DEPARTMENT OF CORRECTIONS
ARA POUTAMA AOTEAROA

3 July 2020 C121146

s9(2)(a)
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Tēnā koe s9(2)(a)

Thank you for your email of 17 April 2020, requesting further information about an incident which occurred at Christchurch Men's Prison on 29 October 2019. Your request has been considered under the Official Information Act 1982 (OIA).

You requested:

> *The report/findings of the review carried out into the incident where inmates at Christchurch Men's Prison swam in a dumpster in the engineering block.*

Please find the operational review into this incident attached. As you will note, all of the recommendations have been accepted, with many of these already completed. Completed ones include:

- The staff to prisoner ratio has been reviewed and changed to one staff member per 10 prisoners;
- There is now an instructor on the workshop floor at all times;
- All non-prisoner areas are now kept locked unless in use;
- Any unplanned absence is covered by appropriate staff members;
- Increased engagement with health and safety exercises and monthly compliance, along with a refresher in incident response training;
- All areas have been cleaned out of any unused material or scrap;
- The kitchen was emptied out of any unnecessary items; and
- Instructors have begun online training modules around incident response.

It is important to note that this incident involved only a small number of the 19 prisoners who were working in the workshop at the time of the incident. The five prisoners who were found intoxicated had their employment in the workshop terminated. In addition, three were transferred to Otago Corrections Facility. The assault on a staff member by one of the prisoners was referred to Police.

Although this incident was unacceptable, I would like to make it clear that there was no risk to public safety as a result, as the engineering workshop is located within the secure perimeter of the prison.

Please also note that two references in the review are unfortunately incorrect. Firstly, paragraph 36 of the review suggests that the staff-to-prisoner ratio at the time of the incident was 1:8, which is contradicted by the improvements that have been made to ensure a staffing ratio of 1:10. Further consultation with the region has revealed that, although the ratio may have been as low as 1:8 at certain moments during the incident, this was due to other staff passing through the workshop who were not actually involved in managing those prisoners. For much of the time the incident was ongoing, the ratio was somewhat higher than this, which has been rectified moving forward by ensuring the staffing ratio is always at least 1:10.

Secondly, the reference to the engineering workshop making Corrections around $700,000 annually is incorrect as this does not take into account the expenses associated with operating the workshop, such as staff salaries. Current financial projections for the 2019/20 financial year indicate that the workshop will operate at a net loss. Corrections accepts this net loss as being outweighed by the benefits of providing on-the-job training to prisoners, which can lead to a qualification and work experience and may result in employment opportunities upon their release from prison.

Note that some information in the review has been withheld under section 9(2)(a) of the OIA, to protect the privacy of natural persons, including deceased natural persons. Some further information has been withheld under section 6(c) of the OIA, as the release of this information would be likely to prejudice the maintenance of the law, including the prevention, investigation, and detection of offences, and the right to a fair trial.

The interviews attached to the review as Appendices J,K, L and M have been withheld in full pursuant to section 9(2)(ba)(i) of the OIA, as the making available of the information would be likely to prejudice the supply of similar information, or information from the same source, and it is in the public interest that such information should continue to be supplied.

> *If employment action was taken against any staff in relation to this incident I would also like to know the outcome of that action.*

As per our previous response to you (reference C117542), we declined to release the operational review as we were considering whether this matter would result in employment investigations taking place. After the review was completed, it was ultimately decided that no formal employment investigations in relation to this incident would proceed.

I trust the information provided is of assistance. Should you have any concerns with this response, I would encourage you to raise these with Corrections. Alternatively, you are advised of your right to also raise any concerns with the Office of the Ombudsman. Contact details are: Office of the Ombudsman, PO Box 10152, Wellington 6143.

Please note that this response may be published on Corrections' website. Typically, responses are published monthly, or as otherwise determined. Your personal information including name and contact details will be removed for publication.

Ngā mihi nui

Rachel Leota
National Commissioner

ARA POUTAMA AOTEAROA
DEPARTMENT OF CORRECTIONS

Operational Review

Date:	10 December 2019
Prepared By:	George Massingham, Lead Advisor Leadership
Review Commissioner:	Ben Clark, Regional Commissioner, Southern Region
Subject:	Christchurch Men's Prison (CMP) – Incident in the Engineering Workshop on 29 October 2019

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EXECUTIVE SUMMARY

1. This report outlines the findings of the operational review into the incident which occurred at CMP Engineering Workshop on 29 October 2019.

2. Tāne were working in the Engineering Workshop where they are required to construct and refurbish waste skips. As part of the quality assurance checks and to assess whether any additional work needs to be carried out on the skips, they are filled with water. Any holes could indicate structural weakness, and if the skip is lifted when full of material such as concrete, this could create a significant safety risk. This is standard practice within the prison engineering setting for safety reasons. Depending on the customer and skip specifications, they are filled with water to check that they are sealed and the lifting lugs are capable of taking the load requirements. While this work was underway, five tāne were found in an intoxicated state and to have been climbing in and out of the skip which contained approximately 2 – 2.5 m3 of water. They were suspected to have ingested homebrew.

3. Two instructors and the Principal Instructor (PI) were assigned to the Engineering Workshop providing supervision, guidance and training to the 19 tāne employed in the workshop. At the time of the incident two of the instructors were tasked with duties related to engineering business, which removed them from the workshop and resulted in one staff member supervising 19 tāne. (Work is being undertaken

Regionally to review the staffing levels for the Engineering Workshop. This review will be informed by the nature of the work environment, the tāne working in it and the resultant assessed risk. This will ensure adequate supervision of the tāne and work being undertaken. In the interim, the ratio has been reduced to 1:10).

4. Following notification of the incident, staff responded appropriately providing support to staff in the workshop, along with ongoing care to the tāne. No radio call was instigated. A "Code Blue" call would have ensured an immediate response from staff. Practice would be improved if responding custodial staff were more familiar with the layout and egress points of the workshop. This familiarity would be achieved through ensuring the occurrence of monthly emergency exercising, which will enhance response capabilities.

5. The outside area of the engineering environment has a large amount of 'old equipment' left over from previous work or unusable materials. While work had occurred to steadily clean up this area, to support a safe and healthy working environment, the workshop and surrounding areas are required to be re-organised including the removal of excess material. Additional camera coverage is required as there are areas where coverage was not available and this will also support supervision of tāne.

6. The production of engineered material from the workshop is held up in high esteem by the Assistant Prison Director (APD) and Industry Manager, and the figure of making the Department $700,000 a year was quoted. However, over the years the purpose of what is now known as offender employment has changed from that of production and revenue gathering to training and work ready skills. The focus on production has potentially not kept up with current thinking across the rest of the prison estate and may have supported a culture of production being the priority, and a move away from a greater level of supervision of tāne in the workplace.

7. The findings from the review have identified the opportunity to enhance post incident responses by ensuring all staff are aware of the need to complete incident reports, and that notifications are made to the appropriate personnel in a timely manner. It is important "hot" and "cold" debriefs are undertaken. This provides staff with the opportunity to discuss what happened, and lessons that can be learned from the way the incident was handled. It also provides the opportunity to identify what support staff may require.

PRISONER DETAILS			
Tāne involved	PRN	Roc*Rol	Most Serious Offending
s9(2)(a) [redacted]			

STAFF INVOLVED	
Name:	**Designation: (Job Titles)**
s9(2)(a) [redacted]	Instructor
	Principal Instructor (PI)
	CO
	CO
	CO
	Principal Corrections Officer (PCO)
	CO
	Senior Corrections Officer (SCO)
	CO
	Security Manager
	Industry Manager
Pablo Godoy	Assistant Prison Director (APD)

Joanne Harrex	Prison Director (PD)

BACKGROUND

8. On Tuesday 29 October 2019 Instructor s9(2)(a) was working in the Engineering Workshop at CMP. At approximately 11.45am, tāne s9(2)(a) entered the instructor's office in a confused state, stating he had been assaulted. He sat down on the settee. s9(2)(a) telephoned Kotuku Unit (a nearby residential unit) asking for support.

9. They agreed to send CO s9(2)(a) to assist. Upon arrival they (s9(2) and s9(2)(a) assessed the situation and called the Security Unit for support. Security Unit staff and Incident Response Officers (IROs) responded.

10. Security Unit PCO s9(2)(a) responded to the request for support, as it was explained that there had been an assault by tāne under the influence of an unknown substance. PCO s9(2)(a) called upon two members of the Site Emergency Response Team (SERT) and the Security Manager to join him.

