OFFICE OF THE INSPECTORATE
Te Tari Tirohia

Special Investigation

Report of investigation into the management of three wāhine at Auckland Region Women's Corrections Facility

DEPARTMENT OF CORRECTIONS
ARA POUTAMA AOTEAROA

OFFICE OF THE INSPECTORATE
Te Tari Tirohia

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Please note: This report contains information which may cause distress given its graphic nature.

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Foreword

It is important to recognise that generally over the period with which this investigation is concerned, the management of three wāhine began appropriately, with difficult behaviours being responded to in accordance with Departmental policy.

However, from around mid-2019, the management of the wāhine began to depart from Departmental policy, with significant failures to adhere to the requirements of the Prison Operations Manual and the Corrections Regulations 2005.

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

I am disappointed and concerned that this investigation has identified such significant issues in so many areas, both custodial and health, and at many levels.

This report sets out a catalogue of failures that should not have arisen and, having arisen, ought to have been identified and remediated promptly.

Not only did the system fail the wāhine, it also failed to support the staff who were charged with managing them.

These wāhine felt invisible and unheard. Despite reaching out to seek help, it is obvious to me how they came to this conclusion. It is also concerning that some staff felt powerless to intervene when they felt uncomfortable about the management regime.

My overarching recommendation must be, and can only be, that Correction undertakes at pace, a robust review, rethink and redesign of the way in which wāhine across the prison network are managed.

The future must begin today and the call to action must be authentic, bold and courageous if change is to be transformational, and surely it needs to be for both wāhine and staff.

Janis Adair
Chief Inspector

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Introduction

1. On 17 February 2020, I received a letter (**Complaint Letter**) via email from Amanda Hill, a lawyer representing Ms B, Ms A and Ms C, raising a number of concerns about the management of these three wāhine at Auckland Region Women's Corrections Facility (**ARWCF**).
2. Following initial inquiries, I decided to conduct a Special Investigation into the management of these wāhine over the period February 2019 to February 2020.
3. Some of the issues relating to Ms C were addressed through the Inspectorate's complaints process during the investigation period. Ms C was not satisfied with the result of that process and referred these complaints (and others) to the Office of the Ombudsman (**Ombudsman**). I have corresponded with the Ombudsman and have agreed that Ms C 's experiences would be covered in this report in order to address the concerns relating to her.
4. The issues considered in this report intersect with two court proceedings:
   4.1 A sentencing decision relating to [redacted]. On 4 February 2021, Judge McNaughton issued a reserved decision setting out his findings as to the management of Ms B insofar as they related to the sentencing exercise (**Sentencing Decision**).[1] The Judge made a number of findings critical of the Department of Corrections (**Corrections**). I have noted the findings of the Judge where they relate to aspects of this report. I do not depart from those findings, although I make some broader comments with the benefit of the greater fact-finding exercise undertaken through the Special Investigation.
   4.2 A High Court judicial review brought by Ms B and Ms A challenging the regulatory authorisation and use of pepper spray. As I am conscious not to prejudice the High Court process in any way, my report avoids conclusions as to the authorisation and use of pepper spray. My comments are confined to the factual narrative. From Corrections' response to a draft of this report provided by way of consultation, I understand that the factual narrative is not in dispute in the High Court proceedings.
5. This report is structured as follows:
   5.1 The Introduction comprises sections on Methodology and Background.
   5.2 I then set out a summary of the factual narrative of the management of the three wāhine. This is important for understanding the issues that have arisen in their proper context. This summary is a shortened version of the detailed narrative which is set out in Appendix D.
   5.3 The report then considers the issues of concern identified during the course of the investigation, including the matters in the Complaint Letter and discussed in the Sentencing Decision, although the identified areas of concern are ultimately more wide-ranging than either of these. This report concerns a period of 12 months and sets out the treatment of the three wāhine in detail. Nevertheless, it is not an exhaustive analysis of every single issue that arose in the course of their management. The report focuses on the key areas of concern identified.
   5.4 The report then concludes with my findings and recommendations to Corrections.
6. I was asked by the Chief Executive of the Department of Corrections to provide an indication of my findings prior to finalising my investigation report and approaching

[1] *R v* Ms B [2020] [redacted]

Corrections for comment. I provided this on 17 March 2021. I understand that it has since been made publicly available.

7. I acknowledge the information provided by and on behalf of the three wāhine, which has brought to light many issues of significant concern.

8. I also acknowledge the co-operation and assistance provided by the management and staff of Auckland Region Women's Corrections Facility.

9. I would like to credit the very thorough work done by Inspectors of Corrections Louise MacDonald and Rochelle Halligan on this investigation, as well as the assistance of Fiona Irving, Principal Clinical Inspector.

Findings

1. The findings of this investigation are set out below. Given the length of the review period they are necessarily generalised in some respects in order to capture the key areas of concern without introducing an unhelpful level of detail.

General findings

2. This investigation found a systemic failure of oversight. The involvement of the multidisciplinary team and senior prison staff ought to have prevented the management of these wāhine from developing into a regime that was both highly restrictive and contrary to minimum entitlements in some significant respects.
3. The issues identified in this investigation do not stem from a lack of processes or regulation. Rather, the existing regulations and processes were not followed.

Specific findings

Maximum security classification

4. The maximum security classification for women was introduced in 2009. In my view there are questions as to whether this security classification is appropriate for wāhine, given the low numbers at any one time to allow association.

De facto cell confinement and segregation; access to information and news

5. For significant periods of time in the second half of the review period:
   - 5.1 The three wāhine were effectively managed as though they were subject to sentences of cell confinement for disciplinary offences, meaning they were denied access to a power outlet, ordinarily a minimum entitlement, and therefore to radio and television. This meant that they were also denied appropriate access to news and information.
   - 5.2 The three wāhine were effectively kept segregated without following the process for directed segregation. As maximum security prisoners, they should by default have been able to associate with each other, but in practice this was denied.

Complaints

6. Wāhine complaints were frequently not dealt with in accordance with policy. This meant that a critical oversight function was lacking. This failure was particularly unfortunate as the wāhine raised many of the issues in their complaints that have formed the conclusions in this report. The wāhine themselves provided staff with multiple opportunities to reflect on whether ARWCF's management of them was appropriate.

Misconduct charges

7. Misconduct charges were often withdrawn, seemingly because of a lack of resources to prosecute the charge, which must be done within a fixed time-limit. After a time, staff stopped filing any misconduct charges. This removed a layer of oversight, with unfortunate consequences. Initiating the proper disciplinary process may well have made clear that these wāhine were already effectively under disciplinary confinement.

Use of force documentation and review

8. There were multiple failures to follow guidelines on documenting and reviewing the use of force:
   - 8.1 Planned use of force should always be filmed, and this footage stored appropriately and securely; this does not appear to always have occurred.

8.2 Whenever there is a use of force there must be a review. It was not unusual for a review to not occur, not be recorded, or take place a significant time after the incident (although some reviews were done on time, and done well).

Management plans

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

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

9.2 At least four staff be present to unlock a cell, which was one more than was required for male maximum security prisoners. Corrections officers would often arrive in large numbers, which tended to escalate the behaviour of the wāhine.

9.3 The wāhine follow precise instructions when food is delivered, including to kneel on the floor before the cell is opened. The management plans stated that not following instructions should be taken as a refusal to eat, so if the wāhine did not comply food would often be withheld and not re-offered. In my view this went beyond reasonable management. For example, on one video Ms A can be seen sitting at the opposite end of the cell but refused to kneel when instructed. Staff withheld food.

9.4 Every time the wāhine left their cells they were required to be handcuffed. This changed from being handcuffed in front to behind the back (including when using the telephone and including when speaking to their lawyer).

Health

10. The health needs of the three wāhine were not appropriately met, and review at risk assessments were not carried out at all times when they should have been.

Staff

11. Unit staff lacked proper oversight and guidance. Their behaviour was reactive rather than strategic, dealing with issues locally and informally instead of ensuring that procedure was followed. It is notable that:

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

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

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

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

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

Recommendations

I make an overarching recommendation that Corrections address the findings and confirm that no prisoners are subject to a similar management regime throughout the prison network.

In my view, the way in which wāhine across the prison network are managed requires a swift and robust review, rethink and redesign, and should in particular involve:

i. A consideration of the staffing, management and oversight of ARWCF in order to provide assurance that no other systemic issues persist. Given the broad range of findings, staff competency should be addressed at every level, including custodial and health staff.

ii. A review of the use of maximum security classification for wāhine.

iii. A review of the use of management plans across the prison network.

iv. A review of the management of Corrections Regulations 2005 cl.55 (Health centre manager to be notified of certain segregation directions) across the prison network.

v. A consideration of developing a national guideline for staff to support meaningful management of Corrections Regulations 2005 cl.76 (Certain prisoners at risk or seriously ill) (a) and (b)

vi. A consideration of how Corrections can better support staff to manage wāhine (including those who present with complex and challenging behaviour) in a culturally appropriate, gender-responsive and trauma-informed manner.

Methodology

10. On 17 February 2020, the Chief Inspector received the Complaint Letter raising concerns with the regime that three of Amanda Hill's clients Ms B , Ms A and Ms C were subject to at Auckland Region Women's Corrections Facility (**ARWCF**). A copy of the letter is attached at Appendix A.
11. The Chief Inspector determined that a review of the management of the wāhine regarding the specific complaints be conducted.
12. Following initial inquiries, a Special Investigation was commissioned by the Chief Inspector to review Ms B 's and Ms A ' management during the period 1 February 2019 to 17 February 2020.
13. The Chief Inspector corresponded with Ms Hill by email during the course of the investigation to advise of timeframes.
14. Ms C 's management was not initially included in the investigation, as some of her concerns had been previously dealt with by the Office of the Inspectorate via the complaints process, and she separately made a complaint which was being investigated by the Office of the Ombudsman. It was agreed through correspondence with the Ombudsman that it would be appropriate to include Ms C in this report.
15. We interviewed:
    - 15.1 Ms A .
    - 15.2 Ms C .
    - 15.3 Key senior ARWCF staff in place during the investigation period, including the Prison Director, two Acting Prison Directors, the Residential Manager (for the Motivation, Management, and Intervention and Support Units (**ISU**) and the Acting Residential Manager (Remand, Programmes and Assessment Units).
    - 15.4 The Acting Principal Corrections Officer – Management Unit.
    - 15.5 One Corrections Officer from the Management Unit.
16. We reviewed:[2]
    - 16.1 The District Court transcript of Ms B 's evidence. This was provided by Ms Hill in lieu of an interview.
    - 16.2 All of the documents from each file, including all incident reports, use of force documentation, segregation documentation, misconduct documentation, PC.01 complaints,[3] offender notes and the electronic health files.
    - 16.3 Around 36 hours of CCTV and on body camera (**OBC**) footage.
    - 16.4 Minutes of meetings where the management of the three wāhine was discussed, principally the minutes of multidisciplinary team (**MDT**) meetings.
    - 16.5 Prisoners' professional telephone call registers.[4]
    - 16.6 The Management Unit desk file.
    - 16.7 Applicable provisions of the Prison Operations Manual (**POM**), the Health Centre Manager Legal Responsibilities guidelines, the Corrections Act 2004 (**Act**) and the Corrections Regulations 2005 (**Regulations**).
    - 16.8 The Sentencing Decision.

2 Note, all excerpts from documents are included verbatim.
3 The PC.01 is the form in POM for making a complaint.
4 A register of all attempted and successful prisoner calls to lawyers via the unit telephone.

17. We visited ARWCF on 3–5 November 2020.

18. After the draft report had been completed, we consulted with Corrections, the three wāhine and Corrections staff at ARWCF:

18.1 We provided a draft copy of this report to Corrections for consultation.

18.2 We provided a draft copy of this report to the three wāhine who, through their counsel, provided comments in response. Relevant additional information was provided in some areas, and where appropriate this has been included in our report. In some cases additional information has not been included, because addressing it would have required us to reopen the investigation, yet it would have been unlikely to change our findings.

18.3 Exceptionally, for this report we took the further step of providing interested staff who worked at ARWCF during the review period with the opportunity to meet with us personally to discuss the draft report. We spent four days meeting with Corrections staff individually. All staff we spoke to agreed with our overall findings.

18.4 We are grateful to both the wāhine and Corrections staff who provided feedback and thank them for their participation.

Background

Auckland Region Women's Corrections Facility

19. ARWCF is located in Wiri, South Auckland. The prison opened in 2006 as New Zealand's first purpose-built women's prison in the North Island. It is one of three female prisons in New Zealand.
20. The prison is designed as a campus-style facility that accommodates both remand and sentenced wāhine. Sentenced wāhine are classified from minimum to maximum security.
21. The high and low security parts of the prison are separated by a long central row of buildings comprising classrooms, the gym and other support service areas. There are five low-medium security units in the low security side of the prison. The low security side of the prison also includes eight minimum security Self Care houses and two Mothers with Babies houses.

The high and maximum security units

22. The prison has five residential units on the high security side of the prison, including the Intervention and Support Unit (**ISU**) and the Management Unit. The high security area of the prison has five individual buildings which house four residential units: Management, Motivation and Support, Remand, and Programmes and Assessment. There are two support units with beds that are used on a temporary basis and are not counted as part of overall operation capacity: the ISU and the Separates Unit, which has the cell confinement cells.
23. The Management Unit and Separates Unit are located within one building; they each form a wing on either side of a shared guard room.
24. The following table lists the units, category of prisoners housed and the total bed capacity for high and maximum security prisoners.

Unit name	Category of prisoner	Available beds (operational capacity
Building 14 Intervention and Support Unit (ISU)	All prisoners assessed as at risk of self-harm or on medical oversight	14*
Building 20 (C Wing) Management Unit	Prisoners on directed segregation and maximum security prisoners	18
Building 20 (D Wing) Separates Unit	Prisoners serving a period of cell confinement following a disciplinary hearing	6*
Building 21 Motivation and Support Unit (consisting of two wings – E & F)	High security (including prisoners on remand and sentenced prisoners)	32
Building 22 Remand (residential unit consisting of two wings – G & H)	Unclassified/High security prisoners	90

Building 23 Programme and Assessment Unit (residential unit consisting of two wings I & J)	High security prisoners	90

* Beds are not included in the total muster capacity.

The unlock regime for high and maximum security prisoners

25. A typical regime for high security prisoners would be approximately 8.30am-11.30am and 1.00-3.30 on unlock, although it varies from prison to prison. There are no set unlock times for maximum security prisoners. During the review period there were never more than six maximum security prisoners and sometimes as few as one at ARWCF. They were housed in the Management Unit (C Wing), which also had prisoners on directed segregation orders, which would have complicated any unlock regime because they would not have been able to have been unlocked with the maximum security prisoners.

26. Maximum security prisoners are unable to associate with high security prisoners, but maximum security prisoners should be able to associate with each other. The decision to prevent a prisoner from associating or socialising with other prisoners of the same security classification is controlled by the Corrections Act 2004. The Act prescribes who may make orders directing prisoners to be segregated (**directed segregation orders**), when and by whom they can be extended and how often they must be reviewed by a Visiting Justice. Facilitating association between prisoners is particularly challenging with maximum security women prisoners, because there are not usually many of them at any one time (as compared to maximum security male prisoners).

27. During parts of the review period, ARWCF had an unusually high prisoner population (ie most of its beds were occupied) and was experiencing staff shortages. In that situation, prisons will typically conduct "rolling unlocks" where, rather than unlocking all prisoners in a unit at the same time, smaller groups of prisoners would be unlocked together for shorter periods. Unlock hours would also be restricted if there was an emergency, for example if a prisoner activated a sprinkler or assaulted another prisoner. ARWCF does not keep (and nor is it common practice across the prison network to keep) records of when each prisoner is unlocked (although keeping such records was common practice previously). It is therefore not possible to obtain an accurate understanding of how long the maximum security prisoners at ARWCF were on unlock each day before they were moved to Separates cells in October 2019, or whether they were on unlock during the same hours as other maximum security prisoners and were therefore able to associate. However, there are indications that staff at ARWCF may have treated maximum security prisoners as if they were subject to directed segregation orders and unlocked such prisoners at different times even when they were not in Separates cells.

The Office of the Inspectorate's inspection activities

28. As part of its process of prison inspections, the Inspectorate carried out an inspection of ARWCF in 2020 and produced a wide-ranging report[5] covering substantially all aspects of prisoner management: induction/reception, duty of care, health, environment, good order, purposeful activity, reintegration and prison staff. This report made a number of critical findings, but I acknowledge that the 2020 report did not deal directly with some of the matters dealt with as part of this Special Investigation. The Special Investigation has been run in parallel with the 2020 inspection, and deals with

[5] The report is available at: https://inspectorate.corrections.govt.nz/__data/assets/pdf_file/0004/42538/ARWCF_inspection_report_FINAL.pdf

the subject matter in much greater detail. The Inspectorate has also carried out recent inspections in Arohata Prison (15-18 September) and Christchurch Women's Prison (10-15 October), and is currently conducting a thematic inspection entitled: "The lived experience of wāhine in New Zealand prisons". The lived experience investigation involved site visits to all three sites, including ARWCF on 26-29 January 2021.

Staff at ARWCF

29. During the review period there was a high turnover of staff in senior positions at the site. Many of the management staff were not appointed to their role but were acting in a more senior role than the one to which they had been appointed. Many lacked custodial experience, for example their experience was in another part of Corrections such as community probation, and those who had custodial experience did not always have experience managing women prisoners.

30. For example:

30.1 At the beginning of the review period, in February 2019, there was an Acting Prison Director. When her term came to an end the role was advertised but no applicant was successful. An experienced prison director was seconded to the role (after the review period he was appointed as ARWCF Prison Director). When he was on leave during the review period (cumulatively approximately three months) other senior Corrections staff, usually but not always the Deputy Prison Director, were appointed as Acting Prison Director.

30.2 For most of the review period (8 April 2019-1 November 2019), the Deputy Prison Director role was filled by a secondee from Spring Hill Corrections Facility. When she was on leave or acting as Prison Director, her role was filled by a Senior Advisor (who had been appointed on a temporary basis to assist in implementing changes at ARWCF). The Senior Advisor was also occasionally Acting Prison Director.

30.3 Three different people were appointed to the Custodial Systems Manager role during the review period, including a Principal Corrections Officer seconded to the role and another who was in the role for two different terms within the review period. The Custodial Systems Manager is responsible for administering the use of force reviews, directed segregation and the compliance process in general.

30.4 During the review period ARWCF did not have a permanently appointed Health Centre Manager. The Clinical Team Leader, who was relatively new to Corrections, was acting in the Health Centre Manager role and leading a health team which was significantly short of staff throughout the review period.

31. Of the management staff who had the most direct and frequent contact with Ms B, Ms A and Ms C:

31.1 The Residential Manager position (whose duties included day-to-day oversight of Ms B, Ms A and Ms C) was replaced twice during the review period. Two of the Residential Managers were Principal Corrections Officer on secondment.

31.2 The Principal Corrections Officer position (whose duties also included day-to-day oversight of Ms B, Ms A and Ms C) was replaced once within the review period. An officer from the ISU would assist if the Principal Corrections Officer was absent.

The Wāhine

32. Set out below is some information relevant to each wāhine. This is included for context and to reflect their conviction and offending history.

Ms B

33. Ms B is a 27-year-old sentenced mainstream prisoner. [redacted].
34. [redacted]
35. A Corrections report[6] prepared in December 2019 [redacted]
36. Ms B has been involved in a number of incidents in prison since 2016 (nine in 2016, 14 in 2017, 24 in 2018), which include threats towards staff, assaults on staff, setting fires, smashing windows, property damage, contraband, fighting, jumping over fences, and disobeying orders.
37. Prior to and during the period of the Special Investigation Ms B was in a relationship with Ms A.

Ms A

38. Ms A is a 34-year-old sentenced mainstream prisoner. [redacted].
39. [redacted] On 2 August 2018, Ms A was convicted of arson and sentenced to six months imprisonment (in relation to an incident at ARWCF on 10 April 2018). [redacted] On 11 August 2020, Ms A was convicted for other arson and sentenced to a cumulative sentence of five months imprisonment (in relation to an incident in the Management Unit, ARWCF on 30 July 2019).
40. A Corrections' report[7] stated [redacted]
41. From June 2017 to January 2019, Ms A was the subject of 36 incident reports, which included threats towards staff, assaults on staff, activating sprinklers, setting fires,

6 The Prisoner Profile report was completed by the Residential Manager in December 2019.
7 The Prisoner Profile report was completed by the Residential Manager in December 2019.

smashing windows, property damage, contraband, fighting, being out of bounds, and disobeying orders.

42. Prior to and during the period of the Special Investigation Ms A was in a relationship with Ms B. She also has a close relationship with Ms C, who she regards as a sister.

Ms C

43. Ms C is a 36-year-old who is currently remanded on charges for which she is due to appear in the Rotorua District Court on 28 April 2021. [redacted]

44. [redacted] She was transferred to ARWCF on 12 February 2019.

45. During this sentence she was charged by the Police in relation to offences that occurred while at ARWCF during this review period as follows:

    a) 14 October 2019: Other Arson - sentenced to six months imprisonment on 7 October 2020

    b) 15 November 2019: Two charges of Crimes Act common assault – sentenced to six months and 21 days imprisonment on 17 August 2020

    c) 25 November 2019: Crimes Act common assault – sentenced to six months and 21 days imprisonment on 17 August 2020.

46. On 4 December 2019, Ms C was transferred to Arohata Prison as a maximum security prisoner. She was released from Arohata on 1 March 2020.

47. [redacted]

48. From July 2017, Ms C was the subject of five incident reports for a variety of non-compliant behaviours while at ARWCF. In 2018, while at Christchurch Women's Prison, she was the subject of 23 incident reports (10 relating to violent behaviours towards staff and prisoners), with a further four incidents in 2019 prior to transferring to ARWCF on 12 February 2019.

The perspectives of the wāhine

49. The narrative section below outlines how the three prisoners were managed on a daily basis during the review period.[8] This was drafted by reference to the records kept by ARWCF, particularly the offender notes and incident reports. These and the management plans establish that Ms B, Ms C and Ms A were housed in Separates cells for more than three months and prevented from associating without any segregation order, and that their management plans included conditions such as the requirement that the wāhine lie on their stomach with their fingers interlocked behind their heads in order for their food to be delivered.

50. While these findings can be supported by ARWCF's records alone, it is important that the prisoners' own voices are included at the heart of this report. Where relevant, the narrative section references the interviews held with Ms C and Ms A and the transcript of the evidence Ms B gave in the District Court about ARWCF's management of her. This report also quotes from the many written complaints the prisoners submitted during the review period, squarely raising many of the issues that have led to the findings in this report.

51. Therefore, before turning to the chronology narrative, informed by ARWCF's records, this report sets out summaries of Ms A and Ms C's interviews, and Ms B's court transcript.

52. The specific comments by the wāhine need to be read in light of the consideration provided within the narrative section, but it is nevertheless helpful to begin by noting their perspectives on their management during the 12 month period.

Ms C

53. Ms C was interviewed by two inspectors on 23 March 2021 and has provided a written response to a draft of this report.

54. She said that on 23 March 2019, after being pepper-sprayed, she was in the decontaminated area and handcuffed when she "*was tripped by an angry officer*" and "*thrown head first to the ground*". She was taken to Middlemore Hospital with a head injury.

55. Ms C recalled ARWCF's Health Centre had "*some involvement*" with her but it was through the cell window. She was visited daily by a nurse but the nurse would speak to her through the cell door.

56. When Ms C was in C Wing in the Management Unit, she recalled being taken into the D Wing for yard time, where each prisoner would be in a separate yard. Ms B said that at the "*start [the prisoners] went at the same time, then it stopped and one at a time*", and that they "*couldn't speak with people*".

57. Ms C described being in the "*pound*" (the Separates cells) in detail: The cells had "*no power, no TV, no radio*". They would "*just sit and think about how we could protest*" and would think about "*just giving up*". Ms C said she did not receive her hour out every day. She said that she and the other wāhine in the Separates cells "*wanted our rights*". She said that the wāhine were ignored, that they had to lie on their stomach naked to get food. They were given "*at risk blankets*" (non-destructible blankets used in the ISU). Restricted quantities of sanitary products and limited amounts of their personal toiletries were provided to the prisoners. Toilet paper was limited and sometimes withheld. Ms C said that staff were "*told to ignore us*". She

[8] Reference should also be made to Appendix D, which provides a more detailed narrative.

described being handcuffed to make telephone calls, and not getting her minimum call of up to five minutes per week. The staff held the phone, even during lawyer's calls.

58. Ms C said that if only one prisoner received their food, they would share it between the three of them by "*fishing*" (ie moving the food under the cell door to another cell with a strip of bedding or similar).

59. She said the mail of the wāhine was withheld because the prison "*didn't want us writing to people about what's going on*". Ms C said that the "*night staff worried about us*". They "*would talk to us – they knew it was wrong [and] encouraged us to go through [a] lawyer*".

60. Ms C conceded that the prisoners "*were pulling sprinklers*". She said this was "*in protest*" to "*get the attention of the [Prison Director]*".

61. A scheduled visit with Ms C 's mother was cancelled. She had been "*waiting three years to see mum*". Staff thought Ms C had a razor in her possession, but Ms C said the staff did not collect her razor and so she put it in the rubbish bin. Ms C said she was strip searched and even though the razor was not found the visit was cancelled. Ms C "*needed her [ie her mum] more than anything*".

62. On 18 July 2019, Ms C says she was in a D Wing yard when she was smashed in the face with an officer's shield. She landed on her head and the officer kicked her head and dragged her to the ISU. Ms C said she "*was stripped of my dignity*".

63. Ms C had four journals in which she wrote about her childhood. They were taken off her and she got them back when she was transferred to Arohata Prison. Ms C said the staff read her journals and taunted her about things she had written in them.

64. Ms C had particularly strong memories of the ISU, which she described as "*disgusting*" and "*inhumane*". Prisoners in the ISU are not given underwear because of the risk of self-harm. [redacted]

65. Ms C said of her time at ARWCF that she felt "*sick as a woman to be degraded like that*".

66. Ms C said being on her own changed her a lot. She has started "*acting out*" and has "*mistrust in Corrections*". She said that being in "*a wing of people overwhelms me*". The words she used to describe herself after being at ARWCF were "*paranoia, no trust, made me violent, PTSD, head injury … flashbacks – shields and helmets, non-sociable, strip me of dignity, mana*". She said she "*wasn't like this before*".

Ms A

67. Ms A was interviewed on 4 November 2020 and has provided a written response to a draft of this report.

68. Ms A said that her time at ARWCF had "*affected [her] mental health*". She said "*I'm not the same person*", and that she had "*changed due to isolation*". She feels "*weary*" and "*distrusts staff as a result*".

69. Ms A said she reached a "*tipping point*" after months in D Wing and covered her cell observation windows and the cell in the camera with the rationed toilet paper with which she had been provided. She said it "*took days to save up*".

70. Ms A said she volunteered to go to D Wing because the other two wāhine were in D Wing and she "*felt bad cause I had a TV etc*". She "*felt obligated*" out of "*love*". She said

[9] ARWCF has responded and confirmed that it is able to provide disposable underwear. [redacted]

that the three of them "*had each other's back*", and that there were "*no other people*". Ms B has been her partner for three and a half years and Ms C was her friend for life.

71. Ms A said the regime in directed segregation "*felt like maxi*".

72. Of her time in C Wing, Ms A said that there was "*nothing happening*", it was "*frustrating*", there was "*no TV to start*If the unit was full, she would have one hour in the Separates Unit yard, but the prisoners "*never had yards together*" when they were in C Wing.

73. Ms A said that when she was first classified as a maximum security prisoner, "*we didn't know about management plans*". She said that the plans were placed under her door. Ms A said she asked questions of the psychologist, nurse and Residential Manager about who was involved, and was told there was a panel.

74. There was a sign at the door of the unit that said "DO NOT INTERACT WITH THE INMATES".

75. To receive food, Ms A said she had to go face down on her stomach towards the back of the cell, hands behind her head and cross her feet, and remain that way until the food had been passed through the hatch and the hatch was relocked. It made her "*paranoid*".Ms A acknowledged that when she was in C Wing she had put her limbs out of the hatch, but said it was the "*only way to get senior staff to come*" and was "*simply out of frustration*".Ms A said of having to lie down to receive food, she "*felt so little*" and it affected her mana. She remembered "*ignoring directions to lay on stomach*" because she was "*just sick of it*".

76. Ms A said that when she was in D Wing, she was either in the cell or the yard. If she was in the yard, the yard door was kept closed. If the door was opened, it would only be such that there was a small gap.

77. Ms A said that when she used the cell alarm there was "*constantly*" no answer.

78. Ms A said that her behaviour, including activating the sprinklers, verbal abuse and assaults, was "*out of frustration*", "*not knowing what's happening*", and because she felt she had "*no control*". Every request had to go to the MDT meetings, but her management "*never changed*".

79. Ms A said she "*tried to get help from staff*", but said they had "*no empathy*", and she "*felt it was 'us v them'*". She said some "*tried to engage*" but "*other staff judged them*".

80. Ms A acknowledged that in hindsight "*I need structure*" and "*normal interaction*"; she and the other prisoners were "*treated like dogs*".

81. Ms A said that when a misconduct charge was filed she would wait to see the hearing adjudicator because she "*wanted interaction*". She did not often appear before the hearing adjudicator, but was not told that the misconduct charge had been withdrawn.

82. Ms A talked about Ms B 's rings, which she was told they needed to hand over. She submitted a PC.01 complaint volunteering to be strip searched, to walk around a metal detector and to have her cell searched. She was "*still housed in D Wing after [the] searches*".

83. After she was pepper sprayed, Ms A said she was sent to the decontamination yard and "*hosed like a dog*", with "*staff teasing*".

84. Ms A said that in C Wing she had standard prison clothing, with five undies, bras and socks, but that in D Wing she "*had to exchange [clothing] one-for-one*" because "*staff didn't want prisoners to accumulate*". Ms A remembered male staff opening the food hatch while Ms A was naked, waiting for her clothing exchange. She said she

started covering the windows and washing her clothing, but the toilet paper fell off the camera and the CCTV showed Ms A with no top on.

85. Ms A said that to speak to her lawyer on the telephone she was handcuffed and the telephone was on speaker. She was only allowed one five minute call a week. She "*couldn't be myself with [my] kids*".

86. Ms A acknowledged that she and the other wāhine had drawn and put up pictures of stick figures with knives, with "*fuck you*" and "*die*" written on it. She said it was "*stupid*" and "*pathetic*", and that the "*prisoners knew they would come out worse off*". The trigger for the pictures was a sign she said had been placed near her cell instructing officers not to engage with wāhine.

87. Ms A said that even when the wāhine had periods of being compliant "*nothing changed*". She "*wanted to return to C Wing*" and "*tried to be good*".

Ms B

88. Ms B gave sworn evidence in the District Court on 4 September 2020 and has provided a written response to a draft of this report. The following is from the notes of evidence:

88.1 She was pepper sprayed inside her cell at the end of August or early October.[10] She asked staff why they were moving her "*and they said, 'we don't have to give you those reasons, we're moving you'. There were "more than six, there was more than six staff outside*". She refused because the officers would not say why she was being moved. When they used pepper spray, "*I was scared, I stood in the shower cubicle and I was like 'Yous can't do that.' And they did, they just gas busted me out*".

