Protective measures

Complaints process

26. An out-of-date copy of the DHB complains process was provided (dated April 2009).

27. The complaints process is readily available in the Unit dining room although contact details for District Inspectors were not displayed in an area easily accessible to clients.

28. Suggestions, Compliments and Complaints forms were located next to the client telephone.

29. Health and Disability posters were visible throughout the Unit.

30. There was one recorded complaint in the Unit for the six months preceding the visit. The complaint was dealt with in a timely and satisfactory manner.

Records

31. There were eight clients in the Unit on the day of the visit and the Inspectors checked all of their files.

32. Four clients were being detained under the Mental Health (Compulsory Assessment and Treatment) Act, and five under the Criminal Proceedings (Mentally Impaired Persons) Act.

33. All files contained the necessary paperwork to detain [and treat] the clients in the Unit.

34. The Inspectors attended several multi-disciplinary team (MDT) meetings and considered them to be comprehensive and well attended. The social worker provides feedback to each client following the MDT and provides a copy of the meeting outcomes.

35. Section 76 MHA reviews (Certificate of Clinical Review of Conditions of Patient Subject to Compulsory Treatment Order) were in date.

Recommendations – protective measures

36. I recommend that:

a. Contact details for the District Inspector should be displayed in an area easily accessible to clients.

b. The DHB should consider reviewing its complaints management policy to include a review date.

Material conditions

Accommodation

37. Set in the grounds of Hillmorton Hospital, the Unit, both inside and out, is clean and tidy and has an open, spacious feel about it.

38. There are nine bedrooms (all with en-suite facilities) separated into male and female zones. Rooms are reasonably large with adequate storage and natural light. Bedrooms can be locked from the inside and have curtains for privacy. The Unit does not use night safety orders.

39. Clients have access to clean bedding on request and laundry facilities at their disposal.

Figure 1: Typical bedroom

Figure 2: En-suite bathroom

40. There are several quiet areas and three TV lounges (a general lounge and separate female and male lounges). All areas were clean and tidy although the carpet, in places was worn and frayed. The air-conditioning was not particularly effective with some rooms and offices stifling in the summer time.

Food

41. Meals are prepared in the main hospital and bought to the Unit in a trolley. Clients have a choice of meals from a daily menu. The quantity and quality of the food on the day of the visit was satisfactory. There were no complaints about food.

42. Breakfast is scheduled from 8.00 – 8.30am, lunch is 12pm and the evening meal from 5pm. Supper is also provided. Clients cannot access refreshments unless under supervising of staff. All meals are served in the dining area.

43. The Unit hosts BBQ and take away evenings on a weekly basis.

44. There were no concerns with regards to the quality or quantity of meals.

Recommendations – material conditions

45. I recommend that:

c.	Worn and frayed carpet should be replaced (this was a suggestion for improvement following our visit in 2012). The air-conditioning system needs to be overhauled.
d.	Clients should be able to access refreshments (minimum of water) throughout the day.

Activities and communications

Outdoor exercise

46. Clients have open access to fresh air throughout the day in a spacious, well maintained garden with adequate seating and shade.

Figure 3: Garden

Figure 4:Courtyard

47. The inspectors had no concerns with clients' access to fresh air.

Leisure activities/programmes

48. Two, part-time occupational therapist provide a wide range of programmes and leisure activities, either individually or in groups, to those clients well enough to access them, including community outings and a weekly women's group (see Appendix 1).

49. Clients have access to a selection of gym equipment (in the Unit) and a large sports hall (shared across the site). A well presented sensory modulation facility is available from 8am – 8pm.

50. A moderate sized activities room also doubles as a drop in centre/meeting room where clients can meet and discuss issues with staff or hang out with other clients at the coffee bar.