11. Upon entering the workshop corridor, they saw Instructor s9(2)(a) dealing with s9(2)(a) and moved further down the corridor where CO s9(2)(a) was stood dealing with another injured tāne. Tāne s9(2)(a) was being held down by tāne s9(2)(a) . Both tāne appeared to be under the influence of an unknown substance s9(2)(a) . It seemed that s9(2)(a) was helping s9(2)(a) by talking to him and keeping him awake. This was allowed to continue for all of the On Body Camera (OBC) recorded incident response.

12. Tāne s9(2)(a) appeared behind PCO s9(2)(a) who told him to leave the area. He did so. PCO s9(2)(a) turned his attention to the tāne on the floor for a few moments before he turned and saw s9(2)(a) who had returned with a screwdriver in his hand.

13. PCO s9(2)(a) took the screwdriver from his hand and passed it to CO s9(. What was not seen by the PCO was that CO s9(2)(a) had been preventing s9(2)(a) from entering the area. s9(2)(a) had grabbed her wrist and pushed her out of the way. He had then pushed against her hitting the screwdriver into her Stab Resistant Body Armour (SRBA). This was captured on OBC. PCO s9(2)(a) removed the screwdriver without further issue and without knowing of the preceding assault.

14. After a period of attempted de-escalation by three staff including the Security Manager, s9(2)(a) was then placed in handcuffs and escorted out of the workshop. He provided resistance when he was within the unit fence line. (Clarification on whether force was used on s9(2)(a) as part of the move is provided in paragraph 85 under 'General', below).

15. In the meantime, medical staff were working on the physically injured and requested the support of the ambulance service and the doctor who was working on site.

16. Tāne under the influence were then moved to the Intervention and Support Unit (ISU); one went to hospital and those not deemed to be involved in the incident were moved back to their unit. The 15 tāne not involved in the physical altercations or obviously under the influence were moved by supporting staff without issue.

17. It seems clear that it was a small subgroup of the tāne working in the workshop that was involved. The majority carried on working and/or followed the instructions of staff.

18. Tāne s9(2)(a) was later removed from Kotuku Unit as information had been received he was also believed to be intoxicated but this had not been initially identified. This information was received from s9(2)(a)

19. Staff who had been involved continued with their duties and most left the site at the end of their shift.

20. At 2.57pm, PCO s9(2)(a) informed the National Incident Line.

21. A few attempts to contact the PD were made via phone and email. The PD was in a Coronial Court Hearing and unable to receive messages. The information was subsequently passed on (by phone) to the PD by the Custodial Systems Manager (CSM) during her return journey to the prison. Other managers who were involved in the incident such as the Security Manager and Industry Manager were still at the prison.

22. No hot debrief was held.

23. Information received from the staff involved and from one of the workers involved suggests they had been using a waste skip full of water to cool off (picture of skip at Appendix A) and drinking homebrew (Appendix B shows the large pot it is believed to have been served in). This was supported by the staff accounts and wet clothes seen on the footage.

SCOPE OF REVIEW

24. The purpose of the review was to gain an understanding of the situational and environmental factors related to the incident.

25. The Reviewer was asked to provide a full operational review of the incident including but not limited to:

- What happened and what occurred as a result
- Who was involved and to what extent
- Where the incident occurred
- The control and supervision of the area
- The response to the incident
- The post-incident response and notifications
- On site controls and management of the incident up to, including and post incident.

26. The review also considered the extent to which all relevant standards, procedures, operational systems, work practices and internal risk controls were in place and being complied with.

27. Particular attention to the following areas is required, (but not limited to) the included the Prison Operations Manual (POM), Corrections Acts 2004 and Corrections Regulations 2005, Corrections Services Integrated Incident Framework, Offender Employment Policy and Procedures Manual and relevant Health and Safety legislation.

28. A copy of the Terms of Reference is annexed as Appendix C.

METHODOLOGY / REVIEW PROCESS

29. The review was completed by George Massingham, Lead Advisor Leadership with the support of Kym Grierson, General Manager Integrated Practice, who attended the cold debrief. The process for this review involved analysis of case documentation which included:

- A review of information held on the Integrated Offender Management System (IOMS), including incident reports
- A review of Corrections Business Reporting & Analysis (COBRA)
- Camera footage was also reviewed which included CCTV and available OBC
- POM

- Collective Employment Agreement (CEA)
- Offender Employment Manual (OEM).

30. A number of site visits were conducted to CMP for the purpose of gathering information, reviewing the workshop and interviewing staff. These visits occurred on:
    - 1 November 2019
    - 5 November 2019
    - 25 - 26 November 2019
    - 6 December 2019

31. The review included interviews with staff members and two of the tāne involved. These were:

    - Tāne A (did not consent to name being used)
    - s9(2)(a) [redacted]
    - s9(2)(a) [redacted]
    - s9(2)(a) [redacted]

FINDINGS [redacted]

General

32. A review of the incident reports showed only three homebrew incidents in this workshop in the past ten years. No accompanying Event Reviews/Briefs were located. The more frequent incidents are related to drugs and weapons.

33. The usual day as described by the instructors is as expected by the Reviewer and shown by the auditing paperwork provided by the team. The nature of the environment, the industry and the workers meant there are no set routines and staff are reactive to the needs of the workers. The staff provided an overview of a general day in the workshop which has been attached as Appendix D.

People

34. There were 19 tāne in the Engineering Workshop at the time of the incident as exhibited by the muster sheet attached as Appendix H.

Staffing levels

35. Four staff were on shift (three instructors and one PI) – s9(2)(a) [redacted]

36. The ratio of staff to tāne of 1:8 was in place. This ratio was confirmed by the PI and Industry Manager as being in placed for the workshop. This is similar to ratios used

at other prisons/other industries. The industries do not have a fixed staffing ratio applied nationally. However, most sites have developed safe working ratios for their industries and trainings.

37. The ratio seems to be used for the number of employable instructors rather than a safety ratio. The purpose of the instructor is to supervise, educate, train and develop the workers.

38. s6(c) [redacted]

39. The instructors have worked in the workshop for multiple years between them. The PI and instructors informed of not previously having a fixed ratio for supervision of the tāne and felt that the current practice was suitable for the workshop.

40. The practice at other prisons is that, if an instructor is absent from the workplace the workers would not be released from their unit or would be returned to their unit to maintain the ratio.

41. Usually the absence is covered by the PI being in the workshop (his base location). For longer absences/holiday cover an instructor from another area may be used. The unintended consequence is that area maybe no functioning at below ratio, as it is not usual practice to reduce the number of workers.

42. At the time of the incident, two of the three instructors were away from the workshop. They were engaged in meetings and quoting for a job within the prison, but outside of the workshop.

43. At the time of the incident, the ratio was 1:19. When discussing the ratio with the APD, Industry Manager and PI, the comment 'only being a guide' was made several times. Workforce Development Project (WDP) ratios are a guide, however, they are the basis of the staffing model and are used as minimum standards for custodial staff ratios. As there is no national consistent ratio, each prison sets their own requirements. Best practice would mean a set ratio was in place and the number of workers would be reduced accordingly.

Responding Staff

44. SERT and IROs from units responded as would be expected in terms of POM. Staff actions during the response phase were, on the whole, as expected.

45. There was an obvious need for a co-ordinate response when viewed via OBC. Initially this did not occur, but was later picked up by PCO s9(2)(a) [redacted]

46. PCO s9(2)(a) [redacted] took visible control of the situation and provided support, guidance and leadership during and after the incident.

47. OBC footage demonstrated some very respectful, positive interaction with tāne by responding staff. This is demonstrated by CO s9(2)(a) covering s9(2)(a) bare backside with a blanket/item of clothing to maintain his dignity. Good practice was evident via the OBC footage of the de-escalation.

Recommendations

A. Work is being undertaken to review a safe staffing level for the workshop at a Regional level, informed by the nature of the work environment, the tāne working in it and the resultant assessed risks. This review will then allow for adequate supervision of the tāne and the work being undertaken. The recommendation is for that work to continue and the findings to be implemented.

B. Recognition of PCO s9(2)(a) and CO s9(2)(a) for their positive personal impact on the incident.

C. A greater level of emergency response practical training across non-custodial areas of CMP. Emergency exercises need to be undertaken regularly by workshop staff, with appropriate forms completed and recorded.