88.2 Ms B explained that she pulled the sprinkler because "*they wouldn't give me clean bedding, clean towels and the only way to get that is to get wet and yea, it's something you don't want to do, but if you want a clean towel to have a shower and clean stuff, well, that's what I had to do*".[11]

88.3 Ms B 's understanding of D Wing was that it was for a sentence after a misconduct hearing. She said that when, after lighting a fire on 14 October, she was transferred to D Wing, she was told it was for 14 days and "*To me it felt like I was getting punished by them, like instead of doing the process of being charged, being formally internally charged and sense of a visiting justice and getting my accumulative days then getting set there to go and serve them, they skipped that whole process and put me straight into the pound*".[12]

88.4 Ms B said that staff "*weren't lodging our complaints and they weren't giving us time on the phone to talk to the Ombudsman*".[13] She said that she knew staff were not lodging the complaints "*Because they've got a set time of 24-hours to – so it says at the bottom of the PC01 form that they've got 24 hours to issue you with a receipt number and the staff that's lodged it and they weren't giving our receipts*".[14] She said "*the actual process, so the actual PC01 process, the complaint form process wasn't working.*"[15]

10 NoE 2/7 [line number/page number].
11 NoE 26/13.
12 NoE 15/16.
13 NoE 30/17.
14 NoE 1/18.
15 NoE 24/21.

88.5 Ms B said she lodged complaints about "*Not having adequate bedding, not having sanitaries, not having toilet paper, not having towels. Like just your basic things, like our minimum entitlements*".[16]

88.6 Ms B said that after she was transferred to D Wing, her 26-year old cousin was also moved to D-wing. She said they moved her cousin out of D Wing because she was "*deteriorating … Like she just wasn't communicating with anyone. Just, yeah, crying every day. Like just couldn't handle how we were getting treated, like it was pretty hard on her*".[17]

88.7 Ms B described how "*if we wanted breakfast, lunch or dinner we had to lie down on the ground facing the back of our cells with our hands interlocked behind our head and our feet pointing to the ceiling*".[18] She said this was "*because I had put my hands outside the hatch … because it was the only way I could get to see the PCO*".[19] She said "*we'd starve because we were too humiliated and felt downgraded. We felt we were getting treated like animals. So we'd starve because we weren't gonna lie down, every single time, just to get a meal*".[20] She said that if she did not lie down, staff would say "*we'll take that as a refusal … And we're telling them, 'Hey we're not refusing, we just don't wanna get down'*".[21] She said the longest she could go without food before agreeing to lie down was three days,[22] but that Ms C and Ms A would help her by sharing their food, which they tied to the end of a ripped T-shirt, which Ms B would pull under her door.[23]

88.8 Ms B described covering her window with paper towels because "*I didn't want anything to do with them. Yeah, I was just mentally over it, I couldn't take it anymore. I didn't want them to look at me. And then once I covered my windows with that, they took those away from me*".[24]

88.9 Ms B said that she walked round her cell in a sports bra because staff "*wouldn't give me my clothes. Like they wouldn't give me my personal – like my underclothing, like singlets and that type o' stuff…. So I was in my room, walking around in a sports bra. [You would] try and save [the prison-issued clothing] so that the next day it was nice and clean. 'Cos they wouldn't give our clothes every day, they wouldn't give us clean prison issue every day*".[25]

88.10 Ms B said that at the time she self-harmed, she "*just felt like dying, I just felt like, oh, I can't take this anymore, couldn't handle, I just couldn't handle it any more. Like I was just waking up, dark, going to sleep, dark, waking up crying, going to sleep crying, it was just nah, it was pretty hard out*".[26] She said that in the days leading up to her suicide attempt she "*told the manager. I told the PCO. I told the staff. Like they were asking me, 'How are you?' and I'm like 'Bro, I just wanna die".[27] She said that staff responded by encouraging her to "talk to Ms A]*".[28]

16 NoE 31/19.
17 NoE 22/20.
18 NoE 2/21.
19 NoE 14/21.
20 NoE 1/22.
21 NoE 25/25.
22 NoE 30/25.
23 NoE 2/26.
24 NoE 28/23.
25 NoE 13/24.
26 NoE at 14/32.
27 NoE at 27/38.
28 NoE at 30/38.

88.11 Ms B said that she was not given any books "*right up until January*".[29]

88.12 In cross-examination, Ms B was asked about her interactions with staff when they came to her cell before a planned use of force. She said that "*every time they did come, they were there with shields. So, numbers, I was just automatically intimidated from the get-go*".[30] She conceded there were times when she threatened violence against staff: "*at that time, I was in a hostile situation where it was coming from both sides; me to them, them to me. So, felt like I was going to war*".[31] "*Every single time they came ready for war really. That was their mentality, 'We're doing this whether yous like it or not, and we're gonna use as much force and as much pepper spray as it takes to get yous outta there*".[32] "*[I]t was just a never-ending repetitive cycle of ugly. Every day*".[33] "*There's no one coming forward saying, 'Come on, we gotta change the room now.' It's just immediately 'We're gonna use force.' So I immediately guard up, that's my natural reaction, so I just kick into survival mode by then. 'Cos I know it's inevitable*".[34]

88.13 Ms B said that staff did not explain her management plans: "*They just slide it under your door and ask you, 'Can you sign this?'*"[35]

29 NoE at 8/39.
30 NoE 17/2. The cross-examination was on 20 November 2020.
31 NoE 26/6.
32 NoE 1/14.
33 NoE 33/14.
34 NoE at 11/17.
35 NoE 10/11.

Narrative of events

89. This section sets out a summary and explanation of the key events over the 12 month period of the Special Investigation. The detailed narrative is contained in Appendix D, which sets out the offender notes and incident reports referred to in this summary. We have included references in the footnotes to the relevant parts of Appendix D.

February 2019

90. The review period commenced on 1 February 2019. At that stage:

90.1 Ms C had been residing at Christchurch Women's Prison (**CWP**) since 16 June 2018 with a high security classification.

90.2 Ms A had been residing at ARWCF since 25 May 2017 (and had been classified high security in 20 November 2018).

90.3 Ms B had been residing at ARWCF since June 2015. She was moved to Assessment F Unit on 20 November 2018 with a high security classification. Since the review period, Ms B had been transferred to Arohata Prison, and was due to return there from ARWCF (where she has been for sentencing at Auckland District Court) on 30 March 2021.

91. On 1 February 2019, all three women were in high security units (Ms B and Ms A were in the Assessment or Motivation Unit, which was used for high security prisoners but was not the main high security building). This means the women would have been associating with other prisoners of the same security classification in their respective units. They had access to television and radio in their cells, as well as library books, and were able to access a shared space during their designated unlock hours. High security units operate on a 8am to 5pm regime, and are locked over the lunch period (in practice, this would typically mean prisoners are unlocked from 8.30am-11.30am and then from 1.00pm-3.30pm). At this time ARWCF was experiencing staff shortages across the site and a high population, which resulted in "rolling unlocks" – ie: rather than unlocking all prisoners in the high security unit at the same time, small groups of prisoners would be unlocked together for shorter periods.

92. At the beginning of the review period Ms B and Ms A, who were in a relationship throughout the review period, had both applied to be transferred to Arohata Prison in Wellington. On 7 February 2019 they had both submitted complaints that these applications had been ignored. The wāhine were advised that they would not be transferred together because of their history of behavioural issues when imprisoned together.[36] Both wāhine withdrew their applications in response.

Separates cells

93. On 8 February 2019, Ms C was moved within CWP to a Separates cell, which lacked a general power outlet. Part C of Schedule 3 of the Corrections Regulations 2005 ("Items in cells and self-care units") requires a "general power outlet". The Part C items are not required in Separates cells, which is used when a prisoner has had a penalty of

[36] These behavioural issues were largely from outside the review period. They include use of force, assault on staff/prop on 5 November 2017 (includes other prisoners); non-compliant abusive behaviour on 30 November 2017; activate sprinklers 1 December 2017 (includes other prisoners); prop in toilet 15 January 2018 (involves one other prisoner); threatening numerous prisoners (who contacted staff asking not to be unlocked with Ms A and Ms B) 6 February 2018; both smashed their windows (as did other prisoners) 21 February 2018; search operation to find lighter/ignition – lighting fires in Motivation wing – 26 February 2018; Ms A ran away from staff and jumped in Management Unit yard to Ms B – 10 March 2018.

cell confinement imposed by a hearing adjudicator or Visiting Justice in response to a misconduct charge.[37] However, Part C items are a requirement for cells not used for cell confinement, "as far as is practicable in the circumstances".[38] Purpose-built cell confinement cells that lack a general power outlet are not designed or intended for non-disciplinary purposes.

94. The practical effect of being in a cell specially designed for cell confinement, without a general power outlet, is that the prisoner is unable to watch television or listen to the radio. The lack of a power outlet may also prevent some prisoners from lighting fires and setting off the sprinkler system (although as discussed below, there are other ways of setting off the sprinkler system).

95. The cell confinement cells at CWP and ARWCF are sometimes described as "separates" or the "pound". In ARWCF, the "separates" were in wing D of the Management Unit (sometimes called Management Separates).

96. Ms C's placement in a Separates cell with no power outlet at CWP on 8 February 2019 was not part of a misconduct penalty. She was placed on directed segregation and relocated to the cell following an assault on another prisoner apparently because all other cells in that unit were occupied. She remained there until 12 February 2019, when she transferred to ARWCF. As this report is concerned with ARWCF, this incident at CWP is not dealt with any further. It is, however, important to note at the outset the use of cells without power outlets outside of the misconduct process, as this became an area of concern at ARWCF.

Incident reporting

97. The day-to-day management of prisons is guided by POM. Prisoners are able to read POM on the electronic kiosks in the units. POM prescribes how Corrections staff are to report incidents, including whether the incident must be notified, which includes at the least a telephone call to the Incident Line and the completion of an incident report in Corrections' Integrated Offender Management System (**IOMS**).

98. When Ms C was made subject to a directed segregation order, following an assault on another prisoner, that led to the order and the move to the Separates cell. POM requires any "serious" assault to be notified and any time that staff respond with a spontaneous use of force.[39] Three incident reports were filed for this assault.

8 February 2019-

99. In early February there were incident reports arising from two events:

99.1 On 8 February an incident report stated that during the morning Ms B's cell was empty, with a duvet inner and pillow placed to make it appear that she was in bed. She was actually next door in Ms A' cell.[40] Misconduct charges were filed against both prisoners. They appeared in front of the hearing adjudicator on 14 February and pleaded guilty. They were each sentenced to seven days' cell confinement, and loss of privileges for 21 days for Ms A and 28 days for Ms B. The sentences were commenced on 6 March, after the prisoners withdrew their appeals.

37 For the powers to impose a penalty of cell confinement, see Corrections Act 2004, ss 133 and 137. For the minimum cell requirements for confinement cells, see the Regulations cl 157.

38 Clause 67(2)(b).

39 IR.06.Sch.01.

40 See [A13]

99.2 On 9 February an incident report stated that Ms A was observed passing contraband lozenges to another prisoner. No misconduct charge was filed against Ms A for this.

12 February 2019 - Ms C transferred to ARWCF

100. On 12 February 2019 Ms C was transferred from CWP to ARWCF. This was at Ms C's request, to return to her home region. Ms C was placed in a cell in the Assessment or Motivation unit for one night, and then in C Wing in the Management Unit for two nights before being moved on 15 February 2019 to the High Security Unit, where Ms B and Ms A were placed. Management cells at ARWCF in C Wing are ordinarily used for maximum security prisoners and prisoners on directed segregation, but it would not be unusual for a new prisoner like Ms C, who had been on directed segregation at CWP, to be placed in a management cell for a short period while she was being assessed, before she was transferred to the High Security Unit. Ms C's directed segregation order in CWP would have ended when she transferred; it did not continue at ARWCF.

101. Ms C and Ms A knew each other from before Ms C was transferred Ms A referred to Ms C as her "*sister*".

17-24 February 2019 – Ms C and Ms A used threatening language

102. In the period 17–24 February 2019, the following offender notes and incident reports relate to Ms C:

102.1 An offender note dated 17 February 2019 recorded abusive behaviour by Ms C towards staff on her cell intercom, demanding extra hygiene products after she had already received one packet of pads and six tampons.[41]

102.2 There is an offender note dated 20 February 2019 recording abusive and demanding behaviour from Ms C towards staff, complaining that her property from CWP had not yet arrived.[42]

102.3 There is an offender note dated 24 February 2019 stating that Ms C was physically aggressive in demanding her "*buy-ups*" from staff (items that she had purchased). "*I want my buy-up. It's not that hard, just go fucking get it*".[43]

103. There is an incident report dated 17 February 2019 recording threatening language from Ms A to staff ("*I'm going to smash you bitch*").[44] A misconduct charge was filed in respect of Ms A' threatening language. On 4 March 2019 Ms A appeared in front of the hearing adjudicator. She pleaded guilty and was admonished and discharged.

26 February 2019 – Ms C moved to C Wing and placed on directed segregation two days later

104. On 26 February 2019 Ms C was moved to C Wing. She was placed on directed segregation because of threatening behaviour.[45] Section 58 of the Corrections Act authorises the prison manager to:

41 At [A28].
42 At [A31].
43 At [A32]. Ms C finished a penalty of three days' cell confinement on 24 February 2019 for a misconduct charge from her time at CWP. She had appealed a sentence of seven days' loss of privileges, which the Visiting Justice at ARWCF amended to three days' cell confinement. Ms C underwent cell confinement in her usual cell.
44 At [A29].
45 At [A33].

> … direct that the opportunity of a prisoner to associate with other prisoners be restricted or denied if, in the opinion of the manager,—
> (a) the security or good order of the prison would otherwise be endangered or prejudiced; or
> (b) the safety of another prisoner or another person would otherwise be endangered.

105. The effect of the order placing Ms C on directed segregation was that her ability to associate with other prisoners was limited. She was transferred to a cell in C Wing of the Management Unit, which was used for prisoners on directed segregation. This enabled ARWCF to manage such prisoners separately from other prisoners. The cells in C Wing include general power outlets, in compliance with the Regulations as they apply to cells not used for penalties of cell confinement.

106. A directed segregation order can require the prisoner's association to be "restricted" or "denied". A prisoner on "denied" directed segregation must be visited by the manager, or an officer authorised by the manager for that purpose, at least once a day.[46] A prisoner subject to a segregation direction "must be detained, so far as is practicable in the circumstances and if it is not inconsistent with the purposes of the segregation direction, under the same conditions as if he or she were not subject to a segregation direction".[47] The requirements for cells for segregated prisoners are set out in clauses 57 and 58 of the Regulations and include a general power outlet "so far as is practicable".

107. The Case Manager met with Ms C on 27 February 2019.[48]

108. Although Ms C was moved to C Wing on 26 February 2019, the directed segregation order did not commence until 28 February 2019. She was effectively managed under segregation for two days without the required documentation.

27 February 2019 – Ms C submitted complaint alleging unclean cell

109. On 27 February 2019 two complaints from Ms C were registered in IOMS. The date entered for prisoner complaints on IOMS is the date that staff register the prisoner's complaint, and it is possible that some of the complaints were registered after the prisoner made the complaint. One of the complaints registered on 27 February 2019 was that on arrival at ARWCF, Ms C stated that she was initially placed in a cell with faeces and wet toilet paper for the day.[49] Prisoner complaints forms (PC.01s) have sections for staff to complete in response to the complaint. Staff responded:[50]

> … advised staff have been spoken to about ensuring the cell is clean prior to placing the prisoner in even if they are temporarily placed in a cell over the lunch lock up time, while organising a suitable permanent cell placement.

110. On 28 February 2019 Ms C was approved to have a telephone call with her partner. There had been issues with Ms C calling her partner since arriving at ARWCF, as the partner's telephone number had been entered incorrectly on Ms C's list of approved outgoing calls in IOMS, and Ms C's telephone card had been lost when she was being moved between cells.[51]

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46 Corrections Regulations 2005, cl 56.
47 Corrections Regulations 2005 cl 62.
48 At [A33]. During the review period it appeared that Ms A was generally having fortnightly meetings with her Case Manager, and Ms B was generally having monthly meetings with hers.
49 At [A42].
50 At [A43].
51 At [A45].

5-18 March 2019 – Incident reports and offender notes recorded non-compliant behaviour from Ms A and Ms C

111. During March 2019, there were the following offender and incident reports:

111.1 On 5 March 2019, an incident report recorded Ms A throwing two cartons of milk under another prisoner's cell door. She was warned for this behaviour by the Senior Corrections Officer; no misconduct charge was filed.[52]

111.2 On 6 March 2019, an offender note recorded that Ms C demanded she have her yard time in the afternoon rather than the morning. After staff advised that she could not dictate to staff her yard time, the Principal Corrections Officer and Senior Corrections Officers met with Ms C and approved her to have yard time in the afternoon.[53]

111.3 On 6 March 2019, an incident report recorded Ms C using abusive language and threatening behaviour during the evening medical round.[54]

111.4 On 10 March 2019 an incident report recorded that during the morning medical round Ms C, who has a skin condition, asked for her cream. The nurse replied that there was no cream, and Ms C "was very angry [and] threw her medication to [the nurse's] face".[55] A misconduct charge was filed.

111.5 On 14 March 2019 an incident report recorded that Ms C declined to be searched by the drug dog, kicked the dog and was verbally abusive.[56] A misconduct charge was filed.

111.6 On 15 March 2019 offender notes recorded non-compliance from Ms C, who was sticking her legs out of the food hatch in her cell,[57] and refusing lock until she received a television.[58] The offender note recorded that Ms C had been provided with a television on 13 March and that it appeared she had traded it, but she was provided with a further television to "*maintain staff safety*".[59]

111.7 On 18 March 2019 Ms C was not at her door to be locked and, as a consequence, her lock the following day was to be delayed by one hour.[60]

6-19 March 2019 - Ms A and Ms B moved to Separates cells for cell confinement; Ms C sentenced to five days' cell confinement, served in own cell

112. On 6 March 2019 Ms A and Ms B moved to Separates cells in D Wing to commence their sentences for the 8 February incident where Ms B was in Ms A' cell. They returned to the High Security Unit on 13 March.

113. On 11 March 2019 Ms C's directed segregation order expired and she returned to the High Security Unit the following day.

114. Ms C appeared in front of the hearing adjudicator on 19 March 2019, for the misconduct charges arising from the 10 March 2019 incident where she threw her medication in the nurse's face and the 14 March 2019 incident where she kicked the drug dog, and entered a guilty plea. She was sentenced to cell confinement for five days

52 At [A43].
53 At [A51].
54 At [A50].
55 At [A56].
56 At [A61].
57 At [A64].
58 At [A65].
59 At [A65].
60 At [A67].

and seven days' loss of privileges.[61] On 19 March 2019 Ms C commenced her cell confinement sentence (in the same cell). It is not necessary to use the purpose-built cells for cell confinement; prisons may instead remove the television and radio from the prisoner's own cell and have the prisoner serve their cell confinement there. However, it is important if this occurs that good records are kept, including in the offender notes, recording when the prisoner commenced cell confinement and the television and radio were removed, because the sentence dates do not appear in the prisoner movement documents. There is no mention in Ms C 's offender notes records that she was serving a cell confinement sentence from 19 March in her own cell. It is likely that this was recorded on the wall of the guard room of the High Security Unit, so Corrections Officers knew when Ms C should come off cell confinement.

115. During Ms C 's period of cell confinement there were a number of offender reports describing non-compliance:

115.1 On 20 March 2019, when Ms C was unlocked in the afternoon she moved her property to another cell, insisting that she be placed in a cell closer to Ms A and Ms B .[62]

115.2 On 22 March 2019, offender notes recorded that Ms C refused to be locked,[63] that later she was verbally abusive to a Corrections Officer ("*I ain't fucking talking to you fucken bitch*"),[64] and that she refused to remove her hat when in the wing.[65]

23 March 2019 assault – Prisoners involved in assault on prisoner; staff deployed pepper spray

116. On 23 March 2019 all three wāhine were involved in an assault, leading to a spontaneous use of force by the officers. At this point all three wāhine were in the High Security Unit and able to associate during unlock. The incident reports recorded that during the morning unlock, Ms A and Ms B were on the top landing, stomping on and exchanging punches with another prisoner.[66] As the officers began to intervene, Ms C ran past to join the fight. A Corrections Officer tried to grab Ms C but she turned around, raised a closed fist and said "*fuck off*". Ms C lunged at another officer, who deployed pepper spray and took Ms C to the ground.

117. The incident reports recorded that Ms B and Ms C advanced towards staff in a threatening manner, and that in response the officers deployed pepper spray. This is supported by the CCTV footage.[67] One officer was off work for five days as a result of the incident.

118. CCTV and OBC footage confirmed Ms A and Ms B were on the top landing and can be seen exchanging punches with another prisoner. Staff responded and Ms C ran past the officer, who deployed his pepper spray.

61 Technically Ms C was sentenced to three days' cell confinement for throwing her medication at the nurse, and five days for kicking the dog, but the sentencing would have been served concurrently.

62 At [A68].

63 At [A69]

64 At [A70].

65 At [A71].

66 At [A23].

67 At [A75].

119. All three wāhine were removed to the decontamination area, which is standard practice wherever pepper spray has been deployed. After decontamination, all three were assessed by a nurse[68] and locked in their cells.

23 March 2019 assault – Wāhine made subject to directed segregation orders

120. Directed segregation orders were made in respect of all three prisoners under s 58(1)(a) of the Corrections Act. Ms C and Ms B were transferred to cells in C Wing in the Management Separates Unit, where prisoners on directed segregation were typically held. Ms A was transferred to a cell in the Assessment or Motivation Unit, in part to keep Ms B and Ms A separate because of their behaviour when they were together (including their assault on 23 March against another prisoner).

121. There are specific requirements to protect the health of prisoners subject to a directed segregation order or placed in a cell under a penalty of cell confinement. The Corrections Regulations 2005 requires that:

121.1 the Health Centre Manager "*must be notified reasonably promptly by the prison manager after a prisoner is placed in a cell in circumstances where, as a consequence of any segregation direction, the prisoner is denied the opportunity to associate with other prisoners*";[69]

121.2 the Health Centre Manager of a prison must ensure that "*special attention is paid*" to such prisoners.[70]

122. The Health Centre Manager Legal Responsibilities Guideline (2013) states that when a Health Centre Manager is notified that a prisoner has been placed on a directed segregation order then a review of the prisoner's history must be undertaken to determine if an assessment of the prisoner is needed. The decision must be recorded on the prisoner's electronic health record. The electronic health records for the three wāhine do not include this information, which suggests the Health Centre Manager may not have been notified that the prisoners were placed on directed segregation, or that there is a gap in the record-keeping.

March 23 2019 assault – Misconduct charges filed against all three wāhine

123. Misconduct charges were filed against all three wāhine.[71] The charges were heard on 1 April 2019. Ms C and Ms A were sentenced to seven days' cell confinement and 28 days' loss of privileges. Ms B was sentenced to five days' cell confinement and 10 days' loss of privileges. It appears that the sentences of cell confinement were served in the prisoners' own cells by removing the televisions and radios, rather than in one of the purpose-built Separates cells in D Wing.[72] This is an appropriate approach, but it should be recorded in the offender notes. Because the wāhine did not move cells for their sentence, it is not possible to confirm through the electronic records (by reference to the prisoner movement documents) when the cell confinement penalty ended.

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68 Ms C was later referred to the Emergency Department on 27 March for assessment of a head injury due to increasing and worsening headaches since banging her head post use of force on 23 March. She was discharged with the diagnosis of post-concussion headache.

69 Clause 55.

70 Clause 76(2).

71 At [A82], [A84] and [A86]. The offender note for Ms A recorded that she was unlocked on 3 April 2019 for her charges to be heard. However, no charges were heard that day, and Ms B and Ms C 's charges were heard on 1 April 2019. The 3 April 2019 offender note may be retrospective.

72 In response to a draft copy of this report Ms B and Ms A confirmed that they served these sentences in their own cells.

124. Ms A appealed her sentence. The appeal was dismissed on 17 April 2019, which is when she commenced her sentence of seven days' cell confinement.

23 March 2019 assault – Use of force review not completed

125. POM requires that where there has been a use of force, "*including individual carry pepper spray*", that there is a review "*as soon as possible after the incident*", by an officer nominated by the prison director.[73] POM prescribes that the review:

125.1 considers "*whether the situation was handled in the most appropriate way, what led to the situation, and what strategies need to be put in place to avoid future situations that lead to the use of force*";

125.2 covers "*what led to the incident, and what steps were taken to avoid the use of force (negotiation etc)";*

125.3 be "*documented and made available to any subsequent investigation*";

125.4 ensures that the "*underlying causes of the incident are identified, analysed and action planned to resolve or minimise cause*";

125.5 be "*forwarded to the regional commissioner for approval of planned actions, and to ensure follow up*";

126. The reviewing officer must place "*a record of findings in the Use of force register*" and inform "*the prison director of the findings*".[74]

127. No evidence has been found that the spontaneous use of force on 23 March 2019 was reviewed. As detailed elsewhere in this report, this became an ongoing issue.

23 March 2019 assault – Ms C made an allegation of staff assault, managed in compliance with the PC.01 and IR.07 process

128. Ms C made a PC.01 complaint that was registered in IOMS on 26 March 2019, alleging that when she was in the decontamination area after the 23 March 2019 assault between prisoners, a Corrections staff member had planted Ms C 's face into the concrete and cut her face and head open.[75] When interviewed during this investigation, Ms C said she was sitting handcuffed in the decontamination area when she "*was tripped by an angry officer*", throwing her head first to the ground. She went to Middlemore Hospital with a head injury.[76]

129. Prisoner complaints about staff conduct and attitude must be referred to the Prison Director under POM.[77] If the complaint alleges assault by staff on a prisoner, the allegation must be managed according to the instructions set out in IR.07 of POM. The Inspectorate determines which IR.07s will be monitored to ensure the site has appropriately managed the complaint through the IR.07 process. This complaint was managed in compliance with IR.07:

129.1 On 27 March 2019 Ms C was interviewed by the Residential Manager in relation to her complaint of injuries she sustained during the decontamination process on 23 March 2019.[78] The IR.07 notification was completed.

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73 IR.05.07 "Post Incident Review".

74 This is paragraph 10 of IR.05.07, but IR.05.08 prescribes how the Use of force register shall be maintained.

75 At [A96].

76 The electronic medical file records that "*Nurse assessment for injury to head following use of force. Ms has hx of brain injury. During use of force was pushed on concrete and hit her head on the right side. Throbbing head and has blurry vision. Pain 10/10. Feels dizzy and nauseated. Three abrasions noted to left side of head. Vital signs checked and normal*". The Inspectorate has viewed OBC and CCTV of the decontamination.

77 PC.01.07, paragraph 5(a).

78 POM requires prisoners to be interviewed within three days of making a PC.01 complaint.

129.2 The IR.07 notification stated that OBC footage indicated the officer was professional in her approach to the decontamination process and only used enough force to contain the situation.

130. The PC.01 form has sections for staff to enter their response.[79] POM requires that where the complaint concerns staff conduct and attitude, it "must be referred to the prison director". It is standard practice for this to be recorded in the response section. There is no record that Ms C 's complaint was elevated to the Prison Director.

131. When a prisoner PC.01 complaint is registered in IOMS, a category of complaint must be selected. Ms C 's complaint was registered under "other" rather than "staff conduct and attitude". This undermines the ability of Corrections to extract data across prisoner complaints, for example the proportion of complaints that involve staff conduct as opposed to property.

23 March 2019 – Ms A given a nebuliser for her asthma

132. After the 23 March 2019 assault, Ms A complained that she was having difficulty breathing. The electronic health file recorded that she was assessed by a nurse and given medication via a Ventolin inhaler but to "*minimal effect*", and so a nebuliser medication was "*given with good effect*".

133. The offender notes and electronic health file include a number of references to Ms A ' asthma or difficulty in breathing. Given the relatively regular exacerbations in Ms A ' asthma, best practice would have been to implement an asthma plan. The electronic health file recorded only five peak flow tests measured since being in custody.

[redacted]

24 March 2019 - Non-compliance recorded, including sprinkler activations

134. The offender notes and incident reports recorded the following non-compliance after the 23 March assault:

134.1 On 24 March 2019 an offender note recorded that Ms C threw an apple through her food hatch at a staff member.[81]

134.2 On 24 March 2019 at 3.45pm Ms A activated the sprinkler in her cell.[82] This is a significant problem as the sprinkler continues until a contractor comes on site to turn off the water. The cell floods and water comes into the unit under the door. The prisoner must change cells while the water is pumped out and the contractor resets the sprinkler from inside the cell (in this case Ms A was placed in the yard while the water was pumped). At 5.10pm Ms A set off the sprinkler again.[83] Ms A was assisting with cleaning up the water when she ran out the back door towards the fence along the Management Unit yard. An officer ran towards Ms A , who hit the officer on the left shoulder with a closed fist. The officer deployed pepper spray. Misconduct charges were filed. Ms A appeared on 1 April 2019 before the hearing adjudicator and entered a guilty plea. She was sentenced to seven days' cell confinement and 28 days' loss of privileges. She appealed but the sentence was

79 At [A89].

80 [redacted]

81 At [A87].

82 At [A89].

83 At [A91].

upheld on 17 April 2019. The cell confinement sentence appeared to have been served in Ms A ' own cell.

5 April 2019 – Ms C and Ms A came off directed segregation; 6 April 2019 - Ms A assaulted a prisoner and made subject to a new order of directed segregation

135. On 5 April 2019 the directed segregation orders for Ms A and Ms C expired without being extended. Ms A remained in the Motivation Unit, which was a residential unit, but on a less restrictive regime.

136. On 6 April 2019, Ms A ' first day off directed segregation, incident reports recorded that she assaulted multiple prisoners, punching two wāhine in the face with a closed fist and a third with an open hand.[84] A misconduct charge was filed, and on 11 April 2019 Ms A appeared before the hearing adjudicator and entered a guilty plea. She was sentenced to seven days' cell confinement and 14 days' loss of privileges. Ms A ' appeal, together with her appeals against the sentence for the 23 March 2019 assault and for activating her sprinkler and assaulting staff on 24 March 2019 were all dismissed on 17 April 2019 by the Visiting Justice. She would have served all three sentences concurrently, ie seven days' cell confinement in total.[85] It appears that she served her sentence in her own cell in the Motivation Unit, although this is not recorded in her offender notes.

137. Ms A was subject to a new directed segregation order. The directed segregation document was not completed in compliance with POM, with the result that Ms A ' order was not reviewed within the required timeframes.

138. POM states that if a prisoner is removed from segregation and within five days of removal is subject to a new direction, then "the timing legislative reviews */ continuation / expiry* ***remains from the first day of the original direction***" (emphasis in original).[86]

139. The previous order had been made on Saturday 23 March 2019 and had expired on Friday 5 April 2019. The segregation document for the new order recorded that: it was made on Sunday 7 April 2019 with an initial end date of Saturday 20 April 2019 (ie 14 days later). It was extended on 16 April 2019 and expired on 6 May 2019. The start date of the previous order should have been recorded. The failure to do this meant, for example, that the requirement under s 58(3)(b) of the Corrections Act that a Visiting Justice review a directed segregation order every three months would be calculated from 7 April 2019 rather than from 23 March 2019.