51. Pool, snooker and table tennis are also available to clients in the Unit.

Figure 5: OT lounge area

Figure 6: OT/activities area

52. The Inspectors had no concerns with clients' access to programmes and leisure activities.

Access to visitors/external communication

53. Clients can receive visitors if they choose. Visits take place in one of two rooms leading off the main foyer. There is some flexibility around visiting times depending on the visitors' personal circumstances. Visitor rooms were clean and tidy.

54. A telephone was available for clients in the Unit; however, its location (dining room) did not provide the user with adequate privacy.

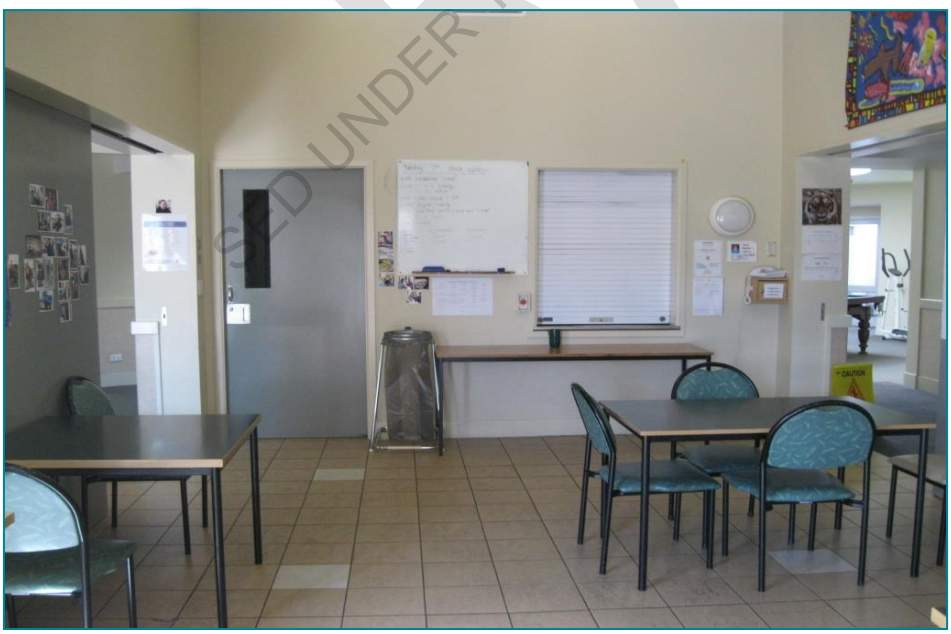

Figure 7: Telephone located in dining room (next to serving hatch)

55. Currently clients do not have access to computers however; a policy has been developed and awaiting sign off by the service management team.

56. Consumers' mail is delivered to the unit Monday to Saturday.

57. The Inspectors have no concerns with clients' access to family and friends.

Recommendations – activities and communications

58. I recommend that:

e.	Clients should be offered privacy when accessing the telephone.

Acknowledgement

59. I appreciate the full co-operation extended by the manager and staff to the Inspectors during their visit to the Unit. I also acknowledge the work involved in collating the information sought by the Inspectors.

