

# Report of the Independent Inquiry into the Waikeria Prison Riot

29 December 2020 - 3 January 2021





## Our Whakataukī

*Mā te titiro me te whakarongo ka puta mai te māramatanga*  
By looking and listening, we will gain insight

December 2022

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## Mihimihi

E amo ake ana te titiro ki te rangi, ki te nui o te rangi, ki te tapu o te rangi.  
 Ka tau te aahuru nui ki Te Kiingi Maaori me ngaa whakahirahira o te tangata.  
 Maapuna ake ki a Raukawa, ki a Maniapoto ngaa iwi o te papa whenua.  
 He tai o mate ka riro ki tuua o Paerau, ki te tai o ake ake.  
 Ka hokia iho te kupu whakatau a Te Arikini Te Atairangikaahu, “Ko te iti me te rahi,  
 naaku katoa”. Hei manaaki, ka whakamaru maa taatou katoa.  
 Huihuia ake, teenaa koutou, teenaa taatou.

*We must look to the heavens, the vastness and the sanctity of the spirit realm.  
 May their serenity be visited upon the Maaori King and all peoples.  
 An acknowledgement of Raukawa and Maniapoto the tribes of the land.  
 We farewell those who have left us on the tides of forever.  
 We return to the tongikura (guiding statement) of Te Arikini Te Atairangikaahu when  
 she said “All of the people, however small or large, are my people”. We have a duty to  
 care and protect them with all we have.  
 Teenaa koutou, teenaa taatou.<sup>1</sup>*

1. Some of the te reo used in this report reflects the Waikato-Tainui iwi preference for using doubled vowels rather than tohutō (macrons). This is used where Waikato-Tainui iwi dialect has been provided to this inquiry.



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## Foreword

This report details my Inquiry into the riot at the Top Jail of Waikeria Prison, which began on 29 December 2020 and ended six days later on 3 January 2021.

The riot was violent, destructive, and presented a real risk to life. Its magnitude was unprecedented in New Zealand correctional history. It was not a peaceful protest; nor was it a proportionate response to prisoners' dissatisfaction with prison conditions. Nonetheless, this Inquiry has found significant issues with the Department of Corrections Ara Poutama Aotearoa's preparedness for, and response to, this disorder event.

Prior to the riot, prison conditions and prisoner behaviour combined to create a risk of disorder, which was not appropriately managed. When disorder broke out in the Top Jail's yard 116, there was a lack of early decisive intervention. Several opportunities were missed to prevent the situation from escalating to the extent that it did. Once fires became established there was a delay in ordering the evacuation of the prison. During the first few hours after disorder started, the prison's response was characterised by poor communication and ineffective command and control.

This Inquiry also found issues with training, equipment, building security, staff roles, and health and safety, among others. Corrections had not fully addressed the lessons from previous disorder events, such as the Spring Hill Corrections Facility riot in 2013.

The riot was a time of danger for staff and those prisoners who were not involved. The Top Jail was evacuated without loss of life due to the courageous actions of staff. It was also a time of great concern for whānau and family of staff and prisoners.

I want to acknowledge the ongoing impact of this event and the trauma it caused, not only to staff and prisoners in the Top Jail, but to staff from across the prison network who were involved. So too, the significant impact on staff of the relocation of prisoners from the Top Jail to prisons across the North Island.

My determination has been to robustly inquire into, and report on, what happened before, during and after the riot. Further, to make recommendations for improvements where necessary, to ensure Corrections is better prepared for a future event of this nature.

I have heard a great deal from interviews with staff and evacuated prisoners. I also received submissions from the Corrections Association of New Zealand, the Public Service Association and the New Zealand Nurses Organisation.

Following such events there are always lessons that can be learned. My approach to this Inquiry was not to find fault with the decisions or actions of any individual, rather to take a systems, practice and policy wide review of matters within the scope of the Terms of Reference.

I have been supported by a Panel of Independent External Advisors: Sir David Carruthers, Lady Tureiti Moxon, Dr Robert Joseph and Baden Vertongen. This is the first time I have appointed a Panel to assist me in my work and I am greatly appreciative of their support.

I also want to recognise the other agencies which responded to the riot for their assistance with my Inquiry – New Zealand Police, Fire and Emergency New Zealand and St John Ambulance. I acknowledge the engagement with the Independent Police Conduct Authority given its oversight role and separate investigation into aspects of the Police response.

This report is the result of months of exhaustive inquiry and is testament to the dedicated efforts of my team to investigate fairly, impartially and objectively. There is much to learn and to action. It is my intention to report on my findings and recommendations publicly, and I intend to report on Corrections' progress periodically.

This report has been written in a way to avoid commenting on culpability for criminal conduct. In order not to prejudice the criminal, civil and Waitangi Tribunal proceedings in any way, the report is confined to the factual narrative and avoids commentary on such matters which are appropriately the responsibility of the aforementioned proceedings.

I trust this sentinel event realises positive outcomes for Corrections, its staff and those in custody across the prison network.



Janis Adair  
Chief Inspector

## Glossary of Acronyms

<b>ACR</b>	Advanced Control and Restraint
<b>AOS</b>	Armed Offenders Squad
<b>CIMS</b>	Co-ordinated Incident Management System
<b>EOC</b>	Emergency Operations Centre
<b>FENZ</b>	Fire and Emergency NZ
<b>HCM</b>	Health Centre Manager
<b>HSIR</b>	Health Services Incident Reporting
<b>IOMS</b>	Integrated Offender Management System
<b>ISU</b>	Intervention and Support Unit
<b>MECF</b>	Mt Eden Corrections Facility
<b>NCC</b>	National Coordination Centre
<b>PAPP</b>	Team Leader Prison Population
<b>PCO</b>	Principal Corrections Officer
<b>PNT</b>	Prison Negotiation Team
<b>PTAT</b>	Prison Tension Assessment Tool
<b>RoC*RoI</b>	Risk of re-conviction multiplied by the risk of imprisonment
<b>RMT</b>	Remand Management Tool
<b>SCO</b>	Senior Corrections Officer
<b>SERT</b>	Site Emergency Response Team
<b>SHCF</b>	Spring Hill Corrections Facility
<b>SMEAC</b>	> Situation > Mission > Execution > Administration/Logistics > Command/Signal

## 1. Executive Summary

### Overview of the riot

1. On Tuesday 29 December 2020, 21 remand prisoners were in yard 116 in the high security facility (known as the Top Jail) at Waikeria Prison. The Top Jail housed 212 prisoners in total. At around 10am, a Corrections Officer observed a prisoner in the yard giving another prisoner a haircut with a disposable razor. The Corrections Officer asked for the razor to be handed over, and a verbal altercation took place. Corrections officers told prisoners they would be returned to their cells if they did not return the razor.
  2. At 10:22am, staff directed the prisoners to exit the yard one by one, but this was unsuccessful as some prisoners refused to comply (with one saying to staff: *"You're dreaming bro, get the fuck out of here"*). There was no intervention to this direct challenge to staff authority. Tension in the yard escalated and some of the men began covering themselves in soap in anticipation of resisting removal from the yard. The two CCTV cameras in the yard were covered with wet toilet paper and some prisoners covered their faces with their t-shirts and their eyes with clear plastic food wrap.
  3. The men were told that if they handed over the razor, they would not have to return to their cells. At 10:42am, a prisoner made a call on the yard payphone (to an approved number) where he said: S 18(c)(i) [REDACTED]. After some discussion between staff and prisoners, the razor was handed over to staff at around 10:45am, the cameras were uncovered, and the men were left in the yard.
  4. Shortly after 11am, the prisoners in the yard held what appeared to be a brief meeting and, following this, several calls were made from the yard payphone where the men said S 18(c)(i) [REDACTED].
  5. Corrections officers observed prisoners smoking cannabis, meaning the men had access to both cannabis and an ignition source (such as a lighter or matches).
  6. At 11:26am, a prisoner made a telephone call and said: S 18(c)(i) [REDACTED].
  7. At midday, another prisoner used the yard payphone. The call was diverted to Newshub, and he said: S 18(c)(i) [REDACTED].
  8. At 1pm, Newshub called Corrections' media line and said there was going to be a riot at Waikeria Prison.
  9. At around 1:45pm, prisoners again covered the cameras in the yard. Around 12 prisoners asked staff if they could leave the yard, but were prevented from leaving by other prisoners.
  10. Staff called a Code Blue at 1:47pm. This required all identified incident responders to go immediately to the yard.
  11. From around 1:50pm, fires were lit in the yard.
  12. At 2:20pm, the prisoner called Newshub again, saying: S 18(c)(i) [REDACTED].
  13. Corrections officers did not regain control of the yard despite the escalation in disorder. This was apparently for a number of reasons:
    - » In the early stages, some staff viewed the situation as resolved once the razor was handed over.
    - » Staff appeared to have been reluctant to clear the yard due to a real or perceived availability of staff to respond safely.
    - » It seems that the corrections officers who observed the cannabis being smoked did not take any immediate action in relation to the presence of contraband. (An incident report and misconduct report were later generated, however, there is no evidence to suggest that senior staff were advised of the cannabis and ignition source at the time).
2. Telephone calls made by prisoners in the yard were not known to staff at that time.

14. Staff attempted to fight the fires with hoses, but the water pressure was not powerful enough to reach the fires. Also, the men in the yard blocked the water from coming into the yard.
15. Fire and Emergency NZ (FENZ) responders arrived at the Top Jail at around 2:30pm.
16. At 3:15pm, the Waikeria Prison Advanced Control and Restraint (ACR) unit was activated.
17. At around 3:20pm, prisoners (including one who had been smoking cannabis earlier) were able to breach the mesh grille covering the yard. Nine prisoners climbed through the grille and gained access to the roof. The nine were members of seven gangs, and three had made telephone calls saying S 18(c)(i) [REDACTED]. At 3:25pm, pepper spray was deployed through the yard gate in response to the prisoners going on the roof.
18. At about 3:25pm, a Code Red was called. A Code Red requires the establishment of an Emergency Operations Centre (EOC) to assess the need to lock down the prison and respond to a serious incident.
19. At 3:54pm, staff were heard commenting via on-body camera that the smoke was “toxic”.
20. At 4:16pm, ACR assistance was approved to be called in from other Central Region and some Northern Region prisons.
21. The extraction by staff of the remaining prisoners from yard 116 began at around 4:30pm and was completed at 4:55pm.
22. The prisoners on the roof were able to access other areas of the prison. Over the course of the first day:
  - » From 5:10pm, they started breaking other prisoners out of their cells using a large metal object as a battering ram. By 5:50pm they had broken out seven members of the Mongols Motorcycle Club and one Comanchero Motorcycle Club member. Later they forced out two prisoners, who were unwilling to leave their cells, and threatened to burn them and throw them off the roof. They then broke out two more, making a total of 12 additional prisoners who went on the roof.
  - » They also accessed a principal corrections officer’s office and took a bolt cutter, stab proof vests, staff uniform and cellphones.
  - » They set a number of further fires in the Top Jail.
23. At 4:45pm, the EOC was set up and began considering, among other things, the evacuation of the prisoners from their cells in the Top Jail, containment of the incident, appreciation of the risks and preservation of life.
24. At about 9pm, prison negotiators noted that the two prisoners who appeared to be unwilling participants wanted to get down from the roof. Staff distracted the other prisoners, allowing these two men to safely come down.
25. Another two men voluntarily came down from the roof on the evening of the first night. The 17 who remained, all gang members, were subsequently charged by Police in relation to their actions. Note, the prisoners who incited the incident in the yard but did not go on the roof, were not later charged by Police. Neither were they charged with a misconduct by Corrections.
26. At around 8:45pm, staff began evacuating prisoners from their cells in response to the fire risk. The evacuation was completed just after midnight and it was confirmed that the Top Jail was clear of prisoners, apart from those on the roof, by 1am.
27. Staff continued to negotiate with the prisoners on the roof on days two and three.
28. On 31 December 2020, the men on the roof requested and then met with Kuia and Kaumātua. They also requested and then later met with the Co-Leader of Te Pāti Māori. One of them dropped a note off the roof, outlining their complaints (see Appendix I).
29. The same day, at around 2:45pm, the prisoners gained access to the armoury and acquired shields, helmets, personal protective equipment, a Halligan bar (forceable entry tool), a bolt cutter and an electric grinder. Later that day, one man surrendered from the roof after being assaulted by other prisoners.

30. On day four of the riot there was a tactical change of staff. With the new leadership came a clear and immediate drive to bring the incident to an end and the intervention plan, which had been developed in the preceding days, was finalised.
31. Just after midnight on 2 January 2021, around half of the men came down to the ground and confronted ACR and Police Armed Offenders Squad (AOS) members. Sponge rounds were used by Police to drive the men back from staff, and they returned to the roof.
32. On day five of the riot the intervention plan was approved.
33. At 7:15pm that evening, ACR and AOS entered the Top Jail with a view to securing the Chapel area. In response, the prisoners lit fires. The ACR and AOS members withdrew, but fire rapidly destroyed the area where the prisoners had been sleeping which forced them out onto the roof.
34. The 16 prisoners remained on the roof until 3 January 2021, day six of the riot, when they all surrendered. The Kaumātua, Kuia and Co-Leader of Te Pāti Māori returned to the site to witness the surrender.
35. The fires lit by the prisoners resulted in extensive damage and ultimately the destruction of the Top Jail.

### *Underlying causes of the riot*

36. Underlying tensions at the Top Jail escalated into a series of breaches of order that were not properly contained and ultimately led to the riot. It appears to have been primarily opportunistic: while there was some degree of organisation once the riot began, particularly by the Mongols MC, this Inquiry has not found any evidence of planning prior to the event.
37. Those underlying tensions were in part a result of systemic failures within the Top Jail prior to the riot. Some of the men felt mistreated by staff and were dissatisfied with the physical conditions and the way they were managed. The environment at the Top Jail had previously been found by my Office, and the Office of the Ombudsman, as being not conducive to the humane treatment of prisoners. The prisoners' daily cell-to-yard regime was devoid of meaningful engagement.
38. The dissatisfaction of the prisoners in the Top Jail was exacerbated by a concerning and disrespectful staff culture. Disappointingly, we observed instances where staff spoke to prisoners in an inappropriate, disrespectful and unacceptable way on 29 December 2020 prior to the riot. That said, this may have been the result of staff lacking adequate support and training to work in the challenging Top Jail environment.
39. Of separate concern was the placement of gang members within the Top Jail. Due to the site's decision (made on the advice of the Persons of Extreme Risk Directorate), all of the Mongols MC members had been placed in a single unit. While there were no Mongols MC members involved initially, as the riot progressed they became the largest and most influential group. The Inquiry notes that prior to the riot, managing the Mongols MC members in the Top Jail had presented significant challenges to staff who did not receive any additional training for this environment.
40. The ease with which prisoners could obtain contraband (including cannabis, razors and ignition sources), and take such contraband into the yard, was also a concerning factor which directly contributed to the riot.
41. The combination of these and other factors led to an unhealthy level of tension. This was not appropriately reflected in the Prison Tension Assessment Tool (PTAT), which is designed to "assess the overall level of tension or 'temperature' in ... prison units". Whether this was due to a normalisation of such incidents, systemic failures within the prison or a lack of staff experience and inadequate training, the result was that tensions were able to increase largely unchecked.
42. It appears that not all staff were adequately trained or supported to deal with disorder behaviour that could develop into this type of event. The beginning phases of the riot show escalating incidents of disorder that were not properly addressed. From staff actions and inactions, it appears that the type of behaviour that was seen in yard 116 that day was not considered out of the ordinary by the staff.



43. Issues with the physical design and maintenance of the Top Jail also contributed to the riot:
  - » A failure to maintain the integrity of the mesh grille in the yard meant it could be broken to gain access to the roof. This was one of the key factors that led to this disorder event in the yard becoming a site-wide incident that resulted in the loss of the Top Jail.
  - » From a building design perspective, the fact that prisoners could access all of the Top Jail once on the roof certainly contributed to the scope, duration and impact of the event.
44. Ultimately, the riot was caused by a series of inadequate responses to escalating events (such as the non-return of the razor, prisoners challenging the authority of the staff by refusing to leave the yard, and prisoners smoking cannabis in the yard while being observed by staff), together with the underlying risk factors identified above.
45. However, despite the fact the prisoners involved may have had legitimate concerns about the Top Jail and the conditions under which they were being managed, it must be acknowledged at the outset that the riot, and the risks to life, trauma caused, and the destruction of the Top Jail were the direct result of actions by the prisoners. This was not a non-violent protest, as was claimed by the prisoners on the roof.
46. This Inquiry identified issues with the complaints process at Waikeria Prison, including access to making a complaint. We are also aware of a broader issue regarding the willingness of prisoners to utilise the complaints system.
47. As part of this Inquiry, we reviewed other major disorder events in New Zealand and overseas. An analysis of these major incidents highlights a number of similarities and common themes of many prison disorder events. They provide valuable lessons in how to mitigate the risk of a riot occurring. While some lessons appeared to have been learned from previous riots and major disorder events, Corrections has generally been slow to implement learnings across the prison network.

### *Missed opportunities to contain the riot*

#### **General**

48. A number of opportunities to prevent and de-escalate the incident were missed. It is concerning to note at the outset that a riot was not identified on Waikeria Prison's Risk Register.
49. The initial incident arose from the use of the razor in the yard. This was avoidable. Some corrections officers were aware that a prisoner in the yard was in possession of a razor he had not given back to staff in the days prior to the riot. However, in the footage of the riot, corrections officers were heard to say they did not strip search this prisoner or the prisoner who shared his cell, or search their cell that day. They did strip search the prisoners and search the cell the next day, but did not locate the missing razor. They did not take any other action to mitigate the risk of the razor, including preventing the prisoners from going into the yard, entering offender notes or incident reports, or informing senior officers.
50. However, while the razor incident triggered this disorder in yard 116, a major disorder event could have arisen from any number of the other underlying tensions and risks.
51. A further opportunity to contain the escalating disorder in yard 116 occurred when the prisoners refused to comply with an instruction to exit the yard approximately 20 minutes after the haircut was observed by corrections officers. Intervention in some form was required when the prisoners refused to comply with the officer's instruction. However, staff failed to take effective steps to intervene or plan for intervention.
52. No intervention was taken when prisoners were seen smoking cannabis in the yard, although an incident report and misconduct report were later completed. This meant there was an ignition source in the yard.
53. Corrections officers are trained in effective methods for de-escalating tension and restoring order. In this situation, the actions of some staff at the early stage were ineffective and unnecessarily confrontational.
54. More than five hours passed from the time the razor was observed to the time the prisoners broke through the yard's mesh grille. It is plain in hindsight that earlier intervention should have occurred, and did not, primarily because corrections officers did not respond to the concerted indiscipline that occurred after the razor had been removed from the yard. In particular, the Site Emergency Response Team (SERT) was not available to assist in de-escalating the situation as its members were used to cover core shifts and SERT's role at Waikeria Prison focused on intelligence gathering and searching, rather than emergency response.

**Command and control**

55. Once the prisoners accessed the roof at around 3:20pm, the initial response was marked by a continued lack of command and control. There did not appear to have been a clear plan or decision-making process, even acknowledging that it was a rapidly developing situation.
56. The immediate response to the incident was led by the On-Call Manager, and subsequently by the Prison Director and Regional Commissioner – Central (both of whom had been on leave, but responded to the incident). They were based on site at Waikeria and were joint Incident Controllers. The Prison Director of Spring Hill Corrections Facility (SHCF) took over the role of Incident Controller during the night shift. While these three were all trained in the Co-ordinated Incident Management System (CIMS), none had experience managing an incident of this magnitude.
57. The EOC was set up about an hour and a half after the prisoners first accessed the roof. Following the evacuation, the overall approach to the riot on the first three days was to contain the incident and negotiate a peaceful surrender. It was not until the National Coordination Centre (NCC) was formally established on the fourth day of the riot, and the tactical staff changes in the EOC (referred to above), that the focus shifted to intervening to bring the riot to an end, and an intervention plan was put in place.
58. One aspect of concern is the absence of a capability within Corrections to contain the prisoners' actions once they were on the roof (noting Corrections staff were not trained to operate at height).
59. Although staff were mobilised, and many acted courageously, they did not have clear direction on how to respond to the evolving situation. The prisoners on the roof were able to access a number of critical areas of the Top Jail, while continuing to light fires. The FENZ report noted at least 37 separate sources of fire in the Top Jail.
60. The decision to exclude the Chief Custodial Officer from a leadership role during the riot (to undertake a review of Corrections' response) resulted in his significant operational experience not being available. Moreover, given his involvement in the initial response to the riot, this was arguably a potential conflict of interest.
61. This Inquiry has had the benefit of listening to the telephone calls made by a number of prisoners in yard 116 on the morning of the riot. These provided significant insights into the prisoners' intentions, which were not available to frontline staff or decision makers at the time. Notwithstanding this, it was evident a disorder event was taking place in the yard which had not been resolved.

**Response to the riot****Evacuation**

62. Almost 200 prisoners were confined to their cells in the Top Jail on 29 December 2020 when the fires were lit. It was a terrifying ordeal for a number of these prisoners who could smell burning, see smoke, and who struggled to breathe for hours. It would have been obvious to them that there were prisoners on the roof. Many prisoners reported that they thought they were going to die as smoke entered their cells. At this time, cell intercoms were not being responded to, and many of the prisoners reported they were not told what was happening.
63. The evacuation began at around 8:45pm and was completed just after midnight.
64. Some of the evacuation was carried out in darkness, which would have undoubtedly added to the confusion and fear. While a number of staff acted courageously during the evacuation, there appeared to be a lack of a clear plan or, if there was, it was not well communicated. The delay in commencing the evacuation and the lack of an organised response raises a number of significant concerns:
  - » Most importantly, the evacuation was not started early enough to prevent a real risk to safety and even life.
  - » At the time the evacuation was commenced, on-body camera footage showed some staff were aware that smoke was affecting prisoners in their cells. It is not clear whether the Incident Controller who made the evacuation decision was aware of this. He later explained that while he was waiting for sufficient staff resources to arrive, *"the lack of resources would never override a real and immediate threat to life"*.
  - » Initially, prisoners were unlocked one by one, however, an increased appreciation of the risk (as a result of the fires and smoke spreading) resulted in staff unlocking all cells in order to speed up the evacuation. Prisoners cooperated with staff directions.



- » When corrections officers undertook a final check to ensure all prisoners had been evacuated, two prisoners were discovered in their cells. The evacuation of prisoners in the Intervention and Support Unit (ISU) was particularly concerning. These men were some of the most vulnerable in the Top Jail and some were woken at around 11pm by staff in full ACR uniform. This was observed to be undertaken at pace and under urgency, with limited explanations as to what was happening. Some were physically removed from their cells and appeared to be disorientated and confused.
  - » The evacuated prisoners were transferred to the low security facility in the first instance, and transferred to other prisons the next day.
65. The late decision to evacuate was, in part, because the true scope and scale of the rapidly evolving situation may not have been comprehensively relayed to the decision makers. There was a disconnect between what was known by those in charge and those on the ground. Had the enormity and urgency of the situation been known it is likely the decision to evacuate would have been made much earlier. It is noted that the Incident Controller directed staff to remove keys, radios and pepper spray from areas across the Top Jail.

### Intervention

66. Once the evacuation had occurred and there was no perceived risk to life other than to the men on the roof, the Incident Controllers believed (at least initially) the risk of aggravating the situation further by intervening was outweighed by the benefits of seeking a non-violent conclusion.
67. Believing they were adequately contained, staff continued to negotiate with the prisoners on the roof on days two and three. Corrections led the response, alongside other agencies, including Police, FENZ and St John Ambulance.
68. At the point in time the Top Jail was lost to the violent actions of the prisoners, it was both necessary and appropriate for the decision makers to take time to plan strategically and operationally with partner agencies to bring about a safe resolution to the riot. To have not done so would likely have led to a confrontational incident and serious harm to life of both staff and the prisoners.
69. The tactical decision not to physically intervene during the first three days was not well communicated or understood by some involved in the riot response. Many of those spoken to were critical of what they perceived to be a “*watch and wait*” strategy in the face of steadily increasing risk to life and property.
70. On day four of the riot there was a tactical change of staff, in part to mitigate staff fatigue. On 1 January 2021, the Commissioner Extreme Risk Directorate was appointed National Incident Controller and the NCC was formally established at Corrections’ National Office (rather than being operated remotely). The acting Regional Commissioner for the Northern Region was brought in as Incident Controller on site, with the Prison Director Otago Corrections Facility as the night-time Incident Controller. With the new leadership came a clear drive to bring the incident to an end and the intervention plan, which had been developed in the preceding days, was finalised.
71. On day five of the riot the intervention plan was approved by the Incident Controller and endorsed by the NCC and the Chief Executive. The Acting Police Commissioner was consulted and approved the proposed AOS tactical response.
72. At 7:15pm that evening, ACR and AOS teams entered the Top Jail with a view to securing the Chapel area, which had earlier been barricaded by the prisoners on the roof. In response, the prisoners lit fires in the Chapel area, above where the ACR and AOS team members were attempting to enter the building. The ACR and AOS teams withdrew, but fire rapidly destroyed the area where the prisoners had been sleeping and where their food, water, clothing and blankets were being stored. This forced the prisoners out onto the roof.
73. The change in leadership and tactical approach brought about an end to the riot, assisted by the inability of the prisoners to retreat to the (now destroyed) Chapel area, and rainy overnight weather conditions.

### Post-incident response

74. The way in which evacuated prisoners were moved first to the low security units and later to other prisons was initially unstructured and unplanned, with little consideration given to any factors other than vacant beds in other prisons. Further, there were some instances of inaccurate documentation recording which prisoner was placed in which vehicle and to which site they were being transferred.

75. We heard mixed messages about the support provided to both prisoners who were evacuated and to staff. While some were satisfied that Corrections had provided adequate support given the trauma they had experienced, others felt there was little to no support provided.
76. Some staff have been unable to return to work, more than a year later, due to physical or psychological trauma caused by their response to the riot and are in the process of being medically retired.
77. The Top Jail was damaged to such an extent it was no longer able to be used. The riot resulted in the loss of 310 beds, including 26 ISU beds. This was a significant loss of capacity for Corrections' Central Region and the prison network as a whole.
78. As well, Waikeria Prison lost key functions for its whole site including the kitchen, laundry, Receiving Office and AVL suite. This seriously impacted the low security facility and its ability to provide services for the 500 prisoners who continued to be housed there.
79. After the surrender, Corrections transitioned to recovery management. In its Recovery Report, Corrections stated its recovery from the riot *"...has focused on the planning of current and future operations at Waikeria Prison and the wider prison network, and on the wellness and wellbeing of our staff and of the people in our care affected by the incident"*. The Recovery Report highlighted the need to develop interim solutions to keep the site operational until the completion of the new build.
80. A new 600 bed facility to accommodate high security prisoners is currently under construction at Waikeria Prison, and is due for completion by 2023. The Waikeria Mental Health and Addiction Service, now renamed Hikitia, will operate from a 100 bed dedicated mental health and addiction facility, Te Wai o Pure.

### *Health Services preparedness and response*

81. While there were positive aspects of health service delivery in the immediate response, system-wide shortcomings in some of Corrections' Health Services were also identified.
82. Notwithstanding the significant risk to the health and safety of both staff and prisoners during the riot, Corrections' Health Services leadership lacked cohesion and its response was, at times, confused.
83. Corrections' Health Services were not well integrated into the overall emergency response. None of Corrections' Health Services Senior Leadership Team on duty during the immediate response period had formal Corrections' CIMS training nor had they undertaken any joint emergency management training as a team prior to the riot.
84. While Waikeria Prison's health team members managed the immediate health needs of the prisoners with a high level of competency, including mobilising mental health services, ongoing health service delivery was negatively impacted at the receiving sites.
85. The loss of the Intervention and Support Unit at Waikeria had an immediate and sustained impact on SHCF, creating many resourcing challenges. This compromised the ability of the SHCF health team to meet the immediate needs of a significantly higher volume of prisoners, many of whom required complex mental health care and support. It placed and has continued to place significant stress and pressure on health staff at a number of sites.

### *Comments on Chief Custodial Officer's report*

86. The Chief Custodial Officer completed an Operational Review Report: Waikeria Prison Riot – 29 December 2020 to 3 January 2021 (Chief Custodial Officer's Report). This was completed as a swift and primarily forward-looking review, with terms of reference that focused on recommendations for improvement to procedures and standards.
87. This Inquiry team has had the benefit of a much longer investigation period and broader terms of reference – particularly with regard to conditions in the Top Jail prior to the riot.
88. Without intending criticism of the Chief Custodial Officer's Report, my report departs from its conclusions in some respects.

### Concluding comments

89. This Inquiry welcomes Corrections' Hōkai Rangi strategy which aims to address the over-representation of Māori in the corrections system and uplift the oranga (well-being) of Māori and others in custody.
90. Hōkai Rangi's realisation has been impeded by the COVID-19 pandemic. Understandably, Corrections had to prioritise its response to the pandemic. We note the ability of prisoners in the Top Jail to access Hōkai Rangi aligned kaupapa was limited. The, at times, disrespectful staff culture and generally poor conditions were inconsistent with the principles of Hōkai Rangi.
91. We note that the prison fostered a positive relationship with mana whenua, who were involved with the riot response.
92. While my findings indicate a number of deficiencies and missed opportunities, these have to be viewed in the context of a volatile, dangerous and rapidly evolving incident. The riot was an extremely challenging, life-threatening situation, especially once prisoners had breached the roof.
93. The actions of the prisoners involved in the riot cannot be sanctioned. This was not a peaceful protest nor a proportionate response to underlying issues at the prison. It was a riot in which lives were put at risk and the Top Jail destroyed. The prisoners acted with no regard to the safety of themselves and others and put the lives of fellow prisoners and those who responded to the incident in danger.
94. Underlying risks and tensions meant that a major disorder event was at least predictable, and neither the prison nor Corrections demonstrated a preparedness or capability to respond to an incident of this nature, scope and scale.
95. In conclusion, while this Inquiry has made a number of findings and recommendations, the overarching theme of those must be and can only be that Corrections plan, prepare and practise for another potential event of this nature. Corrections' focus must not only be on its response, but also how it works alongside other agencies.

## 2. Methodology

1. The Chief Executive of the Department of Corrections Ara Poutama Aotearoa tasked this Inquiry to investigate and report on the circumstances surrounding the riot that began at Waikeria Prison on the afternoon of 29 December 2020, including Corrections' response, and its preparedness for such incidents across the prison network. This is set out more fully in the Terms of Reference (Appendix A). From the Terms of Reference, key questions were developed for each of the four phases of the Inquiry. These provided a framework to guide the Inquiry team's programme of work.
2. The Chief Inspector appointed four Independent External Advisors to support her as she developed the programme of work and during the course of the Inquiry. They are Sir David Carruthers, an eminent member of the legal community; Lady Tureiti Moxon (Ngāti Pāhauwera, Ngāti Kahungunu, Kāi Tahu), who has extensive experience in Māori health, education, social justice and Whānau Ora; Dr Robert Joseph (Tainui, Tūwharetoa, Kahungunu and Ngāi Tahu), Associate Professor of Law, nominated by the Maniapoto Māori Trust Board; and Baden Vertongen (Ngāti Raukawa ki te Tonga), a senior lawyer and mediator, nominated by the Raukawa Settlement Trust. The Chief Inspector considered it was vital to have these Independent External Advisors, who include representatives of mana whenua, to provide an independent perspective with significant kaupapa Māori experience. Terms of Reference were developed for the Independent External Advisors (Appendix B).
3. The report of the Inquiry has been written in a way to avoid commenting on culpability for criminal conduct. In order not to prejudice the criminal, civil and Waitangi Tribunal proceedings in any way, the report is confined to the factual narrative and avoids commentary on such matters which are appropriately the responsibility of the aforementioned proceedings.
4. Supported by cultural advisers, Te Paiheretia and a Principal Inspector, the Chief Inspector met with King Tuheitia (Te Kiingi Tuheitia Pootatau Te Wherowhero VII), his wife Makau Ariki Te Atawhai and the Chief of Staff Ngira Simmonds on 18 May 2021. The next day, with members of the Independent External Advisors and her Inquiry team, the Chief Inspector was formally welcomed at Waikeria Prison with a pōwhiri at Te Whare o te Ao Marama (Te Tirohanga, low security unit) to signal the commencement of the engagement phase of the Inquiry.
5. The Chief Inspector established an operational team with a wide variety of skills and experience, including custodial, cultural, legal, investigation and oversight, clinical psychology, health, rehabilitation and case management. It also had a kaupapa Māori lens, with the support of Te Tari o te Kingitanga.
6. The Chief Inspector personally led the interviews with senior Corrections staff.
7. During the course of the Inquiry, The Chief Inspector briefed the Chief Executive on progress related to key milestones of the Inquiry's work.
8. As part of this investigation, the Inquiry team reviewed a large number of key documents. These include:
  - » Operational Review Report: Waikeria Prison Riot – 29 December 2020 to 3 January 2021 (Department of Corrections, March 2021). This is the Chief Custodial Officer's Report. The Chief Inspector read this after her Inquiry was substantially concluded. This report highlights the ways in which this Inquiry diverges from the findings of the Chief Custodial Officer's Report.
  - » Waikeria Prison Riot: Tuesday 29th of December 2020 to Sunday 3rd of January 2021; Operation Emery: A debrief of the Police Response (New Zealand Police, 2021).
  - » Fire Investigation Report (Fire and Emergency New Zealand, 2021).
  - » Inspection reports from the Office of the Inspectorate and the Office of the Ombudsman.
9. The Inquiry team undertook an extensive review of available CCTV, on-body camera and drone footage from Corrections, Police and FENZ.<sup>3</sup> Some quotes from on-body camera audio footage have been included in the report.

3. Note, while viewing footage, this Inquiry was often unable to identify individual staff due to the lack of unique identifiers on their uniforms.

10. The Inquiry team interviewed and conducted information gathering and focus group sessions, including with:
  - » Mana whenua
  - » Prisoners who had been residing in the Top Jail and were evacuated on 29 December 2020
  - » Staff from Waikeria Prison and other sites who responded to the riot
  - » Prison Health Services
  - » Kaumātua, Kuia and kaiwhakamana (volunteers who have approved access to prisons to enable the well-being of Māori offenders)
  - » Staff from National Office
  - » Staff from the Central Region
  - » Staff in leadership roles, including the National Commissioner, the Deputy Chief Executive Māori, Chief Custodial Officer, Regional Commissioner and Prison Director.
11. In total, 111 individual interviews were conducted (22 with prisoners, three with mana whenua and 86 with staff). Focus groups were held with 10 Kaumātua/kaiwhakamana, 29 prisoners and 41 staff. The majority of interviews were recorded and transcribed. Some quotes from these interviews have been included in this report.
12. The Chief Inspector invited and received submissions from the three unions which represent Corrections staff: the Corrections Association of New Zealand, the Public Service Association and the New Zealand Nurses' Organisation. These submissions have been helpful and informative as the Inquiry has formed its views
13. The Chief Inspector invited 16 of the 17 prisoners who were involved in the riot, via their legal representative, to speak to us. She wrote separately to one prisoner who was self-representing. None responded.
14. The Chief Inspector emailed and wrote to the Co-Leader of Te Pāti Māori a number of times, inviting him to be interviewed, but did not receive a response.
15. The Inquiry team engaged with FENZ, Police, the Independent Police Conduct Authority and St John Ambulance.
16. Telephone calls from yard 116 were listened to.
17. No cell intercom recordings could be accessed, as they were destroyed by fire.



### 3. Findings and Recommendations

#### Recommendation 1

Corrections must provide a comprehensive progress report to the Office of the Inspectorate, in writing, on all recommendations arising from this Inquiry in six months and thereafter at six monthly intervals.

#### Recommendation 2

Corrections must ensure there is a robust assurance framework in place to monitor and validate progress on this Inquiry's recommendations.

#### General

1. Many staff demonstrated significant courage in responding to the riot, particularly when evacuating prisoners from the Top Jail. Notably, staff who returned to the building after the fire was well under way, to ensure that no prisoners had been left behind, did so at considerable personal risk. Without their actions, lives would most likely have been lost.
2. During the riot, Corrections took active steps to mitigate the risk of other disorder events across the prison network.
3. The riot was not a peaceful protest. The prisoners involved acted with violence, caused deliberate and extreme damage to the facility, and put the safety of staff, emergency responders, other prisoners and themselves in real jeopardy. This was not an appropriate, proportionate or justified response to their dissatisfaction with their conditions and management in the Top Jail.
4. Waikeria Prison was generally unprepared for an event of this nature. There was a lack of early, decisive intervention to address the increasing tension and disorder in yard 116. Earlier and more decisive intervention would likely have prevented the situation from escalating to the extent that it did.
5. At the time the Top Jail was lost to the prisoners' violent actions, it was both necessary and appropriate for the decision makers to take time to plan strategically and operationally with partner agencies to bring about a safe resolution to the riot. To have not done so would likely have led to a confrontational incident and serious harm to life of both staff and the prisoners.
6. Staff were not sufficiently trained for a major disturbance or for a multi-agency response of this scope and scale.
7. Corrections worked promptly and proactively to establish a process to compensate those who lost property during the riot.

#### Findings of previous reports

8. Corrections previously accepted a number of findings from the Office of the Inspectorate's 2017 and 2019 inspection reports into Waikeria Prison, and recommendations from the Office of the Ombudsman's inspection report of 2020. Corrections' response to these findings and recommendations was not fully implemented and contributed to the unsuitable conditions in the Top Jail prior to the riot. These included:
  - » the physical conditions of the Top Jail not being conducive to the humane treatment of prisoners, or to their safety or rehabilitation
  - » inadequate supervision of prisoners in the Top Jail yards
  - » problems with the provision of clothing and bedding to prisoners in the Top Jail.
9. Corrections failed to adopt some key learnings and recommendations following the riot at Spring Hill Corrections Facility in 2013, including those relating to increasing Advanced Control and Restraint capability, and activating the National Coordination Centre immediately when it became clear a significant event was unfolding. These failures negatively impacted Corrections' response to the Waikeria riot.

## Waikeria Prison prior to the riot

### Policy

10. While the Hōkai Rangī strategy was visible at Waikeria Prison, more work is needed to fully realise its core principles. This was not unexpected given its relatively recent introduction in August 2019 and the intervention of the COVID-19 pandemic.

### Recommendation 3

Corrections should continue with the development and realisation of its Hōkai Rangī strategy.

### Prisoner management

11. Prisoners in the Top Jail were largely on a restricted yard-to-cell regime, with limited to no opportunity for meaningful engagement or activities, including tikanga Māori programmes.
12. While Waikeria Prison had a clear process for the placement of prisoners, categories of remand prisoners in the Top Jail were often mixed. This occurred without an exemption from the National Commissioner as required under regulation 186(3) of the Corrections Regulations 2005.
13. An exemption was given to Prison Directors allowing them to mix remand and other prisoners when necessary for the management of COVID-19. However, this exemption required the Prison Director to demonstrate that COVID-19 was having an impact on the prison's operations. Remand and other prisoners in the Top Jail were being mixed without any legitimate COVID-19 rationale.
14. A number of Mongols Motorcycle Club members were being managed together in the Top Jail. This likely contributed to the increased tension in the unit prior to the riot.
15. The policy at Waikeria Prison to always use handcuffs on a category of prisoner, most notably members of the Mongols Motorcycle Club, when escorting them around the prison was problematic.

### Recommendation 4

Corrections must review its management of remand and sentenced prisoners in terms of their opportunities for meaningful, purposeful activities, including rehabilitation (where appropriate), education, work and reintegration.

### Recommendation 5

Corrections must ensure the correct processes for the placement of prisoners are followed at all times.

### Recommendation 6

If the Prison Director believes there to be exceptional circumstances that justify the mixing of remand prisoners, an application for an exemption must be made to the National Commissioner under regulation 186(3) of the Corrections Regulations 2005.

### Recommendation 7

Corrections must consider the placement of prisoners connected with gangs, particularly those connected with the newer transnational gangs. Each of these prisoners must have an individualised management plan, taking into account their specific needs and risks.

### Recommendation 8

Each prison's gang management plan should, where appropriate, take into account the advice of the Persons of Extreme Risk Directorate.

**Recommendation 9**

Each prison's gang management plan should be kept up to date, relevant and effective, with regular meetings held and terms of reference developed.

**Recommendation 10**

Corrections must ensure that all instructions as to the application of handcuffs comply with the relevant legal framework.

**Case management**

16. Case management at Waikeria Prison fell well below acceptable standards of practice in 2020. Of particular concern was that remand prisoners were not engaged with in accordance with their risk, needs and responsivity. A prisoner could spend a significant amount of time on remand awaiting sentencing without engaging with case management.
17. Currently, Corrections' automated standards of practice do not provide an accurate reflection of service delivery. Findings in areas such as case management show that the automated standards of practice can provide an inaccurate picture of service delivery.

**Recommendation 11**

Corrections must ensure that case management across the prison network meets standards of practice.

**Recommendation 12**

Corrections should ensure that automated standards of practice have a robust assurance framework in place to monitor and validate results.

**Prisoner complaints**

18. The prison's complaints process, in particular the ability of prisoners to access the complaints process, was ineffective. Many prisoners expressed a lack of faith in the process.

**Recommendation 13**

Corrections must ensure that the formal complaints process is properly explained to prisoners during their inductions, and that complaints information is readily available.

**Recommendation 14**

Corrections must ensure that complaints are processed and actioned (where appropriate) in a timely manner.

**Staffing**

19. Some custodial staff did not feel that the Top Jail was a safe environment for less experienced staff. A number of staff at the Top Jail held acting roles for which they were not adequately trained and/or did not have sufficient experience.

**Recommendation 15**

Corrections should ensure that staff who are working in challenging high security environments, and staff who are appointed to acting roles, have sufficient training, experience and support to fulfil their responsibilities.



## Culture

20. Staff interactions with prisoners in the Top Jail were characterised by the frequent use of abusive language, which indicates an adversarial environment as well as a lack of respect. This type of language was a feature of the early stages of the incident and escalated the tension.

### Recommendation 16

Corrections must introduce further training and performance management to remedy deficiencies in respect of culture and the Code of Conduct, and to reinforce expectations about staff behaviour.

## Clothing and bedding

21. Notwithstanding the increased expenditure in recent years on clothing and bedding at Waikeria Prison, there were shortages of these items prior to the riot.

### Recommendation 17

Prisons across the network must ensure that prisoners have access to sufficient, appropriately sized and clean clothing and bedding.

## Waikeria Prison's ability to predict, prevent and respond to escalating disorder

### Risk management

22. Waikeria Prison's Risk Action Plan did not include the risk of a riot or major disturbance. The Deputy Regional Commissioner made a decision in October 2019 to exclude this risk from the site plan and place it at the regional level. Additionally, the Risk Action Plan was out of date and should have been reviewed in July 2020.
23. One event review was conducted at Waikeria Prison in 2020, compared with six at Spring Hill Corrections Facility, despite there being a number of serious incidents at Waikeria Prison that year which would warrant an event review.

### Recommendation 18

Corrections should develop guidance and training for when and how event reviews are conducted, to ensure consistency across the prison network.

### Recommendation 19

Corrections must direct that 'risk of riot' be considered and recorded on site risk action plans across the prison network.

### Recommendation 20

Corrections must ensure all site risk action plans across the prison network are current and up to date.

### Prisoner management

24. Poor prisoner behaviour at Waikeria Prison was frequently not managed appropriately.
25. Staff did not properly respond to the escalating prisoner behaviour in the yard during the four hours prior to the prisoners gaining access to the roof.
26. On the first day of the riot, 21 prisoners were in yard 116. This created an environment in which staff did not feel they could safely clear the yard or otherwise de-escalate the situation.
27. A plan to return the prisoners in the yard to their cells should have been developed once the prisoners refused to follow instructions. The decision to let the prisoners remain in the yard following such concerted indiscipline demonstrated poor judgment.

28. Prisoner disorder and staff-prisoner tensions were normalised at the Top Jail to such an extent that a disorder event of this nature was at least predictable. Yet staff seemed not to fully appreciate this risk, nor was it properly recorded in the Prison Tension Assessment Tool.

### Recommendation 21

Corrections must reinforce to staff and management the importance of consistent practice in managing poor prisoner behaviour.

### Recommendation 22

Corrections must ensure that staff are properly trained to recognise and respond to incidents involving escalating disorder.

### Recommendation 23

Corrections should consider implementing policies directed at escalation of response when concerted indiscipline incidents occur in a prison yard.

### Recommendation 24

Corrections must remind staff of the importance of ensuring the number and mix of prisoners in any given yard can be safely managed should the need arise to clear the yard.

### Recommendation 25

Corrections must ensure staff are trained in evacuating yards in the event of such disorder.

### Recommendation 26

Corrections should consider whether the Prison Tension Assessment Tool needs to be refreshed. It also needs to ensure that staff are trained to accurately record information in the Prison Tension Assessment Tool.

### Recommendation 27

Corrections should ensure that any review should consider a robust assurance framework for the Prison Tension Assessment Tool across the prison network to ensure consistency and proper monitoring.

## Razors and haircuts

29. Staff were aware of the missing razor in the days leading up to the riot but had not followed Corrections' razor policy or responded appropriately.
30. Section 188 of the Corrections Regulations states that the hairstyle and facial hair of a prisoner awaiting trial or during trial may be cut or shaved only to the extent necessary to preserve the appearance of that prisoner at the time of his or her reception to the prison. This section is outdated and no longer has any evidential benefit or utility.
31. Policies relating to haircuts were not properly understood by staff working in the Top Jail at the time of the riot.
32. The prisoners' lack of access to haircuts caused significant tension between staff and prisoners in the Top Jail in the period immediately preceding the riot.

### Recommendation 28

Corrections should ensure that prison staff are aware of the razor policy, including the importance of ensuring that all razors are accounted for and that incident reports are completed if razors are missing.

**Recommendation 29**

Corrections should work to amend the Corrections Regulations to ensure the sections relating to haircuts for prisoners on remand are relevant and appropriate.

**Recommendation 30**

Corrections should clarify the section on prisoner haircuts in the Prison Operations Manual. It should also ensure that staff in frontline roles understand prisoners' rights with regard to haircuts.

**Facilities and equipment**

33. The mesh grille used in the yards was not fit for purpose at the time of the riot. The Prison's failure to maintain the integrity of the mesh grille meant that prisoners could break the grille and gain access to the roof. This single factor transformed the event from one that was contained in the yard to one that spread throughout the Top Jail and ultimately resulted in the destruction of the Top Jail.
34. The Top Jail design was such that, once prisoners were on the roof, they had access to the entire Top Jail facility, including operationally crucial areas such as Master Control, the armoury and the Health Centre.
35. The exterior walls of West and East Units were built of hollow concrete blocks and the window bars were not set in concrete. This played a large part in prisoners being able to use a battering ram to break other prisoners out of their cells.
36. The loss of Master Control was particularly impactful in terms of Corrections' ability to respond to the riot, as it meant oversight via closed-circuit television was lost and the viewing of on-body camera footage was delayed. This loss had a significant impact on Corrections' ability to fully understand and respond to the developing situation.
37. Because staff were not trained to work at height, no security inspection of the roof had taken place. This meant prisoners on the roof were able to access various items they then used as weapons, tools and a battering ram. Access to these items enabled the riot to escalate.
38. Large quantities of hazardous, flammable and potentially explosive substances were located in the paint shop in the Top Jail. During the evacuation, fire in the paint shop posed an elevated risk. Inadequate consideration appears to have been given to the placement of the paint shop in the Top Jail from a risk perspective.
39. The prison's firefighting capability (including hoses and water pressure) and training was insufficient to extinguish the fires in the yards.

**Recommendation 31**

Corrections must carry out an immediate (and thereafter regular) assessment of its physical facilities in prisons across the prison network, including the integrity of walls, yard coverings/mesh.

**Recommendation 32**

Corrections must consider whether any other prisons across the prison network share this vulnerability, and ensure any future facilities are designed to ensure that prisoners accessing one area of the roof cannot compromise the security of the entire facility. If similar vulnerabilities are identified at any other site an immediate work plan should be implemented to remediate this.

**Recommendation 33**

Corrections should consider establishing a second Master Control or an alternative electronic storage location at sites across the prison network so key information remains available even if a prison's primary Master Control is lost.

**Recommendation 34**

Corrections should review options for inspecting the roof area of prisons, or other generally inaccessible areas, to ensure those areas are clear from items that could create security risks.

**Recommendation 35**

Corrections must consider the placement of hazardous substances in prisons, so that fire risk is minimised.

**Recommendation 36**

Corrections must review the prison network's firefighting capabilities and training, and ensure these are fit for purpose.

**Incident control**

40. Although senior managers were available to respond to the incident within a reasonable timeframe, command and control was not effective in the initial incident response.
41. The riot occurred over the Christmas holiday period which meant some of the site's senior management/leadership team were on leave and, while not readily available, responded promptly to the incident.

**Recommendation 37**

Corrections must ensure senior staff are trained to recognise and respond appropriately to an incident of this nature.

**Recommendation 38**

Corrections should establish a national emergency response team capable of deploying operationally experienced staff over any holiday period.

**Staff training**

42. Although Corrections' previous Gold/Silver/Bronze incident management training has been superseded by Coordinated Incident Management System (CIMS) training for incident management, the CIMS model was not widely understood by some key staff during the riot response.
43. Once prisoners had accessed the roof, Corrections staff did not have the capability to contain the prisoners' actions. As noted earlier, this was because staff (including Advanced Control and Restraint) were not trained to operate at height.

**Recommendation 39**

Corrections must ensure staff across the prison network understand that CIMS is the incident response framework, and Gold/Silver/Bronze is no longer in use.

**Recommendation 40**

Corrections must ensure CIMS training is provided to staff across the network to embed this framework as Corrections' incident management response.

**Recommendation 41**

In person (as opposed to online) CIMS training must be conducted as the preferred delivery option. Where appropriate, training exercises should be conducted with partner agencies.

**Recommendation 42**

Corrections should consider the adequacy of resourcing, equipment and training for custodial staff to be able to safely intervene in incidents taking place at height.

**Recommendation 43**

Corrections should consider that, in the short term, agencies which have the necessary capabilities are notified as soon as an incident involving the need to operate at height occurs.

**Working with other agencies**

44. The Local Level Agreement between the Waikeria Prison Manager and the Waikato District Commander of the New Zealand Police, and the Memorandum of Understanding between Corrections and the New Zealand Police, were last updated in 2012 and 2015 respectively.
45. This Inquiry was told that, on 30 December 2020, WorkSafe was informed by Corrections' Safety Business Partnering team of the incident. However, due to the holidays, there was no response to telephone calls to WorkSafe but several messages were left. WorkSafe did not return the calls Corrections made to them. No further action was taken by Corrections.
46. In the absence of any formal record of the notification held by Corrections it is unclear what was reported, when, and by whom.

**Recommendation 44**

Corrections must ensure all Local Level Agreement and Memorandum of Understanding documents between Corrections and Police (and other emergency services) are current. Corrections must also take steps to ensure all key staff are aware of and familiar with the content.

**Recommendation 45**

WorkSafe, as the Health and Safety regulator, must be fully apprised of all incidents where there is a serious or immediate risk to a person's health and safety because of an unplanned or uncontrolled work incident. Notification must be robust and an acknowledgment must be received.

**Recommendation 46**

The Chief Safety and Wellbeing Officer must review the current practices and processes for notifying the relevant regulator to ensure they are robust and documented.

**Recommendation 47**

The Chief Safety and Wellbeing Officer should liaise with WorkSafe to ensure all of Corrections' obligations are discharged pursuant to the Health and Safety at Work Act in respect of this incident.

**Hazardous substances**

47. While there was a hazardous substances register for the Top Jail at the time of the riot, prison staff could not provide this register to Fire and Emergency NZ staff who requested it on their arrival at the prison.

**Recommendation 48**

Hazardous substance registers must be kept and maintained in accordance with Corrections' obligations under the Health and Safety at Work (Hazardous Substances) Regulations 2017 and also be available electronically.

**Recommendation 49**

All appropriate staff must know of and be able to access this register.

**Recommendation 50**

Access to the register should form part of multi-agency emergency exercises.

## The evacuation

### Incident control

48. The late decision to evacuate was, in part, because the Incident Controllers were not aware of the true scope and scale of the rapidly evolving situation. There was a disconnect between those in charge and those on the ground. Had the Incident Controllers known of the enormity and urgency of the situation, it is likely they would have decided to evacuate much earlier. The delayed evacuation caused distress and trauma to those involved. It was fortunate that lives were not lost, and that physical injuries were as limited as they were.
49. Corrections' ability to efficiently co-ordinate the attendance of ACR teams from around the country greatly assisted the evacuation.
50. The evacuation itself was not well organised. Command and control was ineffective, and decision-making unclear. The way in which prisoners were evacuated was not systematic, and there was a real risk that prisoners could have been inadvertently missed (indeed two prisoners were initially left behind and only discovered once a final sweep of the cells was made).
51. The Incident Controllers were not properly apprised of the rapidly escalating seriousness of the situation. They appeared overly cautious in deciding to order the evacuation due to the perceived enormity of the decision and the risks involved. This caution likely reflected the fact that staff were unaware of the existing evacuation plans and had not been involved in mass evacuation training exercises.
52. Waikeria Prison's Top Jail evacuation plans were last updated and approved in 1998. The evacuation plan for the At Risk Unit (now the Intervention and Support Unit) was last updated and approved in 2001.
53. The behaviour of the prisoners being evacuated from the Top Jail during the riot was commendable. This good conduct directly contributed to the ability of staff to evacuate the Top Jail without loss of life or serious injury.

### Recommendation 51

Corrections must ensure all sites across the prison network have up-to-date evacuation plans.

### Recommendation 52

Corrections must take steps that all key staff are aware of and familiar with the content of evacuation plans for their prison.

### Recommendation 53

Corrections must ensure staff receive regular training in prison evacuation, and conduct emergency evacuation exercises both as a single agency and as part of a multi-agency response.

### Prisoner management

54. During the riot, communication with prisoners in their cells was wholly inadequate. Many prisoners believed that they would not survive the fires.
55. The evacuation of prisoners in the Intervention and Support Unit was particularly concerning. A number of these vulnerable prisoners were woken up and physically removed from their cells with little to no explanation as to what was occurring. Many of these prisoners observed on closed-circuit television and on-body camera footage appeared disorientated.
56. We acknowledge the decision, despite the urgent situation that staff were facing, to prioritise early evacuation of the four directed protective segregation prisoners in the Top Jail's East North Wing, and to transport them separately. However, the prisoners in the Intervention and Support Unit were among the last groups to be evacuated. One of the Incident Controllers (the Regional Commissioner – Central) is of the view that his decision to evacuate the Intervention and Support Unit last was a carefully considered one. Notwithstanding this, while there was some decision-making taking place, this Inquiry has found that the evacuation of the Intervention and Support Unit was hampered by poor communication and ineffective command and control.



**Recommendation 54**

Corrections should consider how to communicate with prisoners remotely and collectively in the event of an emergency (such as by the use of cell intercom). Corrections should also ensure that staff know how to use the intercoms in this way.

**Recommendation 55**

Corrections must ensure that communication with prisoners is considered a priority during an emergency.

