EXECUTIVE SUMMARY

Background

1 On 11 August 2000 the South Island Regional Manager, PPS requested that an employment investigation be undertaken in relation to staff working in the ERU. During the investigation it became apparent that there were management and systemic issues that had a significant impact on the events under investigation and could pose substantial risk to PPS. This report deals specifically with management and systemic issues identified during the employment investigation.

2 The findings of this report will relate to the South Island region. However, in our opinion, we consider it likely that many of the causative factors could be found throughout the Service.

Scope

3 This report addresses issues related strictly to what could be categorised as management and systemic. Where it is identified there is a failure to respond in a manner required by legislation, the PPM or normal responsible management practice, or where the systems in place have not been sufficiently robust to enable management to correctly deal with new or evolving situations there is an explicit finding. To support the statements within this report, findings made during the employment investigation will be described. These findings have been written to avoid direct references to any person and are aimed at providing a clear identification of the operational issues that need to be addressed within PPS.

Methodology

4 The data gathering processes for this report and the employment investigation report took place simultaneously. The methodology involved:

- Interviewing staff.
- Examining the activities that did or did not take place.
- Examining the legislative and/or policy requirements for the activities.
- Identifying the evidence to support the findings.
- Findings based on:
  - Substantiated evidence
  - Legal or procedural requirements
  - Identified non-compliance

Purpose of the Report

5 The intention of this report is to identify where mistakes were made and to deal with those mistakes. Before the organisation can move on from this

point, it must first acknolwedge its mistakes and develop processes in the light of those mistakes so that they are less likely to recur.

Contributing Factors

6 The Investigation Team is of the opinion that the issues discussed in this report resulted from management losing its strategic focus when dealing with a favoured group carrying out activities that often place the members of the group, other people and PPS in high-risk situations. The key system failures that allowed this to happen included:

- A lack of strategic planning;
- A lack of strategic direction;
- A lack of accountability;
- No written financial and personnel delegations.

7 The Investigation Team considers the most suitable method for addressing the identified mistakes is the application of the Department's risk management framework to all activities being undertaken. This approach to dealing with work system failures and potential failures should now form part of the management planning and operational processes.

8 These organisational risk factors will remain within the organisation while managers consider it appropriate to accept 'operational reality' as an excuse for non-compliance of work system requirements. There is a justification for accepting the 'operational reality' argument at the time of the failure, that is, when it is found that the operational reality of the situation will not allow proper compliance with organisational policies and procedures. Application should then be made for a local exemption from the procedural requirements. Under no circumstances should managers accept the 'operational reality' excuse for non-compliance with legislation and regulations.

Findings

9 Findings from the employment investigation have been used to support the statements contained in this report. These findings appear at the end of the relevant section of the report and have had all personal references removed.

Overall Finding

10 The issues raised in this report can be seen in other institutions although not usually to the same extent. PPS needs to examine the issues with an open mind and with the intention of making sure that where weaknesses (risks) exist they are identified, analysed and treated. The headings and sub-headings used in this report will provide a suitable starting point.

Options for Management

11 PPS managers be required to be able to demonstrate that the Department of Correction's Risk Management Framework has been applied to ensure all likely risk factors are identified, analysed and mitigated before, during and after all organisational activities.

12 PPS management to review its current strategic reporting procedures to ensure all work groups and entities are correctly aligned to the organisational goals and objectives. This review should formalise suitable reporting structures to support activities that include but are not limited to:

- Strategic Planning;
- Strategic Direction; and
- Issue and review of Written Delegations.

13 PPS management to review its current Regional Operational Planning procedures to ensure all work groups and entities have clearly documented policies and procedures that ensure transparancy and maintain organisational and regional accountability, compliance and performance measures. This review should formalise suitable operational processes for undertaking and recording planning activities that include, but not limited to:

- Operations' Planning;
- Vehicle Check Points Planning and Performance Measurement; and
- Handling, Management and Disposal of Exhibits.

14 PPS management to review its current management practices of operations that are not considered as 'business as usual' conducted by corrections staff. The documented procedures that could be considered include, but are not limited to:

- Risk assessments of proposed operational activities;
- Documentation of the Operational Plan;
- Clear statement setting out expected expenditure and resource allocation approvals;
- Sign Off/Approval of Operational Plan by approving Regional Manager;
- Conduct and documentation of briefings and debriefings of all personnel involved in the conduct of the operation;
- Completion of final report outlining the results of the objectives as set out in the Operation Plan; and
- Completion of report on non-compliance issues where 'operational reality' prevented full compliance.

15 PPS management to undertake a review and provide a clear statement of expectations and requirements for procedures to be followed regarding:

- The use of off-duty corrections officers to perform PPS dutys, particularly where the activity could require the off-duty officer to deal with inmates;
- The authorisation of training activities for corrections officers that is not part of an approved training schedule; and
- Maintenance and signing of Time Sheets by corrections officers.

Recommendations to the General Manager PPS

16 We recommend that you:

(a)	**Receive** this report on the management and systemic control weaknesses arising from the ERU investigation;	**YES/NO**
(b)	**Note** that the report is directed at the identification, acceptance and correction of systemic control weaknesses found during the investigation and likely to be found in other areas of PPS;	**YES/NO**
(c)	**Accept** the findings and the Options for Management;	**YES/NO**
(d)	**Refer** this report to NST for implementation of the Options for Management;	**YES/NO**

INTRODUCTION

Purpose

17 The purpose of this report is provide the General Manager, Public Prisons Service (PPS) with information to enable him to identify areas of risk in relation to non-compliance with legislation and departmental standards. This includes the Penal Institutions Act 1954, Penal Institutions Regulations 2000 and policies and procedures. It is to address the management and systemic issues arising from the Emergency Response Unit (ERU) employment investigation.

Background

18 On 11 August 2000 the South Island Regional Manager, PPS requested that an employment investigation be undertaken in relation to staff working in the ERU. During the investigation it became apparent that there were management and systemic issues that had a significant impact on the events under investigation and posed substantial risk to PPS. This report deals specifically with management and systemic issues identified during the employment investigation.

19 The findings of this report will relate to the South Island region. However, in our opinion, we consider it likely that many of the causative factors could be found throughout the Service.