D. Further training/exercising of all site staff with regards to the layout and egress points of the workshop are needed to ensure a safe and orderly response can occur.

Environment

48. The Engineering Workshop is a large fenced area within the heart of CMP. It is surrounded by residential units and other buildings. It has both vehicle and pedestrian gates. It is within close proximity of residential units and responding staff. The outside area can be seen on three sides through a chain link fence, the fourth side is a solid concrete wall.

49. The inner area of the workshop is a large open area with head high dividers in place between various workstations, which are reportedly to limit the risks from sparks generated by welding activity at these workstations. Various tools and pieces of equipment are placed around the area. Adjacent to the workshop area is a corridor with a number of rooms off of it. These are the instructor's offices, toilets, kitchenette, storerooms, tāne tea rooms and toilets. s6(c)

50. The outside area has a large amount of 'old equipment' left over from previous work or unusable materials. These are scrapped on occasion. They are left in various locations and easily accessible to tāne within the workshop fence line. Large pots, old meal trolleys and large pieces of metal framing were observed. s6(c) . A number of screws, nails and other potential weapons were sighted on the ground of the external area.

51. The perimeter fence has a number of areas where it has been repaired or is in need of repair due to damage and wear and tear. This in addition to the fence line not being attached to the concrete means s6(c) [redacted]

52. The tāne areas have a large amount of clutter. I viewed the area post incident and pre-clean up and again post clean up and considered it to still be too cluttered. Appendix A shows the items in the background.

53. The area was painted dark colours and seemed to be poorly lit. There was an absence of Departmental Health and Safety and Wellbeing (HSW) notices and industry posters or general information covering the walls.

54. There was no control of access to the ceiling space, where a second batch of homebrew was located (the access point is in the corridor). This has subsequently been locked, to prevent access.

55. The noise levels within the workshop are high due to the amount of machinery. Telephone and radio communication work well in the area.

56. The day time temperature was reportedly 18 degrees Celsius (Appendix E).

Recommendations

E. All old/broken material is disposed of immediately or placed in an area inaccessible to the tāne. Any material provided to the workshop for repairs (i.e. kitchen equipment is registered in a log and tracked).

F. The frequency of general tidying up is increased. Thus removing the amount of materials that could be potentially weaponised. This would improve the HSW practice and reduce the likelihood of injury.

G. An improved process for fixing the fence.

H. s6(c) [redacted]

I. Use the wall space as an opportunity to inform and educate tāne. The wall paint colour and lighting throughout the corridor and rooms should be reviewed to increase visibility.

Tools and Resources

57. s6(c) [redacted]

58. The HSW notice board and the Emergency Response Flipchart are held in the instructor's office and are in an easy to reach location.

59. The APD reported the Engineering Workshop would join the feeder unit Kotuku when conducting emergency exercise. This was not the understanding of the workshop staff or the unit. In addition, the workshop has not completed any emergency exercises this year beyond the six monthly evacuation drill.

60. OBC footage was saved from two cameras only. It would be expected that the majority of the responding staff would be carrying and using OBC. One of the two activated OBCs is turned off by the wearer when the incident is in the latter stages (but not ended), after prompted by a fellow CO. It would be expected that the OBC would remain on until the incident is concluded.

61. No radio message was passed onto the whole of the site. This meant external visitors from the s9(2)(b)(ii) [redacted], who were with the workshop instructors walked into the workshop whilst tāne were being treated, moved and de-escalated. A 'Code Blue' call would have advised the whole site and would have increased the co-ordination of the response. Responding staff were entering an unknown situation without the level of understanding one would expect. While this worked during the incident as it was quickly controlled, the incident had the potential to expand and responding staff would have been put at risk if it had done so.

62. The instructors explained the process of controlling all chemicals and HAZMAT. There is a storage location separate from the main workshop which is controlled by key access. The items required are on an as needed basis.

63. There is no obvious management of empty paint pots. The second batch of homebrew found in the ceiling space by SERT following a post incident search was brewing in a discarded paint pot.

64. A number of large volume (greater than 500ml) containers can be seen on the OBC footage. These were less obvious when site visits were conducted post incident.

65. Bins are emptied every few days. This reduces the amount of rubbish in the area.

66. Tāne can be seen wearing a multitude of different clothing; there is no obvious Personal Protective Equipment (PPE) as standard issue.

67. The use of a larger volume of water to test the weld quality of the product (skip bins) may be an industry standard but it does present a challenge in the prison environment. Appendix F is an email from the National Manager Offender Employment explaining this method is our preferred solution.

68. The review has not been able to find the source of the homebrew or the ingredients used. The tāne interviewed would not divulge this information.

Recommendations

J. A review of CCTV coverage in the workshop area to provide the optimal level of coverage.

K. OBC education for staff. All OBCs should have been turned on and used throughout the incident.

L. Reinforcement that an emergency call via radio allows all parties to understand what is occurring and act accordingly.

M. All empty pots, tins and containers are removed and/or punched to prevent their use for homebrew.

N. The use of water as a weld testing option should be reviewed. It has benefits from a build testing perspective. However, it is safe operation in a prison environment needs to be reviewed. A potential solution could be a method of preventing access to the water. A solution maybe a lockable lid for example.

Practice Frameworks and Policies

Production versus Training/Work Ready Skills

69. The production of engineered material from the workshop is held up in high esteem by the APD and Industry Manager and the figure of making the Department $700,000 a year was quoted. However, over the years the purpose of what is now known as offender employment has changed from that of production and revenue gathering to training and work ready skills. The dominant focus on production has potentially not kept up with current thinking across the rest of the prisons and may have supported a culture of production being the priority and a move away from a greater level of supervision of tāne in the workplace.

Health and Safety and Wellbeing

70. Basic HSW practices do not seem to be highly valued. This is evident by the large amount of left over/old equipment left around. A focus on good house keeping would reduce the risk of HSW issues emerging. Regular tidying up and removal of broken or excess equipment and materials will reduce the likelihood of slips, trips and falls. Workers can be seen wearing a mixture of PPE and their own clothes.

71. The initial raising of the alarm was by telephone only. This has the effect of only informing a few rather than all staff. The expected practice would have been a 'Code Blue' call via radio. This could have been targeted if required with a brief explanation of staff required to respond. Whilst I accept the reasons for the instructor choosing not to make the initial call via radio, it is not best practice and could have raised the risk level of those entering the area.

Incident Response

72. OBC footage demonstrated some very respectful, positive interaction with tāne by responding staff.

73. CO s9(2)(a) covers the bare body parts of a tāne receiving treatment from the nurses. This is good practice to protect the dignity of the individual.

74. The medical staff responded quickly to provide support to the unfolding incident.

75. ISU, health and staff completing constant observation performed well.

Post Incident

76. Not all staff involved in the incident completed incident reports. Those who did had varying levels of detail within the reports. All incidents reports submitted can be found at Appendix I.

77. No incident report requested the testing of those suspected to be under the influence. At the cold debrief the PD requested misconducts be laid against those involved. However, due to the timeframe since the incident it was too late to initiate alcohol/drug testing. The correct process as stipulated in POM is:

> ***S.07.01.04 Reasonable grounds testing***
>
> *All requests for testing must be accompanied by an incident report or a security intelligence report signed by the prison director or staff member authorised for the purpose by the prison director, approving the "reasonable grounds".*

78. Therefore, no alcohol or drug testing was requested of the tāne.

79. A hot debrief was not completed.

80. Chain of Evidence seems to be correct.

Staff Welfare

81. There was no record of the Employment Assistance Programme (EAP) or assistance from the Post Incident Response Team (PIRT) being offered at the time of the incident. They were offered at the cold debrief on 1 November 2019 by the PD.

82. No known referrals to the Welfare Co-ordinator have been made at the time of the Review.

83. Follow up with CO s9(2)(a) occurred by her Manager. A Police referral was made for the assault.

Notification of Incident

84. The National Incident Line was notified of the incident at 2.57pm which is approximately three hours after it began. The notification was made by PCO s9(2) . Technically, it was a severe event (staff member assaulted, no injury) and required reporting within two hours of the incident being advised. However, having viewed the OBC footage it is not clear when exactly the assault was reported, as at no time did the staff member raise the assault. When interviewing PCO s9(2) he confirmed he was unaware until much later about the assault and if he had known, he would have reported it earlier.