**Recommendation 56**

Evacuation should have regard to the needs of vulnerable prisoners such as those in Intervention and Support Unit care or protective custody, and should provide guidance on the priority to be given to their evacuation.

**Potential hostage taking**

57. During the riot two prisoners, Prisoners P and Q, were broken out of their cells against their will by the prisoners on the roof. Staff identified the risk to Prisoners P and Q and acted with initiative to intervene. They distracted the other prisoners and provided Prisoners P and Q with safe passage down from the roof.
58. Prisoners P and Q were visibly traumatised and one of them showed signs of having been physically assaulted.

**Recommendation 57**

In a hostage situation consideration must be given to handing the control of the incident to Police, given the increased risk and threat to life.

**Recommendation 58**

In responding to any serious disorder incident, Corrections must ensure the Incident Controller is kept apprised of any escalating risks, including the taking of hostages.

**Fire alarms**

59. Fire alarms sounded continuously at the prison throughout the evacuation, although everybody was already aware of the fire. This caused increased stress for both prisoners locked in their cells and staff.

**Recommendation 59**

Corrections should consider whether fire alarms in a major incident can be silenced remotely once an initial response is achieved, and who should have the authority to make this decision.

***Corrections' response to the riot*****Staff training and incident response**

60. Following the evacuation, Corrections and its partner agencies considered a number of strategies to de-escalate and resolve the situation involving the prisoners on the roof. The involvement of local Kuia and Kaumātua was a good decision. It demonstrated commendable insight and helped de-escalate the incident. The Kuia and Kaumātua also played a key role in the ultimate surrender of the men on the sixth day of the riot.
61. During the initial response to the incident, staff appeared to be unclear about what was happening and looking for leadership. Opportunities to act in the initial stages of the riot were lost due to ineffective command and control.
62. Staff involved in opening the Emergency Operations Centre were not sufficiently trained and practised in doing this (including not knowing a key password). This resulted in delays to effective command and control being put in place and a lack of ability to access crucial information such as closed-circuit television footage.

63. Tactical advisers, who should have been providing advice to the Emergency Operations Centre, focused instead on assisting the Advanced Control and Restraint response during the riot.
64. During the initial stages of the riot, the Emergency Operations Centre was managing both the riot response and the day-to-day operations of Waikeria Prison's low security facility (which was challenging given the loss of vital services including telephones, kitchen facilities and the Intervention and Support Unit). In circumstances where the Emergency Operations Centre was primarily required to manage a critical incident which was still developing and had no clear end in sight, this dual role was undesirable and split the Emergency Operations Centre's focus.
65. The National Coordination Centre began by operating virtually. The physical National Coordination Centre was not opened until 1 January 2021 (the fourth day of the riot). This factor, at least in part, contributed to Corrections' response, in particular not fully utilising the CIMS roles and responsibilities.
66. Corrections should have finalised an intervention plan sooner. The quality of command and control improved when the second CIMS management team took over the National Coordination Centre and the Emergency Operations Centre on day four and the intervention plan was actioned.
67. The multi-agency response was not well developed and would have been assisted by all parties being co-located in an Emergency Operations Centre and National Coordination Centre. It does not appear that exercises had been carried out with emergency services prior to the riot to practise a response to a major incident.

**Recommendation 60**

Corrections must ensure that any CIMS training highlights the importance of the inclusion of iwi/Māori in response and recovery.

**Recommendation 61**

Corrections must ensure that staff are provided with initial training and refresher training to respond to incidents of this nature, including opening an Emergency Operations Centre.

**Recommendation 62**

The Incident Controllers should have focused exclusively on the management of the incident.

**Recommendation 63**

Corrections should, during critical incidents, ensure a separate team is tasked to manage the ongoing functions of the site. This would allow the Emergency Operations Centre to focus exclusively on the emergency response.

**Recommendation 64**

Corrections must ensure a National Coordination Centre is opened in a timely manner when a significant incident is evolving. Where possible, Corrections must also ensure that the National Coordination Centre is operated physically rather than virtually.

**Recommendation 65**

Corrections should consider more effective ways of working with emergency services partner agencies, including multi-agency response training drills or exercises.



**Recommendation 66**

Corrections should consider how Incident Controllers and partner agencies work alongside each other when responding to critical incidents. Corrections should develop clear guidelines about the circumstances in which incident control should pass to a partner agency such as Police, particularly when there is widespread criminal offending or risks to life or property.

**Recommendation 67**

Exercises should not be conducted exclusively online or as 'desktop' trainings. Where possible, practical trainings should be prioritised.

**Recommendation 68**

Local intelligence teams must be included in single agency and multi-agency emergency exercises.

**Chief Custodial Officer's role**

68. Although he was initially involved in the incident response providing advice to the acting National Commissioner, the Chief Custodial Officer was later excluded from further participation in order to undertake the operational review of the incident and draft a report. This meant his skills and knowledge were not utilised in responding to the riot.
69. The Chief Custodial Officer was initially involved in the incident response, before being removed from this role to undertake the operational review of the incident and draft a report. In both respects, this raised the risk of a conflict of interest, perceived or otherwise.

**Recommendation 69**

Corrections should consider how best to use the skills and experience of specialist staff in assisting with its response to an incident of this type.

**Recommendation 70**

Corrections should carefully consider who should undertake operational reviews of incidents, to avoid any actual or perceived conflict of interest.

**Staff roles and resourcing**

70. This Inquiry found that access to food, water and accommodation for responding staff was inconsistent between different groups.
71. A management decision was made at Waikeria Prison to prioritise the Site Emergency Response Team as an intelligence gathering and searching team, rather than as an emergency response unit. While Site Emergency Response Team members were on duty on 29 December 2020, they were being used to cover core shifts around the prison. This significantly impacted the prison's ability to respond to the early stages of the incident. The Site Emergency Response Team was established following a recommendation arising from the Spring Hill Corrections Facility riot, as an emergency response team.

**Recommendation 71**

Corrections should ensure, when responding to any future event, that the logistics function is properly established to fulfil its role of providing the necessary food, water and accommodation for responding staff.

**Recommendation 72**

Corrections should review the Site Emergency Response Team tactical model as it is a critical resource for responding to an incident of this nature.

**Recommendation 73**

Corrections should ensure intelligence teams are fully resourced. This should include diverting resource if necessary when significant incidents are occurring.

**The Prison Negotiation Team**

72. The Prison Negotiation Team was not used effectively during the riot. Prison Negotiation Team members were not briefed prior to being deployed and were used in insufficient numbers. Prison Negotiation Team negotiation coordinators should have been deployed. Prison Negotiation Team members were not regularly able to provide updates to the Emergency Operations Centre and said they were poorly treated. They:

- i. were not provided with food or water to the same extent as other staff
- ii. did not have access to sufficient toilets, time out areas, or accommodation
- iii. were subject to verbal abuse by a Waikeria Prison manager for failing to solve the incident quickly
- iv. received no psychological support or debrief.

73. The Prison Negotiation Team had to rely on Post-it Notes to communicate with each other and did not use on-body cameras to record interactions with the prisoners.

**Recommendation 74**

Corrections should ensure that Prison Negotiation Team members are deployed according to best practice and policy, and are supported during and post any incident.

**Recommendation 75**

Corrections should review equipment provided to the Prison Negotiation Team and ensure they are properly equipped for deployment at incidents of this nature.

**Advanced Control and Restraint**

74. The riot also highlighted deficiencies with the Advanced Control and Restraint team's ability to respond to an incident of this nature and duration:

- i. Advanced Control and Restraint teams were ill-equipped to operate in the prison once the fires were under way, as the teams did not carry items such as head torches or in-helmet communication devices. They were also at risk while operating in the burning prison as they were wearing flammable personal protective equipment on the outside of their flame-resistant overalls.
- ii. Advanced Control and Restraint teams were not sufficiently equipped to respond when confronted with prisoners armed with weapons.
- iii. As with other Corrections staff, Advanced Control and Restraint teams were not trained to operate at height which limited their ability to respond.
- iv. Custodial staff and Advanced Control and Restraint uniforms do not have unique identifiers. This makes it difficult to identify staff, both from an incident management and investigation perspective.

- v. Advanced Control and Restraint staff were issued with only one set of equipment, which meant they had to wash their overalls between each shift in order to have clean clothing. This also raised concerns as to contamination risks, including from asbestos.
  - vi. Some Advanced Control and Restraint staff were not current with their Advanced Control and Restraint certification when deployed to the riot (72 were certified, 63 were not).
  - vii. Advanced Control and Restraint staff, as with Prison Negotiation Team and other staff, were not able to take rest breaks during the early part of the incident.
75. Not all Advanced Control and Restraint and prison staff who responded to the incident were equipped with pepper spray.
76. Although Advanced Control and Restraint staff had access to personal protective equipment (such as shields, helmets, face masks and respirators), staff who initially responded to the riot did not have use of this type of personal protective equipment. This placed staff at risk from smoke inhalation and being injured when prisoners started to throw items from the roof.

### Recommendation 76

Corrections should consider international best practice for Advanced Control and Restraint team equipment and uniforms.

### Recommendation 77

Corrections should consider the addition of unique identifiers to the uniforms of custodial and Advanced Control and Restraint staff.

### Recommendation 78

Corrections should ensure that all Advanced Control and Restraint teams are sufficiently trained, certified and ready to deploy at all times.

### Recommendation 79

Corrections must ensure that staff are properly equipped to respond to serious disorder incidents, with consideration given to individually-issued personal protective equipment. Corrections must also ensure that sufficient quantities of pepper spray are available on site to enable all staff to respond to such incidents.

## Information and technology

### Drones

77. During the riot, Fire and Emergency NZ and Police used drones, which provided Corrections with invaluable high-quality live footage and recordings.

### Site plans

78. No up-to-date site plans of the Top Jail were available to support the response to the riot.

### Radios

79. The ability of staff to communicate via radio during the initial stages of the riot was compromised. When prisoners on the roof obtained staff radios, communication over these channels became insecure and staff could no longer use their radios.

### Telephones and cellphones

80. Prisoners also had access to staff telephones. Further, cellphone blockers had been turned off to allow staff to use cellphones as a result of the compromised telephones. This meant prisoners were able to use cellphones they may have located on site or had as contraband.

81. Known vulnerabilities in the prison telephone system meant prisoners were able to communicate key information about their intentions to riot, including to the media, from the yard telephone.<sup>4</sup>

#### On-body cameras

82. The ability to properly review Corrections' response to the riot was hampered by a lack of on-body camera footage. Not all staff involved in the incident response (including Advanced Control and Restraint) had on-body cameras, and not all of those wearing on-body cameras turned them on. Further, some on-body cameras were orientated in the wrong direction, which significantly limited their utility.

#### Log keepers

83. During the riot, Corrections' reliance on manual log keepers meant that critical information relating to the events, the response and records of decisions made, were not always accurately recorded. Telephone discussions would not have been documented in the log. This limited the ability of this Inquiry to easily review what took place.

#### Corrections Business Reporting and Analysis database

84. During the riot, Corrections Business Reporting and Analysis database did not provide accurate, real time data about who was housed in the Top Jail. However, this information was available to staff from paper records and a variety of other sources.

#### Prisoner records

85. The loss of prisoner records, including paper-based health files and warrants, as a result of the fires highlighted serious deficiencies in Corrections' storage of documents. Not only were prisoner records not stored in fireproof cabinets, but there was a problematic reliance on paper-based documentation.

### Recommendation 80

Corrections should consider the use of drones during incidents, and for other operational activities.

### Recommendation 81

Corrections should ensure that site plans are current, available and accessible. Corrections should consider a broad range of technical solutions to assess the operating environment to assist emergency responders and its response, should they be required.

### Recommendation 82

Corrections should consider methods staff could use to communicate if radio communications become unavailable or compromised.

### Recommendation 83

Corrections should consider ways in which staff telephone lines could be 'cut' promptly if rioting prisoners gain access to key staff areas.

### Recommendation 84

Corrections should consider options to mitigate the above vulnerabilities of the prisoner telephone system, including risks associated with three way calling and the ability of prisoners to share PIN numbers or use released prisoners' PIN numbers.

### Recommendation 85

A single, secure method of communication during a critical incident should be available if needed.

4. Telephone calls made by prisoners in the yard were not known to staff at that time.

**Recommendation 86**

Corrections must invest in a sufficient number of cameras to ensure all staff can be issued with one when on duty. Staff must be reminded of the importance of keeping cameras charged, and turning them on, and having them correctly oriented when an incident is commencing or occurring.

**Recommendation 87**

Corrections should consider establishing a dedicated videographer role as part of a response to an incident.

**Recommendation 88**

Corrections must provide staff with training with respect to what is required by a log keeper.

**Recommendation 89**

Corrections should consider options for recording conversations in the Emergency Operations Centre and the National Coordination Centre, including the opportunity to record telephone calls.

**Recommendation 90**

Corrections should adopt a data solution that allows for 'live' information to be accessed.

**Recommendation 91**

Corrections should explore secure online options for the storing of information.

**Recommendation 92**

Corrections should complete a review of physical storage solutions across the prison network and resource the implementation of new solutions in accordance with policy and statutory obligations where necessary.

**Recommendation 93**

Corrections should review where back-up files are kept and their accessibility during emergency response events.

**Equipment**

86. Emergency response equipment, including Control and Restraint, Advanced Control and Restraint, and tactical equipment, was able to be accessed by prisoners during the riot.

**Recommendation 94**

Corrections should review where and how emergency equipment is stored in sites across the prison network to ensure it can be accessed by staff but not unauthorised persons.

**Prisoner management during the incident****Pepper spray**

87. MK9 pepper spray was deployed during the incident in yard 116. It was sprayed through the door grille of yard 116 and up through the roof where the prisoners had gone.

88. Approval of the Prison Director is required before the MK9 pepper spray is able to be issued and deployed. Approval was not sought or given to issue the MK9 pepper spray on the first day of the riot.
89. The Prison Operations Manual provides for a series of post pepper spray use procedures. It does not appear that these decontamination procedures were actioned following the use of pepper spray in yard 116. This Inquiry recognises that post deployment decontamination was simply impractical.
90. No use-of-force reviews were completed for the use of pepper spray in the yard, or with respect to the removal of prisoners from the Intervention and Support Unit. While this is understandable, the Corrections Act 2004 and the Corrections Regulations 2005 both require these reviews to be undertaken when force is used.

#### Use of force

91. During the incident in yard 116, on-body camera footage also recorded a corrections officer directing a firefighter to spray prisoners and showed a firefighter aiming a hose at both the fire and the prisoners.
92. This use of force was unauthorised and the request to the firefighter from the corrections officer was clearly wrong.

#### Recommendation 95

Corrections should ensure staff receive regular training on the proper deployment procedures for MK9 pepper spray and the appropriate post deployment procedures (including decontamination) where this is possible and/or practical.

#### Recommendation 96

Corrections must ensure that the appropriate approvals are able to be obtained under urgency, including in an emergency.

#### Recommendation 97

In the event of an incident which requires a multi-agency response, partner agencies must jointly assess any risk, agree on how it is to be mitigated, and communicate this to staff.

#### Recommendation 98

Multi-agency responses must be premised on the principles of consultation, coordination, collaboration and cooperation.

#### Evidence management

93. The note written by the prisoners on the roof listing their complaints was unable to be located by this Inquiry. A photograph of the note was taken by Police and a copy of the photograph was provided to this Inquiry.
94. Clothing removed from the rioting prisoners following their surrender on 3 January 2021 was placed in bags and held in storage at the prison. It was handed to Police as evidence only after Inquiry staff alerted the Prison Director to its existence.

#### Recommendation 99

Corrections should ensure there are processes in place for the handling of evidence during incidents, and that evidence is recorded in scene logs and brought to the attention of the Incident Controller.

#### Legislation

95. No notification was given to the Minister of Corrections that the incident at Waikeria Prison was a prison emergency pursuant to section 179D of the Corrections Act 2004.
96. It is not clear whether consideration was given to whether the incident met the relevant criteria and whether determination/notification was appropriate.

**Recommendation 100**

Section 179D should be considered whenever there is an emergency affecting the safety or health of prisoners (or any class or group of prisoners) or the security of the prison and in respect of which the Chief Executive reasonably believes that the Corrections system is no longer able to fulfil its purpose of ensuring custodial sentences are administered in a safe, secure, humane and effective manner.

**Recommendation 101**

Corrections should develop guidelines for which type of emergencies might arise and when section 179D should be considered.

**Recommendation 102**

Consideration of section 179D should form part of any emergency response plan.

**Recommendation 103**

Legal advice should be sought before a decision pursuant to section 179D is made.

***Corrections' actions following the riot*****Prisoner management**

97. We acknowledge the pressure of needing to rehouse a large number of prisoners without notice, however, the transfer of prisoners to other prisons was generally unstructured and unplanned. Little consideration was given to factors other than the availability of vacant beds in other prisons.
98. Prisoners evacuated from the Top Jail did not have review risk assessments carried out prior to transfer. We acknowledge that, given the immediacy and urgency of the situation, this was understandable except in the cases of Prisoners P and Q.
99. Directed segregation was not used correctly post-incident for some prisoners. Reviews of segregation by the receiving sites did not identify errors in the reasons for the approval and continuation of segregation directions.
100. Prisoners who were relocated after the incident were ultimately assessed on an individual basis and moved to a site that worked best for their offender plan, court hearing, New Zealand Parole Board hearing, or release near family and whānau.

**Recommendation 104**

Corrections must ensure that incidents involving the large-scale transfer of prisoners involve the Prison Population Team from the outset. This is a key role within the CIMS structure.

**Recommendation 105**

Corrections should remind staff of their obligation to ensure prisoners placed on segregation are managed and reviewed in accordance with policy, and that decisions are properly documented.

**Staff well-being**

101. Insufficient long-term post-incident support was available to staff. Although some staff were positive about the initial support they received, this Inquiry heard that the quality of support appeared to have decreased over time.



**Recommendation 106**

Corrections must review its procedures with respect to ongoing post-incident support for staff affected by serious disorder incidents.

**Recommendation 107**

Corrections must ensure those affected by the Waikeria Prison riot are being offered appropriate and adequate long-term support.

**Recommendation 108**

Corrections should consider the use of a specialised trauma team (as used by some other agencies) to respond to staff needs following a major incident.

**Informing the public**

102. Corrections' communications team communicated promptly and proactively with the public via the media and Corrections' website during and after the riot.
103. Two press conferences were held and Corrections issued regular press releases during the riot. These were clear and informative, and provided reassurance to the public and whānau of both prisoners and staff.

**Health Services****Facilities and conditions**

104. Consistent with reports by the Office of the Inspectorate and the Office of the Ombudsman, this Inquiry found significant shortcomings with prison conditions in the Top Jail prior to the riot. These conditions led to a high level of dissatisfaction among some prisoners.
105. Some members of the Waikeria Prison Health Services team reported that it took some time to provide additional office space and technical equipment required to support ongoing health service delivery at the site after the riot. This Inquiry notes that the post incident response was constrained by such matters as building availability and Resource Management Act consents.

**Recommendation 109**

Corrections must ensure that appropriate facilities and technical support is provided for health services delivery following a major incident.

**Recommendation 110**

Corrections should review and refresh the Prison Operations Manual and Health Services Manual to ensure that Health Services have a more active role in maintaining the public health/hygiene and sanitation standards of prison environments in line with relevant legislation.

**Complaints**

106. This Inquiry found the current Health Services complaints and incident management systems are fragmented. It is not possible to reliably assess all health-related complaints as they are recorded in multiple places. There was little assurance that health incidents were being reviewed and analysed with appropriate actions taken. This makes identifying themes and trends and undertaking meaningful analysis problematic.

**Recommendation 111**

The Health Services incident management system must be reviewed and updated to ensure effective reporting and management of incidents which supports quality improvements to health service delivery.



### Incident control

- 107. Some of the Health Services Senior Leadership Team reported that they were not aware of their roles and accountabilities in response to a major incident.
- 108. The Health Services Senior Leadership Team reported not having undertaken any joint emergency management training together as a team prior to the riot.
- 109. None of the Health Services Senior Leadership Team had formal Corrections-based CIMS training or experience at an executive level since coming into their roles. Those who had experience or training had gained this in positions with previous employers.

#### Recommendation 112

Health Services clinical governance systems must be reviewed and strengthened to enable the robust analysis, monitoring and reporting of trends and themes relating to complaints and incidents, and to evaluate any improvements made at national, regional, and local levels.

#### Recommendation 113

Corrections must ensure the role of Health Services is formalised and fully integrated into the overarching emergency management system and structure.

#### Recommendation 114

Corrections must ensure Health Services senior leaders are fully trained in CIMS appropriate to their role in the organisation.

#### Recommendation 115

Corrections must ensure that Health Services leaders participate in regular multi-agency emergency exercises at all levels of the organisation.

#### Recommendation 116

Corrections must consider much more careful planning of leave and delegations across the Health Services Senior Leadership Team to ensure that suitably qualified and experienced staff are available in the event of a serious disorder incident.

### Staff roles

- 110. The ability of the Acting Deputy Chief Executive Health to advocate for the safety and wellbeing of the prisoners or to respond effectively when significant health issues arose was compromised by the lack of clarity between the function and purpose of the National Coordination Centre and the Executive Leadership Team.
- 111. Two nurses were part of the Prison Negotiation Team during the riot. While the nurses performed these duties professionally and competently, the use of nurses in a Prison Negotiation Team created the potential for professional and ethical conflicts. It also had the effect of removing experienced staff from important clinical roles.

#### Recommendation 117

In an emergency, the Deputy Chief Executive Health or designate must be available to act as an advocate for prisoners without other competing interests.

**Recommendation 118**

Corrections should review the selection of staff in prison negotiator roles to ensure there are no ethical or professional conflicts.

**Prisoners' mental health support**

112. There appears to have been adequate psychological assessment and mental health support at the Top Jail prior to the riot, although there was a waitlist for forensic services. The Top Jail clinic environment was dated but fit for purpose, and the Intervention and Support Unit had recently undergone a review to increase mental stimulation and access to suitable activities for prisoners.
113. Prisoners generally seem to have been well supported immediately following the incident, with adequate clinical assessment and a high level of health service delivery provided for those displaced across Waikeria and other receiving prisons. There was also positive collaboration with external providers to support the wellbeing of all displaced prisoners. The prisoners received immediate delivery of psychological and mental health interventions, including trauma group sessions, although some experienced a delay in receiving other mental health support.
114. The loss of Waikeria Prison's 26 Intervention and Support Unit beds was significant. The impact was felt directly by the Spring Hill Corrections Facility Health team, which reported having neither the appropriate space nor staff to manage the increased numbers of mentally unwell men safely. The stress and pressure on the Spring Hill Corrections Facility Health team was considerable and has been sustained over a prolonged period.

**Recommendation 119**

Corrections must strengthen the role and accountability of the Regional Health Services management in recovery planning for any future emergency.

**Asbestos****Decontamination**

115. Decontamination processes were neither offered nor provided to the prisoners on the roof after their surrender or prior to their transfer from the site.
116. Despite having a recent asbestos management plan in place, it was not readily available when requested by Fire and Emergency NZ, and emergency procedures outlined in this plan were not followed. As a result, risks relating to exposure to asbestos-containing material were not proactively managed.

**Recommendation 120**

Where asbestos-containing material is known to be present in a prison, asbestos management plans that meet industry standards must be in place and include:

- i. Risk mitigation strategies to prevent and/or limit exposure to all staff and prisoners in the short, medium and long term.
- ii. Procedures to be followed if staff or prisoners are exposed to asbestos-containing material (including decontamination, management and laundering of gear and clothing, and cleaning of transport vehicles).
- iii. The roles and responsibilities of each agency in a multi-agency emergency.

**Staff training and awareness**

117. Staff had limited knowledge and understanding about the risks relating to exposure to asbestos-containing material during the riot and what measures they needed to have considered to keep themselves safe .

**Recommendation 121**

Training should include the safe and effective use of personal and respiratory protective equipment in the event of potential exposure to asbestos-containing material, including a procedure to verify that respiratory protective equipment is properly fitted every year, and is cleaned and maintained.

## 4. Introduction

1. On the morning of 29 December 2020, a verbal altercation took place between staff and a group of prisoners in an exercise yard in the Top Jail (high security area) of Waikeria Prison. Tensions mounted, starting with arguments over the use of a razor in the yard, and by late morning prisoners were talking about rioting.
2. By early afternoon, prisoners had spoken to the media about their intention and started lighting fires.
3. By mid-afternoon, a group of prisoners broke through the mesh grille covering the yard and got onto the prison roof. From there they accessed other parts of the prison.
4. The fires worsened hour by hour, and by mid-evening staff began to evacuate nearly 200 prisoners from their cells.
5. Corrections led the operational and strategic response, alongside other agencies including Police, Fire and Emergency NZ (FENZ) and St John Ambulance. Corrections and Police staff attempted to negotiate with the prisoners on the roof.
6. On day five of the riot, Police and Corrections staff entered the Top Jail to attempt to take back an indoor area used by the rioting prisoners. The prisoners responded by lighting more fires, which destroyed their sleeping area and forced them onto the roof without shelter.
7. The 16 prisoners surrendered the next day, in the presence of Kaumātua, Kuia and Te Pāti Māori Co-Leader.
8. Fortunately, there was no loss of life or serious physical injury. The riot caused many millions of dollars of damage and destroyed the Top Jail.

### *Historic context*

9. Ngāti Raukawa ki Wharepūhanga and Ngāti Maniapoto ki te Raki are mana whenua – ahi kā on the land Waikeria Prison is located.<sup>5</sup> They are hapū of the Ngāti Raukawa and Ngāti Maniapoto iwi, respectively. These iwi belong to the Waikato-Tainui confederation.
10. This Inquiry has been advised by Independent External Advisor Dr Robert Joseph that the Raukawa Settlement Trust is the post settlement governance entity for the Ngāti Raukawa iwi. The Maniapoto Māori Trust Board was established under the Maniapoto Māori Trust Board Act 1998 and is the (pre-settlement) iwi authority which forms the governance and management arm for Ngāti Maniapoto. Both represent mana whenua and have a duty to ensure the voices of mana whenua are heard and that their kaitiaki and manaaki obligations are honoured. They also live with the legacy of colonisation, land confiscation and the intergenerational impacts this has had on iwi, hapū and whānau. As such, they are mandated to safeguard the collective interests of whānau and hapū (i.e. health, economic, social, and cultural outcomes) and to ensure Te Tiriti o Waitangi settlements are upheld for present and future generations.

### *The prison*

11. Waikeria Prison is situated on a 1,200 hectare site in south Waikato, in Corrections' Central Region. The land on which the prison sits was Māori ancestral land acquired in 1910 under the Public Works Act 1905.
12. Parts of the prison opened in 1911 and it was gazetted as a borstal institution until 1981 (although it also became a detention centre for youth in 1961). Borstal training was abolished in 1981, and from 1981 to 1985, it became a youth institution. After this, it was reinstated as a men's prison.
13. While parts of the Top Jail date back to 1911 (including the Chapel, Central Unit and medical rooms), over time the prison was extended. In the 1960s the West Unit, East Unit, gym, laundry, bakery and Master Control were built. The exterior walls of West and East Units were built of hollow concrete blocks and the window bars were not set in concrete. This played a large part in prisoners being able to use a battering ram to break other prisoners out of their cells. (See Appendix C). The Receiving Office was built in the 1980s; the high security Separates Unit<sup>6</sup> in 1982; and the Intervention and Support Unit (ISU) in 2000. The design was such that if access to the roof was gained, it was possible to easily access all these areas.

5. Ahi kā refers to burning fires of occupation, continuous occupation - title to land through occupation by a group, generally over a long period of time [Te Aka Māori Dictionary].

6. Separates cells are used to accommodate prisoners who have been found guilty of a misconduct and sentenced to a period of cell confinement.

14. The Top Jail had an overhead covered walkway (called a bridge) above the exercise yards. Staff were rostered on 'sentry' duty when prisoners are in the yards. The sentry officer walked back and forth along the bridge, supervising prisoners.
15. Waikeria Prison has seven low-medium security units. Te Ao Mārama, Rata, Karaka, Totara and Puriri units are located 3.5km from the Top Jail. Nikau and Miro units are situated in another part of the prison, nearer the Top Jail. Karaka, Nikau, Rata and Totara units can accommodate up to 80 prisoners each, while Puriri and Te Ao Mārama have 60 beds each and Miro has 66 beds.
16. Prior to the riot, Waikeria Prison had the capacity to house up to 806 male prisoners with security classifications from minimum to high, including remand prisoners.
17. The Top Jail, designed for high security prisoners, had the capacity to house 277 prisoners (including 26 at-risk prisoners in the ISU). Most cells were double-bunked.
18. In 2012, Central Unit was closed due to structural integrity concerns.
19. In 2015, Corrections made the decision to close the remainder of the Top Jail, as it was nearly 100 years old and reaching the end of its life. Conditions in the prison were poor by any standard. It was expensive to operate and the cells had limited natural light. The building had seismic issues which would require significant remedial work and capital investment to bring it up to an acceptable standard. The closure was scheduled to be completed by 2016.
20. Corrections closed the West Unit in 2015, but an increase in the prison population meant the East Unit remained open. In early 2017, Corrections re-opened the West Unit. (See Appendix D for more details).
21. The Top Jail was considered "*the best of the worst*" available option for re-opening. Its large catchment area in the North Island and close proximity to the Hamilton District Court made it a logistically attractive option. A senior staff member told us Corrections was caught between a "*rock and a hard place ... the Department basically thought we'd get through the next two years and we'll all be good*".
22. The Office of the Inspectorate prison inspection reports of 2017 and 2019, and the Office of the Ombudsman's report of 2020 found the conditions at the Top Jail were substandard and not conducive to the humane treatment of prisoners, largely due to the age of the facility.
23. A new prison facility with 2,000 beds was initially planned for the site, but in 2018 this was reduced to 600 beds (including a 100-bed dedicated mental health and addiction service). This is currently under construction at the Waikeria site and is due for completion by 2023.

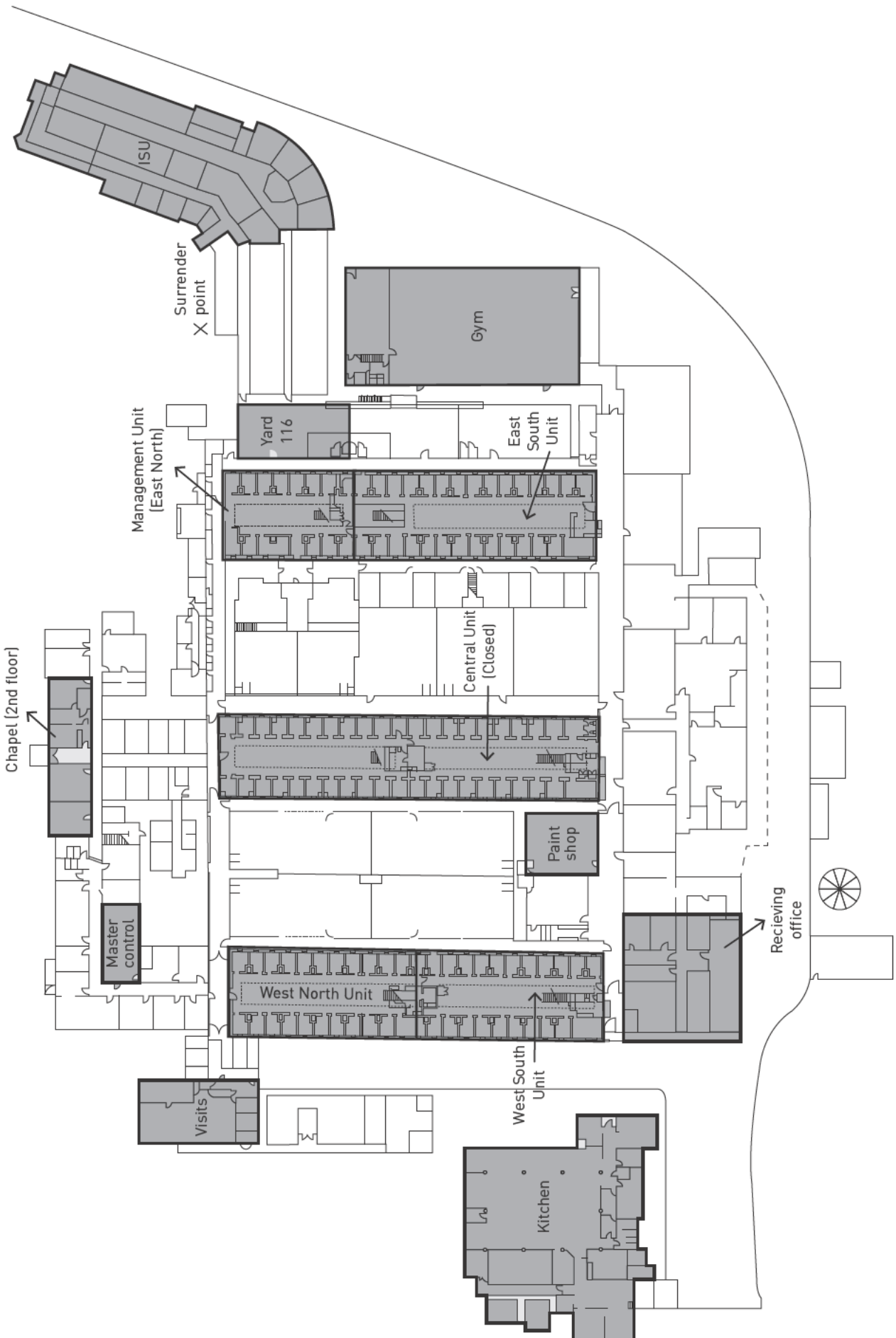
### The prisoners

24. On 29 December 2020, 704 prisoners were housed at Waikeria Prison.<sup>7</sup> Of the 212 prisoners in the Top Jail, 101 had a status of remand accused, 35 were remand convicted, 73 were sentenced, and three had a status of recall-outstanding.<sup>8</sup> (See Appendix E for more information about the prisoner population at Waikeria Prison).
25. Only prisoners who have been sentenced receive a formal security classification. Remand prisoners are unclassified, but are managed as high security by default (although some were assessed as low risk and housed in the low security facility).
26. On 29 December 2020, the Top Jail housed 140 prisoners who were unclassified, 61 prisoners who were classified as high security, four as low medium, five as low and two minimum.
27. In the Top Jail, 163 prisoners identified as Māori, 34 as European/Pākehā, 12 as Pasifika, one as Asian, one as Middle Eastern/Latin American/African, and one as 'Other'.
28. Eighteen gangs were represented in the Top Jail. Those with the most members were the Mongrel Mob (43 prisoners), Black Power (34), Head Hunters MC (11), the Mongols MC (9) and the Killer Beez (6). Four members of the Comancheros MC were in the Top Jail.

7. This included eight 'off-site transfers' - prisoners who are included in the prison population but who are held off site for a variety of reasons, including that they are in a hospital or psychiatric facility.

8. 'Recall-outstanding' is when a parolee is returned to prison to resume serving their sentence of imprisonment, but the Parole Board is yet to hear the recall application.

# Map of the Top Jail





## 5. Timeline of the riot

1. What follows are the key events of the riot, but the timeline is not all-inclusive. Information has been gathered from a variety of sources, as outlined in the methodology. [Prisoners are identified as Mr A, Mr B etc.]

### Prior to 29 December 2020

2. On or around 27 December 2020, Corrections Officers gave four razors to two prisoners (one of whom, Mr H, was later charged by Police for his involvement in the riot) in a double-bunked cell in the Remand Unit (East South Wing) of the Top Jail at Waikeria Prison. Only three razors were returned to staff. The cell was not searched for the missing razor until the following day, but nothing was found. The prisoners were not searched.

### Day 1 – 29 December 2020

3. At 7:48am on 29 December 2020, while officers were collecting breakfast trays in the Remand Unit, Mr F (who was later charged by Police for his involvement in the riot) challenged a Corrections Officer to a fight in his cell. A Corrections Officer told Mr F to return to his cell and said he did not want to charge him for disobeying a lawful order. Mr F returned to his cell and was later placed into yard 116 for the day.
4. At around 9am, 21 prisoners from the Remand Unit entered yard 116.
5. At 10:02am, a Corrections Officer said she thought a prisoner in the yard had two razors.
6. One prisoner, Mr H, was getting his head shaved by another, Mr A (who was later charged by Police for his involvement in the riot), in the yard shower. A Corrections Officer asked for the razors back (but the prisoners refused to hand any over). She telephoned an SCO to discuss whether they could “run the yard in” (i.e. return the prisoners to their cells). At 10:05am, a Corrections Officer told the prisoners she was going to “run the yard back in”. Prisoners can be heard shouting abuse at her in response.
7. At 10:14am, a number of corrections officers were seen outside yard 116. A prisoner was heard saying: “Tell us we were meant to get haircuts, where the fuck is it”. Another said: “Just give us haircuts. Eh, fuck. You don’t get haircuts then you start acting this shit”.
8. At 10:16am, a Corrections Officer said Mr H had concealed a razor as his cell had been searched earlier.
9. At 10:17am, a number of corrections officers met in the wing staff room to discuss the situation. One said: “Haircuts is not a right, they’re not allowed to change their appearance”.<sup>9</sup>
10. At 10:22am, a Corrections Officer directed the prisoners to exit the yard one by one or the yard would be ‘split up’ (to reduce the number of prisoners in the yard). A Senior Corrections Officer (SCO) opened the yard grille. The prisoners refused to comply with the instruction. One said: “You’re dreaming bro, get the fuck out of here” and another approached the yard grille and repeatedly said: “Get the fuck out”. The yard grille was then closed.
11. At 10:23am, a Corrections Officer stated: “It’s always this yard we have issues with”. She also said: “I knew he [Mr H] had one razor”.
12. From around 10:24am, the SCO and some other staff stood by the yard 116 gate. The SCO said: “Those who don’t want to be involved in this can come out”. One of the prisoners in the yard said: “Where is the unit manager and who is he?” The SCO replied: “There is no unit manager”. Another Corrections Officer said: “Ah fuck, we’re going to split them” and “we’ve got pepper spray drawn so let’s go”. Another Corrections Officer observed the prisoners were now wearing coverings over their heads.
13. At this time, a Principal Corrections Officer (PCO) tried to negotiate with the prisoners in the yard for the return of the razors. One prisoner said: “We want haircuts. We want fucking haircuts. You said we could have haircuts”. Another prisoner said: “We were supposed to get haircuts a couple of days ago ... because you won’t give us haircuts, we have to resort to this”. The PCO said: “We don’t have to, it’s a choice, it’s a privilege”.

9. Prison Operations Manual M.01.01.Res.01 states: “Barbering facilities will be provided for hair cutting, but remand prisoners are not permitted to significantly change their appearance prior to trial or the completion of court proceedings.”



14. At 10:29am, the PCO received a call from Master Control that the prisoners were “soaping up” (to make it difficult for staff to hold them) and some had plastic bags over their faces (to protect them from pepper spray). The PCO discussed this with an SCO while other corrections officers stood by. The PCO stated she would give the prisoners a few minutes, see if they would give the razor back, and if not, she would charge them all with ‘propping’ (that is, concerted indiscipline which means refusing to comply with a lawful order of staff).
15. At 10:30am, the prisoners started to cover both CCTV cameras in yard 116 with wet toilet paper. Several covered their faces with clothing.
16. At this time, the SCO and the PCO discussed what to do, including giving the prisoners a final chance to come in from the yard one at a time. They also discussed the use of pepper spray and the number of staff needed to clear the yard.
17. At 10:38am, the PCO telephoned the prison’s On-Call Manager to apprise him of the situation. She advised that the plan at that stage was to negotiate with the prisoners, then potentially charge them with propping, then seek approval to use MK9 pepper spray.
18. At 10:38am, a Corrections Officer commenced a log of events.
19. Also at 10:38am, Mr H made a call from the yard payphone using a former prisoner’s pin.<sup>10</sup> S 18(c)(i) [REDACTED]  
[REDACTED] The telephone call ended.
20. At 10:41am, the PCO spoke to the men through the grille. She asked for the razors and asked if anyone in the yard wanted to come in. The prisoners said there was only one razor. The PCO pointed out that the prisoners give the staff “lip” and said: “We don’t talk to you like that do we? No”. One prisoner replied: “Yeah you do, [a Corrections Officer] and her fucking little sidekicks and shit up there” referring to the bridge. Another prisoner said: “If we had haircuts this wouldn’t be happening in the yard”. The PCO said: “Remember we actually don’t have to give you haircuts, we give you haircuts because the staff choose to. As remand prisoners you all know, you’re not supposed to change your appearance”.
21. At 10:42am, prisoner Mr R (who was not later charged by Police) made a call from the yard payphone. S 18(c)(i) [REDACTED]  
[REDACTED]
22. At around 10:44am, a razor and a comb were returned to the PCO by one of the prisoners in yard 116.
23. At 10:45am, Mr R telephoned the same number, S 18(c)(i) [REDACTED]  
[REDACTED]
24. At 10:45am, there was a discussion among staff in the East Unit. The SCO explained that there had been insufficient staff available to safely “run the yard in”.
25. Some officers said: “we can’t handle 21 men in one yard” and that the yards would be split up tomorrow. There was also a comment from the PCO that: “This is not over, and I am expecting more trouble from that yard”.
26. The PCO then informed the On-Call Manager that a razor had been returned and asked if the prisoners should still be run in. The On-Call Manager decided that the yard did not need to be run in as the prisoners had complied with the request.
27. At 10:47am, the PCO returned to yard 116 and asked the prisoners to uncover the camera, which they did.
28. At 10:49am, prisoner Mr W (who was not later charged by Police) made a call on the yard payphone saying S 18(c)(i) [REDACTED]  
[REDACTED]

10. Which meant he could access the former prisoner’s approved telephone numbers and the call could not be attributed to him.

11. Telephone calls made by prisoners in the yard were not known to staff at that time.

12. That is, using clothing like a balaclava.

29. At 10:52am, a staff member said, in discussion with others: *"It's always this yard we have issues with"*. There was also discussion about splitting up the yards going forward as officers had been talking about it *"for months"*.
30. At 10:52am, one prisoner was observed standing on the shoulders of another. He appeared to be looking at the space between the overhead shelter and the mesh grille.
31. A Corrections Officer said Mr H should have been strip searched when the razor was not handed back on 27 December 2020. However, this did not happen as the corrections officers were understaffed and *"under the pump"*.
32. At 10:56am, Mr B (who was later charged by Police for his involvement in the riot) used the yard payphone and said: <sup>S 18(c)</sup>  
[REDACTED]
33. At around 11am, the prisoners were observed washing off the soap they had put on their bodies and taking off their face coverings.
34. At 11:04am, two Corrections Officers who were on sentry duty observed prisoners, including Mr A, smoking cannabis (which indicated there was an ignition source in the yard). A Corrections Officer instructed the prisoners to stop smoking, but they refused.
35. At 11:10am, some of the prisoners stood in a circle in the yard and were talking. Some were wearing face coverings.
36. At 11:10am, Mr E (who was later charged by Police for his involvement in the riot) made a payphone call. <sup>S 18(c)(i)</sup>  
[REDACTED]
37. At 11:26am, Mr Y (who was not later charged by Police) made a payphone call and said: <sup>S 18(c)(i)</sup>  
[REDACTED]
38. At 11:56am, Mr B used the yard payphone and said: <sup>S 18(c)(i)</sup>  
[REDACTED]
39. The other person attempted to transfer the call to Newshub, but it was cut off on the first attempt. The second attempt was answered and then cut off. The third call was successfully transferred. A three-way call took place for 12 minutes at around midday. Mr B talked to a reporter from Newshub. The following is a summary:  
<sup>S 18(c)(i)</sup>  
[REDACTED]
40. Mr B attempted to call back his approved number 12 times between 12:32pm and 2:18pm. These calls either went to answerphone or did not connect.

13. Note, between January 2015 and October 2021 there was one assumed suicide of a prisoner in the Top Jail. The death in custody figures for Waikeria Prison are similar to other prisons of a similar size.

41. Other relevant payphone conversations the prisoners in yard 116 made included:
- » At 12:42pm, Mr D (who was not later charged by Police) made a call. S 18(c)(i)
  - » At 1:37pm, Mr X (who was not later charged by Police) made a call and said S 18(c)(i)
42. At 1pm, a Newshub reporter telephoned Corrections' media line and said they had been told there was going to be a riot at Waikeria Prison. Newshub explained that, following the Spring Hill Corrections Facility (SHCF) riot several years earlier, it was important to pass this information on to Corrections.
43. Over the next 50 minutes, the General Manager Communications and Government Services passed this information to the Acting National Commissioner.<sup>14</sup> There was some initial confusion among Corrections staff as to where the riot was apparently going to take place. Several telephone calls were made before the Regional Commissioner – Central (who was on call) and the Acting Prison Director (who was on leave) were contacted.
44. Around this time, the Acting National Commissioner telephoned the General Manager Communications and Government Services to say that the situation was being addressed. He also telephoned the Chief Executive. The Regional Commissioner telephoned the Acting National Commissioner and said there were no issues but telephoned back within a couple of minutes to say a small fire had been lit. The Acting National Commissioner then telephoned the Chief Executive to advise about the ongoing incident.
45. The Acting Prison Director then contacted a PCO to find out what was happening and he was advised of the incident earlier with the razor and the events up to that time. The PCO then contacted an SCO and instructed him to go around the Top Jail units to assess the situation.
46. At 1:46pm, Mr X made another payphone call from the yard. S 18(c)(i)
47. At 1:47pm, the camera in yard 116 was covered again and a fire was lit. Many prisoners had covered their faces. At this time, a Code Blue was called.<sup>15</sup>
48. The PCO then telephoned the prison's On-Call Manager to relay this information. The On-Call Manager asked the PCO to check all the yards and cameras and make sure staff were safe. At 1:50pm, Master Control informed the On-Call Manager there was disorder in yard 116.
49. Some corrections officers went up to the bridge to retrieve firefighting equipment but discovered it had been removed.<sup>16</sup> A fire reel hose was found near the ISU and dragged through the grilles that led up to the bridge. Corrections officers attempted to put out the fire, but the hose was too short and the water pressure insufficient. The prisoners obstructed their efforts by covering the yard grille with towels and other items. Master Control was informed. A corrections officer gave orders to another staff member to go to the ISU to retrieve shields, which officers then used to deflect objects and urine that were being thrown at them.<sup>17</sup>
50. About this time, around 12 prisoners asked to leave yard 116 but were prevented by other prisoners. A corrections officer reported seeing multiple prisoners begin to "smash the roof". Other fires were started. The officer also reported that a prisoner was screaming: "Burn this shit down, they will listen to us now". A prisoner in yard 116 was heard saying: "All you had to do was ... change our dirty sheets and treat us properly. Fuck you".
51. At 1:49pm, Mr X made another payphone call and said: S 18(c)(i)
52. At 1:54pm, Mr Y (who was not later charged by Police) made a payphone call. S 18(c)(i)

14. Who was in Christchurch.

15. A Code Blue means that all identified incident responders (corrections officers) needed to go immediately to the incident scene.

16. The firefighting equipment above the yards had been removed about a decade earlier.

17. FENZ estimated that between three and five fires were lit in yard 116.



64. We note that around this time, a Corrections Officer with a shield standing near the door to yard 116 had items and urine thrown at him.
65. At 2:42pm, a PCO told the On-Call Manager that the prisoners were using items in the yard to block the firefighters' attempts to put out the fire.
66. The On-Call Manager said the priority for the Acting Prison Director and the Regional Commissioner was "containment" at that time. He mentioned implementing a SMEAC plan,<sup>19</sup> but said they could not proceed until the Acting Prison Director gave formal approval.
67. At 2:44pm, Mr G (who was later charged by Police for his involvement in the riot) made a payphone call and said: <sup>S 18(c)(i)</sup>  
 [REDACTED]
68. At 2:49pm, Mr Z (who was not later charged by Police) made a payphone call. <sup>S 18(c)(i)</sup>  
 [REDACTED]
69. The payphone in yard 116 was then smashed by a prisoner and there were no further calls.
70. At 3:15pm, the Waikeria Prison Advanced Control and Restraint (ACR) team deployment was approved and activated. An ACR Section Leader assumed the role of Acting ACR Commander.
71. At 3:19pm, staff spoke to each other about possibly getting rid of miscellaneous wood and debris around the site which could be used as weapons.
72. Several staff were on the bridge. A PCO said: "If they [prisoners] get out, there is nowhere they can go". Another staff member asked what the On-Call Manager was doing and the PCO replied: "He's still sorting it". A prisoner in the yard can be heard shouting: "Once we get on that roof, we're away".
73. At 3:20pm, an SCO telephoned the On-Call Manager and advised that prisoners were attempting to break through the mesh grille above yard 116. The corrections officers and FENZ staff were told to exit the bridge as the prisoners appeared to be about to breach the top of the yard.
74. Officer D told the Inquiry he remained on the bridge and made a request for FENZ staff to turn the water back on. He picked up the FENZ firehose and aimed it at the prisoners who were attempting to breach the top of the yard, expecting water to flow through. The water was not turned back on.
75. Staff were seen carrying MK9 and MK60 pepper spray canisters.
76. At 3:22pm, prisoners, led by Mr A and Mr F, breached the mesh grille covering the yard. Nine prisoners climbed through the grille and gained access to the roof onto the East bridge. They were then sighted on top of the gym.
77. At 3:25pm, a Code Red was called.<sup>20</sup> At this time, Corrections considered the incident a riot.<sup>21</sup>
78. When the prisoners breached the top of the yard, FENZ staff were withdrawn to areas outside the buildings under the protection of Corrections staff. As events escalated, they were withdrawn to outside the perimeter wire. After this withdrawal, fires were ignited in many different locations in multiple structures throughout the Top Jail.
79. At 3:25pm, MK9 pepper spray was sprayed through the door grille of yard 116 and up through the overhead grille where the prisoners had breached.

19. A style of organising information about a military situation for a unit in the field > Situation > Mission > Execution > Administration/Logistics > Command/Signal.

20. A Code Red means corrections officers must secure their own area and perform muster and security checks, the Incident Controller assesses the need to secure the prison (i.e. return all prisoners to units, lockdown and apply perimeter control) and designated staff must report to the Emergency Operations Centre.

21. According to IR.06 Schedule 1, a riot is defined as a "concerted, organised disorder event requiring external agency involvement".



5. TIMELINE OF THE RIOT
80. At 3:26pm, a Corrections Officer asked: *"So, who's got command? ... Do we know what our instructions are yet?"* A Corrections Officer said: *"Nah, it just seems like we're falling back"*. Around this time, the On-Call Manager was seen walking around the Top Jail talking to several corrections officers.
  81. At 3:31pm, several prisoners were sighted on the roof through the Central Wing exercise yards. The East bridge was seen to be on fire.
  82. At 3:34pm, two Corrections Officers had a conversation. One of them asked whether she would get into trouble for what was unfolding. The other reassured her that she would not and said: *"This was actually inevitable. It's been a brewing pot for a long time in this unit"*. One Corrections Officer asked: *"Who's in control?"*
  83. At 3:41pm, a Corrections Officer noted that *"all the ACR staff are getting geared up"*. Another later said: *"They just called all the ACR members to come in"*. Another Corrections Officer replied: *"They should have done this way earlier"*.
  84. At 3:44pm, the prisoners were reported to be smashing the rooftop windows of the West Unit. At that stage, prisoners in those wings were still in their cells.
  85. At around 3:49pm, prisoners were reported on top of Master Control and sighted on the Visits centre roof.
  86. At 3:52pm, the cameras in yard 116 were uncovered. Twelve men remained in the yard. At this time, some men on the roof could be heard saying they wanted pizzas and nicotine lozenges.
  87. At 3:54pm, some corrections officers could be heard commenting about the smoke. One said it was toxic and that plastic was burning. Another said: *"Some of this stuff has asbestos in it"*.
  88. At 3:58pm, a fire was sighted on the roof near the Central Wing.
  89. At 4:01pm, a further three fire appliances and other FENZ staff and equipment arrived.
  90. At around 4:02pm, corrections officers became aware that the prisoners on the roof had broken the air conditioning units. Several corrections officers outside the Top Jail building told prisoners in West Unit cells that their air conditioning had been compromised. One Corrections Officer said: *"They're going for the air con now, so it's about to get real warm for you guys"*. Another Corrections Officer said, *"very warm. You guys are going to get hot"*. One prisoner said: *"Get us out, eh"*. Other prisoners were concerned as they could smell smoke and asked what was happening.
  91. At 4:05pm, the Master Control log recorded that media from TV3 arrived on site and were turned away.
  92. At around 4:12pm, one prisoner could be seen on the roof above the East Unit near the cells where Mongols MC members were accommodated. Mr I (who was later charged by Police for his involvement in the riot) was sighted holding a large metal object. A prisoner in his cell called out to Mr I: *"Come and get us out"*.
  93. Mr I spoke to corrections officers (who were attempting to talk him down from the roof) and said: *"This whole thing started from a razor, we waited for haircuts for 3-4 months"*. He also said: *"Are you going to treat us properly ... you don't care, why should we care? ... you came here and colonised this shit"*.
  94. At 4:15pm, corrections officers became aware that the prisoners had broken into a PCO's office near Master Control. The office contained a bolt cutter, stab resistant body armour, a staff uniform and cellphones.
  95. Around this time, the On-Call Manager was briefed by staff and co-ordinated the initial response.
  96. At 4:16pm, the Chief Custodial Officer instructed the Principal Adviser - Tactical Operations to activate ACR from the Central and Northern Regions (SHCF, Tongariro, Auckland Region Women's Corrections Facility and Mt Eden Corrections Facility [MECF]).
  97. At 4:20pm, a briefing was held to co-ordinate the extraction of the remaining 12 prisoners in yard 116. At 4:22pm, additional Waikeria ACR staff arrived on site.