Scope

20 This report addresses issues related strictly to what could be categorised as management and systemic. That is, where a failure to respond in a manner required by legislation, the PPM or normal responsible management practice, or where the systems in place were not sufficiently robust to enable management to correctly deal with new or evolving situations, there is an explicit finding. To support the statements within this report, findings made during the employment investigation will be described. These findings have been written to avoid direct references to any person and are aimed at providing a clear identification of the operational issues that need to be addressed within PPS.

Investigation Team

21 The investigation team comprised of Maureen Love, Manager, Human Resources, South Island Prisons, John Kinney, Team Leader, Operational Audit – Internal Audit Group and Tony Dyer, Manager Operational Risk.

Methodology

22 Because they could not be separated out, the data gathering processes for this report and the employment investigation report took place simultaneously. The methodology involved:

- Interviewing staff.
- Examining the activities that did or did not take place.
- Examining the legislative and/or policy requirements for the activities.
- Identifying the evidence to support the findings.
- Findings based on:
    - Substantiated evidence
    - Legal or procedural requirements
    - Identified non-compliance

Operational Standards and Reality

23 It has been argued and accepted by the decision-makers that the investigating team lacked an appropriate understanding of the 'operational realities' of managing a prison. Based on this, the decision-makers accepted that the team failed to appreciate and factor into the findings that a strict interpretation and application of the law and procedures is <u>not always</u> suitable to the operational needs of a prison. The argument was that, in many instances, staff must respond in ways that are not covered by the legislation, policies and procedures and that it is acceptable to do so in certain circumstances.

24 The investigation team is not experienced in carrying out custodial duties, that is, they have had no 'key time'. The team relied on legislation and the Department's policies and procedures as being the required operational standards together with, the advice of experienced operational managers. The 'operational reality' issue did not surface until the conclusion of the investigation. Had there been any documented requests for rationalisation of impractical policies, notice would have been taken in the compilation of the investigation report. As a result, the investigation team has made all of its findings exclusively on the documented standards, policy and legislation.

Risk Management Framework

25 Not all of the systemic failures discussed in the report are covered under the ICR. It is important that the Department's Risk Management Framework is adopted and used at all levels of the organisation. Had a risk management approach been used in these instances many of the failures would have been dealt with. For example, identifying and managing the risks associated with VCPs; the risks associated with organisational objectives where no planning had taken place for their achievement.

Report Format

26 This report has been developed to address four major areas of management and systemic issues. These areas can be categorised as:

- Strategic
- Operational Processes
- Management of Operations
- Human Resources

Option for Management

27 PPS managers be required to be able to demonstrate that the Department of Correction's Risk Management Framework has been applied to ensure all likely risk factors are identified, analysed and mitigated before, during and after all organisational activities.

STRATEGIC

28 trategic risks to PPS are those that, in many ways, enabled the circumstances leading to the need for the investigation to arise. The investigation found that there were shortcomings in the four major strategic management areas of planning, direction, accountability and delegations.

Planning

29 Local management was able to set up a group of staff with significant resource allocations without a business case to do so, outside the existing structure and without suitable accountability systems in place.

30 There was a brief ‘Vision Statement’ when it was initially formed but this never developed further into a proper management plan able to link the Unit’s activities with the organisational aims and objectives. As a result the Unit was able to develop its own direction that, often, did not coincide with the organisational direction.

31 The ERU never had a clear business plan under which it was to operate, and combined with the Unit’s lack of management, this enabled the circumstances to arise where the Unit acted without direction or control for most of its existence.

32 The lack of a suitable Business Plan also enabled management to:

- use the Unit as an ‘odd-job’ group that would be used to perform duties for which its members were not trained and, in some cases, for which they had no authority to undertake; and
- enabled ERU management to perform in a totally unacceptable way, acting as they please in dealing with staff, inmates and visitors.

33 It was this lack of a Business Plan that led to the lack of guidance and direction for the members of the Unit. The failure to develop and implement a Business Plan for the activities of the ERU led to the following specific findings during the investigation:

33.1 When the ERU was set up there were no strategic or business plans developed that gave a clear picture of its purpose, resourcing, budgets and targets.

33.2 There were no clear qualitative or quantitative performance measurements in place for the ERU’s manager to achieve.

33.3 The Manager gained the ERU responsibility by default, ie., there was no transparent appointment process.

33.4 Two senior managers oversaw the activities of the ERU. This created unclear management lines, lack of accountability and responsibility for the actions of the Unit and resulted in the inappropriate use by ERU staff of delegations and the ability to avoid getting the correct authorisation and approvals for some activities.

Direction

34 The lack of proper plans and initial organisation resulted in the ERU lacking strategic direction. Its activities were never qualified and did alter over time. The Unit's duties were usually reactive or followed simplistic lines usually without co-ordination of other sections or activities within the prison. This lack of strategic direction resulted in the following findings:

34.1 The ERU was never required to provide complete records of actions taken with regard to:
- Seizure of property
- Seizure of drugs
- Arrest of non-inmates

34.2 Joint activities with members of the New Zealand Customs, Police and Army were on an ad hoc basis based on whom the members knew.

34.3 The ERU was tasked by senior management to perform activities outside their training and mandate.

34.4 The ERU was tasked with activities not consistent with the corporate goals and objectives of the PPS or the Department.

34.5 Two senior managers were responsible for the Cost Centres operated by the ERU and had the ability to approve expenditure from these without reference to the other.

34.6 The dual reporting line for ERU management made responsibility and accountability unclear and enabled the ERU managers to pick which senior manager to go to for approval regarding any activity being undertaken.

Accountability

35 There were never any clear lines of accountability over the Unit. The Unit's managers did not have to provide performance reports (as there were no performance measures) and their activities were either unknown or misunderstood by senior managers. The Unit did not have to (and did not) provide regular performance updates. Similarly, senior managers did not provide any documented, specialised controls for compliance within the ERU.

36 The only controls placed over the activities of the ERU were the organisational and legislative requirements placed over all other areas of the organisation. However, it was found there was consistent non-compliance with the requirements by members of the ERU. Examples of the lack of accountability over the actives of the ERU are:

36.1 There appear to be no checks in place to ensure that staff were acting in accordance with PPM particularly in relation to the high risk activities such as the seizure of unauthorised items and the treatment of visitors.