85. The area of concern is the lack of reporting to the Regional level in the absence of the PD. PCO s9(2)(a) was unaware of the need to inform the Regional Commissioner and did what is required of him in accordance with policy.

Leadership

86. No obvious leadership in the PD's absence amongst the senior leadership was evident. The PD was not on site and was not able to answer her cell phone. However, no alternative escalation to Regional/National leadership was put in place by those on site. The lack of a Deputy and the non involvement of the APD meant this reporting did not occur. It would have been appropriate for the APD to work with the CSM and Security Manager to escalate the issue in the absence of being able to reach the PD (either to the Senior Advisor to the Regional Commissioner or to the Regional Commissioner). The incident line should have also been alerted at the earliest moment. Best practice would also suggest the APD should have taken the lead in the situation including initiating the hot debrief. The APD did remain onsite to debrief the PD in person upon her return.

87. The incident occurred in the Engineering Workshop. A Level 5 Manager and the Industry Manager were both in the workshop during the incident response, but no one led the hot debrief. The APD's only involvement seems to have been in sending the PD an email about the incident later in the day. Leadership engagement at an early stage and in the immediate aftermath would support a 'one team' approach. This would also mean some of the tasks missed would have been captured including the expected National and Regional reporting.

General

88. A staff member covered her OBC when using her radio. The hand used to press the radio button covered the camera. This is not a nefarious act rather the poor placement of equipment upon the person.

89. Management of tāne meals into the workshop seems to be well done, for example no fruit is supplied with lunch to prevent the potential of homebrew being manufactured. This has been in place for the past two years.

90. There are disconnects between offender employment and custody staff. Areas such as the lack of emergency exercising, tāne supply and understanding who should complete expected tasks post incident are examples of a break down in the relationship. Areas of tension are easy to see.

91. The movement of s9(2)(a) from the workshop to the Kotuku Unit yard was reviewed by s9(2)(a), Principal Advisor Tactical Operations. This review confirmed Use of Force was applied, although the force used was minimal, it was used on two occasions:

- whilst the workshop and the tāne was taken to ground
- when handcuffs were applied to the tāne.

92. There was a failure to report the use of handcuffs and complete the associated Use of Force paperwork.

Recommendations

O. A review of the purpose of the workshop to ensure it is in alignment with offender employment vision.

P. A review and enhancement of the HSW practices in the workshop especially around those of good house keeping.

Q. A clear process be put in place for the selection of tāne to be trained/work in this area, whereby security classifications and risk are reviewed and controls identified to manage when needed. Any concerns should be reviewed in consultation with the Industries Manager, APD and custody staff.

R. A localised review of the footage to highlight the good practice and recognise staff involved, beyond those mentioned in this report.

S. A reminder and support for staff at all levels to ensure incident reports are completed in accordance with our policy.

T. All incidents to have a hot debrief.

U. The senior members of the leadership team understand and carry out their incident management role and the reporting functions in the absence of the PD.

V. Ensure all staff have access to EAP, PIRT and the Welfare Co-ordinator.

W. It is important for the site to review all matters when incidents occur to identify any potential Use of Force and ensure associated processes are adhered to.

CONCLUSION

93. Five tāne working within the CMP Engineering Workshop were intoxicated on homebrew and some of them used the skip bin testing process (filling it with water) as a pool to cool down.

94. During this event, s9(2)(a) was injured when he was either assaulted or fell. An assault on [redacted] occurred.

95. s9(2)(a) did make contact with a CO twice, firstly with his hand to push her out of his way and the secondly with a screwdriver. Whilst he denies doing so, this is a matter for the Police.

96. A second batch of homebrew discovered in a search of the workshop post incident was recorded as being at 9% alcohol, the results can be found at Appendix G.

97. No alcohol or drug testing took place or were internal charges were requested for the intoxication.

98. The staff ratio being applied in the workshop is below what may be considered to be best practice.

99. The responding staff conducted themselves, on the whole, as expected and showed good levels of interaction and de-escalation.

100. The standard of incident reporting needs improvement.

101. The practicing of emergency exercises fell below what would be expected.

RECOMMENDATIONS:

This was a significant incident that, thankfully, did not result in a more serious outcome.

The Review rightly makes a large number of recommendations focused around practice, during and after a major incident; an improved health, safety and wellbeing orientation; more of a 'one team' focus between staff groups; and greater personal accountability shown by managers. I know that the Prison Director immediately implemented several changes in the Engineering Workshop, including improvements to the physical environment and changes to the staffing ratio. There is an action plan that contains each of the recommendations, all of which both the Prison Director and I accept. The site is making good progress in delivering on them. Doing so is essential to provide confidence that we can safely and securely

support the men in our care to learn employment related skills during their time in our custody.

a)	**Note** the contents of this review	**Yes / ~~No~~**
b)	Accept the recommendations within the review	**Yes / ~~No~~**

SIGN OFF:

Approved By: (Review Commissioner)	Ben Clark	Regional Commissioner, Southern Region	14.02.2020

APPENDICES:

Appendix	Content
A	Two photos of the skip with water in it
B	Potential homebrew serving pot
C	Terms of Reference
D	Usual day in the Engineering Workshop narrative
E	Weather Report for 29 October 2019
F	Confirmation of water testing
G	ESR results of homebrew
H	Daily Muster Sheet
I	Completed incident reports
J	Tāne A interview notes
K	s9(2)(a) interview notes
L	Instructor s9(2)(a) interview notes
M	PCO s9(2)(a) interview notes

Appendix A 1

Appendix D2

29/10/2019 12:45


29/10/2019 12:45

Appendix C

Internal Memorandum
Corrections Services

To: Ben Clark, Regional Commissioner, Southern Region

From: Neil Beales, Chief Custodial Officer

Date: 01 November 2019

Subject: TERMS OF REFERENCE for a Chief Custodial Officer's Review into the incident in the engineering workshop at Christchurch Men's Prison on 29 October 2019

Purpose

1. The purpose of this memorandum is to direct an Operational Review and provide terms of reference into the incident in the engineering workshop at Christchurch Men's Prison on 29 October 2019

2. George Massingham, Lead Adviser Leadership, will lead the review, assisted by Kim Grierson, General Manager Integrated Practice and Gavin Dalziel, Lead Advisor Prison Facilities.

Background

3. On Tuesday 29 October 2019 in the Engineering Workshop at Christchurch Men's Prison, a call was made at approximately 11:45am for additional staff assistance by the Engineering Instructor, s9(2) [redacted]. A prisoner had entered his office in what appeared to be a confused state, and claimed that he had been assaulted, with injuries that appeared to be consistent with an assault.

4. Security Officer s9(2)(a) [redacted] and responding IRO's attended the workshop, where they found 4 prisoners who appeared to be under the influence of an unknown substance. During the course of moving the affected prisoners out of the workshop, one of the IRO's was pushed and then lunged at by a prisoner with a screwdriver in his hand. The screwdriver made contact with her SRBA. A Police assault referral is to be made.

5. Following medical evaluation, one prisoner required transport to Christchurch Hospital where he remained overnight, and the three others were kept on observation in the ISU. All were vomiting and clearly under the influence of a substance. A further prisoner was moved to the ISU from Kotuku Unit later in the day, suspected to be under the influence of a substance, and having been assaulted in the workshop.

6. A search of the Engineering Workshop located a large metal pot inside an old bain marie trolley. An amount of yellowish liquid substance consistent with homebrew was found inside the pot, and secured as evidence. It also became apparent that the s6(c) [redacted], where they had filled a rubbish skip with water using a firehose and had been using it as a swimming pool during the morning. The engineering workshop has been closed until all evidence can be secured and recorded, a full and detailed search of the area undertaken and assurance can be given to the Prison Director that it can be safely re-opened. Additional assurance is being sought that the required systems and practices are in place to safely manage prisoners in the workshop.

The Review

7. To provide a full operational review on the incident including but not limited to:

    - What happened and what occurred as a result
    - Who was involved and to what extent
    - Where the incident occurred
    - The Control and Supervision of the area
    - The response to the incident
    - The post-incident response and notifications
    - On site controls and management of the incident up to, including and post incident,

8. The review will also report on the extent to which all relevant standards, procedures, operational systems, work practices and internal risk controls were in place and being complied with.