98. At around this time, a prisoner in a West Unit cell told the corrections officers outside that he could smell gas. There was some confusion among the corrections officers about whether there were gas pipes in the units and on the roof. An SCO confirmed that gas pipes did run across the roof. Downer<sup>22</sup> was contacted to shut off the gas in Master Control.
99. At 4:22pm, corrections officers noted that the prisoners on the roof were getting food from the prisoners in their cells.
100. At 4:23pm, a PCO said the Mongols MC members in the cells in the East Unit were telling the prisoners on the roof what to do. At around this time, one Corrections Officer asked: *"Where's the ACR that they fucking called?"* The PCO asked: *"Why did they wait until they got on the roof?"*
101. At 4:24pm, more prisoners were sighted on the roof above the East Unit wearing items of staff uniform.
102. At 4:30pm, corrections officers were still talking to Mr I, who said, *"you treat us like animals"* and mentioned the cell-to-yard regime. Another prisoner was heard to say: *"That's what happens when officers treat us like bitches"*.
103. At around 4:30pm, staff began to extract the remaining prisoners from yard 116. The prisoners were taken to the Top Jail Separates Unit and strip searched. All the prisoners had been moved from yard 116 by 4:55pm. One other prisoner was in the Separates Unit who had not been in yard 116 that day.
104. At 4:32pm, a fire was spreading along the ventilation shafts on the rooftop in the East Unit near yard 118. Firefighters could not reach the fire in the East Unit as prisoners on the roof were throwing glass at them.
105. At 4:36pm, prisoners on the roof were threatening staff on the ground below. Fire and smoke were seen coming from the Top Jail.
106. At 4:42pm, seven prisoners were observed leaving the East Unit roof, headed towards the north end of West Unit.
107. At 4:43pm, the first Emergency Operations Centre (EOC) activities were recorded in the log. The EOC was set up on site in the Administrative Building.<sup>23</sup> The On-Call Manager led the incident response until 5:43pm.
108. A virtual National Coordination Centre (NCC) was also set up on 29 December 2020. The Acting National Commissioner was the National Incident Controller from 29-31 December 2020.
109. At 4:48pm, there were reports of a fire in or near yard 118 which was producing enough smoke to enter the ventilation system in the East Unit.
110. Around this time, staff were heard expressing concerns for the prisoners in their cells and the need for them to be evacuated to safety. Staff around the perimeter fence discussed how the situation should not have escalated to this point and queried who was in charge of the response. Some staff were seen running from the Top Jail with no additional protective equipment (such as shields and helmets) while prisoners threw items, including glass, from the roof above.
111. At 4:53pm the Master Control log recorded that the Acting Prison Director asked the On-Call Manager to prepare an evacuation plan in the event that multiple prisoners would need to be extracted from the site.
112. During the afternoon and evening, the Principal Adviser Prison Population (PAPP) worked with the EOC to develop plans to transfer the prisoners from the Top Jail to other prisons.
113. At 4:56pm, an SCO in Master Control said a muster count needed to be carried out.
114. At 4:57pm, the Health Centre Manager (HCM) telephoned St John Ambulance, Police and FENZ to update them on the fire status.
115. At 4:58pm the EOC log recorded: *"updated PD, thought process - preservation of life"*.

22. The assets and facilities management contractor.

23. Between the Top Jail and the low security facility.

116. At 5:02pm the EOC log recorded: *"nine unaccounted for ... nine on roof", "start moving to RO. Haven't started plan yet"*. At this time the ventilation system was compromised.
117. At 5:07pm, the fire in the ventilation system was extinguished. At 5:08pm, a decision was made by the EOC, in consultation with Downer, to leave the ventilation running.
118. At 5:08pm, prisoners on the roof broke out Mr M (who was later charged by Police for his involvement in the riot) from his cell in the West Unit using the metal bar as a battering ram. The prisoner who shared Mr M's cell remained in the cell.
119. At 5:11pm, the gas supply to the Top Jail was shut off.
120. At 5:14pm, prisoners on the roof returned to the East Unit. A Corrections Officer approached another Corrections Officer and told her: *"They've got prisoners out of West Wing. They're about to break the Mongols out. They've got a battering ram"*. A staff member commented: *"This is out of control"*.
121. At 5:15pm, St John Ambulance arrived on site.
122. Between 5:15pm and 5:45pm, the 12 prisoners who were extracted from yard 116 and initially moved to the Separates Unit, were moved to the West Unit due to extensive smoke.
123. At 5:16pm, Police arrived on site and reported to the EOC at 5:27pm.
124. At 5:17pm, the EOC log recorded that staff on duty were all accounted for.
125. At 5:19pm, the prisoners on the roof broke out prisoners Mr U and Mr K (who were both later charged by Police for their involvement in the riot) from the East Unit.
126. At 5:31pm, prisoner Mr S (who was later charged by Police for his involvement in the riot) was broken out of his cell in the East Unit.
127. At 5:32pm, Mr T and Mr J (who were both later charged by Police for their involvement in the riot) were broken out of their cells in the East Unit.
128. At 5:39pm, prisoners were seen attempting to break out Mr N (who was later charged by Police for his involvement in the riot) from his cell in the East Unit using an object as a battering ram.
129. At 5:41pm, the EOC log recorded that maps of the site were to be emailed to the Area Assistant Commander.<sup>24</sup>
130. At 5:43pm, the Acting Prison Director arrived on site. He had telephoned Waikato Police District Command Centre as he made his way to the prison. From this time until 6:11pm, he was the Incident Controller.
131. At 5:45pm, ACR staff went to the armoury<sup>25</sup> to be kitted out.
132. At 5:51pm, the prisoners broke out Mr O (who was later charged by Police for his involvement in the riot) from his cell in the East Unit. At 5:54pm, Mr N was broken out of his cell in the East Unit.
133. Mr L, Mr V, Mr P and Mr Q were also broken out of their cells at some point. Those broken out of cells included seven members of the Mongols MC and one Comanchero MC member. One other prisoner, a member of the Mongrel Mob, whose cell was broken open, did not leave his cell.
134. Some prisoners did not want to be broken out. One told this Inquiry: *"I could hear the people shouting through the roof; I could hear officers telling them to come down. The next minute I'm hearing they're trying to break into people's cells ... [I] barricaded my door because I didn't want any bar of it. I knew the first person who's going to step in and ask me to come, I'm going to fight them"*.

24. The Inquiry is unclear whether this is a FENZ or Police role.

25. Where ACR and other equipment was stored.

135. At 5:55pm, concerns were expressed about staff continuing to use their radios as it was suspected that prisoners may have accessed them.
136. At 5:58pm, some staff expressed concerns about the prisoners locked in their cells. One staff member said that when they went through a unit, several prisoners were crying, saying they were having difficulty breathing and asking to be let out. The staff member said: *"I wouldn't be surprised if we have lost someone"*.
137. At around 6pm, the Prison Negotiation Team (PNT) was deployed.
138. At 6:06pm, advice was provided by Corrections' Intelligence team that the prisoners on the roof were *"prepared to take anyone on if they come through"*.
139. At 6:11pm, the Regional Commissioner arrived on site. From this time until 3am, he was the Incident Controller.
140. At around 6:11pm, prisoners broke into the Medical Unit (Health Centre) and lit a fire.
141. At 6:13pm, five ACR members were deployed to protect Master Control.
142. At 6:16pm, the EOC log recorded that the Regional Commissioner declined the offer of the Police Armed Offenders Squad (AOS) at that stage. It was noted that FENZ had drones.
143. At 6:25pm, the Prison Director arrived on site. He was the Incident Controller (along with the Regional Commissioner) until 3am.
144. At a 6:38pm EOC briefing, it was recorded that the prisoners on the roof were *"tooling up – wanting a fight ... need confirmation of all prisoners out ... roof only visibility ... major concern not CCTV – don't know what we're going in to ... any specific prisoners we have to protect from these guys"*.
145. At 6:52pm, six men on the roof were observed breaking into the bakery and taking boxes. At around 6:56pm, a PCO said there was a fire near the bakery. Another Corrections Officer said: *"Apparently they've got in the bakery, now they've got knives"*.
146. At 6:52pm, it was recorded that five staff were in Master Control and two were in the ISU - *"No officers armed pepper spray"*. It was noted: *"Getting plan together"*.
147. At 6:59pm, a FENZ drone was deployed.
148. At 6:59pm, a muster check of Top Jail prisoners was conducted.
149. At 7:08pm, a Corrections Officer assumed the primary negotiator role, supported by two others, and three Police negotiators arrived on site at 7:10pm.
150. At 7:11pm, ACR staff from SHCF arrived.
151. At 7:15pm, the Master Control log recorded that prisoners who got on the roof were using a landline in the prosecutor's office.
152. At 7:25pm, the NCC Incident Controller was briefed by the Acting Prison Director.
153. At around 7:29pm, ACR staff arrived from Tongariro Prison.
154. At 7:31pm, the EOC log recorded there was a plan if Master Control was breached.
155. From 7:35pm, Corrections staff started removing the keys and pepper spray from the Top Jail and took them to the Administration Building (where the EOC was located). The Master Control log recorded a direction from the EOC that if Master Control needed to vacate, the perimeter fence would be deactivated.

156. At 7:39pm, the EOC log recorded that the prisoners on the roof did not want to talk to staff and were threatening to throw a prisoner off the roof.
157. At 7:40pm, the National Incident Controller's log recorded *"links in with Police + Fire established, including Police AOS"*.
158. From 7:43pm, Correction Officers carried out welfare checks of the prisoners in their cells. This appeared to consist of briefly looking into the cells. It does not appear that the prisoners in the cells were spoken to. Many prisoners said they were hungry as they had not had dinner. One said he could not breathe. At this time, on-body camera footage showed the fire alarms were sounding, the sprinklers had been activated, prisoners were banging on their cell doors and calling out, and there was water on the ground inside the Top Jail.
159. Around this time, a Corrections Officer said they would not be surprised if someone had died as the fires appeared to be out of control.
160. An SCO told staff: *"The information is, they're going to try and break a prisoner out and throw them off the roof"*. A PCO added: *"One of the segs [that is, a segregated prisoner]"*.
161. At 7:46pm, approval was given for ACR staff to enter the Top Jail and assist with securing the grilles and removing the keys (to restrict prisoners on the roof from accessing and moving through the Top Jail).
162. At 7:51pm, the EOC asked the National Incident Controller to identify around 230 beds across the prison network in case the Top Jail needed to evacuate prisoners. The message was passed to the movements and logistics team, and beds in the North Island were identified by 8:26pm.
163. At 7:56pm, a prisoner on the roof could be heard asking where the camera crews were.
164. At 7:58pm, the EOC log recorded: *"ACR to complete PCLC [prisoner cell and location check] with face to name muster upon securing [Top Jail]"*.
165. At 8:02pm, the EOC log recorded that *"identifying staff who's still on site. All staff to make calls home next of kin"*.
166. At around 8:05pm, the Regional Commissioner, in the EOC, briefed Police on the situation.
167. At 8:08pm, a major fire was reported in the West Unit between yards 101 and 102. ACR staff entered to assess the fire.
168. At 8:09pm, the Regional Commissioner briefed FENZ staff in the EOC. ACR was tasked to ensure FENZ could gain access to the building.
169. At 8:34pm, the EOC log recorded that the Regional Commissioner informed staff of a plan for evacuation of Top Jail *"should it be required"*.
170. At 8:37pm, the EOC log recorded: *"keys/radios from Master Control now in site admin"*.
171. At 8:38pm, the EOC log recorded there was *"no threat to life"*.
172. At 8:39pm, the EOC log recorded *"unknown male"* asked to come down from the roof, *"with no charges"*. This did not happen.
173. At 8:43pm, the EOC instructed officers to commence evacuating prisoners from West South Wing to be taken to Miro Unit in the low security facility. The log recorded: *"move to be made now"*.
174. At 8:45pm, the National Incident Controller log recorded: *"Intel so far is: disturbance re: complaints about conditions on site. Not primarily about violence but won't mess around if staff attempt to intervene"*. ACR reported much black smoke, primarily caused by mattresses, which was potentially toxic. *"No immediate threat to life."* The site's fire suppression capability was queried: *"confirmed sprinklers have activated in some places and work earlier in the year leaves site in better position ... [there was] no indication prisoners ready to come down or preparing to attack staff"*.

175. At 8:47pm, staff were instructed to bring the prisoner escort vehicles to the entrance of the sally port<sup>26</sup> gate to evacuate prisoners from the Top Jail. One Corrections Officer said: *"I think we'll be lucky if we don't have one dead ... the smoke is that bad and they can't get out of their cells ... we should have done this hours ago ... they'll be dragging bodies out"*.
176. At 8:51pm, St John Ambulance set up in Miro Unit in preparation for the evacuation of prisoners.
177. At 8:51pm, the EOC log recorded that Mr G asked to come down from the roof, but he did not surrender until 3 January 2021.
178. At 8:54pm, ACR staff headed along the southern corridor into West South Wing to begin evacuating prisoners.
179. Footage from around this time showed at least six fires burning throughout the Top Jail. A number were located near the air vents.
180. At around 9pm, an ACR member saw two prisoners (Mr P and Mr Q) on the roof, seemingly disengaged and distanced from the other prisoners. The prison negotiator distracted the other prisoners and Mr P and Mr Q came down from the roof on a ladder, aided by the ACR member.
181. Mr P and Mr Q were placed in a prisoner escort vehicle driven by a PCO. When Mr Q was loaded into the prisoner escort vehicle, a Corrections Officer asked if he had been on the roof. Mr Q responded: *"I am, miss, they ripped my bars open, grabbed all our food then started to burn us alive"*. The PCO reassured him, and they proceeded to Rata Unit in the low security facility.
182. At 9:21pm, the EOC log recorded that fire was seen above the paint shop.
183. At around 9:25pm, the SHCF Prison Director arrived on site and attended an EOC briefing, which was also attended by AOS. The briefing noted the plan for a total evacuation of the Top Jail, and that prisoners would be transferred to other prisons the following morning. It was also noted:
- » It was not known how many prisoners were on the roof.
  - » Prisoners had *"free rein"* over the roof.
  - » Evacuating prisoners would exit through the Receiving Office.
  - » Concerns were expressed about the five staff in Master Control.
  - » The SHCF Prison Director would identify how many could go to SHCF as soon as possible.
184. At the 9:45pm National Incident Controller briefing it was recorded: *"Not good news ... Multiple fires up there now, more than last ... Police AOS with us at latest briefing. Support role only, not yet formally deployed. 7 + dog handler ... Roofs most compromised by fire. Fire service can't go in at the moment ... Welfare number one priority ... Goal - High security to be vacant by midday tomorrow so reduces risk of copycat tomorrow"*.
185. At 9:46pm, ACR staff arrived from MECF.
186. At 9:56pm, the EOC log recorded that the paint shop and the Receiving Office were on fire. Following this, prisoners were evacuated through the Visits Centre instead.
187. At 10pm, Downer was called in to disable the fire alarms in the Top Jail.
188. At 10:11pm, the EOC gave an order that all remaining prisoners in the Top Jail be evacuated. Staff were instructed to open all cells and evacuate all prisoners. They were to be held in the sally port and then taken to units in the low security facility.
189. At 10:18pm, ACR staff arrived from Auckland Region Women's Corrections Facility.
190. From 10:29pm, prisoners from the East Unit and the ISU were evacuated, with support from ACR staff. Note, at this time staff were still working in the ISU.

26. A sally port is a protected point of entry into a secure location, such as a prison. Often, a sally port consists of an enclosed area with a solitary gate on either side, only one of which can be opened at any given time.



5. TIMELINE OF THE RIOT
191. Prison staff removed prisoners from their cells through smoke and in close proximity to the fires. Those evacuated included two prisoners found semi-conscious in their cell. One had his head down the toilet and the other was under the bunk bed. Another prisoner was found in a cell that had filled with smoke and had flames visible through the back window. Two prisoners were missed during the initial evacuation. When staff later performed a final sweep, one man was found under a bed and another was found in the Separates Unit.
192. In the ISU, some prisoners were asleep when their cell doors were opened by ACR staff, and they appeared disorientated and confused. Staff shouted directions and physically moved the prisoners and escorted them to the sally port. Staff offered prisoners reassurance while they were being held in this area before being loaded into a prisoner escort vehicle and taken to the low security Medical Unit. They were taken to the ISU at SHCF the next day.
193. At 10:47pm, two prisoners (Mr L and Mr V) came down from the roof.
194. At 11:20pm, the Master Control log recorded that *"Master Control windows attacked by heavy projectiles. No breach"*. Some ACR staff came to Master Control to assist. However, they were then called away to another area of the prison but left the staff in Master Control with MK9 pepper spray.
195. At 11:52pm, the EOC log recorded that *"prisoners from Visits area to be evacuated a.s.a.p. as fire is spreading towards kitchen"*.

### Day 2 – 30 December 2020

196. Just after midnight on 30 December 2020 (day two), four prisoner escort vehicles from SHCF arrived to collect prisoners evacuated from the Top Jail. Three prisoner escort vehicles took prisoners to SHCF in the early hours of the morning.
197. At 12:06am, the EOC log recorded: *"All Top Jail prisoners currently in the Top Jail sallyport to get onto the SHCF buses a.s.a.p. All need to be identified"*.
198. At 12:31am, the other prisoner escort vehicle took the four prisoners who had come down from the roof and four prisoners on directed segregation to Auckland Prison.
199. By approximately 1am, all prisoners in the Top Jail, other than those on the roof, had been evacuated and taken to units in the low security facility. In total, 195 prisoners were evacuated. Police were stood down for the night.
200. All staff, including Master Control, were ordered to withdraw from the Top Jail (except ACR staff and perimeter staff).
201. At around 1:12am, the EOC log recorded that *"a surrender plan was to be confirmed"* for the prisoners on the roof. Upon surrender, the prisoners would be taken to prisons in Auckland.
202. Sentenced and remand evacuated prisoners were placed together overnight in the low security facility. They were held in classroom and dining areas and given food and drink. Voluntary segregated prisoners were held separately.
203. At 1:38am, some prisoners in a Miro unit classroom complained about the conditions of their overnight arrangements. The classrooms had been cleared and evacuated prisoners were to sleep on the floor.
204. From 3am-8am, the SHCF Prison Director was the overnight Incident Controller (also on 30 and 31 December 2020 from 8pm-8am).
205. At 6:43am, a prisoner in a classroom in Miro Unit forced open and broke a door. All 12 prisoners in the classroom were placed on directed segregation and taken to SHCF that morning.
206. The remaining evacuated prisoners were re-located to prisons around the North Island throughout the day.
207. At 7:58am, the EOC log recorded that the telephones in the Top Jail were to be *"cut off"*.
208. At 8:17am, the prisoners on the roof demanded food and water, but this was denied by the Regional Commissioner.
209. At 9:19am, a Code Blue was called in Te Ao Mārama Unit. Prisoners who had been evacuated were becoming angry and threatening.



210. At 9:24am, the EOC log recorded: *“comms reported 16 non-compliant prisoners. However, 17 prisoners have been identified to still be in HSF [the Top Jail]”*.
211. Of the 17 prisoners on the roof, seven were Mongols MC members (including their second in command), three were Comanchero MC members, two were Nomad members, two were Filthy Few members, and there were one each from the Killer Beez, Westside Outlaws, King Cobra and Crips gangs. Of note, none of the seven Black Power gang members in yard 116 went onto the roof.<sup>27</sup>
212. At 9:30am, the EOC requested more prison negotiators. Five negotiators arrived from SHCF around 10:15am.
213. At 9:30am, a multi-agency briefing took place. It was agreed that Police would take control of the incident if there was an imminent threat to life.
214. From 9:53am, members of the media arrived at the prison and were stopped at the gate.
215. At 11am, a multi-agency briefing took place, with Police, St John Ambulance and FENZ. The EOC log recorded: *“AOS/ACR commanders meeting – good relationship building”*.
216. At 12:15pm, the Chief Executive and the Chief Custodial Officer arrived on site. They attended the EOC and were briefed. They held a media conference that afternoon.
217. At 12:24pm, the prisoners on the roof were seen using landline telephones (not connected to the Prisoner Telephone Monitoring System). The EOC log recorded that all telephones at the Top Jail were disconnected by Spark from 12:38pm.
218. At 1pm, Wellington ACR staff arrived on site. Hawkes Bay Regional Prison ACR staff also arrived that day.
219. At 1pm, the NCC briefing recorded *“17 prisoners unaccounted for ... sighted 14 on the roof ... not willing to negotiate, they are abusive”*. Then: *“We have no intention to attempt to move them, waiting ... they have access to weapons, including knives ... focused on waiting to tire, get hungry and give up”*. It noted that the prisoners may have access to a cellphone and those broken out of cells were all Mongols MC members. The briefing also noted: *“Top Jail is beyond saving”*.
220. At 1:01pm, a multi-agency briefing was held. It was noted that the Prison Director was *“confident”* that the 17 prisoners on the roof had been identified. The EOC log recorded advice given to staff regarding asbestos in the building and decontamination: *“exposure to staff who have been in the vicinity. All staff need to shower themselves/clothing - masks should be used at all times by staff”*. It was also noted that Corrections would report the incident to WorkSafe.
221. At 1:57pm, prisoners on the roof made another request for water. They also requested the Co-leader of Te Pāti Māori to attend and asked not to be called *“rioters”* as it was *“against their human rights”*. They said they would not negotiate until they had water.
222. At 2:56pm, the EOC log recorded that: *“need to know names of prisoners before truck [prisoner escort vehicle] leaves – [Regional Commissioner] responded ‘you will get names, however the truck may have left’”*
223. At the 3pm EOC briefing, the decision was made to refuse the demands made by the prisoners on the roof. The EOC log recorded that the Regional Commissioner said: *“perps talking to press – ‘they are in control, willing to die for this’”* and they had a *“direct line out to the media”*.
224. At 3:52pm, 12 MK9 pepper spray cannisters were approved for use by ACR staff in the Top Jail.
225. At 4pm, the NCC briefing recorded that of the 17 prisoners unaccounted for, 16 had been positively identified by FENZ drone footage. The prisoners had been communicating with the partner of the Mongols MC President, in Auckland Prison, who *“didn’t know in advance but is now ‘supporting the boys’”*. His telephone calls had been stopped.
226. At 4:22pm, it was believed that the prisoners on the roof had access to staff radios and uniforms.
27. This Inquiry has formed the view that, by this point, the prisoners on the roof were being organised by the Mongols MC members who had been broken out of their cells rather than by the initial group who broke out of yard 116.

227. At 4:32pm, Kaumātua and Kuia were informed of the incident by the Deputy Chief Executive - Māori. The Chief Executive and Chief Custodial Officer left the site.
228. At around 4:48pm, activist group People Against Prisons Aotearoa (PAPA) posted messages on social media purportedly from prisoners on the roof. The messages highlighted the poor conditions of the Top Jail and criticised how the prisoners involved in the riot were being managed. (See Appendix G for the PAPA messages).
229. At the 5pm EOC multi-agency briefing, a decision was made to share the asbestos safety plan with National Office and that all staff needed to wear correct personal protective equipment (such as shields, helmets, face masks and respirators). It was recorded in the log that concerns about asbestos were reported to WorkSafe.
230. At around 5:15pm, a plan outlining where the prisoners would be transferred after surrender was communicated by the Commissioner Extreme Risk Directorate. Three prisoners would be transferred to MECF and the others would go to Auckland Prison.
231. At the 7pm EOC multi-agency briefing, it was noted that ACR staff would continue to negotiate overnight, as would the prison negotiators.
232. The prisoners asked via a prison negotiator if they could meet with Kaumātua and Kuia. They said they would come down from the roof if this was arranged. A meeting was arranged for the following day.
233. A prison negotiator said: *“They told me several times they’d come down if a Kaumātua came onsite”*.
234. At 7:45pm, the Prison Director briefed a prison negotiator to engage with the prisoners on the roof about Kaumātua being present when they surrendered.
235. At 8:25pm, a multi-agency briefing was held. The EOC log recorded that St John Ambulance reported: *“Issues tomorrow NYE [New Year’s Eve]”*.

### Day 3 – 31 December 2020

236. At 12:05am, the EOC log recorded a possible sighting of a prisoner with a cellphone taking a photo or video.
237. At 3:14am, prisoners were seen on the roof with food and water.
238. At 8am, at the EOC briefing, a site-wide radio silence order was put in place.
239. The Kaumātua and Kuia arrived on site and were given a briefing by the Prison Director and Police.
240. At 8:29am, an ACR extraction plan continued to be developed and was discussed, among others, with Police, prison negotiators and Kaumātua and Kuia.
241. At 8:30am, the NCC log recorded that the prisoners had said *“they’d be willing to come down from roof if they could speak to a Kaumātua”*.
242. At 9:40am, the EOC log recorded that the prisoners requested to speak to the Kaumātua and Kuia as a group.
243. At 10:05am, the Kaumātua and Kuia began speaking to the prisoners, who performed a haka to welcome them to the Top Jail. The Kuia performed a karanga and the Kaumātua performed a waerea.<sup>28</sup> Several prisoners spoke to the Kaumātua and Kuia, and told them their concerns about the conditions at the prison.

28. The haka was ‘Toia mai te waka’ (‘Haul the canoe’). A karanga is a ceremonial call of welcome. A waerea is a protective incantation to protect the visitors and to bring rangimārie (peace and calmness) to the situation.

244. The prisoners voiced concerns, including:

*“It’s not an act of violence or a protest or a riot. We’re asking to be treated as humans. We’re tangata whenua ... No mental health help – getting worse and worse ... We do want to get this resolved in a peaceful way ... We just want some help that’s all ... They were going to get away with it for two more years until the new jail is built ... We’re getting treated unfairly, it’s got a lot to do with the system here based on colonisation. It’s not suited to us, we’re not European ... We can’t get any rehabilitation ... Systemic racism ... A number of us have been taken away from our families and been sent here ... We haven’t shown violence once ... If they’re really worried about our health and safety, they’d give us some water ... They’re meant to be negotiating with us ... They were just telling us what to do ... don’t treat us different because some people have been overseas and have been sent back ... They use our tikanga against us. We must eat food with a toilet in our room ... We can’t do any tikanga programmes, we can’t even go to church ... I don’t want my kids coming in here and living what I’ve lived through ... They say write a complaint but ain’t shit done about the complaints ...”*

245. The Kaumātua told them:

*“We are not going to be able to fix the world, but we understand some of the things that you are talking about ... So how do we progress some of these things? We are going to have to go away and have a think about it and then see who we have to persuade ... in a way that action gets done ... Everyone’s heard the issues. We will have a think and a bit of a kōrero to see how we can get something in place”.*

246. At around 10:39am, the conversation ended and the meeting was closed by the Kaumātua with a karakia. The Kaumātua and Kuia told the prisoners they would reflect their discussions to Corrections staff. The Kuia told this Inquiry:

*“From the time that I did the karanga and they came to the fence, they were absolutely like that took a mask off and became young Māori men who needed someone to tell what their problem was to. And so we just stood there and listened. We didn’t comment because ... what could we say to make it better? When they finished, all we said to them is, in te reo, we take on board everything you have said, we can’t promise you anything or do anything, but we’re here to let you know that you asked for a Kaumātua and a Kuia and this is who we are.”* (See Appendix H for the transcript of this conversation).

247. The prisoners were given bottles of water. A prison negotiator then asked the prisoners if they wanted to come down, but they refused.
248. At 11:10am, it was suspected that the prisoners had access to Master Control as a CCTV camera was seen moving.
249. At 11:17am, the EOC log recorded that Police reported that they could not account for one of the prisoners on the roof and were concerned it could be a homicide.
250. At 1:17pm, the EOC log recorded that FENZ would supply 75 radios for use on site, due to a prisoner being sighted wearing a staff radio and earpiece.
251. At 2:20pm, PAPA put the prisoners’ ‘manifesto’ online.
252. At 2:45pm, an EOC briefing was advised that the prisoners had gained access to the armoury room and acquired shields, helmets, personal protective equipment, a Halligan bar, a bolt cutter, and an electric grinder, and were reportedly manufacturing weapons.
253. At the briefing, the EOC discussed the approach of waiting for the prisoners to come down from the roof – “sit and wait” – and how long this should continue given risks to the life and health of the prisoners. It noted that negotiations had ceased at this time and that ACR would not be acting as the situation had gone too far. Police identified that if there was a threat to life, plans needed to be made to immediately hand over control to Police. If command was to be passed over to Police, more AOS members would be needed. The Police suggested that containing the prisoners’ access to a smaller area would be a good tactic. The Regional Commissioner noted there was no rush to implement a plan, but a plan needed to be in place.

254. The briefing detailed that the site's cellphone blockers needed to be turned off so staff could use cellphones to communicate. It was also noted that the Kaumātua had met with the prisoners and would be available on an on-call basis. The suggestion of the Co-leader of Te Pāti Māori coming on site was discussed, and possible issues were raised. It was decided that the Co-leader would only be able to speak to the prisoners if prison negotiators and/or ACR were present and he would be asked to leave the site if he requested time alone with the prisoners. There was some information suggesting the prisoners on the roof would come down and surrender if they were able to speak to the Co-leader.
255. The 4pm NCC briefing noted that the National Incident Controller would be replaced the next day by the Commissioner Persons of Extreme Risk Directorate. It was recorded that *"negotiations had been generally constructive but no suggestion they'll be coming off the roof any time soon. They have access to food and water so no major incentive right now"*.
256. At around 4pm, a prison negotiator reported that one of the prisoners on the roof had been assaulted after wanting to come down. The negotiator reported that Mr S had threatened to kill Mr C (both of whom were later charged by Police for their involvement in the riot) if they did not receive water. ACR and prison negotiators witnessed Mr C being assaulted by two unknown prisoners on the roof. After this, Mr S approached Mr C and asked staff why they had not stopped the assault. He then attempted to use Mr C as a bargaining tool and told staff that if they did not give the men food and water, he would slit Mr C's throat. Mr S then told Mr C he could leave the roof if he wanted. At 4:41pm, Mr S came down from the roof and threatened staff before going back up.
257. At 4:16pm, Mr C surrendered and was taken to Nikau Unit Separates in the low security facility, leaving 16 prisoners on the roof. He was provided with food and a change of clothes and assessed by health staff. He was also spoken to by Police. He was transferred to Auckland Prison the next day.
258. At the 5pm EOC briefing, it was recorded there was *"a plan to go in (last resort)"*, which would be triggered if there was a threat to life. More AOS staff would be required *"if we need to go in"*. In the meantime, they would *"continue to sit and wait"*.
259. At around 7:21pm, the Co-leader of Te Pāti Māori arrived on site and was briefed in the EOC. At 7:26pm, he was escorted by the Regional Commissioner to the Top Jail. At 7:34pm, the Co-leader started speaking to the prisoners, who performed a haka.
260. At that time, a handwritten note, outlining their complaints, was dropped from the roof. This note was taken to the EOC and photographed by Police. This Inquiry has obtained a copy of the photograph of the note. (See Appendix I for the contents of the note).
261. At 8:16pm, the EOC log recorded a call from National Incident Controller: *"reverse decision [Prison Director Northland Region Corrections Facility] (day) 01-01-21 [Prison Director Otago Corrections Facility] (nights) 01-01-21"*, meaning a new command structure would be brought in the next day.<sup>29</sup>
262. At 8:42pm, the prisoners on the roof made another request for food and water. Water was provided at 9:16pm. They used a staff radio to convey their thanks.
263. At the EOC briefing at 9:44pm, it was recorded that water could be given to the prisoners on the roof, but not food. It was reported that the prisoners wanted to see in the New Year together. Critical planning would continue overnight and they would *"watch and wait"*. A new team to head the EOC would arrive on 1 January.

### Day 4 – 1 January 2021

264. At 12:30am on 1 January 2021, a radio call was received from ACR reporting a grinding sound coming from behind Master Control. It was later established the sound was from an electric grinder the prisoners had taken from the armoury. At around 1:40am, prisoners were seen in Master Control and operating the boom gate.
265. At 3:18am and 3:25am, the Spark helpdesk was contacted to get the staff telephones disabled.
266. At 4:55am, the prisoners on the roof threw items at staff.

29. The Regional Commissioner, Prison Director Waikeria and Prison Director SHCF had, until then, understood they were to continue in their respective roles in the EOC. The National Incident Controller was also replaced.



267. At the 7:50am EOC briefing, control of the incident was handed over to the newly appointed Incident Controller and command team. The Acting Northern Regional Commissioner became the daytime Incident Controller and the Prison Director of Otago Corrections Facility became the night-time Incident Controller.
268. At the 8:30am NCC briefing, the log recorded that the incoming National Incident Controller's first action was to "get full appreciation".
269. The National Incident Controller arrived at Corrections' National Office in Wellington at 9:20am. At 9:30am the EOC log recorded that "groups [of prisoners on the roof] were starting to fight, some possibly want to come down".
270. At the 10am EOC briefing, the log recorded that FENZ had assessed the asbestos risk as low. There was a decontamination plan.
271. At around 11:10am, the NCC advised the EOC that staff on the ground should not intervene if the prisoners started fighting between themselves. At 11:11am the NCC decision log recorded that the integrity of the roof was not known, there was no finalised intervention plan, staff were not trained to operate at height, and the prisoners on the roof had ACR equipment and weapons.
272. At 11:25am and again at 6:19pm, drone footage showed the prisoners had access to food.
273. At 11:30am, an NCC handover meeting took place. It was recorded that the prisoners were getting "fractious between selves". Concern was expressed about the prisoners' access to medication, and that "they may take uppers and [which might have an] influence on behaviour". The response to the riot was named Operation January.
274. At around midday, the NCC was physically established at National Office.
275. At 12:13pm, prisoners appeared to have access to water.
276. At the 12:30pm EOC briefing, the Tactical Adviser – Central presented an intervention plan. Further detail planning was requested with Police and ACR. A mission statement was to be completed. Thirty cellphones were now on site for use by staff.
277. At 1pm, the NCC briefing log recorded that the mission of Operation January was "to regain order and control at Waikeria Prison by regaining order and control safely". It recorded that the prisoners had access to Master Control. A direction was given to shut down the power to Master Control.
278. At 1:30pm, Chief Executive meeting notes recorded "... Intel from prisoner who came down is that they have lots of food but are running out of water".
279. At 3:25pm, the NCC decision log recorded that the EOC Incident Controller advised that the prisoners were dropping down from the roof individually, which provided an opportunity to apprehend prisoners. The NCC Incident Controller gave approval for ACR members to arrest the prisoners. Five staff would be needed for each prisoner and must be sure that it was "not a trick".
280. At the 6pm NCC briefing, a number of options were presented, including taking back key areas of the prison, arresting prisoners if alone, and making it possible for prisoners to surrender by putting up ladders.
281. At 7pm, the EOC log recorded that the intervention plan was approved. The surrender plan was approved. Kaumātua would be involved in the surrender.
282. At the 8pm EOC briefing, it was recorded that the surrendering prisoners would be taken to the ISU for decontamination and held until daytime.
283. At 10:21pm, four prisoners were seen at ground level but retreated to the roof when they encountered staff.
284. At 10:46pm, there was an explosion on the roof and two prisoners appeared to be caught in it, having dropped something into a fire.

## Day 5 – 2 January 2021

285. At 12:01am on 2 January 2021, the EOC log recorded that ACR reported that prisoners were agitated and verbally abusing staff.
286. At 12:06am, some prisoners came down from the roof and confronted ACR and AOS staff on the ground. The prisoners had weapons, were challenging staff to engage with them, and were throwing projectiles at them. AOS members fired sponge rounds to force the prisoners back to the roof.
287. At 12:08am, the EOC log recorded that 40 extra ACR staff were requested on site. They arrived at 1:29am.
288. Throughout the night, prisoners lit and fuelled more fires and threw objects at staff.
289. ACR staff attempted to keep the prisoners awake all night. Staff made noises, erected a ladder and threw objects.
290. At 6:55am, prisoners were reported to be trying to light another fire using hand sanitiser and shredded paper.
291. At 8am, the EOC briefing recorded that the objective was to save the ISU and kitchen and complete the plan for intervention.
292. At 9am, the EOC briefing reported the aim of *“having a suite of plans by midday to present to [Chief Executive], but to be clear not going in yet”*. From a health and safety perspective, *“staff are getting fatigued and conscious of traumatic experience”*. It was recorded that rain was forecast for that day.
293. At 10:01am, corrections officers removed knives from the Top Jail kitchen.
294. At the NCC 11am briefing, the use of sponge rounds by the AOS team overnight was discussed, and that some prisoners may have bruising. The risk was assessed as escalating, and the focus was now on working towards an intervention plan for the evening. The EOC briefing recorded that ACR would make regular incursions to create distractions around site but would not enter the building. Electricity had been disconnected.
295. In the early afternoon, two National MPs (the member for Taranaki-King Country and National’s Corrections spokesperson) arrived at the prison, but were denied entry as they had not made a formal request to the Minister of Corrections to visit.
296. At around 3:13pm, additional ACR members arrived on site.
297. At 4pm, the intervention plan was presented to the Chief Executive and Acting National Commissioner: *“Mission to safely arrest 16 prisoners and secure the Top Jail”*. Briefing notes recorded: *“For confidence as to why this is now necessary, reasonable and proportionate – full risk assessment completed in NCC covers all factors ... essentially assessment is, overall change in setting means it is now safer to intervene rather than continue to hold”*. It was noted that the Chief Executive *“acknowledged hard work, professionalism and collaboration – very confident in professionalism and training of staff”*.
298. At 5pm, a meeting with the Chief Executive, Acting National Commissioner and NCC Incident Controller outlined the rationale for the intervention plan. This included that staff were fatigued and frustrated prisoners were gaining more ground, the situation was escalating, the impact on the prison network and Waikeria Prison’s low security facility (where prisoners did not have access to telephones or visits). The Chief Executive endorsed the plan and was *“assuring himself experts have done what they would reasonably be required to do to assess this is reasonable and proportionate”*. It was also recorded that: *“Prisoners also almost got themselves trapped between fires last night – significant risk to their life if that continues”*.
299. The 5:30pm NCC briefing recorded: *“Robust conversation held with [Chief Executive and Acting National Commissioner] challenging questions could easily be answered – reflects the level of planning and specialist support and ultimately understood this is the window of opportunity that needs to be taken – not just for Waikeria, but also the wider impact on the network. This plan is not without risk but we have mitigated to the level we needed to”*.
300. At 6pm, the EOC log recorded that the intervention plan was signed off in conjunction with Police. It was expected to take place between 6:30pm and 7:30pm that day. The Acting Police Commissioner was informed of the intervention plan and the AOS tactics.



301. The intervention began at 7:15pm, with entry by ACR and AOS staff into the Top Jail. They moved along corridors and cleared rooms as they progressed to ensure no prisoners were hiding. The entrance to the second-floor Chapel was blocked by barricades. As staff worked to remove the barricades, the prisoners set fires and dropped objects on staff. The fire quickly spread to the Chapel building. Realising that access to the Chapel had been compromised and the extreme risk to staff, the ACR and AOS staff withdrew at around 7:33pm.
302. As staff were withdrawing, prisoners on the roof threw objects at them. Within minutes of the staff exiting the Top Jail, the Chapel became fully engulfed in fire.
303. The fire in the Chapel destroyed the area the prisoners used for shelter and storage. It destroyed their supplies and restricted the prisoners to a small area on the roof. The EOC assessed that the loss of the Chapel would result in the prisoners surrendering, which they did the following morning. Footage showed the prisoners standing directly on top of the roof, with the fire burning underneath.
304. That night, for the first time since the riot began, it started to rain heavily.
305. At 7:51pm, the EOC log recorded that five prisoners were *“reported to be surrendering”*. This did not happen.

### Day 6 – 3 January 2021

306. At 1:45am, prison negotiators, who had talked to the prisoners throughout the night, advised that the prisoners *“finally responded, stated that they want to come down now”*.
307. At around 3am EOC briefing, the Top Jail building was deemed so unsafe that ACR staff were no longer permitted to enter.
308. At 4:01am the EOC log recorded that *“prisoner agree to come closer to negotiator and talk face to face”*.
309. At the 8am EOC briefing, it was recorded that the aim that day was *“to bring it to an end”*. The Co-leader of Te Pāti Māori would return to the site for the surrender.
310. At the 8am NCC briefing it was recorded that the prisoners were *“pretty quiet overnight, lit fires mainly to keep selves warm, fires put out, still in clothing wet by rain, had half a bucket of water – tired and now starting to talk about wanting to end it. Plan is to see resolution today”*. It was recorded that the Co-leader was travelling to the site and Kaumātua and Kuia from mana whenua would also be involved.
311. At the NCC 9am briefing, it was recorded that *“ultimately prisoners are now on the roof with limited options remaining ... men are indicating they want to come down... hope to have this peacefully resolved today”*.
312. At 9am the EOC log recorded that Mongrel Mob (Kingdom chapter) had encouraged its members to meet at the prison gate at 11am.
313. At 10am, the prisoners requested food and water. They were advised that this would be provided when they surrendered. Around that time, the Co-leader came on site with the Kaumātua and Kuia.
314. At the 11am EOC briefing it was noted that the surrender plan had been completed.
315. At 11:11am, prison and Police negotiators confirmed that the prisoners were ready to surrender.
316. At the Chief Executive’s briefing 11:15am, it was recorded that the prisoners said they wanted to come down, *“acknowledge they might not but the time is right ... This will be a ‘slow-time’ plan and a very controlled surrender”*. During the briefing, the Incident Controller telephoned to confirm that the prisoners wanted to surrender *“immediately”*.
317. At 11:55am, the prisoners performed a haka pōwhiri to welcome the Kaumātua and Kuia, who responded with a karanga, a karakia<sup>30</sup> and waiata.

30. Taakina te kawa!/Ko te kawa noo wai?/Ko te kawa noo Rehua-i-te-rangi/Ko te kawa noo Hine-rangimaarie/He kawa tupua! He kawa tawhito!/He kawa ora! He kawa ora!/Tuuturu owhiti, whakamaua kia tiina!/Hui e! Taaiki e! - This karakia speaks of traditional fundamental ancestry that brings a ‘korowai’ of peace, of calm and of restitution. It is a pledge to settle the spirit and to bring a sense of tranquillity.

318. From around 12pm, the 16 prisoners surrendered, coming down from the roof using a ladder, one by one. They were handcuffed, searched and provided with water.
319. The prisoners were photographed and taken to cells in the ISU (which was undamaged). The prisoners were strip-searched, given towels, food, water and a change of clothes, and put into cells. Health checks were carried out.
320. At 2:10pm, a multi-agency debrief took place in the EOC. This included Police, FENZ and St John.
321. At 3:48pm, the prisoners were placed in prisoner escort vehicles. Three were transferred to MECF and the remainder to Auckland Prison under Police escort.
322. At 4:45pm the NCC hot debrief was held. It recorded that the incident was *“well under control at all times”* and the team was *“calm and measured”*.

#### 4 January 2021

323. At 6:04am the EOC log recorded *“no visible sign of the fire”*.
324. At 1:30pm, the NCC briefing recorded *“Moving from response to recovery mode”*. There was discussion about asbestos testing.
325. From 4 January 2021, the Regional Commissioner was appointed as Incident Controller in the NCC, leading the recovery phase. After a week, the NCC was officially closed.
326. A review of the drone footage identified several messages left on the roof. These include:
- » *“We want Tamati [sic] Waititi, basic human rights, water”*
  - » A drawing of the Māori sovereignty flag with the words *“Tino Rangatiratanga”*
  - » *“MONGOLS MC”* with symbols.

#### Other information about the riot

##### The resources available to the prisoners on the roof

###### Water

327. Some prisoners on the roof appeared to have access to water (at least until the intervention plan was executed on 2 January 2021). They also had access to cans of drink from the case management area, and the Health Centre had two containers of water. Further, most of the toilets in the Top Jail had traditional cisterns which held three to four litres of drinkable water each. The prisoners were observed on drone footage carrying what appeared to be water in a bucket.
328. Water was provided to the prisoners by Corrections staff on 31 December 2020, after the meeting with the Kaumātua and Kuia.
329. Once the Chapel was lost to fire after the intervention on 2 January 2021, the prisoners no longer had ready access to water. They told staff they would surrender if they were provided with water.
330. The decision was made not to provide water to the prisoners if they remained on the roof, but instead to offer water if they surrendered. The decision was made that:
- » Water would be offered in a controlled manner as part of the surrender plan
  - » Water would be in sight of the prisoners at the identified surrender point, and negotiators would advise the prisoners they would receive the water individually as they surrendered.
331. Health Services were concerned that the decision was made without the benefit of expert health and psychological input.
332. On 3 January 2021, the Chief Medical Officer and Chief Psychologist raised concerns with senior managers, and advice was prepared setting out the decision, decision-making process, and pros and cons of providing water to the prisoners. This advice was shared with the Incident Controllers.

### Food

333. The prisoners on the roof had access to food from a number of sources. They had taken canteen food from prisoners in their cells and broke into the bakery on 29 December 2020. They also had access to staff food.
334. Mr Q, who was broken out of his cell, said: *“They ripped my bars open, grabbed all our food”*.

### Clothing and supplies

335. The prisoners were seen wearing staff uniforms. They also found a metal bar on the roof that they used as a battering ram. On 31 December 2020, it was confirmed that the prisoners had gained access to the armoury and had stab resistant body armour, shields, helmets, personal protective equipment, a Halligan bar, a bolt cutter, an angle grinder and other tactical gear.
336. By 1 January 2021, the prisoners were known to have access to binoculars, a crowbar, 12 helmets, three shields and respirators, as well as tools from the paint shop, telephones, radios, cigarettes and other supplies, including cellphones found in an office. A PNT staff member told this Inquiry:

*“One guy was literally walking around like an officer on top of the roof. He had the blue cargo pants on, the boots on, the blue tee shirt on, blue [stab resistant body armour], the blue Corrections cap, and literally the whole lot. He had a radio on, like up there on his vest and that.”*

### The site’s communication system

337. Corrections’ Tactical Options Manual of Guidance describes Advanced Control and Restraint (ACR) teams as:

*“Corrections staff specially trained and equipped to respond to serious incidents in prisons where prisoners are acting in a highly threatening, aggressive and violent manner. These incidents can be highly volatile, physically demanding and beyond the capabilities and training of regular custodial staff. ACR Units can be deployed at site level by the Prison Director, within regions by the Regional Commissioner or nationally by the National Commissioner.”*

338. Activating the ACR team on day one was challenging given the Prison Director and Deputy Prison Director were both on leave. The Regional Commissioner approved the activation of ACR. Staff had to telephone each ACR member individually. A PCO had previously set up a texting system to contact ACR staff, but Master Control did not know about it at the time and the system was not used.
339. Morning and evening briefings at the EOC took place between night and day staff, as well as briefings with other agencies such as FENZ.
340. We heard from a member of the EOC that communications presented a challenge throughout the riot, but especially in the initial stages.
341. While cellphones were issued after landlines were lost, there was a delay in the cellphone blockers being deactivated and there was limited reception.
342. Corrections was unable to use radios from 31 December 2020 onwards as the prisoners on the roof gained access to these, meaning communication over these channels was not secure. Corrections was able to use FENZ radios, which provided a secure radio system.
343. Prisoners had access to staff telephones and, due to cellphone blockers being turned off to allow staff to use cellphones in lieu of radio communications, prisoners were able to use cellphones they had located or they had as contraband.
344. Corrections lost telephones and computers when the Honeywell room (which housed electronic security and IT equipment) was set on fire on 1 January 2021. Wifi connectivity was also lost.
345. The loss of communications created significant health risks, as nurses could not access MedTech<sup>31</sup> or contact senior managers.

31. The electronic patient management system used by Corrections to record and store patient clinical information.

346. We heard from two Incident Controllers that they were under-resourced in regard to communication ability and there needed to be a secondary communication system.

347. An Incident Controller told this Inquiry communication had been disjointed between responders:

*“That was really starting to fall apart on the second night I was there so when I came in the third night, we changed from our radio system to the [FENZ] radio system. In hindsight that was the best move we did, we should have done that at the start because then everyone would’ve been on the same communication channel - Police, Fire, ambulance crews, all listening to the same radios - so to come in on night three and have that in place that was fantastic, that was really strong learning from that. Prior to that it was very much we’d communicate ourselves, Fire communicated with themselves, Police were communicating themselves so it was that regular coming together throughout the night that kept the communication alive.”*

## 6. Waikeria Prison prior to the riot

1. The Terms of Reference of this Inquiry directed the Chief Inspector to examine what was known prior to the riot.
2. This Inquiry found that while the riot was primarily opportunistic, substandard conditions and systemic failures within the Top Jail contributed to underlying tensions and ultimately led to the events on 29 December 2020. Once the incident commenced, systemic failures allowed it to escalate rapidly which led to the riot.
3. Indicators of the underlying and escalating tensions were not properly reflected in the Prison Tension Assessment Tool (PTAT). Whether this was due to a normalisation of such incidents, systemic failures within the prison or a lack of staff experience and inadequate training, the result was that tensions were able to increase largely unchecked.
4. Corrections did not know that a riot was imminent until the telephone call from yard 116 to Newshub which was then relayed to Corrections.
5. This section examines what was known prior to the riot. It also sets out, where relevant, staff and prisoner insights.

### Hōkai Rangi

6. Hōkai Rangi is Corrections' strategy for 2019-2024 for long-term organisational commitment to addressing the over-representation of Māori in the corrections system and uplifting the oranga (well-being) of Māori and others in Corrections' care and their whānau. At its core are six pou: Partnership and Leadership, Humanising and Healing, Whānau, Incorporating a Te Ao Māori Worldview, Whakapapa and Foundations for Participation.
7. Hōkai Rangi reflects the goal of Corrections that it be *“free from racism and actively works to recognise and eliminate unconscious bias”*.
8. This Inquiry welcomes the Hōkai Rangi strategy which, when fully realised, will bring about a positive and significant transformation across the prison network, and into the community as men and women leave prison and reintegrate. While launched in 2019, Hōkai Rangi's realisation has been impeded by the COVID-19 pandemic. During 2020, Corrections clearly had to focus on its pandemic response and the health of people in prisons.
9. This Inquiry interviewed the Deputy Chief Executive Māori, who was part of the Māori Leadership Board which developed Hōkai Rangi. He commented:

*“Its intent initially was to respond to a call from the Waitangi Tribunal for the Department to have a dedicated Māori focus strategy to address the disproportionate reoffending rates of Māori ... It started as a Māori strategy, it then became the organisational strategy. It's been in place for nearly two years now. Hōkai Rangi for me is not a detailed playbook on what the Department should do, it's more of a destination description of where the Department should get to.*

*Hōkai Rangi ... it gave a big shift to the Department ... based on those principles of partnership and leadership. And I think that came through in the Waikeria stuff, you know, getting our partners to come in and help us.*

*“[As for] Humanising and healing approaches, we're still on a journey for that but I think the Department and key leaders in the Department actually they talk about these things now. I've been told five years ago, ten years ago, it would be unheard of. Hōkai Rangi is long-term, like it's a 15-year, 20-year sort of a journey. You can ... see where we've fallen short but, equally, you can point to a lot of things that are going really well.”*



10. At interview, the National Commissioner said:

*“The commitment to Hōkai Rangi for the organisation is a watershed moment and, like many watershed moments, the immediate effect or changes don’t come instantly ... It will continue to be an evolving initiative and I feel that many of our staff have always embraced a humanising and healing approach to their work [although many staff are still] bureaucratic, administrative and not connected.*

*“So it will take time for us to be able to build capability in that area, to set expectations of how we would like to transition people on that journey. Treating people decently and well is the obligation for all Correction jurisdictions around the world. Some do this better than others but we, in New Zealand, need to be reflective of the people that we are providing services to ... the majority of people in our care are from Māori communities and we need to be reflective of practice that’s going to suit their needs ... the most important thing that people should be taking out of Hōkai Rangi is the humanitarian way of operating and that we cannot stand behind process, policies, procedures that somehow disconnect us from making a humanitarian approach...*

*“[Hōkai Rangi supports being] able to provide a bit more of a human approach to actually assist people in a variety of ways ... accommodation, employment, training, support, trauma support, mental health care. We have been doing a whole range of other things and of course from a te ao Māori lens uplifting the importance of culture, the importance of identity, and allowing people to flourish in that way.”*

### Was Hōkai Rangi being realised?

11. This Inquiry found that while Waikeria Prison had several Hōkai Rangi aligned kaupapa, these generally pre-dated the introduction of the Hōkai Rangi strategy. While we note the relatively recent introduction of Hōkai Rangi at the time of the riot, the ability of prisoners in the Top Jail to access Hōkai Rangi aligned kaupapa was limited.
12. At a high level it was evident that the, at times, disrespectful staff culture and generally poor conditions were inconsistent with the principles of Hōkai Rangi.
13. The prison fostered a positive relationship with mana whenua. Te Roopu Kaumātua o Waikeria, a group of prominent mana whenua elders, provide support to the Prison Director and staff on matters of Māori protocol. They conduct ceremonies including pōwhiri, blessings and openings, set the tikanga for the site, and regularly meet with the Prison Director. Supporting prisoners is not part of their function, but they are available to see prisoners, if requested. The group spoke highly of the Prison Director as being supportive of engagement with mana whenua.
14. Waikeria Prison encouraged Kaiwhakamana involvement with the men on site. Kaiwhakamana (kaumātua who have access to prisons to enable the wellness and well-being of their people) are specified visitors, and include kaumātua, kuia, tohunga, spiritual leaders and others. The purpose of their visits can include advising prisoners and whānau about whakapapa and tikanga, assisting prisoners to establish contacts with iwi/hapū/whānau, and providing spiritual and religious support. The Hōkai Rangi strategy includes an action to *“ensure Kaiwhakamana are supported, resourced appropriately, and treated respectfully”*.
15. The prison’s low security facility has a number of Hōkai Rangi aligned kaupapa:
  - » Te Tirohanga – a programme aimed at reducing re-offending by providing a rehabilitation pathway founded on a kaupapa Māori therapeutic environment. Access to Te Tirohanga is based on a number of criteria including being sentenced, having a RoC\*RoI<sup>32</sup> between 0.3 and 0.69, and having a classification lower than high security. Te Tirohanga was not available to prisoners in the Top Jail as the majority of those prisoners were remand or high security.
  - » Te Whare o Te Ao Mārama – a Māori cultural space developed to meet the needs of the men. This was not available to remand prisoners.
  - » Prisoners took part in the annual inter-prison Kapa Haka Whakataetae, and the annual kapa haka competition competing for the Mangatutu Cup.
  - » Whānau were welcomed on site for Whānau Day. In 2019, 180 whānau members were welcomed on site. The men and their families shared photos and played games. Staff mingled with the families and shared a hāngī lunch with kapa haka entertainment. The men in the Top Jail did not take part due to their high-risk rating.
32. The RoC\*RoI (risk of reconviction/risk of imprisonment) tool is used to predict the likelihood of an offender committing further offences. It is a computer-based statistical model which uses an offender’s criminal history and demographics to assess their risk of re-offending. It specifically predicts the probability of reconviction within the next five years, the seriousness of the re-offending and the likelihood of imprisonment.

16. Other activities in the low security facility included:
- » The men cooking for the children's visits
  - » Inviting whānau to kapa haka competition
  - » Buying and making Christmas presents for the prisoners' children
  - » Tutors teaching carving and te reo Māori
  - » Facilitators offering tikanga and kaupapa lessons for staff
  - » Extended unlock hours.
17. Fewer activities were available in the Top Jail, but this Inquiry was told about morning karakia and waiata, and kapa haka.
18. In early 2020, a Cultural Capability Uplift Programme was started at Waikeria Prison. As part of this, the General Manager Rautaki Māori conducted three sessions at the site. However, this did not continue due to a lack of consistent engagement by staff.
19. This Inquiry heard from one Kaumātua that when Hōkai Rangī was introduced across the prison network, prisons were not sufficiently prepared to deliver it. The Kaumātua expressed doubts that the custodial staff at Waikeria Prison understood Hōkai Rangī.