36.2 There were no checks put in place by management to ensure that the financial management practices were being carried out by relevant staff in accordance with required procedures.

Delegations

37 PPS managers are assigned with explicit delegations to enable them to manage their areas of responsibility including financial, operational and personnel issues. The authority is delegated from the General Manager to the Regional Manager and the Regional Manager can then sub-delegate. Delegations must be in writing and relate to the individual and not the position.

38 The investigation found there were almost no formalised delegations for senior PPS operational managers within the Christchurch area. The Crime Prevention Officer had no written delegations with regard to any responsibilities. When staff acted up into positions which have delegations they are not provided with any form of sub-delegations. One of the results of this situation is that staff approved expenditure in direct contravention of the Code of Conduct.

39 Other evidence relating to the failure to provide proper delegations to managers includes:

39.1 Contrary to the Finance Manual and the Code of Conduct, expenditure was approved by the person who was one of the beneficiaries of that expenditure.

39.2 Managers with no financial responsibility or delegations for the cost centre to which the expense was charged, approved expenditure.

39.3 Payroll staff adjusted travel allowance claims on timesheets where they assumed the staff member had not made an entitlement claim. During the review of timesheets, the action taken by Payroll staff was incorrect and has cost PPS additional monies. The staff had initially completed their timesheets correctly and were not entitled to the payment.

39.4 Payroll staff have actioned advances without the requisite approval of the relevant Cost Centre Manager.

39.5 Unauthorised staff were able to regularly approve timesheets for their work mates. This is an inappropriate practice as timesheets are a claim for monies and therefore should only be approved by those with the correct financial delegation.

39.6 No checks were conducted on whether the appropriately delegated person is approving expenditure.

39.7 There appears to be no formal training conducted for staff “acting in positions” to assist them carry out their functions in accordance with documented procedure.

Option for Management

40 PPS management to review its current strategic reporting procedures to ensure all work groups and entities are correctly aligned to the organisational goals and objectives. This review should formalise suitable reporting structures to support activities that include but are not limited to:

- Strategic Planning;
- Strategic Direction; and
- Issue and review of Written Delegations.

OPERATIONAL PROCESSES

41 Operational processes are those activities undertaken by custodial staff as part of their 'business-as-usual'. The standards to be applied are defined in PPM and can be further supported by local procedures.

42 The major operational issues requiring comment that were raised during the investigation can be categorised under the headings, planning, vehicle control points, exhibits and operations' management.

Planning

43 In many of the activities undertaken by the ERU operational plans were formulated using the military style 'SMEAC' format. Copies were apparently made available to various managers within the Christchurch Prison, South Island Region and National Office. In some instances plans were not drawn up prior to the activity, for example, the Operation Build-Up plan never passed the draft stage (even though it exactly follows what happened from emails sent during the Operation). Additionally, the draft has been developed by editing the plan for Operation Blitzkrieg, which did not take place until four months after Operation Build-Up.

44 Poor operational planning presents a significant risk to the organisation as managers are approving activities and authorising expenditure of resources without having been told what is to be undertaken. Poor planning can also be seen as the main cause of the constant need for staff to be working in high-risk activities in their own time. The claim that excessive work was the reason for the non-compliance found during the investigation is not supported by the other actions of the staff. For example, it was found staff had sufficient time for some members to undertake activities not specifically relevant to PPS such as, personal fitness, yard maintenance for absent managers, bonding sessions (called training days) and unapproved baton training with the police.

45 Set out below are some of the organisational risks associated with a lack of PPS operational planning;

45.1 Operational Plans were not always developed in a timely way to provide sufficient information to support the managerial decision making processes. There were insufficient documentation and audit trails to verify that the activities undertaken complied with all PPS requirements.

45.2 Senior management cannot ensure members undertaking operational activities will maintain compliance with PPM if they are unaware of what is to happen.

45.3 Senior management accept what they are told verbally about the environment, operational issues, operational risks and intelligence as factual without documented information, further assessment or formal checking processes.

Vehicle Check Points (VCP)

46 The following PPMs apply to VCPs and can be used to measure the level of compliance during this activity:
- B.15.02, 'Searching persons other than inmates'
- B.15.03, 'Handling Exhibits'
- B.19, 'Narcotic Detector Dog Handlers'

47 VCPs expose PPS staff to dealing with unauthorised items such as alcohol, weapons and unlawful items including drugs. Additionally, VCPs increase the risks that always exist when staff deal with members of the public, particularly, those who resent authority. The investigation team did not locate any form of local operational checking that would address these significant risks to PPS eventhough a document was found to describe processes that would enable full compliance. Because VCPs became a major part of the ERU function they were also a major focus of the investigation.

48 Plans were never drawn up for conducting VCPs. There are considerable resources required for running of VCPs, however, they were never examined from a management point of view during the period covered by the investigation. Additionally, had plans been drawn up and followed, the management would have an audit trail that would allow them to be assured of the level of compliance by staff.

49 There were no arrangements for recording the effectiveness of VCPs. In fact, the National Office requested the provision of some data but this was never received.

50 There was no documentation kept that allowed measurement of the staff activity. The 'statistics' collected locally from each of the Christchurch VCPs were not passed on to any other area as performance measurements and do not give a clear indication of the work carried out. For example, they do not show the number of vehicles stopped or searched or the number and particulars of people stopped and searched. Records of people being denied access to the institution are all that was kept. In nearly all the cases this also included taking a photograph of the person and any contraband found on that person or in their vehicle.

51 The following are findings made with regard to the management of the Vehicle Check Points:

51.1 A 'Standing Order' that complied with the above PPM requirements provided by one of the ERU training officers was neither complied with nor audited.

51.2 Consistent non-compliance in dealing with contraband seized at VCPs where the chain of custody was, as a matter of course, broken was not identified through the present checking procedures. However, these processes do not provide for suitable auditable document trails such as:
- Receipting
- Exhibit sheets
- Numbered forms register

51.3 There is evidence that the statistics recorded at VCPs are inaccurate and do not reflect in all cases what has occurred. This includes the statistics relating to the seizure of unauthorised items and arrests. No records were kept of the number of vehicles that were stopped and searched.