6 April 2019 – Ms C reclassified as a maximum security prisoner

140. On 4 April 2019 Ms C was reclassified as a maximum security prisoner, pending review by the Chief Custodial Officer, and was informed on 6 April 2019. Ms C remained in C Wing of the Management Unit, where she had been on directed segregation, but from this time as a maximum security prisoner and without a directed segregation order.

141. There was one other maximum security prisoner in C Wing at this time. As fellow maximum security prisoners, Ms C and the other wāhine should have been able to associate during unlock. The Corrections Act sets out specific requirements that must be met before prisoners may be prevented from associating. There is no evidence that ARWCF's two maximum security prisoners did not associate during this period, and the Inspector does not express a view on this. Because there were few maximum security

84 At [A111].
85 See s 140(1)(b) of the Corrections Act 2004.
86 M.07.04 Segregations reviews and revocations.

women prisoners, ARWCF had limited experience at managing such prisoners. The classification was introduced for women in 2009. ARWCF was accustomed to managing directed segregation prisoners in C Wing, who would have been prevented from associating. Based on the way ARWCF managed maximum security prisoners in the later period of this review, it is possible that ARWCF managed the two maximum security prisoners during this period as if they were subject to directed segregation orders and could be prevented from associating.[87]

April 2019 - Offender notes and incident reports recorded non-compliant behaviour

142. The incident reports and offender notes during April recorded:

142.1 On 3 April 2019, Ms C used threatening language.[88] No misconduct charge was filed.

142.2 On 7 April 2019 Ms C was escorted to High Medical (the high security health unit). The offender note recorded that Ms C cooperated with having handcuffs placed on her but said that "*she will kill the officers that pepper spray her next time*".[89]

142.3 On 9 April 2019 an incident report recorded that Ms B passed lozenges.[90] She pleaded guilty to a misconduct charge on 11 April 2019 and was sentenced to seven days' cell confinement and 14 days' loss of privileges. An appeal was upheld on 17 April 2019, on which date Ms B was transferred to a Separates cell in D Wing to commence her cell confinement. She was transferred back to her cell in C Wing on 24 April 2019.

142.4 On 13 April 2019 two incident reports recorded that Ms C was verbally abusive to an officer, punched the wall and kicked over a rubbish bin.[91] Pepper spray was drawn but not deployed. No misconduct charge was filed.

143. An offender note from 17 April 2019 provided insight into Ms A' motivation. She was unlocked to appear in front of the Visiting Justice. She moved towards the Management Unit fence on the way to and from the hearing to speak to Ms B, although she was compliant when asked to move.[92]

17 April 2019 – Ms B and Ms A commenced seven days' cell confinement

144. On 17 April 2019 both Ms B and Ms A commenced seven days' cell confinement for separate incidents, in D Wing and the Motivation Unit respectfully. Ms C remained in C Wing as a maximum security prisoner. There are offender notes from late April in relation to Ms A and Ms B recording compliant behaviour. An offender note from 18 April noted that Ms A was compliant and played table tennis with the staff.[93] An offender note from 19 April described Ms A as compliant during her time in D Wing.[94]

87 In response to a draft copy of this report, Ms C said that she was unable to associate with the other maximum security prisoner during this period.

88 At [A102].

89 At [A114].

90 At [A133].

91 At [A157].

92 At [A166].

93 At pA169].

94 At [A171]. There are positive offender notes for both Ms B and Ms A on 21 April 2019: at [A172] and [A173]. See also the offender note for Ms B on 23 April 2019: at [A176].

22 April 2019 – Ms B 's directed segregation order expired and she returned to C Wing

145. On 24 April 2019 Ms B returned to her cell in C Wing. Her directed segregation order from the 23 March 2019 assault had expired on 22 April 2019 without being renewed, so it is unclear why she was returned to C Wing. She was a high security prisoner and should have returned to the High Security Unit. It is possible Ms B preferred the Management Unit, which is smaller, but the inconsistency in treatment risked confusing prisoner expectations. There is no explanation in the offender notes supporting the decision to keep Ms B in the Management Unit.

April 2019 - Ms C advised that she cannot do programmes while classified as maximum security

146. On 8, 9 and 12 April 2019 a number of PC.01 complaints from Ms C were registered in IOMS. These included:

146.1 On 8 April 2019 a further complaint was registered that an officer had assaulted Ms C on 23 March, throwing her to the ground and causing an injury to the right side of her face and head.[95] The complaint was closed on the same day it was registered.

146.2 On 9 April 2019 a complaint was registered that Ms C had been removed from the programme she had been completing at CWP.[96] The response was that Ms C "was advised that whilst she maintains a maximum security classification, that she will not be able to carry out any programmes on her sentence plan". This likely reflected the impracticality of facilitating a group class for a maximum security prisoner. But we consider that more effort should have been made to provide education for maximum security prisoners which could have included by audio-visual link. Given that a maximum security classification is only reviewed every six months, Ms C was effectively told she would not be undertaking any programmes for the next six months, which would impact on her potential for reintegration at the end of her sentence, and make it more difficult for her to show progress at any Parole Board hearing.[97] Section 78 of the Corrections Act states that "A prisoner is entitled …

> (c) to access to further education that, in the opinion of the prison manager, will assist in—
>
> (i) his or her rehabilitation; or
>
> (ii) a reduction in his or her reoffending; or
>
> (iii) his or her reintegration into the community.

146.3 On 12 April 2019 a complaint was registered that Ms C had been advised that she would only receive a five minute telephone call once a week as part of her management plan as a maximum security prisoner.[98] We consider that the restriction to five minute weekly telephone calls, while in compliance with the prisoner's minimum entitlements under s 77(3) of the Act, was unreasonable, and that minimum entitlements should not be treated as the maximum to which a prisoner is entitled. The complaint recorded that Ms C had a son at kindergarten.

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95 At [A120].

96 At [A137].

97 See also at [A569], where on 2 September 2019 in the context of a discussion about changing Ms B 's Case Manager, the Principal Corrections Manager asked her "*what she would do to work towards lowering her security classification so she will be able to complete programmes*". Cf the offender note on 17 September 2019 for Ms A, who was able to study through correspondence a Level 4 Certificate in Creativity and Art through the Learning Connexion: at [A594].

98 At [A154].

146.4 On 25 April 2019 two PC.01 complaints from Ms C were registered, including that that she was assaulted on two different occasions within ARWCF, that she was thrown off a stool to the ground, and that after being handcuffed and pepper sprayed she was pushed to the ground causing her head to split open.[99] Staff followed the appropriate processes for responding to complaints about staff members.

May 2019 – Issues with Ms C 's conduct

147. In early May, offender notes and incident reports recorded two incidents of non-compliance from Ms C .

147.1 On 1 May 2019 an offender note recorded that Ms C went up to the windows of other prisoners' cells during her unlock time, contrary to staff instructions. Although Ms C was classified as maximum security at this stage, there was no order preventing her from associating with other maximum security prisoners. There was one other maximum security prisoner in C Wing at this point in the review period. It is possible that ARWCF managed the wāhine as if they were subject to directed segregation orders and could be prevented from associating.

147.2 On 9 May 2019 an incident report recorded that Ms C had ripped up a bed sheet to create a "fishing line", used by prisoners to "fish" items between cells.[100] A misconduct charge was filed. Ms C entered a guilty plea on 21 May 2019 and was sentenced to five days' cell confinement and five days' loss of privileges. It appeared likely that Ms C commenced the sentence on 21 May within her own cell. Ms C was moved to a Separates cell in D Wing on 31 May, but it is not clear whether her time from 31 May in D Wing related to a sentence for a misconduct charge.[101]

May 2019 – Ms B recorded as being compliant

148. During the first half of May 2019 there are offender notes confirming positive interactions between Ms B and staff.[102]

14-17 May 2019– Ms A flipped table, activated sprinklers

149. Ms A mentioned in a meeting with the Case Manager on 14 May 2019 that she was upset at not moving back to the High Security Unit despite her directed segregation order expiring on 6 May 2019.[103] It appeared that Ms A was advised that she and Ms B would not both be placed in the High Security Unit due to a non-association order preventing the two from associating (the order, dated 2 April 2019, stated Ms A would "*not be housed in the same wing or unit as prisoner* [Ms B]". It is unclear why Ms B remained in C Wing in the Management Unit after her directed segregation order expired on 22 April 2019, although given that Ms B had not been moved back to the High Security Unit, the non-association order would not have prevented Ms A from being moved there.

150. On 15 May 2019 during unlock in the afternoon, incident reports recorded that Ms A was yelling and began throwing plastic plates and bowls at the staff base window

99 At [A181].
100 At [A191].
101 In response to a draft copy of this report, Ms C has said that she commenced this sentence immediately, in her own cell, and that her time in D Wing on 31 May did not relate to a sentence from a misconduct charge.
102 See the 8 May offender note at [A190], and at [A203].
103 At [A193].

(this can be seen on CCTV footage).[104] Staff then observed Ms A attempt to flip a table. Staff entered the wing with pepper spray drawn. Ms A grabbed one half of the table tennis table and attempted to use it as a shield. Staff instructed Ms A to stop and that otherwise pepper spray would be used. Pepper spray was deployed, Ms A then threw the table down and began running. Staff deployed pepper spray again, and took Ms A to the ground. She continued to resist, but staff were able to put handcuffs on Ms A and transfer her to decontamination and then back to her cell.

151. CCTV confirmed Ms A was in the wing and appeared agitated. Staff were trying to talk with her. A couple of staff left the area and returned to the guardroom. At this point there were only three staff in the unit. Ms A became more agitated and so the staff left the area. Shortly afterwards Ms A threw plates, bowls and cups at the guardroom windows. She then picked up a table and threw it to the ground. Ms A picked up the table tennis table and dragged one half down the hallway. At this point five staff entered the unit and approached Ms A who was at the end of the hallway. Ms A had the table tennis table on its side and was using it as a shield. Pepper spray was drawn by two staff, as they got closer to Ms A she pushed the table towards them and then ran at staff. Pepper spray was deployed, and staff attempted to restrain Ms A, who had her left arm wrapped around an officer who had fallen to the floor. Staff and Ms A were affected by the pepper spray. Ms A was offering hard resistance. After a short time, Ms A was turned onto her stomach where she again offered hard resistance and was fighting against staff. Additional staff arrived to support and replace staff affected by pepper spray. After approximately four minutes Ms A was stood to her feet and relocated to be decontaminated.

152. There is no documentation in the health file that Ms A was seen by a nurse following the use of force.[105] She was seen the following day in response to having sore knuckles.

153. In response to the 15 May incident, Ms A was placed again on directed segregation, pursuant to s 58(1)(a). This was extended on 27 May 2019, 10 June 2019 and again on 10 July 2019. The order finally expired on 14 August 2019.

154. A misconduct charge was filed. On 16 May 2019 and 17 May 2019 incident reports recorded that Ms A activated the sprinkler in her cell.[106] Misconduct charges were filed for both sprinkler activations.

155. Ms A appeared before the hearing adjudicator on 21 May 2019 and entered guilty pleas for all three misconduct charges - the 15 May 2019 throwing plates incident, for which she was sentenced to five days' loss of privileges, and the 16 May 2019 sprinkler activation, for which she was sentenced to five days' cell confinement and 14 days' loss of privileges.

16 May 2019 – Ms B climbed the yard fence

156. On 16 May 2019 incident reports recorded that Ms B climbed the fence of the yard in C Wing in the Management Unit and remained near the top of the fence between approximately 11.15am and 1.25pm.[107] While Ms B was not a maximum security prisoner at this stage, her ability to climb the fence emphasised that the Management Unit, which was not designed for maximum security prisoners, was not fit-for-purpose. This incident likely prompted a practice of using the yards in D Wing, which were

104 At [A195]. The CCTV and on body camera footage is discussed at [A200].
105 Required in POM IR.05.02
106 At [A204] and [A213].
107 At [A206].

separate for each cell, for maximum security prisoners in C Wing. Offender notes on 20 and 29 May and 1 June 2019 recorded that Ms B was being given her yard time in a Separates cell yard in D Wing, presumably in response to the risk that she might climb the fence again, and that she was unhappy about this.[108]

157. Later that day another incident report recorded that Ms B activated her sprinkler. She was placed on directed segregation, which was extended on 28 May and 11 June until it expired on 15 July 2019. However, the directed segregation order would have had little effect, as Ms B remained in her cell in the Management Unit with no change in her management regime. This emphasises that keeping Ms B in the Management Unit after her directed segregation order expired on 22 April risked confusing prisoner expectations as to their management in relation to their security classification and relevant directed segregation orders.

158. Misconduct charges were filed for both incidents. Ms B entered guilty pleas to both charges on 21 May 2019 before the hearing adjudicator and was sentenced to five days' cell confinement and ten days' loss of privileges.

19 May 2019 – Ms A informed that had been diagnosed

159. On 19 May 2019 an offender note recorded that had been diagnosed with [109] Staff advised her to obtain the hospital details closer to the time was to be admitted, to ensure she would have the approvals in place to be able to telephone in the hospital.

20-22 May 2019 – Ms C recorded as being compliant

160. Around 20 May 2019 there is a short period in which offender notes recorded that Ms C was being compliant.[110] On 23 May 2019 there is an offender note that Ms C was continuing to ask about the officer who allegedly pushed her head on the concrete during decontamination after the 23 March 2019 prisoner assaults.[111]

24 May 2019 – Ms C activated the sprinkler and was placed in a Separates cell without the movement between cells recorded

161. On 24 May 2019 an offender note recorded that Ms C activated a sprinkler and was moved to a Separates cell in D Wing in the Management Separates Unit, where she was still trying to activate the sprinkler in the Separates cell.[112] However, when the Inspectorate obtained the records of prisoner movements, there was no record of this. This suggests the move was temporary to avoid a further sprinkler activation while staff pumped water out of Ms C 's cell in C Wing and reactivated the sprinkler system.

162. Moving prisoners between cells without recording the movement is a serious health and safety issue. There is an obvious risk that staff may not know where a prisoner has been placed if prisoners need to be evacuated or located during an emergency. There is no incident report for the sprinkler activation, in breach of POM.[113]

108 At [A220], [A237] and [A258].
109 At [A219].
110 At [A223].
111 At [A225].
112 At [A227]. The offender note was created on 4 June but referred to events on 24 May.
113 IR.06.Sch.01.

24 May 2019 – Ms B found in possession of contraband

163. On 24 May 2019 Ms B's cell was searched, and staff found tobacco wrapped in white paper in a container filled with tea bags.[114] A misconduct charge was filed. On 6 June Ms B appeared before the hearing adjudicator and entered a guilty plea. She was sentenced to 14 days' loss of privileges.

30 May 2019 – Ms C charged for fishing

164. On 30 May 2019 incident reports recorded there was a "fishing line" (usually a ripped bed-sheet) between Ms C's cell and another prisoner's cell, attached to a part of Ms C's damaged television.[115] A misconduct charge was filed. [redacted] Ms C appeared before the hearing adjudicator on 11 June 2019 and entered a guilty plea. She was sentenced to five days' cell confinement and five days' loss of privileges.

31 May 2019 – All three wāhine activated their sprinklers; Ms C moved to a Separates cell outside the disciplinary process

165. On 31 May 2019 all three wāhine activated their sprinklers from their respective cells in the Motivation Unit (Ms A) and C Wing of the Management Unit (Ms C and Ms B):[116]

165.1 At approximately 11.30am incident reports recorded that Ms C prevented staff from locking the food hatch, after receiving lunch, by putting her legs out of the hatch.[117] There was no misconduct charge for this incident.

165.2 At the end of the morning unlock, incident reports recorded that Ms A refused to be locked.[118] She climbed to the top of the fridge. After staff were unable to persuade her to climb down, staff decided to disengage. Ms A then activated the sprinkler. She was escorted to her cell and then activated the sprinkler there. A misconduct charge was filed but withdrawn on 14 September 2020 because the incident had been referred to the Police.[119]

165.3 At approximately 3.35pm incident reports recorded that Ms B activated the sprinkler in her cell. She was moved into a different cell within C Wing.[120] No misconduct charge was filed.

165.4 At just after 5.30pm Ms C activated her sprinkler.[121] She was relocated to another cell in C Wing, and activated the sprinkler in that cell at approximately 6.00pm. She was then moved to a Separates cell in D Wing, presumably because there was no power outlet in D Wing cells and it was more difficult to activate the sprinkler. This move was recorded in the prisoner movement register. A misconduct charge was filed, but was withdrawn six and a half months later on 15 January 2020 because Ms C had by that point been transferred to Arohata Prison.[122]

166. The lack of misconduct charges for Ms B's sprinkler activation and Ms C's sticking of her legs through the food hatch, and the lack of follow-through of [redacted]

114 At [A231].
115 At [A238].
116 In response to a draft copy of this report, Ms A said that she set off the sprinklers because she was in the Motivation Unit, separated from Ms C and Ms B, and she felt she was being treated differently to other prisoners.
117 At [A241].
118 At [A247].
119 At [A249].
120 At [A250].
121 At [A244].
122 At [A246].

Ms C's charge for activating the sprinkler are concerning. Without misconduct charges there is no consequence for prisoner misconduct, and this may have contributed to a culture of imposing informal penalties without following the statutory disciplinary process.

167. An offender note from 1 June 2019 recorded that Ms C was abusive towards staff all day.[123]

168. Ms C remained in a Separates cell in D Wing from 31 May until 2 June 2019, when she was moved to another Separates cell in which she stayed until 6 June 2019 before moving back to a C Wing cell. It is not clear why Ms C was in a Separates cell between 31 May and 6 June 2019. It could be that the 31 May-6 June 2019 period included the five days' cell confinement penalty imposed on 21 May 2019. Usually the cell confinement penalty must commence on the day it is imposed, but if Ms C had appealed the sentence it could have been delayed, and she might have chosen to withdraw the appeal once she was placed in D Wing. Alternatively, she may already have completed her sentence within her own cell. We were unable to confirm what happened because of the inadequacy of the record-keeping.[124]

169. On 2 June 2019 a PC.01 complaint from Ms C was registered in IOMS, stating "*I don't see why I was brought to the pound [ie a Separates cell] when everyone else in unit gets moved to another cell. I have not been served any paperwork for being here … I'm urgently requesting interview with inspector …*".[125] Staff completed the response section of the PC.01 form by noting that "*this is a duplicate of [complaint] number 495854, therefore will be closed*". Ms C's complaint 495854 was not registered in IOMS until 7 June 2019.[126] It included the response that after Ms C's second sprinkler activation "*the decision was made by Management Team to relocate her to D Wing whereby the sprinklers in the cell are difficult to tamper with*". This complaint confirmed that ARWCF staff were using Separates cells for purposes outside the formal disciplinary process.

1 June 2019 – Ms B refused lock leading to a spontaneous use of force

170. Incident reports from 1 June 2019 record that at approximately 11.15am Ms B was being moved back to C Wing from D Wing where she had been given her yard time.[127] She went to the C Wing yard window and refused to go to her cell for lock. This led to a spontaneous use of force in which four Corrections Officers took control of her left arm, right arm, head and legs respectively. Handcuffs were applied and Ms B was locked in her cell. She was assessed by a nurse.

171. CCTV confirmed that Ms B refused to follow staff instructions: Ms B was at the window, initially approximately five staff were in attendance, with two close and three a short distance behind. Staff were trying to gain compliance and assist her to her cell. Staff were on each side of her arms when she appeared to lunge at staff, resulting in a spontaneous use of force. Four staff were involved in the use of force and Ms B gave hard resistance. Approximately two minutes later additional staff arrived (there were 12 staff in attendance) and Ms B was under control on the floor. More staff arrived and Ms B was walked back to her cell.

123 At [A259].

124 In response to a draft copy of this report, Ms C said that she did not appeal her sentence, which she had already served in her own cell, and that this period in D Wing was outside the disciplinary process.

125 At [A266].

126 At [A274].

127 At [A260].

172. A misconduct charge was filed. Ms B appeared before the hearing adjudicator on 11 June 2019 and entered a guilty plea. She was sentenced to seven days' loss of privileges.

173. The use of force review was completed on 16 June 2019.[128] It noted that there had been no request to save the CCTV and OBC footage relating the spontaneous use of force. This is a good example of why the use of force reviews are important; if no request for the footage to be saved has been made, the review should note this.[129]

4 June 2019 – Ms C recorded as being non-compliant

174. On 4 and 5 June 2019 offender notes recorded Ms C being non-compliant:

174.1 An offender note dated 4 June 2019 recorded that Ms C was verbally abusing staff and demanding that her yard door be opened after she had received her one hour minimum entitlement of yard time.[130]

174.2 An offender note dated 5 June 2019 reported that the Residential Manager visited Ms C who was abusive.[131]

9 June 2019 – Ms A climbed onto the roof of the Management Unit to speak to Ms B

175. On 9 June 2019 incident reports recorded that Ms A, who was still in the Motivation Unit on a directed segregation order, ran from the Motivation Unit yard and climbed up the fence outside D Wing in the Separates Unit.[132] She managed to go onto the roof of the yard fence above where Ms B was having her yard time. Ms A was on the roof from approximately 2.00pm. Corrections staff negotiated with Ms B and Ms A. Ms A came down shortly after Ms B returned to her cell, at approximately 6.00pm. Both prisoners were strip-searched, and Ms B was found to be in possession of lozenges.[133]

176. A misconduct charge was filed against Ms A, who appeared on 11 July 2019 and entered a guilty plea. She was sentenced to 10 days' cell confinement and 49 days' loss of privilege. This was the last misconduct charge against Ms A during the review period that was followed through. Between 10 July 2019 and 15 January 2020 Ms A was charged with misconduct 13 times, but each charge was withdrawn because the required time period had lapsed, either because there was no adjudicator available or prosecutors had been deployed.

177. Offender notes for the period 12-19 June 2019 recorded positive interaction between Ms A and staff.[134]

15 June 2019 - Ms B abusive towards staff

178. On 15 June 2019 an offender note recorded Ms B being abusive towards staff ("*fucking bitch, fucking pigs*").[135] On 16 June 2019 an offender note recorded Ms B as apologising to staff for refusing to be locked on 1 June 2019.[136] On 19 June and 21 June 2019 offender notes recorded that Ms B looked low and depressed.[137] No

128 At [A263].
129 The footage was saved and viewed by the Inspectorate.
130 At [A272].
131 At [A273].
132 At [A282].
133 At [A283].
134 At [A298], [A302], and [A303].
135 At [A299].
136 At [A301].
137 At [A304] and [A307].

Review At Risk Assessment was completed. This must be done any time "*the prisoner begins to display negative signs or change in mood or behaviour*".[138] An offender note dated 23 May recorded that Ms B was compliant and in a good mood.[139]

23 June 2019 – Ms B submitted complaint about staff conduct but the IR.07 process not followed

179. On 23 June 2019 a PC.01 complaint from Ms B was registered in IOMS alleging that a staff member had pushed down on her "*shoulder with his knee and whilst my arm was already restrained*".[140] Allegations of staff assault must follow the IR.07 process and the Prison Director must be notified. The IR.07 process was not followed by staff responding to this complaint, and there is no record of the Prison Director being notified. Ms B was seen by the Medical Officer for review of her shoulder and referred to a physiotherapist.

180. On 21 June 2019 Ms B discussed moving to Arohata Prison with her Case Manager.[141]

28 June 2019 – Ms B transferred to Arohata Prison

181. On 28 June 2019 Ms B was transferred to Arohata Prison where she remained until her return to ARWCF on 14 August 2019 as a maximum-security prisoner. Later that day an offender note recorded that Ms A told the Senior Corrections Officer that unless all three prisoners were all moved to Arohata they would ensure they all were reclassified as maximum security prisoners, because ARWCF was the only facility at that stage holding maximum security prisoners, and this would ensure they all stayed together.[142]

29 June 2019 – Ms C abusive towards Corrections Officers

182. On 29 June 2019 incident reports recorded that during the evening medical round, Ms C threw her cup of water at two Corrections Officers, saying: "*come on bitch I will see you on the outside*" and "*don't you even fucking look at me*".[143] A misconduct charge was filed, but was withdrawn on 29 July 2019 because no adjudicator was available within the required timeframe and prosecutors had been redeployed.

183. An incident report dated 30 June 2019 records that during a cell search of Ms C 's cell a "fishing line" (a piece of ripped sheet used for transferring objects between cells) was found hidden inside an emulsifying ointment container.[144] A misconduct charge was filed. Ms C appeared before the hearing adjudicator on 10 July 2019 and entered a guilty plea. She was sentenced to seven days' loss of privileges.

2 July 2019 – Ms A moved to C Wing in the Management Unit

184. On 2 July 2019 Ms A was transferred to a cell in C Wing in the Management Unit. There is no offender note recording the reason for the transfer, but it can reasonably be inferred that with Ms B having been moved to Arohata Prison, keeping Ms A in the Motivation Unit to keep her and Ms B separate was no longer necessary. Ms A stayed in C Wing until she was transferred to a Separates cell on 11 July 2019

138 M.05.02.01(1)(o).
139 At [A308].
140 At [A309].
141 At [A307] and [A311].
142 At [A314]. See also at [A323], where she told her Case Manager on 2 July she would "*do whatever she can to be with her partner*", and at [A324], where she talked to the Deputy Prison Director about moving to Arohata Prison.
143 At [A319].
144 At [A321].

for her sentence arising from when she climbed the D Wing fence on 9 June 2019.[145] She returned to C Wing on 21 July 2019. For the first week of July offender notes recorded positive engagement between Ms A and staff.[146]

10 July 2019 – Ms A used threatening behaviour against an officer

185. On 10 July 2019 incident reports recorded two incidents:

185.1 At approximately 10.45am staff were escorting Ms A to her cell after her yard time in D Wing. An incident report recorded that Ms A lunged at the officer shouting "*It's all your fault. You didn't give me my fuckin phone call yesterday*".[147]

185.2 At approximately 3.45pm an incident report recorded that Ms A refused to be locked. The report recorded that staff tried to reason with Ms A for 40 minutes, but Ms A became aggressive and advanced on staff in a threatening manner.[148] Staff responded with a spontaneous use of force, placed Ms A in handcuffs and placed her in her cell and had her assessed by a nurse.

186. Misconduct charges were filed for both incidents but were withdrawn because the time had lapsed, and no adjudicator had been available during the required timeframe and prosecutors had been redeployed.

187. On 11 July 2019 Ms A was escorted to the Visiting Justice for sentencing in relation to the incident on 9 June 2019 when she climbed the roof of D Wing. Incident reports recorded that when Ms A was outside the Management Unit she dropped to her knees refusing to move.[149] She was placed in handcuffs. A follow up summary recorded that Ms A would be placed on misconduct, but no misconduct charge was filed. It is not clear why.

13-24 July 2019 – Ms C misused telephone and activated sprinkler

188. From 13 July 2019 the offender notes and incident reports recorded various examples of challenging behaviours from Ms C, who was in a cell in C Wing in the Management Unit at this time:

188.1 All prisoners are issued individual PIN numbers for telephone calls.[150] An incident report dated 13 July reported that Ms C had used Ms A' PIN number to make a telephone call.[151] Swapping PIN numbers is a misuse of the telephone.[152]

188.2 An incident report dated 2.30pm reported that Ms C requested to move into another cell due "*to no flushes in her toilet*".[153] Staff asked her to wait while another prisoner was using the wing telephone. Ms C began hitting a chair against her cell window, threatening to assault the first staff member who opened her door,[154] and then activated her sprinkler with the chair. At approximately 3.30pm Ms C was moved into another cell in C Wing. On 2 August 2019 charges for this and the misuse of telephone were withdrawn because no adjudicator had been available.[155]

145 In response to a draft copy of this Report, Ms A recalled that she had been doing well in the Motivation Unit.
146 At [A326].
147 At [A329].
148 At [A330].
149 At [A334].
150 See the Prison Operations Manual C.02(5).
151 At [A336].
152 See the Prison Operations Manual C.02.08(3)(iii).
153 At [A338].
154 At [A339].
155 At [A340].

188.3 Incident reports for 14 July 2019 recorded that, on being unlocked for yard time, [redacted] Ms C ran across the cell to her previous cell, and then to the staff base and then the kitchen area, arguing with staff and picking up a bin and aiming it at staff.[156] After an officer removed the bin from Ms C, she got onto the kitchen bench, saying *"come on [officer] let's have a one on one here"*. Another officer intervened and managed to escort Ms C to her cell. Ms C appeared about to spit at one officer, prompting a spontaneous use of force. The report recorded that Ms C attempted to bite and kick one of the officers. On 2 August 2019 the misconduct charge was withdrawn because no adjudicator had been available.[157]

188.4 An offender note for 15 July recorded that Ms C was threatening towards staff and threatened to set off her sprinkler.[158]

188.5 Incident reports dated 16 July 2019 recorded that at approximately 2.15pm [redacted] Ms C activated her sprinkler. After the water was pumped out of the wing, [redacted] Ms C was escorted in handcuffs to another cell in C Wing. Ms C *"kept demanding that I move her to D Wing for 'time out on her own'"*. The incident report recorded that Ms C then activated the sprinkler in her new C Wing cell at approximately 3.19pm, and approval was given by the Prison Director to move her to a Separates cell in D Wing. There is no evidence that a use of force review was completed, in breach of POM. Although the transfer to a Separates cell was at [redacted] Ms C 's request and after she had activated sprinklers in two C Wing cells, it was not part of the statutory disciplinary process. Ms C remained there until 19 July 2019.

188.6 Incident reports from 17 July 2019 recorded that Ms C threatened a staff member while locked in her cell (*"stupid old fucking bitch"* and *"things are going to start happening"*).[159] On 2 August 2019 the misconduct charge was withdrawn because no adjudicator had been available.

188.7 Incident reports from 17 July 2019 recorded that Ms C and Ms A, who were both in D Wing (Ms C at her request, Ms A because she was serving a cell confinement penalty) refused to come back into their cells from their yards.[160] Ms C toilet was blocked. Staff unlocked Ms C 's yard door so she could go into the yard while her toilet was fixed by a contractor. [redacted] Ms C said she needed to go to the toilet and she needed a lawyer's telephone call, and began banging on her window. [redacted]. The yard door was then closed. The contractor arrived at 4.20pm to fix the blocked toilet and at approximately 4.40pm the yard door was opened. Ms C and Ms A, who was also in her yard, refused to come back into their cells. Ms returned to her cell at approximately 7.21pm and Ms C at approximately 7.26pm. The misconduct charges were withdrawn because no adjudicators were available within the required timeframe.[161]

188.8 Incident reports dated 18 July 2019 recorded that Ms C refused again to come into her cell from her yard.[162] She was there from approximately 1.37pm. Authorisation for a planned use of force was given at 10.20pm, and she was moved

156 At [A341].
157 At [A343].
158 At [A346].
159 At [A352].
160 At [A354].
161 At [A356] and [A357].
162 At [A359].

to the ISU just before midnight. The misconduct charge was withdrawn because it could not be heard within the required timeframe.[163] CCTV footage provided evidence of a briefing before staff entered the cell and then the yard Ms C appeared aggressive and abusive and offered hard resistance. Ms C appeared to have a seizure and staff called a medical emergency and attempted to place her in the recovery position. Ms C then started screaming and an officer tried to engage to reassure her she was OK and that staff were looking after her, asking her to relax and providing reassurance. Something was placed under her head. Ms C started screaming *"fuck you cunts – you did this to me"* and spat at staff. She appeared very agitated and was breathing very fast and shallow and staff told her *"stop banging your head on the ground"*. In between shaking she was screaming *"fuck you"* to staff then stated she *"can't breathe"* and she *"can't see"* and alternated between *"fuck you, go on smash it again"*. It was noted by health that Ms C did not appear to be having a seizure.