### Staff views

20. While received positively by senior leaders, staff working in prisons had mixed views of Hōkai Rangī.
21. Some staff said Corrections' culture was inhibiting true realisation of Hōkai Rangī. There was a perception that Hōkai Rangī was being re-interpreted on site to suit the staff, and tended towards a "tick box" approach. One staff member felt there was a lack of prison staff buy-in and initiatives were being called "Hōkai Rangī aligned" but were not. There was also a perception that Corrections had no real desire to change and there was a perceived disconnect between National Office, the Minister's Office and what prisoners experienced in the Top Jail.
22. At interview, the Chief Māori Health Officer explained:
- "We really require some very strong leadership regionally, and we require to be able to cascade that through so that it actually lands for the men and the wāhine and the rangatahi who are in our care. That's a massive gap right now because it's not landing. So how we talk is totally different to what's happening out there."*
23. A Top Jail staff member noted a lack of understanding of the Hōkai Rangī strategy, particularly among longer-serving staff. A staff member expressed frustration, stating that in their view realisation of Hōkai Rangī had stalled. Other staff said they believed there was no budget to embed Hōkai Rangī and there was a lack of investment in cultural uplift for staff.
24. We heard concerns from some staff that there was a natural tension between the humanising approach under Hōkai Rangī and 'getting got' (i.e. being manipulated by prisoners). Staff noted that training in this area would be beneficial.
25. A Top Jail PCO told us:
- "Hōkai Rangī is about stepping out of whatever ways you've been working with the prisoners in the past ... we're trying to humanise things."*

The Health Centre Manager told us:

*"[A nurse] would hold her clinics in Māori. The guys appreciated it and they had the options to go forward. We've accessed kawakawa and all sorts of things for years if guys wanted it. It's always been an option here. We've had Tohunga in here. We've had all sorts of people. Hōkai Rangī, we're just extending what we already have been doing. If they wanted to speak in te reo, ISU, anyone on site, I've got nurses and they would go and do that. They always had that option."*

**Prisoner views**

26. Some prisoners at Waikeria Prison felt Hōkai Rangi was not visible. Some said they felt corrections officers had only a superficial understanding of Hōkai Rangi, for example concentrating on karakia and waiata, rather than meaningful and humanising interactions with prisoners. Some prisoners were not aware of Hōkai Rangi.
27. Prisoners raised a number of other issues, which indicated that the realisation of Hōkai Rangi was limited, namely:
- » The Top Jail's 'cell to yard' regime meant there was limited engagement in meaningful activities
  - » The lack of privacy when on the toilet and having to eat next to an uncovered toilet
  - » The poor behaviour of some staff.

**Kaiwhakamana**

28. The Kaiwhakamana at Waikeria Prison have whakapapa links to mana whenua. The small number of Kaiwhakamana and the nature of their work meant they were unable to support men from other iwi. They did not work with the staff.
29. Kaiwhakamana were able to visit men in the Top Jail and did so (if they had time).
30. This Inquiry heard from Kaiwhakamana that they struggled to provide support to the prisoners. Prisoners sometimes required a lot of time and it placed a heavy burden on Kaiwhakamana, some of whom had full-time jobs.
31. We heard from some Kaiwhakamana that they appreciated the support provided by the Prison Director. They felt the Prison Director understood the importance of their work and did his best to support them.
32. This Inquiry is aware that Corrections is currently in the process of:
- » Developing a Kaiwhakamana policy which reinforces the important role Kaiwhakamana play in rehabilitating people in Corrections' care and strengthens the processes around communication and administration support.<sup>33</sup>
  - » Increasing the number of Kaiwhakamana to allow more people to benefit from their assistance.
  - » Holding a national hui for Kaiwhakamana to communicate progress. Prison Directors and Regional Commissioners will be invited.

**Physical conditions**

33. Prior to the riot there had been several reports about the operating environment and conditions in the Top Jail at Waikeria Prison; namely the Office of the Inspectorate's inspection reports for 2017<sup>34</sup> and 2019,<sup>35</sup> and the Office of the Ombudsman's inspection report from 2019.<sup>36</sup> These reports made various adverse findings about the conditions in the Top Jail.
34. This Inquiry found that many, if not all, of the issues raised in the above reports were present to some degree at the time of the riot.

**Environment**

35. The Office of the Inspectorate's 2017 report found the Top Jail facilities were in very poor condition. The cells were dark, damp, had minimal natural light and little air flow. The floor in toilet areas was stained, the floor coverings were lifting and decaying and the shower block was dirty with peeling paint. The reports noted that the stainless-steel cell toilets did not have lids, which was a hygiene issue because meals were eaten in the cells. The pillows were reported to be dirty and offered little support. The duvets were also dirty and thin.
36. The Office of the Inspectorate's 2019 report found there had been no meaningful progress to improve the condition of the Top Jail. It noted that most high security prisoners had no option but to use showers in the exercise yards. The yard showers were used year-round, including in bad weather and winter. While the showers appeared clean, they were in poor condition. Cell toilets were dirty and had no privacy screens.

33. The Kaiwhakamana policy was approved in September 2021 and has progressed to the implementation planning stage.

34. <https://inspectorate.corrections.govt.nz>

35. <https://inspectorate.corrections.govt.nz>

36. <https://www.ombudsman.parliament.nz>

37. The Office of the Ombudsman's report echoed the above concerns and further noted that most men in the Top Jail were double-bunked in cells designed for one person, leading to cramped, uncomfortably hot and overall poor conditions. While screens had been installed around the toilets, they still did not have lids. Prisoners were required to receive all meals, other than lunch, in their cells and had to eat near an uncovered toilet, which the Office of the Ombudsman said was *"both unsanitary and culturally inappropriate"*.
38. The Office of the Ombudsman also found that the shortage and quality of prisoner kit was problematic and there was a general shortage of towels, sheets, pillows and clothing. The bedding was in a poor condition, being stained, lumpy and torn.
39. Interviews conducted for this Inquiry confirmed the issues outlined above.

40. A prisoner told this Inquiry:

*"I spoke to the other men, like they were [imprisoned] in '78 and the 80s, and they'd gone back there and they're like, it just hasn't changed. I've got mates that had served there on and off for years and it's just never changed."*

41. We heard from prisoners that they felt Waikeria was worse than other prisons. Some prisoners made comments which indicated the challenging conditions in the Top Jail were normalised. A prisoner told this Inquiry:

*"My experience there was I guess normal if that makes sense, like even though the conditions were shit and rugged that's what I thought jail was, and it felt normal."*

### Security measures

42. The Top Jail had various layers of security. The physical confines of the building is a secure area that accommodated prisoners. It had security measures such as grilles and doors which were operated by keys attached to staff belts.
43. There was clear ground between the Top Jail and the perimeter fence, which was an anti-climb fence with razor wire at the top to deter and prevent prisoners from climbing it. An electric fence ran parallel to the anti-climb fence.
44. The pedestrian and vehicle gates in the fence (sally ports) were remotely controlled from Master Control (meaning that corrections officers did not physically carry these keys).
45. The Top Jail had an extensive CCTV system to monitor the exterior of the building, as well as yards, corridors and residential wings. We note there was no CCTV coverage of the roof which initially hindered Corrections' ability to respond to the riot.
46. Staff were equipped with on-body cameras. We were told that all corrections officers in the Top Jail were able to access on-body cameras. Notwithstanding the availability of on-body cameras, this Inquiry found that not all staff involved in the incident response (including ACR) had on-body cameras, and not all of those wearing on-body cameras had them turned on or orientated in the right direction.
47. Security was also maintained by the searching of cells, prisoners and visitors. The Site Emergency Response Team conducted targeted searches based on intelligence received. Intelligence was used to identify and disrupt activities by prisoners that were unlawful or threatened the security or good order of the site.
48. Prison staff (including ACR staff) were not permitted to go on the roof of the Top Jail, as they were not trained to operate at height. This meant the ability of staff to conduct security inspections on the roof was minimal and was restricted to activities such as looking from the bridges above the yards.
49. This Inquiry found that the prisoners who went on the roof were able to access various items they used as a battering ram, tools and weapons. These items enabled prisoners to break out other prisoners from their cells which allowed the riot to escalate. This could have been prevented had security inspections of the roof area taken place.
50. Unlike some other sites, Waikeria Prison did not have razor wire on the roof which is designed to prevent widespread access across the roof.

### Mesh grille

51. This Inquiry found that staff did not inspect or maintain the integrity of the mesh grille above the yards. Staff were not permitted to go onto the roof to inspect the mesh for security purposes, and the mesh was not easily checked from inside the yards.



52. The design of the mesh itself was flawed. The National Manager of Asset and Facilities Management said the mesh was not designed to withstand someone attempting to break through using force or an implement. The site facility maintenance contractor was responsible for the ongoing maintenance of the site, including the mesh grille.
53. Given that preventing prisoner access to the roof was imperative to containing any disorder, prisoners should not have been able to reach the mesh even by climbing onto objects within the yard.

### Concrete blocks

54. The exterior walls of West and East Units, built in the 1960s, were made of hollow concrete blocks and the window bars were not set in concrete. This played a large part in prisoners being able to use a battering ram to break other prisoners out of their cells. (See Appendix C).

### Toilets

55. Each cell had a toilet and there was one toilet in each yard. Toilets did not have lids by design, but some prisoners made cardboard lids. We heard that the prevalence of double-bunking led to a reluctance by prisoners to use the toilet in their cell. Toilets in cells had a screen, but this Inquiry heard this gave little privacy. We note these toilets were similar to those in high security units across the prison network.
56. Prisoners said they found it culturally insensitive to eat next to a toilet and upsetting when they wanted to use the toilet and the person they shared a cell with was eating. Some prisoners were so intimidated they would wait to use the toilet in the yard.
57. Another prisoner told us it should have bothered him to eat in his cell with dirt, bugs and the toilet, but it became normal.

### Showers

58. This Inquiry heard from several prisoners that the showers were dirty. Most prisoners were required to shower in the yards. There was one shower in each yard.
59. Some prisoners told us that they did not get a shower if they did not go to the yard. However, a staff member said prisoners who do not go to the yard might be taken to the yard after other prisoners had left for the day.
60. Managers and prisoners confirmed that prisoners in the Top Jail had regular and consistent access to soap and shampoo. Small bars of soap and sachets of shampoo were issued to prisoners each day on their way to the yards.

### Yards

61. Yard 116 was around 150m<sup>2</sup>, and 21 men were in this yard of the day of the riot.
62. This Inquiry heard that conditions in the yards were poor and they were dirty. A prisoner told this Inquiry:
- "... the conditions in those yards; so, there's one toilet, you'd have, sometimes 20 blokes out there - absolutely filthy, yep. The conditions are like; you've got a jail that's a hundred years old, there's been a lot of bodies go through there ... that was probably the most grubbiest six months of my life; up at that Top Jail, yeah."*
63. A prisoner told us that once when they came into the yard, the toilet was blocked and flooded the yard. Staff were informed and said they would fix it, but the prisoners remained in the yard with the water and sewage for the remainder of the day.
64. Yards had minimal shelter in bad weather.
65. This Inquiry heard from prisoners and staff that there were too many men in the yards. Staff saw this as the only option as there would otherwise not be enough yards for prisoners to exercise in given the unlock regime.



66. We heard from some prisoners that they enjoyed being in the yards, some for up to six hours each day. But some prisoners felt unsafe in the yards. A staff member told us that fighting was common and would mostly happen in the CCTV blind spots. We were told it was not uncommon for prisoners to smoke cannabis in the yards or play violent games of 'crash'.<sup>37</sup> We were told the corrections officers would largely ignore issues such as these in the yard.

### Facility maintenance

67. In September 2020, the Top Jail was issued with a Certificate of Compliance. The fire suppression systems were assessed as compliant.
68. Regular and consistent maintenance was completed at the site, mainly for electrical work, plumbing, heating, ventilation and air conditioning.
69. Evidence was provided from the site of work undertaken to rectify some of the issues identified in the 2019 Office of the Inspectorate Report, for example cells, communal residential areas and exercise yards had been cleaned and painted.
70. We note that the Top Jail always passed its Building Warrant of Fitness, completed annually by an independent certifier employed by Downer.

### Hygiene and sanitation

71. We reviewed several external hygiene and sanitation audits of Waikeria Prison.<sup>38</sup> These audits assessed communal ablution areas (including staff toilets and showers, but not showers and cell toilets), kitchen and dining areas, and the laundry. While the audits identified several areas of concern in the Top Jail, the majority of inspected items in the Top Jail units passed the hygiene and sanitation inspection.
72. This Inquiry found evidence of improvement in the hygiene, cleanliness and overall monitoring processes in areas in the Top Jail.

### Cleaning programme

73. A cleaning programme for the Top Jail was developed in 2019, with the aim of regularly monitoring all areas and keeping them clean.
74. Some staff accepted that the conditions in the Top Jail were austere and it should have been closed, but did not generally accept that hygiene was poor.
75. Conversely, other staff and many of the prisoners said it was not clean and was a difficult place to be. This Inquiry heard from some prisoners that cells were not clean. Rubbish bins in cells were not frequently emptied. We heard it was difficult for some prisoners to access cleaning supplies.
76. Some prisoners reported having scabies, bed bugs and boils caused by the conditions in the cells. However, Health staff did not think there was an increased proportion of skin infections due to lack of cleanliness.
77. A staff member told us that the prisoners would get toilet paper and disinfectant every day and, on request, a scrubbing brush, mop and bucket.

### Meals

78. Prisoners were served food in accordance with the Corrections' National Menu. Three meals daily plus supper were served on a four-weekly cycle. The diet is based on Ministry of Health Food and Nutrition Guidelines for NZ Adults. Special diets can be requested. The type and quantity of food served reflects the work needs of the prisoner.<sup>39</sup>
79. Prisoners generally received breakfast and a cup of tea in their cells between 7am and 8am. Lunches were taken into the yard with the prisoners. Dinner, with a cup of tea, was served in the cells at around 4pm.

37. A game similar to rugby league where prisoners crash into each other.

38. Including: Spotless, Audit Report: Waikeria Prison: 6 Month Hygiene and Sanitation Review, dated 14 September 2019, 27 February 2020 and August 2020.

39. Prison Operations Manual: F.01.Res.01 Catering.

80. Hot meals came from the kitchen at 4pm (and sometimes as early as 3:30pm). Meals were delivered on insulated trays that keep food hot for up to two hours. We heard that staff in the Top Jail had to be reminded to ensure lids on the hot meal dinner trays were kept on and closed (lids were taken off to pour tea). It could take 30 to 45 minutes for trays to be delivered. Some prisoners (including Mongols MC members and others on management plans or in the Management Unit in East North Wing) were given meals in paper bags. This was a safety precaution to prevent high risk prisoners receiving trays which could then be used as weapons and it also meant their cell door did not have to be re-opened to collect trays.
81. There were mixed comments about the standard of the food. Some prisoners told us the food was cold or came in small portions.
82. We heard concerns from staff and prisoners about how food was delivered, particularly that trays were placed on the floor and often left uncovered.

### Water quality

83. Waikeria Prison's drinking water (for both staff and prisoners) has been described by prisoners as brown in previous Office of the Inspectorate and Office of the Ombudsman's Reports. Some prisoners we spoke to described the water as dirty and of poor quality. We heard from staff that it was discoloured but safe to drink.
84. The drinking water is sourced from a bore located within the prison site. The water is treated on-site at a water treatment plant (built in 2011) with chlorine gas and sand filters. This water supply is classed and registered as a self-supplier. As such, it is not required to comply with New Zealand Drinking-Water Standards. However, Downer manages the network in accordance with these standards.
85. Corrections commissioned a report in January 2021 in response to a claim that the Waikeria riot was in part due to the poor water quality.<sup>40</sup> This report stated:
- "The Waikeria Prison drinking water is managed by applying the water safety plan. The plan has been developed with consideration to health and New Zealand drinking water guidelines. The water quality is operated, monitored and tested in accordance with this plan. The water quality is regularly tested by an independent laboratory and test results made available to authorised Department of Corrections representatives. The water quality test results in the past six (6) month period have returned within acceptable levels with one minor exception, where a network test for Iron (Fe) exceeded."*
86. Water testing is conducted regularly. Iron and manganese are minerals commonly found in groundwater supplies which are not considered a health issue. High levels can cause water discolouration, stain plumbing fixtures and contribute an unpleasant metallic taste to water. In the six months preceding the riot, manganese levels were below the guideline value. Iron levels were below the guideline value in all months except one. The water was safe to drink. There have been no E. coli detections since the bore has been in operation.
87. If brown water was reported, testing and flushing of the water network was undertaken.

### Clothing

88. The 2019 Office of the Inspectorate report found Waikeria Prison had made good progress in improving the management of clothing. Prisoners in the Top Jail had no concerns about the condition and quantity of clothing. Kit lockers appeared well stocked, with appropriate amounts of spare clothing. However, by 2020, access to clean and appropriately sized clothing or kit was an issue.
89. The 2020 Office of the Ombudsman inspection report said the shortage and quality of prison kit across the facility was:
- "Problematic ... Generally there was a lack of towels, sheets, pillows, and clothing. Inspectors observed bedding in poor condition, including stained, lumpy and torn pillows, torn mattress covers, and thin duvet inners ... There were inconsistencies relating to the process for replacing kit across the site"*
90. This Inquiry heard that approximately \$10,000 was spent each month at the site on replacement clothing, bedding and towels. A double order had been made in November and December 2020.

40. Waikeria Prison Drinking Water Quality Report (Downer, 2021).

91. The Top Jail had no unit washing machines and all clothing was sent to the central laundry. There were some inconsistencies among staff about the laundry process. Clothing was not individually issued to prisoners and did not go to the laundry in individual bags. Clean laundry was returned to the unit and placed in kit lockers, but prisoners did not always receive the right sized kit. Staff told us there was always a shortage of clothing.
92. Several prisoners told this Inquiry of their dissatisfaction with the provision of appropriately sized clothing and adequate items of clothing, especially as many exercised daily.
93. We heard from some staff that prisoners received clean kit if they asked for it. However, other staff accepted that clean kit was not always available, due to the laundry capacity.
94. We also heard that staff would conduct cell searches in order to remove any excess clothing, which often caused tension between staff and prisoners. Staff said the kit issues were caused by prisoners damaging their clothing, ripping clothing to personalise it or do exercise, or ripping sheets to make clotheslines.
95. We heard that prisoners would often keep kit which fitted them, wash it themselves in the sink or showers with body soap or shampoo, and dry it in their cells (often by making clotheslines out of sheets).
96. A few days before the riot, a staff member drafted an email (which this Inquiry has seen) to the Top Jail Residential Manager outlining his concerns about prisoner access to clean clothing. The email was not sent because the staff member realised management would be on leave over Christmas.

### **Towels and bedding**

97. Staff reported that towels would be given on demand if prisoners put used towels outside their cells. However, this Inquiry heard from prisoners that towels were replaced infrequently.
98. We heard from prisoners and staff alike that mattresses were very poor quality.
99. Staff advised that prisoners regularly damaged their sheets by ripping them to use as clotheslines (this is common across the prison network), as mentioned above, and using them to dry their clothes.
100. A staff member told us that bedding was washed once a week and prisoners had to initiate a change of bedding by stripping their bed and placing it outside the cell. Staff advised that they used to enter the cells and strip the beds but this practice ended because the prisoners disliked staff entering their cells.

### **Other factors**

#### **Yard-to-cell regime**

101. This Inquiry found the restrictive yard-to-cell regime for prisoners in the Top Jail was devoid of meaningful engagement and contributed to the tensions in the unit.
102. The Top Jail operated an 8am to 5pm regime. This meant core unit staff worked between 8am and 5pm and prisoners were unlocked while these staff were on duty. Most prisoners in the Top Jail spent every day, from around 9:30am to 2:30pm, in the yards (around 5-6 hours a day) and the rest of the time they would be locked in their cell. Prisoners on directed segregation had one hour in the yards each day. The Mongols MC members' regime was a little different (discussed in the Mongols MC section of this report).
103. We were told:
  - » Getting the prisoners out to the yards took around 1–1.5 hours
  - » Two officers generally unlocked the cells
  - » Every prisoner was rubbed down and their shoes checked, they were then scanned with a handheld metal detector
  - » Clothing and towels being taken into the yard were placed on a table and searched
  - » Prisoners were given shampoo, soap and lunch
  - » Staff then checked on prisoners who had decided not to go to the yards
  - » The search table had two charts, one for noting who had requested a lawyer call and one for haircut requests
  - » Generally, prisoners could access the gym in half hour slots on certain days during their yard time.

104. This Inquiry found that, due to the regime, staff had limited ability to engage with the men and performed little more than a security and movements function. Such a role is not conducive to rapport building which is a key component of any unit as it supports good culture, good relationships and role modelling. It also impacts on staff ability to intervene and/or de-escalate when required.
105. The exception was the Management Unit (in East North Wing). The Management Unit PCO said the lower prisoner to staff ratio in this unit allowed officers more time to interact with prisoners and they were able to respond to requests in a more timely manner.
106. Prisoners did not have recreation time in the wings. Each unit housed a range of different categories of prisoners which presented potential security risks. For example, a unit may have housed a range of different gang members, segregated and mainstream prisoners and sentenced and remand prisoners. This meant that other than yard time, there was no ability for men to interact or engage in constructive activities while unlocked. If a prisoner chose not to have yard time, he remained locked in his cell.
107. One consequence of not having recreation in the unit was the prisoners did not have access to kiosks which were located in the units. Activities usually conducted by prisoners via the kiosks, such as ordering canteen items, were completed on paper forms.
108. Church services were held every Sunday in two programmes rooms (two services were held at 9am and two at 10:30am). A maximum of 10 prisoners could attend each service.

### Haircuts

109. Access to haircuts was a point of tension prior to the riot. Some staff appeared to believe that prisoner access to haircuts was a *“privilege not a right”*.
110. The Prison Operations Manual states that barbering facilities will be provided for hair cutting, but remand prisoners are not permitted to *“significantly change their appearance prior to trial or the completion of court proceedings”*.
111. This is supported by regulation 188(1) of the Corrections Regulations 2005 (the Regulations) which states that, *“Unless a health centre manager directs otherwise on the grounds of health, safety, or cleanliness, the hairstyle and facial hairstyle of a prisoner awaiting trial or during trial may be cut or shaved only to the extent necessary to preserve the appearance of that prisoner at the time of his or her reception to the prison”*. It is also supported by regulation 70(1) of the Regulations which states that a prisoner may keep or adopt the hair style of their choice (unless the health centre manager directs otherwise on the grounds of health, safety or cleanliness). However, this does not apply to remand accused prisoners.
112. Prisoners in the Top Jail were permitted to have their hair cut by request, under staff supervision. Remand prisoners were permitted to have their hair cut, but could not significantly change their appearance. Staff supervised haircuts to ensure they complied with this regulation.
113. Haircuts took place at weekends. Prisoners would be advised which yards would get haircuts the coming weekend and those wanting a haircut could put their name down. Each yard would have access to haircuts every two to three weeks, with a prisoner as the barber. Haircuts were sometimes cancelled for a number of reasons, including the weekend prior to the riot, because of poor prisoner behaviour. We observed on on-body camera footage the prisoners in yard 116 complaining that they were denied access to haircuts.
114. Staff informed us that a maximum of 10 haircuts would be done each weekend. We were told that haircuts were not done as often as prisoners liked, and prisoners requested more haircuts than the staff could manage. Prisoners attending court or receiving visits would be prioritised.
115. Some prisoners told us there was no clear process for getting a haircut and it was sporadic. Prisoners stated they could often only get haircuts before court or transfers. Accordingly, this Inquiry heard that prisoners would often give themselves haircuts with razors, as occurred in yard 116 prior to the riot.
116. Just before the riot started, a prisoner in yard 116 was heard saying *“we were supposed to get haircuts a couple of days ago”* and then *“because you won’t give us haircuts we have to resort to this”*. A PCO responded: *“We don’t have to, it’s a choice, it’s a privilege”*.



117. The corrections officers then had a conversation among themselves, where one could be heard saying: *“We need to remember that haircuts are not a right for these men, they are remand and can’t change their appearance”*.

### Razors

118. The Prison Operations Manual states that high security prisoners should be issued one disposable razor each day on request when they are locked in their cell. Unit staff must record that a disposable razor has been issued to a prisoner, and must collect the razor no later than 90 minutes after issue. At the time the used razor is returned, unit staff must check there are no razors missing.
119. Razors were distributed to prisoners in the Top Jail twice a week or on request (such as before a visit or court appearance). Each prisoner was given one razor which was distributed and collected using a ‘face to name’ muster board, which recorded which prisoners had been issued a razor to ensure the correct number of razors were returned to staff.
120. The Prison Operations Manual states that if a prisoner refuses to return a razor after it has been allocated, staff have reasonable grounds to strip search the prisoner to locate the unreturned razor. If the missing razor was not found, a search of the prisoner’s cell must be completed. Prisoners can be placed on misconduct for returning a razor with missing blades, not returning a razor within the allocated time, having a razor in their possession outside allocated times, and using the razor for any purpose other than personal grooming.
121. As set out above, on or about 27 December 2020 a staff member gave four razors to two prisoners (both of whom were in yard 116 at the time of the riot). Only three razors were returned to staff.
122. On-body camera footage from 29 December 2020 records an exchange between corrections officers. One Corrections Officer was heard saying (referring to the 27 December 2020 incident): *“This started a few days ago”*.
123. She went on to describe the earlier incident, saying she had given the four disposable razors to Mr H and the prisoner he shared the cell with. The Corrections Officer said the missing razor was probably in yard 116. She said:
- “We should have got them out right there and then and stripped them but you know ... but we didn’t have enough staff here to do it but [another officer] and I went in and turned [the cell] upside down the next day and searched it but he would have had it strapped to his groin.”*
124. The provision of four razors to two prisoners in a double-bunked cell was a breach of the Prison Operations Manual, as was the fact that only three razors were returned, with no immediate action taken by staff.
125. Following this, staff had reasonable grounds to strip search the prisoners to locate the unreturned razor, but did not. Nor did they conduct a search of the prisoner’s cell that day. No file note or incident report was made, nor was this escalated to a manager. These were significant failings which likely led to the presence of a razor in yard 116 on the day of the riot.

### Canteen items

126. Access to canteen items was not found to be an issue of concern. Waikeria management advised that prisoners in the Top Jail were able to order their canteen items (known as P119) on a paper form due to limited access to kiosks. The maximum amount that a prisoner can spend on their canteen order each week is \$70. Orders were placed by staff on Saturday, and delivered to units every Tuesday.

### Telephone calls

127. Prisoners were able to make personal telephone calls to approved numbers using telephones in the yards. Prisoners who chose not to go to the yard could request to be unlocked from their cell to use the wing telephone. Prisoners employed in the wing also had access to the wing telephone.
128. Some prisoners told us the process of getting telephone numbers approved could take weeks.<sup>41</sup> We heard from some prisoners that telephones in the yard were sometimes broken or damaged. In some circumstances, prisoners were able to use staff telephones, for example for compassionate reasons. ‘Standovers’ are commonplace across the prison network, with prisoners intimidating others into letting them use their telephone PIN numbers or phonecards.

41. Reasons for this could include staff not being able to contact the person whose telephone number was being approved.



129. The prison telephone system had a number of known vulnerabilities. Prisoners in yard 116 on 29 December 2020 were able to use the yard telephone to make calls to unapproved numbers using three way calling and PIN numbers belonging to other prisoners (including those who had been released). This is commonplace across the prison network.

### Visitors and whānau

130. Visits were facilitated Monday-Friday at the Top Jail. Different categories of prisoners could receive visits on certain days. Children could visit on certain days. Prisoners could meet with family and whānau for one hour each week.
131. Applications could be made for AVL visits when whānau could not visit the site. AVL visits were part of the management plans for the Mongols MC members for contacting whānau in Australia.
132. The prison prioritised the AVL facility for Court hearings, lawyer meetings and Community Corrections meetings over family and whānau visits.
133. If time permitted, staff could allow prisoners to have a shave or haircut before a visit.

### Prisoner behaviour

134. The environment in the Top Jail was universally acknowledged to be challenging for both prisoners and staff. Violence and non-compliance from prisoners was common, and gangs had a significant influence.<sup>42</sup>
135. Prisoner behaviour in the period just prior to the riot was poor. A Safer Custody Panel meeting held at the prison in November 2020 noted there was an increase in incidents, staff abuse, threats and a number of staff assaults in the Top Jail. In December 2020, threats against and intimidation of staff in the Top Jail were noted.

## Staff

### Staff/Prisoner interactions

136. This Inquiry found that the working conditions in the Top Jail were challenging and complex.
137. Some staff thought there was a lack of experience and strong leadership in the management team at Waikeria Prison. Some told us Top Jail units were no longer led by a settled and mature group of officers who understood the dynamics of control and compliance.
138. Frontline staff told us the Waikeria Prison management team did a walk around of the Top Jail units about once a week. Apart from that, however, several senior corrections officers noted they only saw managers when there was a problem.
139. While some prisoners reported having good relationships with some staff, this Inquiry found that staff interactions with prisoners were often adversarial, disrespectful and characterised by the use of abusive language.
140. This Inquiry heard from several prisoners that communication from staff was poor. We heard that staff would often say they could help prisoners but would be too busy and fail to follow up or apologise for not being able to do so. We heard from some prisoners that some staff sometimes took a long time to respond to cell intercoms. One prisoner told us that usually the call was disconnected without any staff member making contact. He said that if the staff member made contact, it was usually to tell prisoners off for using the cell intercom or dismiss their concerns.
141. Some prisoners told us they would get frustrated by staff being unresponsive and they would abuse or assault staff.
142. We heard from several prisoners that it was hard to get anything they needed, such as forms, initial telephone calls and telephone numbers approved.
143. We heard from both staff and prisoners that staff were not equipped to handle the specific needs of the prisoners.

42. Similar conditions were found in the Office of the Inspectorate's 2017 inspection report.

144. A prisoner in the Management Unit (East North Wing) noted there was a high turnover of staff which led to a lack of consistency. There would be regular flooding of cells and smashing of televisions by prisoners. Smoke alarms would go off as prisoners were smoking in their cells. He told us:

*“There was already a lot of tension in my [East North] unit from the first day I moved in there ... The way it was run with the clothing and the bedding and just the management there ... The staff seemed to have control of it, but it wasn’t without ... issues of poor behaviour by the prisoners. From smashing TVs ... Sometimes we had two floods in our unit a day ... Setting off sprinklers in the unit. There was a fire lit in one of the cells. A mattress was lit on fire ... It was just out of control.”*

145. We heard from some prisoners that gang members got preferential treatment: better food and bedding and being able to get away with poor behaviour.

### Staffing levels

146. At the time of the riot, Waikeria Prison was fully staffed for senior custodial roles (with eight level 5 managers,<sup>43</sup> 19 principal corrections officers and 50 senior corrections officers). There were 246 corrections officers, with 27 vacancies.<sup>44</sup>
147. Despite the vacancies, the prison had sufficient staff to cover shifts. We heard from the Regional Commissioner who confirmed that, in his view, both numbers and capability were generally sufficient in the Top Jail.
148. Notwithstanding this assessment, this Inquiry found that issues arose during the riot due to perceived difficulties with staff availability.<sup>45</sup>
149. We were told by some staff that in the lead up to the riot the site experienced staff shortages, and security staff<sup>46</sup> were being used in units which led to disruptive behaviour by prisoners due to a lack of consistency with prisoner management. We also heard that staffing numbers were always an issue in East North Wing (the Management Unit) and when staff were off sick the replacements were not always “a good fit”.
150. At the time of the riot, the average length of service for staff in each unit ranged from three years three months (Remand Unit) to five years five months (West North Wing). The ISU had the longest serving staff, with an average length of service of 11 years five months.
151. Both the Prison Director and Acting Prison Director (the Deputy Prison Director) were on leave when the riot began on 29 December 2020. An On-Call Manager was working and was able to refer issues or decisions to the Acting Prison Director. We note the Regional Commissioner was also on call.

### Staff recruitment and retention

152. We were informed that Waikeria Prison had not experienced any issues recruiting staff in 2020 over and above what would be expected for a site in a remote location. However, we were also informed that a large number of the SCOs and PCOs were newly appointed in those roles.
153. The average turnover rate of corrections officers at Waikeria Prison in 2020 was 7.9%, which was consistent with the national average across all public prisons.
154. We found overall that there was a relatively stable workforce at Waikeria Prison.

### Staff training

155. Staff employed in custodial focused roles (i.e. corrections officers and employment instructors) are required to be qualified in certain core competencies.
156. This Inquiry was told that 72% of Waikeria Prison staff had completed tactical options training, and 85% had completed Fire and First Aid training.<sup>47</sup> On 29 December 2020, all corrections officers on duty in the Top Jail were current in First Aid and Fire training, and all corrections officers except one was current in tactical options training.

43. Level 5 managers include custodial systems manager, operations support, deputy prison director, receptions/movements, residential and security manager.

44. Based on data from the Organisation Chart, Click Roster (Corrections’ workforce management software) and Waikeria Prison Rostering Officer.

45. For example, the reluctance to clear yard 116 due to real or perceived staffing shortages, and the delayed decision to evacuate the prison.

46. Security staff were not based in a particular unit.

47. As at 11 January 2021.

**Advanced Control and Restraint training**

157. ACR staff, once qualified, are required to complete a re-certification course and annual training days. Corrections provided training records for the 135 staff from across the prison network who were deployed in an ACR role during the riot. Of these:
- » 72 staff were current with their ACR certification
  - » 63 staff were not current with their ACR certification.
158. We were told that in 2020, COVID-19 restrictions and core staffing requirements at the prisons meant not all ACR team members could be re-certified.
159. Four-day site-based trainings are held each year for ACR, delivered by regional tactical advisers or the national instructor. ACR members from around the country are trained together, which helps enable continuity of response and ensures ACR members from different prisons can easily slot into a response at any prison. However, one ACR member advised this Inquiry that they were not getting as much ACR and tactical training as they would like. Several staff have pushed to change the structure of the training, to have more scenario-based training and get the command element into the planning and operational phase of what must be done in a real-time event.
160. The Principal Adviser Tactical Operations told us that although a number of staff were not certified, that did not mean they were not competent in ACR drills or skills.
161. This Inquiry heard a number of concerns about ACR training from the Principal Tactical Instructor, including:
- » Tactical advisors and ACR unit commanders did not have the knowledge or experience they needed during the riot due to training only occurring once a year.
  - » There is no pass/fail assessment for ACR commander training and initial ACR training.
  - » There are no course reports to the trainees and no level of competencies that must be obtained. If there are concerns about a trainee's capability, the prison director and tactical adviser can remove them from the ACR role.
162. ACR members discussed the following training needs in debrief sessions after the riot ended:
- » Respirator training
  - » Method of entry training
  - » Having more regular training/refreshers training
  - » Having training based in their own region so that it caters for their needs and is more practical
  - » Learning the CIMS structure.

**Co-ordinated Incident Management Structure training**

163. The Co-ordinated Incident Management System (CIMS) was introduced to New Zealand in 1998 as its official response system. Soon after this, Corrections adopted CIMS to guide its emergency response. CIMS *“enables agencies to work effectively together using shared approaches for all aspects of emergency response including structure, control and command, communication, terminology, and resource management”*.
164. Following the Canterbury earthquakes, a hybrid system of the Gold/Silver/Bronze command structure was introduced as Corrections' incident management system. Most other agencies continued to use CIMS, which led to inconsistencies in any multi-agency responses to incidents involving Corrections.
165. In 2018, Corrections' Executive Leadership Team endorsed the use of CIMS as the incident management system.
166. All the managers at Waikeria Prison, including the Prison Director, Deputy Prison Director and On-Call Manager (on the day of the riot) had completed CIMS training.
167. This Inquiry heard from several senior Corrections staff that emergency related training should be reviewed, especially in relation to the re-introduction or at least clarification of the status of the Gold/Silver/Bronze training. Many viewed Gold/Silver/Bronze as an effective way to provide training related to tactics, rather than relying on CIMS which is an operational model that provides the structure of a response rather than tactics.

168. A staff member told the Inquiry they did not think CIMS was rolled out properly in a way that everyone understood, and staff were more comfortable with the Gold/Silver/Bronze classifications for incident responses. Another staff member noted Corrections was at risk because the CIMS model was not widely understood and it was not clear where authority and delegation sat, while the Gold/Silver/Bronze classifications were easy to understand.
169. CIMS functions appear to be misunderstood among some key staff within Corrections, meaning that staff who do not understand the role held by an NCC often “push back” on its oversight. This lack of understanding was perhaps demonstrated by the fact that an NCC was not formally established until day four of the riot.

### Intelligence training

170. Waikeria Prison had one intelligence analyst and two intelligence officers, who were on-site Monday to Friday. The team regularly engaged with the Waikeria management team, through one-on-one meetings with the Prison Director and the Deputy Prison Director every fortnight and attendance at various forums, such as Safer Custody Panel meetings. The Regional Intelligence Manager met with the Prison Director and the Deputy Prison Director on a semi-regular basis, at least once a month.
171. Intelligence officers attended the Top Jail briefings, although not every day. The intelligence analyst reviewed the PTATs and would follow up as necessary.
172. The team would collate briefing documents or information reports, prisoner telephone mass disclosures, intelligence reports and tactical subject profiles. Documents were graded based on their background or reliability or source. If information was just talk or hearsay, it was graded as 6 and considered not necessarily reliable. Information graded A1 was considered categorically reliable and true.
173. Intelligence staff used a Critical Incident Response Manual, which is aligned with Corrections’ move to the CIMS model. The manual is a guiding document for the Intelligence team’s response in a critical incident, which typically includes producing intelligence reports and subject profiles.
174. Intelligence staff are trained to respond to critical incidents through basic CIMS training, regional sessions, workshops and an annual conference. However, staff are not generally involved in prison-based emergency exercises.

### Adequacy of staff training

175. We heard mixed messages about whether new recruit training was adequate. Some staff told us they felt their training prepared them for the job and taught them everything they needed to know to keep safe. But this Inquiry heard from others that training for new staff was not adequate and did not prepare them suitably to deal with the realities of the job, especially in the challenging conditions of the Top Jail. Some staff did not feel that the Top Jail was a safe environment for less experienced staff.
176. A staff member commented that the prison population had become more violent (for example, as shown by increasing staff assaults) with an increase in mental health issues. Staff had little training around managing mental health issues, appropriate care and, crucially, the rules around use of force.
177. We also heard that ongoing training was often completed online and there were often technical issues (i.e. the computer had no audio) and some staff treated it as a “tick box” exercise.
178. We note that corrections officers, including ACR members, do not currently receive training on working at heights or roof top extractions. We heard there had been repeated requests from staff and ACR members for this type of training following the rooftop incursion in Tongariro Prison in 2013, a similar incident at Hawkes Bay Regional Prison Youth Unit, and recommendations made to senior Corrections staff by those involved in tactical options.
179. We heard that the intervention carried out on 2 January 2021 involved staff using, as entry equipment, contractors’ tools they were not trained to use. A staff member involved in tactical options was concerned at the lack of training around entry and a lack of method of entry capability.
180. We were informed that prior to the riot, Waikeria Prison staff did not complete multi-agency training.
181. Finally, we note that a significant number of staff were in acting roles, at Waikeria Prison generally and in response to the incident. The staff in acting roles may not have had the support and experience to be effective in those roles.



**The Emergency Management Exercise and Assurance Programme**

182. The Top Jail (excluding the ISU) had an evacuation plan, dated 1995, which was approved by Bay Waikato Fire Region in 1998. The plan was supposed to be updated annually. An evacuation plan for the At Risk Unit (now the ISU), dated 1998, was last approved in 2001.
183. The Emergency Management Exercise and Assurance Programme requires staff to complete monthly emergency management exercises (for example, in response to concerted indiscipline, fires, serious assaults, medical emergencies, suspicious mail, escapes and bomb threats).
184. A review of the East Unit and West Unit records for the latter half of 2020 showed both units were conducting monthly exercises. Of note, both East and West Units conducted an exercise relating to concerted indiscipline in July 2020 and a fire evacuation in October 2020. These exercises did not involve actual evacuations.
185. We were told FENZ had been notified of the evacuation plans for the Top Jail, which involved having twice yearly trial evacuations. While this Inquiry heard that Waikeria Prison may have had an exemption from undertaking the trial evacuations, it is concerning that more certainty was not able to be given on this point and it is not clear where the exemption was recorded (if anywhere).
186. Whether or not there was an exemption in place, the evacuation on 29 December 2020 was not well organised and was unsystematic which significantly increased the risk to life and safety.

**Training for a major disturbance or multi-agency emergency response situation**

187. While staff reported receiving training that was generally relevant, there was a lack of effective planning, training or exercises at Waikeria Prison for dealing with a major disturbance or a multi-agency emergency response situation.
188. The Regional Commissioner told this Inquiry that the Waikeria Prison site was, and had always been, skilled in managing incident operations, but not on the scale of the riot.
189. One staff member told us he believed there had not been a live drill evacuation in the Top Jail in approximately seven years. A PCO told us their team did a desktop emergency exercise approximately once a month, and while the team had not done a live drill in around four years, they had assisted the East Unit and West Unit in a live drill.
190. A staff member who had previously been an SCO in the security team noted that security staff would practice yard extractions, but not on a regular basis.

**Training to identify, respond to and contain disorder events**

191. Several prison directors and others in management positions raised concerns about the standard of training provided to incoming staff.
192. A senior staff member told this Inquiry that one of the biggest risks on site was the number of inexperienced staff, for example those who had never been involved in incidents. He noted that while managers were usually targeted for training, incidents more commonly happened after hours when the management team was not present, and therefore all staff need to be equipped to respond to situations that could or were escalating:

*“Your initial response will dictate how bad something gets. If you don’t deal with something in a timely manner in the appropriate way, it can escalate to millions of dollars of damage. I’ve seen it. Just one or two staff making a wrong call through a lack of experience”*

193. The riot highlighted that while training programmes may appear sufficient, individual staff have varying levels of competence, confidence and exposure in dealing with disorder incidents.
194. An Incident Controller told the Inquiry he believed Corrections was well prepared for incidents generally, but not necessarily for the most extreme events. He further noted there would always be a need for multi-agency operations in extreme circumstances, and that preparation was key:

*“[Corrections is] pretty well prepared [for large incidents or in particular incidents involving disorder] for the most of it. It’s when they go to the extreme end, like on the roof and fires and that and wire extraction ... that’s where a combination of resources will always be required. The secret there is working together and training and knowing each other’s capabilities.”*



195. Similarly, while some staff reach the standard at training, they may not perform to the required standard in a live situation. This can and should be rectified with additional training.
196. Following the riot, Corrections identified a series of insights and actions to be addressed, including reviewing ACR operating model practices and response times, cross agency emergency drill practices to ensure familiarity with location of EOCs and familiarity with each site, and reviewing Corrections' CIMS capability.
197. This Inquiry was informed that progress had been made on these actions, including the review of the ACR operating model being completed.

## *Prisoner placement*

### **General principles**

198. Generally, prisoners are placed in units that match their security classification and category (i.e. mainstream prisoners are housed together and segregated prisoners are housed together). Remand prisoners are housed separately from sentenced prisoners. Remand accused prisoners are housed separately from remand convicted prisoners. In cases where this is not possible, the prison should manage these groups under separate regimes to keep them apart. If the Prison Director believes there to be exceptional circumstances that justify the mixing of prisoner categories, an application for an exemption must be made to the National Commissioner under 186(3) of the Corrections Regulations 2005.
199. Unclassified prisoners, including remand prisoners, are managed as high security. The exception is when the Remand Management Tool (RMT) is used, which assesses a remand prisoner's risk as high or low. Those assessed as RMT Level 1 are deemed high security, whereas those assessed as RMT Level 2 are deemed low security and likely to not receive a high security classification once sentenced.

### **Placement at Waikeria Prison**

200. Waikeria Prison had a process to determine a prisoner's placement on arrival. A number of factors were considered when making placement decisions, including an individual's classification, remand status, length of sentence and eligibility for programmes and interventions. In the Top Jail, the Shared Accommodation Cell Risk Assessment (SACRA) was used when prisoners were placed in a double cell.
201. Waikeria Prison management confirmed that in the last quarter of 2020 all new arrivals were received into West South Wing to be assessed, inducted and processed before being placed into a unit.
202. New arrivals on remand were assessed using the RMT and those who were RMT Level 2 were placed in either Miro or Totara low security units. Those assessed as RMT Level 1 were placed in the Remand Unit. Remand prisoners on voluntary segregation were also housed in the Remand Unit and put into a separate yard. Waikeria Prison provided a copy of the most recent exemption, granted from 30 September 2020, that allowed remand accused and remand convicted prisoners who had been assessed using the RMT to be mixed in low security units only. The exemption was valid for one year and had to be reviewed yearly. It is positive to note that Waikeria utilised this tool and placed RMT Level 2 prisoners in low security units.
203. The exemption did not extend to the Top Jail. This Inquiry found, upon collating and reviewing data, that remand accused and remand convicted prisoners were doubled-bunked in the Top Jail. We also found examples of remand accused and sentenced prisoners mixing in the yards.
204. During the COVID-19 pandemic, prison directors were given an exemption to mix remand accused prisoners with other prisoners. This exemption allowed prisons to have specific bubbles within isolation units for the 14 day periods required, rather than needing to separate each category into its own bubble. To use the exemption, the Prison Director needed to demonstrate that COVID-19 was having an impact on the prison's operations. This exemption was not used at Waikeria Prison.
205. Despite this, it appeared that Waikeria Prison mixed high security prisoners when there was no legitimate COVID-19 rationale.
206. This Inquiry's review of segregated prisoners within the Top Jail on 29 December 2020 showed that voluntary segregated prisoners were held across a number of Top Jail units.

- 207. Sentenced prisoners were placed in units based on their security classification. High security sentenced prisoners were placed in West North Wing. Prisoners of all other security classifications were placed in the low security units where there were more opportunities for employment and programmes.
- 208. There were exceptions for placements in certain circumstances. For example, a minimum security prisoner was placed in the Top Jail the day prior to the riot,<sup>48</sup> which was appropriate in the circumstances. All categories of prisoners could be housed in the ISU.
- 209. The Top Jail’s Management Unit (East North Wing) held prisoners on directed segregation, those on directed protective segregation (i.e. who were at risk from other prisoners), and the Mongols MC members.
- 210. New arrivals with an at-risk status, as well as those assessed at other times as at-risk, were placed in the ISU.
- 211. It appears that prisoners were often moved to different cells or units, resulting in little stability in cell placement. The rationale behind this is unclear.
- 212. We heard that staff took an active role in trying to ensure that yard placement was appropriate. Staff tried to balance predominant gangs in yards. Prisoners who were not gang affiliated could use neutral yards. For vulnerable prisoners, who did not want to mix with others, there were four smaller yards in the Top Jail that could accommodate up to 10 prisoners each.

### The management of gang members

#### Corrections’ Gang Strategy

- 213. At the time of its creation, Corrections’ Gang Strategy (2017-2021) noted that approximately one third of the New Zealand prison population were gang members. It recognised the challenges associated with gangs in the prison context:

*“Gang affiliated people cause a disproportionate number of problems in the prison setting, including violence, intimidation, extortion and fraud.”*

- 214. Corrections’ vision in prisons is:

*“For all prisons to be safe environments that promote the safety of staff and aid the rehabilitation and reintegration of offenders - free from gang intimidation, violence, and the manipulation of people and controls that aid illicit activities and antisocial behaviour.”*

- 215. To achieve this vision, the Gang Strategy’s focus (in 2020) was on:

- » **Containment and disruption:** Containing and disrupting the negative influence of gang affiliated people within the custodial environment, and the efforts and capabilities of gang members under its management to organise and commit crime from within prisons and in the community.
- » **Rehabilitation and reintegration:** Reduce the reoffending rates of gang affiliated people through meaningful rehabilitation, reintegration and engagement.
- » **Harm reduction:** reduce the harm caused by gangs in prisons and the community.

#### Waikeria Prison’s Gang Management Plan

- 216. S 6(c) [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

48. Due to his behaviour towards a staff member in the low security facility.

217. S 6(c) [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
218. S 6(c) [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
219. S 6(c) [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]
220. S 9(2)(c) [REDACTED]
- [REDACTED]

#### Steps taken to implement the strategy

221. S 6(c) [REDACTED]
- [REDACTED]
222. S 6(c) [REDACTED]
- [REDACTED]
223. S 6(c) [REDACTED]
- [REDACTED]

#### Mongols Motorcycle Club members

224. The Mongols Motorcycle Club was established in California in 1969. Mongols MC New Zealand was established in mid-2019 by ex-Bandidos MC members in Tauranga. The majority of the founding members were deportees from Australia (including two who were involved in the riot).

225. The gang operates with a high level of sophistication, has a history of violence and has well-established international connections. The gang has access to large amounts of money which, in a custody context, builds support from other gangs.

#### At Waikeria Prison

226. Corrections gathered intelligence information about the Mongols MC, some of which was provided to the management team at Waikeria Prison.

227. S 6(c)

228. While there were no Mongols MC members in yard 116 initially, as the riot progressed they became the largest and most influential group. For that reason, the way in which they were managed and placed in the Top Jail is relevant to assessing contributing factors to the riot.

229. Nine Mongols MC members were in the East North Wing in the Top Jail on 29 December 2020, including the club's Vice-President, Sergeant at Arms, patched members and prospects. Four shared double-bunked cells with other Mongols MC members. Two of the prisoners involved in the riot were classified as members of different gangs at that time and have since been re-classified as prospects for the Mongols MC.

230. Four of the Mongols MC members had been deported from Australia, and two had been subject to a Returning Offender Order. One other prisoner involved in the riot (not a Mongols MC member) had also been deported from Australia and had been subject to a Returning Offender Order.

231. This Inquiry heard from Waikeria Prison's management team that although the Mongols MC members were discussed monthly at the Transnational Organised Crime Governance Group meeting, little action or support relating to their management, extra intelligence resourcing, staff resourcing, or specialist training was provided. We found little to no information or evidence that highlights how staff in the Top Jail were supported or trained to work in this environment with this group of men.

232. The known Mongols MC members were initially housed in the Top Jail's West Unit (where all new arrivals were housed). Based on information from intelligence reports and Police that the Mongols MC members were dangerous and at odds with other gangs, it was decided that the Mongols MC members would be kept together in one unit and one yard and managed as a collective. We were told that this decision was made on the advice and oversight of the Persons of Extreme Risk Directorate. We were informed this was to ensure the safety of staff, the Mongols MC members and other prisoners, and to stop the Mongols MC from recruiting other members.

233. Some staff believed Corrections was housing the Mongols MC members together to enable intelligence gathering, but this Inquiry has not seen any evidence supporting this. We heard in interviews that not all staff were told why the Mongols MC members were managed as they were (which possibly led to staff speculation). The decision to house the Mongols MC members together presented significant challenges to staff who had received no additional training in this regard, and also contributed to overall tensions in the unit.

234. On 26 May 2020, two Mongols MC members had an alert in IOMS stating that any movements within the prison or transfers were to be approved by the Persons of Extreme Risk Directorate.

235. The Mongols MC members were placed in the same yard regardless of their remand or sentenced status. We also note that staff said that placing members of the same gangs together, rather than spreading them around, was dangerous.

236. During the two months Mongols MC members were housed in the West Unit, it was noticed that they were having an influence on staff and a negative impact on other prisoners in the unit. It was also noted that the Mongols MC members had the ability to orchestrate incidents such as threatening to get prisoners in the yard to 'prop' (concerted indiscipline). Intelligence reports and a lack of IOMS case noting and incident reporting raised concerns for the management team. S 9(2)(c)

237. To mitigate these risks, the Mongols MC members were moved to the Management Unit (East North Wing) on 24 September 2020. The rationale was that the Management Unit had a higher staff-to-prisoner ratio, the staff in the Management Unit were more experienced and less likely to be manipulated or intimidated by the Mongols MC members. Around this time, following difficulties managing the group as a whole, the Mongols MC members were separated into two yards according to their status (remand or sentenced).
238. We were informed that a decision was made to house the Mongols MC and Comanchero MC members separately.
239. It was also decided that the Mongols MC members were not to access the prison gym for security reasons and to ensure staff safety (as only two staff were present in the gym at a time). Instead, gym equipment was provided to the Mongols MC members in the yards.
240. Between June and October 2020, there were a number of incidents involving Mongols MC members. These included threatening behaviour, disobeying orders and possession of unauthorised items. We also heard there were constant threats being made to staff by the Mongols MC members, especially by the President (before he was transferred to Auckland Prison). From what is known about staff fears, many incidents may not have been recorded in file notes or incident reports. In contrast to this, a Residential Manager told us that when Mongols MC members were in the West Unit they were polite and respectful, and there were no issues. The staff member described having a “*decent working relationship*” with the Mongols MC President. However, the Residential Manager noted that this changed dramatically when the Mongols MC members were moved to East North Wing and the Mongols MC President was transferred to Auckland Prison.
241. On 9 October 2020, the Mongols MC President was transferred to Auckland Prison to be managed under the Persons of Extreme Risk Directorate. Before his departure, he allegedly told the Receiving Office that the other Mongols MC members would “*play up*” once they knew he was gone. Indeed, two Mongols MC members assaulted staff the same day. On 18 October, two corrections officers told the management team that Mongols MC members had been “*bragging*” about staff assaults and indicating they would assault staff and encourage others to do so at any opportunity they got. An incident report noted that Mongols MC members were in contact with the Mongols MC President via family members and they would do what they could to get to Auckland Prison. Shanks<sup>49</sup> were also found in a yard.
242. On 19 October 2020, the Prison Director directed that all Mongols MC members be placed on behavioural management plans. The assaults on staff on 9 October were considered evidence that the group acted on orders and as a collective. We were informed that the Persons of Extreme Risk Directorate was aware of the management plans.
243. In summary, the management plans applied to all Mongols MC members and associates and required that:
- » Each prisoner was unlocked with a minimum of four officers at the cell door (or five if there was an identified need). This was later reduced to a minimum of three officers.
  - » Each prisoner was escorted down the stairs with four officers, where they were then handed over to another group of four officers who would walk them to the allocated yard. This was later reduced to two officers.
  - » When movements occurred, each prisoner was to be rubbed down, searched, handcuffed and placed in a yard with other Mongols MC members.
244. The unit PCO could approve AVL sessions for deported prisoners who had family living in Australia (this was “*behavioural dependant*”).
245. Each management plan recorded that the reason for placement was due to the prisoner’s gang affiliation and the need for more controlled management. Each prisoner had an individual management plan, with very little that was specific to that individual.
246. A review of each prisoner, including misconducts, incidents and file notes, identified a wide range of behaviours. Many of the Mongols MC members on a management plan had multiple misconducts, incidents and negative file notes. However, one prisoner had no recorded misconducts, one incident<sup>50</sup> and no negative file notes, but his management plan stated he was known for aggressive behaviour and a poor attitude to complying with staff instructions and prison rules. He was managed in the same manner as the other prisoners.

49. An improvised weapon like a knife.

50. When all the Mongol MC members refused to leave a yard.



247. This Inquiry heard that the Mongols MC members were a threat as a group rather than as individuals. This was shown by incidents of ‘propping’ and gang members following instructions from the gang President. Gang members acted as a collective and therefore were managed as a collective.
248. We heard from a prisoner on this management plan:
- “I personally felt a little bit demeaned and a little belittled because we were getting handcuffed everywhere we went. So, from our room to the yard, if we had to go to medical, or if we had to go to visits, you know, we were getting handcuffed everywhere.”*
249. We heard that some senior staff, including the management team, felt that Waikeria Prison did not have the resources to adequately manage the Mongols MC members given the heightened risk they posed. A senior staff member told us:
- “Those men, specifically the members of the Mongol Motorcycle Club, they should have been moved offsite long before this event took place. [At the transnational crime meetings] I think [managers] made a point of letting people know exactly the impact they were having on this environment, and we didn’t have the resources to manage them effectively, and in managing them drained our staff; and their behaviour I think it’s well documented, and certainly warranted them being moved.”*
250. Staff had no additional training for managing the Mongols MC members. A staff member commented there was not necessarily a need for additional training as the Mongols MC members were simply dealt with as high security prisoners. A PCO told us:
- “They were deemed high security prisoners. We’re high security staff members and whether it’s two people to unlock the door or four of you, we know what to do in those situations.”*
251. Prison staff found the constant threats and intimidation from the Mongols MC members to be draining. As a result, the managers worked to provide respite days where staff would be allocated to escorts or something different to give them a break from the unit.

