17 March 2021

SPECIAL INVESTIGATION INTO THE MANAGEMENT OF THREE PRISONERS AT AUCKLAND REGION WOMEN'S CORRECTIONS FACILITY: PRELIMINARY INDICATION OF INVESTIGATION FINDINGS AND RECOMMENDATIONS

Introduction

1. As you are aware, my investigation into the management of three[1] wāhine at Auckland Region Women's Corrections Facility (**ARWCF**) is in its final stages, and we anticipate providing a draft report to the Department by way of consultation by 31 March 2021.

2. You have asked for a preliminary indication of my findings and recommendations in order to allow the Department to focus its consideration of remedial actions prior to the full report being available.

3. This letter sets out that preliminary indication. I emphasise that the drafting and consideration stage of my report is still underway, and there has been no consultation on potential adverse comment.

4. In terms of the contents of the final report and next steps I note that:

   4.1 At this stage it is unlikely to be necessary to consult with parties other than the Department. Any adverse comments in the report are likely to be limited to systemic issues, so a response from senior management will be appropriate. Individual staff members will not need to respond.

   4.2 I am conscious that aspects of the management of these wāhine are currently before the courts, and that the report ought not undermine those proceedings. This could be dealt with by withholding the relevant aspects from publication or disclosure under the Official Information Act 1982, but I am conscious that any redaction would be better avoided in order to promote transparency and confidence in the process. I am currently aware of two proceedings, but please let me know if there are others, or if my understanding below is incomplete:

      (a) I understand Ms Bassett is to be sentenced in late March. The District Court Judge has made highly critical comments about her management regime. As this proceeding is set to conclude prior to the finalisation of my report I do not understand there to be any limitations on my ability to comment due to this proceeding.

[1] The Inspectorate had already investigated aspects of the management of one of the prisoners, S 9(2)(a) [redacted], and the issue had been elevated to the Ombudsman. This prisoner's management is closely linked to the other two prisoners, and this report will cover all three. The Ombudsman has proposed to refer the matter to the Inspectorate, and the Inspectorate intends to accept that referral on the basis that S 9(2)(a) [redacted] be included in this report.

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(b) Ms Cripps and Ms Bassett have brought a judicial review against the Department. We have been provided with the third amended statement of claim, which alleges that the Cell Buster and Mk9 were not validly authorised through regulations, and that their use is in breach of ss 9 or 23(5) of the Bill of Rights Act 1990. The claim alleges that the applicants each had the Cell Buster or Mk9 pepper spray used on them on "approximately four occasions" during their incarceration.[2] The use of various forms of pepper spray forms part of the factual narrative for my report. I intend to address the potential overlap with the judicial review proceedings by:

(i) avoiding any legal conclusions that might encroach on the matters before the High Court;

(ii) limiting the report to a description of the events of each instance in which pepper spray was used; and

(iii) confirming at the consultation phase that (as I anticipate) the factual conclusions in my report will not affect any matters in dispute before the High Court.

Preliminary indication of findings and recommendations

5. As will be seen from the below, I can indicate that my report is likely to largely confirm the criticisms of the Department that were recently made by the District Court.

6. Unlike the District Court Judge, I do not intend to make any findings or comments as to the cruelty or inhumanity of the management regime, but I do expect that my findings will largely confirm the factual position.

Summary of events

7. Over the period with which this investigation was concerned the management of these wāhine began appropriately, with difficult behaviours being responded to in accordance with Department policy.

8. However, from around April 2019 the management began to depart from Department policy, with some significant failures to adhere to the requirements of the Prison Operations Manual (**POM**) and the Corrections Regulations 2005 (**Regulations**), in particular:

8.1 The wāhine were being housed in confinement cells for reasons not directly connected to disciplinary matters, meaning that minimum prisoner entitlements were not being provided.

[2] Paragraphs 3.31 and 3.32.

8.2 Use of force became frequently necessary, but was not being reviewed as required by policy.

8.3 Issues began being dealt with more informally than I consider to have been appropriate, in particular:

(a) Prisoner complaints about conditions were frequently dealt with through discussions with staff in circumstances where elevation would have been warranted given the seriousness of the issues identified.

(b) Misconduct charges were not routinely filed, which meant that there was an absence of proper consideration and appropriate remedial steps. It seems possible that staff took the view that these women were already effectively under disciplinary sanctions due to their management, and that the formal process was not worthwhile.

8.4 Unit staff were directed not to engage with the wāhine.

9. Ultimately the wāhine were in a position where there were no more privileges or entitlements to remove, leading to increasingly difficult behaviour, and increasingly coercive actions to control behaviour.

10. I regard the development of this situation as a systemic failure of oversight. Oversight by the multidisciplinary team and senior prison staff ought to have prevented the management of these wāhine from developing into a regime that was both highly restrictive and contrary to minimum entitlements in some significant respects.

Indicated findings

De facto segregation

11. Prisoners were effectively kept segregated without following the process for directed segregation. As maximum security prisoners, they should by default have been able to associate with each other, but in practice this was denied.

Use of separates cells

12. ARWCF contains what are known as confinement or separates cells, which are intended to be used for disciplinary purposes only because they lack certain facilities that are otherwise required by the Regulations, in particular a general power outlet. Regulation 67 requires cells, "so far as is practicable in the circumstances" to have the items specified in Part C of Schedule 3, which includes a general power outlet; whereas Regulation 157 does not have the same requirement for cells used for cell confinement.

13. These cells are located the same unit wing as the management units (used for directed segregation and maximum security prisoners). The building as a whole was referred to as the management unit, which may have caused confusion, and a consequent gap in the regional and national oversight.

Use of force

14. Planned use of force should always be filmed, and this footage stored appropriately and securely; this does not appear to always have occurred. This is a significant concern in a sensitive prisoner management environment.