188.9 An offender note from 18 July 2019 recorded Ms C encouraging other prisoners to activate their sprinklers.[164]

188.10 Offender notes dated 21 and 22 July 2019 recorded Ms B engaging appropriately with staff in the ISU.[165] However, after Ms C returned to a cell in C Wing in the Management Unit on 22 July 2019 an offender note recorded that Ms C refused to be locked and became verbally abusive to staff.[166]

188.11 An incident report dated 24 July 2019 recorded that Ms C pushed a piece of paper out of her cell with a hand-drawn single finger pointing to the words *"Fuck rite off Put this in ur ARSE"*.[167] The misconduct charge was withdrawn on 1 August 2019 because it could not be heard within the required timeframe.

188.12 On 26-27 July 2019 Ms C appeared to have had positive interactions with staff[168] but an offender note dated 31 July 2019 recorded that Ms C was abusive towards staff.[169]

188.13 An offender note dated 23 July 2019 noted that Ms C was to be escorted with four officers at all times, "as per maxi movement protocol on site".[170] It was not clear why maximum security prisoners must be escorted with four officers; the required number for male maximum security prisoners is three officers, and ARWCF's desk file refers to three-one for maximum security prisoners.

188.14 Offender notes from 1 and 2 August 2019 recorded Ms C as being compliant.[171]

18-20 July 2019 – Ms C was observed having what appeared to be a seizure; complained was suffering from migraines

189. On 19 July 2019 PC.01 complaints from Ms C were registered stating that she had had seizures the previous evening as a result of her head injury from 23 March.[172] An incident report on 20 July reported that Ms C *"was lying on the floor behind*

163 At [A364].
164 At [A376] and [A375].
165 At [A384] and [A385].
166 At [A387].
167 At [A391].
168 At [A400].
169 At [A413].
170 At [A389].
171 At [A414] and [A420].
172 At [A379] and [A381].

the cell door and appeared to be having a seizure … The nurse arrived together with the Incident Responding Officers and Site Emergency Responding Team[173] *and the nurse carried out her assessment. She appeared to be fine afterwards and was relocked*". Following the nurse's assessment, Ms C was referred to the Emergency Department for review of her shoulder and head injuries. Ms C was also seen by the Medical Officer on 22 and 26 July 2019 for review.

190. In the ISU, Ms C was seen by members of the Intervention and Support Pilot Team (mental health clinical nurse specialist, psychologist and cultural advisor). [redacted] Ms C [redacted]

191. Ms C 's electronic health file recorded that she frequently complained of migraines, which she related back to her injury on 23 March.[175] On 17 June 2019 there is a note that Ms C was "*asking when she's going to see doctor for migraines*" and on 30 June 2019 there is a note that a Medical Officer appointment had been booked. On 15 July 2019 the electronic health file stated that Ms C was "*to be placed on [Medical Officer] list for review*". On 19 July 2019 a use of force note by the nurse recorded that Ms C was "*yelling out about needing to be seen by a doctor regarding her head injury*".

192. A private psychologist report on Ms C dated 19 December 2019 made several recommendations including that Ms C "*be immediately referred for a neurological examination as she has suffered a number of trauma to her brain. Her neurological difficulties may well be contributing to her inability to manage and control her anger*".[176]

21 July 2019 - Ms A returned to C Wing, lit a fire

193. Ms A returned to her cell in C Wing on 21 July. An offender note dated 23 July recorded her hostile behaviour.[177] At a meeting on 26 July 2019 with her Case Manager, Ms A is recorded as being highly motivated to complete a graphic design

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173 Site Emergency Response Team (SERT)

174 Post concussion syndrome is when symptoms of concussion continue for several weeks. A second injury to the head of a concussed person can be very dangerous. It can cause brain swelling, coma or death. Serious or long-term effects are much more likely if a brain injury is repeated (Ministry of Health).

[redacted]

176 On 27 May 2020 when at Arohata Prison the Medical Officer referred Ms C to a neurology specialist in response to the private psychologist's recommendation.

177 At [A390].

programme for which she had been waitlisted, but that she was "*not willing to do any rehab programmes and will continue to not work with her staff. She said that her recent incidents are due to the fact that she does not want to be here at ARWCF …*"[178] Offender notes for 27-29 July 2019 recorded that Ms A was compliant but frustrated that there had been no agreement for her to transfer to Arohata Prison.[179]

194. On 29 July 2019 an incident report recorded that Ms A made a three-way call to Ms B, by calling an approved third party who then connected her to Ms B.[180] A misconduct charge was filed but it was withdrawn on 23 August 2019 because no adjudicator had been available within the required timeframe.

195. Ms A met with a Senior Advisor on 30 July. The offender note recorded that the conversation was positive and that the Senior Advisor offered to have daily conversations with Ms A,[181] but 25 minutes later she set fire outside her cell.[182] All prisoners in C Wing (including Ms C) were taken to D Wing temporarily because of the fumes from the fire extinguisher. Ms A "*stated she was going to commit suicide*". A Review At Risk Assessment was completed and Ms A was deemed "*no apparent risk at this time*". A misconduct charge was filed but withdrawn on 23 August 2019 because no adjudicator was available within the required timeframe.

196. The Residential Manager and Principal Corrections Officer met with Ms A on 30 July 2019. Ms A stated that she had heard that Ms B was returning to ARWCF and that Ms A no longer wanted to transfer to Arohata Prison.[183] The Residential Manager advised that they would not be in the same prison, and Ms A stated that she "*will do anything to be able to stay here, even if it meant to become Maxi again*".

31 July 2019 – Staff interviewed Ms C about a complaint regarding staff conduct; IR.07 process followed

197. Ms C completed a complaint[184] regarding 'staff conduct' that related to a use of force on 18 July 2019 at 11.10pm. Allegations about an assault by staff on a prisoner must be managed under IR.07. POM also requires that a "*prisoner must be interviewed within 3 working days of the complaint being registered*".[185] POM requires that the officer receiving the complaint must provide the prisoner with the numbered copy of the IOMS generated complaint registration form within 24 hours of receiving the complaint.[186]

198. On 31 July 2019, seven days after Ms C had submitted a PC.01, she was interviewed by the Security Manager and an IR.07.Form.01, 'Notification of staff related incident', was completed and reported to National Office as required.

199. The IR.07 was closed on the same day on the basis of Ms C requesting all footage relating to allegations for her lawyer's attention.

200. On 16 August 2019 the Practice Manager Custodial, Northern Region completed an event review with the purpose of reviewing the circumstances that led to planned use of force being applied to Ms C in the Management / Separates Unit on 18 July 2019.

201. The IR.07 outcome was:

178 At [A399].
179 At [A401] and [A402]
180 At [A403]. Three-way calling is a breach of the Prison Operations Manual: C.02.08(3)(b)(i).
181 At [A405].
182 At [A406].
183 At [A410].
184 At [387]
185 PC.01.09(1).
186 At PC.01.06(3).

There is no evidence presented that would uphold the allegations made by Ms C. The force used was reasonable. The technique applied to take initial control of Ms C was not as described in the tactical training practice guide, however, the situation being presented warranted the prisoner being taken to ground to gain control and eliminate the risk of harm to staff or Ms C. This action was executed to the best of the staff's ability with the situation being faced at that time.

202. This IR.07 was reviewed / monitored by the Inspectorate. The review identified:

An initial Event Review was completed on 26 August 2019 by the Practice Manager Custodial, Northern Region. This review was focused on the planned use of force event and did not specifically address the allegations made by Ms C. This was raised with the Prison Director who subsequently commissioned a further Event Review to address the specific allegations, this was completed on 17 April 2020. The latter review concluded that there was no evidence to support the allegations although lessons learnt from the earlier review were noted and addressed. There were several administrative failings identified that were recommended to the site to accept.

203. This is a good example of how the IR.07 process can ensure national oversight where there has been a complaint about staff use of force.

31 July 2019 – The telephone call policy for prisoners on directed segregation

204. On 31 July 2019 Ms A requested a telephone call, but as she had had one the previous day she was advised that under her new management plan she would only be able to have one five minute telephone call a week. In the end she was allowed to have a telephone call to inform her family of the new condition in her plan about telephone calls, on the basis that she would not have another telephone call for a week.[187] In a meeting with the Residential Manager and Principal Corrections Officer, Ms A complained about receiving only one five minute telephone call under "*the new regime in the Separates Unit*".[188] A PC.01 complaint from Ms A about the telephone call regime was registered in IOMS on 3 August 2019, complaining about only being able to "*speak with my children once a week 4-5minutes*".[189] The response was that Ms A would need to come off directed segregation to have the restrictions on her telephone calls lifted. This is not inconsistent with practice in other prisons when prisoners are under a directed segregation order, but it may reflect a perception that minimum entitlements are maximum entitlements, which is not appropriate.

187 At [A412].

188 At [A416].

189 At [A444]. See also the offender note for 17 August 2019, in which Ms A requested a telephone call but was advised she had already had her telephone call for the week: at [A485]. And the offender note on 19 August 2019 records that Ms A "*was a bit angry and frustrated when her five minutes was over while her son cried from the other side of the phone. The PCO spoke to her reconsidering a phone call again tomorrow concerning of her son*": at [A487]. The 20 August phone call is noted at [A489]. Cf the offender note for 3 September at [A572], where she was given two telephone calls, one each in the morning and afternoon, and the offender note for 7 October 2019 recording the PCO's meeting with Ms A and that she stated [redacted] – "*Officers encouraged Ms A to understand that it is not our intention to keep her from calling her family but rather something that we encourage. The violent and abusive outbursts will only prevent staff from facilitating her calls*". On 27 October 2019 a PC.01 complaint from Ms C was registered complaining that "*we have Been having 10 minute calls daily since February and We become frustrated when we cannot have our ph calls to our Kids my partner & Mother*", at [A868].

2 August 2019 – Ms A activated sprinkler; alleged staff gave her a black eye; IR.07 process not followed

205. On 2 August 2019 at approximately 1.45pm Ms A activated her sprinkler. Staff needed to transfer Ms A to a different cell while they pumped the water out of her cell, and to reset the sprinkler. Incident reports recorded that Ms A refused to be relocated, saying *"[f]uck off! Come on then!"*.[190] A planned use of force had been authorised, and the MK9 pepper spray was deployed. CCTV footage showed staff actively trying to engage with Ms A and a lengthy period of discussion prior to staff entering Ms A' cell.[191] Ms A was assessed by a nurse following decontamination and treated for acute symptoms of asthma. Misconduct charges were filed but withdrawn on 23 August 2019 as no adjudicator had been available within the required timeframe.[192]

206. Ms A was placed in a Separates cell from 2 August to 5 August 2019, for reasons outside the statutory disciplinary process.

207. On the following day 3 August 2019 Ms A told staff that she might need to see medical for some *"superficial injuries to her facial area"*.[193] A complaint from Ms A was registered in IOMS that same day complaining that she had: [194]

> … swelling around my eye it is going to become a black eye & my tooth is broken I have bruising all over my body.[195] I fell like the S.E.R.T team did not have to pepper spray me & use force with the shields and body paddings … im being given little amounts of toilet paper & im housed in D-wing by myself with no documents stating. Why i am being placed here like this.

208. She repeated the allegation in a meeting with the Residential Manager on 5 August 2019, and stated that *"when she sees SERT, it doesn't scare her, it makes her go into defence mode"*.[196] The response to the PC.01 form stated that *"approval was sought by the staff and given by the [Prison Director] to allow [Ms A] to be housed in D Wing over the weekend to help mitigate the risk of more sprinkler activations from her"*. There is no reference in the response to the allegation that Ms A had a black eye. The complaint process and IR.07 process required for allegations of staff assault was not completed; there is no evidence that the Prison Director was notified.

209. Offender notes from 3 and 4 August 2019 described Ms A as *"calm"* and her behaviour as *"good"*.[197] She returned to her C Wing cell on 5 August 2019.

210. An offender note dated 6 August 2019 recorded that Ms A misused the telephone by engaging in a three-way call with Ms B.[198] No misconduct charge was filed. On 7 August 2019 Ms A met with the Case Manager, and said she was willing to swap places with Ms B and that she wanted to do the graphic design course at Arohata Prison.[199] On 8 August 2019 an incident report recorded that Ms A received lozenges from another prisoner, which she swallowed before agreeing to a strip

190 At [A425].
191 At [A424].
192 At [A426].
193 At [A430].
194 At [A446].
195 Ms Ms A was assessed by a nurse on 5 August for swelling around her eye but there was nothing mentioned in the assessment about a broken tooth or other bruises on her body. No ACC claim form was made for her injuries.
196 At [A451].
197 At [A443] and [A449].
198 At [A452]. Three-way calling is a breach of the Prison Operations Manual: C.02.08(3)(b)(i).
199 At [A457].

search.[200] A misconduct charge was filed but was withdrawn on 2 October 2019 because no adjudicator had been available within the required timeframe.

14 August - Ms B returned to ARWCF

211. A complaint from Ms A was registered in IOMS on 9 August 2019 complaining that there was no review date for the non-association order between Ms A and Ms B.[201] On 14 August 2019 an offender note from the Residential Manager confirmed that the non-association order had been reviewed and deactivated.[202] That same day Ms B arrived back at ARWCF as a maximum security prisoner and was placed in a cell in C Wing.[203]

7-11 August 2019 - Ms C recorded having positive interactions with staff

212. Offender notes for 7, 8 and 11 August 2019 recorded positive interactions with Ms C.[204] However, offender notes and incident reports for 12, 14 and 15 August 2019 recorded Ms C abusing and threatening staff.[205] For the threatening language on 15 August 2019 ("*what think you're funny aye bitch, I'll fucken smash you, you wait*") a misconduct charge was filed, but withdrawn on 2 October 2019 because no adjudicator was available within the required timeframe.

213. An offender note for 19 August 2019 recorded Ms C being compliant.[206] Ms C met with the Residential Manager on 20 August 2019 and they discussed that the review of Ms C's security classification was approaching. Ms C said that she "*believes that she has made a big improvement on her behaviour and that she knows there is also room for improvement*".[207] An offender note on 21 August 2019 described Ms C's behaviour as "*excellent*".[208]

14 August 2019 – Ms C submitted a complaint about bedding

214. On 14 August 2019 a PC.01 complaint from Ms C was registered, which complained about the "*wooly duvet cover*" she had been given, that she should have been given cotton sheets because of her medical condition and that her new pillow was missing.[209]

215. POM requires that a "*prisoner must be interviewed within 3 working days of the complaint being registered*".[210] Staff interviewed Ms C on 20 August 2019, well outside the required timeframe.

216. The response recorded that staff advised Ms C that "*she is provided with suitable bedding. All bedding in the Management Unit is the same. It has also been explained to her that every prisoner is only entitled to one pillow and if staff find an extra pillow in their cell, they are entitled to remove it*".

217. The management plans provided to the Inspectorate included a condition that the wāhine would receive the non-destructive bedding provided to wāhine in the ISU. While the offender notes do suggest that Ms C was sometimes observed "fishing"

200 At [A461].
201 At [A463].
202 At [A470].
203 At [A471].
204 At [A459], [A460] and [A466].
205 At [A468], [A469] and [A480].
206 At [A486].
207 At [A488].
208 At [A493]. See also the positive offender note for 22 August: at [A497].
209 At [A473].
210 PC.01.09(1).

items to other cells on strips ripped from bedding, I consider the bedding required by the management plans disproportionate to such a risk and unreasonable.

16 August 2019 – confusion over Ms A ' power being turned off

218. On 16 August 2019 Ms A should have still been serving her penalty of 49 days' loss of privileges commencing 11 July 2019. However, a cell search identified that Ms A ' television was still working.[211] Ms A claimed that the "*the unit manager had authorised for the prisoner to have her power back on*". Staff checked and confirmed that the Residential Manager had not authorised this, but "*it was decided that the prisoner can have her power on as she is due to come off [loss of privileges] shortly*".

20 August 2019 - Ms B met with Residential Manager: they discuss the rings

219. Ms B, who had returned to ARWCF on 14 August 2019, met with the Residential Manager and Principal Corrections Officer on 20 August 2019 to discuss her management plan.[212] The Residential Manager asked Ms B about rings that had been seen in her possession and some stuffed animal dogs in her cell. Prisoners are only allowed to keep property specified in the schedules to the Department of Corrections Authorised Property Rules.[213] Schedule 1.4(b) specifies that prisoners may keep one wedding band but other rings are not allowed. An offender note dated 2 September 2019 recorded that Ms B handed over two rings to be placed in her property, and that she still had the plain silver band, which she was entitled to.[214] However, an offender note dated 12 September 2019 recorded that Ms B still had some rings in her possession, stating "*she will have to give them one or two at a time*".[215] On 12 October 2019 an offender note recorded that officers observed Ms B wearing her three rings again.[216] On 1 November 2019 an offender note recorded that staff removed two rings during a search of Ms B 's cell.[217]

220. Apart from the issue over the rings, the offender notes during this period for Ms B were generally positive.[218] On 25 August 2019 an offender note recorded Ms B calling out to a staff member: "*you're one of them that assaulted my darling … you were with SERT that day they gave my darling a black eye*".[219] This is a reference to the planned use of force to escort Ms A after she activated the sprinkler on 2 August 2019. The offender note recorded that all three wāhine ended up banging on the windows, at times laughing, with Ms C calling out "*she made my sister cry*" and Ms A telling the officer "*you intimidated me*".

21 August 2019 – Ms A reclassified maximum security

221. On 21 August 2019 Ms A was reclassified as a maximum security prisoner because of "*recent behaviour and incidents that have posed a risk to both staff and other prisoners*".[220] From this point on within the review period, all three wāhine were classified as maximum security.

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211 At [A483].
212 At [A383].
213 Promulgated by the Chief Executive under s 45A of the Corrections Act 2004.
214 At [A570].
215 At [A585].
216 At [A748].
217 At [A901].
218 See the notes for 16 August [A484], 20 August [A492].
219 At [A505].
220 At [A494].

24 August 2019 – Ms C submitted a complaint about having her yard time in D Wing

222. On 24 August 2019 a number of PC.01 complaints from Ms C were registered. One of these was about being required to have her yard time in a D Wing yard.[221] The response recorded that staff used D Wing yards for prisoners in C Wing when they were short staffed:

> …due to staff levels from Friday 23-8-19 to 25-8-19, it was necessary to have all prisoners in Management Unit to have their time out at the same time in D wing in order that the staff from Management could be redeployed elsewhere. This is not a regular occurrence and certainly one we do not like doing. [Ms C 's management plan], which is a living document, has been updated to include that we may have to utilize the yards in D Wing if we are unable to use the C wing yard …

223. The use of the D Wing yards for high or maximum security prisoners in C Wing is not inappropriate by itself. Ms B had previously climbed the C Wing fence, which was not designed for maximum security prisoners and may not have been fit for use.[222] But the use of D Wing yards, even for legitimate safety concerns, may have led to or exacerbated the following problems:

223.1 It may have encouraged staff to view D Wing as an extension of C Wing, rather than a separate unit with different cells for a specific exclusive purpose.

223.2 It may have appeared more convenient to use D Wing yards where prisoners were required to be segregated, especially if the unit were short-staffed. It would mean prisoners could be in the D Wing yards at the same time, rather than staff unlocking prisoners one at a time for individual yard time. But that assumes prisoners were required to be kept apart; where there were more than one prisoner of the same security classification not subject to directed segregation orders, they should have been able to associate. Using the separate D Wing cells may have encouraged a habit of keeping prisoners in the Separates Unit apart from each other.

223.3 The offender notes in the review period showed that prisoners in C Wing were not consistently required to take their yard time in either the C Wing or D Wing yards. Inconsistencies like this risked confusing prisoner expectations

224. The inconsistent use of the yards is highlighted in some of the offender notes from late August 2019. On 26 August 2019 an offender note recorded Ms B coming out "*for her time out in the C Wing yard*".[223] However, an offender note dated 29 August 2019 recorded that Ms C "*was advised that she could not have her yard time in C Wing however she could still have it in D Wing*".[224] An offender note dated 30 August 2019 recorded that "*because of [Ms C 's] recent behaviour in the yard when there were dignitaries on site it was deemed more suitable to offer her time out in D Wing while [an incident that was happening in Motivation unit] was still happening*".[225] On 26 September 2019 an offender note recorded that Ms B was offered yard time in C Wing twice, but she wanted it in D Wing.[226]

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221 At [A514].

222 Although the use of the D wing yards for C wing prisoners preceded Ms B climbing the fence: see the offender note for Ms C dated 3 March 2019, at [A46].A46]. And an offender note records Ms A being given her yard time in D wing on 10 July: [A329A329]

223 At [A519].

224 At [A535].

225 At [A538].

226 At [0].

25 August 2019 – Ms C observed "fishing"

225. An offender note dated 25 August 2019 recorded Ms C "fishing", with a long string of grey cloth tied around a bottle coming out from under her cell.[227] An incident report dated 27 August 2019 recorded that Ms C was verbally abusive towards staff members after phone cards not belonging to her were removed from her cell ("who the fuck do you think you are come in here and touch my stuff") and that Ms C attempted to kick a staff member.[228] A misconduct charge was filed but it was withdrawn on 2 October 2019 because no adjudicator had been available in the required timeframe.

27 August 2019 – Ms C submitted complaints

226. On 27 August 2019 a PC.01 complaint from Ms C was registered complaining that her sports bra and underwear were missing from the laundry.[229] Staff interviewed Ms C on 29 August 2019 within the three day timeframe, and Ms C was reimbursed $100.

227. Another PC.01 complaint from Ms C was registered on 1 September 2019, complaining that when she returned from a psychologist's appointment, a jersey her mother had given her had been ripped.[230] Staff interviewed Ms C within the required three day timeframe, stating that the jersey was torn when staff took it off another prisoner who refused to release it. Ms C was reimbursed $120.

228. A further PC.01 complaint from Ms C about her missing clothing was registered on 16 October 2019.[231]

229. On 27 October 2019 a PC.01 complaint from Ms C about her missing or damaged clothing was registered in IOMS.[232] As well as the $220 worth of clothing that had previously been claimed, Ms C complained that a hat worth $50 and glasses worth $40 were missing.

230. On 3 November 2019 a PC.01 complaint from Ms C was registered in IOMS, complaining that "*Im already owed $380 for all the under garments, clothing products & Hat & sunglasses the prison misplaced, I have a further $300 of clothes not given back to me*". On 18 November 2019 a PC.01 from Ms C was registered, complaining that she had not yet been refunded for lost property.[233] The response was completed after Ms C had been transferred to Arohata Prison on 4 December 2019 but noted that the items would be reimbursed and the sunglasses had been found. On 24 November 2019 a further PC.01 complaint for Ms C was registered.[234]

29 August 2019 – Ms C received her parole report; her behaviour recorded as deteriorating

231. On 29 August 2019 Ms C received her parole report.[235] Offender notes dated 30 August 2019 recorded Ms C being verbally abusive towards the Case Manager ("*you fat fuck*").[236] An offender note dated 1 September 2019 recorded that

227 At [A503].
228 At [A523].
229 At [A528].
230 At [A552].
231 At [A787].
232 At [A868].
233 At [A973].
234 At [A1038].
235 At [A535].
236 At [A537].

Ms C was shouting out to another prisoner to "*get*" a particular officer.[237] A subsequent offender note from the same day recorded that Ms C told another prisoner "*if you wanna smash someone, make sure you do it where the pigs won't see*".[238] On 4 September 2019 Ms C met with her Case Manager to discuss the parole report and advised that she was not happy with comments in the report.[239]

30 August 2019 – Ms A and Ms B recorded as passing items and threatening staff

232. Incident reports from 30 August 2019 recorded Ms A passing a sweatshirt to Ms B after they had both been told that items were not to be passed between prisoners.[240] A further incident report that day recorded Ms B throwing a carton of rotten milk at an officer.[241] No misconduct charge was filed.

233. On 31 August 2019 incident reports recorded that during a meeting with the Senior Corrections Officer, Ms A accused the officer of "*trying to get a reaction out of her*", and attempted to kick an officer and attempted to head butt the Senior Corrections Officer.[242] Again, no misconduct charge was filed. Ms A was assessed by health staff, which required her to be transported to Middlemore Hospital. The offender note recorded that Ms A had a sprained wrist but no fractured bones.[243] Ms A requested to lay charges with the Police.

234. On 1 September 2019, an offender note recorded that Ms A accused a unit officer of holding her by the throat the previous day, saying that "*she did not forget things and that she would get the officer when she was not expecting it*".[244]

235. On 2 September 2019 staff met with Ms A to discuss the incident on 31 August 2019.[245] The Senior Corrections Officer said:

> I take responsibility for that escalating I should of disengaged and come back to her when she'd calm down My decision to continue to try and talk to her, it didn't help when her partner was yelling from behind us in her cell, then she reacted. I told her I take responsibility for that incident I made an unwise decision … She mentioned being choked with two hands, I informed her I was in front of her the whole time and I didn't see her being choke with one or two hands, however we'll agree to disagree she can follow the process with her concerns.

236. Ms A submitted a series of PC.01 complaints requesting the CCTV footage from the alleged staff assault on 31 August 2019. The first was registered on 1 September 2019 stating "*Im wanting to know how a officer can put both hands around my neck & strangle me while standing up against the wall with other officers holding on to my arms trying 2 reinstrain me*".[246]

237. On 5 September 2019 Ms A was interviewed by the Residential Manager in relation to her allegation of assault by staff on 31 August 2019. The IR.07 notification was completed. The IR.07 states "Ms A *wishes to view the footage and a C.05 Form will be completed. Once that is viewed a decision will be made as to where to from here*". There is no other information in relation to the outcome.

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237 At [A547].
238 At [A548].
239 At [A576]. See also the offender note dated 18 September, in which Ms C told her Case Manager that she intended to challenge the report: at [A596].
240 At [A539].
241 At [A541].
242 At [A543].
243 At [A546].
244 At [A549]. The Inspectorate has viewed footage of the alleged assault.
245 At [A568].
246 At [A558].

238. Further PC.01 complaints about viewing the footage were registered on 30 October 2019,[247] and 1 December 2019.[248] The response to the 1 December 2019 complaint was that "*[t]he previous request she filled out was being processed by another Manager who is no longer working at our site*". Ms A was able to view the footage she had requested on 24 January 2019.[249] We consider that it should not have taken almost five months to provide Ms A with the footage, and that the reason given for the delay – that the manager who had processed the complaint had left – is inadequate.

3 September 2019 – Ms A recorded as behaving well; Ms B recorded as in good spirits

239. An offender note dated 3 September 2019 acknowledged Ms A' good behaviour, and it was agreed she could use the scissors and sellotape to make a birthday card for [redacted][250] That same day Ms B declined to be unlocked because she remained angry at staff, but was otherwise in "*good spirits*" and made a birthday card in her cell.[251]

6 September 2019 – Ms C recorded as raising issue about one-for-one exchange of clothing

240. As part of the management plan for the three wāhine, they were required to undress and hand over their clothing, including their underwear and bra, before receiving new clothing. An offender note dated 6 September 2019 recorded that Ms C wanted all her property at once.[252] As discussed elsewhere in this report, I consider that conditions such as these, including the condition that prisoners be provided with limited amounts of toilet paper, were unreasonable.

7 September 2019 – Ms B and Ms A began to decline yard time

241. Offender notes dated 6 and 11 September 2019 noted that Ms B and Ms A were generally declining their yard time, only going into the yard approximately every third day.[253]

242. On 17 September 2019 Ms A met with her Case Manager, and agreed that she would commence by distance learning a Level 4 Certificate in Creativity and Art through Learning Connexion.[254]

16 September 2019 – Ms C damaged a telephone; 20 September 2019 [redacted] Ms C informed she would remain maximum security

243. Incident reports dated 16 September 2019 recorded that during a telephone call [redacted] Ms C became angry when advised that the review of her security classification was not until October and she slammed her handcuffs down, breaking the base of the telephone.[255] A misconduct charge was filed, but was withdrawn on 9 October 2019 because no adjudicator had been available within the required timeframe and prosecutors had been redeployed.

247 At [A888].
248 At [A1090].
249 At [A1261].
250 At [A572].
251 At [A574].
252 At [A579].
253 At [A580] and [A581] and [A582].
254 At [A594].
255 At [A587].

244. The offender note for 19 September 2019 recorded that Ms C interacted well with staff at a meeting with the Principal Corrections Officer, Senior Corrections Officer and other officers to discuss her management plan.[256] However, when on 20 September 2019 Ms C was informed that her security classification had been reviewed and she would continue as a maximum security prisoner, the offender note recorded that Ms C told staff that "*she will play up every day. 'Don't work in here, I will be an arsehole everyday'*".[257] On 21 September 2019, incident reports recorded that following a telephone call, Ms C attempted to pass a phone card to another prisoner and resisted officers by dropping her weight, dragging her feet and wrapping her right leg around another officer's leg.[258] Ms C told officers to pepper spray her and accused officers of trying to smash her head. Ms C suffered a cut to her wrist from her handcuffs.

23 September 2019 – All three wāhine blocked their hatches, preventing them from being relocked after lunch

245. Incident reports dated 23 September 2019 recorded that all three wāhine placed their hands or legs through their food hatches, preventing the hatches from being locked.[259] Ms A placed her hands through the hatch after her sandwiches had been passed through, but Ms C placed her leg out before the food had been delivered and staff were unable to deliver her lunch. Ms B stated "*she was over Management Unit and all the rules*". Ms C was upset about her classification. At 12.30pm the Deputy Prison Director spoke with the wāhine, and Ms A and Ms B removed their legs so that the hatches could be locked. Ms C 's hatch was not able to be locked until approximately 8.30pm. Misconduct charges were filed against all three wāhine, but they were all withdrawn on 14 October 2019 because no adjudicators had been available within the required timeframe and prosecutors had been redeployed.

24 September 2019 – Ms C activated her sprinkler and was moved to Separates cell outside the disciplinary process

246. Incident reports dated 24 September 2019 recorded that Ms C activated her sprinkler at approximately 10.00am.[260] Ms C was transferred at 1.36pm to a Separates cell in D Wing (a planned use of force was authorised for the transfer), and she stayed in D Wing until 27 September 2019. The use of the Separates cells was outside the statutory disciplinary process. The incident reports recorded that "*[d]ue to previous threats against staff [Ms C] was left secured in [her C Wing cell] while a movement to another cell was planned*".

247. While Ms C was being transferred to the Separates cell, she became non-compliant and punched the Senior Corrections Officer in the helmet.[261] A misconduct charge was filed for the assault but not the sprinkler activation (although there is a note that a Police report was completed, so the sprinkler activation may have been referred to external charges). The misconduct charge for the assault was withdrawn on 14 October 2019 because no adjudicators had been available within the required timeframe and prosecutors had been redeployed. There is no evidence that a use of force review was completed.

256 At [A599].
257 At [A604].
258 At [A607].
259 At [A609].
260 At [A615].
261 At [A617].

248. On 26 September 2019 a PC.01 complaint from Ms C was registered, alleging that she had been "*left in wet clothing for 8 hours yesterday*".[262] She was not interviewed by staff until 12 November 2019, a month and a half after the complaint was registered, well outside the required three day timeframe. Staff commented that Ms C "*has been spoken to and it has been agreed to move forward in a more positive path*". There is no record in the offender notes or incident reports from after the sprinkler activation of Ms C being given dry clothing.