### The Transnational Organised Crime Governance Group

252. The Transnational Organised Crime Governance Group was set up in 2019, in response to the emergence of the Comanchero MC in New Zealand. Its scope grew to respond to the presence of the Mongols MC in New Zealand. Members of the Group include the Commissioner Persons of Extreme Risk Directorate, the Chief Custodial Officer, Intelligence and site representatives, and Police.
253. Meetings were held approximately every month. Meeting minutes, from prior to the riot, which were reviewed by the Inquiry team revealed growing concerns with Mongols MC member placements and management within the prison.

### Safer Custody Panel

254. Safer Custody Panels were established at all prisons in October 2016, at the direction of the Reducing Violence in Prisons Working Group. Their purpose is to:
- » Contribute to the outcomes of the Staff Safety Plan.
  - » Reduce the number of incidents of violence and bullying within prisons, against both staff and prisoners.
  - » Contribute to prison order through a reduction in incidents and misconduct.
255. Panels are comprised of a multidisciplinary team and are to meet regularly, at least every month.
256. Waikeria Prison management confirmed that Panel meetings took place four times in 2020 (in March, July, November and December). This was reportedly due to COVID-19.

257. Of the Panel meetings that did take place, the following records (from the minutes) are of note:
258. In March 2020:<sup>51</sup>
- » It was observed that new gangs, such as the Mongols MC, were emerging in New Zealand and, due to them setting up in Tauranga, it was likely that members would soon arrive at Waikeria Prison.
259. In July 2020:
- » Members of the Mongols MC were present in Waikeria Prison.
  - » The site had been chosen to accommodate members of the Comanchero MC and Mongols MC. They were assessed as bringing a different dynamic – they had access to money, would target staff to manipulate them, and were accessing information about staff. It was noted that only two Mongols MC members would talk to staff. The minutes stated that staff should keep file notes, not interact with members of the Mongols MC alone, and activate their on-body cameras when interacting with them.
  - » There was a focus on intelligence on the Comanchero MC and Mongols MC. It was noted there was talk on telephone calls about a run-in with staff. The prison was interested in any requests for moving.
  - » There was ongoing conflict between the Mongols MC members and the Greasy Dogs gang. It was noted that the Mongols MC members had links to other prominent gangs in the Bay of Plenty.
  - » Notwithstanding the above, no Mongols MC members were listed as people of interest, although one prisoner involved in the riot (a Comanchero MC member) was so listed. Since May 2020, two other prisoners involved in the riot (both Mongols MC members) had an IOMS alert stating that any movements within the prison or transfers were to be approved by the Persons of Extreme Risk Directorate.
  - » Finally, it was noted there was an increase in use of force during this period, as well as an increase in the number of assaults.
260. In November 2020:
- » There was an increase in incidents, staff abuse, threats and a number of staff assaults in the Top Jail.
  - » Mongols MC members made complaints about their property. Ten Mongols MC members were noted to be generally non-compliant, actively recruiting, and making lots of complaints.
  - » It was noted that Waikeria Prison, with its limited resources, was struggling to manage the Comanchero MC and Mongols MC members.
  - » There were still no members of the Mongols MC listed as people of interest.
261. In December 2020:
- » Threats against and intimidation of staff were noted. A recent Code Red incident was discussed.
  - » Ongoing crime checks were being completed regarding the Mongols MC members, due to a visitor recently smuggling in contraband.
  - » No members of the Mongols MC were listed as people of interest, but two other prisoners involved in the riot were.

## Access to interventions

### Rehabilitation

262. This Inquiry found that prisoners in the Top Jail had limited access to programmes and other interventions. They were subject to restrictive yard-to-cell regimes which we found to contribute to incidences of disorder and overall tensions in the Top Jail. A senior staff member told us:

*“We had three programmes rooms that logistically to get the guys there from the yard, it was just a nightmare from start to finish. You would spend longer moving them than those guys would spend in a classroom, because of the set up and the layout of it.”*

51. There was no commentary around the PTAT even though it was noted there were multiple incidents of fighting, staff assaults and incidents in the yards.

263. Eligibility for rehabilitative programmes depends on a number of factors, including security classification, RoC\*RoI, type of offending, and sentence length. We note, rehabilitation programmes were not available to remand prisoners.
264. In previous years, a number of programmes were delivered in the Top Jail. This included four Alcohol and Other Drug Brief Intervention programmes<sup>52</sup> between July 2017 and April 2018 delivered to 34 participants (including remand prisoners); four Short Motivational Programmes in 2017, two in 2018 and one in 2019; and in 2018 a Short Rehabilitation Programme was delivered for four participants.
265. During 2020, one rehabilitative programme was run in the Top Jail (the Short Violence Prevention Programme). Seven prisoners from the Top Jail and low security facility took part. The Mauri Tū Pai Maintenance programme was also facilitated.
266. In contrast, a number of programmes were run in the low security facility, including the Medium Intensity Rehabilitation Programme, the Short Rehabilitation Programme, Te Tirohanga, maintenance programmes, the Special Treatment Unit Rehabilitation Programme and the Adult Sex Offender Treatment Programme.
267. This Inquiry heard from various members of the rehabilitation team who told us there was a desire to run a Short Rehabilitative Programme in the Top Jail, but there were insufficient numbers of eligible and suitable prisoners to participate. We also heard the following reasons why such programmes were not run in the Top Jail:
- » The environment in the Top Jail meant facilitators often had safety concerns and felt uncomfortable delivering programmes
  - » Facilitators were not able to deliver programmes in a way that was free from distractions from other prisoners walking past, banging on the doors and shouting outside
  - » The layout of the Top Jail (and the lack of rooms that could be used for programmes), and the high numbers of remand prisoners
  - » The culture of non-compliance among prisoners in some units, meaning they did not want to participate in rehabilitative programmes.
268. We heard from several prisoners that the lack of access to programmes meant they were bored and unstimulated. A prisoner told us:
- “The thing that used to bother me was the time was not being used constructively ... I feel like there should be more education ... [otherwise] because when you get put into the yard you become very destructive to yourself, and a lot of the guys are not educated that they don’t realise that they’re in that mindset.”*
269. Another told us:
- “All programmes are down on the [low security facility]. You get nothing up top ... the same routine every day.”*

### Industry, training and work

270. A range of industry training and work opportunities were available at Waikeria Prison, which prisoners could use to gain qualifications.
271. Opportunities for low security prisoners included work on the farm, on the external grounds, horticulture, painting, engineering, in canteen and distribution, as a barista, and in the catering kitchen. Opportunities available to prisoners in the Top Jail included working in the main kitchen, bakery, laundry and painting.
272. Around 32 prisoners in Top Jail worked in the industries that were available in the Top Jail. About 14 prisoners had daily jobs in East and West Units as cleaners, kit locker workers and a barber. Other jobs were found for prisoners on an ad hoc basis for tasks such as window cleaning or putting writing paper in envelopes.
273. Staff told us management had directed them to find work for as many prisoners as possible, especially those who were vulnerable or had no financial support.

52. This is no longer part of the suite of interventions offered by the Department, since June 2018.

274. None of the prisoners on the roof during the riot had a job. As such, they received the \$2.70 weekly unemployment incentive allowance. Prisoners with jobs could earn up to 60c an hour. The allowance can be used to buy canteen items. Two of the prisoners in the yard (who did not go onto the roof) had jobs (as a wing cleaner and a painter).

### Learning and education

275. Three programmes were run in both the Top Jail and low security facility in 2020, namely Skills for Life (Power of Positive Change), Skills for Life (Smart Choices), and Skills for Life (Te Taumata). Generally, a wider range of programmes were available to low security prisoners, including Tikanga, Parenting Support Services and further Skills for Life programmes.
276. Waikeria Prison's Learning and Interventions Delivery Manager told us there were a number of challenges to delivery in the Top Jail. Access to classrooms was difficult and, when available, there were problems with timing due to the reliance on custodial staff for movements.
277. A number of volunteer activities were run in the Top Jail and low security facility in 2020, including one to one literacy and numeracy, pre-employment workshops, church services and canine therapy visits. Generally, a wider range of activities were available in the low security facility, including cooking, meditation, yoga, Bible studies and a motivational programme.
278. Education Tutors completed education assessments and learning pathway reports for all new arrivals at Waikeria Prison, including those in the Top Jail. The learning pathway reports outline the individual's goals and recommend future interventions based on their learning needs and previous achievements. This included intensive literacy and numeracy, industry training opportunities, secure online learning<sup>53</sup> and self-directed learning.<sup>54</sup> The data provided shows that 715 education assessments and learning pathway reports were completed at Waikeria Prison in 2020. However, the site was unable to provide us with information about how many of these were completed in the Top Jail.

### Psychological support

279. In 2020, psychological assessments, screenings and treatment were carried out in the Top Jail. These were primarily provided to prisoners who were deemed high risk (i.e. with RoC\*RoI scores of 0.7 and above), or who did not meet the criteria for a medium intensity programme. A psychologist would then determine the appropriate rehabilitative pathway for the individual. In 2020, 28 psychological activities were completed, including the delivery of the Short Violence Prevention Programme.
280. This compares with 18 psychological activities in 2017, 35 in 2018 and 46 in 2019.
281. We heard that the ability to provide psychological services in the Top Jail was impacted by the frequency that prisoners were moved between units, prisons, or were released from prison.

### Access to legal advisors

282. This Inquiry was advised that prisoners from the Top Jail had frequent and consistent access to legal services. A legal advisor is permitted to enter the prison at any time agreed to by the Prison Director. Lawyers and prisoners were able to communicate by telephone, AVL and face to face meetings.
283. Prisoners were able to request contact with their lawyer by notifying unit staff each morning. Lawyers' calls were conducted once the yards had been run in. Two staff were required to facilitate lawyers' telephone calls, which were conducted in an office with a telephone that was not recorded. A staff member would telephone the lawyer and when the call was answered the lawyer would be asked to hold the line, and then the prisoner would be unlocked to take the call. This saved taking the prisoner from his cell for the telephone call if the lawyer was not available.
284. The calls were documented in a book stored in each unit's guard room, which have been destroyed by the fire.
285. Prisoners could also have their lawyer added to their telephone list as an approved number. This would allow a prisoner to call their lawyer from a payphone at no cost to the prisoner. Payphones were located in the yards, wings and in a holding cell.

53. Suites that contain computers with access only to certain educational websites.

54. Self-directed learning is provided by external providers such as Open Polytechnic, Te Kura and universities.



## Complaints Process

286. This Inquiry found issues with the complaints process at Waikeria Prison, including access to making a complaint. We are also aware of a broader issue regarding the willingness of prisoners to utilise the complaints system.<sup>55</sup>
287. The prisoner complaints process is set out in the Prison Operations Manual. Complaints should be dealt with at the lowest level if possible, usually by staff in the unit or site. The prisoner completes a PC.01 form and hands it to a staff member to enter into IOMS and the PCO is notified. The prisoner must be provided with a receipt for the complaint within 24 hours. The PCO decides who is best placed to take the action to resolve the complaint and interview the prisoner. If the complaint cannot be resolved at the unit level it must be referred to the next appropriate level within three days of being registered in IOMS.
288. If the prisoner is not satisfied with the outcome of their PC.01 complaint, they can escalate their complaint to the Office of the Inspectorate or the Office of the Ombudsman. These agencies will usually expect the complaint has been managed through the prisoner complaint process first, unless it is a case of urgency or safety.
289. Prisoners can make a complaint directly to external agencies, such as the Office of the Ombudsman, the Health and Disability Commissioner, the Privacy Commissioner and the Human Rights Commission.
290. Whānau and other prisoner representatives can also make complaints. Waikeria Prison had a nominated manager to receive all complaints or contacts from whānau members.

### Issues with the complaints process

291. We heard about the normalisation by prisoners of the poor conditions and ineffectual complaints process.
292. Many prisoners we spoke to had knowledge of the PC.01 complaint process. A few said there was a general mistrust among the prisoners about the complaints process which made them reluctant to make complaints.
293. We heard from prisoners that:
- » the complaints process did not work and was a waste of time
  - » PC.01 forms were hard to access and understand
  - » staff sometimes tried to convince prisoners not to make complaints
  - » prisoners would not receive receipts when they made a complaint
  - » complaints forms would be thrown away or go missing
  - » the complaints process was not visibly displayed or openly discussed
  - » the contact numbers for the Office of the Inspectorate and Office of the Ombudsman were not advertised.
294. Other reasons prisoners cited for not wanting to make a complaint included the fear they would be viewed as a 'nark', and the risk of losing their job or being transferred to another unit or another prison away from their whānau.
295. This Inquiry acknowledges that a low number of complaints does not necessarily correlate to an absence of prisoner dissatisfaction.

### PC.01 process

296. At Waikeria Prison there was an increase in complaints from 2019 (587) to 2020 (674). Similarly, there was an increase in complaints from 2019 (309) to 2020 (372) from prisoners in the Top Jail. There were increases in complaints from prisoners in the East Unit (156 in 2019, 208 in 2020), the ISU (2 in 2019, 28 in 2020) and Top Jail Separates Unit (3 in 2019, 10 in 2020), and decreases in complaints from the West North Wing (86 in 2019, 75 in 2020) and West South Wing (62 in 2019, 51 in 2020).
297. The top three complaint categories across both 2019 and 2020 were: Health services, prisoner property, and staff conduct and attitude.

55. Note, an independent external reviewer, overseen by the Chief Inspector, conducted a review of the complaints process in 2021.



298. Two thirds of the complaints were registered in IOMS within the required timeframes, and one third were not.
299. Five of the prisoners involved in the riot made eight PC.01 complaints in 2020. A further eight complaints were made by the two prisoners who surrendered on the first day (Mr L and Mr V). Of these 16 complaints, seven were made in December 2020 and 12 were made when the prisoners were in the Top Jail. The complaints covered a range of issues, including communication (i.e. access to a telephone), food services, visitors, prisoner management, prisoner welfare, staff conduct and attitude, and the complaints process itself.

### Complaints to the Office of the Inspectorate

300. The Office of the Inspectorate received 324 complaints from 124 prisoners at Waikeria Prison in 2020. The most common complaint categories were prisoner property, the complaints process, prisoner health, prisoner welfare and prisoner telephone. Other complaints included staff conduct and attitude, prison conditions (including access to haircuts and being denied yard time) and food services. None of the prisoners involved in the riot made a complaint to the Office of the Inspectorate in 2020.

### Complaints to the Office of the Ombudsman

301. The Office of the Ombudsman received 25 complaints from prisoners at Waikeria Prison from 29 December 2019 to 29 December 2020. Twenty-two complaints were closed with no investigation. Of these, 13 were referred back to the Department's complaints process, eight were closed with 'explanation or advice provided', and one complaint was withdrawn.
302. Two complaints were closed 'resolved without investigation', with the closure code noting remedial action had been taken to benefit the complainant. One investigation was undertaken, and this complaint was 'resolved during investigation', with the closure code noting remedial action had been taken to benefit the complainant.
303. The most common complaint related to the prisoner complaints process (11). This included where no response had been received, no acknowledgement of the complaint, and being unhappy with the outcome of the complaint. Other common complaint categories related to property (6), staff conduct and attitude (4), health services (4) and prison conditions (3).

### Correspondence received by Corrections' Ministerial Services

304. Corrections' Ministerial Services team manages all correspondence received via Corrections' email address<sup>56</sup> and all correspondence to the Minister of Corrections that is referred to Corrections.
305. Ministerial Services received 58 pieces of correspondence relating to Waikeria Prison in 2020. Four of these related to complaints made by family and whānau members about a prisoner's management in the Top Jail. Two of these were from whānau of two of the men on the roof during the riot. One was from a member of the public raising concerns about the treatment of a prisoner in the Top Jail.
306. There were 13 contacts made by prisoners at Waikeria Prison, with two prisoners (one from the Top Jail) raising complaints about their management. The others covered a range of complaints or concerns, including assistance with lost property, transfer requests and programme placements.

### Allegations against staff (IR.07s)

307. The IR.07 process applies in the event of an allegation being made against any staff member of a prison. The purpose of this process is to ensure:
- » all allegations are appropriately addressed, in a fair, timely, and effective manner
  - » the stress on both staff and prisoners is minimised
  - » information and documentation is stored in a secure system (the allegations against staff database) with limited access for staff, and prisoner confidentiality.
308. When an allegation against staff is made, the Prison Director assigns a manager to investigate. Depending on the nature of the complaint, a manager from another prison or the Regional Commissioner may be asked to conduct the investigation. If the allegation is criminal in nature, the incident is referred to Police. The Chief Inspector monitors prisons' investigations of allegations of physical or sexual assault, and any other serious allegation.

56. [info@corrections.govt.nz](mailto:info@corrections.govt.nz)

309. Waikeria Prison recorded three IR.07s in 2020. All related to assaults (two were deemed serious, one non-serious). Of the three, one remained open in March 2022. The open complaint was made by a prisoner involved in the riot who was allegedly assaulted in July 2020 and hospitalised as a result. This matter has been referred to Police and the Corrections' Integrity Assurance Team. The other two IR.07s were not upheld and have been closed.
310. This Inquiry was told of one other matter of relevance which was referred to the Integrity Assurance Team in 2020 as it involved one of the prisoners on the roof who surrendered the first night. The matter was not upheld.
311. The number of IR.07s recorded at Waikeria Prison is low compared to other sites across the prison network. By way of comparison, Rimutaka Prison recorded 15 IR.07s in 2020 and Christchurch Men's Prison recorded 40. The reason for Waikeria's relatively low number of IR.07s recorded is not known. This may be due to not all allegations against staff being entered into the database (or older allegations not being entered into a new Corrections' database in 2020) or that prisoners were reluctant to complain. It is also possible there were, in fact, only three allegations about staff during this time period. A Waikeria Prison manager advised this Inquiry that all allegations against staff were entered into the database.
312. There appear to be discrepancies between the IR.07 data and the PC.01 complaints data. In the 12 months prior to the riot, there were 84 PC.01 complaints about staff conduct and attitude, 19 of which involved allegations against staff. Given the nature of these allegations, we would have expected them to be formalised through the IR.07 process. It is not clear why they were not.
313. Further, the Office of the Inspectorate received eight complaints about staff conduct, six of which were referred back to the prison to initiate the IR.07 process. However, this did not happen.

## Custodial Operations

### Incident reporting

314. Incident reports and file notes form the 'paper trail' of prisoners' behaviour during their time in prison. They are legal documents that are used in a variety of ways, such as:
- » in misconducts hearings and as evidence in Court
  - » to keep the Minister and the Chief Executive informed
  - » to provide Inspectors of Corrections and security monitors with reports that assist the follow-up of incidents within prisons
  - » to provide statistical data that indicates where remedial action should be directed.
315. Staff involved in an incident are required to submit a report on their actions and what they witnessed. Severe incidents require an incident report to be submitted within two hours of Corrections' incident line being notified. Moderate incidents require a report to be submitted before the end of the staff member's shift.
316. This Inquiry identified that in some incidents staff did not submit reports as required.
317. There are four types of prison disorder events:<sup>57</sup>
- » **Riot** – *"concerted, organised disorder event requiring external agency involvement"*
  - » **Prop** – *"group of prisoners refuse to obey a lawful order"*
  - » **Hostage** – *"prisoner takes a person against their will and makes threats on their welfare in exchange for some benefit"*
  - » **Fire or arson** – *"prisoner(s) light fires"*.
318. Riot, prop and hostage are categorised as severe events

### Incidents in the Top Jail in 2020 generally

319. Between 29 December 2019 and 29 December 2020, there were 2,121 incident reports recorded at Waikeria Prison. Of these, 1,004 related to the Top Jail. The occurrence of incidents in the Top Jail appeared to be relatively stable in 2020.

57. Prison Operations Manual: IR.06.Sch.01 Incident Categories (with notifiable flag).

320. The units with the highest number of incidents were in the Top Jail – the East Unit (522), West North Wing (236) and West South Wing (173).
321. The most common primary incident in the Top Jail was recorded as ‘prisoner behaviour’ (625),<sup>58</sup> followed by ‘prisoner management’ (265).<sup>59</sup> In more detail, the most common incidents were: having contraband or unauthorised items (182), threatening staff (137) and fighting (114). Other incidents of note include destroying prison property (77), disobeying a lawful order (66), propping (17), covering cameras (8) and setting fires (3). Nineteen incidents related to prisoners in the Top Jail lighting fires or possessing unauthorised items relating to fires (such as lighters or wicks). These incidents appeared to have increased during 2020.
322. Of the above incidents, prisoners setting fires is characterised as a moderate incident, as is having contraband (depending on the items). Moderate incidents require immediate notification to the Incident Line between 8am and 5pm. If the incident occurs outside those hours, notification is required at 8am the following day. An IOMS incident report must be completed before the end of the staff member’s shift.

#### Incidents in the yards

323. Between 29 December 2019 and 29 December 2020, there were 204 incidents in the Top Jail yards, and 37 incidents in yard 116.
324. The most common incident in the yards generally was prisoners fighting. Other incidents included prisoners propping (refusing to leave the yard), covering the cameras, having unauthorised items, smoking cannabis, attempting to climb the yard walls and lighting fires.
325. Incidents of note in yard 116 were incidents relating to propping and smoking cannabis.

#### Incidents in the seven days leading up to the riot

326. From 21-28 December 2020, 20 incidents were recorded in the Top Jail. These include:
- » 12 incidents of abuse, threats of violence or violence towards staff
  - » Two incidents of prisoners fighting
  - » One incident of a prisoner attempting to bribe a corrections officer.
327. Of the 12 incidents involving abuse, threats of violence or violence towards staff, four involved three prisoners who were involved in the riot.

#### Incidents involving those involved in the riot

328. In 2020, there were 113 incidents relating to the prisoners involved in the riot while at Waikeria Prison.
329. There was an increase in the number of incidents over 2020. From January to September 2020, there were 10 or fewer incidents each month. From October to December 2020, the number of incidents increased each month (up to 19 in December).
330. The incidents involved a range of behaviour including fighting, assaulting and threatening staff, smoking cannabis, refusing to lock,<sup>60</sup> disobeying lawful orders, destroying prison property, having a cellphone, lighting fires and receiving contraband items from visitors.
331. Incidents of note during this period are set out below. It is of concern that except for the incident on 9 October 2020, the PTAT level remained at green.
332. On 13 August 2020, 11 Mongols MC members refused to leave the yard until they could speak to a PCO about their concerns with property and mail (in particular, why theirs was taking longer than other prisoners), and why they were being treated differently to other prisoners. They covered yard cameras and covered their faces with towels. They stated they were ready for the corrections officers and prepared for pepper spray. The Mongols MC President spoke to a PCO and the Top Jail Residential Manager at the yard grille. The PCO told him he would speak to him one on one in the Unit, as opposed to having a debate at the yard grille. After some consideration, the Mongols MC President told the PCO that everyone in the yard would return to their cells.

58. This includes a variety of behaviour including assaults on or threats to staff or other prisoners, obstructing cameras, disobeying lawful orders, smoking and fighting.

59. This includes using mechanical restraints on a prisoner, non-lethal weapons, use of force and segregation.

60. Refusing to lock either means prisoners refusing to return from the yard or refusing to have their cell locked.

333. On 16 September 2020, the Mongols MC President was verbally abusive to corrections officers on the way to the yard. Once at the yard, he allegedly said: *"What if we all rush the gate, what are we [staff] going to do about it?"* and made a number of verbal threats. Four other Mongols MC members were at the yard grille and appeared to be trying to push it open.
334. On 7 October 2020, the Mongols MC President and five other Mongols MC members refused to leave the yard due to perceived unfair treatment. They had covered the cameras. The Mongols MC President shouted at an SCO, and one prisoner was heard saying: *"We are not leaving the yard as we are being treated unfairly, like we are animals as we have no TVs and no chairs, so we have to eat on the floor. When is the team coming to get us, because there is going to be a big mess ... I want to kill someone"*. He turned to another Mongols MC member and said: *"Me and the bro have nothing to lose, fuck the boys in blue, someone is getting killed"*. The Mongols MC President and another Mongols MC member said they would not leave the yard and did not care if corrections officers used water hoses on them. They yelled to the other yards and told them not to go inside either.
335. On 9 October 2020, two Mongols MC members assaulted two corrections officers as they were returned to their cells. The assault appeared to have been unprovoked. The PTAT Level was raised to Amber for the Remand unit (where the incident occurred).
336. On 18 October 2020, there were discussions between two Mongols MC members about assaulting staff (and encouraging other Mongols MC members to do so) so they could be transferred to Auckland Prison where the Mongols MC President had been transferred.
337. On 19 October 2020, a prisoner asked a Corrections Officer: *"When was the last time an officer got stabbed up in this prison?"*
338. On 19 November 2020, a prisoner refused to comply with instructions and was verbally abusive. A Code Blue was called.
339. On 26 November 2020, a prisoner was found with a shank.
340. On 7 December 2020, a Mongols MC member received a package containing tobacco papers and two cellphone chargers during visits.
341. On 16 December 2020, a Mongols MC member threatened a Corrections Officer in the yard.
342. On 27 December 2020, a Mongols MC member from the Remand Unit used intimidating language towards staff. He told a Corrections Officer she needed *"permission from the Mongols"* before she could go to the top landing, due to this being *"Mongols territory"*.
343. On 27 December 2020, a prisoner from the Remand Unit made threatening comments to staff when told he was not getting a haircut. This was same prisoner seen cutting another prisoner's hair with the razor in yard 116 on the morning of the riot.
344. On 27 and 28 December 2020, another prisoner from the Remand Unit threatened staff and challenged them to a fight. In the first incident, the prisoner threw down his belongings at the grille of yard 116 and challenged staff to a fight. In the second incident, he threatened a member of staff and told him *"my boys are going to follow you home"*. This prisoner was involved in a similar incident of challenging staff to a fight in his cell on the morning of the riot. However, no incident report was made in relation to this incident that this Inquiry viewed on on-body camera footage.
345. It appears as though incidents were not always reported. For example, on 9 October 2020, there was a prop in yard 114. The Mongols MC President told the other prisoners in the yard not to leave. The yard was run in, but Mongols MC members refused to come out until they had seen Mongols MC members from yard 110 come in. There was no incident report in relation to this, but a file note was created by a Corrections Officer.
346. A PCO told this Inquiry that in the period prior to the riot he had been given a note from a prisoner that said:  
*"WAIKERIA STAFF BEWARE OF MONGOL CELL [XX] OK CHEERS!"*
347. These examples demonstrate an environment where prisoner disorder events and the corresponding escalation of risk were normalised.

## Use of force

348. There were a total of 115 reported use of force incidents at Waikeria Prison between 29 December 2019 and 29 December 2020. Of those, 73 took place in the Top Jail (excluding the ISU), 28 took place in the ISU, and 14 took place in other parts of the prison.
349. Spontaneous use of force was by far the most common category: 62 instances were reported in the Top Jail and 18 in the ISU. In the Top Jail 10 use of force incidents were reported occurring during control and restraint (pre-planned use of force), and six in the ISU. The other category of force used in the Top Jail and ISU was 'non-threatening physical contact'.
350. One particularly relevant use of force incident occurred in March 2020 when a group of prisoners refused to leave yard 116, stating that they wanted showers. Fourteen prisoners were subsequently pepper sprayed and moved back to their cells.
351. Four of the prisoners involved in the riot were involved in use of force incidents from 29 December 2019 to 29 December 2020.
352. One of these prisoners complained of being assaulted during a use of force incident, and the matter was referred to Police. Three prisoners involved in the riot were involved in nine use of force incidents in 2020 at other sites.
353. Issues relating to camera footage (either CCTV or on-body camera footage) were identified in approximately 10% of use of force reviews. This often related to footage not being saved, cameras not turned on or cameras not recording until after the use of force had taken place.

## Contraband

354. Contraband in prisons includes alcohol, communication devices, drugs, drug paraphernalia, tattoo equipment, weapons and other items. Items that are prohibited may include everyday and seemingly innocent items that while not illegal, may be used inappropriately by prisoners. Tobacco and smoking equipment (e.g. lighters) have been considered contraband from 1 July 2011, when smoking was banned in all prisons.
355. Corrections employs a range of screening methods to prevent contraband from entering prisons and intelligence staff work to identify and mitigate risk areas in the physical environment and to stay informed about new methods of concealment.
356. The volume of contraband able to be accessed by prisoners at Waikeria Prison, in particular in the Top Jail, was concerning. Note, this is an issue that is prevalent across the prison network.
357. Between 29 December 2019 and 29 December 2020, there were 469 incidents relating to contraband at Waikeria Prison. Of these, 162 incidents were at the Top Jail, most commonly involving drugs, weapons, tobacco and smoking equipment and tattoo equipment.
358. The prisoners involved in the riot were involved with 23 contraband incidents, including weapons (6 incidents), tobacco and smoking equipment (6) and drugs and drug paraphernalia (5). Of these 23 incidents, eight did not lead to misconduct charges being laid. It is of concern that incidents involving contraband did not lead to misconduct charges, as we would expect.

## Prison Tension Assessment Tool

359. The Prison Tension Assessment Tool (PTAT) was developed in 2016 and is used to record tension at each site across the prison network.
360. The PTAT is used to:
- » Record the tension at a site
  - » Assess the overall level of tension in prison units
  - » Identify trends of tension
  - » Manage the risk of violence.



361. The PTAT uses a scoring system to determine tension levels based on observations, experiences, and interactions with prisoners, including the number of incidents in a day and the number of prisoners involved in an incident. There are three tension levels – low (green), medium (amber) and high (red). An amber or red assessment generates an email to site and regional managers. The tension level can be overridden by a PCO.
362. PTAT assessments for each unit should be completed after unit lock up, but additional assessments can be completed at any time (for example, if an incident occurs or if staff feel the unit tension is high). Staff should be informed of the PTAT status during briefings, including any steps taken in relation to the previous day's PTAT results.
363. In the two weeks prior to the riot, the PTAT level in Waikeria Prison was green. Such an assessment should indicate that, prior to the riot, the prison (and the Top Jail) was not experiencing, and had not recorded, any increase in tension. It also indicates that the Top Jail was not experiencing any adverse or hostile behaviour from the prisoners.
364. However, this assessment is inconsistent with comments made by staff during the riot (captured on on-body camera) that the riot was *"inevitable. It's been a brewing pot for a long time in this [Remand] unit"*,<sup>61</sup> and with what is now known about the level of tension in the Top Jail immediately preceding the riot.
365. This information was not reflected in the PTAT outcomes, and it is unclear if staff who identified issues in the Top Jail passed this information on to their SCO or PCO.
366. This Inquiry heard concerns that the PTAT was not being utilised in the way it was intended, namely to provide corrections officers with a tool to report on things that did not 'feel' right as opposed to just highlighting a potential increase in tension solely due to incidents. While we were informed that no tool will ever be able to accurately detect all increases in tension, it is clear the PTAT was not being appropriately used.
367. During 2020, there were 33 instances where the tension level was elevated to amber or red in the Top Jail. This was generally in response to assaults on other prisoners or staff. In 16 of the 33 instances, the tension level was overridden and lowered to green.
368. The PTAT level often rose when there was dissatisfaction with the prison's conditions. For example, the PTAT level rose at various times in 2020 when canteen items were not delivered, prisoners were not receiving clothing, prisoners had a lack of access to telephones, and prisoners were not receiving haircuts and showers. There were also a number of instances of fires being lit in the yards, contraband being found in cells and drugs being smoked in yards.
369. We believe, in some cases, the decision to override the PTAT was wrong due to the nature, severity or quantity of incidents. There is also at least one example of the PTAT level not reflecting what is recorded in incident reports. For example, on 7 October 2020, an incident report recorded that members of the Mongols MC told corrections officers that they were treated unfairly, like animals, had no access to televisions and chairs and had to eat on the floor. They also spoke about killing someone. The PTAT level was green following *"prisoners propping in the yard"*. In the circumstances, the PTAT level should not have been green.
370. We spoke to several senior managers at Waikeria Prison and asked why the PTAT level in the Top Jail often remained green when there had been incidents. We were informed that the volatile nature of the Top Jail meant that incidents were common and frequent, and the baseline tension was high. Therefore, the PTAT level would not be raised as this level of tension was, in effect, 'business as usual'.
371. We note the Chief Custodial Officer, members of his team and representatives from the Corrections Association NZ and the Public Service Association visited Waikeria Prison, including the Top Jail, two weeks prior to the riot. The planned visit was part of a programme of work regarding safety and reducing violence across the prison network. We understand that no significant issues were identified.
372. In our view, prisoner disorder was normalised to the extent that the tensions in the Top Jail, and the potential for an incident of this nature, were not properly appreciated, or identified in the PTAT.

61. Conversation between corrections officers on 29 December 2020 at 3:34pm.

### Code Blues and Code Reds

373. In a Code Blue, all identified incident responders must go immediately to the incident scene.
374. In a Code Red, identified incident responders must go immediately to the incident scene. Designated managers and staff report to the Emergency Operations Centre (EOC). All others stand by for direction. Muster and security checks are carried out. The Incident Controller assesses the need to secure the prison (i.e. return all prisoners to units, lock down units and apply perimeter control).
375. This Inquiry reviewed incident reports from 29 June–29 December 2020 which involved either a Code Red or Code Blue.
376. During this period, a Code Blue was called in the Top Jail 135 times and there were two Code Reds (one of which was called on 29 December 2020 in relation to the riot, and the other was in October 2020 and related to a community incident).

### Unit induction interview

377. A unit induction interview must be completed within 72 hours of a prisoner entering the site, and includes information about their rights, obligations, privileges and access to services. Between 1 January and 29 December 2020, 88% of induction interviews were completed on time. Of the others, 1.6% were not started, 0.1% were incomplete and 4.5% were completed late.
378. The prisoners we spoke to told us the induction process was limited. Several prisoners said the induction was limited to being handed paperwork. Another prisoner told us that the induction was minimal – he filled out a form to get his telephone numbers organised and staff explained how he could see Health staff. Another prisoner told us he did not remember getting an induction, instead he learnt about the Top Jail processes through word of mouth from other prisoners.

### Event Reviews

379. Event reviews began in 2017 with the aim of reviewing systemic failings or issues within prisons or Community Corrections (as opposed to finding fault with individuals). Regions conduct event reviews for different purposes. We were told that the Central Region generally has a high threshold for when an event review is commissioned.
380. There was one event review at Waikeria Prison in 2020 related to an incident involving a lost knife in the bakery. By way of comparison, in the Central Region, there were six event reviews at SHCF and none at Tongariro Prison during this time. Notwithstanding the Central Region's high threshold, a number of incidents at Waikeria Prison did not result in event reviews being undertaken. These included three cases of concerted indiscipline (props) in the yards, one alleged serious assault on staff, three alleged sexual assaults on staff, and two alleged sexual assaults prisoner on prisoner.

### Prisoner Transfer Requests process

381. Corrections uses the Prisoner Transfer Request (PTR) tool to record all requests and decisions for inter-prison transfers, as well as escort bookings.
382. Transfers take place for a variety of reasons, including prison population pressure, court hearings, medical appointments, placement management, personal request, acceptance into a programme, placement review and release. PTRs can be declined for a variety of reasons including court hearings, changes in circumstances, security classification, category (remand, sentenced), programmes, medical appointments and prison population pressure.
383. Eighteen PTRs were made for 10 prisoners involved in the riot to move from Waikeria Prison to another prison in 2020. Two of these requests were made by the prisoners and the others were made by staff.

### Misconduct reports

384. According to the Prison Operations Manual, Corrections' misconduct procedures ensure prisoners who are subject to disciplinary action have their charges heard in accordance with legislation. If found guilty of non-compliance with the rules and regulations of the prison, prisoners are to be disciplined in a *"fair, just and humane manner"*.
385. Between 1 January and 29 December 2020, 1,480 misconduct charges were laid at Waikeria Prison. Of these, 869 were in the Top Jail and 22 were not laid within the required timeframe (including four in the Top Jail).

386. The most common types of misconduct charges in the Top Jail were:
- » having an unauthorised item (206 charges)
  - » disobeying lawful orders/failure to comply (231 charges)
  - » assaults or fights (204 charges)
  - » behaves in an offensive, threatening, abusive or intimidating manner (121 charges)
  - » deliberately damaging property (89 charges).
387. In the Top Jail, the misconduct charges were resolved in the following way:
- » in 549 cases the process was completed
  - » 221 were withdrawn
  - » 64 were cancelled
  - » 15 were dismissed
  - » in 20 cases the outcome was unknown (17 of these occurred in December 2020).
388. Also of note, December had the lowest percentage of misconduct charges with the process complete and an increase in the number of charges withdrawn.

#### **Misconduct charges regarding prisoners involved in the riot**

389. Of the 17 prisoners involved in the riot, 16 had misconduct charges in 2020. These 16 faced a total of 66 charges. An increasing number of misconduct charges were laid as 2020 progressed (namely, two misconduct charges in August, six in September, 10 in October and November, and 17 in December). The charges included disobeying lawful orders/failure to comply; fighting; having an unauthorised item; acting in an abusive, threatening, or intimidating manner; and deliberately damaging property.

#### **Shared Accommodation Cell Risk Assessments**

390. The purpose of the Shared Accommodation Cell Risk Assessment (SACRA) is to reduce the level of risk prisoners pose to each other when placed in shared cells. The key parts of SACRA are an assessment of whether or not a prisoner is suitable for cell sharing (being double-bunked), and then, who they may be compatible to share a cell with. A compatibility assessment is only completed when the staff member is satisfied that the prisoner is suitable to share a cell.
391. A Shared Accommodation Cell Risk Assessment (SACRA) must be completed before prisoners share a cell. Between 1 January and 29 December 2020, Waikeria Prison completed SACRAs on time in all cases.
392. However, when reviewing cell placements for the prisoners involved in the riot, we identified a number of prisoners were sharing a cell with a prisoner of a different category (i.e. remand accused and remand convicted), which is contrary to policy.

#### **Case Management**

393. Case managers support prisoners to take responsibility for completing activities aimed at addressing their rehabilitation and reintegration needs and ultimately to reduce the likelihood and seriousness of re-offending.
394. Waikeria Prison's performance is assessed against Corrections' standards of practice, which cover the following:
- » Initial contact with prisoners
  - » Planned contact with prisoners
  - » Undertaking risk assessments
  - » Creating an initial offender plan
  - » Report to Parole Board
  - » Release planning.

395. A case manager is required to meet with a prisoner within 20 working days of the prisoner's arrival at the site. In relation to making initial contact with prisoners on their caseload, Waikeria Prison's performance was assessed as 'good' in only one month in 2020. For five of the months of 2020 its performance was 'average' and in six of the months its performance was 'poor'. We found that remand prisoners were not engaged with in accordance with their risk, need and responsivity.<sup>62</sup> Instead, prisoners were seen for an initial contact and then usually within 30 days after they were sentenced. Accordingly, prisoners could spend significant amounts of time on remand awaiting sentence without any engagement with case management.
396. Case Management standards of practice are a quantitative, automated function for providing baseline information. These dashboards do not provide any insight into qualitative data such as the quality of work or practice being completed with prisoners. For example, if a case note is created and saved within the timeframes allowed for, the standard of practice will be met, irrespective of whether there is any content within the case note or not. Similarly, the case manager chooses their own next planned contact date and there is no check in place to ensure this is reasonable and/or based on risk need responsivity principles.
397. At the time of the riot, 34 men in the Top Jail did not have a case manager. The 17 prisoners involved in the riot had been assigned a case manager, but only five had been listed for a programme.<sup>63</sup> The prisoners had been seen by a case manager and their next planned contact was to occur within 30 days of sentencing.
398. For more detailed information about case management at Waikeria Prison, see Appendix J.

### Case Officers

399. A case officer must be assigned to a prisoner within three days of them arriving in a unit. A case officer is a corrections officer or senior corrections officer who supports rehabilitation and is the conduit between the prisoner and their case manager. Between 1 January and 29 December 2020 in the Top Jail, case officers were assigned 96% on time, 1.3% were assigned late and 2.5% were not assigned. Case officers were assigned to cell numbers rather than prisoners. This meant if a prisoner moved cells, he might be assigned a different case officer, which could limit continuity of support. Further, the cell-to-yard regime in the Top Jail would likely have limited case officers' abilities to meet prisoners on their case load.

### Deaths in custody and self-harm threat to life incidents

400. Between January 2015 and October 2021, ten prisoners died in custody at Waikeria Prison. One of the deaths occurred in the Top Jail, and the others were in the low security facility. Eight of the deaths were considered from natural causes and two were assumed suicides (one of which was in the Top Jail). The death in custody numbers for Waikeria Prison are similar to other prisons of a similar size.
401. There were 12 self-harm attempts with a threat to life recorded at Waikeria Prison between January 2015 and October 2021. Seven of these occurred in the ISU, three in the low security facility and two in the Top Jail (one in the Remand Unit and one in the Receiving Office).

### Risk register

402. The purpose of a risk register is to identify key risks and the corresponding controls and actions put in place to manage these risks. The focus is on preventing the risks from occurring and managing them if they do occur.
403. The risk of a major disturbance or riot is recorded in:<sup>64</sup>
- » The Enterprise Risk Profile, which is owned by the Chief Executive and the Executive Leadership Team.
  - » The Corrections Services Leadership Team Risk Profile, which is owned by the National Commissioner.
  - » The National Risk Register.
404. Waikeria Prison's Risk Action Plan did not include the risk of a riot or major disturbance. This Inquiry heard that it was included on previous risk registers but a decision was made in October 2019 by the Deputy Regional Commissioner that the site would concentrate on its most immediate and critical health and safety risks. The risk of riot was placed on the regional risk register.

62. The risk-need-responsivity model reflects the idea that people are not all alike, nor do they respond to interventions in the same way. But rather a combination of factors needs to be considered when analysing and developing rehabilitation plans for individuals.

63. Rehabilitation programmes are only available for sentenced prisoners.

64. It is also identified as a critical Health and Safety risk.



### Local Level Agreement between Waikeria Prison and Police

405. The Local Level Agreement between the Waikeria Prison Manager and the Waikato District Commander, dated 2012, states that in relation to a major incident, including a riot, notification will be made via the Prison Services Incident Line and NZ Police Communications Centre.
406. Regarding control of an incident, the Local Level Agreement states:
- "In the circumstances of imminent risk of death or serious bodily injury, or where it is critically necessary to resolve the incident urgently, the senior police officer on-site may be obliged to assume overall operational control of the incident."*
407. In the response to the riot, this Inquiry heard that Corrections would only have handed control to Police when there was an imminent threat to life. Control was never handed to Police.
408. Regarding training, the Local Level Agreement states:
- "It is agreed that where advantageous, Police and the Corrections Department may hold joint training sessions and are encouraged to advise each other of possible training opportunities and invite each other to participate."*

### Memorandum of Understanding between Corrections and Police

409. Corrections and Police signed a Memorandum of Understanding in 2015 (the MoU). This states that Corrections and Police will provide each other with mutual assistance, support and information in the event of critical incident events, such as a riot. Control of incidents depends on their nature and scale.
410. In the prison environment, initial command will sit with the site Incident Controller. However, there may be circumstances where command of a prison incident or specific operational elements of an incident are handed to Police Commanders (such as if there is an imminent risk of death or serious bodily injury, or where it is critically necessary to resolve the incident urgently). In those circumstances, the Regional Commissioner or Prison Director will retain control over, and responsibility for, those parts of the prison not directly and immediately affected by the incident.
411. In relation to multi-agency training, the MoU sets out that, on an annual basis, Corrections and Police will review and consider joint exercises at reasonable intervals.

### Waikeria Prison development

412. A new 600 bed facility to accommodate high security prisoners is currently under construction at Waikeria Prison. The new facility is being built as a Public Private Partnership, and construction is due for completion by 2023. It will include a 100 bed dedicated mental health and addiction facility, Te Wai o Pure. The Waikeria Mental Health and Addiction Service, now renamed Hikitia, will operate from Te Wai o Pure and also deliver services through an outreach team to prisoners in the Central Region (i.e. at SHCF and Tongariro Prison). It is estimated that around 2,000 prisoners could benefit from Hikitia services annually in the Central Region.
413. The new facility will replace several units at Waikeria Prison, including the Top Jail. It was Corrections' intention that, upon the successful operational build-up of the new facility, those units would be decommissioned and retired from use, with the Top Jail being demolished.
414. More than 50 prisoners have been employed on the project under the prison's Release to Work scheme.
415. This Inquiry was informed that the riot impacted the new build only minimally. Contractors were unable to access the site on 30 December 2020, but were back from 31 December 2020, albeit in lower numbers than prior to the Christmas shutdown period due to the holidays.



416. The new facility is intended to strengthen mental health services, and provide more rehabilitation, education and training space, and opportunities for people in prison.<sup>65</sup>

*“The new facility represents a step forward to realising our organisational strategy Hōkai Rangī. The new facility will feature more spaces for whānau interaction than seen in any of our prisons to date. Multiple visits facilities combined with greater use of technology to promote contact between prisoners and their whānau will help support their reintegration with the community.”*

417. Every unit will have AVL capability to assist in keeping prisoners connected to their whānau. There will also be more visits/family rooms in line with the humanising and healing aspect of Hōkai Rangī.
418. Hikitia will be delivered by a workforce, named Māwhitiwhiti, which will be reflective of the partnership with Māori cultural, clinical and custodial roles. Māwhitiwhiti will include staff employed by Corrections, Waikato District Health Board,<sup>66</sup> and non-government organisations.
419. Corrections is working in partnership with mana whenua (Raukawa ki Wharepūhanga and Maniapoto ki te Raki), and the Waikato DHB to design and deliver Hikitia. The foundation for Hikitia is set out in the Mana Whenua – Ahi Kā Foundation Document.<sup>67</sup>
420. Hikitia is not a replica of, or replacement for, the prison’s former Intervention and Support Unit (ISU). Prisoners referred to Hikitia will have choice in utilising this service. Hikitia will not manage people subject to the Mental Health Act who require compulsory treatment. The Waikato DHB will continue to manage people subject to the Mental Health Act at Puawai – the Midland Forensic Services unit based at Waikato Hospital.

65. Information from this section has been primarily taken from [https://www.corrections.govt.nz/news/waikeria\\_prison\\_development](https://www.corrections.govt.nz/news/waikeria_prison_development)

66. On 1 July 2022, District Health Boards were replaced by Te Whatu Ora which leads the day-to-day running of the health system across New Zealand.

67. Mana Whenua – Ahi Kā Foundation Document for the Waikeria Mental Health and Addiction Service (Department of Corrections, 2020-2021).

## 7. The response to the riot

### *The evacuation*

1. It does not appear that, at the time of the riot, Waikeria Prison had an up-to-date evacuation plan. The Top Jail (excluding the ISU) had an evacuation plan, dated 1995, which was approved by Bay Waikato Fire Region in 1998. The plan was supposed to be updated annually. An evacuation plan for the At Risk Unit (now the ISU), dated 1998, was last approved in 2001. This Inquiry has not found evidence that staff were aware of the existence of these evacuation plans.
2. The need to evacuate the prison should have been considered when it became apparent that FENZ was not able to contain the fires started by the prisoners in yard 116. However, evacuation does not appear to have been contemplated until after 4:48pm, when staff reported a fire near yard 118 which was producing enough smoke to enter the East Unit ventilation system and expressed concerns about the safety of prisoners held there.
3. Apparently unaware of the outdated existing plan, at 4:53pm the Acting Prison Director asked the On-Call Manager to prepare an evacuation plan in the event that multiple prisoners would need to be extracted from the site.
4. We heard there was a plan (of approximately one page) made for the evacuation detailing how to move prisoners from high security to low security units, to get an even spread and ensure those prisoners would not be a risk to other prisoners. Plans had to be adjusted in the moment due to increasing risk to prisoner and staff safety. For example, it was initially intended that the prisoners evacuate through the Receiving Office, but when it caught fire the prisoners had to be evacuated through the Visits area.
5. Prior to the evacuation, many prisoners confined to their cells sought reassurance from staff as sounds of the riot intensified and smoke entered the wings. There did not appear to be any clear communication or reassurance provided to prisoners in the cells throughout the day, or indeed later in the night when prisoners were being evacuated and asking where they would be taken. We heard from prisoners that their intercom calls went unanswered, and they were largely kept uninformed as the riot progressed.
6. During the hours the prisoners spent in their cells and during the evacuation, many exhibited high levels of anxiety and distress.
7. The evacuation commenced at 8:43pm. Prior to this point, there were multiple indications that the fire would force the evacuation of all or part of the Top Jail. We heard many comments from staff in the on-body camera footage over several hours that prisoners were distressed, could not breathe and needed to be evacuated, and that there was serious risk to life.
8. On-body camera footage showed that staff at the Top Jail were aware that smoke was harming prisoners in their cells. Some staff were frustrated and concerned that the order to evacuate was not made earlier. The delays also put the staff involved in the evacuation in unnecessary danger.
9. When the evacuation did occur, the situation had become critical. Fire and smoke hindered the evacuation, with the additional hazard of water on the ground from hoses and sprinklers, as did the fact that the evacuation was carried out in darkness due to the late hour.
10. Initially, the evacuation was reported to have been conducted in an orderly and controlled manner, with the ACR teams and staff bringing out individual prisoners into the Receiving Office one at a time. Directed and protective segregated men were evacuated first. However, with increased urgency, staff evacuated the other prisoners at the same time. We heard that had this not been done, prisoners would have lost their lives.
11. At one stage there were approximately 50 prisoners in the sally port after being evacuated from their cells. A fire truck needed to come through, so a decision was made to get a prisoner who was respected by other prisoners to tell them to turn around and back up to the fence. The prisoners did so, and the fire truck came through the sally port without any incident. There were other challenges and dangers involved in the evacuation, including some prisoners on the roof throwing objects at staff and prisoners as they exited the building.
12. On-body camera footage of the evacuation showed staff relied on cards placed in the cell door card slots to determine whether prisoners were inside. Cells were thought to have been cleared when there was no card in the card slot.

13. Prison staff acted courageously, some without personal protective equipment or respirators, to remove prisoners from their cells through smoke and in close proximity to the fires. Those evacuated included two prisoners found semi-conscious in their cell. One had his head down the toilet and the other was under the bed. Another prisoner was found in a cell that had filled with smoke and had flames visible through the back window.
14. However, despite the way cells were cleared, two prisoners were missed during the initial evacuation. When staff later performed a final sweep, one man was found under a bed in his cell and another was found in a cell in the Separates Unit. We heard from many staff about this, including:
- "I'm not sure how they were evacuating the wings and all that, and how they were checking that each cell was cleared ... I was told by the people who did it, that they weren't too sure. Like, they saw a cell that should have already been done because they'd moved on, and they were like, 'Have you done that cell? Has someone done that?' and they were like, 'Yeah, I'm pretty sure. But we'll double-check.' They looked and there was no-one in there. Then for whatever reason they just thought they'd have a proper look. The guy was under the bed ... Like, people do when they panic, he climbed under the bed."*
- "We've got about 20 seconds let's do a double check of as many cells as we can before this place is completely engulfed in flames. And we luckily got to a cell. Thought we heard a noise, opened it and there was a guy in there still, so we pulled him out with about a second before he was blinking burnt alive to be honest."*
15. This Inquiry is of the view that better planning and organisation of the evacuation may have mitigated the need for additional checks of the Top Jail cells and the corresponding additional risks to staff.
16. We heard from the Regional Commissioner that the focus was on preserving life and he waited until there were sufficient staff available. He considered he began the evacuation "a little bit early" prior to it being an absolute necessity:
- "My exact words were, 'Start the evacuation now while we still have some time before it becomes absolutely critical.' And so, I thought, 'we've still got a little bit of time. We haven't got a lot.' So it was as close as it could be to make sure, in my mind, that we could get everybody out safely, and not lose people. But conversely, late enough that we got enough staff resources to do it safely, and there was a balance point in the middle there, and you can't argue with the fire, it was progressing really rapidly which is why we had to get people out, and it was incredibly close."*
17. A senior staff member told us preservation of life was the priority:
- "... early on we just said, our goal is to save life. That was it. It wasn't to save the buildings, it wasn't to do anything else, it was to save life and [we] committed that that was our one focus. If we saved a building, we saved a building, if we didn't, we didn't. It was about ensuring staff and the men that were in there could get out safely."*
18. The evacuation of prisoners in the ISU was particularly concerning. These 10 men, who were all assessed as at risk, were some of the most vulnerable prisoners and they appear not to have been told anything about the riot until they were woken up at around 11pm by ACR staff in full ACR gear and physically removed from their cells. Many of these prisoners appeared disorientated on on-body camera footage viewed by the Inquiry.
19. The ISU was evacuated last because it was not on fire, however, this Inquiry is of the view that greater consideration should have been given to an earlier evacuation of the ISU given the vulnerability of the prisoners accommodated there.
20. There was a disconnect between what was known to staff on the ground and in the EOC during the evacuation. It does not appear that the EOC was aware of the scope and scale of the rapidly escalating fires and the risk to life.
21. Similarly, decisions made in the EOC and relevant updates were not being communicated effectively to staff. Staff were not able to accurately relay what was occurring to prisoners because they themselves were not adequately briefed on the situation.
22. Notwithstanding the confusion and fear felt by many of the evacuated prisoners, they were compliant and well behaved. There were no issues of note relating to the behaviour of the prisoners being evacuated. This greatly assisted the ability of staff to safely evacuate the Top Jail. Any prisoner disorder during the evacuation would have greatly increased the risk to safety.