Judge Peter Boshier
Chief Ombudsman
National Preventive Mechanism

Appendix 1. Unit photographs

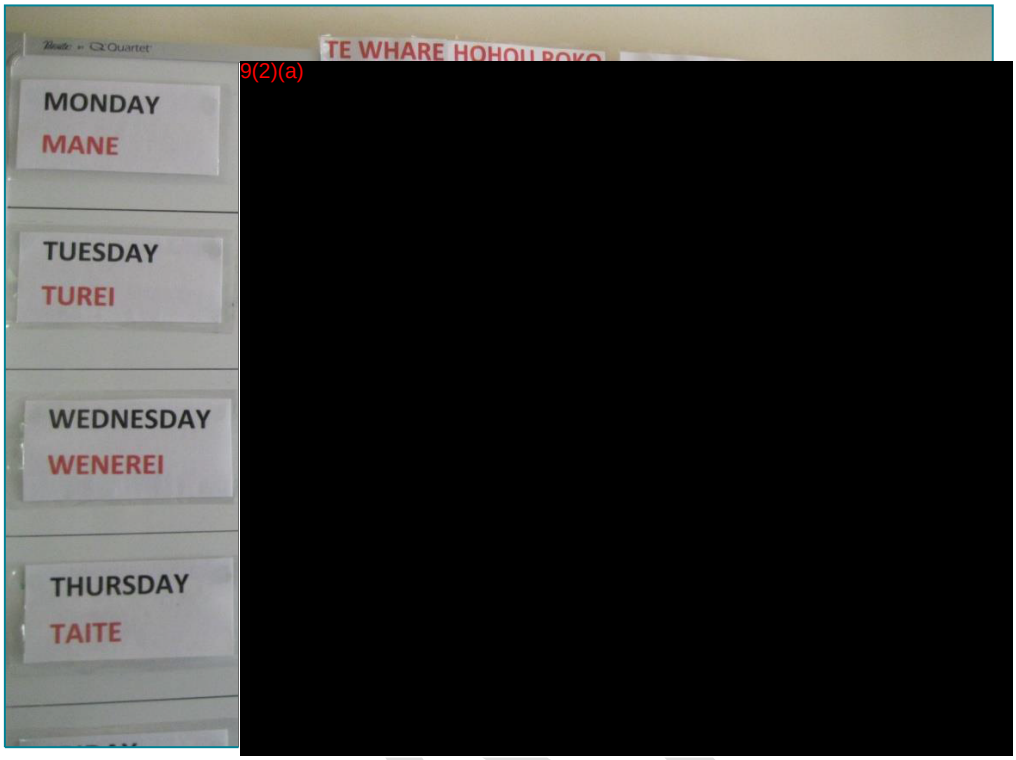

Figure 8: Activites board

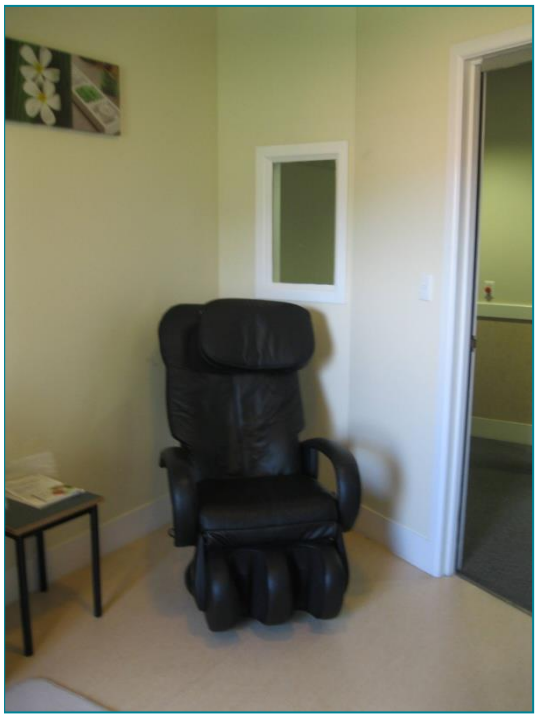

Figure 9: Sensory room

Figure 10: Sensory room

Figure 11: Entrance into the Unit – male area to the left, females straight ahead

.