25 September 2019 - Ms A threw cup towards officers

249. An offender note dated 25 September 2019 recorded that Ms A was angry at not being given her breakfast first, and when officers opened her food hatch she threw a cup out towards the officers.[263] The hatch was closed and Ms A was not given any breakfast.

250. There are offender notes for 25 and 26 September 2019 recording aggressive behaviour from Ms C, banging on her door and window.[264]

251. On 26 September 2019 a PC.01 complaint from Ms A was registered in IOMS complaining that she had been locked in her cell for over 48 hours.[265] The response was completed on 12 November 2019 (ie 12 working days later). The response is well outside the required timeframes, but we also consider that it is inadequate given the seriousness of the allegation, possibly reflecting the delay:

> Prisoner has been spoken to and unfortunately incidents occur which jeopardises the safety of all which then impacts the unlock regime of the unit.

27 September 2019 – Ms A threw telephone against wall

252. An offender note dated 27 September 2019 recorded that Ms A "*seemed to be in good spirits*", and was looking forward to her telephone conversation with her art tutor.[266] However, incident reports for later that day recorded that Ms A threw a telephone against a wall and attempted to kick an officer in the leg.[267] Ms A had become frustrated when she requested a telephone call and was told this was unlikely to be possible because the unit was having a long lock and Ms C was already on the telephone. However, at 3.40pm it was decided that Ms A could have a telephone call. She was unlocked, and she approached the telephone and threw it and attempted to kick an officer. The staff responded with a spontaneous use of force, and she was moved back to her cell. A misconduct charge was filed, but withdrawn on 31 October 2019 because no adjudicators had been available within the required timeframe and prosecutors had been redeployed.

253. CCTV provides evidence of Ms A being taken to the telephone. She threw the receiver at the wall and as she was walking away from the telephone, towards staff, she attempted to kick the officer and a spontaneous use of force occurred.

254. An offender note dated 27 September 2019 recorded that Ms B was abusive towards staff and was not unlocked because of her threats against staff.[268]

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262 At [A627].
263 At [A624].
264 At [A623] and [A626].
265 At [A643].
266 At [A648].
267 At [A649].
268 At [A655].

255. There are offender notes from 28 and 29 September 2019 recording abusive language from Ms B towards staff, including that she was "*going to assault staff should she come out of her cell for yard time*".[269]

28 September 2019 – Ms C kicked an officer

256. Incident reports dated 28 September recorded that Ms C refused to be locked, and kicked an officer in the leg three times and attempted to head butt the officer.[270] When that failed, Ms C spat in the officer's face. There is no evidence that misconduct or external charges were filed. There is no evidence a Review at Risk Assessment was completed following the use of force on Ms C. The use of force review (#89/19) was completed on 6 November 2019 and confirmed the force was considered proportionate, reasonable and necessary.[271]

257. Incident reports dated 29 September 2019 recorded that Ms C assaulted staff when unlocked for yard time.[272] Ms C preferred a different Separates cell within D Wing for her yard time to the one staff had chosen, and became abusive. Ms C kicked the Principal Corrections Officer, prompting staff to engage in a spontaneous use of force. She continued to resist, attempting to bite the Principal Corrections Officer and standing on her foot. A misconduct charge was filed, but it was withdrawn on 14 October 2019 because no adjudicators had been available within the required timeframe and prosecutors had been redeployed.

258. OBC footage provided evidence of staff assisting Ms C back to her cell following the use of force. Ms C can be heard being abusive towards the staff.

30 September 2019 – Ms C activated sprinkler

259. Incident reports dated 29 September 2019 recorded non-compliant behaviour as follows:[273]

259.1 At approximately 10.00am Ms B put her leg out of the hatch, and threw an apple out of the hatch at a Corrections Officer who was distributing lunch.

259.2 Ms C activated the sprinkler in her cell. She later tried to repeat this activation but was unsuccessful because there was no water.

259.3 A short time later Ms C appeared to be having a seizure.[274] Health assistance was requested.[275] The nurse advised she needed to put a device on Ms B's finger, and as the officer lifted Ms C's wrist she punched the officer with a closed fist. She was restrained and transferred to Medical and then moved to a Separates cell until 2 October 2019. She was moved to Medical in a wheelchair, during which she attempted to use her knee to hit a Corrections Officer. No misconduct charge was filed.

259.4 Ms B and Ms A were abusive to staff and were encouraging Ms C "*to fight all the way*".

269 At [A662] and [A663].
270 At [A657].
271 At [A660].
272 At [A664].
273 At [A674].
274 There is some history of her having what appeared to be a seizure, which she has said was as the result of a staff assault on 23 March. The Inspectorate has not viewed footage of these seizures as the footage would not play.
275 The notes from the nurse are focussed on the wrist and record nothing about a possible seizure.

1 October 2019 – Planned use of force to relocate Ms B and Ms A; no video footage provided

260. Incident reports dated 1 October 2019 recorded that a planned use of force was authorised should Ms A and Ms B refuse to move cells for staff to carry out cell searches.[276]

261. The incident reports recorded that staff explained to Ms A that they would be relocating her and that she was given the opportunity to place her hand through the food hatch so staff could apply handcuffs before they opened the cell door, which she declined. Staff asked Ms A to move to the back of the cell, but she did not. She was advised that if she did not walk peacefully force would be used, including pepper spray. The cell door was unlocked, and officers entered the cell and restrained Ms A. Ms A had a plastic bag over her head with a black and white piece of material around her neck. This may have been in anticipation of pepper spray being deployed but this is not clear.[277] Staff removed the bag, and after "*much physical struggle as she gave hard resistance the entire movement*", Ms A was relocated to another cell within C Wing.

262. The incident reports recorded that staff engaged with Ms B through the cell door, but she refused to move peacefully, instead verbally abusing staff, threatening to kick the officer's head in, and covering all her windows with a towel and toilet paper.[278] Ms B was given an option to put her hands through the hatch for handcuffs to be applied, but she declined. She was advised that force would be used. Just after 9.30am Ms B 's cell door was unlocked and an officer entered, deploying the MK9 pepper spray at Ms B 's face. The officers exited the cell immediately, removing some of the toilet paper from the window. Five minutes later the cell was unlocked again and Ms B was escorted to the decontamination area.

263. No video footage of the planned use of force has been provided, although POM requires that a planned use of force be filmed.[279] The use of force review suggested that the footage was saved in the wrong place. IR.05.07(11) requires that "*all available footage from hand held video cameras, OBC and any CCTV footage relevant to any incident … must be retained and a copy downloaded to a secure electronic device … and sent to Tactical Operations Group coordinator within 3 working days of the incident*".

264. No misconduct charges were filed.

1 October 2019 – Prisoners refused to stand at the back of the cell while food delivered

265. An offender note dated 1 October 2019 recorded that during the lunch round Ms B refused to comply with staff directions to move to the back of the cell, and was verbally abusive towards staff.[280] Staff made one further unsuccessful attempt as they returned to the staff base. There is no evidence that staff made further attempts or that Ms B received her lunch that day.

266. An offender note dated 1 October 2019 recorded that Ms C refused to comply with the instruction to stand at the back of her cell so that dinner could be provided.[281] She was given one more opportunity to comply, but continued to refuse. There is no evidence of further attempts to engage and it is possible that dinner was not provided.

276 At [A687].
277 Ms A has confirmed this in response to a draft copy of the report.
278 At [A689].
279 At [A700]. See the Prison Operations Manual IR.05.07.
280 At [A696].
281 At [A682].

267. The requirement to stand at the back of the cell was a term of Ms C's and Ms B's management plans. It is a standard requirement for maximum security prisoners. We consider that the requirement was appropriate, although we discuss the more onerous requirements imposed later (for example, to lie on the floor) separately.

2 October 2019 – All three wāhine activated sprinklers and relocated to Separates cells outside of disciplinary process; Cell Buster pepper spray used

268. Incident reports dated 2 October recorded that all three wāhine activated their sprinklers, and were relocated to Separates cells where they remained until 8 October 2019:[282]

268.1 Ms B activated her sprinkler at approximately 9.22am.[283] At 12.45pm a planned use of force was authorised to relocate Ms B to a Separates cell in D Wing. At 2.00pm the Control and Restraint team went to Ms B's cell. She had covered both of her windows with a towel and her mattress, and was asked to uncover them. Ms B did not comply, saying that staff "*had to unlock the cell door and go in and get her*", and that "*she was scared and wanted the male Officer to be removed from C&R team*". At approximately 3.07pm the cell door was unlocked and the staff removed coverings from the window, so they were able to see Ms B through the observation window. At 3.15pm the staff regrouped in the staff dining room. It was considered that because of the water and debris on the floor from a broken TV it was considered too slippery for staff to enter safely. Staff concluded that the MK9 pepper spray would not be effective because Ms B was under the bunk with her face covered. After further requests for Ms B to move peaceably, at 3.33pm the Cell Buster pepper spray[284] was deployed. At approximately 3.47pm Ms B complied with staff instructions, and staff were able to enter and handcuff Ms B and escort her to the decontamination area, before she was transferred to a Separates cell in the D Wing. A misconduct charge was filed but was withdrawn. The charging document recorded that Ms B's reason for activating the sprinkler was that she wanted a towel.[285] She had been in a wet cell for approximately 6 hours 47 minutes.

268.2 Ms A and Ms C activated their sprinklers in the evening, and were relocated to Separates cells in D Wing, but without any use of force.[286] No misconduct charges were filed.

269. At this stage it appeared that planned uses of force were being authorised in advance of attempts to relocate prisoners, in anticipation that force may be necessary, but CCTV footage from 2 October 2019 showed that staff continued to try to negotiate with the wāhine first and force remained a last resort. A use of force review was completed on 12 December 2019, but the information was not completely accurate, with the IR.05.Form.03 for Ms B indicating the MK9 pepper spray and Cell Buster pepper spray was used, when it was only the Cell Buster pepper spray.

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282 There is an offender note in relation to Ms A moving back on 8 October 2019, which recorded that she "*understood that there will be consequences should there be a relapse in behaviour, the regime will revert back to their absolute minimum entitlement*", at [A744].

283 At [A710].

284 A canister of MK9 pepper spray equipped with a hose and wand attachment, used under a cell door.

285 At [A712].

286 The incident report for Ms C is at [A705]. There is no incident report or offender note in relation to the sprinkler activation, although there is an incident report for the relocation: see at [A708].

4 October 2019 – Wāhine instructed to kneel; Ms C rushed the hatch

270. Offender notes dated 4 October 2019 recorded that staff instructed the wāhine that before the food hatch was unlocked, the wāhine were required to go to the back of their cells and to go on their knees with their hands on their heads:

270.1 Ms B declined to comply with the new direction, saying "*I'm not getting on my knees for my lunch, why do I have to beg for my lunch*". Her lunch was not given due to "*a safety risk if she were to place her hands or feet through the hatches when it opens*".[287]

270.2 During the dinner delivery, Ms C initially complied with the direction, but while staff were putting Ms C 's meal through the hatch Ms C ran towards the hatch and tried to put her hands through, throwing her cup of hot tea under the door.[288]

271. There is a further reference to Ms C refusing to stand at the back of the cell in an offender note dated 14 October 2019 (staff informed Ms C "*by not complying with my instructions will result in a refusal to except breakfast prisoner replied yes I'm refusing*").[289] Offender notes for 23 and 24 October 2019 recorded that on both days Ms B 's food hatch was left open overnight.[290] There were no incident reports, and no evidence of any escalation to senior management. An offender note dated 24 October 2019 recorded that Ms A (who, together with Ms C and Ms B was in a Separates cell at this stage) refused to stand at the back of her cell and abused staff.[291] Staff disengaged and the offender note confirmed that Ms A did not receive breakfast. There is also an offender note dated 26 October 2019 confirming that Ms A did not receive her breakfast because she did not comply with the instruction to go to the back of her cell.[292]

272. On 28 October 2019 an offender note recorded that Ms A was asked to go to the back of her cell, "*arms behind head, on tummy, legs crossed and facing back door*".[293] The note recorded that Ms A initially said she was too sore to do this, but after some negotiation she complied and was given her breakfast.

273. Offender notes for 2 November 2019 recorded that Ms C was asked to lie on her stomach with her head facing down and fingers behind her head.[294] Ms C lay on her stomach with her knees bent but not with her head flat or hands interlocked. When staff insisted Ms C interlock her hands she replied "*aw fuck you, fuck off, our just making me really hate you, fuck off you can have your breakfast and stick it up your arse you fat fuck*". Staff disengaged and there is no evidence that Ms C received breakfast. She declined to go to the back of her cell at lunchtime and stated that she did not want her meal.[295] An offender note for 3 November 2019 recorded that Ms C did not receive her breakfast because she was non-compliant.[296]

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287 At [A722].
288 At [A720].
289 At [A763].
290 At [A835] and [A845].
291 At [A847].
292 At [A853].
293 There is a management plan for Ms A with a review date of 31 October 2019 that required her to lie down with her fingers and legs crossed "*Due to recent events with Ms A placing her arms/legs out of her hatch*".
294 At [A904].
295 At [A903].
296 At [A910].

6 October 2019 – Ms C submitted complaints including that she was kept in Separates cell while not subject to a penalty of cell confinement

274. On 6 October 2019 a number of PC.01 complaints from Ms C were registered in IOMS. These included that:[297]

> We have Been placed in D-wing (pound) with No paperwork, We are Not on CC's or LOP's and are having our own personal toiletries Drip fed to us in pottles I have Been here over a week, staff do Not interact with us they Simply Record us on their cameras. We have had toilet paper drip fed, Been Refused Sanitary things and had to Beg for clean clothing and clean towels, Been declined for our hour outside which causes us aggravation this is all degrading unhumane, We already have consequences when we pull the sprinkler Being in the pound is double punishment.

275. The response was dated 12 November 2019 (well outside the required timeframe, even if the complaint was received the same day it was registered). It simply stated: "*Prisoner has been spoken to and this was a measure put in place to minimise the threat to staff with such items being left in her cell. Prisoner has all her toiletries and no further action required*". The complaints also allege that Ms C's wrists were "*pulled and twisted*" and that this was why Ms C had activated the sprinklers ("*in protest*"). We consider that the complaints raised serious issues and that the responses were inadequate and failed to escalate the allegations appropriately.

10 October 2019 – Ms B retained civilian clothing

276. An offender note dated 10 October 2019 recorded that Ms B "*still has minimal civilian clothing*" and that staff would remove it once Ms B received the full prison-issued uniform.[298] Given Ms B had transferred to ARWCF on 14 August 2019, it is unclear why she would still have retained civilian clothing as late as 10 October 2019 (see also an offender note from 1 November 2019, noting Ms B "*was in full prison issued uniform, this is an achievement for her because usually she's resistant with wearing her prison issued uniform*"[299]). This highlights issues of consistency in how prisoners are treated across the site.

11 October 2019 – Ms C apologised to a unit officer but then resumed abusive behaviour

277. Offender notes dated 11 October 2019 recorded that Ms C apologised to a unit officer for her bad behaviour over the previous five weeks, but later in the day Ms C began yelling at an officer after she asked the officer to get her "slice" out of the fridge where it had been hardening.[300] The officer asked Ms C to wait until they had finished their task and she began to abuse the officer, saying she would show the officer what abuse was like when she was unlocked the next day.

278. Offender notes dated 12 October 2019 recorded that Ms C claimed that it was "*her unit*" and that the Principal Corrections Officer was not running the unit.[301] Offender notes recorded that an item was missing from C Wing. All cells were searched and the item was found under Ms C's bed.

297 At [A730].
298 At [A751].
299 At [A901].
300 At [A754]. See also the offender note for 10 October 2019 recording Ms C's compliant behaviour: at [A749]. A slice is a food item.
301 At [A756].

14 October 2019 – all three wāhine refused to stand at the back of the cell while staff deliver breakfast; Ms C assaulted a staff member

279. Offender reports dated 14 October 2019 recorded that the wāhine refused to stand at the back of their cells while staff delivered breakfast. They were asked if they were refusing to follow instructions and all replied "*yes I'm refusing*" according to the notes.[302]

280. An offender note dated 14 October 2019 recorded that as Ms C was being escorted from a telephone call back to her cell, she charged at the door in an attempt to assault an officer with the door. Staff responded with a spontaneous use of force, and on the way back to her cell Ms C kicked a staff member.[303] A misconduct charge was filed in relation to the attempted assault but not in relation to the kicking of the second officer.[304] The charge was withdrawn on 6 November 2019 because no adjudicator had been available during the required timeframe. There was no review of the use of force.

281. At approximately 6.40pm during the medical round, Ms B ran out of her cell and around C Wing.[305]

14 October 2019 – Ms B lit a fire in C Wing, and two days later was transferred to a Separates cell outside the disciplinary process

282. Incident reports dated 14 October 2019 recorded that during lockup a fire was lit in the middle of the lounge.[306] It was discovered at approximately 10.30pm. The whole wing was filled with smoke. The wāhine were banging on the doors and observation windows. Ms B was charged by Police, and was sentenced on 22 March 2021.[307] The incident reports recorded that Ms A complained of difficulty breathing and was assessed by a nurse.[308]

283. There were nine wāhine in the Management Unit that night (including the four alleged perpetrators) who had to be evacuated due to smoke, with the Fire Service attending. The incident report follow-up notes stated that CCTV footage was given to the Police. This was not included in the footage provided to the Inspectorate for this investigation.

284. An offender note dated 15 October 2019 recorded that during the evening medical round, Ms B pushed past the officers and ran to Ms A ' cell with what appeared to be a photo album, and then began to run around the cell.[309] Staff disengaged and Ms B returned to her cell, blowing kisses to Ms A .

285. Incident reports dated 16 October 2019 recorded that Ms B activated her sprinkler at approximately 4.44pm.[310] The incident report recorded that this occurred shortly after Ms B had been told that her involvement in lighting the fire on 14 October 2019 had been "confirmed": Ms A and Ms B started to argue, with Ms A saying she "*wanted out*", which is when Ms B activated her sprinkler.[311] The offender note from 17 October 2019 recorded that Ms B said "*she wanted to get [Ms A ']*

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302 See the offender note for Ms B at [A774], for Ms A at [A772] and for Ms C at [A763].

303 At [A764].

304 At [A768].

305 At [A777].

306 At [A778].

307 Ms C and two others were identified as perpetrators. Ms C was charged by the Police and sentenced on 7 October 2020: at [A839].

308 At [A773].

309 At [A785].

310 At [A791].

311 See also the offender note from the PCO dated 17 October 2019, that Ms B said that she "*wanted to get [Ms A] whom at the time was listening to loud music*": at [A802]. An offender note dated 18 October notes that "*unit staff will not get involved with their relationship/break up*": at [A810].

attention whom at the time was listening to loud music".[312] A planned use of force was authorised but Ms B indicated she would comply, and she was relocated to a Separates cell, where she remained until 13 February 2020, except for a brief period in the ISU. No misconduct charge was filed for activating the sprinkler. The use of the Separates cell for three and a half months was outside the statutory disciplinary process.

286. An offender note for Ms B dated 17 October 2019 recorded that after an internal visit with her family she appeared "*like she was in tears*", declined yard time and chose to stay locked.[313] She said "*don't tell me to be good, I'm over it*". Ms B was provided with a disinfectant spray bottle to clean her cell, but refused to give it back. Offender notes for 19 and 20 October 2019 recorded that Ms B was still refusing to give back the spray bottle.[314]

18 October 2019 – Ms C assaulted and threatened staff

287. Incident reports dated 18 October 2019 recorded that Ms C threatened to stab staff after she was advised that she would not receive her canteen items that day because of a mistake in the calculations.[315] Ms C abused staff, including the Residential Manager. A misconduct charge was filed but withdrawn because there was no adjudicator available within the time required.

21 October 2019 - Ms C threatened a staff member

288. An incident report dated 21 October 2019 recorded that Ms C threatened she was going to "*get*" a staff member, began punching her cell window and threatened to pull her sprinkler when staff told her at 3.15pm to wait for her telephone call until her usual time of 3.30pm.[316]

22 October 2019 – Ms C activated her sprinkler and was moved to a Separates cell; Ms A requested to be moved with Ms C and Ms B; both wāhine moved outside the disciplinary process

289. An incident report dated 22 October 2019 recorded that Ms C activated her sprinkler after demanding to make a telephone call at 10.33am and being told her call would be at her usual time of 3.30pm.[317] The sprinkler was turned off at 11.00am and around 1.30pm a planned use of force was approved to move Ms C .[318] Ms C covered her face with materials and MK9 pepper spray was not considered suitable. Staff entered the cell and were able to grab hold of Ms C , moving her onto a mattress on the floor and placing handcuffs on her. Ms C was relocated to a Separates cell in D Wing. She stayed there until she was moved to Arohata Prison on 4 December 2019, apart from brief spells in the ISU. The relevant entry on the Use of force register does not include the Prison Director's signature, as required by POM IR.05.08(1)(o).

290. An incident report dated 22 October 2019 recorded that Ms A put her hands through the hatch when staff tried to serve lunch, refusing to withdraw her hands until she was provided with her lunch.[319] There is no record of Ms A receiving lunch. A misconduct charge was filed but withdrawn.

312 At [A802].
313 At [A800].
314 At [A814] and [A817].
315 At [A808].
316 At [A822].
317 At [A825].
318 At [A826].
319 At [A830].

291. Later on 22 October 2019 Ms A was moved to a Separates cell in D Wing which, in the Inspectorate's interview with her, she told us was done at her own request, because she did not want to be separated from the other two.[320] She elaborated that she thought it unfair she remain in C Wing with access to a TV and stereo. She remained in a Separates cell until 13 February 2020.

292. Neither Ms C, who spent approximately the next one and a half months in a Separates cell, nor Ms A or Ms B, who both spent the next approximately three and a half months in a Separates cell, were subject to the statutory disciplinary process for imposing a penalty of cell confinement.

293. An offender note for 22 October 2019 recorded that Ms B told staff that she had been informed that she would be moving back to C Wing after seven days.[321] The Residential Manager explained that Ms B would remain in D Wing at that stage and her management plan would be reviewed on a weekly basis, and that "*there is no set time frame*".

26 October 2019 – The wāhine submitted complaints about being kept in Separates cells while not subject to a penalty of cell confinement

294. Three PC.01 complaints from Ms B were registered on 26 October 2019, including allegations about the way the prisoners were kept in Separates cells:[322]

> We have been housed in the Cell confinement unit D wing, where there are no power Outlets and We have been told we are to live here till further notice. On the kios [kiosks] it states that bylaw we due to be housed long term where power Outlets are available here in Dwing management there are no power Sockets and it is Cell confinement day in day Out.

295. Ms B was not interviewed until 17 days after the PC.01s were registered. The response was that staff had "*spoken to the prisoner and she does not wish to pursue this any longer*".[323] On 27 October 2019 nine PC.01 complaints from Ms C were registered, in one of which Ms C complained that only a few of her PC.01s had been loaded, and that the staff "*sit in the fishbowl most of the day*" (although the complaint was registered on 27 October 2019, Ms C was not interviewed until 8 November 2019, outside the required timeframes).[324] On 27 October 2019 a PC.01 complaint from Ms A was registered in IOMS, stating that (Ms A was not interviewed until 14 November 2019):[325]

> PRISON CONDITIONS 'WE ARE SITTING IN THE POUND WITHOUT POWER OR OUR T.VZ AND STEREOS, AND HAVE BEEN REFUSED OUR MEALS AND LUNCHES DRIP FED TOILET PAPER, NO SOAP OR SHAMPOO GIVEN. HO HOUR OUT DAILY, WE ARE BEING HELD IN D-WING (POUND) IM NOT ON CC'S OR LOP'S IV BEEN GIVEN A AT RISK BLANKET NO SHEET'S, PILLOWS OR DUVETS

320 Note that offender notes for 17 October 2019 recorded that she "*was displaying good behaviour with positive attitude*": at [A796]. And see the MDT minutes from 17 October 2019 stating that Ms A has "*told unit staff that she does not want to have any involvement anymore with setting fires and activating sprinklers. She informed staff that her relationship with Ms B is over and that she wants to move on*". See also the file note for 20 October 2019 confirming Ms A' good behaviour: at [A816].

321 At [A834]. This appears to have been consistent with Ms B 's comment on Sunday 20 October 2019 that she intended to hold onto her disinfectant spray bottle until she moved cells on Tuesday (ie seven days from her first day in the cell confinement cell on 16 October) because she wanted to clean her cell every day: at [A817].

322 At [A864].

323 In response to a draft copy of this report, Ms B said that she disagrees that she did not wish to pursue this any longer.

324 At [A868].

325 At [A874].

296. On 30 October 2019 a PC.01 complaint from Ms C was registered, which complained that she was being drip fed toilet paper, and "*[w]e are housed in D-wing … No power, struggling with ADHD locked in our Rooms 24 hours a day*".[326] Ms C was interviewed on 8 November 2019, outside the required timeframe, and the response stated that she had since been issued with a full roll of toilet paper and had not blocked her toilet since then.

297. On 4 November 2019 a PC.01 from Ms C was registered, complaining that wāhine in the Separates cells did not have enough to do.[327] The response was that Ms C "*agrees that a lot has happened and now things* are *looking so much more positive*". The interview with Ms C was only four days after the PC.01 was registered, suggesting that it was completed by the wāhine earlier if "*a lot has happened*" since the complaint was originally made. The complaint states:

> We are wanting more maori staff in our unit … We have Been in Cell confinement going on 2 weeks Now & had staff do absolutely Nothing for us But ignore us, None of our issues have Been Met, We weren't given our P119 forms all weekend. We do Become frustrated and its Not healthy for us, we are locked 24 hours No offer of yard or fresh air Iv had continuous Anxiety attacks, staff being sarcastic and triggering Behind the windows. No communication. Officer X hanging up the intercom childish, unprofessional Behaviour from Corrections.

298. A further two PC.01 complaints from Ms C were registered on 18 November 2019. Ms C was not interviewed until 12 December 2019, when she had been transferred to Arohata Prison):

> Prison Management - I have Been in cell confinement housed in D-Wing 28 days Now and along with the other 2 maxi prisoners, We are here on accusations of a fire that took place in C-Wing None of us Were involved with that!!!the person that is responsible has Been taken Back to high Security There is No power outlet and We are Not on cc's or Loss of privleges. We should Be entitled to T.V and stereo just like every other prisoner, D-wing is the "Pound" Were struggling with anxiety & ADHD, Nothing to do.
>
> Prison management - We have Been housed in the pound 29 days Now, our curtains cover us up that staff place up as if we don't exist, in the last month here we have Been Refused meals, Refused toilet paper. Refused phone calls to our families Refused visits, Refused interaction with my physchologist, Refused. our mail Being sent out and prison director holding (withholding), Refused human interaction. There is no power outlet to watch tv or to plug our stereo. Disgusting, the footage will show we are Not on cell confinement or loss of privleges

23 October 2019 – Ms C kicked a Corrections Officer

299. On 23 October Ms C kicked a Corrections Officer twice while being relocated from an interview room to her cell, demanding to use a telephone.[328] Staff responded with a spontaneous use of force. The use of force review was completed and signed off by the Prison Director delegate on 28 November 2019, but the relevant entry in the Use of force register lacked details about the remedial actions required, the person responsible and the Prison Director's signature (see IR.05.08(1)(c) and (o).[329] The use of force review was completed on 18 November 2019 and signed off by the Prison Director on 28 November 2019. The relevant entry in the Use of force entry failed to identify the

326 At [A884].
327 At [A917].
328 At [A838].
329 At [A840].

person responsible and the Prison Director had not signed it off ((see IR.05.08(1)(c) and (o)).[330]

23 October 2019 – Ms A refused to be locked

300. Incident reports recorded that at approximately 4.30pm Ms A refused to be locked at the end of her yard time, blocking the door to her yard with her mattress.[331] A planned use of force was authorised. At 6.00pm Ms A continued to refuse instructions to come away from the door. Staff observed Ms A through the window use her bed sheets and her jumper to make a swing on top of the yard grill, placing herself at height and preventing staff from using force. Staff entered and removed the mattress that was blocking the door. Staff tried to engage with Ms A again at 6.30pm but without success. Staff continued 15 minute observations and at 7.12pm Ms A said she had had enough and came in. She was given dinner and the mattress was returned. No misconduct charge was filed.

301. Incident reports dated 25 October 2019 recorded that Ms A refused to get locked after calls with family and her lawyer.[332] She walked towards Ms B 's cell, still in handcuffs at her front from using the telephone. The reports recorded that Ms A became resistant, and staff responded with a spontaneous use of force. When Ms A was placed on the floor it appeared that she had passed out. Handcuffs were removed and Ms A began to kick out. Medical attended, and she was returned to her cell in the early hours of 26 October 2019.

27 and 28 October 2019 – Ms C activated sprinkler in Separates cell

302. Incident reports dated 27 and 28 October 2019 recorded that Ms C activated her sprinkler.[333] On both nights she was relocated to a different Separates cell without any issues. A misconduct charge was filed for the activation on 27 October 2019 but withdrawn at the request of the charging officer.[334] Ms C 's electronic health file recorded that she was seen for a mental health review on 27 October 2019. She was

> Complaining of all sorts of things such as anxiety attack and breathing problems. Appeared in nil distress when conversing with nurse. Custody advised Ms C is wanting attention and claims are not genuine as they have not noticed any anxiety attacks or shortness of breath. Follow up at nurse clinic appointment.

303. Ms C 's electronic health file recorded her complaining about anxiety on a number of occasions.[335] There is a record from 22 August 2019 that Ms C stated that she needed to see a doctor for migraines and anxiety. She was reviewed by a nurse and a doctor following this, but her anxiety was not reviewed. Given Ms C 's history of self-reported anxiety, an assessment should have been completed.

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330 At [A840].

331 At [A841].

332 At [A854] and [A859]. CCTV and OBC viewed.

333 At [A871] and [A879].

334 The Inspectorate has been advised that the Prosecutor could not understand how Ms C had reached the sprinkler, but weeks later Ms C advised an officer that she had hooked her T-shirt onto the sprinkler and pulled it to set it off.

335 10 July 2019 "*Says having anxiety, feels like her heart is racing for the last week and has not slept well*"; 22 August 2019; 26 October 2019 "*My anxiety is causing my breathing problem*"; 27 October 2019 "*getting anxiety, breathing problems, shortness of breath. Stuck in pound cell, no fresh air, no power, going in and out of panic attacks*"; 1 November 2019 "*Has been having anxiety attacks and wants anxiety medication. Officer confirmed Ms was having difficulty breathing … Has documented diagnosis Anxiety with depression – on medication with recent dose increase*".

29 October 2019 – Ms C was asked to remove toilet paper blocking cell cameras

304. An incident report dated 29 October 2019 recorded that Ms C had blocked the camera in her Separates cell with wet toilet paper. She was asked to remove the paper, but after complying covered the camera again.[336]

305. We do not consider that there was a reasonable basis for having cameras on in the Separates cells. Cameras are used in the ISU, which is appropriate, but there is no reason for them to be on in the Separates cells.

30 October 2019 – Offender note included unnecessary personal information

306. An offender note dated 30 October 2019 by Ms A' Case Manager discloses sensitive medical information about Ms A.[337] The information appears unnecessary, and given that any custody officer can view offender notes we consider that the information should not have been included. Ms A mentioned this in her interview with us.