23. Comments made by staff during the evacuation, recorded by on-body camera, included:
- » *"It should never have gone this far, it should never have escalated"*
  - » *"We've got lives at risk now"*
  - » *"Someone needs to step up and make some decisions"*
  - » *"Someone's got to be doing something"*
  - » *"We need to get these fullas out"*
  - » *"If it [the fire] goes through the ventilation system they'll be choking".*

### Transfer of prisoners

24. The relocation of the evacuated prisoners was described by some staff as chaotic.
25. The evacuated prisoners were moved via the Receiving Office and held outside the Top Jail building but within the secure perimeter, to be placed into prisoner escort vehicles. Due to the urgency of the evacuation, it was not possible to always keep the various categories of prisoners separated (remand accused and sentenced, segregated, and mainstream). However, we note that the voluntary segregated prisoners were kept separate. The prisoners were transported to the low security facility where they were held pending transfer off site. We heard from some that not all prisoners received a mattress and/or pillow. All prisoners received food and drink.
26. On 29 December 2020, the decision was made to transfer the evacuated Top Jail prisoners off site. That afternoon, the Principal Adviser Prison Population (PAPP) was asked to assist with the transfers and arranged for prisoner escort vehicles from other North Island prisons and First Security to be sent to Waikeria Prison.
27. The PAPP was initially told to develop a plan to relocate 20-30 prisoners. However, he later became aware that far more prisoners needed to be evacuated.
28. Housing mixed category (remand and sentenced) high security prisoners in a low security facility was undesirable and elevated the risk of the situation. However, this was unavoidable and necessary in the circumstances.
29. Three prisoner escort vehicles took prisoners to SHCF in the early hours of 30 December 2020, and other prisoners began to be transferred off site later that morning.
30. The urgency of the situation meant there was no opportunity to consider individual prisoner circumstances (such as upcoming release, court hearing or offender plan objectives). The primary consideration was whether the respective site had sufficient capacity to accommodate the evacuated prisoners.
31. When the PAPP and his team became fully involved in the transfers, greater consideration was given to the prisoners' individual circumstances. Some prisoners who had already been sent off site by the EOC on the morning of 30 December 2020 were brought back to the site so the PAPP could co-ordinate the transfers. Prisoners with lengthy periods of time until their next court appearance or release were sent the farthest away (i.e. to Rimutaka Prison). Those with shorter timeframes to their next court appearance or release date were transferred to prisons closer to Waikeria Prison. Some prisoners were not initially placed in the most suitable location, but the PAPP told us this was corrected by 31 December 2020.
32. We note prisoners who were displaced after the incident were ultimately assessed on an individual basis and moved to a site that worked best for their offender plan, court hearing, New Zealand Parole Board hearing, or release near family and whānau.
33. The PAPP felt there was poor communication between the EOC and his team. Some prisoner escort vehicles were initially refused entry into Waikeria Prison and the EOC told the PAPP that they were not needed. However, the EOC called the PAPP an hour later asking for more prisoner escort vehicles. Further, some prisoner escort vehicles left Waikeria Prison not fully occupied. This meant additional vehicles had to be dispatched to Waikeria Prison to transfer the remaining prisoners.
34. There was no accurate recording of which prisoner was placed in which vehicle and to which site they were being transferred. Some prisons contacted the PAPP to inform him that the prisoners they had received were not who they had been told to expect.

35. We understand this occurred because some evacuated prisoners were placed on the first available prisoner escort vehicle and sent off site.
36. The PAPP felt the EOC was overwhelmed by having to co-ordinate the numbers of prisoners who needed to be evacuated as well as dealing with the riot response. In future, the PAPP identified he would have one of his team go to the EOC to co-ordinate the transfers.
37. The prisoners who incited the incident in the yard but did not go on the roof, were not later charged by Police. Neither were they charged with a misconduct by Corrections.

### *Opportunities for intervention*

#### **In the yard**

38. There were a number of missed opportunities for early intervention to prevent the escalating disorder in yard 116 on 29 December 2020.

#### **The presence of a razor**

39. The presence of a razor in yard 116 and the way in which staff went about trying to retrieve it was a key catalyst to the initial disorder on 29 December 2020. This was avoidable.
40. As previously detailed, there was an incident two days prior to the riot where a Corrections Officer failed to follow procedure with respect to the return of four razors given to two prisoners (both of whom was present in yard 116 and one who was later charged by Police for his involvement in the riot). The prisoners' cell was searched the following day, but the missing razor was not located. It is likely this outstanding razor was the one used by Mr A to cut Mr H's hair in yard 116 prior to the riot.
41. Corrections staff could have prevented the razor being brought into yard 116 by following the procedure set out in the Prison Operations Manual regarding the provision and return of razors. Staff did not take other action to mitigate the risk of the razor, such as searching the cell immediately, searching the prisoners, or preventing the prisoners from going to the yard. No offender notes or incident reports were completed, and senior officers were not informed.

#### **Prisoners' initial failure to comply**

42. A further opportunity to contain the escalating disorder occurred when the prisoners refused to comply with an instruction to have the yard run in approximately 20 minutes after the haircut was observed by corrections officers.
43. Intervention in some form was required when the prisoners in yard 116 refused to comply with the officer's instruction. However, staff failed to take effective steps to intervene or plan for intervention.
44. Available options at this stage included:
  - » Running in the yard
  - » Splitting the yard (as there were spare yards available)
  - » Taking steps to de-escalate the tension in the yard
  - » Activating the Site Emergency Response Team to assist in de-escalating the situation<sup>68</sup>
  - » Calling a Code Blue<sup>69</sup>
  - » Alerting the On-Call Manager.
45. Although planning for these steps may have occurred, there is no evidence of any planning in log entries and on-body camera footage.
46. Around the time of their refusal to exit the yard, prisoners were observed putting plastic bags and clothing over their heads and faces, 'soaping up', and covering the yard cameras with wet toilet paper. Staff did not appear to recognise the actions of the prisoners in yard 116 as behaviours that required immediate intervention.
47. Although by 10:38am the On-Call Manager was informed of the developing situation, staff in the immediate area appeared unsure of what to do and could be seen waiting outside the yard grille and in the unit.

68. Notwithstanding there was no dedicated SERT team, they were available on site and capable of being assembled and deployed.

69. The Chief Custodial Officer's report said a Code Blue was called mid-morning, but this Inquiry has found no evidence to support this.



7. THE RESPONSE TO THE RIOT
48. At around 10:44am the razor was passed to staff. However, it was evident the risk of disorder in yard 116 remained present. Prisoners continued to threaten and abuse corrections officers and a PCO said: *"This is not over ... I am expecting more trouble from that yard"*.
49. Despite the escalating risk the yard was not run in.
50. We heard several explanations from staff as to why the prisoners were permitted to remain in the yard:
- » At 10.45am, an SCO was heard to say:
 

*"The crux of it all is, there's not 66<sup>70</sup> of us to deal with that shit... Running them in the yards, they're not going to come... It's gonna end up being a shit fight that ACR will be activated for. That was the easiest option."*
  - » We also heard from staff that the prisoners were left in the yard due to the PCO's previous agreement that they would not be removed if the razor was returned.
  - » The SCO told us that the decision not to run the yard in at this time was due to concerns about staff safety and the potential for staff to be assaulted.
51. The decision to leave the prisoners in yard 116 was supported by the On-Call Manager. The On-Call Manager and the PCO both considered this action was appropriate as, in their assessment, the prisoners were no longer showing aggression or resistance. It is not clear whether the On-Call Manager was aware of the previous failed attempt to run the yard in.
52. The conduct of the prisoners in refusing to comply with instructions met the definition of concerted indiscipline and necessitated a response. The incident was not resolved.
53. While this Inquiry heard from staff about the concerns relating to staff safety (and this was one of the considerations given for not running the yard in) we form the view that the situation should have been properly escalated as the disorder had not been resolved. Such action included but was not limited to:
- » Activating the Site Emergency Response Team
  - » Calling a Code Blue
  - » Activating ACR.
54. The time directly after the return of the razor was an opportunity to plan for further disorder in yard 116 and to ensure the prisoners were returned to their cells.
55. There is limited evidence that any such planning occurred, other than the discussion around the return of the razor, running the yard in, and the potential use of pepper spray discussed earlier. We saw no evidence of substantive discussion about the potential for escalation and the need for intervention.
56. Further, the language used by some corrections officers to the prisoners in yard 116 during this time was confrontational and did little to quell or de-escalate tensions. Corrections officers are trained in effective methods for de-escalating and restoring order. However, in this situation, the language of some staff at the early stage was unnecessarily abusive.
- The presence of cannabis and an ignition source**
57. The presence of prisoners smoking cannabis in yard 116 at around 11am presented a demonstrable elevation in risk. It indicated prisoners had an ignition source and required action by corrections officers.
58. Although a corrections officer completed an incident report in relation to the cannabis smoking, it is unclear if this information was communicated to a PCO or senior management.
59. Once again, notwithstanding this escalation in risk, no steps were taken to run the yard in, remove prisoners or the contraband in question, call a Code Blue, or activate SERT or ACR. There is no evidence these options were considered.
70. This number, three staff for every prisoner, did not give proper consideration to the prisoners who did not take part in the disorder, or other tactical options available.

### Information that a riot was imminent

60. The next clear opportunity for intervention or preparation for a large-scale disorder event occurred when, between 1pm and 1:35pm, Corrections received information from Newshub that a riot was imminent.
61. This information was passed from the General Manager - Communications and Government Services to the Acting National Commissioner to the Regional Commissioner to the Acting Prison Director to the Security Unit PCO and the On-Call Manager.
62. The On-Call Manager attempted to gain more information by contacting the units and viewing CCTV cameras. He established that the Newshub information appeared to relate to yard 116.

### Fires lit

63. The On-Call Manager went to the Top Jail where he was informed fires were being lit in yard 116. He remained in the Top Jail security office to manage the incident. This enabled him to work with the Security Unit PCO and other staff. The On-Call Manager later moved control of the incident to the EOC based in the Administration Building.
64. After the calls were received from Newshub, the decision to activate ACR should have been at least considered (particularly given what was already known to have happened in yard 116, namely, the razor incident, cannabis smoking, covering of cameras, masking and soaping up and lighting of fires).
65. Around 1:45pm, 12 prisoners who wanted to be removed from the yard were prevented from doing so by other prisoners, a CCTV camera in the yard was covered again, a fire was lit and prisoners in the yard continued to be aggressive towards staff. A Code Blue was called requiring all identified incident responders to report to the scene. At this time a staff member also reported seeing multiple prisoners begin to *"smash the roof"*.
66. At around 2:37pm, a number of staff gathered in yard 118 to await instructions. We heard that some staff believed they should have entered yard 116 at this time. This was another potential missed opportunity for intervention.
67. We heard that the decision not to enter yard 116 was influenced by the potential risk to staff and the perception there were insufficient staff to appropriately respond.
68. We note there were 21 prisoners in yard 116 on 29 December 2020, including some who should have been placed in another yard. We heard this created an environment in which staff did not feel they could safely clear the yard or otherwise de-escalate the situation.
69. Some staff felt that the lack of experienced staff on the floor was a contributing factor to the escalating disorder in yard 116. They felt more experienced staff would have recognised the rising tension in the unit and taken more timely actions to mitigate the risk of the initial altercation escalating to a riot. For example, signalling to ACR the need to prepare for a potential riot or using their knowledge and relationships with the prisoners to prevent the catalyst incidents escalating.
70. We heard from one ACR member that, when he first arrived at the site, ACR waited for long periods while plans were put in place and then approved.

### Prisoners gain access to roof

71. A Code Red was called at 3:25pm after prisoners, led by Mr A and Mr F, breached the mesh grille covering the yard. Nine prisoners climbed through the grille and gained access to the roof onto the East bridge.
72. MK9 pepper spray was sprayed through the door grille of yard 116 and up through the overhead grille where the prisoners had breached but the relevant prisoners were, by that stage, largely out of range.
73. During the hours preceding the riot, staff actions in the Top Jail were suggestive of a lack of effective command and control with respect to the initial response. Staff were observed standing around and seemed unsure of what to do. If there was a plan, it was not effectively communicated to staff.
74. At 3:26pm, a Corrections Officer asked: *"So, who's got command? ... Do we know what our instructions are yet?"* Another Corrections Officer said: *"Nah, it just seems like we're falling back"*.
75. From around 4:33pm, the remaining 12 prisoners in yard 116 were removed and placed in Separates Unit cells.

76. Once the prisoners were on the roof, Corrections effectively lost control of the event as Corrections staff (including ACR teams) are not trained to operate at height.
77. From this point in time any opportunities for early intervention and then containment of the disorder was lost.
78. More than five hours passed from the time the razor was observed to the time the prisoners broke through the yard's mesh grille. At no point following the initial incident in yard 116 did corrections officers regain control of the yard notwithstanding steadily increasing disorder.
79. Earlier intervention should have occurred and did not. This was predominantly due to the fact that corrections officers did not correctly assess or respond to the concerted indiscipline that occurred after the razor had been removed from the yard.

### During the riot

#### Emergency Operations Centre

80. As the riot occurred during the summer holiday period, some of the site management team were delayed in arriving at the site.
81. At 4:43pm on 29 December 2020, approximately an hour and a half after the prisoners first accessed the roof, the EOC was activated in response to the evolving situation.
82. An EOC can call on various policies when dealing with an incident. These include:
- » Prison Operations Manual
  - » Tactical Options Manual
  - » Prison Negotiation Team Negotiation Manual
  - » Business Continuity Plan
  - » CIMS Manual
  - » Incident Response Flipcharts.
83. The EOC, which led the initial response to the riot, was based in the prison's Administration Building.
84. The decision to manage the response on site was sound. It gave the Incident Controllers access to additional staff who may not have been available if the EOC had been based offsite. In addition, it provided visible leadership to custodial staff.
85. After its activation on 29 December 2020, the operation of the EOC was divided into two shifts, a day shift and a night shift.
86. The On-Call Manager led the incident response until 5:43pm on the first day.
87. No log was kept of the On-Call Manager's actions during the first hour and it is not possible to assess any decisions made.
88. Later, Corrections relied on manual log keepers to document critical information about the events, the response and decisions made. Telephone discussions did not appear to have been documented in the log precisely, if at all. The manual log keeping was at times vague and limited the ability of this Inquiry to easily review what took place.
89. The initial response was then led by the Prison Director and Regional Commissioner (both of whom had been on leave but responded to the incident) as joint Incident Controllers, both based on site. The Prison Director of SHCF was the night shift Incident Controller.
90. All three Incident Controllers were CIMS trained. However, they had no previous experience managing an incident of this scope and scale.
91. We heard from staff that on 29 December 2020, there were people filling in roles in the EOC with whom staff were not familiar and/or who staff perceived to be lacking in skill and experience.

92. It became apparent that staff charged with opening the EOC were not sufficiently trained or practised in doing so. For example, staff were not able to access the CCTV footage from the EOC because they did not know the password. We were informed that this issue was shortly resolved by contacting Honeywell,<sup>71</sup> but it resulted in an initial inability to access crucial footage of what was occurring in the Top Jail. Staff inexperience generally contributed to delays in putting in place effective command and control.
93. During this time there were also communication issues between managers based in the EOC, in the Administration Building, and staff at the frontline of the riot who were dealing with prisoners and the escalating situation.
94. Despite these challenges, the EOC appropriately completed several initial tasks, including contacting senior managers to request their attendance, attempting to identify the prisoners on the roof and gathering other relevant information.
95. When they arrived on site on 29 December 2020, Police and FENZ appeared to take an active role in the EOC's activities.
96. The assistance provided by the external agencies was invaluable. However, we note at an operational level the multi-agency response was not well developed and would have been assisted initially by all parties being co-located in an EOC. It does not appear that exercises had been carried out with emergency services prior to the riot to practise a response to a major incident.
97. From 1–3 January 2021, a replacement team took over the running of the EOC.

#### National Coordination Centre

98. From 29 December 2020, the NCC was operated virtually to support and enable the EOC.
99. The Acting National Commissioner was the National Incident Controller from 29-31 December 2020 and managed the incident from the South Island.
100. The Acting National Commissioner told us his role was to get the team on the ground what they needed and provide updates about the incident to others who were not directly involved. While he acknowledged that, with hindsight, it would have been good to have the national decision-making team together earlier, he felt that all the right people were talking to each other, he had the right resources, and there was a structure (despite it not being 'official').
101. He told us: *"I think having people in one place earlier would have been a better thing on reflection."*
102. On day four of the riot there was a tactical change of staff, in part to mitigate fatigue. On 1 January 2021, the Commissioner Extreme Risk Directorate was appointed National Incident Controller, and at around midday the NCC was formally established at Corrections' National Office with all members operating from the one physical location.
103. The decision to operate the NCC virtually for the first three days negatively impacted the response to the riot.
104. This Inquiry has concluded from interviews with senior staff that had an NCC been officially set up earlier, there may have been an earlier intervention as there would have been capacity to consider all the relevant options.
105. An Incident Controller involved in the latter days of the response told us there was no real structure to the management of the event prior to the NCC being formally established.
106. An Incident Controller stated:

*"They [Incident Controllers] seemed comfortable in managing the event on site. But from a strategic perspective, and leaning on my experience, you can't do that ... because you need additional resources from all over the country. In a bigger scheme of things ... we can't mobilise those staff without authorities to do so. And sitting in a regional seat in a prison is not where you need to be to manage the strategic view of the world ... we're doing this so low key when it has the potential to get quite serious, especially with the media interest."*

71. Honeywell is the contractor for electronic security.



107. A former senior staff member commented on the failure to formally establish an NCC promptly in response to the incident. He told us:

*"Why did we not activate a formal structure when we knew it was really quite a significant incident? ... this was pretty obvious from probably the first few hours that this was big, and the whole reason you've got that training in responses is because it's there to serve you well in these times of difficult incidents."*

#### Intervention

108. We note that staff, particularly decision makers, should have been alert to the risk of hostages being taken when on day one of the riot, Mr P and Mr Q came down from the roof, having been forced out of their cells by rioting prisoners.
109. When the men were later transported to the low security unit, CO I commented: *"They're lucky to be alive cos I heard them say 'where's those white fuckers cos we wanna throw them off'."*
110. Decisive action by staff enabled the men to be brought down from the roof without incident. Some staff considered that had Mr P and Mr Q remained on the roof there was a risk they would have been used as hostages by the other prisoners.
111. The focus of the response in the initial stages of the riot was on the safe evacuation of the prisoners in the Top Jail.
112. Once this had been achieved, the response for the next three days focused on keeping the prisoners on the roof contained to the Top Jail and allowing PNT and Police negotiators to negotiate a peaceful surrender.
113. The terms 'watch and wait' and 'sit and wait' were variously used by staff to describe what they perceived was Corrections' approach during this stage of the incident response. The perception was that Corrections was attempting to negotiate with the prisoners on the roof but was not immediately implementing any significant interventions to bring about an end to the riot.
114. This approach was considered appropriate by some staff who believed a safe conclusion would be achieved when the prisoners on the roof eventually ran out of resources, got bored and came down.
115. Some senior staff explained to us that once the evacuation occurred and there was no perceived risk to life, other than to the men on the roof, the risk of aggravating the situation further by intervening was thought to be outweighed by the benefits of seeking a non-violent conclusion.
116. Further, as ACR were not trained to operate at height, an intervention on the roof was not possible. This was seen to significantly limit the options available to the EOC when planning a response, particularly given the men on the roof were thought to have weapons and were lighting fires.
117. We also heard that the prisoners were thought to be sufficiently contained on the roof and unable to escape. The fact they had already destroyed most of the Top Jail also reduced the perceived urgency of the situation and need for intervention. There was obviously an ongoing risk to prison property, but given the extent of the fires, the view was taken that the prison was 'lost' and unlikely to be recovered in any event. Although it was not articulated, the fact that the Top Jail at Waikeria was already set to be demolished in 2023 may have also played a role in this reasoning.
118. On day two of the riot the NCC log recorded:
- "17 prisoners unaccounted for ... sighted 14 on the roof ... not willing to negotiate, they are abusive." Then: "we have no intention to attempt to move them, waiting ... they have access to weapons, including knives ... focused on waiting to tire, get hungry and give up ... Top Jail is beyond saving."*
119. As the riot progressed into the third day, it became clear to several staff that the containment tactic was not necessarily achieving the desired outcome. Corrections had facilitated the prisoners speaking with Kaumātua and Kuia, and given the prisoners water, on the basis that, as recorded in the NCC log: *"They'd be willing to come down from roof if they could speak to a Kaumātua"*.
120. However, after speaking with the Kaumātua and Kuia the prisoners refused to come down from the roof.



121. At the EOC briefing on 31 December 2020, day three of the riot, the EOC considered the 'sit and wait' approach and how long this should continue given the risks to the life and health of the prisoners on the roof.
122. Negotiations stalled and the EOC noted that ACR would not be acting as the situation had continued to escalate. By this stage, prisoners on the roof had broken into the armoury and had access to shields, helmets, personal protective equipment, a Halligan bar, a bolt cutter and an electric grinder. The EOC understood the prisoners were making weapons. It was also apparent that the prisoners had shelter and access to other supplies including water, food, clothing and medicines.
123. The addition of Mongols MC members (who had been broken out of their cells) on the roof appeared to bring about an increase in organisation. Some of the prisoners appeared to be acting as sentries and were seen wearing Corrections' uniforms, stab resistant body armour and carrying radios.
124. The Regional Commissioner felt there was no rush to implement a plan, but a plan needed to be in place.
125. The reassessment of the approach influenced the appointment of new staff in the EOC and NCC from 1 January 2021.
126. Several members of the team that took over the response from 1-3 January 2021 expressed a view that the containment strategy was no longer appropriate as its efficacy was largely premised on rioters being confined to a discrete area with no access to supplies. They felt that as the prisoners on the roof had ready access to provisions, they had no immediate desire to surrender. Many believed that any response short of intervention could result in the riot being drawn out over a lengthy period of time.
127. The more organised the prisoners on the roof became, the greater the risk faced by Police or Corrections staff. Some staff voiced their concerns that the longer Corrections took to intervene, the more time the prisoners had to plan.
128. Further, while many had formed the view that the Top Jail was 'lost', the fires that continued to burn meant the integrity of the building where the prisoners stood and slept was increasingly compromised. This increased the risk to not only the prisoners on the roof but to any responders who would have to enter the Top Jail.
129. An EOC briefing noted a hardening in the attitude of the prisoners on the roof: *"They are in control, willing to die for this"*.
130. A National Incident Controller told us:
- "There was a lack of appreciation of what they were actually managing there. We knew that we didn't have containment. We didn't have them contained on the roof. They had pretty much free range of the prison, which gave them access to food and water which is going to prolong the incident. We knew at that stage through the appreciation that they'd broken into the armoury. So, we knew that they had equipment. They had our vests and shields and everything that we would use, except for pepper spray. It was very well done to get that out in those first few days. We knew that they had an angle grinder that they had used to get through places and so that became a big risk for us, that there was a risk of escape if they were able to get to an area that was unmonitored and unstaffed they could have used that angle grinder to get out. So, there was a risk of escape ..."*
131. A later Incident Controller in the EOC told the Inquiry about the failure to prepare for an intervention in the first three days of the riot. He said:
- "There was nothing on the boards to demonstrate that there had been an appreciation event. Threat and risk assessments hadn't been completed. Intervention plans were allegedly completed and surrender plans hadn't been completed. But there was no knowledge, there was no evidence to support intervention plans had been completed ... We were always susceptible to these guys coming at us, and they'd had three days to prepare ..."*
132. He told us the prisoners on the roof were a significant risk to themselves as the building was being destroyed by fire and potentially asbestos was present.
133. Some frontline staff told us there appeared to be confusion and a lack of decisive leadership about why the intervention took five days to action. They noted that the delays created uncertainty among staff.

134. While some staff told us an intervention plan was being developed, many frontline staff appear to have been largely in the dark about Corrections' response, which contributed to feelings of confusion and frustration.
135. The decision about whether and when to intervene was complex and involved a number of competing factors. As well as those outlined above, this Inquiry was told other relevant considerations included the risk to Corrections emergency response staff and other agency staff including Police, the need for sufficient time to properly prepare an intervention plan, public pressure and reputational risk.
136. By the end of day three the need to intervene was clear. The situation recorded in the NCC log was: *"Negotiations had been generally constructive but no suggestion they'll be coming off the roof any time soon. They have access to food and water so no major incentive right now"*.
137. The overall risk of the situation was further elevated when, at around 4pm, it was reported that a prisoner, Mr S, on the roof had used threats of death/serious violence against another prisoner, Mr C, to try and negotiate the provision of food and water. ACR and prison negotiators witnessed Mr C being assaulted by two of the prisoners on the roof.
138. At the end of day three the EOC briefing noted there was *"a plan to go in (last resort)"*, which would be triggered if there was a threat to life. More AOS staff would be required *"if we need to go in"*. In the meantime, they would *"continue to sit and wait"*.
139. On 1 January 2021, the tactical change in staffing of the EOC and NCC appeared to prioritise bringing the incident to an end, including using force if necessary.
140. The NCC was physically established. An intervention plan, whereby ACR supported by AOS would enter the Top Jail and secure the Chapel, was finalised.
141. The leadership changeover was not without issue. Incoming staff were critical of the apparent lack of communication from the outgoing staff, including an absence of any formal verbal briefing. A whiteboard with planning had been set up in the EOC but, notwithstanding reports that intervention and surrender plans had been developed, there was no evidence of these having been completed. Similarly, threat and risk assessments were reportedly still incomplete.
142. This Inquiry heard that EOC staff who were relieved by an incoming team after the first three days of the riot were critical of the way in which the decision to transfer control of the incident was managed and they felt excluded for the remainder of the riot. They told us this left them feeling disheartened and undervalued.
143. Overnight, at around 12:06am on 2 January 2021, a group of prisoners came down from the roof and confronted ACR and AOS staff on the ground. The prisoners had weapons, were challenging staff to engage with them, and were throwing projectiles. AOS members fired sponge rounds to force the prisoners back to the roof. Throughout the night, prisoners lit additional fires and threw objects at staff.
144. This confrontation incident further emphasised the increasing risk posed by the continuation of the riot.
145. Around 6pm on 2 January 2021, the intervention plan was approved by the Incident Controller and endorsed by the NCC and the Chief Executive. The Acting Police Commissioner was consulted and approved the proposed AOS tactical response.
146. The intervention plan followed the SMEAC format and outlined a plan whereby 57 ACR staff and four AOS members would try to bring the riot to an end.
147. The intervention plan recorded that intervention was considered necessary for the following reasons:
- » The Top Jail's structure was compromised due to the fires.
  - » The asbestos roofing was hazardous.
  - » The prisoners on the roof had control of the Top Jail, had breached key areas (such as Master Control and the Medical Unit), and had access to improvised weapons (including Corrections' shields and personal protective equipment).

148. The ACR team were to lead the intervention, with support from AOS. The plan was to enter the Top Jail via two different entrances in the Chapel and 'hold' that area. A third team would attempt to distract the prisoners and lead them to believe the intervention was taking place at a different location. The aim of the intervention was to reduce the areas the prisoners had access to which would, in turn, force them to surrender and come down from the roof.
149. Appendix C shows the points of entry, Chapel, surrender point and diversion point.
150. The EOC considered, as part of the intervention plan, whether to provide the prisoners on the roof with drinking water and assessed the benefits and risks of doing so. It was decided that the prisoners would be offered water as part of the surrender plan, once they came down from the roof and formally surrendered.
151. At 7:15pm that evening, ACR and AOS entered the Top Jail. They moved along corridors and cleared rooms as they progressed. Once they arrived at the Chapel they found their way was blocked as the prisoners had barricaded this area to prevent access to the roof.
152. While the staff worked to remove the barricades, the prisoners set fire to the barricades and lit fires in the Chapel area above where the ACR and AOS members were attempting to enter the building. The fires took hold quickly and the ACR and AOS members were forced to withdraw around 7:33pm.
153. We were told by some ACR staff that they felt they got out of the Chapel with seconds to spare.
154. As ACR and AOS exited the building, prisoners threw projectiles on the retreating responders.
155. An AOS team on the ground fired sponge rounds and flash devices<sup>72</sup> at the prisoners on the roof to force them back from the edge of the roof. Within minutes of the staff exiting the Chapel, it became fully engulfed in fire.
156. The FENZ report concluded there were likely to be multiple points of origin for the fire and it was probably aided with some form of flammable accelerant.
157. The fires lit by the prisoners following the intervention destroyed the shelter where they had been sleeping and where they stored clothing and blankets. This forced the prisoners out onto a relatively small area of the roof.
158. The EOC assessed that the loss of the Chapel would result in the prisoners surrendering, which they did the following morning.
159. The lack of shelter available to the prisoners was made worse by the rainy overnight conditions.
160. The intervention on 2 January 2021 played an instrumental role in bringing about the surrender of the prisoners on the roof.

### Surrender

161. After negotiations overnight, the prisoners on the roof surrendered on 3 January 2021, day six of the riot.
162. Consistent with the kaupapa Māori approach adopted by Corrections during earlier negotiations, Corrections arranged for Kaumātua and Kuia and the Co-Leader of Te Pati Māori to attend the surrender.
163. While some voiced their concerns about the involvement of a politician potentially politicising the surrender, Kaumātua and Kuia took steps to ensure this did not occur.
164. The Kuia told us that she spoke to the Co-Leader and said:
- "We had a good conversation ... If they're coming down, I'd like it to be mana whenua led, and I said, 'That's me and [the Kaumātua]. You're most welcome to come with us, but I'm not going to give you some talking space'. He agreed. That was good..."*
165. By 11am the surrender plan was completed.

72. A device which creates a flash, smoke and a loud noise to create a distraction.

166. Just before midday, the prisoners performed a haka pōwhiri to welcome the Kaumātua and Kuia, who responded with a karanga, a karakia<sup>73</sup> and waiata.
167. The surrender was recorded by the Incident Controller on a cellphone. The presence of the Kaumātua and Kuia and their interactions with the prisoners is evident. Their involvement in bringing the incident to a peaceful end cannot be overstated. It highlighted the importance of including iwi and adopting a te ao Māori approach in incidents of this nature.
168. The prisoners surrendered and came down from the roof one by one using a ladder. They were handcuffed and provided with water.
169. The prisoners were photographed and taken to cells in the ISU (which was undamaged). Once there the prisoners were strip-searched, given towels, food, water, and a change of clothes, and put into cells. Health checks were carried out.
170. The prisoners' clothing was placed in bags and kept in the storage building until it was handed to Police as evidence (after this Inquiry alerted the Prison Director in mid-2021).

### *The Prison Negotiation Team*

171. According to the Prison Negotiation Team Manual, the preferred option for the resolution of serious incidents is negotiation. The aim of negotiation is to achieve a peaceful resolution to an incident to:
- » Preserve life and prevent injury
  - » Contain and isolate
  - » Protect property
  - » Preserve evidence
  - » Restore order
  - » Preserve reputation and other intangibles.
172. Negotiation is a planned intervention on behalf of the Prison Director/Incident Controller. Each PNT consists of a negotiation coordinator (the team leader), a primary negotiator, a secondary negotiator, and a log keeper. Each team member is required to complete the National Prison Negotiation Qualifying Course and attend refresher training sessions twice a year.

### **The prison negotiators involved in the riot**

173. Waikeria Prison had four prison negotiators. Its negotiation coordinator had left the prison and the role was vacant.
174. Two members of the PNT were registered nurses who worked at the prison. On 29 December 2020, at approximately 6pm, Nurse A was appointed to the role of negotiation coordinator, for which she was not trained. Nurse A assembled the rest of the PNT team.
175. The Incident Controller declined to deploy the Senior Advisor Tactical Operations – PNT, based in National Office, to the negotiation coordinator role on site. However, the Senior Advisor Tactical Operations – PNT provided telephone support to the team on site. Later, during the incident, other team members assumed the negotiation coordinator role, but were also not trained for this. The lack of an experienced negotiation coordinator on site impacted the effectiveness of the PNT deployment.
176. A Waikeria Prison Corrections Officer was the primary negotiator on the first evening of the riot and Nurse B was the secondary negotiator. Nurses A and B's roles ended at 10:30pm. From 30 December 2020 to 3 January 2021, both nurses remained in the EOC as health advisors and were utilised for various roles, including PNT co-ordinations.
177. The PNT worked alongside the Police Negotiation Team.

73. The karakia spoke of traditional fundamental ancestry that brings a 'korowai' of peace, of calm and of restitution. It is a pledge to settle the spirit and to bring a sense of tranquillity: Taakina te kawa! Ko te kawa noo wai?/Ko te kawa noo Rehua-i-te-rangi/Ko te kawa noo Hine-rangimaarie/He kawa tupua! He kawa tawhito!/He kawa ora! He kawa ora!/Tuuturu owihiti, whakamaua kia tiina!/Hui e! Taiki e!

### Issues regarding the PNT during the riot

178. This Inquiry heard about a range of issues regarding the PNT and how it was involved in the riot response.
179. On 30 December 2020, the Primary Negotiator was left negotiating by himself for three hours with no support. He did not have radio contact nor any ability to use a telephone. His first shift was 30 hours long, on his own initiative.
180. A number of communication issues were raised:
- » A PNT member was subject to verbal abuse by a Waikeria Prison manager on the first night of the riot for failing to solve the incident quickly.
  - » When new PNT team members arrived (after Day 1), they received no information regarding the PNT work completed the day or night before.
  - » A negotiator told us he did not receive a briefing from the EOC and there was no negotiation coordinator, meaning there was no structure to the negotiation team. As such, he felt a bit lost and that the prison negotiators were overlooked.
  - » Police negotiators received briefings from the EOC, but the prison negotiators did not. For example, at an EOC briefing on 2 January 2021, the EOC invited Police negotiators, but not PNT. A PNT member attended this briefing after being invited by Police negotiators. The PNT received a “rushed” briefing about the Kaumātua who were coming to speak with the prisoners on the roof.
  - » Some PNT members reported that when a new Incident Controller was appointed in the final three days of the riot, there was much better support for PNT and an instruction for them to have greater involvement and to communicate with the prisoners.
  - » PNT members used Post-it Notes to communicate and pass on information.
181. There appeared to be a lack of knowledge within the EOC regarding the negotiators’ role and some resistance to fully deploy PNT to the site (including not allowing PNT into the EOC briefings during the early stages of the riot).
182. PNT staff did not wear on-body cameras during the riot. The Senior Advisor Tactical Options – PNT told us that, usually, a site provides on-body cameras when the negotiation controller asks for them.
183. Some tension between the PNT and ACR teams was noted – for example, ACR used tactics overnight to keep the prisoners awake without discussing this with the PNT first, and there was a perceived difference in treatment of the ACR and PNT.
184. A former senior staff member told us that when making decisions about negotiations there needed to be a specialist advisor in the NCC:
- “I’m not a negotiation expert, and that’s why I would always take the advice of a [negotiation coordinator], and certainly at the NCC level, I would have wanted somebody like [the Senior Advisor Tactical Options – PNT] in there as my specialist advisor on negotiation telling me what I should and shouldn’t do, and giving me advice.”*
185. The Chief Medical Officer also expressed concerns about the lack of psychological expertise within the PNT.
186. A negotiator told this Inquiry:
- “We’re engaging with the prisoners, taking all sorts of abuse and all that kind of thing. So ... mentally it’s quite a lot ... and you need to debrief with a psychologist before you even drive home. So, that wasn’t happening. It got that bad that at the end the Police were going to get their psychologist in.”*

### Support provided to PNT during and after the riot

187. Some PNT members told us they felt frustrated, demoralised, unwanted and embarrassed after the riot. One told this Inquiry they were not given any support during or after the riot.
188. After the riot, a debrief was held with the PNT. A psychologist spoke with PNT members after the riot, but not during it, as they had been told in training would happen.



189. At interview, the Senior Advisor Tactical Options - PNT told us the ideal would have been to have a team of five negotiators, working three shifts of eight hours each. It was important to have a negotiation coordinator and psychologist to support the negotiators.
190. He told us the negotiators were not being used appropriately during the riot. They were not being invited to EOC briefings and were not getting meals.
191. One acting Negotiation Coordinator who came on site, expecting to be briefed by the EOC, was told *"follow the smoke"*.
192. A member of the PNT told us that his team felt unsupported:
- "We weren't acknowledged as an equal ... I believe we were seen as the distant cousin, that was just there. Not a fully qualified, trained, well-oiled unit, that go in there and can actually achieve some really good outcomes."*

### Command and control of the response

193. Corrections had control of the incident throughout the riot. There was apparently some confusion as to why the incident response was not led by Police. Some concerns were raised by Police, FENZ and St John Ambulance.
194. An Incident Controller told this Inquiry that control would only have been handed to Police if the AOS used firearms. As this did not occur, control of the incident remained with Corrections throughout. The Police Acting District Commander noted in a debrief that Police were focused on the incident being Corrections-led, with Police providing a supporting role.
195. Initially, there were hourly briefings with Corrections, Police and FENZ. We were told Corrections took advice throughout the riot from Police and FENZ. Several Corrections staff reported feeling that their interactions with Police, FENZ and St John were positive and productive. Corrections staff felt well supported by the external services and acknowledged the teamwork that was displayed.
196. When reflecting generally on how the EOC worked with other agencies, an Incident Controller told us:
- "It was probably my best experience in an EOC with all these guys working together. People spoke without worry ... We had constructive arguments. We all were looking for the same outcome, which was a safe conclusion with no lives lost, and we achieved that."*
197. We also heard from an EOC Incident Controller that when he arrived at Waikeria Prison and took control, on 1 January 2021, he made it clear to Police that he was the Incident Controller on site and held a briefing to discuss what had happened so far, the way forward, and his management approach to incidents.
198. We also heard some concerns with how the agencies worked together.
199. This Inquiry was told of one significant lapse in communication when an EOC Incident Controller was not informed that Police had scoped out some areas in the Top Jail which were found to be accessible (in relation to where the intervention plan would be executed). He said that if he had known this had been done, he would have organised an intervention for those areas sooner.
200. Reflecting on the riot in a debrief, a St John Ambulance staff member suggested there should be a multi-agency EOC when an event required a multi-agency response. They noted St John Ambulance staff found it difficult to know what level of resource was needed on site. Given the time of year (the New Year period) its resources were limited and this information would have been helpful to have in advance.
201. A FENZ staff member noted in a debrief that the direction received from Corrections was clear and having a liaison person from Waikeria Prison worked well. However, the Fire Area Commander for Waikato also said during a debrief that FENZ should have had more involvement in the intervention planning as it could have supported a safer strategy given the risk of fire.
202. It was suggested that joint training between services might increase the ability of staff to work together.

203. ‘Hot’ debriefs were held with the EOC and NCC on 3 January 2021. A meeting between the NCC, the Corrections Association NZ and the Public Service Association took place on 3 January 2021 (as the riot was still ongoing). ‘Cold’ debriefs were conducted on 14 January 2021, 21 January 2021 and 4 March 2021. An emergency services debrief took place on 14 January 2021 with staff from Corrections, Police, St John Ambulance and FENZ participating.
204. An EOC debrief took place on 21 January 2021. A debrief for the PNT staff was held on 12 January 2021. Two debriefs were held with ACR staff on 5 January 2021 and 11 January 2021. An ACR leader noted it may have been helpful to have more debriefs for his team. We also note the regional tactical advisers had a separate debrief. The Recovery Management Team facilitated a ‘lessons learned and risks’ workshop on 22 February 2021.
205. At these debriefs, what happened during the riot, what went well and any issues that arose were discussed. We heard from an Incident Controller who was present at some of the debriefs that, in hindsight, they should not have attended as having senior management present means people do not always speak freely.

## Corrections’ communications

### Communication to the media

206. During the riot, Corrections’ Media and Communications team issued daily statements to media and provided responses to media enquiries. The statements provided updates and information as it became known. Key information about the safety of the prisoners, staff and the general public was clearly and repeatedly communicated.
207. In summary, the communications reported:
- » Around 200 prisoners had been transferred from Waikeria Prison to other prisons.
  - » The incident was contained and there was no threat to the safety of the public.
  - » There had been no loss of life or injury to staff or prisoners.
  - » Corrections recognised that the prisoners who were transferred to other sites had been through a traumatic event. Corrections staff were working hard to ensure prisoners could have the support of mental health and other health services.
  - » The prisoners who had been moved were being supported to contact family and whānau members.
  - » Corrections was prioritising the prisoners’ re-engagement with education, employment and rehabilitation activities that had been interrupted.
  - » Corrections considered Hōkai Rangi during the response to the riot.
208. Corrections held two press conferences, the first on 30 December 2020. Following the surrender, on 3 January 2021, Corrections Minister Kelvin Davis, Chief Executive Jeremy Lightfoot and National Incident Controller Jeanette Burns addressed the media. The press conferences were clear and informative, and provided reassurance to the public and whānau of prisoners and staff.

### Telephone calls

209. A staff member told this Inquiry that before the telephone lines were cut, Waikeria Prison received between 30 and 50 calls asking where whānau or loved ones were, and noted:
- “A lot of them [were asking], ‘is my son safe, is he still in the building that is burning?’ You know, those sort of things, and I think any parent will react like that, I think it’s just normal ... [We responded] ‘I can’t tell you where he is but I can just tell you he is safe; because nobody’s in the building and nobody was hurt.’”*
210. Between 2-5 January 2021, all incoming telephone calls to Waikeria Prison were diverted to the Incident Line at Corrections’ National Office. A script was developed to provide information to whānau and friends who called. This provided a consistent response to concerns about prisoners at Waikeria Prison or those who had been transferred. Information about individual prisoners was not released, but assurance was provided that the prisoners in the Top Jail had been evacuated and were safe and well, and prisoners in the low security facility were also safe and well.
211. Corrections regularly updated its website. An advisory message was uploaded to advise whānau of telephone issues at the prison due to fire, and Corrections was working to fix the issue as soon as possible.

212. The prisoners evacuated to the low security facility were not able to make telephone calls. It would have been impractical to facilitate this. Prisoners were permitted one free telephone call once they arrived at their destination prison.
213. After the incident concluded, some staff expressed concern about a lack of communication to families and whānau of Corrections staff, as they had only received information from the media and social media.

#### Communication with iwi, mana whenua and kaumātua

214. Corrections asked iwi to inform them of any local families or whānau they should communicate with about the riot and the evacuation of prisoners from the Top Jail to other prisons.
215. The DCE Māori provided regular updates to mana whenua during the riot. On 10 March 2021, the DCE Māori provided a further update on the recovery process to mana whenua to be shared at a kaumātua meeting on 12 March 2021.

#### Communication with WorkSafe

216. This Inquiry was told that, on 30 December 2020, WorkSafe was informed by the Department's Safety Business Partnering team of the incident. However, due to the holidays, there was no response to telephone calls to WorkSafe but several messages were left. The advice to WorkSafe was about the fire and not specifically asbestos. WorkSafe did not return the calls the Department made to them. No further action was taken by the Department. In the absence of any formal record of the notification held by the Department it is unclear what was reported, when, and by whom.

#### Comments on the Chief Custodial Officer's report

217. Following the riot, the Chief Custodial Officer was instructed by the Acting National Commissioner to complete an operational review into the circumstances surrounding the riot. The Chief Custodial Officer's report, dated March 2021, sets out the causes of the riot, how it was managed, and what Corrections can learn as an organisation. Rather than repeat the conclusions from the Chief Custodial Officer's Report, we set out below the key areas in which our findings differ. We note for completeness that this Inquiry had the benefit of a much longer investigation period whereas the Chief Custodial Officer's Report had to be completed at pace. Key differences include:
- » We understand there were 212 prisoners in the Top Jail on 29 December 2020, not 211 as stated in the Chief Custodial Officer's Report.
  - » While we agree there was no intelligence held by Corrections that indicated the riot was pre-planned, we consider that the underlying tensions were known, and a disorder event of the type that occurred in the yard was, if not inevitable, then at least predictable.
  - » The Chief Custodial Officer's Report notes there are no records of any of the prisoners involved in the riot using the formal complaints processes available to them, including contacting the Office of the Inspectorate or the Office of the Ombudsman, to raise any significant concerns about the age and fitness of the site. This Inquiry establishes that there was real cause for dissatisfaction among prisoners, whether they utilised the complaints system or not, and we are aware that a number of prisoners expressed a lack of confidence in the prison complaints system.
  - » The Chief Custodial Officer's Report said the incident started from 1:45pm on the day of the riot. Our view is that the disorder event in yard 116 had been ongoing for several hours by that time, which in turn presented a number of opportunities to intervene. This is important for understanding the riot, its causes, and opportunities to avoid what later occurred.
  - » While we agree that staff acted with courage when evacuating prisoners from their cells on 29 December 2020, this Inquiry found that the evacuation should have happened much sooner than it did. The delay in evacuating prisoners put both their lives and the lives of staff at risk. We disagree that the evacuation was "immediate" or "exceptionally well managed".
  - » The Chief Custodial Officer's Report identifies three occasions where the review team observed that language used by staff fell below expected professional standards and was inappropriate. This Inquiry has identified far more than three occasions, and this appears to have been a normalised feature of staff and prisoner interactions. This revealed a concerning culture within the Top Jail.
  - » Regarding the multi-agency response, the Chief Custodial Officer's Report stated that no complaints or significant issues were raised by any responding emergency services in relation to Corrections' handling of this incident, nor had any services raised concerns that procedures unduly hindered them in their tasks. With the benefit of the Police debrief report, we now understand that Police consider there were a number of aspects of Corrections' cooperation that could have been improved.

218. Given the Chief Custodial Officer's involvement in the initial response to the riot, it was a potential conflict of interest for him to then be tasked to undertake the review and prepare a report.

### Summary of Fire and Emergency New Zealand Report

219. As part of this Inquiry, we were provided with a copy of the Fire and Emergency NZ Fire Investigation Report (approved by the Waikato Area Manager FENZ on 15 September 2021), which said prisoners lit at least 37 fires over the course of the riot. It noted there were probably further points of ignition, but these could not be identified beyond a reasonable doubt so were not included in the report. The FENZ Report concluded:

*"Given the circumstances around this incident the cause of these fires was determined to be the deliberate ignition of introduced materials by a competent external ignition source of multiple area and points of origin throughout the facility known as the Top Jail."*

220. The FENZ Report stated that the accelerants used were unknown, but evidence pointed to the possible use of flammable hand sanitiser liquid collected from throughout the Top Jail. It concluded that other items potentially used to start or accelerate fires were likely to be:

- » Aerosol cans of fly spray or tyre shine, each with highly flammable propellant gas.
- » Flammable liquids - thinners, mineral turpentine, paints etc (potentially from the Paint Shop).
- » Toilet rolls.
- » There was also evidence that a form of Molotov cocktail may have been used.

221. In response to the evacuation, the FENZ Report stated:

*"[the] evacuation of prisoners from one of the cell blocks was undertaken in very trying conditions with structures on fire close by causing smoke levels closer to the floor requiring both staff and prisoners to rush the evacuation before all the buildings in that location were consumed by fire."*

222. During the riot, FENZ staff were tasked with protecting the kitchen from fire. To do this they needed to enter the compound under the protection of ACR and AOS teams to deploy firefighting equipment.

223. A significant number of FENZ resources were deployed in response to the riot, including:

- » Ten pump fire appliances.
- » Two aerial firefighting appliances.
- » Five water tankers.
- » Ten various support vehicles.
- » One Command Unit.
- » One canteen unit.
- » Eight executive officers and operational staff, both career and volunteer, who staffed the site 24 hours a day for the duration of the riot.
- » Four specialist fire investigators.
- » Four drones and approximately eight drone operators. These were available mostly 24/7 to provide an aerial observation capability for the multiple fire starts and spread. There were times the drones were not flying due to the changing location of the Command Unit and battery recharging periods.
- » Three portable dams and multiple portable pumps.

224. At the peak of the riot, it is estimated there were around 75 FENZ staff at the scene.



225. This Inquiry heard other concerns from FENZ, including that:
- » FENZ was not provided with a Hazardous Substances Register to identify what was stored on the site (i.e. paint and hand sanitiser).
  - » A tactical plan would normally be available to assist in the pre-planning phase so FENZ staff would know who they were talking to, where equipment was stored and be provided with a site map.
  - » FENZ could have been involved in the intervention plan and supported this action from a safety/fire health and safety perspective.
226. We heard that pre-planning, running combined exercises, correct use of fire systems, security protocols and mutual understanding of roles and actions would go a long way to cementing relationships between Corrections and FENZ. It would also increase awareness and understanding of each organisation's respective needs and capabilities.

### Summary of Operation Emery Police debrief report

227. As part of this Inquiry, we were provided with a copy of the Police debrief report on its response, Operation Emery, which summarised the key findings from its debrief on 23 March 2021.
228. The Police Report noted that Police were initially informed of the incident via the Fire Communications Centre and were not initially requested to attend by Corrections. The Police report detailed that the riot response was a Corrections-led operation supported by Police staff including specialised tactical squads – the AOS, Police Negotiation Team and Police dogs.
229. The Police mission was to *“assist Corrections with logistics and advice as requested to enable them to resolve the situation with no loss of life and minimal property damage”*.
230. Police and Corrections were clear from the outset that it was a Corrections-led incident. However, from the Police perspective, this created some issues and raised the question as to whether Police should have taken over as the lead agency given:
- » Criminal offending was taking place at the prison
  - » The request was made for the AOS, Police negotiators, Police dogs and Police helicopter
  - » Consideration by Police of using force against the prisoners.
231. The Police Report also noted:
- » Police staff were not initially invited into the EOC.
  - » Changes to the Corrections' Command and Control structure (from the morning of day four) *“altered the intent, which may not have been effectively communicated to Police, causing some confusion at times”*.
  - » The structure of Corrections briefings proved challenging for Police who have a different methodology with a formal agenda and timings. Police staff noted that on some occasions briefings commenced early, leaving them without context.
  - » Intelligence resource was not added into the EOC from Corrections until day five. There was only the support to the EOC from the District Command Centre intel staff.<sup>74</sup> *“Intelligence can play a crucial role in terms of operational intelligence that supports the Operation Commander.”*
  - » Although ACR teams are well trained and equipped to deal with violent/rioting prisoners in confined spaces, they lack any *“mid-range less than lethal option (i.e. sponge rounds)”* or the ability to work at heights.
  - » AOS members successfully deployed 40mm sponge rounds. *“Without it, on Friday [1 January 2021] evening, the small force of ACR and AOS would have almost certainly been overrun by the larger group of violent prisoners who had come off the roof intent on a confrontation and or escape.”*
  - » Corrections had different tactical considerations, such as the supply of water to the prisoners, utilising the ACR team to keep the prisoners awake, and the use of third-party interventions. The Police Report said the Police negotiation team would have provided different advice, which may have contributed to different responses or an earlier resolution.

74. Our Inquiry has revealed that intelligence from Corrections was provided from the first day, however, the Intelligence Manager was not invited on site until day three.



- » There needed to be better collaboration between the Corrections' negotiation team and the Police negotiation team. Police negotiators were later told by Corrections, post the incident, that Corrections negotiators were told to remain disjointed from Police negotiators for fear they would take over.

232. The Police Report recommended the way in which Corrections and Police communicated and worked together required further exploration. It recommended looking at developing co-responder models – which could be tabletop exercises, joint training with tactical staff, communication channels, briefings, and any other considerations that would allow the operation to run smoother. It also recommended consideration should be given to the development of standard operating processes for prison riots.

### *Determination of a prison emergency*

233. The Corrections Act 2004 contains a mechanism for the formal determination of a prison emergency. Such a determination provides protections from certain liabilities and requires the Minister of Corrections to be notified. Implicit in such a notification is that the relevant emergency requires the intervention of other government departments, for example Police or Ministry of Defence.
234. A prison emergency is defined in the Act as an emergency affecting the safety or health of prisoners (or any class or group of prisoners) or the security of the prison and in respect of which the Chief Executive reasonably believes that the corrections system is no longer able to fulfil its purpose of ensuring custodial sentences are administered in a safe, secure, humane and effective manner.
235. Section 179D of the Corrections Act 2004 provides that the chief executive must notify the Minister within seven days of determining the existence of a prison emergency. The notification must be in writing and must, among other things, set out the actions taken to date in respect of the emergency and specify any action proposed to be taken to enable the corrections system to fulfil its purpose.
236. Pursuant to section 179E of the Act, the effect of such a determination is there is no cause of action against the Crown, a Minister of the Crown, an officer or employee of a Minister of the Crown, the Chief Executive, an employee of Corrections, a contractor, or an independent contractor, to recover damages for any harm or loss that is due directly or indirectly to any failure by any person to comply (or comply fully) with any provision of this Act or the regulations if the failure occurs during a prison emergency and it is impossible or unreasonable in the circumstances to comply (or comply fully) with this Act or the regulations.
237. There is no exemption from liability for a person where the act, omission or failure was committed in bad faith or gross negligence. Further, the Act does not prevent the Crown from making any ex-gratia payment it considered justifiable on the basis of fairness or hardship, limit section 104 of the Public Service Act 2020<sup>75</sup> or affects any cause of action relating to unlawful arrest or detention.
238. While the Minister was kept informed throughout the Waikeria riot there was no determination or notification pursuant to section 179D.
239. It was open to the Chief Executive to consider section 179D. However, it is unclear whether 179D was explicitly considered by anyone involved in the response.
240. We further understand there was no legal consultation on the issue of whether section 179D should be explored at the time.

75. Which protects public service chief executives, deputy commissioners and public service employees and provides immunity from liability in civil proceedings for good-faith actions or omissions when carrying out their responsibilities or when performing their functions, duties and powers.

## 8. Impact of the riot

### *Impact of the riot on staff*

1. The riot had an almost universal impact on hundreds of Corrections staff. We were told of the impact on staff mental health and note that some staff later suffered from post-traumatic stress disorder.
2. A PCO told this Inquiry:

*“With the Hōkai Rangi Strategy, which is a great document and it’s got its place obviously, it’s hard to do that when you’ve had the lived experience of threats, weaponed assaults, the whole place burnt down.”*

### **Wellbeing support during the riot**

3. This Inquiry found there was some good work done supporting the mental and emotional wellbeing of staff during the riot, including the provision of support from managers, the Employee Assistance Programme and psychological first aid.
4. However, interviews with staff across a variety of teams raised issues relating to the provision of food, accommodation, clothing, exposure to heat/sunlight, working long hours and a delay in providing the necessary wellbeing support.
5. This Inquiry heard that the EOC and NCC considered that the riot would end quickly, so they did not consider the welfare of PNT and ACR staff, who were working long hours.
6. In an ACR debrief the day after the prisoners surrendered, it was made clear there needed to be a greater focus on the wellness and wellbeing of the responding staff, particularly in relation to accommodation, food, families/whānau and communication.
7. Staff noted that after every shift there was a debrief, including sessions with the Post Incident Response Team where people were asked how they were coping.
8. The Employee Assistance Programme Critical Incident Response Team was brought on site on 1 January 2021 to provide support to staff.
9. On 2 January 2021, the Corrections’ Staff Wellbeing Support Services Team provided support to staff and management involved in the response to the riot, and provided psychological first aid to 229 people when they were on site.

### **Support after the Top Jail evacuation**

10. On the first night of the riot and after the evacuation of the prisoners from the Top Jail was complete, the Regional Commissioner decided to delay negotiations with the prisoners on the roof for the evening to enable staff to have a break. He explained:

*“We’d just gone through the major operation of evacuation. I’ve got a lot of staff on site that were very fatigued. They’d done very long hours. There would have been adrenaline, there would have been some trauma. All those sorts of things. And so, I went, ‘No, we won’t engage directly at this point. We need to rest our staff.’”*

11. The Regional Commissioner told this Inquiry he instructed that every staff member be spoken to by a Post Incident Response Team member before leaving to check on their welfare and ensure they were fit to drive home. Staff were required to telephone when they arrived to make sure they got home safely. The Regional Commissioner also said he sent messages around the site for staff to take time to contact their whānau and let them know they were safe.
12. However, we heard concerns from some staff that they did not receive a welfare check prior to driving home.

### **Food**

13. This Inquiry heard conflicting information about whether sufficient food was provided to staff responding to the riot and who it was provided to.
14. An Incident Controller involved from Day 4 was satisfied with the provision of food and water:

*“Largely St John’s and Fire were doing that [organising food supplies] ... People were getting an opportunity to rotate out and have breaks and also I went forward a couple of times and took water bottles and stuff to the teams.”*

15. However, some members of the PNT noted a lack of food and water. One negotiator told us the PNT felt neglected:
 

*“A lot of the food and the logistic side of it was thought about for ACR and for other areas, but negotiators were pretty much forgotten about ... That demoralised the team.”*
16. Another member of PNT told us the negotiation team had enough water but, on one occasion, PNT was provided with two lunch packs between four people, each containing a biscuit and a sandwich. They were told they could have some of the food provided to ACR, however there was not enough.
17. Issues with organising meals for ACR staff were also noted. The ACR team reported having lunch and then having to go nine hours without a meal, not being fed after night watch shifts, and no consideration being given to dietary requirements.
18. A Corrections’ senior leader noted he was aware the ACR and PNT teams felt unsupported in terms of food and accommodation and suggested that the Department should think about deploying a logistics person as part of the EOC to deal with those issues.
19. This Inquiry found that for the first two days of the incident, the logistics role in the EOC was marked “none”, indicating that no staff member was apparently assigned to the role.