51.4 The requirement of the National Crime Prevention Officer to provide statistics was not followed by the VCP staff and therefore not able to be provided to the National Office.

51.5 National Office failed to follow up on the lack of information being provided (Canterbury was not the only area not providing the information).

51.6 The failure to collect the relevant data has prevented comparisons between regions and the development of effective performance measures.

51.7 Photographs taken of people refused entry to a prison and later banned were retained in PPS files. Had there been suitable overview of the procedures this practice could have been identified and stopped.

Exhibits

52 PPS procedures for the seizure, recording, handling and disposal of exhibits coming into the possession of corrections officers are set out in PPM B.15.03. The Procedure Standard states:

An exhibit must be handled, stored, recorded and moved in a manner that ensures the validity of its use as evidence.

53 PPM, B.15.02.R6 (3) specifies that any unauthorised items seized from a visitor must be treated as an exhibit.

54 Based on these PPS requirements it is clear that any unauthorised items seized from a visitor to an institution must be treated as if it were an exhibit.

55 The ERU did not follow the procedures required in the PPM. In fact, in many cases, particularly where alcohol was seized, the investigation team was informed no record whatsoever was made of the seizure. There was general non-compliance with the PPM by members of the ERU. There is a clear lack of accountability and no audit trail in most instances examined.

56 The investigation team found a total lack of management oversight in this high-risk area of operations. Corrections officers were seizing unlawful items such as, drugs and weapons, then carrying these items on their person without any supporting records being made to acknowledge the seizure. All exhibits seized from visitors were usually given to the officer in charge of the VCP who then took them back to the ERU office. Exhibit bags were used but were generally not sealed. There are almost no records of any exhibits from VCPs being dealt with as required by PPM B.15.03. The investigation team found many sealed and unsealed exhibit bags in the ERU office area containing seized exhibits. These exhibits were lying around the office or had been put into a box for shipment to Wellington for use in a museum. These exhibits included weapons and drugs. One exhibit bag found by

the investigation team was empty and had never been sealed. Information recorded on the exhibit bag indicated it had contained drugs and a purse belonging to a woman. The contents were never found and there was no record of what had happened to this exhibit.

57 Senior managers did not appear to understand the requirements of PPM B.15.03. There was little knowledge among senior managers interviewed with regard to the procedural needs for documenting and appointing a designated officer to dispose, destroy or keep exhibits (see next section below). There is also a lack of understanding in the need to have all exhibits of drugs and other unlawful articles disposed of by the police and not Corrections Officers. The latter issues have been observed in several institutions.

58 Accountability procedures in dealing with exhibits should begin with the purchase of the exhibit bags used by staff. Currently there is no recording of the receipt of exhibit bags and although they are numbered there are no registers to record the movement of the bags. Numbered exhibit bags are to be found lying about offices and staff common rooms in most institutions.

59 As a result of this general lack of accountability it is not possible for a clear audit trail to be followed.

60 The failure to implement suitable management controls over exhibit handling procedures indicates several managerial and systemic failures. These include:

60.1 PPS exhibit bags are not recorded in a manner that enables accountability to be maintained.

60.2 Management failed to ensure PPM procedures were being followed in dealing with exhibits. For example, a box of nine, numbered but unrecorded exhibit bags containing unauthorised and unlawful items was located in the Crime Unit office. None of these exhibits had been treated in accordance with PPM requirements. No audit trail was attached to any and therefore, it was not possible to track back from whom the items were seized, when and by whom. One of the open exhibit bags indicated that it contained cannabis and a purse containing cannabis seized at a VCP was found to be empty. This is one example where there is substantive evidence of the removal of drugs.

60.3 The potential for the removal of drugs and other unauthorised items seized at VCPs was high because of the failure to comply with PPM and the failure of management to check for compliance with PPM.

60.4 Claims that drugs were retained, after seizure from visitors, were kept for training purposes could not be verified because no records were kept of the seizure, appointment of a designated disposal officer or disposal.

60.5 Very little of the considerable amount of contraband seized by members of the ERU is recorded in the Exhibit Register held by the institution's Security Office.

Disposal of Exhibits

61 PPM B.15.03 sets out that the disposal of exhibits must be witnessed, recorded and signed by a designated staff member and one other staff member. When an exhibit is no longer required a designated staff member must decide whether it be:

- Retained for staff training,
- Retained for museum purposes, or
- Destroyed.

Illegal items and drugs must be given to the police for disposal. The Superintendent is responsible for appointing a designated officer for disposal of exhibits.

62 It was found that with regard to the management of exhibits seized by the ERU, the Superintendent had not designated any staff member for their disposal. The investigation team was told however, that the disposal occurred by way of:

- The retention of a museum that does not officially exist,
- Retention of drugs for staff training purposes although no records were kept of courses run or members attending,
- Disposal of alcohol by various means and by unknown means, and
- Storage of retained items said to have been disposed of.

63 There are no ICR checks for the disposal of exhibits. ICR checks did not pick up the non-compliance and they are not targeted at the highest risks.

64 The Institution's exhibit register held by the Security Officer showed items had been twinked out and written over the top. This practice allows for the removal of exhibit items and removal of any record of that item. This practice should stop immediately.

65 It would appear that, at no time during the existence of the ERU, did senior managers consider the risks involved for PPS in the activities of the group. It was well known that drugs were being located and people arrested through the activities of the ERU. However, local senior managers conducted no checks and no action was taken with regard to the exhibits kept by the Unit and not disposed, in particular, the methods used for the disposal of seized drugs.

Option for Management

66 PPS management to review its current Regional Operational Planning procedures to ensure all work groups and entities have clearly documented policies and procedures that ensure transparancy and maintain organisational and regional accountability, compliance and performance measures. This review should formalise suitable operational processes for undertaking and recording planning activities that include, but not limited to:

- Operations' Planning;
- Vehicle Check Points Planning and Performance Measurement;
- Handling, Management and Disposal of Exhibits.