2 November 2019 – Ms C failed to return razor and refused to wear prison-issued shorts; her visit with mother cancelled

307. At the beginning of November Ms C was scheduled to have a visit with her mother, whom she had not seen for three years.[338] Unfortunately the visit was cancelled after Ms C failed to return a disposable razor. Incident reports recorded that:

307.1 On the morning of 2 November 2019 Ms C was offered prison-issued cotton shorts so she could get dressed before she went to the back of her cell to receive her breakfast.[339] Ms C refused and said "*it is ok she has jumpers wrapped around her*". However, when asked to lie down she responded "*you just want to be a pervert*".

307.2 Ms C was issued a razor in the morning at approximately 10.30.[340] POM states that a single disposable razor may be provided each day upon request, but that unit staff "must collect the disposable safety razors issued to prisoners no later than one and a half hours (90 minutes) after issue".[341] The offender notes recorded that when staff went around to hand out lunch and collect the razors, Ms C stated she had flushed hers down her toilet. An offender note recorded that Ms C stated that:[342]

> … she'd flushed her razor down the toilet in a packet of pineapple lumps … She said to call the plumber so he could retrieve the packet of pineapple lumps that supposedly has the razor. I didn't call the plumber because her toilet is not blocked and she's aware that her rubbish can be collected by unit staff when her meal is given through the hatch. The purpose of the toilet is not to be used as a rubbish bin.

307.3 The argument about Ms C's clothing continued when staff were delivering lunch, and Ms C threatened staff ("*Fuck you bitch, remember I'm getting out. I'm going to stab you in the eye*").[343]

308. An offender note dated 3 November 2091 recorded that staff attempted to give Ms C cotton clothing so that she could dress and go out into the yard while staff

336 At [A882].
337 At [A886].
338 Notes from interview with Ms C dated 23 March 2021.
339 At [A903]. And [A904].
340 At [A905].
341 At F.06.02(1).
342 At [A886].
343 At [A903].

searched her cell for the razor.[344] Ms C initially continued to insist she had flushed the razor, but after she was advised that the visit with her mother had been cancelled she confirmed she had the razor and said "*I've got the razor, I'm going to slit your throat when this door gets opened*". She further threatened to rub [redacted] over an officer's face, to get another officer and to stab a third officer in the eye and slit the officer's throat.

309. Ms C requested a telephone call with her mother. She was advised that she was only allowed to have one telephone call a week, and that as she had had a telephone call on Wednesday 30 October 2019 and it was Sunday 3 November 2019 she could have a telephone call the following day, which would be a Monday. That suggests that staff perception was that prisoners were only able to have one telephone call within every Monday-Sunday week. Ms C stated that her mother was flying out to Thailand the following day.

310. In an interview with the Inspectorate carried out in preparation of this report, [redacted] Ms C said that staff had collected the razors an hour and a half after they were issued, but that they did not come to her door. She therefore threw the razor in the rubbish, and was unable to provide it when requested later. The cancellation of the visit was a significant event in her time at ARWCF.

3 November 2019 – Ms A reported as having difficulty breathing

311. Incident reports dated 3 November 2019 recorded that Ms A told staff at about 6.30pm that she was having difficulty breathing.[345] The nurse was notified while she was completing the medical round. Ms A called through the intercom again and at approximately 7.10pm a nurse came over to Ms A' cell during the medication round and spoke to Ms A through the window. The nurse advised staff that Ms A should be seen in Low Medical. At 7.32pm approval was given for Ms A to be unlocked. The four staff, as required by the management plan, assembled. Ms A was unlocked at 7.46pm and escorted in handcuffs to Low Medical for the nebulizer.

4 November 2019 – Wāhine put up abusive pictures

312. Incident reports dated 4 November 2019 recorded that the three wāhine had placed abusive pictures or notes on their windows, which were first observed in the evening:[346]

312.1 Ms B had three drawings. The first had a picture of a stick figure bent over with a knife pointing to its rear end with "*I hate you all*" written underneath. The second depicted a group of five figures hanged, with each figure labelled one pig through to five pig. The third picture also depicted five stick figures hanged, with the name of five management staff underneath the figures.

312.2 Ms C had four drawings, each of a different officer, including the Residential Manager, and each with a picture of a penis and an offensive comment ("*Eats it All*", "*Loves it this way*", "*Takes it up her Ass Haha*", "*Takes it like a man*").

312.3 Ms A had notes: one said, "*I hate you all*" and the other "*Mighty Mongrel Mob foreva*".

344 At [A909].
345 At [A912].
346 The drawings are described in an incident report from the day staff: [A920] and the night staff: [A925].

5 November 2019 – Planned use of force to remove pictures and recover razorblade

313. On 5 November 2019 in the evening a planned use of force was authorised to recover Ms C's razor blade and to remove the pictures.[347] The wāhine complied with the direction to take down the pictures and move to a different cell for a strip search while a search of the cell was conducted. Nothing was found in the cells or during the strip search, although the pictures were removed, as were papers from the ceiling covering the lights, a fishing line and gang related drawings. The wāhine were locked back in their cells where hot meals and clean bedding was provided. No use of force was required. The matter was referred to the Police.

6-13 November 2019 – Wāhine recorded as compliant; wāhine met with Residential Manager and requested changes to management plans including to not be required to lie down before receiving meals

314. Following the pictures being taken down, there was a period of largely compliant behaviour,[348] except for an incident on 11 November 2019 when Ms B threatened to pull her sprinklers as "*she has nothing to loose and she will pull the sprinklers for a week if she doesn't get moved [to C Wing]*".[349]

315. On 13 November 2019 the Acting Residential Manager and Principal Corrections Officer met with each of the wāhine to discuss their management plan and short term goals:

315.1 Ms C requested to have more than one five minute telephone call a week because it "*is just not enough to communicate with her partner and children*".[350] She also asked to have her regular bedding back, and to be able to go into the yard and have her yard door open.

315.2 Ms A requested more telephone calls with her children. It was agreed that the Principal Corrections Officer would follow up with Ms A about her art course.

315.3 Ms B asked that for the new week, she would "*like to be able to not lay on the floor to be given her food*". Staff reminded her that the only reason she was asked to do that was because she liked to hang her hands and legs out of the hatch. Staff were willing to give it a chance this week to see if they will comply when hatches are open. Ms B also requested that her yard door remain open during her yard time to allow the air to flow through to her cell.

316. The requests for more than once a week telephone calls, for the yard door to remain open during yard time and that the prisoners not be required to lie down for the food to be delivered appear reasonable. On 14 November 2019 Ms C's bedding was changed from non-destructible ISU bedding to standard prison-bedding.[351] Ms C requested a brand new duvet inner. She was given a clean duvet inner but refused to take it. There are later offender notes that suggest that staff continued to have an understanding that the prisoners were restricted to weekly five minute calls.[352] While staff may have loosened the requirement to lie down before the hatch was unlocked for a short period, Ms C was being required to lie down by the evening of 15 November 2019, Ms B was required to lie down by 18 November

347 At [A926].

348 See offender notes for Ms C dated 6 November [A930], 7 November [A935], 9 November [A940] 2019,], See offender notes for Ms B dated 6 November [A933], 8 November [0] 2019,], See offender notes for Ms A dated 6 November [A931] and [A932], 9 November [A941].

349 At [A945].

350 At [A949].

351 At [A959].

352 For example, an offender note for Ms B dated 18 December 2019 stated she "*made her one 5 minute call for the week*", at [A1160].

2019 and Ms A was required to lie down by 23 November 2019, and the requirement to lie down does not appear to have been re-lifted.[353]

15 November 2019 – Ms C charged at staff, injuring nurse

317. Incident reports recorded that on 15 November 2019 during the morning medication round Ms C charged through staff, grabbing an officer's vest.[354] One officer had a tender shoulder and another suffered a scratch. The nurse was knocked backwards against the wall and required time off work and support to assist her return to work (she made a complaint with the Police, which brought external charges). Staff responded with a spontaneous use of force to restrain the wāhine and relocated her back to her cell. She was charged with Crimes Act assault and sentenced on 17 August 2020.[355] A use of force review was completed.[356]

318. Later that evening Ms C was asked to lie on the ground before her food was placed through the hatch "*because she assaulted a staff member*".[357] This suggests that after the meetings with the Residential Manager on 13 November 2019 staff had ceased requiring prisoners to lie on the ground. Ms C started yelling and threatening staff ("*Im going to fucken kill you bitch*"). Staff disengaged.

319. An incident report dated 15 November 2019 recorded that Ms A refused to come in from her yard.[358] She claimed that staff had given her a filthy duvet inner. When staff attempted to close the yard door Ms A yelled out that her arm had been squashed. The offender note stated that staff observed Ms A attempting to stick her arm into the gap between the yard door and the frame. The following day Ms A was informed that because of this behaviour the yard door would be shut during her yard time, suggesting that staff had acquiesced in the 13 November 2019 request of the wāhine for the yard door to be left open during yard time.[359]

17–18 November 2019 – Ms C drew pictures of the Prison Director; refused to comply with instruction to lie down before receiving lunch

320. An incident report dated 17 November 2019 recorded that Ms C had drawn pictures of the Prison Director in an inappropriate way and had refused to remove the pictures.[360]

321. An incident report dated 18 November recorded that Ms C refused to lie down before receiving her lunch.[361] The report stated that Ms C "*asked why is she going back to having her back on these consequences, she was informed due to her stating staff will be assaulted and threatening behaviour, she has admitted stating 'she will assault staff'*".

322. The requirement to lie down was originally introduced to respond to the risk that prisoners would stick their hands through the food hatches and attempt to assault staff

353 In response to a draft copy of this report, Ms B and Ms A said that the requirement to lie down on the floor was relaxed for a short period only.
354 At [A959].
355 At [A963].
356 In response to a draft copy of this report, Ms C said that she was upset at the cancellation of the planned visit by her mother, and did not intend to hurt medical staff.
357 At [A964].
358 At [A965].
359 At [A968]. This is consistent with an offender note dated 16 November 2019 for Ms B, in which staff offered to keep her yard door open during her yard time, but she requested that it be shut due to her partner's yard door being closed: [A969].
360 At [A971].
361 At [A975].

(eg throw food, liquid).[362] It is not clear how the requirement protects staff where the prisoner has used threatening language, or how it protects staff against the risk that prisoners charge against staff during the medical unlock (this is why the requirement was re-introduced on 15 November 2019). Medical unlock requires the prisoner to be present to take medication and drink, then open their mouth to show medication has been consumed.

18 November 2019 – Ms A requested to be able to telephone about a family member

323. An offender note dated 18 November 2019 recorded that Ms A .[363] Ms A requested approval to call her family. Two hours after the initial request, Ms A called on her intercom, anxious to make a call. The offender note recorded that the other two wāhine were ready to set off the sprinklers, but Ms A was saying to wait she was talking to the Corrections Officer. The officer said she had no authority to authorise a telephone call, and was waiting for confirmation.[364] The officer said that the Principal Corrections Officer would decide whether to authorise a telephone call first thing in the morning. Ms A agreed to leave it until the morning. There is no offender note indicating whether the PCO did contact Ms A ' sister or what the outcome was.[365]

324. An offender note dated 19 November 2019 recorded that the Case Manager met with Ms A , who was "*unmotivated and refuses to work with [the Case Manager] to complete practice tools. She advised that she been in her cell for 5 weeks with no tv and is in no mood to be compliant and work with staff*".[366]

19 November 2019 – All three wāhine activate sprinklers; Cell Buster pepper spray deployed

325. Incident reports dated 19 November 2019 recorded that at approximately 2.50pm all three wāhine activated their sprinklers.[367] A planned use of force was authorised in order to transfer the wāhine out of the wet cells into alternative Separates cells. Staff were briefed on the planned relocation at approximately 4.50pm. The incident reports recorded:[368]

325.1 At approximately 5.11pm officers cautioned Ms C . The incident reports recorded that Ms C resisted and MK9 pepper spray was deployed. Ms C continued to resist and verbally abused staff, but staff were able to lock her in the new Separates cell without any incident.

325.2 At approximately 4.50pm staff approached the cell of Ms B , who declined to follow instructions and was verbally abusive. Staff deployed the Cell Buster pepper spray twice approximately 10 minutes apart. Following the second burst Ms B was compliant; she was placed in handcuffs and moved to the decontamination area and then to the new Separates cell.

325.3 At approximately 8.10pm, staff approached Ms A ' cell. She was given several opportunities to comply; she refused instructions and was verbally abusive. The Cell Buster pepper spray was deployed, but Ms A continued abusing staff and

362 For example, Ms C had previously thrown an apple through a food hatch: at [A87].
363 At [A980].
364 The offender note referred to the Security Principal Corrections Officer, but the context suggests this is intended to be a reference to the Principal Corrections Officer.
365 In response to a draft copy of this report, Ms A said she could not recall a phone call with her sister being facilitated, but thought it "highly unlikely".
366 At [A892].
367 At [A987].
368 The Inspectorate also viewed OBC, although there was no audio.

kicking her cell door. The Cell Buster pepper spray was deployed a second time (and possibly a third time);[369] approximately 20 minutes later Ms A complied. She was escorted to the decontamination area and the transferred to the new Separates cell.

326. Use of force documentation for all three wāhine was registered as required. The use of force reviews were completed on 3 December 2019 and signed off by the Prison Director delegate on 9 December 2019.[370] No misconduct charges were filed.

20 November – All three wāhine activate sprinklers; Cell Buster pepper spray deployed

327. Incident reports for 20 November 2019 recorded that all three prisoners activated their sprinklers at approximately 3.25am.[371] In order to relocate the prisoners to dry cells, a planned use of force was authorised approximately twelve hours later, with the staff briefing at 3.05pm:[372]

327.1 At 4.04pm staff approached Ms A' cell. The incident reports recorded that Ms A was non-compliant. At 4.11pm the final brief for the team was held. Ms B could be heard saying she wanted to "*stab [an officer] in the throat with sharpened pencil*". At 4.22pm the team entered D Wing and gave instructions to Ms A, who was non-compliant. At 4.28pm an officer deployed the Cell Buster pepper spray, and again at 4.37pm. Ms A was still non-compliant. At 4.58pm Ms A' door was opened and an officer deployed the MK9 pepper spray. The cell door was closed for two minutes before the team entered the cell and handcuffed Ms A, who was then escorted to the decontamination area before being taken to the new Separates cell.[373]

327.2 Ms C was compliant and was relocated to a new Separates cell without force being used.

327.3 A staff member spoke to Ms B at approximately 6.26pm. The team approached Ms B's cell at approximately 6.32pm and gave her instructions. The incident report records that Ms B was non-compliant. Staff opened the cell door and removed the mattress. The Cell Buster pepper spray was first deployed at approximately 6.36pm. The cell door was opened at 6.42pm and Ms B was handcuffed and escorted to the decontamination area. She was secured in her new Separates cell at approximately 6.58pm.

328. There is a use of force review for Ms C, although she was compliant and no force was used.[374] The review summary would appear to be a cut and paste from the use of force reviews for Ms A and Ms B.[375] There is reference in the use of force reviews to footage being viewed, but there is also reference to no footage being available. IR.05.07(11) requires that "*all available footage from hand held video camera, OBC and any CCTV footage relevant to any incident … must be retained and a copy downloaded to a secure electronic device … and sent to Tactical Operations Group coordinator within 3 working days of the incident*".

329. All three wāhine were strip searched. The basis of the strip searches is unclear but it seems from the reports that staff were still looking for the razor that Ms C failed to return on 2 November 2019. Footage provided does not match the amount of

369 One incident report recorded that the Cell Buster was redeployed because the bottom of the door was blocked: at [A988].
370 At [A992].
371 At [A994].
372 At [A998].
373 The Inspectorate viewed footage of decontamination and relocation of Ms A and the cell search and relock.
374 At [A1003].
375 At [A1002].

OBC recording mentioned in incident reports. No Review At Risk Assessments are recorded for the three wāhine, as required following use of force (which includes use of pepper spray).[376] No misconduct charges were filed.

330. For the planned use of force to relocate Ms B and Ms A on both 19 and 20 November 2019, the video footage made available to the Inspectorate confirmed a lengthy period of negotiating (several hours) took place before the officers deployed pepper spray. The relocation of the prisoners on 20 November 2019 occurred over ten hours after the sprinklers were activated. This may have stemmed from reluctance to use force, but there is no record of how the staff duty of care to the wāhine was met during this period while wāhine remained in wet cells. It is not clear, for example, whether the wāhine were given dry clothes, bedding and towels.[377]

331. Further information about the sprinkler activation is provided in offender notes and incident reports from the period between the activation (just after 3.00am) and the first use of force briefing (just after 3.00pm):

331.1 An offender note recorded that Ms C had used toilet paper to activate the sprinkler and had been using it to cover her observation windows. The offender note stated that Ms C 's toilet paper would be dispensed to her (the wāhine had already made a number of complaints about toilet paper being drip-fed.)

331.2 An incident report recorded that at approximately 10.30am staff observed that [redacted] Ms C [redacted] Staff removed it. At that stage, Ms C would still have been in a wet cell. Ms C 's electronic health file recorded that she was: "*Seen in cell lying on the floor.* [redacted]"

332. Ms A ' thumb was injured during the relocation. She was seen in the nurse clinic the following day in the presence of five officers while handcuffed. On 22 November 2019 a Medical Officer examined Ms A ' thumb, and a radiologist confirmed that she had a fracture. She was referred to the Emergency Department, where the thumb was placed in a cast.

21 November 2019 – Ms C [redacted] outside her cell and activated her sprinkler

333. An incident report recorded that on 21 November 2019 Ms C [redacted] which was found approximately at 11.50am.[378] No Review At Risk Assessment was completed despite Ms C 's change of behaviour.

334. An incident report dated 21 November 2019 recorded that at approximately 9.15pm [redacted] Ms C activated her sprinkler. Water outside the cell was pumped to the adjacent cell and diverted into the yard. The plumber arrived at approximately 10.00pm to turn off the water. The wāhine was given a dry duvet inner and a towel through the hatch (although there is no record of dry clothes being provided).[379] There is no record of [redacted] Ms C changing cells, although she was moved to the ISU the following day at

376 POM M.05.02(1)(h)

377 In response to a draft copy of this report, Ms B said that no dry clothing was provided until after decontamination. Ms C said that she was not given dry clothes, bedding or towels until after she had been relocated to a new cell. Ms A said that the prisoners would often strip naked rather than stay in wet clothes, and try to huddle in a blanket.

378 At [A1006]. See also the offender note at [A1007] recording that Ms C requested a whole roll of toilet paper.

379 In response to a draft copy of this report, Ms C said that it was very difficult for her to recall, but that she remembers being left with only wet clothing for a very long period of time.

approximately 1.35pm.[380] The sprinkler can only be reactivated from the inside of the cell. A misconduct charge was filed, but it was withdrawn on 15 January 2020 because the charge had not been prosecuted before Ms C was transferred to Arohata Prison on 4 December 2019.

335. Ms C was seen by a psychologist at the ISU, and Review At Risk Assessments were completed.[381] An offender note by the psychologist stated that Ms C was at an increased risk of harming others, especially staff, and the risk of self-harm would be better managed in a maximum security unit than in ISU.[382] However, she stayed in the ISU until 25 November 2019.

336. An offender note dated 22 November 2019 recorded that during the welfare check in the morning Ms A told the nurse she was "*over it*" and that the nurse advised staff that "*according to her own observation that the prisoner felt suicidal at that time*".[383] Review At Risk Assessments were completed at 10.01am and 12.32pm. The second assessment concluded that Ms A was not at risk of self-harm: "*she told the nurse she feels like she's loosing her mind not that she's at risk*".[384]

23 November 2019 – Wāhine overheard Ms C, Ms B and Ms A planning to escalate behaviour

337. While Ms C was in ISU, another wāhine at the ISU wrote a letter to staff stating that she had overheard Ms C, Ms B and Ms A talking to each other across their respective yards, and that they were planning something:[385]

> Last night [Ms C] said to me that [Ms B] told her to ask me if I'm keen to jump on board. I replied "*I'm not hood no more, I'm doing me, fuck that shit don't even fucken talk to me fool*" they plan to take out as much officers as they can the fire was just the beginning, the sprinklers is a distraction the worst is yet to come. Seriously speaking will put my life on the line for the certain staff of ISU ([redacted]). I'll never let anyone hurt them no matter what this is a promise, so if those 3 bitches want to start there plan here in ISU watch me make their plan fully fail…'

23 November 2019 – Ms A asked to lie down before she is given food

338. Offender notes dated 23 November recorded that Ms A and Ms B were instructed to lie down and interlock their hands behind their heads, but that Ms A declined to interlock her hand because it was in a cast.[386] It was agreed that Ms A would take her mattress and lie at the back of her cell and then staff would unlock the hatch and put the breakfast through. The notes suggest that staff had reverted to requiring all three prisoners to lie down before food was provided, despite the prisoners' requests on 13 November 2019 to dispense with lying down.

339. The offender notes also recorded that Ms A asked for a plastic bag to cover her hand. The nurse advised that Ms A should elevate her hand to keep it from getting wet.

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380 This information is from the ISU daily log, which confirmed the time Ms C arrived in the unit.

381 At [A1024] and [A1025].

382 At [A1027].

383 At [A1028].

384 At [A1030].

385 At [A1034].

386 At [A1035]. There is an offender note recording that Ms C lay down and interlocked her hands on 24 November 2019: [A1040].

25 November 2019 – Ms C transferred back to D Wing and assaulted staff after workbooks withheld

340. On 25 November 2019 Ms C was cleared from at risk status and relocated from the ISU back to D Wing and her Separates cell.[387] An incident report dated 25 November 2019 recorded that Ms C became verbally abusive when staff advised her she could not take her workbooks into her cell but would have them dispensed one at a time.[388] Ms C started to kick behind her, connecting to an officer's right knee. Staff responded with a spontaneous use of force. Ms C was taken to the ground in her cell, saying "*I am going to pull the sprinkler after this*". She was charged by the Police and sentenced on 17 August 2020.[389] There is no use of force review for this incident on the Use of force register (as required by IR.05.07(10)), although there is an entry relating to the incident with the reference number 118/19. The entry lacks the Prison Director's signature, as required by IR.05.08(1)(o)). The reference number is earlier in sequence than the entry for the use of force on 20 November 2019 when the sprinklers were set off, suggesting the database has not been administered consistently. There was a use of force review completed on 2 December 2019 however this was not signed off by the Prison Director.[390]

341. A Review At Risk Assessment was completed, in which Ms C "*openly says she wants to end her life,* [redacted][391] A further assessment that evening concluded that Ms C was not at risk of self-harm, after the Principal Corrections Officer showed Ms C that the books had been placed in an envelope with a seal, and undertook to show her the seal each day to check it had not been broken.[392]

342. When interviewed by the Inspectorate, Ms C said that the workbooks were personal journals provided by her private psychologist, in which she had written about her childhood. She claimed that staff had read the journals.

25 November 2019 – Ms A and Ms B recorded as being compliant

343. During this period of non-compliance by Ms C, various offender notes confirmed that Ms A and Ms B were being generally compliant.[393]

27 November 2019 – Ms C activated the sprinkler

344. An incident report dated 27 November 2019 reported that Ms C activated her sprinkler at approximately 2.06pm and that at approximately 2.35pm she moved peaceably to another Separates cell.[394] A misconduct charge was filed but withdrawn noting that the wāhine had been transferred.

1 December 2019 – Ms B and Ms A submitted complaints about shoes being removed

345. On 1 December 2019 complaints from both Ms B and Ms A were registered, including complaints referring to having their shoes taken away.[395] There is no reference

387 See the offender note dated 25 November 2019 at [A1043].
388 At [A1044].
389 At [A1046].
390 At [A1047].
391 At [A1048].
392 At [A1049].
393 See the offender notes for Ms A dated 24 November [A1040], 25 November 2019 [A1051], the offender notes for Ms B dated 23 November 2019 [0] (some limited verbal abuse), 24 November [A1041], 25 November 2019 [A1052].
394 At [A1067].
395 At [A1090].

in the offender notes provided to the wāhine about having their shoes removed. The response stated that "*the unit PCO may limit both the size and number of permitted items, and the size of a single item, if they believe that issuing these items will interfere with the effective management, security and good order of the prison*".

346. On 30 December 2019 an offender note recorded that Ms B "*was upset when she was taken to DCU because she had to wear prison issued jandals. She wanted to be able to wear her issued sport shoes*".[396]

3 December 2019 – Ms C splashed drink at staff

347. An offender note dated 3 December 2019 recorded that during the morning medication round, Ms C reached her hand through her door and splashed her drink at the nurse, shouting "*that little fucking Asian bitch*".[397] A misconduct charge was filed but withdrawn on 9 December 2019 because she had transferred to Arohata Prison.

3 December 2019 – Ms C requested toilet paper

348. An offender note dated 3 December recorded that Ms C asked for more toilet paper and sanitary pads just before 8.00pm.[398] The officer had previously dispensed toilet paper to Ms C at approximately 6.30pm. The officer told Ms C to wait until the pegging and facility rounds (which record electronically the location of staff). When the officer got to Ms C 's cell to dispense toilet paper and sanitary pads, the officer smelled Ms C yelled The officer disengaged without giving Ms C the toilet paper or sanitary pads.

4 December 2019 – Ms C transferred to Arohata Prison

349. On 4 December 2019 Ms C was transferred to Arohata. An offender note recorded that at 9.30am Ms A asked staff where Ms C had gone, and staff replied that only Ms C can give that information.[399] Ms A threw her toast at the observation window and said: "*[m]ake sure you record this, I am going to get you bitch*". As a consequence Ms A ' telephone call with her lawyer was cancelled.

5 December 2019 – Ms A and Ms B recorded as being compliant

350. During early December Ms A and Ms B were generally compliant (with the occasional exception).[400] An offender note for Ms A dated 5 December 2019 recorded that during a visit from the Residential Manager, Ms A expressed frustration that staff failed to respond to the prisoners' good days:[401]

> She went on to express her frustration about being in D wing for 50 days. She said that staff forget all the good days they have and when they misbehave one day, everything gets taken away. She also went on to say that we don't want to come and talk to her. She was reminded that we come in the unit almost everyday and most of the time, we are told to either 'F' off or just yesterday she had just said, 'Record this, I am going to get you bitch'. She laughed and said, she was just angry and frustrated because her sister was sent away and that she didn't mean it.

396 At [A1186].
397 At [A1099].
398 At [A1102].
399 At [A1109].
400 There are no offender notes or incidents reports for Ms A on 1, 2 or 3 December 2019; Ms B has positive offender notes for 1 December [A1094] and 3 December [A1103] and no notes or incident reports for 2 December 2019.
401 At [A1119].

9 December 2019 – Ms A and Ms B refused to remove paper from their windows and did not receive meals

351. An offender note from the morning of 9 December 2019 recorded that Ms B was "*very agitated and upset … She expressed that she was over being compliant and good because it wasn't getting them anywhere*".[402]

352. An offender note recorded that Ms A appeared to be angry because she was only being given one piece of paper at a time: although Ms B and Ms A had generally been behaving well, they were required to return a piece of paper before another was issued.[403] Ms A became abusive and said "*I'll waste you bitch*" to the Senior Corrections Officer. When staff went to serve dinner both Ms A and Ms B had covered their observation windows with paper.[404] When asked to remove the paper so staff could serve dinner, Ms A replied "*I don't care about my fucken dinner just turn my light off*". Staff disengaged and neither wāhine received dinner.

353. Offender notes recorded that on 10 December neither Ms B nor Ms A received breakfast because they would not remove papers off their observation windows.[405] It looks from the offender notes for Ms A that she may not have received lunch either, which would make three meals in a row.

10 December 2019 – Ms A smashed her cast

354. Offender notes from 10 December 2019 recorded that Ms A refused to go to a medical appointment for her cast to be checked. She smashed her cast herself and then pressed her emergency button asking for the nurse. She was escorted to High Medical for assessment, and then escorted to Middlemore Hospital. Ms A was compliant in going to High Medical and hospital and was given dinner on return.

11 December 2019 – Ms B removed the paper on window

355. Offender notes for Ms B dated 11 December 2019 suggested that she did not receive breakfast or lunch because of the paper over her windows (she woke up to find staff removing it and became verbally abusive). In the afternoon Ms B removed the paper. "*[s]he expressed that she was over everything and having nothing in her cell*". However, there is a retrospective note that was entered on 11 December 2019 recording that Ms B had been compliant and received three meals.[406]

12 December 2019 – The last MDT meeting until 9 January; Ms B's and Ms A' management unchanged during this period

356. On 12 December 2019 the ARWCF the MDT for Maximum Security (Management Unit) met. It did not meet again until 9 January 2020, which meant that no significant decisions for these wāhine were made, including whether to transfer them out of Separates cells.

357. From this period Ms B's and Ms A' situation was essentially unchanged:

357.1 The offender notes for December 13, 14 and 15 2019 do not record any issues of non-compliance for either prisoner.[407]

357.2 The offender notes for Ms B and Ms A on 16 December 2019 recorded both prisoners raising the same issues with the Principal Corrections Officer: they did

402 At [A1137].
403 At [A1134].
404 The offender note for Ms B is at [A1135].
405 At [A1138] and [A1139].
406 At [A1142]. In response to a draft copy of this report, Ms B said that some staff would give her meals without requiring her to lie down at the back of her cell.
407 At [A1147], [A1148], [A1149], [A1150], and [A1151].

not want to lie on their stomach with their legs and arms crossed every time the food hatch was opened; they wanted a whole roll of toilet paper; they wanted ordinary bedding instead of ISU blankets.[408]

357.3 The offender notes for Ms A on 17 December 2019 are positive.[409] Ms B was quiet in the morning, and declined to see her Case Manager, saying "*she did not want to be seen today*".[410] Ms B became abusive when dinner was being served, but when staff asked over the intercom whether she wanted dinner she said she did and was otherwise compliant.[411]

17 December 2019 - Ms A and Ms B given a transition plan document for moving back to C Wing before Christmas

358. The first reference to the transition plan was in a response dated 17 December 2019 to a PC.01 complaint from Ms A, registered on 1 December 2019. Ms A wrote:[412]

> Why do we have a Mngmnt plans if not everything is on it. Like wen we come out of our rooms we have 2 get on our knees& cuffed behind da back. Not allowed to have Our own shoes to wear. Our Toiletvies to be dispenced in little poddels. I want to be refunded 4 my Toiletvies iv bought & they just sit. I don't like that the camera can see us strip our clothes of in order to get clean uniforms. I feel paranoid. Why is cleaning &Sanitary items drip fed to us. But most of all know staff interaction with us is disgusting & wrong. Your management plan is not True & Correct.

359. In the response, the "Agreed Action" recorded that on 17 December 2019 the Residential Manager discussed with Ms A that staff are "*[w]orking on a plan to transition to C Wing where [her] management plan will be amended as she has been incident free for a week*".[413] Ms B was also given a copy of the plan.[414]

360. Other than the discussion about the transition plan, the situation of the wāhine was largely unchanged:

360.1 On 18 December 2019 Ms A' Case Manager brought some crosswords to keep Ms A busy, but staff advised these could not be provided until Ms A moved back to C Wing, as the paper could be used to block the windows.[415]

360.2 In a conversation with the Residential Manager, Ms B was asked about the rings, but she was adamant that she no longer had them and that "*they were taken when a strip search was conducted*".[416] This is consistent with the last offender note to mention the rings, which was on 1 November 2019, and recorded that staff had removed two rings during a search of Ms B's cell.