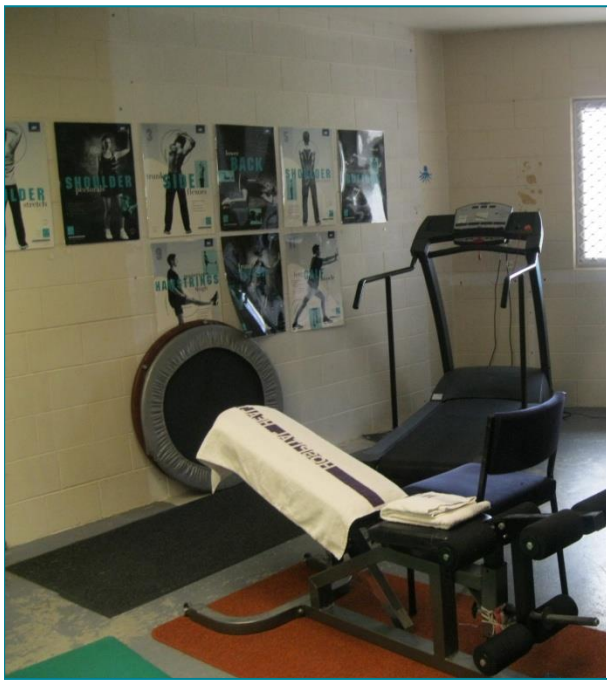

Figure 12: Selection of gym equipment

Figure 13: Male zone

Figure 14: Visitors room

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

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. 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…"*

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.

Under section 27 of COTA, an NPM's functions, in respect of places of detention, include:

1. to examine the conditions of detention applying to detainees and the treatment of detainees; and
2. to make any recommendations it considers appropriate to the person in charge of a place of detention:

a.	for improving the conditions of detention applying to detainees;
b.	for improving the treatment of detainees;
c.	for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

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.

Under COTA, NPMs are entitled to:

1. access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;

2. unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
3. interview any person, without witnesses, either personally or through an interpreter; and
4. choose the places they want to visit and the persons they want to interview.

Appendix 2

SGS New Zealand Ltd
PO Box 8032, Christchurch, Christchurch, 8440
nz.industrial.iqp.admin@sgs.com
www.sgs.co.nz
0800 103 433

Hillmorton Hospital ANNUAL IQP REPORT FOR BUILDING WARRANT OF FITNESS

30 Mar 2020

Building Details

Building Name	CDHB Hillmorton Hospital
Building Owner	CDHB
Building Address	1 Lincoln Road, Spreydon Christchurch Canterbury, 8024 New Zealand
Compliance Schedule (CS) Number	50365
B.W.O.F Expiry Date	1 May

Inspected Details

Inspected By	9(2)(a)
Inspection Date	02 Mar 2020

System 1 – Automatic Suppression Systems for Fire Protection

The Fire sprinkler systems are maintained by	Chubb
A compliance certificate has been requested from	Chubb

System 2 – Emergency Warning Systems for Fire

The site fire alarm system is tested and maintained by	Chubb
A Compliance Certificate has been requested from	Chubb

System 3/2 – Access Controlled Doors

Access controlled doors are part of the security system and are serviced and maintained by	Evotek
A compliance certificate has been requested from	Evotek

System 3/3 – Automatic Release Fire Control Doors

The site auto release fire control doors were checked for correct operation by	Chubb
The site auto release fire control doors were tested by	Chubb
A Compliance Certificate has been issued by	Chubb

System 4 – Emergency Lighting Systems

The self-contained Exit lights and Emergency lights are tested as required either - Monthly, Six-Monthly and annually, these are inspected and tested by	Chubb
A Compliance Certificate has been requested from	Chubb

System 7- Automatic Water Backflow Protection

Submitted 9(2)(a) @ 10:21:16 30 Mar 2020 Version: 32
Submission ID: 4316682
Environment friendly, paperless solution by www.formitize.com

All site Automatic Water Backflow devices are maintained and surveyed by	SGS NZ Ltd
A Compliance Certificate has been requested from	SGS NZ Ltd
Comments	All backflow preventers operated correctly. The air gap for the kitchen supply tank is correct. The kitchen hose vacuums are present and correct.

System 8/1 – Passenger Lifts / Goods Lifts

The site passenger lifts are serviced and maintained by	Otis
The annual certificates are issued by	Otis
A Compliance Certificate has been requested from	Otis

System 9 – Mechanical Ventilation & Air Conditioning Systems

The site HVAC systems are maintained by	Piersons
A Compliance Certificate has been requested from	Piersons

System 14/1 – Emergency Power Systems

A Compliance Certificate has been issued by	9(2)(a)

System 14/2 – System Signage

All system and Building signs have been inspected by	SGS NZ Ltd
Comments	All system signs are present, legible and correct.