MANAGEMENT OF OPERATIONS

67 Operations conducted by the ERU, particularly those likely to draw outside attention, were subjected to high-level management overview. The investigation found that this overview did not provide for proper management of the operations. The three operations that became part of the investigation were given the titles, Build-Up, Mixed Herbs and Highlander. In each case there is no precedent or plan around the decision making processes for:

- Resource commitments;
- Responsibility and accountability for those involved; and
- Follow-up for the outcomes and effectiveness of the operation.

68 It was also apparent to the investigation team that senior management was often not advised of the real circumstances or only partially advised. Because of this and the senior management's lack of checking, the ERU was able to undertake high-risk activities without the proper supervision, training or mandate. In the opinion of the investigating team, a reasonable level of scrutiny of the activities would have alerted management to the dangers involved in the activities of the Unit.

Build-Up

69 his operation was conducted in five phases in December 1999, leading up to New Years Eve (Y2K). The mission for the operations as set out in the incomplete draft operation plan was, "To test security and security systems and to test inmate compliance to instructions within the Canterbury Region." The five phases were conducted in the Christchurch Men's, Rolleston and Christchurch Women's Institutions.

70 An operational plan was never drawn up for this operation. Because there was no forward planning for this operation, senior managers must have given approval on verbal briefings only. The reporting of the activities undertaken consisted only of emails sent to senior managers by the operation commander or second in charge following each phase and the C & R and Use of Force reports. Senior management agreed to the conduct of this operation without providing clear, written instructions to the officers who were to carry out the activities. Additionally, senior managers did not stop the activities when the contents of those emails clearly showed breaches of PPS policies and procedures.

71 This is apparently a significant area of the argument for justifying some actions by imposing 'operational realities' over documented requirements. The investigation team believes that the decision-makers consider the actions were in response to the needs of emergency responses for the 'operational reality of managing a prison'. However, the actions of the ERU should be looked at in the light of how they occurred. The investigation team does not agree that there was any good reason for moving away from the authorised procedures developed by experienced, operational corrections officers, particularly as there has never been any attempt since to improve on these procedures to better meet the so-called 'operational reality'.

72 The activities for the operation consisted of members of the ERU and some additional staff and 'observers' entering various wings/units after the inmates had been locked up for several hours. If an inmate called out for any reason he was ordered to be silent and if he did not comply was removed (usually under control and restraint) and taken to the Maxi (punishment) block.

73 The manner in which the operation was managed did not comply with the institutions own local instructions. In response to an incident several years earlier where an officer had been injured during an unlock after hours, Canterbury Prisons developed an after hours unlock procedure titled, 'The Controlled Unlock Plan'. That procedure was not complied with during Operation Build-Up. The Operation's Manager had given a *blanket approval* to carry out any unlock that the operation's commander deemed necessary during Operation Build-Up. This authority was not documented.

74 In Phase 4 of Operation Build-Up five inmates were removed and taken to the Maxi block. They were all subsequently charged with disobeying a lawful order. Four of these inmates were taken away under control and restraint holds. Another left his cell after negotiation and walked to the Maxi block. From the timings supplied in the documentation available it is apparent that proper procedures were not followed in four of the five instances, as there is insufficient time to undertake the initial negotiation required under PPM B.13.01.R1. No reasons for this non-compliance were provided in any of the documents the investigation team found that related to the incident. In the opinion of the investigation team, the cause of the problems stem from the actions of the ERU. At all times during this operation the inmates concerned were locked in their cells and could not pose any significant threat to the officers moving around outside the cells. The investigation team found it significant that there had been no trouble or security risk of any kind reported prior to the entry of the ERU team into the wings.

75 The fact that one negotiation process was successfully undertaken gives rise to wonder why the proper process could not be attempted in all instances.

76 It was during this operation that people, other than PPS custodial staff were invited by members of the ERU to attend as 'observers'. These 'outsiders' were military police and off-duty members of the police force. While their presence was not authorised prior to the night, senior managers said they would have approved it had they been asked and saw no problems in having non-PPS staff in the wings after-hours.

77 The ERU actions during this operation led to complaints from the inmates to:

- Ombudsman
- Howard League
- Unit Management
- Legal Representatives
- Prison Inspectorate

78 Management response to these complaints did not address the issues causing the inmates to complain and focused on whether or not the inmate complied with a direction. Senior management (or any of the investigating bodies) did not question why the ERU was present at the time the 'non-compliance' took place. Nor did

anybody question the right of off-duty corrections officers and observers to enter the institution and to give lawful directions.

79 Findings with regard to a failure to properly manage Operation Build-Up are:

79.1 The draft Operation Order for Operation Build Up was never finalised, therefore, senior management was approving actions on the basis of a verbal briefing only.

79.2 No intelligence documentation was used to support these verbal briefings as none existed. Claims that intelligence existed indicating problems between different gangs for New Years Eve were not received at the institution until the 29 December 1999 some time after Operation Build-Up was completed.

79.3 The draft Operation Order for Operation Build Up exactly follows the activities undertaken and has typed over the completed Operation Order for Operation Blitzkrieg which was conducted during March 2000 four months after Operation Build-Up.

79.4 Operation Build Up phases were conducted after lockup and in a provocative manner. The presence and activities of fully kitted and large numbers of ERU staff in the wings created concern for the inmates resulting in a reaction. Inmates' reaction to the activities undertaken during Operation Build Up was to question and abuse staff as was predictable.

79.5 There was no urgent emergency situation that required members of the ERU and their support to be in the Units/Wings after lock-up during any of the five phases of Operation Build-Up.

79.6 ERU staff reacted to inmate abuse by unlocking cells of abusive inmates stating that they failed to comply with lawful instructions.

79.7 The timings submitted in the Control and Restraint records and emails to senior managers show that Control and Restraint was used as a first resort to transfer inmates to the Maxi Block in contravention of PPM; B.13, "Use of Force (National Policy)".

79.8 Police and Military Police presence during phases of the operation was authorised by the Operation Commander. The Police Administration was not aware of the presence of the police officers during Operation Build-Up and stated that the police members were not officially on duty when present during the operation.

79.9 Operation Build Up led to official complaints from the inmates.

79.10 Management response to the Operation Build Up complaints did not address the issues causing the inmates to complain.