15. Whenever there is a use of force there must be a review. It was not unusual for a review to not occur, not be recorded, or take place a significant time after the incident (although some reviews were done on time, and done well). The review requirement is designed to ensure that staff can learn from these negative interactions. The failures to properly review were a missed opportunity.

16. Staff generally used force only as a last resort. The planned uses of force, including using pepper spray, usually followed a long period of asking for compliance (including for two hours before Cell Buster spray was used on 19 November 2019). Likewise, when staff cut off Ms Bassett's clothes before the post-suicide attempt strip search, staff did their best to persuade her to consent to the strip search first. This is an area in which my report is likely to contradict some of the comments from the District Court judge: I have yet found no evidence of any deliberate cruelty from staff, or efforts to break the spirits of the wāhine.

17. Overall, I consider that unit staff lacked proper oversight and guidance. Their behaviour appears to be reactive rather than strategic: dealing with issues locally and informally instead of ensuring that procedure was followed.

Searches, property and clothing

18. The reports completed after strip searches do not always set out a reasonable basis on which a strip search would be justified. This is of significant concern, and may indicate an implicit belief that these wāhine did not have the same rights as other prisoners.

19. There is a pattern of the wāhine coming into possession of personal items, including rings and red socks (red is a forbidden colour in prison). The rings became a sticking point: upon suspecting the presence of rings the prisoners and the cells were searched, but staff continued to demand the surrender of the rings.

Management plans

20. Every prisoner in the management unit should have a management plan. These are intended to be individualised and set out clear expectations as to the behaviour required for the prisoner to move forward.

21. Management plans were in place, however some elements were in my view likely to be inappropriate or unnecessary. The management plans were based on maximum security male prisoners, and required for example that:

21.1 Prisoners stand at the back of the cell before the door is opened. This may be unnecessary for women, and appears in this case to have exacerbated tensions.

21.2 Similarly, the management plans required at least three staff to unlock a cell. Corrections officers would often arrive in large numbers, which tended to escalate prisoner behaviour.

21.3 Prisoners follow precise instructions when food is delivered, including to kneel on the floor before the cell is opened. The management plans stated that not following instructions should be taken as a refusal to eat, so if the wāhine did not comply food would often be withheld and not re-offered. There was in my view some evidence that these plans were implemented in a way that went beyond reasonable management. For example, on one video Ms Cripps was sitting at the opposite end of the cell but refusing to kneel when instructed. Staff withheld food.

22. The management plans were signed off by the Residential Manager and the Deputy Prison Director, and discussed at multidisciplinary team meetings. Despite this, in my view there was insufficient experience or expertise brought to bear on whether the management plans were appropriate. The narrative of events suggests that the plans were simply rolled over without much consideration, and were reactive rather than forward-looking.

23. Unit staff lacked the confidence to challenge the management plans, even though a number of staff were clear that they did not like the plans or consider them appropriate.

24. The multidisciplinary team stopped meeting for four to five weeks over the Christmas period. This was highly unfortunate as it appears that Ms Cripps and Ms Bassett were behaving well over this period but there was no change in their treatment.

Prisoner complaints

25. When a prisoner makes an allegation against staff there is a clear process for reporting and investigating the complaint. However:

25.1 Some serious prisoner complaints against staff were resolved internally through a meeting with the Residential Manager. For example, a complaint from Ms Cripps that a staff member choked her.

25.2 Ms Cripps made 30 PC.01 complaints, and Ms Bassett made 21. These appear to have all been resolved internally and not escalated to the Residential Manager.

26. Staff appear to have considered that their hands were tied because the prisoners were classified as maximum security.

Misconduct charges

27. Misconduct charges were often withdrawn, seemingly because of a lack of resources to prosecute the charge, which must be done within a fixed time-limit. After a time, staff stopped filing any misconduct charges.

28. This removed a layer of oversight, with unfortunate consequences. Initiating the proper disciplinary process may well have made clear that these wāhine were already effectively under disciplinary confinement.

Staffing issues

29. There was high turnover of senior staff, and many senior staff were in acting positions.

30. At the start of the reporting period there were long-term staff at the unit level who felt that they had significant control of the prison due to the turnover in senior management. These staff came to know the prisoners well, and there is an indication that prisoners felt that they could influence their conditions through their relationships with these staff.

Indicated recommendations

31. Based on these potential findings I am likely to recommend that the Department:

    31.1 Address the findings, and confirm that no prisoners are subject to a similar management regime throughout the prison network.

    31.2 Consider the staffing, management and oversight of ARWCF in order to provide assurance that no other systemic issues persist.

    31.3 Review the use of maximum security classification for women. The maximum security classification for women was introduced in 2009. In my view there are questions as to whether this security classification is appropriate for women, given the low numbers at any one time to allow socialisation. In the case of these prisoners it may have been more appropriate for them to remain high security prisoners, but subject to directed segregation.

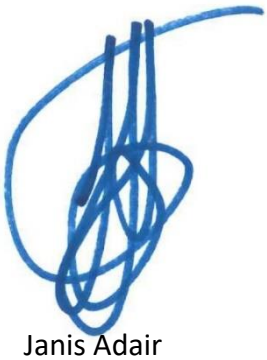
    31.4 Review the use of management plans across the prison network.

CONCLUSION

32. In addition to this, the Inspectorate will be scrutinising the assurance improvements at ARWCF. I may seek your support for additional resources in this regard if necessary.

33. I trust that the preliminary indications above are of assistance. As I and my team work through the drafting and review of the report these may naturally change. I am happy

to provide you with a further update if I consider that there are likely to be other findings of significant concern. Please let me know if that would be of assistance.



Janis Adair
Chief Inspector