System 15/ 1, 2, 3, 4, 5

All escape routes have been inspected by	SGS NZ Ltd
The site fire separations (Passive system and Fire doors) has been inspected by	SGS NZ Ltd
Comments	All exit doors were unobstructed and opened as required. All fire doors and separations were correct , visual inspection only. All evacuation signage were correct, visable and legible. All smoke doors and separations were correct, visual inspection only.

Additional Features

Safety Barriers and Stair Hand Rails	All safety barriers and handrails were in good order as installed.
Disabled Persons Access and Facilities	All disabled access and facilities were in good order as installed.
Comments	All fire equipment has been inspected by Chubb. A visual audit was completed and those inspected were correct.

Final Comment

The Building Warrant of Fitness:	will be signed by SGS New Zealand Limited when all 12A's (Certificates of Compliance) have been received from contractors and any remedial works have been repaired and undertaken as required under the Compliance Schedule.

When signed, a copy of the Building Warrant of Fitness will be forwarded to the local Council with a copy of 12A's signed by respective IQP's for the Council's records.

Once issued, Please arrange to display the Building Warrant of Fitness in a prominent position where all persons using the building have access.

Submitted 9(2)(a) @ 10:21:16 30 Mar 2020 Version: 32
Submission ID: 4316682
Environment friendly, paperless solution by www.formitize.com

Yours sincerely	
Name of the consultant	9(2)(a) [redacted]
Date	30 Mar 2020

Submitted [redacted] @ 10:21:16 30 Mar 2020 Version: 32
Submission ID: 4316682
Environment friendly, paperless solution by www.formitize.com

SGS New Zealand Ltd
PO Box 8032, Christchurch, Christchurch, 8440
nz.industrial.iqp.admin@sgs.com
www.sgs.co.nz
0800 103 433

97 Cashmere Rd Chch Annual IQP Inspection Report 07 Apr 2020

Building Details

Building Name	Princess Marg Hospital
Building Owner	Canterbury District Health Board
Building Address	97 Cashmere Road, Cashmere Christchurch Canterbury, 8022 New Zealand
Compliance Schedule (CS) Number	WOF 51981
B.W.O.F Expiry Date	01 June

Inspected Details

Inspected By	9(2)(a)
Inspection Date	27 Mar 2020

System 1 – Automatic Suppression Systems for Fire Protection

The Fire sprinkler systems are maintained by	Chubb
A compliance certificate has been requested from	Chubb
Comments	The sprinkler systems are tested and maintained by Chubb a 12a certificate has been requested

System 2 – Emergency Warning Systems for Fire

The site fire alarm system is tested and maintained by	Chubb
A Compliance Certificate has been requested from	Chubb
Comments	The Fire alarm Systems are tested and maintained by Chubb a 12a certificate has been requested.

System 3/1 – Automatic Egress Doors

The Site Auto egress doors are serviced and maintained by	Commercial Doors
A compliance certificate has been requested from	Commercial Doors
Comments	Commercial Doors service and maintain the auto egress doors a 12A certificate has been requested.

System 3/2 – Access Controlled Doors

Access controlled doors are part of the security system and are serviced and maintained by	Evoteck
A compliance certificate has been requested from	Evoteck
Comments	The access controlled doors are serviced and maintained by Evoteck, a 12a certificate has been requested.

System 3/3 – Automatic Release Fire Control Doors

Submitted by 9(2)(a) @ 11:51:41 07 Apr 2020 Version: 32
Submission ID: 4349805
Environment friendly, paperless solution by www.formitize.com

The site auto release fire control doors were checked for correct operation by	Chubb
The site auto release fire control doors were tested by	SGS NZ Ltd
A Compliance Certificate has been issued by	SGS NZ Ltd
Comments	All automatic closing fire or smoke doors with checked for operation and were found to be correct.