79.11 A number of the staff who carried out duties during Operation Build Up was not officially on duty. They were working in their own time therefore the authority for them to issue lawful instructions is questionable.

79.12 A letter drafted by the ERU and signed by the Regional Manager thanking the Police for their attendance during Operation Build-Up on 19 December 1999 contained the names of the inmates removed to the Maxi Block that night. This information should not have been contained in the letter.

Mixed Herbs

80 Operation Mixed Herbs is a clear example of where senior managers allowed the situation to develop into something PPS does not have the training, staff or authority to undertake. The response that followed the initial receipt of information could have resulted in an even greater tragedy than the one then threatening the organisation.

81 The operation began when a report was received at PPS National Office that a gang related inmate had threatened the life of a staff member at the Dunedin Prison. A corrections officer from Canterbury, who was visiting Dunedin at the time, began actions in response to this threat. During this time he maintained contact with, and provided advice to, senior managers of his actions. During these initial stages another corrections officer, under the direction of the first officer, contacted the local police with advice of the threat. Based on his advice, the police officer informed him that they would not become involved in dealing with the threat. This refusal by the police was reported to senior management who then, without checking any further, sent the additional members of the ERU to Dunedin to protect the staff member.

82 At no time during or after the operation did a senior PPS manager attempt to contact the police personally to ascertain why they would not act on such an apparently serious matter. During the employment investigation, contact was made with the police officer involved who informed the team members, in writing, that the information he received did not lead him to regard the threat as serious. His written statement was provided to the corrections officer who initially spoke with him and the corrections officer agreed with the contents of the police officer’s statement. Had a senior manager made contact at the time it is most probable this operation and its resultant expense could have been avoided. From the information supplied by the police officer it is also apparent that different forms of information were being passed by those involved in the operation.

83 Members of the ERU were authorised to travel to Dunedin and over the next week they undertook some potentially, extremely dangerous activities. Bearing in mind the threat was to shoot the staff member, these unarmed officers were placed in the Quality Inn Hotel, Dunedin and on public streets with instructions to protect the life of the staff member. They received a briefing on ‘close personal protection’ methods from untrained officers and then went about their duties. These duties included surveilling members of the public staying at the Quality Inn and standing guard both inside and outside the staff member’s home.

84 The officers were issued with PPS batons for use if the armed offender arrived. Batons were being carried outside the boundary of the institution. It is unknown exactly what was expected of these unarmed, untrained and unauthorised staff members if the potential armed threat did eventuate.

85 In the view of the investigation team, the decisions made by senior management to allow the operation to occur exposed their staff, and the Department, to an unnecessarily high-risk situation. It has been stated that it is the duty of PPS management to protect staff from this type of danger. The investigation team agrees completely with this statement, however, the investigation team does not agree that more staff should be put in danger in doing so. If the threat was significant enough to have the ERU spend more than a week in Dunedin then it would have been more practicable to move the staff member and his family away until the threat abated. It is also more practical to engage in high-level arrangements with the proper authority which, in this case, is the police. Endangering more lives, undertaking activities that are not part of the PPS function and expending unnecessary resources is not a suitable response to a perceived threat.

86 There has never been any type of risk assessment, before, during or after the exercise. There has not been any follow-up on the procedural aspects of the exercise for development of more appropriate procedures if such a threat arises again.

87 In addition to the inappropriate operational activities the management also failed to follow proper financial management practices. Officers without the delegations were approving expenditure.

88 At times staff were also performing all these potentially life-threatening activities while off duty.

89 The investigation team made the following findings with regard to the management of Operation Mixed Herbs:

89.1 There is no formal PPS protocol in relation to managing threats to the lives of staff.

89.2 Senior management did not establish a clear understanding of the alleged threat as there had been no preliminary investigation of the information, eg., interview the informant and the people alleged to have made the threat.

89.3 Senior management did not undertake high level discussions with the Police to deal with the threat. The only discussion that took place was at a low level and apparently did not include the provision of all relevant information.

89.4 There was no threat assessment undertaken before, during or after Operation Mixed Herbs.

89.5 The activities authorised and undertaken during Operation Mixed Herbs do not come within the corporate goals and objectives of PPS or the department. For example, PPS staff took over certain areas within the hotel

conducting surveillance on private citizens, members of PPS staff dressed in hotel staff uniforms while conducting surveillance on other hotel guests.

89.6 Senior management authorised PPS officers to undertake duties for which they had no legislated power, training or equipment outside prison property. This included unarmed members of staff placed in a vehicle in a public street with the understanding there could be an armed attack; PPS staff carried PPS batons outside prison property.

89.7 PPS staff inappropriately requested, obtained and recorded personal information on a guest of the hotel. This was done by requesting the Police to carry out a check on the Wanganui Computer. The information is contained in the 'Operation Log'.

89.8 Members of the PPS undertook inappropriate authorisation of expenditure during Operation Mixed Herbs.

89.9 A security system was purchased for the staff member's home. The purchase was not done in accordance with the requirements of the finance manual. It is acknowledged that the system was purchased quickly out of what was apparently deemed to be necessity however the cost was not capitalised as required and was recorded against an activity code for Psychiatric Services within the Dunedin prison cost centre.

Highlander

90 Operation Highlander followed Operation Mixed Herbs by two weeks. The operation related to information obtained that a firearm was hidden in Dunedin Prison. During the investigation there was some uncertainty as to how this information came to light with one member providing different versions. Finally it was agreed that the information came from an inmate after a PPS member had requested he obtain some information on a firearm believed to be in the prison. Twelve months previously, there had been talk of a firearm but this had ceased a considerable time before the operation was commenced. The reasons for asking the inmate to obtain the information are unclear.

91 Once the inmate returned and told the officer he believed a gun was being held in the prison senior management was advised of the reported existence of the firearm and agreed that the ERU should travel to Dunedin. Senior managers advised the investigation team that the decision was made to send the ERU to undertake the search as a training exercise. The team was also told, it was considered, at the time, more appropriate to use the more highly trained and experienced ERU than local officers albeit the Dunedin manager stated that local staff were competent to carry out the search.