9. Particular attention to the following areas is required, (but not limited to) the Prison Operation Manual (POM), Corrections Acts and Regulations, Corrections Services Integrated Incident Notification Framework, Offender Employment Policy and Procedures Manual and relevant health and safety legislation.

10. To report on any other matters relevant to the concerns in respect of this review that may arise.

11. Identify and recognise good practice that occurred during the management of this incident.

12. To make such recommendations for the improvement of promulgated standards, procedures, operating systems, work practices and internal risk controls as may be necessary arising out of the review.

13. During the course of the review, if evidence is found that any procedures or processes adversely affect the security and safety of the prison, prisoners, staff or visitors the Prison Director is to be advised immediately.

14. Should the review team discover, prior to completion of the draft report, any evidence that may warrant a separate employment investigation such as breach of the Code of Conduct, the Chief Custodial Officer and Southern Regional Commissioner should be notified immediately and provided with any evidence.

15. The review team will have access to all relevant information, documentation, equipment, premises and persons to complete this review and may, with the approval of the Chief Custodial Office and/or Regional Commissioner, call on such additional assistance to the review as may be appropriate.

16. The review will be completed, and a draft report represented to the Chief Custodial Officer.

Time frame for review

a) Interim report by 15 November 2019
b) Final report by 30 November 2019 to the Chief Custodial Officer.

APPROVED: ..... Date: 01 November 2019

Ben Clark
Regional Commissioner
Southern Region

Appendix D

Usual Day for an Instructor in the Engineering Workshop

The below is the agreed usual day as discussed with the Instructors and Principal Instructor

Instructors arrive from 6am.

Emails, tool box meeting, update WIP & job boards, searching of the general area etc occurs.

When searching we look for anything unusual, homebrew, bottles/containers etc.

Checks of the fence line are done weekly and are of a visual nature.

Workers arrive around 8am. They move from the unit gate across the road (no more than 5 metres) to the workshop fence line gate. They are rub down and/or scanner searched by unit staff on the way out. The reverse process occurs at the end of the day.
On some occasions Instructors are required to help process if the Unit are short or have too many female staff on (unable to rub down)

Supervision of the workers occurs by walking around and visiting each bay throughout the day. The workers are mostly independent and we provide quality assurance, supervision and guidance. Visual checks of the tools, general area & bays are completed as we move around the floor.

A viewing booth, on a platform is being repaired at present. We are thinking about putting a computer in there so we can keep an eye on the workers and do some of our work online. At the moment we have to go to the office away from the workers.

Workers begin on the machines around 8.30 after they change in to there PPE etc. Toolbox meetings are held with Offenders for new jobs

The workers take around three breaks per day of usually around 30 minutes duration. Lunch arrives around 10.30 & is issued by staff, a name to face muster is completed at this time.

They finish around 2pm Monday to Thursday and 12noon on Friday due to the site wide lockdown.
Upon workers going back to the unit we shut down machines, complete security checks & give the smoko rooms a visual check.

The Engineering workshop are engaged by the prison a couple of times a year to be involved in Emergency Exercises. The most recent would have been a few months ago.

We do fair regular informal exercises and evacuations. These are not recorded anywhere.

As Instructors we do Tac Ops etc just all staff.

If Instructors are required to leave the workshop we cover ourselves as we don't have a spare line or additional staff.

If they are on leave we try to source a replacement Instructor, usually from the other areas, if available, such as:

T3,
P119,
Painting,
Kitchen.

This often means one area will be sacrificed for the day to cover the more essential services.

Throughout the day:

Repairs, maintenance & troubleshooting of machines
Completing training workbooks with Offenders
Answering emails & phone calls
Quoting for Internal & External Customers
Ordering of supplies
Correspondence with customers & vendors
Site Installs (Often times are dictated by Unit routines)
Invoicing & entering of financial information
Supervising external contractors in the workshop (Downers, Electricians etc)
Visiting areas to quote on new jobs
Processing workers back & forth for medical, unit etc
Assisting the wider site with relocation of items via the forklift (bins, deliveries etc)

Appendix E

AccuWeather MAPS NEWS VIDEO SEVERE WEATHER MORE

Tue 29	18°/ 5°	Actual Temp	Precip 1 mm

Record Hi:

Record Lo:

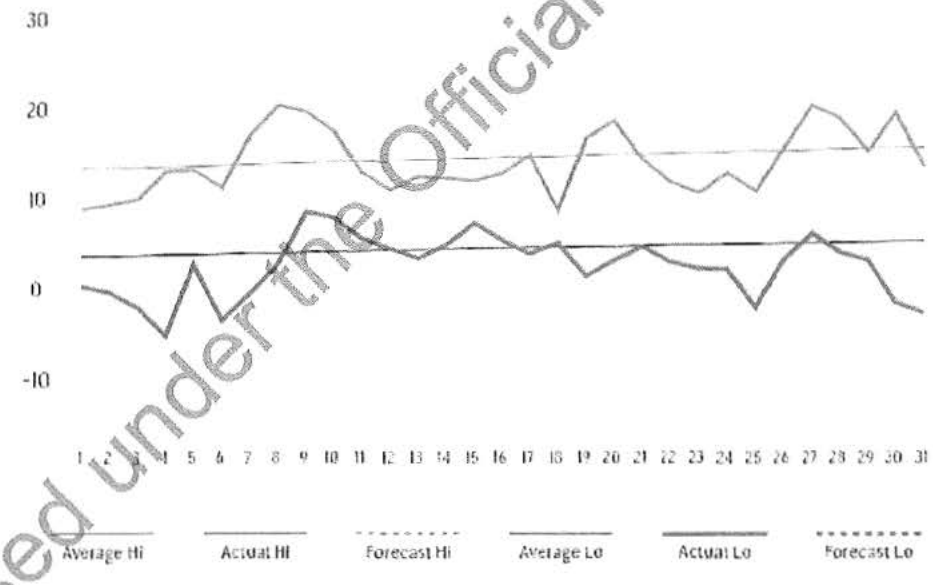
Historical Average Hi: 18°

Historical Average Lo: 7°

Snow: 0.0 cm

Wed 30	22°/ 1°	Actual Temp	Precip 0 mm
Thu 31	16°/ -0°	Actual Temp	Precip 0 mm

< OCTOBER 2019 >



MASSINGHAM, George (LREGRO) Appendix F

From: CLARK, Ben (SREGRO)
Sent: 29 November 2019 05:38 p.m.
To: MASSINGHAM, George (LREGRO)
Cc: BEALES, Neil (WELLHO); COLLINS, Stefan (WELLHO)
Subject: Water testing of waste skip bins

Kia ora George

I noted from your interim report on the Engineering Yard at Chch Men's incident that you had asked Kym Grierson to look into whether water testing was industry standard.

I had asked the same question of Stefan earlier this week in response to a media query. I have copied his comment below, but please liaise with Stefan for further info.

Stefan also has info on the SHCF testing process, which is different due to different apparatus with pre tested parts, as I understand it.
Thanks
Ben

The CMP engineering workshop is manufacturing bespoke waste bins and, in many cases, these require certification of the lifting eyes. The certification itself is granted by an independent expert and is based on the results of a lifting test – that is, a representative weight in put into the bin, it is lifted and the lifting eyes can then be certified as fit for purpose.
There are many products that can be used as ballast for these tests. Concrete blocks are common but if the lifting eyes fail there is a risk of large blocks spilling out of the bin. For that reason, water is our preferred solution – it's less dangerous in the case of a lifting eye failure.

Sent from my iPad

ESR
Science for Communities

Appendix G
ESR Reference
A19ESR20379

21 November 2019

The Manager
Christchurch Men's Prison
Private Bag 4944
CHRISTCHURCH 8140

Attention: Drug Testing Unit

Re: ESR Exhibit Bag #69383

The following items of liquid were received on 13 November 2019:

Two containers: Suspected home brew (specimen id U380834)

The items were given the unique WDT reference number A19ESR20379.

Analysis and Results

A portion of the liquid, from one of the containers, was analysed for the presence of alcohol.

It contained approximately 9% alcohol.

For comparison, the typical beer contains 3% to 5% alcohol by volume.

Destruction

As our storage space is limited, the item will be destroyed after 2 months of the date of this report unless otherwise instructed.