### Accommodation

20. Multiple staff reported being fatigued and having difficulty sleeping when off duty during the course of the riot. As such, it was particularly important there was sufficient and appropriate accommodation available for staff to rest between shifts. This did not always happen.
21. There were difficulties determining who needed accommodation. Some staff who worked at SHCF and MECF lived in Hamilton, so did not need accommodation to be booked, but those arranging it did not know who they were.
22. Staff from other prisons, who travelled to Waikeria Prison at short notice, reported a lack of accommodation. Some staff were forced to drive several hours home after their first shift in the middle of the night or make their own arrangements.
23. There was a lack of communication about accommodation arrangements. Some staff were sent home when accommodation had been booked for them, and other staff arrived at accommodation that was fully booked.
24. In some cases, staff would stay in a hotel one night and the next night there would not be a bed available for them there.

### Clothing

25. We heard complaints about the lack of replacement clothing made available to staff from other prisons who travelled to Waikeria Prison at short notice. Given the urgency of the response, many staff did not bring sufficient personal clothing. This clothing issue came to the attention of the new leadership team that took over on 1 January 2021, and clothing was purchased for these staff.
26. Staff told this Inquiry there were insufficient uniforms for ACR members. ACR staff had to wash their overalls each day as only one set was provided. This took up valuable sleeping time for staff who were already fatigued.
27. ACR staff also told this Inquiry they had to wear their personal protective equipment over the top of their fire retardant overalls, which meant if they were exposed to direct flames or heat the personal protective equipment would likely melt.

### Heat

28. Many staff responding to the riot told this Inquiry of difficulties caused by being outside in the sun wearing personal protective equipment and overalls. It took approximately four days for gazebos to arrive on site to provide shelter.

**Wellbeing support after the riot**

29. On 7 and 8 January 2021, Critical Incident Debrief specialists were on site.
30. The Department's Health, Safety and Wellbeing Team developed the Waikeria Prison Wellbeing Support Plan in January 2021, which outlined support for staff whose wellbeing and mental health may have been impacted by the riot. The plans commonly included:
- » Meetings with the wellbeing advisor
  - » Provision of psychological first aid
  - » Access to a specialist clinical psychologist
  - » Access to Employee Assistance Programme
  - » Access to Kaumātua
  - » Access to union support.
31. Some staff members described the initial post-incident support provided by Corrections as positive. Discussing the staff welfare response, the HCM told us:
- "Everybody had the opportunity to talk. There's a lot of us, and I'll say we were traumatised quite severely. But we all had the opportunity to contact someone and talk to somebody if we wanted it and that was made clear every day. I received a couple of phone calls from National Office from the health team ... That was great."*
32. Conversely, this Inquiry heard from other staff that access to and the provision of wellbeing support varied.
33. On 20 January 2021, the Corrections Association NZ delivered a presentation called 'Stand TALR' to about 25-30 people at Waikeria Prison. A cross section of staff attended from custodial, management, case management and health. Stand TALR is a programme of awareness designed to encourage corrections officers to overcome the resistance, fear and stigma of seeking professional help when faced with mental health challenges following events such as a riot.

**Longer-term support for staff**

34. Staff members generally appeared to be aware of the ongoing support available to them.
35. We were informed the Department has tried to provide continuous avenues for people to gain support rather than imposing a blanket approach on the basis that some deal with trauma immediately and some require assistance after some time.
36. Some staff felt they did not receive adequate recognition for their role in the riot. They received an impersonal email but no personal acknowledgement.
37. One health staff member noted that the overtime pay that she received was low and the time off in lieu that she received was effectively useless as it was difficult for her to take time off due to her responsibilities on site. She made it clear that she did not do her job for the money, but the lack of recognition left her feeling disappointed and undervalued. Another health staff member also noted that she felt undervalued by the lack of compensation she received for her work during the riot.
38. It was identified that many staff needed support as time went on, even if they had not initially felt they needed it. The Recovery Manager told us:
- "[Staff] felt well supported at the beginning but I think as time went on that's when they started to feel like they needed more support. Probably it's just realising how close of a situation they were in etc, and the psychological impacts of that ... So that's actually why we kept EAP [Employee Assistance Programme] on I think for two or three weeks on site."*
39. We are aware that some staff have not returned to work following the riot and have heard conflicting information about the support provided to these people by the Department.

**Displaced staff**

40. Since the riot, and as a result of the loss of the Top Jail, a number of staff (including a Residential Manager, PCOs, SCOs and corrections officers) have been seconded to other sites, including SHCF, Auckland Prison and MECF. Other staff working in the Top Jail prior to the riot have been re-deployed to the low security facility.

41. Around 60 custodial staff from the Top Jail were displaced. However, given the new facility being built at Waikeria, it was important to retain staff for future deployment to the new build. The decision was made that staff would not lose their jobs, despite the loss of the Top Jail, and would be looked after in the interim, including being offered secondments.
42. The relocation of staff to other sites posed some difficulties. There was tension caused by requests for staff from Prison Directors and Regional Commissioners.
43. Corrections identified that it was important to keep staff connected to Waikeria Prison during the new build construction period, despite some of them being on secondment. Staff are rotated so they do not spend the time working at other sites.
44. This Inquiry notes that a number of Waikeria Prison staff have been medically retired since the riot.

### Communication with staff

45. Information was provided to all staff at Waikeria Prison and key staff in the Central Region who were closely connected to the site. The communications included information about staff wellness and wellbeing, expressions of interest for secondments to work at other sites, asbestos risk and management, and personal property.
46. A Waikeria – Information for Staff page was set up on Corrections’ intranet Tātou for staff to access information about the recovery process. It included information about coping after a stressful incident, making property claims, and what steps had been taken in relation to the asbestos risk.
47. Information sheets were provided to staff containing key messages about the recovery phase, the loss of personal property and contact details for questions. Staff were also provided with information about the Waikeria new build development.

## Impact of the riot on prisoners

### Experiences of the evacuated prisoners

48. Prisoners at Waikeria Prison told this Inquiry about the profound impact the riot had and continues to have on them.
49. At the media conference held after the prisoners surrendered, the Chief Executive said:
 

*“I want to emphasise the actions by the men exposed them, other prisoners, our staff and emergency services to significant danger. It caused a huge amount of trauma to the 200 prisoners that were evacuated from the Top Jail, under urgency, during fires. It has significantly impacted on the 500 men that remained at the low jail site. The family and friends of prisoners of Waikeria, including the men who took part in the disorder, have been beside themselves with worry. There is no excuse for the things these men have done.”*
50. This Inquiry heard from the National Commissioner about the sense of personal loss felt by many prisoners:
 

*“They thought the jail had been stolen from them, they thought the rioters had no right to do that to them ... We don’t necessarily want people to feel they have strong connections with prison but, the reality is, we’ve had generations of men going through that Top Jail and it was for many of them, rightly or wrongly, a second home - sometimes even a first home. For many of them that sense of loss has been hugely significant.”*
51. When the riot began, prisoners said they could see smoke, fires and the men on the roof. Prisoners reported being locked for around eight hours as their cells filled with smoke and water. Some reported that smoke was pumping through the air conditioning system into their cells.
52. Staff turned off the water to manage the flooding which, in turn, meant the prisoners had no access to drinking water. One of the prisoners described having black soot in his nostrils and said his back window broke, and a “vortex” of smoke entered his cell. He put his mattress up against the window, but it did little to stop the smoke.
53. A prisoner told us the windows started melting and sooty smoke started coming into his cell. Another prisoner told us he “started getting freaked out” as “everything was on fire”. Two prisoners told us they were anxious about inhaling asbestos-laden smoke.



54. Prisoners we spoke to responded to the effects of the fire in a variety of ways including covering their faces, lying on their bed, trying to smash a window or kick down the door, and crying.
55. Many of the prisoners reported they thought they were going to die. We spoke to one man who, while awaiting evacuation, contemplated taking his own life to avoid burning to death in his cell. He told us he could not stand up or he would inhale smoke, so he got on his hands and knees *“and started to sob and pray,”* thinking he would die. He wrote letters to his children, parents and partner, and sealed them in a hot water flask so they would not burn.
56. Some of the prisoners described their experiences in the following ways:
- “It started to get dark and the power blew out. By this stage we were kicking the doors. We were screaming out for the guards to get us out of there. Cells started to fill with smoke. The plastic on the window ... started to melt.”*
- “Imagine yourself inside a glass dome and everything around you is on fire and all you can hear, this is the sound, is popping popcorn. That’s all I can explain. That’s what we went through. If you can imagine the concrete, how hot it would have been. We were cooking alive. There was 15 of us in a row and we were cooking alive.”*
57. Another expressed distress that they were not evacuated sooner, noting that cats and dogs would be rescued if there was a house fire, yet they were left in their cells.
58. The prisoners told us they felt abandoned. Staff did not respond to the cell intercoms. Prisoners reported that staff would pass by their cells but would not tell them what was happening or whether they were going to be evacuated. A prisoner told us:
- “It was extremely scary ... I’m thinking, ‘this is my last day I’m ever going to be here’. I’m lying on the floor ... I could hear doors getting booted open, but I was fearful that those were the rioters coming in and hurting me. There was still no communication that there was actually an evacuation in progress.”*
59. When an ACR staff member finally arrived to evacuate one of the prisoners, he noted that the room was pitch black with smoke. A prisoner told this Inquiry the fire got to the point of being approximately one metre from his cell window.
60. Many of the prisoners described the trauma caused by being trapped in their cells and how it continued to affect them.

### Directed segregation of some prisoners

61. Following the evacuation of prisoners in the Top Jail, a number of prisoners were subject to directed segregation orders when they should not have been.
62. Twelve evacuated prisoners spent the night in a Miro Unit programme room. One of these prisoners forced open and broke a door. The 12 prisoners were transferred to SHCF on 30 December 2020 and placed on arrival on directed segregation for good order and security of the prison.<sup>76</sup>
63. Verbal approval to place the 12 prisoners on directed segregation was given by the SHCF Prison Director, who was an Incident Controller in the EOC at Waikeria Prison during the riot. The reason was recorded as *“Concerted Indiscipline (Prop) - Failed to comply with instructions. This is in relation to a serious incident at Waikeria Prison”*.
64. On 31 December 2020, eight of these prisoners were transferred to Auckland Prison. A further two were transferred to Auckland Prison on 5 January 2021, and one was transferred to Manawatu Prison on 6 January 2021. One prisoner remained at SHCF.
65. There was only evidence to support the directed segregation order for one of the 12 prisoners. On 8 January 2021, the Senior Advisor to the Regional Commissioner revoked the order in relation to the remaining 11 prisoners due to the lack of evidence.
66. Following the revocation of the orders, 10 of the prisoners continued to be managed on directed segregation for an additional four days, despite the revocation being communicated to Auckland Prison.

76. S 58(1)(a) of the Corrections Act 2004.

### The four prisoners who came down from the roof on 29 December 2020

67. Four of the prisoners broken out of their cells by the prisoners on the roof came down the same night.
68. Prisoners Mr P and Mr Q were broken out of their cells unwillingly by rioting prisoners and taken on to the roof. Mr P and Mr Q escaped a little later, as a staff member distracted the other prisoners. They had been assaulted and told they would be thrown off the roof. Mr L and Mr V were also broken out of their cells and went onto the roof after Mr P and Mr Q had come down. They decided not to take part in the riot and came down after a short time. None of these prisoners were charged by Police in relation to the riot.
69. No at-risk assessments were completed on Mr P or Mr Q at Waikeria Prison prior to them being transported to Auckland Prison. Information regarding these prisoners' traumatic experiences does not appear to have been recorded or passed to relevant staff.
70. This Inquiry offered to meet with Mr P and Mr Q. Mr Q declined and Mr P was interviewed but did not want to talk about the experience of being broken out of his cell.
71. Mr P, Mr Q, Mr L and Mr V were transported to Auckland Prison at 12:30am on 30 December 2020. Upon arrival, they were placed on directed segregation with denied association (under s 58(1)(a) of the Corrections Act). The reason recorded was:

*"Prisoner has been identified as being potentially playing an active part in the disorder event at Waikeria Prison. In this case the event is active and further investigations will be continued and completed – identifying if there is a need for a segregation direction to continue. At this time it is appropriate to deny the prisoner's association with others. This will be to minimise any potential influence on other prisoners to be disruptive."*

72. All four prisoners were managed as maximum security prisoners at Auckland Prison.
73. The segregation orders were all extended on 13 January 2021. Mr Q<sup>77</sup> and Mr P's directed segregation was revoked on 11 February 2021. Mr L's order was revoked on 19 February 2021 and Mr V's on 28 February 2021.
74. The following health alert was placed on Mr L and Mr V's file on 3 March 2021. It was not placed on Mr Q and Mr P's IOMS files until 19 May 2021:
- "At risk of delayed trauma due to displacement from Waikeria prison during top jail fire 29/12/2020."*
75. On 1 July 2021, the Chief Inspector wrote to the relevant Prison Directors advising that these prisoners did not participate in the riot and had no Police charges in relation to the riot. The Chief Inspector requested consideration be given to adding the following statement to the prisoners' deactivated alerts.
- "On 29 December 2020, [prisoner] and his cell mate were broken out of their cell by prisoners who had gained access to the roof. They have no charges related to the riot incident."*
76. This statement was added to each of the alerts. On 7 July 2021, a letter was sent to the prisoners advising them the above statement had been added to their deactivated alert.

### The 17 prisoners charged in relation to their involvement in the riot

77. Of the 16 prisoners who surrendered on 3 January 2021, 13 were transferred to Auckland Prison and three to MECF. All 17 prisoners (including Mr C, who came down from the roof on 31 December 2020) were charged with rioting, aggravated burglary, riotously destroying property, and wilfully setting fire to property endangering life by rioting.
78. In terms of their management, all 17 prisoners were initially placed on directed segregation with denied association. This Inquiry was advised that the denied association order was later changed to allow most of the prisoners to associate in small numbers. Auckland Prison managed all prisoners (except Mr C) as maximum security, whereas MECF managed them as high security. Persons of Extreme Risk Directorate alerts were added in IOMS to all prisoners who were associated with the Mongols MC and Comanchero MC.

77. Mr Q remained on directed segregation following his transfer to Rimutaka Prison on 4 February 2021. It was revoked the day he arrived at Manawatu Prison.

79. There were inconsistencies in the information recorded in the 17 prisoners' offender notes, which made it difficult to determine what health and mental health support had been provided. Some prisoners were waitlisted for educational interventions but had not been able to access them. Some prisoners were able to access cultural support from June 2021.
80. Access to a case manager was also inconsistent. Some prisoners did not have an allocated case manager, some had not had contact with their case manager, and some had only had initial contact with their case manager.<sup>78</sup>

### *Impact of the riot on Corrections' operations*

#### **Impact of the riot on the prison**

81. The Top Jail was damaged to such an extent it can no longer be used.
82. The final financial cost is not yet known. An initial estimate is that the riot will cost Corrections between \$74.3 and \$84.6 million.<sup>79</sup>

#### **Loss of services**

83. Waikeria Prison lost key functions for its whole site including the ISU, kitchen, laundry, Receiving Office, and AVL suite. This left the low security facility without the ability to prepare meals, do laundry, process arriving and departing prisoners, or access video links (for court appearances, appointments, or whānau visits) for the 500 prisoners who continued to be housed there.
84. The riot had an immediate impact on the low security facility (in particular Miro Unit) and SHCF. During the riot a decision was made that SHCF would cook hot meals<sup>80</sup> and do the laundry for Waikeria Prison. Hot meals and laundry were delivered daily. The low security facility was able to prepare breakfast and sandwiches on site.

#### **Loss of beds**

85. The riot resulted in the loss of 310 beds, including 26 ISU beds. This was a significant loss of capacity for Corrections' Central Region and the prison network as a whole.
86. As a result of the configuration of beds between high and low security, the loss of beds placed significant pressure on Corrections being able to house prisoners remanded in custody. Decisions had to be made quickly about where remand prisoners would be housed.
87. Two hundred and fifty-five beds that had been closed in North Island prisons were reopened. This included 45 high security beds at Auckland Prison, 90 high security beds at MECF, 60 lower security beds at SHCF, 15 high security beds at Rimutaka Prison and 45 lower security beds at Northland Region Corrections Facility.
88. SHCF replaced Waikeria Prison as the receiving site for prisoners remanded in custody from courts in the Central Region. To do this, the remand prisoner cap at SHCF was increased from 411 to 471. Any prisoners over the cap are housed at MECF.

#### **Disruption to rehabilitation**

89. There was limited disruption to rehabilitation programmes. The Short Violence Prevention Programme was scheduled to run at the Top Jail from 18 January 2021. Corrections moved the programme to Auckland South Corrections Facility and transferred the prisoners who were to undertake the programme.

#### **Loss of property**

90. The property storage room for Waikeria Prison, located at the Top Jail, was completely destroyed in the fires. Additionally, for evacuated prisoners, all personal property left in their cells was destroyed by the fires. Staff who worked at the Top Jail also had personal property destroyed.
91. Approximately 17,000 pieces of individual property belonging to staff and prisoners were lost because of the riot. This affected around 844 people.<sup>81</sup>

78. As at 2 September 2021.

79. As estimated at 15 March 2021. See: Ara Poutama Aotearoa Recovery Report (Department of Corrections, March 2021).

80. The original plan was to continue to use the Top Jail's kitchen after professional asbestos cleaning took place. However, the decision was later made to decommission the entire Top Jail.

81. Cabinet paper lodged on 6 May 2021 by the Minister of Corrections, *Ex gratia payments to prisoners and staff who lost personal property as a result of the Waikeria Incident*. This was the property of prisoners (212 prisoners housed in the Top Jail, 494 housed in the low security facility and 140 in other locations) and a number of staff.

92. Items lost included identification documents such as birth certificates, driver licences and passports; jewellery, clothing and items with significant cultural value.<sup>82</sup> Items of personal and sentimental significance were also lost, such as children's artwork and photographs.
93. A prisoner told us:
- "This is the last [X] years I've been in prison of my kids' photographs, pictures, drawings. Everything. Irreplaceable ... How do I put a property claim in for that stuff?"*
94. Working through the loss of property and putting processes in place to respond to the loss was a significant undertaking for Corrections. We note that Corrections worked promptly and proactively to establish a process to compensate those who lost property during the riot.
95. All property documentation in IOMS was reviewed to identify the prisoners eligible to claim for the loss of property. This included prisoners who were at Waikeria Prison at the time of the riot, those at other prisons who had property at Waikeria Prison, and those who had been released into the community. A total of 792 prisoners were identified as eligible to make a property claim. The prisoners involved in the riot were deemed not eligible.
96. An email providing information about the loss of property was sent on 8 January 2021 to all Prison Directors. All prisoners who lost property were also advised, by letter and by custodial staff, of the process in relation to payments for destroyed property.
97. To ameliorate the immediate impacts of the lost property, Corrections' Chief Executive decided on 27 January 2021 to make an ex-gratia payment of \$100 to affected prisoners.<sup>83</sup> This payment was made to enable the men to purchase items they required. This decision was communicated to prisoners by a letter dated 29 January 2021. The payments were made on 4 February 2021. Prior to this, urgent claims were considered on a case-by-case basis.
98. On 17 May 2021, Cabinet approved payment to prisoners and staff in response to claims on an ex-gratia basis of up to \$1.3 million for prisoners and \$50,000 for staff.<sup>84</sup>
99. Corrections subsequently developed a process for prisoners and staff to make claims for lost property. A total of 764 prisoners made property claims for a total of \$666,399.12.<sup>85</sup> From mid-July 2021, the prisoners began to receive letters detailing the ex-gratia payment they would receive or giving them reasons for their claim being declined.
100. The Office of the Inspectorate received 87 complaints from 47 prisoners regarding property destroyed due to the riot. Ministerial Services received seven complaints from prisoners related to the delay in receiving compensation for the property.
101. Staff who lost property in the riot completed claims. Thirty-one staff lodged property claims to a total value of \$18,345.75.<sup>86</sup>

### Corrections' Recovery Plan

102. After the surrender of the prisoners from the roof, Corrections transitioned to recovery management. Corrections' Recovery Report defined this as: *"the process of planning, testing and implementing the recovery procedures and standards that are required to restore operations to either their previous service/operational level or an improved future state"*.
103. Corrections used the CIMS framework for its recovery planning and implementation.
104. In its Recovery Report, Corrections stated that its recovery from the riot:
- "...has focused on the planning of current and future operations at Waikeria Prison and the wider prison network, and on the wellness and wellbeing of our staff and of the people in our care affected by the incident."*

82. Ara Poutama Aotearoa Recovery Report: Appendix 1 (Department of Corrections, March 2021).

83. Payments were not made to the 17 who were being considered for criminal charges as a result of the riot. However, the decision-making paper noted that their needs should continue to be assessed on a case by case basis and responded to appropriately.

84. Minute of Decision SWC-21-MIN-0064 (12 May 2021).

85. As at 17 September 2021.

86. As at 17 September 2021.



105. The Report highlighted the need to develop interim solutions to keep the site operational until the completion of the new build.
106. Upon completion of the incident response phase, Corrections' recovery was split into three phases: short-term, medium-term and long-term.

### Short-term

107. Short-term recovery covered the six to eight weeks following the riot. During this period, a Recovery Management Team, led by the Regional Commissioner as Recovery Programme Director and supported by a Recovery Manager, was established to lead the short-term recovery. The focus during this stage included:
- » Monitoring and supporting the wellbeing and welfare of staff
  - » Monitoring and supporting the wellbeing and welfare of prisoners
  - » Taking immediate action to keep essential support functions going (including telephone, television and radio communications)
  - » Managing immediate hazards (such as asbestos)
  - » Reconfiguring IT and electronic security systems
  - » Maintaining good governance processes and working with stakeholders throughout
  - » Ensuring regular communications with staff and prisoners (including those who had been released).
108. In March 2021, Corrections put in place a number of interim measures, at significant expense, until the new build is completed in 2023. These included:
- » Leasing containers to provide a full kitchen at the low security facility, at an estimated cost of \$1.05 million.<sup>87</sup>
  - » Refurbishing an engineering workshop at the low security facility into a laundry at an estimated cost of \$540,000.<sup>88</sup>
  - » Refurbishing two programme rooms in Totara Unit in the low security facility to create four AVL booths, a waiting area and space for staff. Programme space has been created in the Visits hall and a portacom has been purchased. This option was estimated to cost \$1.2 million.<sup>89</sup>
  - » Bringing new buildings on site for office space and reconfiguring existing office space to fit more work spaces, at an estimated cost of \$560,000.<sup>90</sup>
109. A decision was made to refurbish Miro Unit to become a small Receiving Office for Waikeria Prison. This resulted in the loss of 33 beds.
110. On 17 March 2021, the Recovery Management Team disbanded and handed over to general Corrections operations. A number of actions happened in this period to respond to the operational challenges at Waikeria Prison, the loss of beds across the prison network, and the physical and emotional impacts the riot had on individual prisoners and staff. These included setting up a roster to deal with the large number of displaced staff, allocating resources to facilities that received evacuated prisoners, and setting up new systems for Court appearances, AVL appearances and movements.
111. Discussing the short-term recovery phase, the Recovery Manager, noted:

*"Our short-term goals again were around the mental and physical wellbeing of staff and people in our care ... It was, what needs to happen? What are we hearing? What do we need to do?"*

### Medium-term

112. The medium-term phase focused on continuing to keep the site operational and working through any outstanding actions and risks. Demolition of the Top Jail (following asbestos removal) would be completed during this time frame, as would the blessing and burial of any taonga.

87. Waikeria: Lower Jail kitchen facilities works approval and endorsement (Department of Corrections, March 2021).

88. Waikeria: Lower Jail laundry facilities works (Department of Corrections, March 2021).

89. Waikeria: Lower Jail AVL facilities works approval and endorsement (Department of Corrections, May 2021).

90. Waikeria: Lower Jail office space funding approval (Department of Corrections, 22 March 2021).



113. Other medium-term actions included reviewing prisoner property processes, reviewing the ACR operating model practices and response times, cross agency emergency drill practices to ensure familiarity with location of EOCs at each site, reviewing Corrections' CIMS capability, reviewing the approach for koha/reimbursement to mana whenua following incidents, and progressing and delivering preferred solutions for the establishment of new laundry, AVL, kitchen and office accommodation at the low security facility.
114. This Inquiry was informed that progress had been made on all the medium-term actions, with some actions being completed (including reviewing the ACR operating model and the approach for koha/reimbursement to mana whenua).<sup>91</sup>
115. Reviewing the Business Continuity Model was a medium- to long-term action. We were informed that progress had been made on this and the review remained ongoing.

### Long-term

116. Long-term recovery will be complete when the new build at Waikeria Prison is opened. Until then, Corrections will rely on an interim approach to manage the prison population across the prison network and provide necessary services to Waikeria Prison.
117. Long-term actions included reviewing the coverage of negotiation-trained staff post the Making Shifts Work implementation, reviewing document management and the digitisation of medication charts and information, and collating contact information for relevant partners and stakeholders to be held centrally so it can be used in emergency situations. We were informed that some actions have been completed and some work remained ongoing.<sup>92</sup>
118. Ongoing wellness and wellbeing check-ins and support for prisoners on a regular basis were identified as an ongoing action. In response, an addition was made to a Corrections Business Reporting and Analysis (COBRA) report used by case managers to identify prisoners involved in the Waikeria riot. Case managers were then aware of potential trauma from the riot when working with the prisoners. Pocket cards were also developed and provided by the Health team which outlined what prisoners should look for in their own wellbeing and the importance of asking for and accessing help as required once released. The action has been completed.

### Progress

119. Corrections established a number of workstreams for the recovery, and regular updates on progress were provided to the Executive Leadership Team. The workstreams were:
- » Legal, privacy, risk and assurance
  - » Finance
  - » Staff wellness and wellbeing
  - » Prisoner wellness and wellbeing
  - » Operations
  - » Iwi stakeholder engagement
  - » Waikeria Prison Development
  - » Communications
  - » Programme direction and management.
120. As part of the iwi stakeholder engagement workstream, a cultural support plan was drafted. This plan outlined that the recovery team would prioritise a transition aligned to Hōkai Rangi, that utilised the core strengths of the response, and incorporated the Waikeria Prison Development Project's vision for the future. The plan noted that partnerships with iwi were critical in ensuring the recovery programme was managed in a way that was true to tikanga and continued to strengthen the partnership with iwi into the future. Partnerships were prioritised as a critical strategic objective of Hōkai Rangi.

91. As at 29 October 2021.

92. As at 29 October 2021.

121. The recovery phase aimed to manage all recovery activities in partnership with iwi and to navigate any cultural considerations that may exist or emerge over time.
122. Key considerations were:
- » The treatment of taonga.
  - » The development of *“guidelines and communications for instances of lost culturally significant property and the possible recovering of further items”*.
  - » The whakawatea (exit) from the site including the protocols to be observed, who would be involved and timeframes.
  - » Restoring the site and planning for the future.
  - » An acknowledgment of the site, including exploring options for a pou, monument, or information board.

### **The recovery of taonga and blessing of the site**

123. Corrections contracted engineering consultant Beca to provide advice on the recovery of items (evidence and taonga) from the Top Jail. Corrections sought to recover items included carvings, memorial plaques, paintings, key safes and evidence to be handed to Police. Beca also provided advice on the decontamination procedure for those who undertook the recovery mission. The recovery mission was undertaken by Beca and Downer contractors on 10 June 2021. A number of items were recovered.
124. Corrections worked closely with iwi and mana whenua to ensure that the process of taonga recovery prioritised cultural safety. A cultural management plan for demolition of the Top Jail site was developed in conjunction with Raukawa ki Wharepūhanga and Maniapoto ki te Raki, Kaumātua, Kuia and the prison’s Kaumātua rōpū.
125. A decision was made that recovered taonga should be put in storage then buried on the site. Iwi and mana whenua felt it would not be appropriate for recovered taonga to be taken elsewhere. It was also agreed that personal property and taonga could be returned to the owner if located.
126. To date, some taonga (carvings) have been recovered from the roof of the Top Jail, which were taken there by prisoners during the riot. Some taonga, which were able to be safely collected from buildings that were deemed safe such as the ISU and the kitchen, have also been recovered.
127. Once the Top Jail site is demolished, the recovered taonga will be buried where the Top Jail once stood along with a memorial plaque and a service will be held.
128. We are aware of plans to bless and farewell the site. Mana whenua and the Kaumātua rōpū are engaged with Corrections in relation to the demolition of the Top Jail.

## 9. Health Services

### General overview

1. Corrections' Health Services deliver a primary health model of care to prisoners. This includes initial and ongoing health assessments, health education and promotion, screening, immunisations, risk assessment and emergency responses and some disability support services. Health Services are comparable to what would be accessed from a community-based primary health care (general practice) provider although in the case of Corrections, the Health Services are nurse-led.<sup>93</sup>
2. The Health Services employ three nursing scopes of practice - nurse practitioners, registered and enrolled nurses.<sup>94</sup> Other health practitioners provide a range of services and include medical officers,<sup>95</sup> mental health clinicians/counsellors, dentists, physiotherapists and podiatrists. Some prisons employ health care assistants. Local pharmacies are contracted to provide prescribed and over-the-counter medications.
3. Mental health services are contracted to all prisons to provide mild to moderate mental health care and support. Specialist mental health services are provided by regional DHB forensic services. Addictions services are provided by DHB community alcohol and drug services. At some sites prison-based residential drug treatment programmes are delivered by experienced alcohol and other drug counsellors employed by providers contracted by Corrections. Each of the 18 prisons has a Health Centre with a health centre manager who is accountable for the delivery of health services.
4. With the introduction of Hōkai Rangi, a Kaupapa Māori model of care is being developed (with future inclusion of Rongoā Māori practitioners) which aims to deliver equitable health outcomes and help achieve pae ora – healthy futures for Māori.<sup>96</sup>

### Health Services at Waikeria Prison

5. At the time of the riot, the Waikeria Prison Health Services team had one health centre manager, two clinical team leaders, 16 full-time equivalent registered nurses, one health care assistant and one casual enrolled nurse. The Top Jail Health Clinic was staffed by five nurses (three rostered in the morning, and two in the afternoon) and a clinical team leader. Five of the registered nurses identified as Māori and were te reo Māori speakers (two of whom were reported to have undertaken health consultations in te reo). The Health Services team was fully staffed at the time of the riot.
6. Prisoners in the Top Jail were able to access all Waikeria Prison health services.
7. Two medical officers were contracted to provide 16 hours of services a week.<sup>97</sup> The medical officers visited the Top Jail one day a week, and were on call after hours. Dental services were contracted for eight hours each week and, at the time of the riot, were provided in two four-hour sessions (one in the Top Jail dental unit and one in the low security facility dental unit). A physiotherapist provided a four-hour clinic twice a week and a podiatrist provided a one-day clinic every four months.
8. Registered nurses were on site from 6:30am to 9pm seven days a week. A rostered on-call nurse provided after hours health services from 9pm–6:30am. Nurses referred prisoners for pre-hospital accident and emergency assessments to a local accident and medical centre in Te Awamutu. If more serious, prisoners were transferred to Waikato Hospital Emergency Department.
9. Prisoners could also be referred to the Waikato, Lakes, or Bay of Plenty DHBs for a full range of secondary and tertiary specialist services. This included forensic services, clinical nurse specialists for a range of services, district nurses, retinal screening services, epilepsy services, hospice care, sexual health nurses, specialist asthma services, disability support links, social workers, dialysis services, occupational therapists and hepatitis services.
10. The Health Services team was supported regionally by a Regional Operations Director, a Regional Clinical Director and a Clinical Quality Assurance Advisor.

93. The minimum standard for the medical treatment and standard of health care of prisoners is set out under section 75 of the Corrections Act (2004). Section 75 provides that (1) a prisoner is entitled to receive medical treatment that is reasonably necessary and (2) the standard of healthcare that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.

94. Specialist nursing roles e.g. clinical nurse specialists – mental health are also employed.

95. Medical Officers are general practitioners.

96. Hōkai Rangi Actions – Initiative Brief. 2021. Co-design of a Kaupapa Māori Health Service, including resourcing the services of Rongoā Māori practitioners.

97. At the time of the riot, the waiting time to see a medical officer in the Top Jail was about one week for prioritised cases and three weeks for non-urgent cases.

## Mental health and addictions services

11. Two mental health and reintegration clinicians, employed by Emerge Aotearoa, were on site full-time. They took referrals from the entire prison and worked with prisoners with a focus on the management of mild to moderate mental health issues, such as depression and anxiety. At the time of the riot, their active caseload was approximately 20-25 people each.
12. One mental health counsellor from Time to Live Health Care was contracted to come on site one day a week to provide prisoners with support for mild to moderate mental health issues (including anger management and grief).
13. ACC funded counselling was provided on site, for prisoners referred by case managers and health staff or who had self-referred. It could not be determined (at the time of the riot) how many prisoners at Waikeria Prison were either receiving active ACC counselling or awaiting assessment following referral.
14. The local community alcohol and drug service provided an alcohol and other drug service when required. Prisoners who received opioid substitution treatment in the community were able to continue treatment in prison. A six-month drug treatment programme was available on site (in the low security facility), but no short-term alcohol and other drug programmes were available across the prison network.

## Regional Forensic Health Service

15. Forensic services were provided to Waikeria Prison under a Service Level Agreement between Corrections and Waikato DHB's Midland Regional Forensic Health Service. Prisoners could be referred if they presented with acute or serious mental health issues.
16. Prior to the riot, the following Forensic Service staff were on site:
  - » Three psychiatrists, three days a week
  - » Three forensic nurses, four days a week
  - » One forensic nurse, full-time in the ISU
  - » One social worker, if required.

## Health Facilities in the Top Jail at Waikeria Prison

17. Prior to the riot, the prison's main Health Centre was located in the Top Jail. Facilities included:
  - » A medication room, which included patient hardcopy medication charts, all blister packed medications, controlled drugs (in a safe) and medication stocks.
  - » A dental unit.
  - » Treatment and consultation rooms (which had health service clinical equipment and consumables, including the emergency bag, oxygen and other emergency equipment).
  - » Administration, clinical team leader and nurses' offices (where prisoner hard copy files were stored).

## Health Services delivery in the Top Jail prior to the riot

18. Generally speaking, New Zealand prisons accommodate some of the most challenging and vulnerable people. These challenges provide unique opportunities for Corrections' health staff to protect, promote and improve the health of a marginalised population with some of the poorest health statistics. When compared to the community, the prison population has a disproportionately high number of people with multiple (frequently complex) comorbid health conditions.
19. The high prevalence of mental health and addiction needs of people in custodial care<sup>98</sup> means that Corrections is caring for more people with mental health and addiction related issues than any other single institution in New Zealand.<sup>99</sup>

98. Comorbid Substance Use Disorders and Mental Health Disorders Among NZ Prisoners study (2016) identified that: a) nearly all prisoners (91%) had a lifetime diagnosis of at least one mental health or substance use disorder compared to 40% of the general population, b) substance use disorders are seven times higher for the prison population than the general population, c) 87% of the prison population have a lifetime diagnosis of any substance use disorder compared to 12% of the general population, d) mental health disorders are 2.5 times higher in the prison population.

99. Hikitia Newsletter June 2021. Central Regional Mental Health and Addiction Service.

20. We heard from one of the Medical Officers and the Health Centre Manager (HCM) that the prisoners being received into Waikeria Prison had significantly more complex health needs than in previous years and there were a growing number of prisoners withdrawing from methamphetamine and presenting with significant mental health issues.
21. A senior nurse leader told us:
- "... certainly over my time in Corrections, the patient acuity is significantly higher now than it was when I started ... Over the past six-odd years, I've certainly noticed a massive difference in the type of prisoner that we're dealing with."*
22. We heard contrasting views about the quality of health services in the Top Jail. Several prisoners we spoke to said they were satisfied with health services and the wait times were adequate. Although, some said the wait times were too long.

### Health complaints system

23. At the time of the riot, health complaints were recorded in multiple ways:
- » Health request forms directly to the Health Services at the prison site
  - » The PC.01 system
  - » The Health Services Complaint form
  - » External mechanisms including the Office of the Inspectorate, Office of the Ombudsman, the Health and Disability Advocacy Service and the Health and Disability Commissioner.
24. Complaints are also received from prisoners' whānau.
25. This makes it difficult to reliably assess the number and type of health complaints. We heard that some staff considered the system for health-related complaints to be fragmented and it was described as *"disjointed and duplicative"*.
26. There were also concerns that the health complaints system did not have complete visibility from a National Office perspective.
27. When asked how many health-related complaints were received at the prison, we were told there were very few and no mechanism to determine the total number.
28. This Inquiry asked the Manager Health Quality and Practice, who is based in National Office, about the health complaints process:
- "We certainly don't have the level of visibility that provides some assurance that those health centre managers adhere to the [health complaints] policy; that are they being responded to within the timeframes, and are the people happy, and do they receive the response that they need, and we can't confidently say that that's happening."*
29. This Inquiry learnt it was difficult for health leaders to have oversight of the complaints system, as complaints were not centrally recorded.
30. This Inquiry heard staff raise significant privacy and confidentiality issues particularly in relation to the recording of health-related complaints through the generic PC.01 complaints system. This is an issue repeatedly raised by the Office of the Inspectorate and Office of the Ombudsman in previous inspections across various sites.
31. Between 1 January and 31 December 2020, the category which received the most complaints via the PC.01 process in Waikeria Prison was health services (110 complaints). It was also the top complaint category in the Top Jail (60 complaints).
32. Of the PC.01 health complaints in the Top Jail, 25 related to health service delivery, 14 to medication, five to obtaining/disclosing health information, four to access to outside medical services and 12 were recorded as 'other'.
33. The Office of the Inspectorate received 37 health complaints from Waikeria Prison during the 2020 year. Of these, nineteen related to access and quality of care, twelve to medication, two each to placement and complaints, and one each to diet and medical records.



34. The Health and Disability Commission received six health complaints during the 2019/20 period for Waikeria Prison. All related to concerns or issues regarding the provision of health care service delivery. Two of these related specifically to mental health care service delivery and one to the provision of medication. All six were recorded as being resolved.
35. This Inquiry found it was not possible to reliably assess all health-related complaints because they were recorded in multiple places. This made it problematic to identify themes and trends and undertake meaningful analysis.
36. This Inquiry heard concerns from staff about the complaints system. Comments were made that it would be useful to streamline and simplify how complaints were received, logged, analysed and responded to. Prior to, and at the time of, the riot there was no single system that collected or monitored complaints and complaint themes so there could be an appropriate response.
37. In November 2021, Health Services released the updated Feedback Policy: Compliments, Complaints and Suggestions. This policy provided a practice change in that PC.01 health complaints were no longer uploaded to IOMS but passed on to Health Services, to support the privacy of health information.<sup>100</sup>

### Health Services Incident Reporting system

38. The Health Services Incident Reporting (HSIR) policy was first created in 2012 with a review date for 2015. This policy has not been reviewed since its creation.
39. A clinical health incident is defined as *“an event or circumstance which could have or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage”*.
40. From 7 January and 14 December 2020, 45 health incidents were recorded through the HSIR programme at Waikeria Prison, most commonly involving medication (14) and staffing and equipment (6).
41. Of the 45 health incidents, 22 were categorised as Severity Assessment Code serious, major, and moderate (2, 7 and 13 respectively). Eleven health incidents were categorized as minor and 12 as minimal. None of these had a documented review and analysis of the incident or actions/recommendations taken. The incidents were also not closed within their (required) respective timeframes.
42. This Inquiry learnt that health leaders did not have an adequate oversight of incidents.
43. There were concerns about the usability of the HSIR system. We heard that health centre managers did not have time to close off HSIR incidents. We also heard that the HSIR reporting mechanisms *“glitch”* and are laborious and that the system is in urgent need of modification to reflect the practice context.
44. Between 7 January and 14 December 2020, 367 health-related incidents were recorded in IOMS. While some IOMS incidents may be duplicated in HSIR, it would not be expected that all health incidents that are recorded in IOMS would also be recorded in HSIR.
45. We heard from a wide range of health services leaders and managers that Health Services clinical governance systems needed to be reviewed and strengthened to enable robust analysis, monitoring and reporting of trends and themes relating to both complaints and incidents systems and to be able to evaluate any improvement made at national, regional and local levels.
46. When discussing both complaints and incident management systems, the Clinical Quality Assurance Advisor told us: *“There is no current system or framework or even policy that is current to practise”*.

100. The updated Feedback Policy: Compliments, Complaints and Suggestions has a practice change of storing all feedback, compliments and suggestions in a national Health Services Complaints and Official Correspondence register.

### Health Services during the riot

47. This Inquiry heard of many positive aspects of health service delivery during the riot. Waikeria Prison's Health team members managed the immediate health needs of prisoners with a high level of competence.
48. Health leaders and managers from SHCF and the regional management team responded and provided immediate support to their colleagues at Waikeria Prison.
49. During the incident, Waikeria Health Services staff continued to provide health services to the prisoners in the low security facility.
50. The evacuated prisoners who were transferred to Miro Unit were clinically assessed by St John Ambulance staff. Health staff were also present to support these assessments.
51. Health Services had to prioritise emergencies during this period that were occurring elsewhere across Waikeria Prison.
52. The Health Services team spoke positively of the custodial staff who provided support to the prisoners in Miro Unit and the Visits centre. There is evidence of collaborative teamwork to ensure the health and wellbeing of prisoners was assessed during the immediate incident.

### Smoke inhalation

53. Clinical assessments were completed including assessing for smoke inhalation. During the immediate period following the evacuation no prisoners required treatment due to smoke inhalation.
54. However, a number of prisoners we spoke with experienced coughing up black phlegm for approximately two weeks after the incident. The prisoners said that Health Services did not take this seriously and did not show concern for their wellbeing at that time.

### Medication administration

55. During the riot, a custodial decision was made that the low security facility would stay on lock-down for a prolonged period. This meant staff were only able to provide essential health services and welfare checks, and medication administration was delayed on the first night. The Inquiry heard that the delay in receiving medication had a negative impact on the men's well-being. The HCM told us:

*"... the guys were misbehaving, and misbehaving badly because they had not had their medications. I went into the medication room and got the medications. The worst of the worst medications, if you like, that really if they were going to miss they shouldn't miss those ones, and one was fairly strong pain relief. I got those sorted."*

56. This Inquiry found that, in the circumstances, this delay was unavoidable.

### Health response to the prisoners on the roof

57. Medications were not administered to the prisoners on the roof. We noted that the prisoners broke into the Health Centre and dispensary and had access to medicines. It is unclear if medication was acquired, but one prisoner was reported to have informed health staff post surrender that he had found his usual medication and had been taking it.
58. The Inquiry was told that the prisoners who surrendered at the conclusion of the riot were triaged and received thorough health assessments. This was a paper-based assessment. The Inquiry was told that injuries such as burns, cuts, and sponge round wounds were assessed and treated as necessary.
59. One health professional from MECF told this Inquiry that one of the prisoners from the roof arrived at MECF with burns on his face and subsequently required treatment at Middlemore Hospital. The staff member noted that it was unclear to them whether any medication or pain management had been administered to this injured prisoner prior to him arriving at MECF.

### Nurses as members of the Prison Negotiation Team

60. Two nurses were part of the PNT during the riot. While they performed their duties professionally and competently, the use of nurses as prison negotiators created the potential for ethical conflicts, as set out in international standards which state: *“The independence of health-care staff is crucial”*.<sup>101</sup> It also had the effect of removing experienced health staff from important clinical roles.
61. The Regional Operations Director Central commented:
- “What it did is it hampered our ability to have more staff rotation, I suppose, and resting of people. Sometimes they were in black negotiator gear, and then they were in health gear. Then I was trying to get one onto the roster. She was like, ‘I’m not really sure whether I’ve got to do the negotiation’, so that sort of trumped being a nurse.”*
62. Some health leaders and managers recommended that Corrections review the use of health staff in prisoner negotiation roles.

### Health Services disaster and emergency preparedness

63. This Inquiry heard from some members of the Senior Health Leadership team that they were not aware of their roles and accountabilities in response to a major incident. We also heard that the team had never undertaken any joint emergency management training as a team (or with the wider Executive Leadership Team). Nor had they engaged in any evacuation exercises or multi-agency disaster preparedness training with FENZ, Police or St John.
64. We heard that none of the Senior Health Leadership team had formal Corrections’ CIMS training or experience of an emergency of this magnitude at an executive level. Those who had experience or training had gained this in previous roles.
65. We heard from Health Services staff at local, regional and national levels that they were not considered to be integrated into any overarching emergency response structure or plan and there was limited clarity as to the expectations of their roles.
66. We heard that when leave and delegations across the Senior Health Leadership team were planned (prior to Christmas 2020), no consideration was given to the emergency skills and expertise of those acting in senior roles. The expectations of these senior roles in relation to emergency preparedness was never made clear.
67. The Acting Deputy Chief Executive Health at the time of the riot expressed concerns that Corrections’ Executive Leadership Team appeared not to be performing its governance function.
68. The ability of the Acting Deputy Chief Executive Health to advocate for the safety and wellbeing of the prisoners or to respond effectively when significant health issues arose was compromised by the lack of clarity between the function and purpose of NCC and the Executive Leadership Team.

### Health impact of the riot on prisoners

69. Some evacuated prisoners said in interviews with this Inquiry they felt they would always be traumatised, especially since they had already been through a lot in their lives. Some appeared to normalise and minimise the impacts by joking and saying things like: *“What can we do? Nothing”*. Some implied that coping with trauma was normal and said *“[you] just have to get on with it”*. Some prisoners told us the riot was not their first traumatic experience and noted the compounding impact of these experiences.
70. The prisoners were noted to have suffered the following ongoing effects of the riot:
- » Persistent thoughts of the fire and seeing fire
  - » Having flashbacks
  - » Coughing up “black bits”, sometimes for several weeks after the riot
  - » Feeling claustrophobic and triggered by containment (e.g. not wanting to go in vans, feeling anxiety in confined spaces)
  - » Insomnia

101. Guidance Document on Implementing the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) (2015) [https://www.osce.org/files/f/documents/7/b/389912\\_0.pdf](https://www.osce.org/files/f/documents/7/b/389912_0.pdf).

- » Anxiety
  - » Smelling smoke
  - » Post-traumatic stress disorder.
71. Seven ACC claims were made by the prisoners evacuated from the Top Jail – four related to physical injuries and three to mental injuries. We were told that none related to asbestos exposure.
72. As part of this Inquiry, we spoke to a number of evacuated prisoners and reviewed their files to ascertain what support had been provided to them. The interventions provided appeared inconsistent across many of the receiving sites<sup>102</sup> and, we were told in some cases, did not support their health and wellbeing.
73. On 8 January 2021, information was sent to prison directors whose prisons had received evacuated prisoners. This provided prisoners with information about loss of property, access to treatment, programmes, assessments and cultural support, asbestos exposure, dealing with stress from the riot, and support that was available if they felt they were not coping.

### Immediate response to support the mental health and wellbeing of prisoners

74. The Inquiry found evidence of appropriate mental health assessments and treatment, completed by external mental health providers and the regional Intervention and Support Practice teams at MECF and Auckland Prison, to ensure the health and wellbeing of prisoners. There was positive support from regional mental health providers to deliver immediate services to relocated prisoners. There was a regional and National Office discussion about whether the mental health needs of prisoners would be immediate or delayed in presentation. This did not appear to impact the service delivery offered to prisoners.
75. During the immediate period following the riot there was a co-ordinated national and regional response to provide psychological first aid to the prisoners who were transferred across the prison network. Regional Intervention and Support Practice teams at MECF and Auckland Prison and contracted external mental health providers were contacted to provide additional mental health support to the evacuated prisoners.
76. There were regional concerns regarding resourcing for those who may experience delayed trauma, however, according to National Office Manager Mental Health Quality and Practice, the resourcing was sufficient to work with the evacuated prisoners.
77. Immediate mental health emergency incident cover occurred in the following prisons: Waikeria Prison (8 hours), SHCF (5 hours), Whanganui Prison (4 hours), Rimutaka Prison (8 hours), MECF (9 hours) and others (5 hours).
78. On-going support was provided to MECF (224 hours) and SHCF (73 days).

### Trauma sessions for evacuated prisoners

79. Regular trauma group sessions were offered at Auckland Prison and MECF. The trauma groups were provided by the Intervention and Support Practice team from Auckland Region Women's Corrections Facility. This was an example of positive collaboration and teamwork across Corrections' mental health services.
80. The Director Mental Health and Addictions told us about the work the Clinical Manager of the Intervention and Support Practice team at Auckland Region Women's Corrections Facility carried out:
- "His team did a lot of work with the men who went to MECF and they, over a period of time, went over and did the initial assessments with all of those men to make sure that they were okay ... They then did some ongoing group work with the trauma counsellors who reported to him. I believe that was really successful."*
81. While some prisoners appeared unaffected by their experience, a few experienced significant deterioration of their mental health and were referred to the Forensic Service. Corrections liaised with ACC counsellors to take immediate referrals and start working with some of the men.

102. The majority of evacuated prisoners were transferred to SHCF, MECF, Auckland Prison and ASCF. Therefore, this information is primarily referring to these sites.



**Prisoners' experience of psychological support**

82. We heard varying accounts of the support provided to prisoners. The level and quality of support varied between receiving prisons.
83. Some prisoners did not feel they were offered support after the riot, stating that no-one regularly checked in with them and they did not receive communication about their property. Another said when he arrived at his new prison, staff did not speak to him about his experiences or offer support. He was eventually told that if he wanted support he should talk to his probation officer or a psychologist.
84. Another prisoner said he was offered support, but it never eventuated. Another said he got two counselling sessions after "harassing" for it and had been waiting for ACC counselling after being put on the wait list months previously.
85. Conversely, some prisoners spoke highly of managers, saying they were visible and supportive. One told us his PCO had been supportive and had arranged appointments for him with a psychologist and a trauma counsellor.
86. Another prisoner told us:
- "They sent some health person to talk about the safety and wellbeing of our tinana [physical self] ... like I'm a bit freaked out. He goes, 'No, it's alright, we'll help you through it if you need to come back for more stages.' I just wanted somebody to talk to, you know, just to let them [know] how I'm feeling. I don't want to end up getting depressed out of this stuff, and every week they would come over and have a talk to you. That made it easier because I knew then I wasn't alone."*
87. Another prisoner told us:
- "... I've got no time for rehabilitation in prison, I've got no time to listening to corrections officers ... I don't believe that they're promoting this tinana [physical self] and whanaungatanga [relationships with others], I don't believe it at all. Like, I've lost my whole spirit about it, my mental anguish, what I've been through since Waikeria closed has been, like, it's pretty horrible really."*
88. The types of support prisoners indicated they would appreciate included:
- » Mental and physical health support, including referrals to Improving Mental Health counsellors
  - » Trauma counselling
  - » Seeing a case manager or education tutor
  - » Kaiwhakamana and chaplain support
  - » Cultural support (additional to programmes currently offered)
  - » Sleeping medication
  - » An update on compensation claims.
89. A staff member told us work had been done on preparing a small card for the evacuated prisoners with simple mental health guidance such as "this is what delayed trauma could look like" and "this is who you could call if you would like to talk to someone".
90. The HCM at MECF raised the lack of cultural support as an issue:
- "The big area of deficit was cultural support. A lot of men wanted cultural support to deal with that displacement away from their whānau, that kind of stuff. Everything else was okay if they could meet with someone from their own culture to help them deal with it, and we just didn't have that, so that is a real gap. That's a regional gap; we don't really have regional cultural support workers to deal with that sadly."<sup>103</sup>*

103. The Kairuruku Hinengaro (Māori mental health practitioner) role has been introduced more widely since the riot.



## Post-release support

91. The majority of men who were released from prison after the incident were followed up in the community by the regional mental health teams. According to the Director Mental Health and Addictions, follow-up of the men in the community was positive due to the collaboration with Community Corrections.

*“The people who went off to the community [received] a bit of a follow-up and just making sure that they were still okay ... The probation staff and the district managers have been excellent at helping us find those people so that we can check that they’re all doing okay. Again, I think everyone has worked collaboratively.”*

## Impact of the riot on Health Services delivery

92. The destruction of the Top Jail had an immediate and significant flow-on effect for health services across the prison network.
93. For Waikeria Prison, the impact was seen immediately with the loss of the 277 beds (including 26 in the Intervention and Support Unit). This resulted in a 65% decrease in prisoners arriving at Waikeria Prison’s Receiving Office and receiving a reception health triage,<sup>104</sup> when comparing the first five months of 2020 with the same period for 2021.
94. During this time, SHCF experienced a 60% increase in reception health triage presentations in its Receiving Office as remand prisoners (typically managed as high security) who would have been housed in the Top Jail were taken to SHCF.
95. SHCF experienced higher levels of new arrivals, transfers and releases than it had previously. This created a higher demand for its health services and increased the time required for all aspects of medication management, medical officer clinics, and responding to the general health and mental health needs of its prisoner population.

## Loss of health care records

96. Every prisoner in the Top Jail had a hard copy health file (paper records) which were not stored on their electronic health file. These files were stored in lockable cabinets which were not fireproof. Medication charts for prescriptions were stored in folders in the Top Jail dispensary. All these paper-based records were destroyed in the fires.
97. This resulted in a lack of certainty as to the completeness of health records when prisoners were transferred, raising concerns with receiving health teams, particularly about current prescriptions.
98. One consistent concern this Inquiry heard was there was no clear process of documentation used by regional forensic services. Some services utilised their own DHB patient management systems while others used paper-based documentation. This was particularly significant for ensuring an accurate record for forensic medication prescribed for the prisoners in the Top Jail.
99. The Chief Nurse said forensic medication prescribing regimes were not consistent across regions. This process can be challenging for centralising key information and continuity of care for prisoners under forensic care.
100. The Waikeria Prison Health team recognised this potential risk and worked hard to ensure that new prescriptions were faxed to the receiving sites’ health centres prior to prisoners being transferred.
101. An Assistant HCM at a receiving prison told us:
- “For the forensic prison team at Waikeria, our significant issue was that their medications weren’t on MedTech<sup>105</sup> so we had absolutely no idea. Medications weren’t arriving, medication charts weren’t arriving and there was nothing on MedTech. So that was one of the big things.”*
102. We heard positive reports from prison health teams regarding the high level of communication between the Waikeria Prison Health Services team and receiving prisons. There is evidence of multidisciplinary co-ordination to ensure all prisoners were assessed and appropriate health services delivered.
103. There was a strong sense of collegiality and a commitment to providing the best possible continuity of care for prisoners who had been evacuated and were transferred to other prisons.

104. A reception health triage is undertaken by a registered nurse for every prisoner who enters prison and is a useful proxy when determining in and out volumes of prisoner movements. It is also a significant factor for nurse workforce modelling.