92 The search was carried out and although no firearm was located, the officers involved reported that the operation had been a great success. Based on this report senior management authorised the purchase of wine (one bottle between two staff) during the meal that evening. PPS policy does allow for one drink per person with

their evening meal so this approval was not necessary but helped to hide the other actions of the staff member who sought the approval.

93 The invoice for the meals that evening indicated the purchase of wine and a ‘bar shout’ of $280.00. The entire invoice was paid for by PPS. The investigation team was told that the ‘bar shout’ was originally a personal arrangement by three officers but was belatedly approved by senior management for payment by PPS as a mark of appreciation for a job well done. Here, again, there was some confusion as to what had been authorised and what had not. Eventually it was agreed that a senior manager who was not authorised to incur the expenditure had given approval and the invoice was approved by a person who obtained a benefit from the goods and services purchased which is a direct breach of the Code of Conduct.

94 Senior management apparently approved, whether knowingly or not, the celebration of the operation’s ‘success’ by purchasing 17 meals for 14 people, eight bottles of wine at almost $200.00 and a further $280.00 worth of drinks from the bar. All of which is now said to have been sanctioned by a senior manager who never saw the invoice (until shown during the investigation) and approved for payment by a member of the celebrating party at Dunedin. This would indicate a lack of control over the procedures used for the operational and administrative activities during and after the operation.

95 The full cost of the exercise is unknown. However, as senior managers now state it was undertaken as a training exercise it would appear some of the expenditure is questionable. For example, the Department’s explosives dog was flown from the North Island.

96 The investigation made the following findings with regard to Operation Highlander:

96.1 Senior management did not assess the source and validity of the information that was the catalyst for determining the operation was to be undertaken.

96.2 Twelve staff travelled to Dunedin and stayed for two nights to undertake a search that took six hours and for which the local manager had said his staff were capable of carrying out. Additionally, the explosives detector dog and dog handler was flown from Hamilton to Dunedin for the exercise.

96.3 Payment of invoices was approved by people who were the beneficiaries of that expenditure contrary to the Finance Manual and the Code of Conduct.

96.4 No internal control checks are being carried out on whether the appropriately delegated person approves expenditure.

96.5 There appears to be no formal training conducted for staff acting in positions to assist them in carrying out their functions in accordance with procedure.

Option for Management

97 PPS management to review its current management practices of operations that are not considered as 'business as usual' conducted by corrections staff. The documented procedures that could be considered include, but are not limited to:

- Risk assessments of proposed operational activities;
- Documentation of the Operational Plan;
- Clear statement setting out expected expenditure and resource allocation approvals;
- Sign Off/Approval of Operational Plan by approving Regional Manager;
- Conduct and documentation of briefings and debriefings of all personnel involved in the conduct of the operation;
- Completion of final report outlining the results of the objectives as set out in the Operation Plan; and
- Completion of report on non-compliance issues where 'operational reality' prevented full compliance.

98 The most significant issue relating to the systems and processes followed by senior management is that of the failure to act on receipt of the initial complaint about the activities of the ERU. In March 2000, three months before the ERU was disbanded and five months before the investigation commenced (following a further two complaints), a serving member of the Unit made a complaint in writing to a senior manager within the region. No action was taken on this complaint until that manager provided the investigation team with the documentation after the later complaints had been received and action begun to be taken in relation to these.

99 The ERU was set up as an additional responsibility for the Crime Prevention Officer. With this additional responsibility also came a significantly increased budgetary responsibility amounting to in excess of $1M. Following the appointment of the personnel into the ERU the Crime Prevention Officer was then responsible for drug testing, the ERU and his normal crime prevention duties.

100 Although the responsibilities and duties were expanded considerably, senior management did not provide any written personnel or financial delegations to the CPO. In fact, the CPO became responsible to two senior managers both of whom also operated without written delegations when they approved personnel movements and financial expenditure within the Crime Unit.

101 A member of the PPS National Office appointed to the South Island Region eventually was also seen as part of the management structure within the Canterbury Crime Unit. Another officer, initially selected as a member of the drug testing unit was given the overall responsibility for managing its day-to-day activities. The Corrections Officer appointed to carry out administrative duties within the Crime Unit office also assumed management responsibilities over the members with the support of the CPO.

102 This apparently resulted in orders coming from various people which, at times, were contradictory, leading the staff to approach the CPO to clarify whose orders they were to obey.

103 The initial selection processes used to select the ERU staff appear to have been conducted in a more or less open manner. However, once the Unit commenced operating, staffing responsibilities between the drug testing staff and the ERU became blurred. For example, three staff appointed to the ERU were later subjected to misconduct allegations from their own managers. All three were moved from the ERU to drug testing by their Manager. The movements from the ERU to the drug testing unit were seen as demotions by those within the ERU and appear to have been used as a form of punishment without any formal investigation process having occurred.

104 The management approach from all involved in its management was similar to that expected of a military unit where orders are not to be questioned. Discipline was usually conducted at the local level which resulted in misconduct, or perceived misconduct, being handled inappropriately (see previous paragraph).

105 There were significant numbers of people carrying out additional duties in their own time. In most cases they held no expectation of receiving time in lieu or other form of payment for these duties. Many of the activities they undertook in their own time can be considered as high risk placing both themselves and PPS at considerable risk. For example, most of the corrections officers who took part in Operation Build-Up were off-duty. This use of off-duty personnel also extended to vacation time where, in one instance, a member was called back to complete a task during his annual leave.

106 While the staff generally gave freely of their time in an effort to see the ERU succeed there were many instances where it was an expectation placed on the members to work in their own time. It was found that those placing the expectations on others were not so generous and usually received payment for their extra time. Senior managers allowed this practice to continue in spite of the risks inherent in allowing staff to work unpaid which include:

- Health and Safety (ACC)
- Public liability
- Regional budgeting
- Breach of CEC

107 The issue of staff providing off-duty support in areas such as tending a prison garden or even providing inmates with weekend art lessons is not argued. These activities are non-custodial and are different to undertaking confrontationalist activities where off-duty staff are required to use legislated powers provided for on-duty corrections officers. In the view of the investigation team it is inappropriate to argue that they can be said to be on duty if and when something does happen. It presents a considerable reputational risk to the PPS and its management to retrospectively place off-duty officers on duty to legitimise their actions. While they might be corrections officers 24 hours a day, they are not on-duty 24 hours a day.