These results relate to the items as received.
This report may only be reproduced in full.

s9(2)(a)
[redacted]

Forensic Toxicologist

INSTITUTE OF ENVIRONMENTAL SCIENCE AND RESEARCH LIMITED
Kenepuru Science Centre: 34 Kenepuru Drive, Kenepuru, Porirua 5022 | PO Box 50348, Porirua 5240, New Zealand
T: +64 4 914 0700 F: +64 4 914 0770
www.esr.cri.nz

DEPARTMENT OF CORRECTIONS
ARA POUTAMA AOTEAROA

Appendix I

IFUR
Requested: 31-OCT-2019 09:50 AM
By: K, GRIERSON

Incident Follow Up Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00

Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Incident Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK

Description: CIE ENGINEERING WORKSHOP

Author: s9(2)(a) . **Last Updated:** 31 Oct 2019 08:10

Follow Up Report

PD and incident line notified. s9(2)(a) placed on directed segregation. At Risk assessments completed - prisoners at risk due to intoxicated state and moved to ISU. Workshop has been closed down pending a review as per the PD's instruction. Misconducts to be completed - s9(2)(a) assault on staff to be referred to Police. Misconduct generated 31.10.19 s9(2)(a)

Incident Information Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00
Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Author: s9(2)(a) .
Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK
Description: CIE Workshop
Event Date/Time: 29 Oct 2019 12:00 **Created:** 29 Oct 2019 13:57 **Last Updated:** 30 Oct 2019 08:03

Details of the Event:

On Tuesday the 28th of October 2019 I was on duty Engineering Instructor CIE workshop Christchurch Men's Prison. At approximately 1145hrs Prisoner s9(2)(a) entered the instructors office area in a confused state. He stated he had been assaulted and staggered onto a seated area. I immediately called Kotuku unit to ask for support they said they would send CO s9(2) to the workshop to assist. Upon CO s9(2) attendance we assessed the situation and I called security. Once security and IRO's arrived I stayed with Prisoner s9(2)(a) until directed to other duties by the security officer.

Offenders Involved:

Role	Name	PRN/DLICNO	DOB	VNR
VICTIM	s9(2)(a)			

Staff Involved:

Role	Name
WITNESS	s9(2)(a)
WITNESS	

Incident Information Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00
Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Author: s9(2)(a)
Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK
Description: Engineering workshop
Event Date/Time: 29 Oct 2019 12:00 **Created:** 29 Oct 2019 14:59 **Last Updated:** 29 Oct 2019 15:37

Details of the Event:

On Tuesday the 29th of October 2019 I was on duty 0600-1400 hours as Corrections Officer (CO) at Christchurch men's prison, Matapuna unit. At approximately 1202 hours (hrs) I responded to a request for IRO's and medical to the engineering workshop. On my arrival I saw Instructor s9(2)(a) assisting to an injured prisoner known to me as s9(2)(a) in the staff office. s9(2)(a) had a bleeding cut on his upper lip and appeared to be under the influence of an unknown substance. He was conscious and engaging in conversation with myself and Instructor s9(2)(a) I saw a commotion happening further down the hallway and made my way to assist with Officer s9(2)(a) who was assisting to an injured prisoner in the far prisoner smoko room. As I entered the room prisoners known to me as s9(2)(a), boing hold down by prisoner s9(2)(a). Both prisoners s9(2)(a) and s9(2)(a) appeared to be under the influence. Prisoner s9(2)(a) appeared to have a bleeding cut to his left cheek and right elbow. Prisoner s9(2)(a) was in the smoko room and also appeared to be under an unknown influence. I told s9(2)(a) to go back to his unit as the situation was being attended to which he refused to. He left the room and walked into the hallway and then tried to come back into the smoko room. I had put my arm against the door entrance and asked s9(2)(a) to go back to Kotuku unit. He then grabbed my right wrist and pushed me out of the way and walked into the smoko room. Security officer (SO) s9(2)(a) then arrived and assisted me with escorting prisoner s9(2)(a) out of the smoko room. I saw s9(2)(a) with what looked like to be a screwdriver in his hand and as he left the smoko room after SO s9(2) instructed him to. On his way out, s9(2)(a) lunged at me with the screwdriver making contact with my (Stab Resistant Body Armour) SRBA. SO s9(2) then grabbed the screwdriver out of his hand and handed it to me to secure. The screwdriver has been secured in evidence bag number B0205102 and handed to SERT. Prisoner s9(2)(a) was then placed in handcuffs and escorted away. A timeline of events below. 1220 hrs - Nurses arrived to assist with injured prisoners. 1232 hrs - Request for ambulance from nursing staff. 1236 hrs - Ambulance dispatched. 1250 hrs - Ambulance arrives 1320 hrs - ambulance leaves the engineering workshop with prisoner s9(2)(a). Camera footage requested from my On Body Camera (OBC), camera number L7190.

Offenders Involved:

Role	Name	PRN/DLICNO	DOB	VNR
PERPETRATOR	s9(2)(a)			
PERPETRATOR				
PERPETRATOR				
PERPETRATOR				

Staff Involved:

Role	Name
WITNESS	s9(2)(a)
WITNESS	
WITNESS	
WITNESS	

Incident Information Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00
Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Author: s9(2)(a) .
Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK
Description: KOTUKU UNIT CELL 46
Event Date/Time: 29 Oct 2019 14:30 **Created:** 29 Oct 2019 15:24 **Last Updated:** 29 Oct 2019 15:25

Details of the Event:

On 29 October 2019 I was on duty, rostered 1400 - 2200 hours as Senior Corrections Officer (SCO) in Kotuku unit at Christchurch Prison. At approximately 1330 Hours (hrs) I arrived on duty to find out that there had been an incident that had occurred in the engineering workshop. At approximately 1410 hrs I received a phone call from staff informing me that they had received Intel that a second prisoner had been assaulted. Myself and Corrections Officer s9(2)(a) made our way over to cell 46 which is allocated to Prisoner s9(2)(a) . When unlocking the door Prisoner s9(2)(a) was bent over the toilet and incoherent. He would not engage in conversation and wouldn't look at staff. External medical were called and at approximately 1423 hrs Nurse s9(2) arrived and assessed Prisoner s9(2)(a) Prisoner s9(2)(a) was showing signs of a possible assault and also possibly being under the influence of an unknown substance. An At Risk Assessment was carried out and prisoner s9(2)(a) was deemed at risk also required observations for a possible head injury. At approximately 1440 hrs Site Emergency Response Team arrived along with Security Officer s9(2) and Principle Corrections Officer s9(2) to move Prisoner s9(2) to the Interventions Support Unit (ISU). This happened without incident.

Offenders Involved:

Role	Name	PRN/DLICNO	DOB	VNR
PERPETRATOR	s9(2)(a)			

Staff Involved:

Role	Name
WITNESS	s9(2)(a)

Incident Information Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00
Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Author: s9(2)(a)
Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK
Description: PRC ISU cells 18, 16 and 15
Event Date/Time: 29 Oct 2019 13:20 **Created:** 29 Oct 2019 17:35 **Last Updated:** 29 Oct 2019 17:35

Details of the Event:

On Tuesday the 29th of October 2019 I was on duty rostered 1300-2100, Principal Corrections Officer at the Intervention and Support Unit, Christchurch Men's Prison. At approximately 1305 I was advised that we would be receiving a number of prisoners from the Engineering Workshops, who were under the influence of an unknown substance, with some prisoners possible either victims or perpetrators of assaults. At approximately 1315 prisoner s9(2)(a) was placed into cell 18 and strip searched under reasonable grounds to ensure he had no further intoxicants on his person. Prisoner s9(2)(a) had to be assisted to be searched as he was unsteady on his feet. All his clothing was placed in individual paper evidence bags due to the suspected assault. At approximately 1330 prisoner s9(2)(a) was received into the ISU and placed into cell 16, He was also strip searched on reasonable grounds and all individual items of clothing placed individual paper evidence bags. Prisoner s9(2)(a) also appeared to be unsteady on his feet and lost his balance on occasion. At Approximately 1350 prisoner s9(2)(a) was received into the ISU and placed in cell 15, he was also subject to a reasonable grounds strip search with all his clothing placed into individual evidence bags. Prisoner s9(2)(a) made the following comments or words to the effect that he had been drinking home brew in the engineering workshop. He stated that the boys had been drinking home brew with his mate to get him drunk and when they got him drunk they took him around the back and beat him up, he stated that they had to get him drunk to beat him up. This was recorded on my OBC number M7433. Prisoners were placed on continuous observations at the direction of Health, so that they could be monitored.