105. The electronic patient management system used by Corrections to record and store patient clinical information.

**Communications during the riot, including computers (MedTech) and telephones**

104. Access to MedTech at Waikeria Prison was lost during the riot due to the loss of the server. This had a major impact on health staff being able to safely deliver health services and document the health status of prisoners. It is not clear from conversations with clinical staff when the system went down and how long it was unavailable. The HCM reported that *“the wiring was burnt through, and Spark had to come out and fix it”*.
105. The HCM from SHCF, who was relieving the Waikeria HCM at the time, told us:
- “For the running of the prison having MedTech down for two or three days that I was there and not even like the cellphones kind of not working ... I think did impact on the health of men on that site. And the stress for the nurses as well because how were they meant to do any of their documentation and just following up things?”*
106. All communications were disrupted for the Health Services team. The HCM told us:
- “Cellphones were quickly distributed as we had no radios as well. Most custodial people were issued with [FENZ] radios. Cellphone blockers were turned off. This occurred from the 31st – we went into radio silence. Computers were working intermittently during this time on generators.”*
107. During the riot, intermittent electrical supply was considered likely to have an impact on MedTech connectivity and functionality.
108. Again, according to the HCM:
- “We got the use of our phones by about 3-4 days post-riot. The power remained an issue with constant outages, but our computers still fired up. National Office supplied us with phones.”*

**Impact on external health appointments**

109. The riot appeared to have a minimal impact on prisoners' attendance at scheduled external health appointments.
110. According to the Waikeria Prison Administration Support Officer, it was preferable for prisoners to be transferred to SHCF so health appointments could be maintained at the local DHB. However, this was not always possible.
111. National Office staff were involved after the riot, including centralising a database for external health appointments
112. Corrections' Health and Mental Health and Addictions Services contacted regional DHB Forensic Services teams to advise of the possible increase in prisoners on the forensic caseload requiring support. Generally, this information was well received by regional Forensic teams. However, some teams were concerned about the impact on prisoners, the change of service provider and the completion of court ordered reports. According to the Manager - Mental Health and Addictions, some Forensic teams experienced challenges with accessing AVL to communicate with evacuated prisoners.

**Impact of the loss of the Intervention and Support Unit**

113. The Intervention and Support Unit (ISU) at Waikeria Prison, located in the Top Jail, comprised 26 single cells (including one dry cell). The loss of these beds has had a significant and ongoing impact on the Central Region.
114. Prior to the riot, there were 196 ISU cells across the prison network. In the Central Region, 70% of ISU capacity was in the Top Jail. SHCF had eight ISU beds (and two dry cells) and Tongariro Prison has no ISU cells (prisoners assessed as eligible for ISU care are transferred to SHCF, Hawkes Bay or Waikeria prisons).
115. On the day of the riot, 10 prisoners were housed in Waikeria Prison's ISU. Of these, four were on the forensic waiting list for the Henry Rongomau Bennett Centre, Waikato DHB's forensic mental health facility.
116. After being evacuated, the 10 prisoners from the ISU were placed in a Health Centre staff room and observed overnight. A multidisciplinary team met the following morning to determine the most appropriate placement for these men, and they were transferred to SHCF (to the ISU).
117. On 15 January 2021, the Regional Commissioner approved a short-term plan for the Central Region for the management of prisoners at risk of self-harm or suicide who also required care in an ISU (as determined by a multidisciplinary team). This plan included the use of the Management Unit at SHCF as overflow from the ISU.

118. As part of this plan, Waikato DHB forensic services provided a daily psychiatrist clinic (Monday-Friday) at SHCF with forensic nurse support, and an additional mental health clinician position was added to the staff at SHCF.<sup>106</sup>
119. Despite the implementation of the short-term plan, the additional burden on SHCF's health team of managing an increase in acuity (level of severity/complexity of medical conditions) of prisoners became evident almost immediately.
120. Health Services incident reports from this period clearly reflected the relentless pressures and stress that the site was under.
121. SHCF had a high number of prisoners on the forensic caseload (149). On 20 June 2021, an email was received from the DHB forensic team raising concerns about the lack of custodial support to facilitate clinics and the difficulties in seeing scheduled patients on clinic lists.
122. On 6 July 2021, the Principal Clinical Inspector escalated concerns to the Deputy Chief Executive Health in a memorandum, highlighting that:
- "... given the increased demand of general health services and mental health services at SHCF, there was a significant clinical risk that something will be missed, leading to a serious or sentinel event ... and that staff will experience burnout and increased sickness."*
123. The Principal Clinical Inspector concluded with the following summary:
- "Since the start of 2021 following the Waikeria incident, Spring Hill Corrections Facility has had a significant change/impact in their operation. While the remand percentage on site remains relatively the same, the site has higher levels of new arrivals, transfers and releases than they had previously. These higher levels of population movements create higher demand for health services, increasing the time required for all aspects of medication management, medical officer clinics, responding to the general health and mental health needs of the population.*
- Spring Hill Corrections Facility is now the sole facility in the Central Region with an Intervention and Support Unit, and this is under considerable pressure, with men who are at risk having to be managed in the Management Unit (Separates). The site also has an extremely high volume of people who are being managed by the Forensic team, and Forensics report having difficulties in accessing men at scheduled clinics."*
124. This Inquiry also heard about the impact of the lack of ISU beds on MECF, which received prisoners from the Waikato region whose mental health had deteriorated. The MECF HCM told this Inquiry:
- "We're also passing on that burden to the Mason Clinic [Auckland's forensic psychiatric secure unit] ... The Mason Clinic don't have enough beds for the Auckland Northern region and they're taking on Waikato people."*

### Impact of the riot on Health Services teams

125. In the immediate period after the riot, the number of nurses at Waikeria Prison was reduced from 17.9 to 14.7 FTE (full-time equivalent) given the reduced prison population. According to the HCM, the reduced level of FTE was agreed with regional and national health leadership and considered adequate for the health needs of the remaining Waikeria Prison population.
126. In terms of the impact at other prisons, SHCF had an increase of health team staff with two enrolled nurse positions approved by National Office. We heard, though, that there were challenges and delays in getting people into these roles.
127. We also heard that the increase in health staff at SHCF was not sufficient to manage the increased workload and complexity. For example, based on the COVID Vulnerable Summary Report of April 2021, 75.8% of SHCF's prisoner population was highly or moderately vulnerable to COVID-19 due to their age or other health conditions.
128. We heard that both MECF and Auckland Prison experienced no additional pressure on health services staffing in the immediate post-riot period.

106. Memorandum to the Regional Commissioner (Central Region), signed on 15 January 2021, *Central Region at Risk Prisoners Management Plan following Waikeria Rioting*.

## Support for Health staff

129. Debriefing sessions were provided to Waikeria Prison health staff, including daily team communications, during the riot.
130. The HCMs at Waikeria Prison and SHCF told us there was continued support from the regional office leadership after the riot. This included weekly teleconference meetings between the HCM and Regional Operations Manager, and monthly meetings with Prison Directors. We heard that this level of ongoing support was valued and appreciated by the HCMs and health teams at both Waikeria Prison and SHCF.
131. National Office Health Services staff visited Waikeria Prison immediately after the riot to address the team's needs. We heard there was limited follow-up thereafter.
132. We heard some health staff were disappointed that their considerable efforts during the riot (in providing health care under constrained and difficult conditions) were subsequently neither recognised or not acknowledged appropriately by Corrections.

## Maintaining public health/hygiene and sanitation standards

133. Consistent with reports by the Office of the Inspectorate and the Office of the Ombudsman, this Inquiry found significant shortcomings with prison conditions in the years prior to the riot. These conditions led to a high level of dissatisfaction among some prisoners.
134. The Manager Health Quality and Practice told this Inquiry that Health Services should respond if they identify any hygiene and sanitation concerns.
135. This Inquiry identified a number of regulations, legislative provisions and policies relevant to public health, hygiene and sanitation standards in prison environments.
136. The provisions include:
- » The HCM taking all practicable steps to maintain the physical and mental health of prisoners to a satisfactory standard.<sup>107</sup>
  - » If the HCM considers it necessary, they can advise the Chief Executive of the equipment, supplies, facilities, and personnel required to provide for the health needs of prisoners adequately.<sup>108</sup>
  - » Where the HCM identifies an environmental issue that has a direct impact on the health and wellbeing of the prisoners, then they are accountable for raising this issue with the Prison Director.<sup>109</sup>
  - » A registered health professional, a Medical Officer of a prison, or a staff member who is a nurse can make recommendations to any other staff in respect of the health needs of a prisoner.<sup>110</sup>
  - » A Medical Officer of a prison may, and if asked to do so by an Inspector, Office of the Ombudsman or the Chief Executive must, inspect and give a written report on the condition of the prison or any particular aspect of the prison as it affects the health of prisoners.<sup>111</sup>
  - » A Medical Officer of a prison can at any time give the Chief Executive written recommendations on the health of any prisoner, or on any matter relating to the health or safety of prisoners.<sup>112</sup>
  - » Exceptional situations (e.g. in the context of notifiable diseases<sup>113</sup>) may require Ministry of Health public health control measures. Health care practitioners have reporting obligations under this legislation.
  - » Outbreaks of infections (e.g. scabies, boils, furuncles, and other skin infections) are managed locally by the HCM and the designated infection control champion on site.<sup>114</sup>

107. Corrections Regulations, 2020. 73. Duties of a Health Centre Manager.

108. Corrections Regulations. 2020. 73. Section (2)(b)(ii) Duties of a Health Centre Manager.

109. Corrections Regulations. 2020. 73. (4) Duties of a Health Centre Manager.

110. Corrections Regulations. 2020. 79. (1).

111. Corrections Regulations. 2020. 78. Inspections by medical officers.

112. Corrections Regulations. 2020. 79. (3).

113. NZ Health Act 1956. Schedule 1. Infectious Diseases. Guidance on Infectious Disease Management under the Health Act. 1956. Ministry of Health: 2017.

114. Ara Poutama Corrections Health Infection Control Policy. 2020. There is a responsibility for the cleaner to maintain a clean working environment and that the health team monitors this. This, however, only applies to the Health Centre. Although "any significant issues are reported to the ROD [Regional Operations Director]".



## 10. Asbestos risk

This Inquiry conducted a detailed review of Corrections' response to the potential asbestos risk at Waikeria Prison's Top Jail. Below is a summary of this review:

1. Asbestos was used extensively in the building industry for many decades. If left intact or undisturbed, asbestos presents no direct risk. However, if material that contains asbestos deteriorates or is disturbed this may result in the release of asbestos fibres into the environment which could be detrimental to health. Breathing in asbestos fibres can lead to the development of three fatal diseases (asbestosis, lung cancer and mesothelioma).
2. The Health and Safety at Work (Asbestos) Regulations 2016 requires Corrections to identify and mitigate the risk of respirable fibres in the workplace.
3. Multiple areas of the Top Jail were confirmed or presumed to have contained asbestos, including gas heaters, ceiling ventilation, cement soffits, and infill panels to walls on the rooftops.<sup>115</sup>
4. Waikeria Prison had an asbestos management plan, dated 22 August 2019, prepared by Major Consulting Group. The plan included a detailed asbestos register and emergency procedures to be followed when deteriorating asbestos was found or asbestos-containing material was disturbed.
5. On 30 December 2020, after the riot had started, Major Consulting Group recommended a precautionary approach be taken at the Top Jail as the level of exposure to asbestos-containing material was unknown at the time.
6. It was proposed that Major Consulting Group asbestos specialists go on site to conduct air monitoring, take samples, provide training to staff on the wearing and fitting of masks (respiratory protective equipment), and set up decontamination procedures. However, a decision was made not to bring them on site on 1 January 2021 due to safety issues at that time.
7. Major Consulting Group specialists attended the site on 5 January 2021 and concluded that there was a risk of widespread asbestos contamination. Health risks were considered to be low for:
  - » Prisoners who were evacuated at the time the Top Jail was first set alight.
  - » Staff wearing P2 masks<sup>116</sup> outside the Top Jail during the riot.
  - » Other staff, as possible asbestos concentrations in the smoke were likely to be low.
  - » Staff who entered the Top Jail who were wearing P100 masks<sup>117</sup> correctly.
8. Major Consulting Group assessed the health risk as medium for those wearing equipment which had *"likely been exposed to asbestos and other contaminants. [However] Ongoing risk to health low due to one-off exposure and likely concentration of asbestos fibres on clothing"*.
9. Major Consulting Group highlighted that respiratory protective equipment should be properly fitted every year, cleaned and maintained, and that soft clothing should be professionally cleaned *"as a standard procedure following a fire"*.
10. A further Major Consulting Group report, on 9 January 2021, found *"extensive contamination requiring remediation before the main kitchen is recommissioned"* and *"weekly reassurance air monitoring is strongly recommended to ensure controls are adequate for the remaining contaminated areas until they can be fully remediated"*.
11. On 14 January 2021, Major Consulting Group responded to a request from Corrections to assess the level of risk of exposure of respirable asbestos fibres for Corrections staff who entered the site. It concluded:
  - » The activities that were conducted indicate low disturbance in the areas concerned and were only for a short duration.
  - » Corrections staff did not spend any significant time near badly damaged buildings.

115. Asbestos Management Plan. Major Consulting Group. 22/08/2019.

116. Disposable high-filtration face masks.

117. P100 masks provide protection from lead and asbestos particles.



12. Major Consulting Group further advised: *“The risk of exposure to respirable asbestos fibres during an event like this may never be zero; however, asbestos health risks generally arise from prolonged exposure to high levels over a number of years. Regardless, it must be noted that even when there is a low risk of respirable fibres, all reasonably practicable controls should be in place as there is no known safe level of respirable asbestos”.*
13. Subsequent air monitoring by Major Consulting Group found *“all areas tested at the time were below workplace exposure standards”.*
14. Corrections gave serious consideration to recommissioning the kitchen in the Top Jail. Demolition of the Top Jail with asbestos/fire damaged asbestos was considered to be both complex and costly. A decision was ultimately made not to recommission any part of the Top Jail in favour of total demolition.
15. This Inquiry heard from a Team Leader Health, Safety, Wellbeing, who said greater emphasis needed to be placed on emergency preparedness and improved planning on site.

*“Waikeria Prison had many known inherent risks and should have had an emergency plan in place. There was no specific site emergency plan for Waikeria Prison. It would have highlighted, for example, the importance of undertaking the precautionary actions that MCG had recommended and had been poised to undertake during the incident.”*

### Advanced Control and Restraint team

16. ACR staff had full face respirator masks with P100 filters (designed to protect against asbestos fibres) as a standard part of their kit, and were directed to wear these from the day the riot began. Providing this kit was worn appropriately, we understand the ACR staff would have been adequately protected from exposure to asbestos fibres.
17. Major Consulting Group advised that clothing be laundered under controlled conditions. However, the decontamination of uniforms and equipment was not completed until the week of 17 May 2021 (four and a half months post-riot).
18. This Inquiry heard from ACR team members who described washing and drying their fire retardant overalls every day (at home) during the riot, due to smoke and dust, which they had been told contained asbestos. They had each been issued one pair of fire-retardant overalls, which they felt was insufficient.
19. While staff were concerned about asbestos, the Team Leader Staff Wellbeing and Support Services told us: *“FENZ said categorically because the roof was wet the particles weren’t able to disperse so the risk was quite low”.*
20. The Corrections Association NZ undertook an independent assessment of an ACR team member’s stab resistant body armour to determine the presence of asbestos. The report, dated August 2021, concluded there was no asbestos found.
21. The Inquiry heard concerns from some staff they were not told about the potential risk posed by the asbestos in the Top Jail for the first three to four days of the riot, during which time it was reported they had not been wearing masks due to the high temperatures.

### Evacuated prisoners

22. This Inquiry has seen no evidence that decontamination was offered or undertaken for the prisoners who were evacuated from the Top Jail on the evening of 29 December 2020 and prior to transfer to other prisons the next day.
23. Many of the prisoners had been in their cells from the start of the incident until their evacuation late evening. Some prisoners reported having their cells fill with black smoke. Some reported lying on the floor near the cell door in order to breathe.
24. Advice was provided to all prisoners to report to Health or their GP if there were any concerns.

### The prisoners on the roof

25. On 1 January 2021, the Waikeria Prison HCM recorded that: *“Decontamination will be offered on surrender”* to the prisoners on the roof.
26. Following the surrender, on 3 January 2021, the prisoners were strip searched, provided with a change of clothing and placed in the ISU where they were triaged by a senior member of the Health Services team.
27. Decontamination processes were neither offered nor provided to these prisoners immediately after their surrender or prior to their transfer to Auckland Prison and MECF.

## 11. Lessons learnt from other prison riots or major disorder events

1. As part of this Inquiry, we reviewed other major disorder events in New Zealand and overseas.
2. An analysis of these major incidents highlights a number of similarities and common themes with respect to causative factors of many prison disorder events. They provide valuable lessons in how to mitigate against risk of a riot occurring. We note, for completeness, each of the below examples should be considered in the context of their jurisdiction, operating environment, scope and time period in which the events occurred.
3. While some lessons appeared to have been learned from previous riots and major disorder events, Corrections has generally been slow to implement learnings across the prison network.

### *Spring Hill Corrections Facility riot, 2013*

4. The most recent, relevant major disorder event was the riot that occurred at Spring Hill Corrections Facility on 1 June 2013. Corrections' inquiry into that event noted it was, at the time, the largest and most destructive incident of concerted indiscipline experienced in New Zealand prisons in almost 15 years.
5. In brief summary, on the morning of 1 June 2013 staff at SHCF became aware that a small group of prisoners in a unit were intoxicated. They were found to be drinking alcohol they had made themselves. Staff intervened a short time later and a staff member was assaulted. Staff retreated to the staff base which prisoners then began attacking. Staff were ordered to evacuate the unit. The prisoners gained access to the staff base and by midday around 27 prisoners were lighting fires and damaging property in the prison compound. Prisoners used prison property and prisoners' personal files as fuel for the fires.
6. Staff set up a perimeter around the prison to contain the incident and an intervention plan was developed using Corrections' ACR teams. However, it became clear that the fires had developed to such a point that the lives of the prisoners still locked in their cells were at risk and immediate intervention was needed. By 5:21pm, ACR teams started extracting prisoners. Rioting prisoners resisted violently, and ACR members and prisoners were injured as a result. Around an hour later ACR had secured and evacuated the relevant units and the rioting prisoners were transferred to Auckland Prison.
7. The riot at SHCF shared a number of similarities with the Waikeria riot including the following:
  - » **Prison design:** Although significantly different, the physical designs of SHCF and Waikeria Prison contributed to the respective riots. Corrections' inquiry into the SHCF riot noted the overall design and use of the prison contributed to the conditions in which the riot prevailed, and the degree to which it escalated. SHCF was designed as an 'end destination' corrections facility focused on rehabilitation, rather than a prison with a focus primarily on security and control, which was how the units in question were being used. The Top Jail at Waikeria was no longer fit for purpose and the design of the prison contributed to the quick escalation, scale, scope and duration of the riot.
  - » **Restrictive regimes:** The SHCF report noted that the restrictive regime contributed to prisoner discontent. The same applied to the yard-to-cell regimes at the Top Jail at Waikeria Prison.
  - » **Management of high security prisoners:** The SHCF riot occurred in a high security unit which held unmotivated, difficult and disruptive prisoners who were predominately gang affiliated. The SHCF report noted this mix of prisoners contributed to the outbreak of the incident, and the escalation into a full-scale riot. It was the view of the SHCF inquiry team that a significant operational risk was created by having a high density of unmotivated, high security prisoners in a site that was not designed to manage them. As detailed by this Inquiry, the prisoners held in the Top Jail at Waikeria Prison were similarly challenging and predominantly gang affiliated. They were also not provided with sufficient opportunities for constructive activities or meaningful engagement.
  - » **Access to contraband:** Both riots were triggered by prisoners having access to contraband. In respect of SHCF it was 'home brew' made and consumed in the unit and at Waikeria Prison it was the presence of a razor and an ignition source in yard 116.
  - » **Intelligence/incident reporting failures:** Prior to the SHCF riot there had been a number of previous incidents which indicated a potentially dangerous situation in the unit where the riot later began. Intelligence had shown that the making and consumption of home brew was a reoccurring issue in that unit. There was a failure to take adequate steps to deal with the issue. The report into the SHCF riot noted that the combination of the intelligence available and the previous incident should have been significant indicators to SHCF management that rigorous action was required to reduce the risk in the relevant unit.

- » **Missed opportunities for early intervention:** With respect to the SHCF riot, once the contraband was located staff did not immediately intervene to either restrict affected prisoners or make further searches. This failure mirrors those made by staff dealing with contraband in yard 116 on day one of the Waikeria riot.
- » **Rapidly developing fires/the need for evacuation:** The SHCF riot involved prisoners lighting fires and the subsequent need for urgent evacuation of prisoners locked in their cells. As in the Waikeria riot, attempts by the Fire Service to put out the fires were initially hampered by poor water pressure.
8. Unlike at Waikeria, intervention by ACR at SHCF brought about the conclusion of the riot on the first day.
9. Following the SHCF riot, the inquiry team made recommendations including:
- » Corrections should ensure that robust systems are in place so it is able to maintain an effective overview of prisoner placement and prevent high risk prisoners and gang members being held in unsuitable locations.
  - » At SHCF there had been occasions where prisoners were locked in their cells for periods of more than 24 hours, potentially fuelling discontent. This was a direct result of the two hour rolling unlock regime that some units at SHCF had adopted. While this regime was not identified as a direct causal factor of the riot, this practice should be reviewed as soon as practicable and include all prisons to ensure similar issues are not replicated.
  - » Corrections should continue to review, consider and implement improvements to design and security enhancements in campus style facilities.
  - » Corrections should consider introducing Immediate Response Teams, operating at all times in campus style sites.
  - » Corrections should review the capability and response system for ACR teams in order to improve response times and increase availability.
  - » Corrections should review the equipment and resources available to sites and ACR teams, in order to improve how teams are deployed and supported and to enhance their ability to operate in a rapid, safe and effective manner.
  - » The decision to activate the NCC should be made immediately upon request of a Gold Commander, when it is clear that a significant event is unfolding, in order to quickly establish what response is required and what support is available, and to manage communications from a national perspective.
  - » Corrections should have regard to the reports from Opus and from the Fire Service, and assure itself that adequate fire protection is in place in all prisons. This should include arranging regular site familiarisation visits by Fire Service personnel.
  - » Corrections should assess the water supply available at all sites.
  - » Corrections should review the practice of holding the personal files of prisoners within units.
  - » Corrections should take steps to remind all staff of the importance of timely incident reporting, as per the existing requirements.
  - » The inquiry team is aware that the Chief Executive intends to formally recognise staff involved in the intervention and rescue of prisoners in Unit 16B for their courage and bravery and fully endorses this decision.
10. Given the similarities between the SHCF riot and the Waikeria riot, it is disappointing that a number of the recommendations made with respect to SHCF have also been made by this Inquiry.
11. In particular, the learnings relating to the management of high security prisoners do not appear to have been effectively implemented across the prison network.
12. Other issues evident during the Waikeria riot which highlight that the SHCF recommendations were not embedded across the prison network include:
- » Not formally establishing an NCC for the Waikeria riot on the first day
  - » Firefighting capabilities and lack of regular site familiarisation visits by Fire Service personnel
  - » The absence of any review into where prisoner hardcopy files should be held
  - » Deficiencies in timely incident reporting.



13. Issues caused by the inability of staff to work at height have also previously been identified in incidents that have taken place across the prison network. The Chief Custodial Officer told this Inquiry:

*“One of the things that several of us have been talking about over the years ... is our ability to operate at height. We built the tactical training facility with the capability for people to train to operate at heights, so it’s got anchor points on the roof and all this kind of stuff ... the Department hasn’t yet got to that stage where we are training people to operate at height.”*

14. Several senior staff spoken to in this Inquiry told us a lesson that had been learned from the SHCF riot was increasing capability of ACR in prisons and the speed of response needed to shut down or at least contain an event. A staff member said if Corrections had not implemented some of those changes after the SHCF riot, they would not have been able to get the number of staff they needed to Waikeria Prison as quickly as they did.

### **Prison riots in Australia and Canada**

15. This Inquiry examined prison riots in Australia and Canada, which were selected as the two most comparable jurisdictions. The focus was on riots in the last 10 years which resulted in a report by a formal oversight body.
16. Reports reviewed were:

#### **Canada**

- » There has been one riot in a Canadian prison in the last 10 years, in the Saskatchewan Penitentiary in December 2016. A Board of Investigation (an internal mechanism) was established to review the riot.
- » Correctional Investigator Ivan Zinger sent senior investigators to the site immediately, and commented on what they found in his 2016/2017 annual report. Following the release of the Board’s report, he conducted a more in-depth review in his 2017/2018 annual report.

#### **Australia (East)**

- » Riot at Alexander Maconochie Centre, ACT in November 2020 (critical incident review by the ACT Inspector of Corrections Services).
- » Riot at Metropolitan Remand Centre, Melbourne, August 2015 (independent investigation).
- » Riot / series of incidents at Parkville Youth Justice Precinct, Melbourne, November 2016 (independent review).

#### **Western Australia**

- » Riot at Greenough Regional Prison in July 2018 (resulted in an independent review and a post-incident management report from their Office of the Inspector of Custodial Services).
- » Riot at Banksia Hill Juvenile Detention Centre, August 2013 (six reports by their Office of the Inspector of Custodial Services as part of a Directed Review).

17. Our review of the Canadian and Australian riots found a number of common situational and/or contextual factors:
- » The riots involved maximum, high or medium security prisons.
  - » Poor physical conditions, including overcrowding, old facilities, limited recreation and programme space, and degrading security and infrastructure.
  - » Restrictive regimes, sometimes related to staffing issues, leading to long periods of lock and low provision of rehabilitation programmes and other organised activity.
  - » Failure to meet the needs of high numbers of indigenous prisoners.
  - » High numbers of gang associated prisoners.
  - » Begins with a ‘passive protest’, prop or ‘spark’.

18. Our review found a number of common recommendations:
- » Review staffing and operating models.
  - » Review infrastructure (security and living conditions).
  - » Urgent need to improve responsiveness to indigenous prisoners.
  - » Address low levels of capability in emergency management planning and response.
  - » Improve cross agency working (Fire Service and Police).
  - » Better planning for recovery so staff and prisoners responded to more effectively (especially addressing trauma) and 'normal' regimes can be returned to more quickly.
  - » Addressing unlawful treatment of prisoners post-riot – both perpetrators and non-perpetrators.

### *Strangeways Riot, 1990 – Manchester UK*

19. The 1990 riot at Strangeways Prison provides an example of the lessons that also be learnt from riots overseas. The Strangeways riot was Britain's worst prison riot and led to sweeping prison reform in the UK. It shares several similar themes with the Waikeria riot in terms of the pre-conditions that existed prior to each riot and other causative factors.
20. These similarities included:
- » **Age and design:** Both Strangeways Prison and the Top Jail at Waikeria Prison were old buildings which were no longer fit for purpose. The UK Prison Service had accepted that improvements to Strangeways were long overdue. With respect to Waikeria, Corrections accepted that the Top Jail had reached the end of its useful life. The archaic design of both facilities not only contributed to the poor living conditions in each jail but also enabled prisoners to quickly gain access to the roof, and thereafter take control of the prison.
  - » **Poor conditions:** The Woolf Report, which was the inquiry into the Strangeways riot, concluded that the prison conditions at Strangeways Prison were intolerable. The prison was overcrowded and hygiene was poor. There were also issues with the timing and quality of meals and access to clean clothing. The conditions in the Top Jail at Waikeria were also poor in the period prior to the riot. There were issues with clothing, hygiene and meals. In respect of both prisons, prisoners felt their complaints were being ignored.
  - » **Treatment of prisoners:** The regime at Strangeways was extremely restrictive and there were complaints of arbitrary and oppressive behaviour on the part of some prison staff. Similarly, the restrictive yard-to-cell regime and, at times, disrespectful attitude of some staff in the Top Jail at Waikeria feature in this report.
  - » **A failure to properly record, monitor and respond to increasing tension:** Both riots demonstrated a failure to recognise increased tension in the prison. Before the Strangeways riot began there were signs of increased tension and several explicit warnings that trouble would occur. Relevantly, in the month prior to the Strangeways riot, prisoners had twice refused to return from their exercise yard. No attempt was made to co-ordinate the information or prepare the necessary response.
  - » As set out in this report there was a normalisation of elevated levels of tension in the Top Jail at Waikeria prior to the riot. A number of incidents occurred, including that involving the unreturned razor, which should have acted as a warning to management that overall tensions were heightened and there was a risk of a disorder event.
21. In addition to these similarities, important lessons could have been learned from Strangeways with respect to the response, including:
- » **The importance of the quick evacuation of non-rioting and vulnerable prisoners:** A concerning feature of the Strangeways riot was the way in which the rioters targeted segregated prisoners, including sex offenders. Prison officers during the Strangeways riot identified these prisoners as requiring immediate evacuation. Prison officers evacuated most of these prisoners before rioting prisoners entered the wing and staff had to retreat. Rioting prisoners attacked a number of these prisoners including one who later died in hospital.
  - » Conversely, in the Waikeria riot corrections officers took commendable steps to evacuate and keep many segregated prisoners separate. It is of concern that the prisoners held in the ISU were the last to be evacuated from the site at a time when the fire was considerably involved.



## 12. Appendices

### Appendix A: Terms of Reference



#### Terms of Reference for the Independent Inquiry into the Waikeria Riot

##### Background

- 1 On the afternoon of 29 December 2020, 20 prisoners located in a prison yard at the high security 'top jail' facility within Waikeria Prison lit fires and began to riot. While a number surrendered, other prisoners joined in, climbing onto the roof, smashing windows and setting fires. The final 16 prisoners surrendered to Corrections staff on 3 January 2021.
- 2 These Terms of Reference instruct the Chief Inspector of Corrections to investigate and report on the circumstances surrounding the riot and the Department's response.
- 3 The Chief Inspector's investigation will be one of two investigations into this incident. The Chief Custodial Officer will be separately instructed to provide an operational review. The Chief Custodial Officer's review, to be completed at pace, will deliver an interim report by 31 January 2021, and a full report to the National Commissioner by 31 March 2021.

##### The Investigation

- 4 The Chief Inspector's investigation will have access to all relevant information, documentation, premises and persons, and may, with the approval of the Chief Inspector, call on such additional or specialist assistance as may be appropriate. This will include utilising appropriate cultural expertise. During the course of the inquiry the Chief Inspector will advise me of those parties who provide additional or specialist assistance.

##### Terms of Reference

- 5 To investigate and report on the circumstances surrounding the riot that began at Waikeria Prison on the afternoon of 29 December 2020, including the Department's response, and the preparedness for such incidents throughout the prison network.
- 6 The report will provide:
  - Phase 1: A summary of what was known prior to the riot, including facility conditions, complaints from prisoners and family and whānau about the 'top jail', prison tension assessments, incident reports and other indicators.
  - Phase 2: A review of:
    - The immediate response as the incident unfolded, including decisions around containment of the rioting prisoners and deployment of control and restraint options, and the management of the safety of other prisoners and staff.
    - The post-incident response by the Department, including matters of health and welfare, and the involvement of other agencies.
  - Phase 3: Consideration of the Department's preparedness for a major disorder incident at this site and across the entire prison network, including a review of major incident recovery planning, and the relocation of prisoners in response to a major incident.

- Phase 4: Such recommendations as the Chief Inspector considers appropriate, arising out of the findings of the investigation.

### Timeframe

I request that Phase 1 commences immediately, with the Inspectorate to begin by gathering and securing available information including:

- Site specific information, including prisoner type and classification, regimes at the 'top jail', prisoner hygiene and clothing management, programme and rehabilitation opportunities, staffing levels, facility maintenance programme and reports.
- Reports on the 'top jail' by the Office of the Ombudsman and the Office of the Inspectorate and other internal reviews.
- Information such as prisoner, family and whānau complaints to the prison, the Inspectorate, the wider Department or other agencies; incident reports and event reviews; staff conduct complaints; and tension assessment reports.

Phases 2 and 3 will be commenced once the Chief Custodial Officer's review is available. Supplementary Terms of Reference may be provided from time to time.

I request that a final report be provided to me by 31 October 2021.



Jeremy Lightfoot  
Chief Executive  
Department of Corrections

04 January 2020

## Appendix B: Independent External Advisory Group Terms of Reference

29 March 2021

### Background

1. The Chief Inspector of Corrections has been asked to investigate and report on the circumstances surrounding the riot that began at Waikeria Prison on the afternoon of 29 December 2020, including the Department of Corrections' response, and the preparedness for such incidents throughout the prison network.

### Purpose

2. The Independent External Advisory Group ('the Independent Advisory Group') has been established to:
  - » assist, advise, provide counsel and expertise to the Chief Inspector across the work of the Inquiry, and
  - » enhance public trust and confidence in the way in which the Inquiry conducts its work, and in its findings and recommendations at the conclusion of the investigation.
3. The Independent Advisory Group will assist in strengthening relationships with Māori.
4. The role of the Independent Advisory Group will not diminish the rights of Iwi, hapū and Māori to address the Chief Inspector directly on matters important to them.

### Members

5. Members have considerable networks, knowledge and experience, and have been appointed to provide strategic advice and insights from their perspective, both as individuals and as a Group.
6. The membership of the Independent Advisory Group is: Sir David Carruthers, Lady Tureiti Moxon, Dr Robert Joseph, and Baden Vertongen.
7. The Chief Inspector Janis Adair and Assistant Chief Inspector Sara Cunningham will attend all Independent Advisory Group meetings to ensure information flows effectively between the Chief Inspector, the Independent Advisory Group and the Operational Team undertaking the Inquiry's day to day work.

### Guiding principles

8. The Independent Advisory Group recognises the voices of all members and will ensure all members are included in a spirit of trust, respect and good faith.
9. The Independent Advisory Group has agreed to the establishing guiding principles. These guiding principles may be varied at any time the Independent Advisory Group determines is necessary.
10. These principles (could) include but are not limited to:
  - » Ensuring the Inquiry implements a Treaty of Waitangi approach across all aspects of its work
  - » Enhancing the Chief Inspector's relationships with Iwi, hapū and whānau by ensuring appropriate tikanga is observed when engaging with Māori, and
  - » Sharing practical assistance and guidance informed by knowledge, experience and community networks to the Chief Inspector during the Inquiry.

### Secretariat

11. The Office of the Inspectorate will provide secretariat support to the Independent Advisory Group and its members. This will include scheduling of meetings, recording and circulating of meeting minutes, arranging travel as required.

### Meetings

12. The Independent Advisory Group will meet with the Chief Inspector and Assistant Chief Inspector as a group, on a fortnightly basis.
13. So far as possible, the Independent Advisory Group will meet in person for one meeting each month. The location of these meetings will be agreed by the Independent Advisory Group and the Chief Inspector.

**Information sharing requirements**

14. Members must maintain confidentiality of matters discussed at meetings, and any information or documents (not otherwise publicly available) provided to the Independent Advisory Group.
15. Sharing of information will be facilitated by our secure file sharing service Diligent Board Books to preserve the confidentiality of information.
16. Information sharing will respect that the parallel criminal investigation and proceedings are not prejudiced, as required by law.

**Public Comments**

17. While respecting the provisions at paragraphs 14 and 16 above, all information provided to the Independent Advisory Group is official information and may be released under the Official Information Act 1982.
18. Members can make public comment if they wish in relation to the Department of Corrections and their involvement in the Independent Advisory Group. Members must however inform other Members of the Independent Advisory Group, and the Chief Inspector, before any public comment is made.

**Conflicts of Interest**

19. Members are responsible for declaring any real or potential conflict of interest to the Chief Inspector as soon as the conflict arises. Any real or perceived conflicts will be discussed with the Chief Inspector and mitigations put in place if necessary.



## Appendix C: Images

**Image 1:** A cell which was broken into by rioting prisoners. Note hollow concrete blocks.

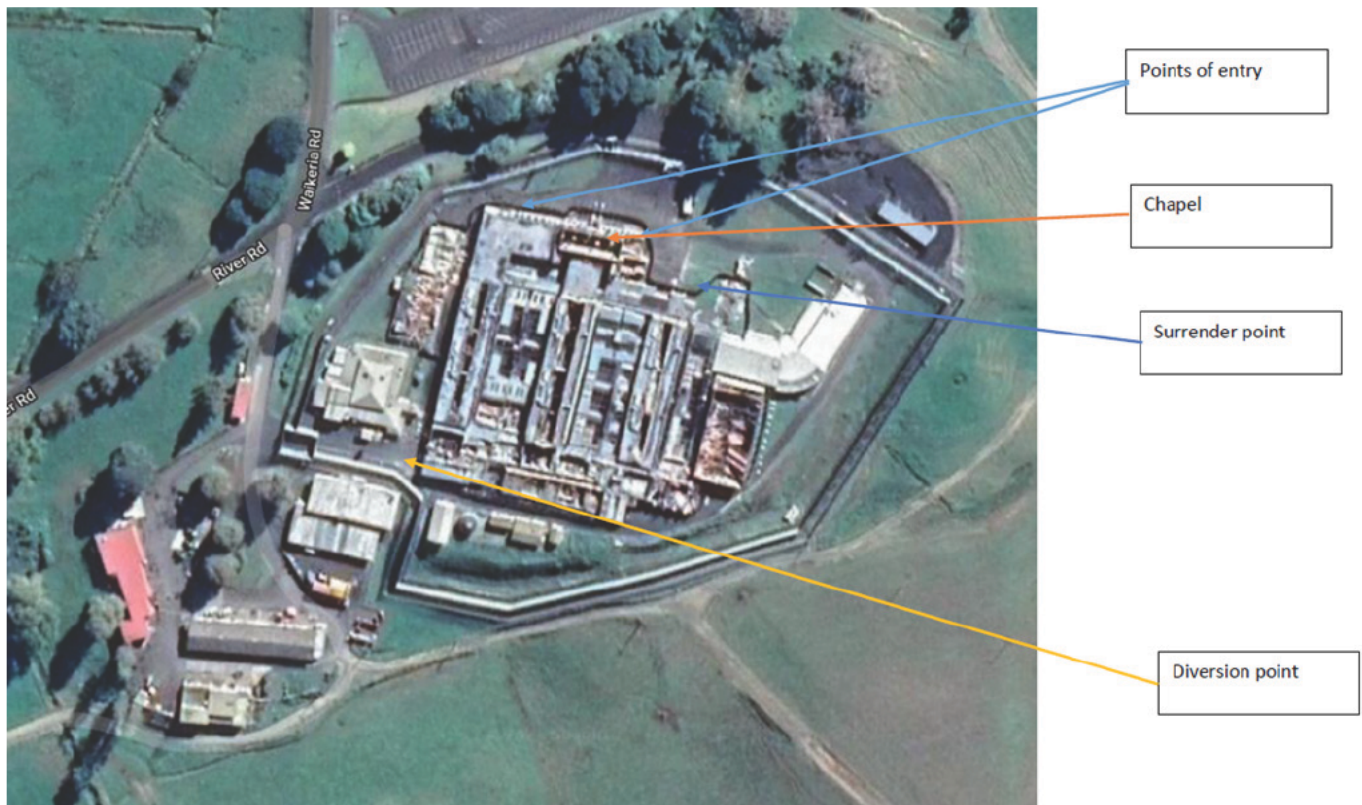


**Image 2:** A large metal bar which was used as a battering ram.





Image 3: Photograph showing points of entry, Chapel, surrender point and diversion point.



## Appendix D: Closure and reopening of the Top Jail

1. The information in this appendix is taken largely from the Implementation Plan: Stronger Prisons: Prison Configuration Phase Two (Department of Corrections, July 2015) and the Operational Readiness Plan: Prison Capacity Programme: Waikeria Top Jail (Department of Corrections, December 2016).
2. In 2012, the Top Jail's Central Unit was closed due to structural integrity concerns.
3. In 2015, Corrections decided to close the remainder of the Top Jail. This decision was made as the Top Jail was nearly 100 years old and was reaching the end of its life. Conditions in the prison were poor by any standard. It was expensive to operate and the cells had limited natural light. The building had seismic issues which would require significant remedial work and capital investment to bring it up to an acceptable standard. The closure was scheduled to be completed by 2016.
4. As planned, Corrections closed the West Unit in 2015. However, an increase in the prison population meant the East Unit remained open. Then, in early 2017, Corrections re-opened the West Unit.
5. The Top Jail at Waikeria Prison was considered *"the best of the worst"* available option for re-opening. Its large catchment area in the North Island and close proximity to the Hamilton District Court made it a logistically attractive option.
6. A senior staff member told us: *"if you ... wanna have people close to their whānau, closer to Courts, it was a rock and a hard place I'd say and I think ... Department basically thought we'd get through the next two years and we'll all be good"*.
7. A number of activities needed to take place to ensure that Waikeria Prison (in particular, the West Unit) were operationally ready to manage the increased capacity. These included:
  - » The clean-up and refurbishment of the West Unit to house prisoners. Some minor work was required to bring it up to standard. This included cleaning cells, checking cell locks, lighting, taps, toilets, beds, windows and power points, obtaining additional televisions and servicing current televisions and replacing the main washing machine.
  - » In relation to the yards, work included cleaning the yards, replacing broken seating, replacing broken and loose asphalt, checking the 'birdcage ceiling panels' were safe and reviewing and ensuring the asbestos casing on pipes in the birdcage ceiling cavity were fully intact and safe.
  - » Ensuring staff areas were appropriately set up. This included obtaining working telephones and computers for the guard rooms.
  - » Purchasing furniture, fittings and equipment such as prisoner bedding, clothing and meal trays. This was reported to be the biggest challenge.
  - » Ensuring sufficient staff were employed. This included hiring a number of new staff.
  - » Ensuring the site was operationally ready, including Industry, Rehabilitation and Learning, Health and prisoner movements.
8. No work was required for the electronic security as it was never decommissioned. For the West Unit, this consisted of CCTV cameras and electronic locks on the two Control Rooms and cell intercoms.
9. A Risk Action Plan was also developed. One identified risk was that there may be an increase in incidents resulting in disruption to the site and harm to prisoners and staff. Actions to mitigate this risk included providing appropriate training to staff (including training in de-escalation techniques) and the site was to consider options to increase prisoner activities through additional programmes, education, employment and physical activity. Waikeria Prison's Risk Action Plan did not include the risk of a riot or major disturbance. A decision had been made to exclude it from the site plan and place it at the regional level.

## Appendix E: The prison population

Note, data in this appendix relates to the period from 29 December 2019 and 29 December 2020.

1. The Waikeria Prison population was slightly higher in 2019 (712) than 2020 (704). The population in the Top Jail was higher in 2019 (237) than 2020 (212).
2. The percentage of prisoners on remand was relatively stable between 2019 (269) and 2020 (264). There was an increase in prisoners on remand in the Top Jail in 2020 (136) compared with 2019 (187). Similarly, there were more sentenced prisoners in the Top Jail in 2020 (73) compared with 2019 (46).
3. The prison had more than twice as many prisoners with a security classification of high in 2020 (65) than in 2019 (30).
4. The number of prisoners who identified as Māori was higher in 2020 (480) than in 2019 (469). In 2020, 158 prisoners identified as European/Pākehā, compared with 179 in 2019. In the Top Jail, 163 prisoners identified as Māori in 2020, compared with 182 in 2019. In the Top Jail, 34 prisoners identified as European/Pākehā in 2020 and in 2019.
5. Age ranges varied across the two years. In 2020, there were slightly more prisoners aged between 30-39 years (254) than in 2019 (233). This was similar for those aged 40-49 years (157/142) and 50-59 years (69/62). There were slightly fewer prisoners aged between 20-29 years in 2020 (183) than in 2019 (211). These trends were also reflected in the Top Jail.
6. On 29 December 2020, 324 prisoners had an active gang indicator, compared with 337 prisoners on 30 November 2019. In general, the percentage of prisoners belonging to each gang remained relatively stable between 2019 and 2020. The exception was those linked to the Mongols MC. In 2019, no prisoners were affiliated with the Mongols MC. In 2020, there were nine Mongols MC members. These trends were reflected in the Top Jail.

*Appendix F: Mr B's telephone calls on 29 December 2020*

1. At 10:56am, Mr B used the prisoner payphone in yard 116 to call an approved number. Part of the conversation was as follows:

S 18(c)(i) [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

2. Mr B called this person again at 11:56am. Part of the conversation was as follows:

S 18(c)(i) [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 3. At around 12pm, Mr B called the number back and it was transferred to Newshub. The following is a summary of this 12-minute call:

S 18(c)(i)



- 4. Mr B attempted to call back his approved number 12 times between 12:32pm and 2:18pm. These calls either went to answerphone or did not connect.
- 5. At 2:19pm, Mr B made another call from the yard phone to a different person. The 12-minute call included the following:

S 18(c)(i)



118. S 18(c)(i)



## Appendix G: People Against Prisons Aotearoa

1. On 30 December 2020, activist group People Against Prisons Aotearoa (PAPA) posted messages on social media purportedly from the prisoners on the roof. The messages highlighted the poor conditions in the Top Jail and criticised how the prisoners involved in the riot were being managed. The messages were as follows:
  - » The prisoners were being treated unfairly and inhumanely
  - » Their basic human needs were not being met
  - » In some cases, they were locked down for 23 hours a day in their cells and did not receive any mental health help or resources
  - » Prisoners would be handcuffed and escorted to the yards and then back to their cells by four guards
  - » They received a 15-minute phone call each week and their visits were often cut short
  - » Their drinking water was brown
  - » They were expected to wash their clothes in the shower and hang them on the ground to dry
  - » They had to use dirty shower water to cook their noodles when their privileges were taken away
  - » It took a long time to be given toilet paper
  - » Sometimes the prisoners had to shower together in a single shower due to the limited time allowed in the yards
  - » Towels were not washed for four weeks and bedding was not washed for three months
  - » Limited clothing was given to the prisoners
  - » Property sometimes took up to three months to be given to prisoners
  - » The gym had been taken away
  - » Medical attention was concerning.
  
2. On 31 December 2020, PAPA posted the prisoners' 'manifesto' online. It is not clear how PAPA received the manifesto. It reads:
 

*"We are not rioting.*

*We are protesting.*

*We have showed no violence towards corrections officers – none whatsoever - yet they show up here in force armed with guns and dogs to intimidate us.*

*We are the ones that are making a stand on this matter for our future people. Showing intimidation to us will only fuel the fire of future violence. We will not tolerate being intimidated any more.*

*Our drinking water in prison is brown. We have used our towels for three straight weeks now. Some of us have not had our bedding changed in five months. We have not received clean uniforms to wear for three months – we wear the same [sic] dirty clothes [sic] day in and day out. We have to wash our clothes in our dirty shower water and dry them on the concrete floor. We have no toilet seats: we eat our kai out of paper bags right next to our open, shared toilets.*

*These are only very few of the reasons for the uprising.*

*We are tangata whenua of this land. We are Māori people forced into a European system. Prisons do not work! Prisons have not worked for the generations before! Prisons just do not work. They keep doing this to our people, and we have had enough! There is no support in prisons, all the systems does is put our people in jail with no support, no rehabilitation, nothing. We have had enough.*

*This is for the greater cause."*
  
3. On 3 January 2021, after the surrender, PAPA posted a message from the whānau of the prisoners involved in the riot. They reiterated their concerns around the conditions at Waikeria Prison. They said Corrections had known about the conditions for years but had forced their loved ones to endure them. The prisoners were unable to access the PC.01 complaint forms and the whānau were unable to make complaints to Corrections.

**Appendix H: Kaumātua speak to prisoners on the roof, 31 December 2020**

1. On 31 December 2020, a Kaumātua and Kuia arrived at the prison and had discussions with the prisoners. Before this, they had been given a briefing by the Prison Director and Police in charge of negotiations. The prisoners performed the haka 'Toia mai te waka' ('Haul the canoe') to welcome the Kaumātua to the Top Jail. The Kuia performed a karanga and the Kaumātua performed a waerea (a protective incantation to protect the visitors and to bring 'rangimarie' [peace and calmness] to the situation). Several prisoners spoke to the Kaumātua. This Inquiry heard that the prisoners were respectful to the Kaumātua and followed Māori protocol. The following is a summary of the concerns the prisoners voiced:

*"It's not an act of violence or a protest or a riot. We're asking to be treated as humans. We're tangata whenua – treated with decency. Haven't been treated accordingly ... for some time now. No mental health help – getting worse and worse. Not getting clean water to drink, the water we drink is brown and it's been like that for some time by now ... We don't want our people to be going through for time and time again for generations to come ... We're not doing this for an act or violence, or gang stuff. We're doing this because we're from here. We're doing this because we want to be treated right. The guns they bring is making us violent. We do want to get this resolved in a peaceful way. But if that means we come down and they lock us up somewhere else then [inaudible]. Now it's happening to the next generation. It's not fair, it's inhumane. If we come down and we've done nothing, then [inaudible]. We just want some help that's all. Help us, don't fight us ... We're human and it's fair we have clean drinking water, we get food. We use the same towel for three weeks. We wash our clothes in the shower and hang them on the ground. No dryers or washing machines. Some of the brothers haven't had their bed / sheets changed for months ... They were going to get away with it for two more years until the new jail is built. We've done something wrong, we're not animals. This doesn't come from nothing, it's a build-up of stuff. We're getting treated unfairly, it's got a lot to do with the system here based on colonisation. It's not suited to us, we're not European. We've asked for things that suit us because we're in a high security unit, we don't get those things. How are we supposed to fix ourselves? We can't get any rehabilitation ... Systemic racism ... It's not just happening here either ... A number of us have been taken away from our families and been sent here. All we have here is the family we have here. This is the family ... We're treated very differently from the rest of the jail ... We haven't shown violence once ... They bring violence, they're going to get violence ... We had to do this so we can be heard ... They say they care about our health and safety ... If they're really worried about our health and safety, they'd give us some water ... They're meant to be negotiating with us ... They were just telling us what to do ... This is bigger than this facility ... We're hurting ... Don't give us brown water, don't treat us different because some people have been overseas and have been sent back ... They use our tikanga against us. We must eat food with a toilet in our room ... We can't do any tikanga programmes, we can't even go to church ... I don't want my kids coming in here and living what I've lived through ... They say write a complaint but ain't shit done about the complaints ... They treat us like animals, fed like animals, taken to yards like animals."*

2. During the meeting, the Kaumātua told the men (this is a summary):

*"We are not going to be able to fix the world, but we understand some of the things that you are talking about. [The Kuia] has been around since [former Māori Affairs Minister] Pita Sharples and co. They have established Māori units and things like that. So how do we progress some of these things? We are going to have to go away and have a think about it and then see who we have to persuade ... in a way that action gets done ... That's why we come here on New Year's. We have got a whole lot of other stuff we could be doing with our whānau but we respect your whakapapa and we respect that you have a whakapapa rangitira and so we have come to show you that we respect that kōrero as well ... Everyone's heard the issues. We will have a think and a bit of a kōrero to see how we can get something in place."*

3. The conversation ended after about half an hour and the meeting was closed with a karakia. The Kaumātua said they would have a discussion with the appropriate people about what the men had said. Reflecting on the interaction, the Kuia said:

*"From the time that I did the karanga and they came to the fence, they were absolutely like that ... took a mask off and became young Māori men who needed someone to tell what their problem was to. And so we just stood there and listened. We didn't comment because one, [we] knew that what could we say to make it better? When they finished, all we said to them is, in te reo, we take on board everything you have said, we can't promise you anything or do anything, but we're here to let you know that you asked for a Kaumātua and a Kuia and this is who we are."*



## Appendix I: Handwritten note dropped from the roof

On 31 December 2020, the prisoners on the roof dropped this handwritten note:

**THIS IS NOT A RIOT  
ITS A PROTEST FOR  
OUR HUMAN RIGHTS  
FOR ALL MINUTES PAST  
AND PRESENT.**

- BEING MADRI AND P. WE DONT FIT  
IN THE EUROPEAN SYSTEM
- HOKAI RANGI ISNT WORKING  
(BEEN HERE 1 YEAR AND STILL NOTHING)
- CIRCUMSTANCES

**PERSONAL TAKING**

- NO OPPORTUNITIES TO DO REHAB  
COURSES EVEN THO WERE  
BEING PRO ACTIVE
- TAKING TOO LONG TO RESPOND TO OUR  
MENTLE AND MEDICAL WELLBEING.
- 47M TAKEN AWAY  
LEVEL OF CARE IS WAY BELOW

**PIT**

- FOOD BEING SERVED IN BROWN BARS  
WITH NO CUTLERY,
- WATER (BROWN)
- SAME TOWER FOR 3 WEEKS.
- EATING FOOD IN THE SAME  
ROOM WITH A TOILET AND  
NO LID

**FROM THE 16.**

## Appendix J: Case Management

1. Case managers provide specialist case management of prisoners with the aim of supporting the prisoner to take responsibility for completing activities aimed at addressing their rehabilitation and reintegration needs and ultimately to reduce the likelihood and seriousness of re-offending.
2. In relation to planned contact with prisoners, Waikeria Prison never met the threshold of 'good' in 2020. In six of the months, its performance was 'average' and in six of the months its performance was 'poor'.
3. In relation to undertaking a risk assessment at every planned contact with prisoners, Waikeria Prison's performance was 'poor' for all 12 months of 2020.
4. In relation to finalising an Initial Offender Plan within 40 days of a prisoner's arrival in custody, Waikeria Prison's performance was 'good' in three months during 2020. Its performance was 'average' in six months and 'poor' in three months.
5. In relation to providing a report to the Parole Board, Waikeria Prison's performance was 'good' in seven months of 2020, and 'average' in five months.
6. In relation to planning the release of prisoners, Waikeria Prison's performance was 'average' in 10 of the months during 2020 and 'poor' for the remaining two months.
7. To provide a quality assurance role, principal case managers are required to complete a practice evaluation on a random sample provided by National Office once a month. In relation to Waikeria Prison, these practice evaluations were only completed in February and March of 2020 due to COVID-19. Later in 2020, they were loosely replaced with release evaluations which are a condensed version of the more thorough practice evaluation whereby principal case managers had to identify three things done well on a case and three things to work on. Practice evaluations for February 2020 were completed in all cases. However, in March 2020 the majority were incomplete. Similarly, the majority of release evaluations for July, August/September and November were not completed.
8. A staff member reported that case management for remand prisoners is difficult because it is uncertain how long they will be in prison. However, when considering the effectiveness of case management, a staff member stated that more can be done around intervention at a remand level, especially intensive alcohol and drug interventions, and that educated guesses around how long a prisoner will be in custody could be made (i.e. if they will be in prison after being convicted). They believed that for people who would only be in custody for a short period of time, the focus should be on what is stopping them getting bail, such as accommodation issues, and how they can reintegrate.
9. A significant part of a case manager's role is to identify programmes or interventions that will support a prisoner during his time in custody. Once the identification has occurred, a case manager then has the role of contacting the scheduler who places the individual on a service list for the specific programme. This way a list is kept readily available of all who are eligible to participate in a programme or intervention when it becomes available.
10. Another function of the case manager role is to liaise with other key stakeholders both internally and externally, such as probation, unit custodial staff, whānau, and reintegration support providers. Case managers create referrals to providers that can support an individual's current or reintegration needs.





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