360.3 Ms B was unlocked on 19 December 2019 for a meeting with the Principal Corrections Officer and Senior Corrections Officers about the rings. Ms B was adamant that she no longer had them and that they were taken by staff.[417]

360.4 On 20 December 2019 Ms A and Ms B declined both breakfast and lunch but Ms A was compliant when asked to sit on the bed facing her window before

408 At [A1152] and [A1153].
409 At [A1154].
410 At [A1156], [A1157] and [A1158].
411 At [A1155].
412 At [A1090].
413 Although the offender note suggests this conversation happened on 18 December 2019: at [A1160].
414 At [A1162].
415 At [A1159].
416 At [A1161] and [A1162].
417 At [A1164].

dinner was served.[418] Both Ms A and Ms B expressed anger about the mixed messages they had received about moving to C Wing before Christmas.[419] They were advised that staff hoped they would be moved before Christmas but the decision was dependent on each person's behaviour. Offender notes for both wāhine end "*Prisoner expressed her despair but PCO informed her to be patient*".[420]

360.5 On 21 December 2019 offender notes recorded that when staff offered Ms A breakfast she responded by saying "*fuck off*".[421] The note recorded two further attempts to offer her breakfast but Ms A did not respond. An offender note for Ms B recorded that she was given her breakfast and was compliant.[422] She asked staff to give Ms A her breakfast, and staff replied that they would not tolerate being told to "*fuck off*". Staff then left, and a few minutes later it was observed that Ms B had thrown her cereal and toast out under her door.

360.6 On 22 December 2019 neither wāhine received breakfast.[423] The offender notes for both wāhine recorded that they had been "*hardly responding to staff for 2 days*". Later, Ms A called on her intercom asking for a book and a shaver. The Corrections Officer responded that this would be discussed with the team, Ms A said "*come on [redacted] we are depressed, we need this*". It was decided that giving prisoners who said they were depressed shavers was not a good idea. When this was communicated to Ms A, she said "*I'm depressed but not in that way*". Both wāhine received their lunch.

23 December 2019 – Wāhine advised they would not be moved before Christmas

361. On 23 December 2019 the Residential Manager told Ms B and Ms A that the transition plan for moving the wāhine out of the Separates cells and to C Wing had not yet been approved. The Residential Manager apologised.[424] The offender notes record that:[425]

> This news made Ms A very upset and she voiced her frustration. She became emotional while expressing her frustration. She is concerned that her partner talks about having negative feelings because they have nothing in D wing. She said if something happens to her partner, she will blame all the staff.

362. A further offender note recorded that Ms A "*says she wants to move and that she can't take it anymore, says she has been good prisoner began to cry while speaking to staff*".[426] Ms B "*became very quiet after voicing her frustration*".[427]

Post-Christmas

363. There are no offender notes for 24 or 25 December 2019, although Christmas Day is a high risk period for prisoners, who are isolated from family. There is a retrospective note on 28 December 2019 recording that when Ms A "*was asked if she'd called her children for Christmas, she replied she hadn't because she only had one telephone call she*

418 At [A1165] and [A1166].
419 At [A1165]
420 In response to a draft copy of this report, Ms B said that she agreed with the accounts during this period, and notes that "she became uncommunicative and emotional during this time". She described "not wanting to live and feeling desperate during this time".
421 At [A1167].
422 At [A1168].
423 At [A1169] and [A1170].
424 At [A1173].
425 At [A1173].
426 At [A1173].
427 At [A1175]. See also the offender note at [A1174]: "*She went very quiet and withdrawn when asked if she had anything else to say She repeatedly stated that she was over everything*".

didn't want to pick one child to call and the others miss out".[428] From after Christmas Day, the prisoners appear compliant:

363.1 On 26 December 2019 Ms A declined yard time (as she often did) but this time the officer encouraged her to have yard time, and opened the yard slightly for fresh air.[429] Ms A asked for new books to read. Ms B declined yard time, but after encouragement requested to have the door opened for fresh air.[430]

363.2 On 28 December 2019 retrospective offender notes recorded that both wāhine received their three meals and had their yard time.[431]

363.3 On 29 December 2019 both wāhine were seen reading their books in the sun.[432]

363.4 On 30 December 2019 Ms A asked for an update on moving to C Wing.[433] She was told that with the holidays there probably would not be an update until next week. Ms A "*replied that she feels like she is about to lose it*". Ms B "*wasn't abusive towards us she just wanted to be left alone*".[434] She talked to staff through the door but "*admitted that she was too angry to look at us through the window and talk to us*".[435]

363.5 On 31 December 2019 Ms B asked if she could have the stereo in the yard to save staff coming in and out to change the cassette tape.[436] Staff advised that the stereo would remain in the wing. This suggests staff had provided a stereo in the wing outside the Separates cells with an extension cord to keep Ms B and [redacted] Ms A entertained.

363.6 On 3 January 2020 Ms B agreed to meet with an Intervention and Support Project Team (ISPT) mental health nurse but changed her mind while the nurse was on the way to the Management Separate Unit and declined to meet.[437]

363.7 On 5 January 2020 Ms A asked for a bucket of water and a scrubbing brush to clean her yard as there were a lot of bird droppings in it.[438] The offender note recorded that she has been mostly reading books, which staff were providing one at a time.

363.8 On 6 January 2020 Ms A was on unlock for some telephone calls, and while walking back to her cell she sat down in front of Ms B 's cell window.[439] [redacted] Ms A said she was "*just having a moment and to just let her see her girlfriend*". When asked again to get up and get locked she did so without any further incidents. [redacted] Ms B asked a lot of questions with regards to moving cells, and staff replied that "*all is dependent on their behaviour*".[440]

363.9 On 8 January 2020 Ms A asked for the newspaper, which staff provided and which Ms A returned, and which became a regular occurrence.[441] From this point Ms A and Ms B appear to have spent significant time reading, including the newspaper, listening to music played on the cassette outside their cells, and they

428 At [A1181].
429 At [A1178].
430 At [A1179].
431 At [A1181] and [A1182].
432 At [A1183] and [A1184].
433 At [A1185].
434 At [A1187].
435 At [A1186].
436 At [A1189].
437 At [A1192].
438 At [A1194].
439 At [A1195].
440 At [A1196].
441 At [A1198].

were provided with printed out separate chess boards so they could play each other calling out their moves.[442]

9 January 2020 – Ms A and Ms B provided letter for MDT meeting

364. On 9 January 2020 Ms A and Ms B provided a letter on behalf of both of them to be read at the ARWCF MDT Maximum Security (Management Unit) meeting (**MDT meeting**), which was read out at meeting:[443]

> We feel that we are well and finely ready to move with ourselves. We cant show you unless you let your leash on us loose. We have colourful past of bad behaviour an all that we wish to leave behind us. We have anti social behaviours because we really are only confine to ourselves an trusting anyone but ourselves is a huge struggle all knowledge of interacting with other is real hard in our case cause we have lost all ability to believe an trust in other because we don't no how to react to other humans. all were basically asking is for help of some sort to bring some humanity back an to feel safe in the environment that you's are creating were well an truly ready an we want so much to feel like apart of society where our minds aint in turmoil in this of the grid having nothing, no hope, no aspiration negative wing. please move us an help us regain the ability to no how to trust the structure an environment we live in thank you Ms & Ms A

365. Unfortunately, the MDT minutes for 9 January 2020 that have been provided to the Inspectorate are almost entirely blank.[444] Afterwards Ms B said "*she wasn't happy with the outcome of the MDT meeting. She had been expecting a confirmed date for the movement to C Wing*" but there was no aggression towards staff.[445] It appears that management staff at the MDT meeting remained concerned about Ms B's rings, although staff had removed rings during a search of Ms B's cell on 1 November 2019.[446]

10 January 2020 – Ms A and Ms B advised that MDT remained concerned that wāhine retained rings; wāhine volunteered to be strip searched

366. On 10 January 2020 complaints from Ms A and Ms B were registered. It can be inferred from the complaints that the prisoners had been advised after the MDT meeting that management staff were concerned that both wāhine remained in possession of Ms B's rings:

366.1 Ms A stated in her complaint that "*I dont know how else to reassure [staff] that I dont have any other than Voluntary to do a strip search & go thru the metal Dector this is NOT RIGHT we have been housed in D Wing like this for over 80 days now, We have been complying & yet again we can not move forward for 2020 bekoz off the above*".[447]

366.2 Ms B stated in her complaint that "*We spoke about this 3 weeks ago an i told our manager an p.c.o. then that i have no longer got rings on my person. i have told them then that i would do a voluntary Strip an be placed around the metal detector in order for reassurance to staff pco manager …*"[448]

366.3 In response to the complaints, staff agreed to search the prisoners as they had suggested. This occurred on 15 January 2020. No rings were found.[449]

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442 At [A1210].
443 At [A1200].
444 At]A1203].
445 At [A1202].
446 The rings are referred to in an offender note for Ms A after the MDT meeting: [A1200].
447 At [A1204].
448 At A1208].
449 At [A1221].

366.4 Staff did find a small metal object in the gap in Ms A ' yard door, like the piece of metal in the cell sprinklers.[450] An incident report recorded that each of Ms B 's and Ms A ' cells had a small hole dug into the wall, about 3-4cm deep.[451] A misconduct charge was filed against Ms B , which was withdrawn at the request of the charging officer because of "*insufficient evidence*".[452]

366.5 After the search on 15 January 2020 management of the wāhine in the Separates cells continued unchanged. Ms B and Ms A appear to have been compliant. Ms A read the newspaper on 18 January 2020 and both prisoners cleaned their cells and had time in yard on 19 January 2020.[453] On 20 January 2020 Ms B refused her yard time.[454]

21 January 2020 – Ms B self-harmed

367. On 21 January 2020 incident reports recorded that at approximately 12.58pm staff heard Ms A yelling and banging on the window to check up on prisoner Ms B as she had not responded to Ms A .[455] Staff looked inside Ms B 's cell and saw that she was lying on her back in the shower area. Staff [redacted] she was placed in the recovery position and was conscious; she sat up and spoke with staff before moving. Staff escorted Ms B to the ISU. Ms B resisted and staff responded with a spontaneous use of force. Ms B kicked at an officer, connecting with the officer's left shin. A misconduct charge was filed, which was withdrawn on 18 February 2020 because no adjudicator had been available. One of the officers drew but did not deploy their pepper spray when Ms B had come out of her cell but refused to let handcuffs be placed on her.

368. At-risk prisoners admitted to the ISU must be strip-searched.[456] [redacted][457] She stood up, but became non-compliant again. Staff then restrained Ms B [redacted]

369. Ms B was seen by a clinical psychologist following her transfer to the ISU.

370. At 3.35pm a Review At Risk Assessment was completed for Ms A in the ISU. She said [redacted][458]

371. Both Ms B and Ms A were discharged from the ISU on 22 January 2020 and returned to their Separates cells. Ms A was placed in Ms B 's previous cell. It is not clear why this occurred, but it was not appropriate to place Ms A in the cell in which her partner had self-harmed on the previous day.

372. A special MDT meeting was convened on 22 January 2020, in addition to the scheduled meeting on 23 January 2020.

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450 At [A1221.
451 At [A1221].
452 At [A1224].
453 At [A1233], [A1235] and [A1236.
454 At [A1237].
455 At [A1243]. In addition to the incident reports and offender notes, the Inspectorate viewed CCTV and OBC in relation to this incident.
456 See the Prison Operations Manual S.01.Res.11.01(1): "All prisoners *must* be strip searched in the following events ... At-risk prisoners must be strip searched each time they enter an at-risk cell".
457 At [A1246].
458 At [A1238].

23 January 2020 – management of the prisoners after Ms B self-harmed

373. After Ms B 's self-harm, the Residential Manager spoke with Ms B about her motivations:

373.1 On 23 January 2020 Ms B was visited by the Residential Manager and the Principal Corrections Officer, who asked Ms B *"why she did what she did a few days ago and her reply was 'she is just over it'"*.[459]

373.2 On 24 January 2020 both prisoners met with the Residential Manager, Principal Corrections Officer and others to review their management plans.[460] Ms B apologised to staff who found her in the cell. The offender note stated:

> She was very open and honest about the reasons why she got to that stage. She has never in her time in prison since she was 18 years old ever felt this way until now. She has never been suicidal but felt she had nothing to live for anymore. She is frustrated with not having anything to do each day. She feels that no matter how much they comply with the rules, nothing changes for them or it feels like nobody cares about her and her partner. She explained that going to ISU the other day made her realise what she is missing out on being in seclusion. She was excited to see all the carvings, paintings, plush carpet, big screen tv and fish tank in the ISU. She feels disconnected to what is happening out of Management especially without a tv or radio.

374. ARWCF's management of Ms B and Ms A continued broadly unchanged after Ms B 's self-harm. The wāhine went back to their December-January routines of reading library books and occasional telephone calls. On 26 January 2020 two PC.01 complaints from Ms A were registered. One noted that she had moved to D Wing voluntarily on 22 October 2019.[461] Three PC.01 complaints from Ms B were registered.[462] On 8 February 2020 Ms B asked if staff could assist her with a book of poems folded into the shape of a heart as a Valentine's gift.[463] On 13 February 2020 both prisoners were transferred to C Wing.

459 At [A1260].
460 At [A1261] and [A1263].
461 At [A1266].
462 At [A1268].
463 At [A1317] and [A1318].

Specific areas of concern

De facto cell confinement and segregation

Relevant sections of the Complaint Letter and the Sentencing Decision

375. The Complaint Letter stated that:

> We understand that Ms B and Ms A are not under formal segregation, nor have they been sentenced to cell confinement as a result of a disciplinary hearing. However, we are instructed that they are being held in cells that are normally used for cell confinement, and it is noted in their management plans that they are being held in the Management Unit. The regime is strikingly similar to a cell confinement regime, without any of the natural justice requirements of a disciplinary hearing (where the sentence of cell confinement would be finite) and with an intention to retain these women on this regime indefinitely. It appears that the rationale for retaining them on the regime has also changed, and we have concerns around the factual basis for ARWCF's treatment of these women.

376. The Sentencing Decision dealt with this issue as follows:

376.1 The legal basis for the conditions in which Ms B was held was not legally clear.

376.2 A penalty of cell confinement may be imposed for up to seven days by a Hearing Adjudicator if a prisoner has committed an offence against discipline. A Visiting Justice has jurisdiction to impose cell confinement for up to 15 days. However, Ms B was not held as a result of a lawful penalty of cell confinement, which in any event could only have been for a maximum duration of 15 days.[464]

376.3 Prisoners may have opportunity of association restricted or denied in accordance with ss 58-60 of the Act, but there is no evidence that a segregation order was in force in respect of Ms B. If such an order was in place it was in breach of the Act because no reasons had been given.[465]

The Investigation

377. The Management Unit consists of two wings known as C Wing and D Wing, separated by a single guardroom.

378. C Wing is intended to be used for prisoners on forms of directed segregation[466] and those classified as maximum security. The wing has one exercise yard and two prisoner telephones, one of which was removed from the common wing area and placed in an interview room to enable prisoners to access the telephone without associating with other prisoners.

379. D Wing,[467] also known as Separates, is designed for housing prisoners sentenced to cell confinement by a Hearing Adjudicator or Visiting Justice following a disciplinary hearing. This is because the cells lack a general power outlet. Regulation 67 requires cells, "*so far as is practicable in the circumstances*" to have the items specified in Part C of Schedule 3, which includes a general power outlet; whereas Regulation 157 does not have the same requirement for cells used for cell confinement. Accordingly, prisoners in D Wing have no television or radios. There are more limited opportunities for constructive

464 At [71]-[72].
465 At [73]-[77].
466 Pursuant to s 58(1)(a) & (b) and s 59(1)(b) of the Corrections Act 2004.
467 Pursuant to Schedule 6 - items and features of the cell used for penalty of cell confinement.

activities and/or programmes and education. Individual yards are attached to each cell and accessed by an electronic sliding door.

380. As detailed in the narrative section:

380.1 The three wāhine were moved to D Wing, on the basis of an escalation in non-compliant behaviours, setting fires and activating the sprinklers.

380.2 The rationale for using the Separates cells was primarily:

380.2.1 to restrict access to electricity, as power points were being used as an ignition source;

380.2.2 to restrict their ability of wāhine to activate sprinklers as they are located higher; and

380.2.3 to enable the wāhine to receive their minimum entitlement to exercise, through access to the D Wing yards, due to the unsuitability of the C Wing yard for maximum security prisoners and the presence of other prisoners in C Wing;

380.3 Ms B said she was initially told that she would be there for seven days but then staff told her that it depended on her behaviour. The management plans for the wāhine came to include a condition that the prisoners were to be held in the Separates cells "*indefinitely*".

380.4 Staff told Inspectors that initial placement in the Separates Unit was intended to be short term, and reviewed weekly. The continued placement was intended to be contingent on their behaviour and compliance with orders.

380.5 Ms B spent a total of 125 days in the Separates Unit without any sentence of cell confinement. This meant that she also spent a total of 125 days without any permitted association despite the absence of any directed segregation order.[468]

380.6 Ms A spent a total of 122 days in the Separates Unit without any sentence of cell confinement. This meant that she also spent a total of 122 days without any permitted association despite the absence of any directed segregation order.[469] There was a three day period of denied association in which there was a directed segregation order in place.

380.7 Ms C spent a total of 60 days in the Separates Unit without any sentence of cell confinement. She also spent a total of 58 days without any permitted association despite the absence of any directed segregation order.[470] However, there is a possibility she was serving five days' cell confinement during the period 31 May 2019 to 6 June 2019, in which case the total was 55 days and 53 days respectively.

381. In my view these represent major departures from appropriate prisoner management.

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468 This does not include time spent in the Management Unit after her directed segregation order expired, or time spent in C Wing when she was required to take her yard time in D Wing, which may have impacted on her ability to associate with other prisoners of the same classification. The evidence is unclear on these aspects and the Inspectorate makes no findings on these points.

469 This does not include time spent in C Wing when she when she was required to take her yard time in D Wing, which may have impacted on her ability associate with other prisoners of the same classification. Nor does it include time relating to Ms A ' allegation on 26 September 2019 that she was kept in her cell for more than 24 hours. The evidence is unclear on these aspects and the Inspectorate makes no findings on these points.

470 This does not include two days in February 2019 during which Ms C was managed on directed segregation before the order was formalised. It also does not include time in April 2019 when Ms C was reclassified as a maximum security prisoner, during which it is possible she was unable to associate with the one other maximum security prisoner, or time on 24 May 2019 when Ms C was moved to D Wing temporarily. It does not include time spent in C Wing when she was required to take her yard time in D Wing. The evidence is unclear on these aspects and the Inspectorate makes no findings on these points.

382. As discussed below in relation to the complaints process, the wāhine themselves considered that they should not have been in D Wing when they were not on a cell confinement order. They submitted formal complaints raising this. For example, [redacted] Ms B made a complaint on 26 October explaining that she had read the relevant parts of POM on the electronic kiosk in the unit, and that she should not be in cell confinement because there was no general power outlet:[471]

> We have been housed in the Cell confinement unit D Wing, where there are no power Outlets and We have been told we are to live here till further notice. On the kios it states that bylaw we due to be housed long term where power Outlets are available here in Dwing management there are no power Sockets and it is Cell confinement day in day Out.

383. The situation appears to have arisen for various interrelated reasons. These are not listed by way of excusing what occurred, but because they are relevant to understanding and improving prison processes:

383.1 The absence of segregation documentation appears to have been due to the fact that the wāhine were classified as maximum security and the prison management's misunderstanding that the segregation documentation was not required.

383.2 This may be because non-association can often occur in practice solely due to the practical operation of the maximum security classification:

383.2.1 Historically, women were not able to be classified maximum security.

383.2.2 The classification was introduced in 2009, with the Management Unit at ARWCF being designated to house all maximum security women prisoners in the country. During the review period there were never more than six maximum security prisoners, so in practice at best the wāhine had limited other prisoners with whom they could associate.

383.2.3 The usual reason for maximum security classification of women prisoners is violent and aggressive behaviours towards other prisoners and/or staff. It is not unusual for wāhine classified maximum security to ask not to associate with each other. In this case other wāhine advised staff that they did not want to associate with Ms B and Ms A, and staff were concerned about the influence Ms B and/or Ms A had on the other wāhine.

383.3 The failure of staff to recognise that the Separates Unit is reserved for cell confinement appears to be a matter of prison staff not understanding the requirements of the Regulations. Given the number of senior staff who were aware that these cells were being used, this is a matter of significant concern.

384. Whatever the reasons, each of the three wāhine was managed for a significant period under a regime that ought only to have applied where directed segregation and cell confinement orders were in place. This should not have been able to occur.

Access to information and news

385. Section 69 of the Corrections Act sets out minimum entitlements that every prisoner has. These include:

> (i) to make outgoing telephone calls, as provided for in section 77(3);
>
> …

471 At [A864].

(k) access to information and education, as provided for in section 78.

386. The prisoners' entitlement to access information and news is set out in s 78(1):

(1) A prisoner is entitled—

(a) To reasonable access to news:

(b) So far as is practicable, to access to library services:

(c) To access to further education that, in the opinion of the prison manager, will assist in—

(i) his or her rehabilitation; or

(ii) a reduction in his or her reoffending; or

(iii) his or her reintegration into the community.

387. Access to information and news affects prisoners in a number of ways. Without access to the news the prisoners are unaware of what is happening beyond the prison, exacerbating their sense of isolation, and making it harder to reintegrate into the community after release. Access to information includes the provision of education, which is fundamental to the rehabilitation of prisoners. The statutory purposes of the corrections system in s 5 of the Act include to:

… improve public safety and contribute to the maintenance of a just society by—

…

(d) assisting in the rehabilitation of offenders and their reintegration into the community, where appropriate, and so far as is reasonable and practicable in the circumstances and within the resources available, through the provision of programmes and other interventions …

388. The ability of the wāhine to access information and news was limited in two ways:

388.1 There is evidence that during the review period, the wāhine were advised they were unable to undertake programmes because they had been classified maximum security. For example, on 9 April a complaint was submitted by Ms C that she had been removed from the programme she had been completing at CWP. The response was that Ms C "*was advised that whilst she maintains a maximum security classification, that she will not be able to carry out any programmes on her sentence plan*".[472] In the management plans of the wāhine there is a statement that each wāhine "*shall not be allowed access to any programmes or education that require her to come out of her cell*". However, Ms A was able to commence distance learning Level 4 Certificate in Creativity and Art through Learning Connexion, which I understand included telephone calls with a tutor.

388.2 The wāhine's ordinary means of accessing news – radio or television – was removed when they were placed in D Wing, including (for Ms A and Ms B) from October through to February. On 8 January Ms A was provided a newspaper at her request; this appears to have become a frequent occurrence.[473] But there is no evidence of newspapers being provided before 8 January, and given the restrictions placed on prisoners receiving paper that appears unlikely. Ms B and Ms A may have had some limited access to the radio when staff played the stereo from outside their cells in the wing, but the earliest reference to this is 31 January, and the reference in the offender notes to the request to staff to change tapes suggested it

472 See also at [A569], where on 2 September 2019 in the context of a discussion about changing Ms B 's Case Manager, the Principal Corrections Manager asked Ms B *"what she would do to work towards lowering her security classification so she will be able to complete programmes*". Cf the offender note on 17 September 2019 for Ms A , who is able to study through correspondence a Level 4 Certificate in Creativity and Art through Learning Connexion: at [A594].

473 The offender note records that Ms A *"asked unit staff if she could read the newspaper then return it to staff when she's finished. This was given and collected later*": at [A1198].

was used for music and did not provide access to the news.[474] In response to a draft copy of this report, Ms B said that she was not aware that there was a pandemic, nor that Whakaari/White Island had erupted.

389. ARWCF's improper use of the Separates cells prevented the wāhine from receiving their minimum entitlement to access the news through radio or television. Other than providing a newspaper to Ms A from 8 January the investigation has not established that any other steps were taken to provide reasonable access to news. This can only have heightened their sense of isolation, particularly in combination with their inability to associate or to make more than weekly telephone calls, and that staff felt they were unable to engage with the prisoners (discussed further below).

390. Restricting the wāhine's access to programmes likely reflected the impracticality of facilitating a group class for a maximum security prisoner. But more effort should have been made to provide education for maximum security prisoners, which could have included by audio-visual link. It is especially concerning that Ms C was advised that she could not participate in a programme shortly after she was reclassified as a maximum security prisoner, as she was effectively told she would not be undertaking any programmes for the next six months. The inability to participate in programmes impacts on a prisoners' potential for reintegration at the end of her sentence, and makes it more difficult for her to show progress at any Parole Board hearing.

Complaints

391. As this investigation has highlighted, it is important for prisoners to be able to raise issues about their management and have those concerns appropriately considered and responded to. Compliance with the complaints process was poor throughout the review period. This is particularly unfortunate as the prisoners raised many of the issues in their complaints that have formed the conclusions in this report. The prisoners themselves provided staff with multiple opportunities to reflect on whether ARWCF's management of the prisoners was appropriate.

The prisoner complaints process

392. There are prescribed processes in POM for how Corrections staff are to respond to prisoners' complaints. These include:

392.1 If a complaint cannot be resolved informally, the prisoner must be given a copy of the PC.01.Form.01 Prisoner complaint.[475]

392.2 When the PC.01.Form.01 has been completed, the staff must register the complaint in IOMS and provide the IOMS generated complaint registration form within 24 hours of the complaint being received.[476]

392.3 The prisoner must be interviewed within three working days of the complaint being registered in IOMS.

392.4 Prisoner complaints about staff conduct and attitude must be referred to the Prison Director under POM.[477] It is standard practice for this to be recorded in the response section.

474 At [A1189].
475 PC.01.03.
476 PC.01.06(3).
477 PC.01.07, paragraph 5(a).

392.5 If the complaint alleges assault by staff on a prisoner, the allegation must be managed as per the instructions set out in IR.07 of POM, which may include monitoring by the Inspectorate.

How prisoner complaints were managed at ARWCF

393. There was widespread failure to comply with a number of the requirements:

393.1 On a large number of the PC.01 complaints, the prisoner was interviewed weeks after the complaint was submitted, in breach of the requirement to interview within three days.[478]

393.2 A number of PC.01 complaints included allegations of staff assault. Some of these were not managed under the IR.07 process. The Inspectorate determines which IR.07s will be monitored to ensure the site has appropriately managed the complaint through the IR.07 process.[479] An opportunity for oversight from the Inspectorate was potentially lost because the appropriate process was not followed (there was a good example of how the IR.07 process can provide important oversight in relation to Ms C's complaint on 31 July 2019, where the Inspectorate identified administrative failings).

393.3 A number of the PC.01 complaints included allegations about staff conduct, but there is no evidence that they were referred to the Prison Director, as required. For example Ms C's 23 March and Ms A' 1 September allegations of staff assault both followed the IR.07 process, but there is no evidence that the complaints were referred to the Prison Director.

393.4 When staff register a complaint in IOMS, they must select a category of complaint. A number of complaints were registered under "other" rather than "staff conduct and attitude". This undermines the ability of the Department to extract data across prisoner complaints, for example what proportion of complaints involves staff conduct as opposed to property.

393.5 Ms A submitted a series of PC.01 complaints requesting the CCTV footage from the alleged staff assault on 31 August. The first was registered on 1 September, with follow up PC.01 complaints on 30 October and 1 December. She was not able to view the footage she had requested until 24 January. The delay was unreasonable and the reason given in the 1 December PC.01 form (that the manager who had processed the 30 October PC.01 form had left) was unsatisfactory.

393.6 At times the response to the complaint was inadequate, which may be related to the delay in attending to the complaint. For example, on 26 September Ms A complained that she had been locked in her cell for over 48 hours. The response was on 12 November (ie 47 days later) and simply said "*Prisoner has been spoken to and unfortunately incidents occurs which jeopardies the safety of all which then impacts the unlock regime of the units*".

393.7 In addition, all three of the wāhine raised issues that staff were not promptly registering the PC.01 complaints in IOMS. This investigation did not include a review of the hard copy complaints, which would be needed to compare the date of the complaint with the date of registration in IOMS. However, the content of some of the PC.01s and the responses are arguably inconsistent with the registration date,

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478 On 26 September 2019 a complaint by Ms C was registered in IOMS, that she was left in wet clothes for eight hours after a sprinkler activation on 24 September 2019. She was interviewed on 12 November 2019, a month and a half later.

479 For example, Ms A' allegation that on 2 August 2019 that a staff member caused her to have a black eye, Ms B's complaint on 23 June 2019 that a staff member had pushed down on her shoulder with his knee.

suggesting that is possible that complaints were not registered within the required 24 hour period.

The impact of not following the complaints process

394. Responding to complaints promptly and correctly is of critical importance to ensure proper unit oversight. These prisoners complained repeatedly (and justifiably) that they should not be in Separates cells. For example:

394.1 On 6 October Ms C complained that she had been left in "*D-wing (pound) with No paperwork, We are Not on CC's or LOP's [cell confinement or loss of privileges*]". The response was dated 12 November.

394.2 Ms A complained on 26 January that "*How is it that iv veen housed in D-Wing since 22.10.2019 & I moved here 'Voluntaringly'*". Ms A was interviewed on 5 and 10 February.

394.3 Ms C was placed in a Separates cell on 31 May in response to a sprinkler activation, where she stayed until 6 June. She made two complaints that she should not be in a Separates cell. One was registered on 2 June, but the response simply noted it was a duplicate of the other complaint, which was registered on 7 June.

395. The lives of prisoners, particularly maximum security prisoners, are dictated almost entirely by the staff responsible for their management. Oversight of unit staff relies on compliance with the detailed complaints process established by the Department.

396. The failure to properly respond to the complaints of the wāhine may have heightened their sense of isolation. Some sense of this appears in Ms A' complaint on 5 December that her previous PC.01 complaints were not registered or responded to:

> Why have I not received any receipts about my PC – 01 I handed in on the 1st of 12th 2019. I handed in 3 PC01 & im over filling them in over & over & not receiving a receipt. Or answers. What is the point in filling these forms out when we still don't a Answer.

Misconduct charges

397. The Corrections Act sets out a formal process for the hearing of disciplinary offences, involving a hearing with a corrections prosecutor and a hearing adjudicator. POM requires that charges must be heard within 14 days (with an ability to apply for an adjournment).[480] During the review period, misconduct charges were frequently withdrawn because no prosecutor or adjudicator was available within the required timeframe. The unit ultimately stopped filing misconduct charges. This removed a level of oversight as the wāhine were not brought before the hearing adjudicator. The lack of a working formal disciplinary process, with consequences for wāhine who offended, imposed following due process, may have facilitated informal ad hoc responses to challenging prisoner behaviour.

The statutory process for disciplinary offences

398. The Corrections Act in ss 128-131 sets out a range of disciplinary offences addressing misconduct by prisoners. Where corrections officers consider that a prisoner has engaged in conduct amounting to a disciplinary offence, the Department may file a charge, which will be prosecuted by a corrections prosecutor before a hearing adjudicator, who can impose penalties of cell confinement up to seven days, loss of privileges up to 28 days, and forfeiture of earnings up to seven days. The prisoner may

480 MC.02.01.

appeal their conviction and/or sentence to the Visiting Justice (the Visiting Justice has jurisdiction to impose cell confinement of up to 15 days and 90 days' loss of privileges).