Offenders Involved:

Role	Name	PRN/DL/CNO	DOB	VNR
PERPETRATOR	s9(2)(a)			
PERPETRATOR				
PERPETRATOR				

Staff Involved:

Role	Name
WITNESS	s9(2)(a)

Incident Information Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00
Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Author: s9(2)(a)
Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK
Description: Engineering Workshop.
Event Date/Time: 29 Oct 2019 12:00 **Created:** 30 Oct 2019 10:24 **Last Updated:** 30 Oct 2019 12:18

Details of the Event:

On Tuesday the 29th of October 2019 I was on duty rostered 0500 - 1300 hours (hrs), Principal Corrections Officer (PCO) Security Officer (SO), Christchurch Men's Prison. At approximately 1200 hours (hrs) I responded to a request from Engineering Instructor to attend engineering workshop as there had been a assault on a prisoner by other prisoners and the prisoners were all under the influence of an unknown substance. I also requested the Security Manager and 2 members of the SERT Team to assist me. On my arrival at the workshop I saw Instructor s9(2)(a) assisting an injured prisoner known to me as s9(2)(a) in the staff office. s9(2)(a) was bleeding from his face and appeared to be under the influence. He was conscious and talking with Instructor s9(2)(a) I asked the instructor if they were all good, he said the prisoner has been assaulted and is under the influence, he also said medical were on their way. I then made my way further down the hallway to assist with Officer s9(2) who was assisting with injured prisoners in the far prisoner smoko room. As I entered the room I observed Prisoner s9(2)(a) , being held down by Prisoner s9(2)(a) . Both prisoners appeared to be under the influence. Prisoner s9(2)(a) was bleeding from cuts to his left cheek and right elbow. I then noticed Prisoner s9(2)(a) attempting to enter the Smoko Room , I told the prisoner to leave and he made his way back out of the room, I then turned away and and turned my attention to the prisoners on the floor . I then turned around again and saw Prisoner s9(2)(a) with a screwdriver in his hand, I then removed the screwdriver from him and gave it to CO s9(2) I then spoke to prisoner s9(2)(a) in the workshop area, he was very agrumentive and wanted to wait until his mate went with him, I explained to him that wasn't going to happen and he needed to move back to his unit so staff could attend and help the prisoners on the floor, the prisoner then fell over as he was under the influence and was assisted to his feet and escorted back to the unit, the prisoner then became aggressive and was placed in handcuffs and placed in the yard under observations. I then returned to the workshop where medical were working on the prisoners in the smoko room and in the staff office. Medical staff requested an ambulance. At approximately 1250 hrs Ambulance arrives on site, and Ambulance staff made a assessment of prisoner s9(2)(a) MO4 generated and signed off, at approximately 1320 hrs - ambulance leaves the engineering workshop with prisoner s9(2)(a) and s6(c)
At approximately 1315 Prisoner s9(2)(a) was taken to the ISU by the SERT team, Prisoner s9(2)(a) had to be assisted to be searched as he was unsteady on his feet. All his clothing was placed in individual paper evidence bags due to the suspected assault. At approximately 1330 Prisoner s9(2)(a) was taken to the ISU by the SERT team He was also strip searched on reasonable grounds and all individual items of clothing placed individual paper evidence bags. Prisoner s9(2)(a) was unsteady on his feet and lost his balance on occasion. At Approximately 1350 Prisoner s9(2)(a) was escorted to ISU by myself and instructor s9(2)(a) he was also subject to a reasonable grounds strip search with all his clothing placed into individual evidence bags. I then made my way to the CSM Office and spoke to RM s9(2)(a) and informed him what had happened. I then made my way back to Kotuku unit and spoke to staff, medical where in seeing Prisoner s9(2)(a) and it was decided to move the prisoner to the ISU as he was under the influence also and also had been assaulted. At approximately 1440 hrs Prisoner s9(2)(a) was taken to the ISU by the SERT, he was also subject to a reasonable grounds strip search with all his clothing placed into individual evidence bags. I then informed National Incident Line of the incident.

Offenders Involved:

Role	Name	PRN/DLICNO	DOB	VNR
PERPETRATOR	s9(2)(a)			
PERPETRATOR				
PERPETRATOR				
PERPETRATOR				
PERPETRATOR				

Incident Information Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00
Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Author: s9(2)(a) .
Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK
Description: OE Engineering Workshop
Event Date/Time: 30 Oct 2019 12:00 **Created:** 30 Oct 2019 12:57 **Last Updated:** 30 Oct 2019 16:35

Details of the Event:

On Tuesday 29 October 2019 I was on duty, rostered 0800 hours - 1700 hours Corrections Officer (CO), Site Emergency Response Team (SERT), Christchurch Men's Prison. At approximately 1200 hours I was required to assist Security Officer (SO) s9(2) with an incident unfolding in the Engineering Workshop where several prisoners were intoxicated and at least one had been assaulted. I made my way there with CO s9(2 and Security Manager s9(2) where we were immediately tasked with moving Prisoner s9(2)(a) to Kotuku Unit by SO s9(2) who seconds after instructing us to move him grabbed a screwdriver from the prisoner's hand and handed to another officer obscured from my view. Prisoner s9(2)(a) was clearly under the influence of an unknown substance and was argumentative and belligerent with staff, refusing to move and challenging us to fight him. A long process of de-escalation was employed which was semi-successful however when he began to move he immediately fell to the ground. I assisted him to Kotuku Unit by holding his left arm while another officer held his right arm. On arrival to the unit Prisoner s9(2)(a) became non-compliant as he was about to be searched so handcuffs were applied. He was rub-down searched and placed in the Kotuku visits courtyard so staff could maintain constant observations on him. I then returned to the Engineering Workshop as medical staff arrived to assess the prisoners that remained there. The nursing staff requested an ambulance as Prisoner s9(2)(a) was in a very poor state and soon after I was also sent to External Medical to uplift the doctor. Once the doctor was inside I remained posted at the vehicle gate to allow fast ingress for the ambulance. Shortly after the ambulance arrived I was replaced on the vehicle gate and then collected the SERT van to assist relocating prisoners to the Intervention Support Unit (ISU). At approximately 1305 hours SCO s9(applied handcuffs to Prisoner s9(2)(a) who was clearly intoxicated, and he was then relocated to Cell 18 in the ISU. During the relocation Prisoner s9(2)(a) s9(2)(a) that smelled strongly of alcohol, down his front and over the seat and floor in the SERT van. A strip search of Prisoner s9(2)(a) was conducted by myself, SCO s9(and CO s9(2) with nil found. All of his clothes were retrieved by PCO s9(2)(a) and secured in paper evidence bags. At approximately 1320 we returned to Kotuku Unit where we uplifted Prisoner s9(2)(a) and relocated him to Cell 16 in the ISU. A strip search of Prisoner s9(2)(a) was conducted by myself, SCO s9(and CO s9(2) with nil found. All of his clothes were retrieved by PCO s9(2)(a) and secured in paper evidence bags. At approximately 1345 hours we uplifted Prisoner s9(2)(a) from the Receiving Office, as he had been placed there by SO s9(2) and relocated him to Cell 15 in the ISU. A strip search of Prisoner was conducted by myself, SCO s9(and CO s9(2) with nil found. All of his clothes were retrieved by PCO s9(2)(a) and secured in paper evidence bags. I then returned to the SERT office where I assisted logging the evidence bags and securing them in the exhibits safe.