108 Most of the staff interviewed stated that there was an expectation that they work in their own time. While management did not agree with this view there is no question that staff freely gave a considerable amount of time. Therefore, irrespective of whether management intended to give the staff the impression they were expected to work in their own time, it was obvious and documented by management that the staff did so and nothing was done to stop this.

109 The investigation team found management and systemic problems relating to the practices associated with personnel management practices, training, general management practices, timesheet management and payment practices.

Personnel Management Practices

110 Once the ERU commenced operations the management practices adopted did not comply with requirements of the Department's Human Resources Manual. In particular, the process used to appoint relieving staff and select staff for training courses has not followed set procedures and resulted in a lack of transparency which created suspicion and the perception of favouritism.

111 Prior to the commencement of the investigation, senior management did not provide formal written personnel and financial delegations to the CPO and most other managers within the Region. Senior managers also allowed staff appointed to act as the CPO to do so without formal written financial and personnel delegations detailing what they were authorised to approve.

112 There was no transparent process for identifying who was to relieve as the CPO in the absence of the incumbent. There was never any written advice to staff affected of who had been appointed to act in the position. This resulted in staff unsure as to who was acting as the CPO.

113 Selection procedures for staff to undertake training on the North Island was not transparent or subject to any type of transparent process known to staff. While the explanations provided during the investigation appeared reasonable, the processes used appeared unfair and covert and therefore became divisive within the Unit. One of the consequences of these practices is that the staff alleged that favoritism occurred.

114 An appointment was made of an Officer to be in charge of the ERU even though the position did not exist and was not advertised. The appointment was officially notified by memo on 18 April 2000. The position was not taken up before the ERU was disbanded.

Training

115 Senior management was aware of the training being provided to members of the ERU. This training included the use of Control and Restraint holds, arrest procedures, long baton and VCP procedures. There was no formalisation of the training and the content has not been developed and documented by qualified training officers. The actual training, in many instances, was not provided by qualified trainers.

116 The investigation team made the following findings:

116.1 Senior management allowed training for the ERU eventhough it was never formalised with properly structured training needs analyses, training courses and qualified trainers providing the instruction on a structured basis. This will lead to a lack of standardisation and an inability to know exactly what is being taught. The end result of this training with respect to the high level of non-compliance when undertaking VCPs is indicative of the need for properly developed and written training courses.

116.2 Staff training has not been audited to ensure variations are not being developed which are contrary to required practice. Staff were provided with training that resulted in their non-compliance with PPM. For example, in the case of VCPs their treatment of unauthorised items and the use of C&R where strip searching became the final part of a C&R takeout.

116.3 Senior management allowed staff to undertake baton training provided by the police. At that time, baton training given by the police was not a requirement for PPS staff. The training was unstructured and the process for certification is questionable given the lack of attendance of some staff who were subsequently certified as competent in baton use.

General Management Practices

117 The inappropriate management practices within the ERU should have been apparent to senior management. There was an obvious lack of compliance in most areas they were involved in, for example;

- VCPs
- operational planning; and
- use of off-duty officers involved in high-risk activities.

Time Sheet Management

118 The treatment of time sheets by members of the ERU and administrative staff made them totally unreliable as a source of accurate information. It was found that staff usually completed their timesheets and then had them approved by a person not authorised to do so. These timesheets were then processed without question.

119 It was also claimed during the investigation that ERU managers kept a ‘red book’ setting out the hours when one member was at work. The reason given for this separate record was the confidentiality of the work being undertaken by the member. Apparently it was too secret for the other members of the Unit to know about. A senior manager supported the claim. The book was not located during the investigation and the people concerned were unable to remember what specific duties were undertaken and recorded in the book. The timesheets of the person concerned contained large amounts of overtime and callbacks and his timesheets often indicate extended periods of duty, a lot of which is not supported by any other documentation. It is the view of the investigation team that this ‘red book’ never existed and was concocted to explain the large claims that had passed through the system without proper checking.

120 Additionally, the investigation team found that data entry staff were adjusting some timesheets where they considered the claims to be wrong. There were no checks over the system and no audit process to ensure compliance.

121 The investigation team made the following findings based on the timesheets examined during the investigation:

121.1 Time sheets are improperly authorised.

121.2 Senior management has not provided any processes to ensure the hours recorded on time sheets are supported by other documentation.

121.3 Senior management has not provided any processes to ensure the procedures used for approving callbacks and overtime was able to be audited.

121.4 Management allowed self rostering of callbacks and overtime.

Management Lines

122 The issues of remote management was apparent during the employment investigation. Several instances of improper activity were found by an officer domiciled within a regional area but responsible to a National Office manager. Because this activity was not detected by the National Office manager the member obtained payments for which there was no entitlement. Reconciliations and proof of purchase to support the expenditure were not always required to support the payments.

Role of the Crime Prevention Officer

123 There is a need to clarify the role of the CPO. It became apparent during the employment investigation that the CPO was accepting responsibility for activities requested by more senior management for which he was not trained and did not form part of his job description. This is another example of the result of failing to develop a suitable Business Plan.

124 Documentation found during the investigation indicated that some correctional officers were being tasked to investigate and/or spy on other Corrections' staff. A reference was found to an Operation undertaken by the ERU that involved members of that Unit installing a surveillance camera within an area of a prison. The operation was so poorly carried out that not only did it fail to identify the 'offender' but the offences for which it was installed continued while the camera was operating.

Clarification of Legal Requirements

125 During the investigation it was found that there was, and apparently still is, uncertainty about the legal requirements for conducting strip searches. This has recently been done with the Permanent Instruction, Public Prisons Circular 2001/30 dated 19 October, 2001.

Option for Management

126 PPS management to undertake a review and provide a clear statement of expectations and requirements for procedures to be followed regarding:

- The use of off-duty corrections officers to perform PPS dutys, particularly where the activity could require the off-duty officer to deal with inmates;

- The authorisation of training activities for corrections officers that is not part of an approved training schedule; and
- Maintenance and signing of Time Sheets by corrections officers.