System 4 – Emergency Lighting Systems

The self-contained Exit lights and Emergency lights are tested as required either - Monthly, Six-Monthly and annually, these are inspected and tested by	Chubb
A Compliance Certificate has been requested from	Chubb
Comments	The emergency lighting systems are tested and maintained by Chubb. A 12A certificate has been requested

System 5 - Air Pressurisation Systems

A Compliance Certificate has been issued by	Chubb
Comments	Chubb maintain the pressurisation system, a 12a certificate has been requested.

System 6 – Riser Mains for Fire Service Use

The site Fire hydrant systems are maintained and tested by	Chubb
A Compliance Certificate has been requested from	Chubb
Comments	Chub service and Maintain the dry Riser systems, a 12A certificate has been requested.

System 7- Automatic Water Backflow Protection

All site Automatic Water Backflow devices are maintained and surveyed by	SGS NZ LTD
A Compliance Certificate has been requested from	SGS NZ LTD
Comments	All Back flow devices, Vacuum breakers and air gaps have been inspected by SGS NZ Ltd

System 8/1 – Passenger Lifts / Goods Lifts

The site passenger lifts are serviced and maintained by	Otis
The annual certificates are issued by	Otis
A Compliance Certificate has been requested from	Otis
Comments	12a Certificate have been requested from Otis Elevators for the lifts.

System 9 – Mechanical Ventilation & Air Conditioning Systems

The site HVAC systems are maintained by	Pierson
A Compliance Certificate has been requested from	Pierson
Comments	All HVAC and ventilation systems are serviced and maintained by Pierson's a 12A certificate has been requested.

System 13 - Smoke control systems

Submitted 9(2)(a) @ 11:51:41 07 Apr 2020 Version: 32
Submission ID: 4349805
Environment friendly, paperless solution by www.formitize.com

A Compliance Certificate has been requested from	Chubb
Comments	A 12a certificate has been requested from Chubb for the smoke control systems.

System 14/1 – Emergency Power Systems

A Compliance Certificate has been issued by	9(2)(a)
Comments	The emergency generator system is serviced amd tested by 9(2)(a) a 12a certificate has been requested.

System 14/2 – System Signage

All system and Building signs have been inspected by	SGS NZ Ltd
Comments	All system signage is complete and legible

System 15/ 1, 2, 3, 4, 5

All escape routes have been inspected by	SGS NZ Ltd
The site fire separations (Passive system and Fire doors) has been inspected by	SGS NZ Ltd
Comments	All exit doors at clear unobstructed and free to use. All fire separations for a checked visually and found to be in good order. All evacuation signage it's clear present and legible. All smoke separations are visually inspected and found to be in good order

Additional Features

Safety Barriers and Stair Hand Rails	All barriers and hand rails were inspected and found to be as installed.
Disabled Persons Access and Facilities	Disabled access and facilities were in good order as installed.
Comments	All fire equipment was visually checked and found to be correct

Final Comment

Comments	The building warrant of Fitness will be issued when all compliance certificates have been received from all your contractors.
The Building Warrant of Fitness:	will be signed by SGS New Zealand Limited when all 12A's (Certificates of Compliance) have been received from contractors and any remedial works have been repaired and undertaken as required under the Compliance Schedule.

When signed, a copy of the Building Warrant of Fitness will be forwarded to the local Council with a copy of 12A's signed by respective IQP's for the Council's records.

Once issued, Please arrange to display the Building Warrant of Fitness in a prominent position where all persons using the building have access.

Yours sincerely	
Name of the consultant	9(2)(a)
Date	03 Apr 2020

Submitted by 9(2)(a) @ 11:51:41 07 Apr 2020 Version: 32
Submission ID: 4349805
Environment friendly, paperless solution by www.formitize.com