Offenders Involved:

Role	Name	PRN/DLICNO	DOB	VNR
PERPETRATOR	s9(2)(a)			
PERPETRATOR				
PERPETRATOR				
PERPETRATOR				

Staff Involved:

Role	Name
VICTIM	s9(2)(a)
WITNESS	
WITNESS	
WITNESS	
WITNESS	
WITNESS	
WITNESS	

Incident Information Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00
Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Author: s9(2)(a) .
Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK
Description: CIE WORKSHOP
Event Date/Time: 30 Oct 2019 12:30 **Created:** 30 Oct 2019 13:41 **Last Updated:** 30 Oct 2019 16:36

Details of the Event:

On Tuesday the 29th of October 2019 I was on duty rostered 0800-1700 hours Senior Corrections Officer (SCO) Site Emergency Response Team (SERT), Christchurch Men's Prison. At approximately 1230 hours I was asked to attend an incident in the CIE engineering workshop area by Security Manager s9(2) to provide support in securing the scene and supplying evidencing equipment. On arrival to the workshop I was briefed by Security Officer s9(2) and asked to facilitate the movements of a number of prisoners from the workshop to the Interventions and Support Unit (ISU) due to them being under the influence of an unknown substance. At approximately 1245 hours I radioed additional SERT staff to respond who were currently on a lunch break. I then secured the incident scene and handed a camera to Corrections Officer (CO) s9(2 to photograph the scene and any items of interest. At approximately 0105 hours I placed prisoner s9(2)(a) in handcuffs who was slumped over a couch, SERT staff removed s9(2)(a) from the scene to the ISU. On transit to the ISU s9(2)(a) s9(2)(a) on the seat and floor of the SERT van also making contact with my leg. s9(2)(a) was place in cell 18 and strip searched by CO s9(2) CO s9(2) and myself. All items on s9(2)(a) were placed in evidence bags and secured. At approximately 1320 hours SERT staff arrived at Kotuku to uplift prisoner s9(2)(a) who was already handcuffed in a secured yard. SERT staff moved s9(2)(a) to the ISU where he was placed in cell 16 and strip searched by CO s9(2) CO s9(2) and myself. All items on s9(2)(a) were placed in evidence bags and secured. At approximately 1345 prisoner s9(2)(a) was received into the ISU by Security Officer s9(2) and placed in cell 15 s9(2)(a) was also subject to a reasonable grounds strip search by CO s9(2) CO s9(2 and myself. During the search s9(2)(a) was barley understandable but stated "they had to take the skinhead out to get him we've been drinking all morning" or words to that affect. All items on s9(2)(a) where placed in evidence bags and secured. At approximately 1400 hours Principal Corrections Officer (PCO) s9(2) and myself went back to the CIE workshop to ensure the scene had been secured and check with staff still based there. At approximately 1415 hours I was handed evidence bag number B0205102 from CO s9(2) which contained a screwdriver that had been used by s9(2)(a) to assault staff during the incident. At approximately 1430 hours Security Officer s9(2) informed PCO s9(2) and I that prisoner s9(2)(a) was also required to be moved to the ISU from his cell in Kotuku. At approximately 1440 I placed handcuffs on s9(2)(a) and escorted him to the ISU. During the movement in the receiving office s9(2) became resistant and non-compliant to continue walking, PCO s9(2) and myself then guided s9(2) to cell 17 in the ISU where all items on his person were secured in individual evidence bags.

Offenders Involved:

Role	Name	PRN/DLICNO	DOB	VNR
PERPETRATOR	s9(2)(a)			
PERPETRATOR				
PERPETRATOR				
PERPETRATOR				

Staff Involved:

Role	Name
WITNESS	s9(2)(a)
WITNESS	
WITNESS	
WITNESS	
WITNESS	
WITNESS	
WITNESS	
WITNESS	

Incident Information Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00
Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Author: s9(2)(a) .
Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK
Description: Engineering Workshop and Kotuku
Event Date/Time: 29 Oct 2019 12:00 **Created:** 30 Oct 2019 13:46 **Last Updated:** 30 Oct 2019 13:51

Details of the Event:

On the 29th of October 2019 I was on duty rostered 0800-1700 hours as a Corrections Officer (CO) in the Site Emergency Response Team (SERT) Christchurch Men's Prison. At approximately 1200 hours CO s9(2) Security Manger (SM) s9(2) and myself were informed by Security Officer (SO) s9(2) that there was a incident in the engineering work shop and required our assistance. At approximately 1207 hours we entered the work shop to find Prisoner now known to me as s9(2)(a) standing at the door. Prisoner s9(2)(a) was being instructed by SO s9(2) to move back to Kotuku. CO s9(2) SM s9(2) and myself escorted Prisoner s9(2)(a) back to Kotuku, s9(2)(a) became non-compliment with CO s9(2 instructions and repeatedly stated "I just want to make sure my mate is ok" we assured him that we are only here to help, He then went on to state "I don't believe you guys, do you want to fight?" While escorting Prisoner s9(2)(a) back to Kotuku, s9(2)(a) tripped and fell on the ground, staff then supported s9(2)(a) back to his feet, staff then placed s9(2)(a) in the Kotuku secure yard where he was subjected to a rub down search. s9(2)(a) became non-compliant I then applied hand cuffs on prisoner s9(2)(a) At Approximately 1242 I noticed the fire exit door of the engineering work shop to be jarred open with the fire hose. I realised that this was where the indecent happened, I was then tasked by Senior Corrections Officer (SCO) s9(to take photos of the scene.

Offenders Involved:

Role	Name	PRN/DLICNO	DOB	VNR
PERPETRATOR	s9(2)(a)			

Staff Involved:

Role	Name
WITNESS	s9(2)(a)
WITNESS	
WITNESS	
WITNESS	

Incident Summary Report

Managing Institution: CHRISTCHURCH PRISON **Incident Date/Time:** 29 Oct 2019 12:00

Incident Description: CIE ENGINEERING WORKSHOP PRISONERS UNDER UNKNOWN SUBSTANCE

Incident Location Institution: CHRISTCHURCH PRISON **Unit:** INDUSTRIES BLOCK

Description: CIE ENGINEERING WORKSHOP

Summary of Incident:

On Tuesday the 29th of October 2019 at about 1155hrs OE staff became aware of an injured prisoner in the engineering workshop. Upon responding they discovered he had been assaulted, so phoned Kotuku unit for additional support. When the extra staff member arrived, it became aware several prisoners had been assaulted and multiple prisoners were under the influence of an unknown substance. A "break break" was radioed asking for more staff assistance. Staff provided first aid to the injured prisoners, and during the incident prisoner s9(2)(a) became non compliant with staff. s9(2)(a) grabbed a staff members wrist and pushed them. Staff then observed s9(2)(a) with what looked like to be a screwdriver in his hand and as he left the smoko room he lunged at staff with the screwdriver making contact with their Stab Resistant Body Armour. s9(2)(a) was then secured in handcuffs. Medical staff arrived when the area was secured and assisted prisoners, however an ambulance was requested which arrived onsite at about 1250hrsvwith prisoner s9(2)(a) on board. It became apparent that the prisoners had consumed a large amount of homebrew, and this resulted in several prisoners being placed in the ISU due to being intoxicated. Misconducts pending.

Incident Components

Primary Category:	CONTRABAND / EXHIBITS	Alcohol	Homebrew Substance	30 Oct 2019 22:10

Incident Components

Primary Category:	CONTRABAND / EXHIBITS	Weapons	CIE Tool	30 Oct 2019 22:10

Incident Components

Primary Category:	PRISONER BEHAVIOUR	Other Prisoner Behaviour	Breaks prison rules	30 Oct 2019 22:12

Incident Components

Primary Category:	PRISONER BEHAVIOUR	Other Prisoner Behaviour	Disobeys lawful order	30 Oct 2019 22:12

Incident Components

Primary Category:	PRISONER BEHAVIOUR	Other Prisoner Behaviour	Fighting	30 Oct 2019 22:13

Incident Components				
Primary Category:	PRISONER BEHAVIOUR	Other Prisoner Behaviour	Other Prisoner Behaviour	30 Oct 2019 22:13
Incident Components				
Primary Category:	PRISONER BEHAVIOUR	Prisoner Abuse/Threat on Staff	Prisoner verbally abuses/threatens staff	30 Oct 2019 22:11
Incident Components				
Primary Category:	PRISONER BEHAVIOUR	Prisoner Physical Assault on Prisoner	Assault- Non-Serious	30 Oct 2019 22:11
Incident Components				
Primary Category:	PRISONER BEHAVIOUR	Prisoner Physical Assault on Staff	Assault- Serious	30 Oct 2019 22:10
Incident Components				
Primary Category:	PRISONER MANAGEMENT	At Risk Assessment	Change of behaviour	30 Oct 2019 22:13
Incident Components				
Primary Category:	PRISONER MANAGEMENT	Mechanical Restraints	Hand Cuffs - other than on escort	30 Oct 2019 22:19
Incident Components				
Primary Category:	PRISONER MANAGEMENT	Segregation	Security Good Order or Safety s 58	30 Oct 2019 22:14
Incident Components				
Primary Category:	PRISONER MANAGEMENT	Use of Force	Non-threatening Physical Contact	30 Oct 2019 22:18
Incident Components				
Primary Category:	PRISONER SAFETY / WELFARE	Hospitalisation	Not accident	30 Oct 2019 22:19