The use of misconduct charges at ARWCF

399. At the commencement of the review period, misconduct charges were routinely filed as part of a response to prisoner misconduct, and there are a number of examples of the charges following the normal process, including appeals to the Visiting Justice. However, on 29 July a misconduct charge against Ms C was withdrawn. It had been originally filed in response to an event on 29 June where it was alleged that Ms C threw her cup of water at two corrections officers. The reason given was that no adjudicator had been available within the required timeframe and prosecutors had been redeployed.

400. This became a repeated pattern. For example, between 10 July and 23 October Ms A was charged with misconduct 13 times, but each charge was withdrawn because the required time period had lapsed, either because there was no adjudicator available and/or prosecutors had been redeployed. Ms A was not charged with misconduct between 23 October 2019 and 15 January 2020. On 23 October a charge was filed against Ms B for failing to comply with a staff direction when a meal was being delivered, but was withdrawn on 12 November 2019 as there were no hearing adjudicators available and the site prosecutors had been redeployed. No further charges were filed against Ms B until 15 January 2020.

401. Throughout the review period, there are examples of behaviour where a misconduct charge could have been filed but was not. This includes examples of serious threats and assaults against staff where the absence of a misconduct charge is especially surprising. No misconduct charges were filed for the following:

401.1 On 13 April, it was alleged that Ms C was verbally abusive to an officer, punched the wall and kicked over a rubbish bin;

401.2 On 30 August it was alleged that Ms B threw a carton of rotten milk at an officer;

401.3 On 31 August it was alleged that Ms A attempted to kick and head butt the Senior Corrections Officer;

401.4 On 30 September it was alleged that Ms C punched an officer with a closed fist, and while being escorted to medical in a wheelchair, attempted to use her knee to hit a corrections officer;

401.5 On 1 October it was alleged that Ms B and Ms A refused to move cells for a cell search and offered hard resistance when officers responded with a planned use of force to relocate the prisoners.

402. No misconduct charges were filed during this period for a number of sprinkler activations: on 31 May, on 2 October, 16 October, and 19 and 20 November where the staff used the Cell Buster pepper spray in relocating Ms B and Ms A after the activation.

The effect of not using misconduct charges

403. Not filing misconduct charges removed a formal consequence for misconduct and a layer of oversight that is contemplated in the Act, with unfortunate consequences. Initiating the proper disciplinary process may well have made clear that these wāhine were already effectively under disciplinary confinement.

Use of force documentation and review

404. Whenever there is a use of force there must be a post incident review. During the review period it was not unusual for a use of force review to either not occur, not be recorded, or take place a significant time after the incident (although some reviews were completed in a timely fashion, and done well). Often the entry in the Use of Force Register lacked some of the requirements in POM (for example it was not signed by the Prison Director). The review requirement is designed to ensure that staff can learn from these potentially dangerous interactions, and that appropriate actions follow if staff actions were inappropriate. The failures to conduct proper reviews are of serious concern.

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

The Prison Operations Manual: post incident reviews and the use of force register

406. POM requires that where there has been a use of force, "*including individual carry pepper spray*", that there is a review "*as soon as possible after the incident*", by an officer nominated by the Prison Director.[481] POM prescribes that the review:

406.1 considers "*whether the situation was handled in the most appropriate way, what led to the situation, and what strategies need to be put in place to avoid future situations that lead to the use of force*";

406.2 covers "*what led to the incident, and what steps were taken to avoid the use of force (negotiation etc)";*

406.3 be "*documented and made available to any subsequent investigation*";

406.4 ensures that the "*underlying causes of the incident are identified, analysed and action planned to resolve or minimise cause*";

406.5 be "*forwarded to the regional commissioner for approval of planned actions, and to ensure follow up*";

407. The reviewing officer must place "*a record of findings in the Use of Force Register*" and inform "*the prison director of the findings*".[482]

Failures to conduct post incident reviews during the review period

408. At times during the review period it appears that no post incident review was completed. This includes after the spontaneous use of force on 23 March 2019 after the prisoner assault in the High Security Unit, which led to Ms C and Ms B being moved to the Management Unit and to Ms A being moved to the Motivation Unit. There is also no evidence that a post incident review was completed for the following spontaneous uses of force: on 24 September when Ms C punched an officer in the helmet, and on 14 October when Ms C charged at the door in an attempt to assault an officer with the door. The repeated failure to complete a review after a spontaneous use of force, whether in response to a prisoner assault against another prisoner or against an officer, is concerning and in breach of POM.

481 IR.05.07 "Post Incident Review".

482 This is paragraph 10 of IR.05.07, but IR.05.08 prescribes how the Use of force register shall be maintained.

Problems with the post incident reviews

409. Where post incident reviews have been conducted as required, the entry on the Use of Force Register often lacks some of the required details, for example, the Prison Director's signature or the person responsible. Other important details are sometimes inaccurate, for example, on the Use of Force Review on 2 October 2019 for Ms B , it records that MK9 pepper spray was used when only the Cell Buster pepper spray was used, and on 20 November a review for Ms C was completed even though no force was used, suggesting a cut and paste approach was sometimes taken.

Missing video footage

410. Where a planned use of force has been authorised, it must be recorded. There are planned uses of forces during the review period where we would have expected more video footage than was provided to this Investigation to have been recorded, and a copy downloaded to a secure electronic device and sent to the Tactical Operations Group coordinator. It appears that, if the use of force was filmed in compliance with POM, a copy was not saved as it should have been. This emphasises the importance of the post incident review, as this type of issue can be identified and addressed.

411. There is a good example of this on 1 June 2019: Ms B refused to go to her cell for lock, and officers responded with a spontaneous use of force. The use of force review was completed on 16 June 2019.[483] It notes that there had been no request to save the CCTV and OBC footage relating the spontaneous use of force.

412. The post incident review for the spontaneous use of on 1 October to relocate prisoners for a cell search lacks any video footage. The use of force review suggests that the footage was saved in the wrong place, but this was not remedied.

Use of force during the review period

413. While the failure to conduct reviews is of significant concern, the investigators were able to review many hours of footage, and it is important to recognise that:

413.1 Staff generally used force only as a last resort, even where a planned use of force was authorised early in anticipation that it may become necessary;

413.2 The video footage available to the Inspectorate confirmed that planned uses of force, including using pepper spray, usually followed a long period of asking for compliance (including for several hours before Cell Buster pepper spray was used on 20 November 2019);

413.3 Likewise, when staff cut off Ms B 's clothes before the post-suicide attempt strip search, staff did their best to persuade her to consent to the strip search first;

413.4 I have as yet found no evidence of any deliberate cruelty by staff.

Management plans

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

415. Management plans were in place, however some elements were in my view likely to be inappropriate or unnecessary.

483 At [A263].

Legal framework

416. Section 51 of the Act requires that the chief executive ensure prisoners sentenced to imprisonment for a term of more than two months have "*an individual management plan*". It must be "*prepared, and revised at regular intervals, in accordance with any instructions in the Prisoner Operations Manual*". Subsection (4) provides:

> Each plan must—
>
> (a) be based on an assessment of the needs, capacities, and disposition of the prisoner; and
>
> (b) make provision for the safe, secure, and humane containment of the prisoner; and
>
> (c) outline how the prisoner can make constructive use of his or her time in the prison (including, in the case of a person sentenced to imprisonment, ways of addressing offending behaviour and preventing reoffending); and
>
> (d) outline how the prisoner may be prepared for eventual release from the prison and successful reintegration into the community; and
>
> (e) include any prescribed matter required to be included in the plan by [POM]; and
>
> (f) be consistent with the resources available to the chief executive to manage the prisoner.

417. While s 51 contemplates a "management plan" covering prisoners' custodial management and a plan for prisoners' rehabilitation and reintegration (see subparagraphs (b) and (d)), in practice the Department's planning documents, called the "remand/offender plan", focussed primarily on rehabilitation and reintegration. There was a concern that such plans may not meet a potential interpretation of s 51 that one document should cover rehabilitation and custodial management.

418. Section 51 was therefore amended in October 2019 to expressly provide that "*[a] plan may comprise more than 1 document, and those documents may be kept in different physical or electronic locations*". The Regulatory Impact Statement prepared by the Department made it clear that remand/offender plans would continue to focus "*primarily on rehabilitation and reintegration*".[484] The offender plans for the wāhine housed in D Wing are separate from the management plans.

419. The only guidance in POM on management plans is for management plans for prisoners subject to directed segregation orders. This provides that "*[t]he plan must also show how the prisoner's minimum entitlements will be maintained and any other activity available within the unit (e.g. cleaning duties, unit's mess-man)*".

The management plans at ARWCF

420. The management plans provided to the Inspectorate are not well documented: they are often undated and in fact some of the templates used lack a space to put a date. Some of the management plans were signed off by the Residential Manager and the Deputy Prison Director, and some of the minutes of the MDT meetings set out the changes to the management plan, suggesting they were discussed at the meetings.

421. It is therefore not possible to be precise as to when conditions changed in the management plans. At Appendix E is a table setting out the wording of some of the conditions in an undated and unsigned management plan on Ms A' file. It has a review date of 31 October 2019, so, assuming a weekly review period, suggests that these conditions were in place by mid-October 2019 at the latest. They are representative of the other management plans that the Inspectorate has seen for the three prisoners during the period October 2019-February 2020 when the prisoners were in D Wing, and are consistent with many of the PC.01 complaints submitted by the prisoners. The conditions included the following items.

484 Regulatory Impact Statement: "Enhancing the Legislative Framework of the Corrections System" (16 October 2019).

421.1 Before food was placed in the food hatch, the wāhine was required to lie on her stomach at the back of her cell, interlocking her hands behind her head and placing one foot over the other with her legs bent at the knees.

421.2 If the wāhine did not comply, this was to be deemed a refusal and "the meal would not be offered again".

421.3 The wāhine was to have "no more" than one five minute call per week.

421.4 During the telephone call, the wāhine was to remain in handcuffs and staff were to dial the number and hold the telephone to the prisoner's ear.

421.5 Wāhine were to be provided with a non-destructible blanket (ie the same blankets as were used in the ISU).

421.6 The wāhine was to have a mattress with a built in pillow and would not be provided with a further pillow.

421.7 Before receiving yard time, the wāhine must have placed her bedding by the hatch. She was to then lie down, interlock her hands and bend her legs at the knees, and staff were to remove the bedding.

421.8 The yard door was to be opened only enough for the wāhine to step sideways through the door into the yard, and while the wāhine was in the yard the yard door was to be closed.

421.9 If during her yard time the wāhine came back into the cell to use the toilet, staff had the discretion whether to allow the prisoner to go back into her yard to complete her yard time.

421.10 The wāhine should not be allowed access to any programmes or education that required her to come out of her cell.

421.11 All wāhine movements were to done with a minimum of four staff.

422. The following conditions appeared in later iterations of management plans for [redacted] Ms A :

422.1 A management plan signed on 24 January 2020, states that "*jandals will be worn within the unit and to medical appointments onsite*" but that for external medical appointments "*shoes can be worn and returned to unit staff prior to getting relocked*". This is consistent with the PC.01 complaints from Ms B and Ms A registered on 1 December that their shoes had been removed.

422.2 A management plan signed on 24 January 2020, states that the prisoner "*is not to go out together in the yard the same time as other prisoners housed in D Wing*". Ms A was not the subject of a directed segregation order at that time, and this condition limited Ms A ' ability to associate without following the statutory process.

422.3 There is an undated and unsigned management plan that states that Ms A "*has been given permission to associate in the yard*". The plan states that the review date for Ms A ' security classification is 18 August 2020, suggesting the plan dates from February 2020 (review dates are every six months). Again, no permission was necessary because no order had been made directing Ms A to be segregated from other prisoners.

422.4 From a management plan signed on 4 November, it appears that Ms A was given ordinary non-ISU bedding for a period, but in a management plan dated signed on 27 November only non-destructible blankets are provided for.

Concerning aspects of management plans

423. There are a number of aspects of the conditions in the management plans that were not appropriate:

423.1 The way in which the prisoners were asked to lie down to receive food was not appropriate. When asked to do this on 4 October Ms B understandably said "*why do I have to beg for my lunch*". The requirement placed prisoners in a humiliating position and is not rationally connected to the risk presented by prisoners hanging their limbs out the hatches. The condition was briefly lifted but reimposed for Ms C on 15 November in response to Ms C charging at staff during the morning medication round although it is not clear how the condition is related to the risk of a prisoner assaulting staff when the cell door is open. The condition was reimposed shortly afterwards for Ms A and Ms B.

423.2 Refusing to provide food to prisoners who did not comply with this requirement was not appropriate. Section 72(1) of the Act requires that "*[e]very prisoner must be provided with a sufficient quantity of wholesome food and drink …*". It is not clear from the offender notes how often prisoners were not fed because they refused to comply, but the narrative makes it clear this was not uncommon.

423.3 The basis for the requirement that four staff be used for escorting a prisoner is unclear. Three staff is the usual maximum number for male maximum security prisoners, and this is the number recorded in ARWCF's unit desk file. Requiring four staff meant that staff were unable to go into the prisoners' cells until four staff had arrived. When Ms B self-harmed on 21 January, the incident reports state that "*as soon as we had the correct number of staff to unlock the cell was unlocked*".485 Video footage shows there were three staff there, and they waited for a fourth. While the delay on that occasion was very short, it highlights the risk of requiring an excessive number of staff before a cell door can be opened.

423.4 The insistence on non-destructible ISU bedding was disproportionate to the risk that prisoners might destroy bedding to create fishing lines. The prisoners raised the issue of bedding on a number of occasions directly with staff and using the PC.01 process.

423.5 The requirement to keep the yard door closed during yard time was unreasonable. The D Wing yards are small (one yard for each cell) and closing the door was a further and unnecessary restriction, compounded by the requirement that if the prisoner came inside to use the toilet, the management plan specified that staff had a discretion to end the yard time (s 7 requires that every prisoner "*may, on a daily basis, take at least 1 hour of physical exercise" and that exercise "may be taken by the prisoner in the open air if the weather permits*"). It is not clear why prisoners were required to walk sideways through the yard door. While there is some evidence that prisoners took their bedding into their yard and refused to come back in, the conditions imposed for yard time as a whole are disproportionate to the risk this posed.

423.6 The management plans confirm that staff mistakenly believed that conditions could be placed in management plans for maximum security prisoners that prevented them from associating, without a formal segregation order. There was a space in the template of the management plan for Ms A signed on 6 November entitled "Placement in the Unit" that stated "Ms A *will be housed in D Wing until further notice. As per Prison Director instructions*". Section 57 of the Act provides that the opportunity of a prisoner to associate with other prisoners must not be denied or restricted, except in accordance with this Act.

423.7 The limit restricting the telephone calls of the wāhine to one five minute call a week would have further isolated wāhine who were already prevented from associating and were without television or radios. A weekly call of up to five minutes duration is

485 At [A1243].

a minimum entitlement under s 77(3) of the Act. Minimum entitlements are not maximum entitlements and should not be treated as such.[486] The wāhine often complained about the limits placed on their telephone calls, which I agree were not reasonable. When asked whether she had called her children on Christmas Day, [redacted] Ms A replied "*she hadn't because she only had one phone call she didn't want to pick one child to call and the others miss out*".

424. The management plans were signed off by the Residential Manager and the Deputy Prison Director, and discussed at MDT meetings. Despite this, in my view there was insufficient experience or expertise brought to bear on whether the management plans were appropriate. The narrative of events suggests that the plans were simply rolled over without much consideration, and were reactive rather than forward-looking. What oversight there was by the MDT meetings was further compromised by the failure of the team to meet between 12 December 2019 and 9 January, which highlights a lack of leadership.

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

Telephone calls

426. Requiring telephone calls to be done with the wāhine's hands handcuffed and with staff holding the telephone may be reasonable if it relates to a risk that the wāhine may damage the telephone or to a risk to staff safety if wāhine are handcuffed in the front. On 16 September Ms C was handcuffed in front, and used the cuffs to break the base of the telephone. On 27 September CCTV footage showed Ms A throwing the receiver at the wall and attempting to kick an officer. There may have been a reasonable basis, therefore, during parts of the review period, for a requirement that prisoners have telephone calls while handcuffed from behind.

427. Having staff holding the telephone would have made it difficult for the prisoners to have open conversations with family, and would have heightened their sense of isolation. Such a condition should be revisited if the risk that justified it is no longer present. It appears possible from the management plans that the requirement to be handcuffed from behind for telephone calls continued during periods of compliant behaviour, and was effectively rolled over throughout the period that the prisoners were in D Wing.

428. The telephone call requirements in the management plans do not distinguish between telephone calls with family and lawyers. There are particular concerns with a condition that would allow a corrections officer to overhear a lawyer's telephone call. If corrections officers did hold the telephone during lawyer's calls, that is a condition that would need to be regularly reviewed and carefully calibrated, for example ensuring that it is not a corrections officer against whom the prisoner has submitted a PC.01 complaint.

429. It is not clear from the offender notes and incident reports whether staff held Ms A' telephone during her calls with her lawyer. When interviewed during this investigation Ms A said that her telephone calls with her lawyer were on speaker phone, and staff stood outside the room but close enough that they could overhear, which suggests staff did not hold the telephone for lawyer's calls.[487]

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486 In response to a complaint about the restrictive telephone policy on 3 August 2019, staff responded that Ms A would have to come off directed segregation to have more telephone calls. This supports an inference that staff were unwilling to consider additional telephone time in circumstances when this may have been of significant comfort to the wāhine.

487 In response to a draft copy of this report, Ms B also said that lawyers calls were on speaker phones, and said that the door was kept ajar and that she believed staff were able to overhear her calls with her lawyer.

430. Whether or not staff held the wāhine's telephones during lawyers' calls, the management plans required more consideration of whether the wāhine were entitled to lawyers calls and how this was to be effected. Clause 86(1) of the Regulations requires that the manager of a prison "must ensure" that a prisoner with a pending proceeding has access to lawyers calls, but "may allow" prisoners without pending proceedings "*reasonable access to a telephone ... for the purpose of obtaining any type of legal advice*". The management plans are contradictory as to whether the wāhine had pending proceedings, and which part of cl 86 applied. For example, the management plan for [redacted] Ms A dated 4 November stated:

> Prisoner Ms A, M is a sentenced prisoner and at present does not have any appeals pending. Any Legal calls are at the discretion of the PCO in accordance with POM around access to Legal Advisors.
>
> Should prisoner Ms A, M be charged with any new external charges then arrangements will be made for her to access legal advice.
>
> It is noted that Ms A currently has external charges for incidents while housed in Mang/Seps

431. Staff reading the plan would have been confused as to whether Ms A had a pending proceeding or not, and may have thought, focussing on the first part of this section of the plan, that there was no obligation to "ensure" that she had access to lawyers calls "at all reasonable times".

Multidisciplinary team meetings

432. After the MDT meeting on 12 December 2019 Ms B and Ms A were generally compliant. Corrections staff prepared a written transition plan with the intention that they would move back to C Wing before Christmas. Hard copies were provided to the wāhine. During this period the offender notes for Ms B and Ms A record that they expressed anger about the mixed messages they were receiving about moving back to C Wing, that each wāhine "*expressed her despair but PCO informed her to be patient*" (offender note for 20 December 2019), and that on 22 December 2019 both wāhine had been "*hardly responding to staff for 2 days*".

433. On 23 December 2019 the Residential Manager told Ms B and Ms A that the transition plan had not yet been approved. The Residential Manager apologised. The offender notes record that Ms A became emotional and "*having negative feelings because they have nothing in D wing. She said if something happens to her partner [redacted] Ms B], she will blame all the staff*". Ms A said "*she has been good prisoner [and] began to cry while speaking to staff*". Ms B "*became very quiet after voicing her frustration*". On 30 December 2019 Ms A asked for an update but was told with the holidays there would probably not be an update until the following week. She "*replied that she feels like she is about to lose it*" and Ms B "*admitted that she was too angry to look at us through the window and talk to us*". [some of this, but not all, overlaps with the mental health section].

434. On 9 January 2020 the MDT reconvened, and the letter from Ms B and Ms A was provided, in which the wāhine described "*having nothing, no hope, no aspiration negative wing*". The minutes for the 9 January 2020 MDT meeting are almost entirely blank. It appears from subsequent PC.01 complaints from Ms B and Ms A that the wāhine were advised that management staff remained concerned that [redacted] Ms B and Ms A remained in possession of Ms B's rings, although staff

had removed rings during a search of Ms B's cell on 1 November 2019. The wāhine volunteered to be strip searched on 10 January 2020, which was done on 15 January 2020. No rings were found.

435. Ms B self-harmed on 21 January 2020. A special MDT meeting was convened on 22 January 2020 in addition to the scheduled meeting on 23 January 2020. No decision was taken at that time to move the wāhine out of the Separates cells, and they remained there until 13 February 2020.

436. Had the MDT meetings continued over the Christmas period, it is possible that the wāhine may have been moved to C Wing prior to Christmas. As recorded in the offender notes, it was obviously distressing for the wāhine to be told that they would not be moving after being given copies of the transition plan that staff had prepared. When the MDT did convene on 9 January 2020, despite the letter from the wāhine the management staff appear to have been focussed on Ms B's rings. The emphasis placed by management on Ms B's rings was disproportionate to any risk they presented. Ms B told staff that the rings had been removed, which is consistent with the offender notes that show rings being removed in November. Even if staff had a basis for concluding that the wāhine retained rings in their possession, this was not a reason to keep them in the Separates cells. The rings did not create a risk to staff safety. There were a series of red flags in the offender notes and Ms B's and Ms A 9 January 2020 letter that should have raised concerns about the mental health of the wāhine.

Health and wellbeing

437. The wāhine had a number of health needs during the review period, not all of which were appropriately managed. Some of this reflected staff shortages at ARWCF's health centre. In summary:

437.1 There were process failures after the wāhine were made subject to directed segregation orders in March 2019, when the Corrections Regulations 2005 require that the Health Centre Manager should be notified and special attention paid to segregated prisoners. The informal nature of the wāhine's transfer to Separates cells meant that these processes may have been bypassed.

437.2 Access to health assessments, interventions and prescribed medications were impacted by security procedures.

437.3 Assessment and management of Ms A' asthma did not meet recommended best practice clinical guidelines.

437.4 Assessment and management of Ms C's headaches or migraines did not meet recommended best practice clinical guidelines.

438. The mental health care of the wāhine is discussed separately below.

The legal framework governing prisoners' health

439. The prisoners' minimum entitlements in s 69(1)(g) of the Act include "to receive medical treatment, as provided for in section 75". That section states:

> (1) A prisoner is entitled to receive medical treatment that is reasonably necessary.
>
> (2) The standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public.

440. Every prison must appoint a "health care manager", who is responsible for ensuring the provision of health care and treatment to prisoners: s 19A of the Act. Under cl 73 of the Regulations, the health care manager "*must take all practicable steps to maintain the physical and mental health of prisoners to a satisfactory standard*".

Specific provisions regarding prisoners subject to directed segregation or placed in a cell under a penalty of cell confinement

441. There are specific requirements to protect the health of prisoners subject to a directed segregation order or placed in a cell under a penalty of cell confinement. The Corrections Regulations 2005 require that:

441.1 the health centre manager "*must be notified reasonably promptly by the prison manager after a prisoner is placed in a cell in circumstances where, as a consequence of any segregation direction, the prisoner is denied the opportunity to associate with other prisoners*" (cl 55);

441.2 the health centre manager of a prison must ensure that "*special attention is paid*" to such prisoners (cl 76(2).

442. There are no national guidelines for the practical, safe, and appropriate application of the requirement that "*special attention is paid*" to prisoners who are segregated or placed in a cell under a penalty of cell confinement.

443. The Health Centre Manager Legal Responsibilities Guideline (2013) provides guidance on the cl 55 obligation. It states that when a Health Centre Manager is notified that a prisoner has been placed on a directed segregation order then a review of the prisoner's history must be undertaken to determine if an assessment of the prisoner is needed. The decision must be recorded on the prisoner's electronic health record.

444. The electronic health records for the three wāhine do not include this information from when they became subject to directed segregation orders after the 23 March assault, which suggests the acting Health Centre Manager may not have been notified that the wāhine were placed on directed segregation, or that there is a gap in the record-keeping.

Daily welfare checks

445. ARWCF had a local procedure in respect of its cl 76(2) obligation to pay special attention to prisoners subjected to directed segregation or penalty of cell confinement, which consisted of daily welfare checks and to arrange any health appointments or follow up as appropriate.

446. A daily welfare check was described in the local procedure as a mental health assessment using the BATOMI framework describing a person's behaviour, appearance, orientation, thought content/disorder, mood (including affect), and insight. The framework used by ARWCF also included description of physical health, risk, the nurse's impression of how the person is presenting, plan and follow up.

447. During the review period, while the daily welfare checks were regular, they were not always daily as required by the local procedure.

448. The review of electronic health files found that these welfare checks appeared to be brief interactions between the nurse and wāhine, standing at the cell door or sometimes when the door could not be opened, were done through a closed door. Custody staff were always present. These types of interactions do not support a therapeutic or private engagement between a nurse and patient.

Specific failures to meet the health needs of the wāhine

449. During the review period, there were failures to meet the health needs of the wāhine in the following ways:

449.1 [redacted] Ms A had asthma and sometimes had exacerbations of this following deployment of pepper spray which required nebulised medication to treat. The offender notes and health file include a number of references to Ms A' asthma or difficulty in breathing. Given the relatively regular exacerbations in Ms A' asthma, best practice would have been to implement an asthma plan. The electronic health file records only five peak flow tests,[488] [redacted].[489] A review of Ms A' health file during the review period had no documented evidence that her asthma was being managed according to recommended best practice guidelines.

449.2 When Ms C raised concerns about her on-going migraines at ARWCF she was seen by a nurse. However many of the documented assessments were limited and did not follow guidelines of clinical pathways, such as basic vital sign observations not being measured, lack of history taking of her symptoms, and use of a headache diary for Ms C to record details of the migraines she was experiencing.

449.3 There is no documented evidence that consideration was given to referring [redacted] Ms C to a Concussion Clinic. This may have provided further assessment of her brain injury, such as a neuropsychiatric assessment. Information from a neuropsychiatric assessment could be used to support custody and case managers in planning and delivery of interventions, and would promote engagement with ACC and access to appropriate services, including after the prisoner is released. The nursing assessments generally are as detailed as best practice would require.

449.4 There were occasions where health appointments (for a nurse, doctor, physiotherapist, Xrays) could not be facilitated due to short staffing, custodial constraints, it was too unsafe to unlock prisoners, or other incidents occurring on site. This resulted in delays for wāhine receiving care.[490]

449.5 There were occasions during the review period when prescribed medication was not administered due to custodial constraints, nurses having difficulty accessing the Management Unit, or it was considered too unsafe to open a cell door.[491]

450. [redacted]

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488 Peak flow measurement is a quick test to measure air flowing out of the lungs and it is often used to help diagnose and monitor asthma and how well the asthma is being controlled.

489 [redacted]

490 Ms B 12.5.19, 12.6.19, 13.6.19, 30.8.19, 5.9.19, 9.9.19, 4.10.19, 5.10.19, 6.10.19, 8.10.19, 11.10.19, 12.10.19, 22.10.19, 26.10.19, 31.10.19, 11.2.20. Ms A 11.3.19, 24.7.19, 6.9.19, 4.10.19, 13.1.20. Ms C 10.4.19, 24.6.19, 25.6.19, 28.6.19, 29.6.19, 27.9.19, 1.10.19, 3.10.19, 4.10.19, 6.10.19, 7.10.19, 9.10.19, 16.10.19, 17.10.19, 20.10.19, 21.10.19, 23.10.19, 28.10.19, 3.11.19, 5.11.19, 26.11.19, 2.12.19, 3.12.19.

491 Ms C 17.7.19 *"due to the safety and security of the staff, Prison Director advised patients cell door was not to be opened."* Ms A 18.1.20 *"unable to give lunch medication due to shortage of staff. Only three officers were available during medication round and four needed to unlock her cell."*

The mental health and review at risk assessment of the wāhine

451. The management of the wāhine had an obvious impact on their mental health. During the review period there were some failings in appropriately responding to and managing health concerns identified or raised by the wāhine at ARWCF relating to their declining mental state. This included failure at times to undertake Review at Risk Assessments, as required by POM.

452. POM requires Review At Risk Assessments to be undertaken any time there has been a use of force or "*the prisoner begins to display negative signs or change in mood or behaviour*".[492] There were a number of occasions when a prisoner was recorded as displaying negative signs or a change in mood, or there was a use of force, yet there is no evidence that a Review At Risk Assessment was done:

452.1 On 19 June and 21 June offender notes records that Ms B looked low and depressed.[493]

452.2 On 28 September Ms C refused to be locked, and kicked an officer in the leg and attempted to head butt an officer. Staff responded with spontaneous use of force.

452.3 On 24 October there is a note from a nurse on Ms A' electronic health file that Ms A did not engage with the nurse and stated she was feeling depressed, and on 27 October a welfare check recorded that Ms A said "*I'm wanting to talk to Medical about my situation … I need to see Medical for anxiety attacks I'm having since I've been in D Wing. It's almost daily …*"

452.4 On 20 November, after the prisoners activated their sprinklers, staff used force including pepper spray to relocate Ms B and Ms A.

452.5 On 21 November Ms C [redacted]

453. Through December 2019 and January 2020, both the offender notes and health records document changes in behaviour for Ms B and Ms A, with them looking depressed, showing changes in mood, not engaging with anyone, or not answering questions around risk status. Yet there is no evidence that Review At Risk Assessments or nurse mental health assessments were completed. Examples of this include:

453.1 On 22 December offender notes record that both prisoners had been "*hardly responding to staff for 2 days*". Ms A asked for a razor and said "*come on [redacted], we are depressed, we need this*".

453.2 On 23 December, after the prisoners were told that despite the transition plan they would not be moving to C Wing before Christmas, Ms A "*began to cry while speaking to staff*" and Ms B "*became very quiet after voicing her frustration*".

453.3 On 30 December, Ms A said "*that she feels like she is about to lose it*" and [redacted] Ms B "*just wanted to be left alone*" and "*admitted that she was too angry to look at us through the window and talk to us*".

453.4 On 9 January Ms A and Ms B provided a letter for the MDT meeting where they wrote of "*having nothing, no hope, no aspiration negative wing*". This was presented to the MDT meeting but there is no record of a Review At Risk Assessment.

454. Changes such as these should be a prompt for further enquiry and assessment and should be carried out in private and within an environment which supports therapeutic

492 M.05.02.01(1)(h) and (o).
493 At [A304] and [A307].

engagement. Noticing changes in a person's presentation can sometimes be clues to identifying deterioration in their mental state or sense of wellbeing.

455. All concerns raised by a person about symptoms of declining mental health and wellbeing should always be taken seriously and followed up appropriately. The effect of isolation can impact on a person's sleep, poor cognitive function and is associated with higher anxiety, depression and suicide rates. Isolation and connectedness are key factors for a person's wellbeing.

456. In their interviews for this investigation, Ms C and Ms A described the impact on their mental health of the time they spent in Separates cells while prevented from associating:

456.1 Ms A said that her time at ARWCF had "*affected [her] mental health*" and said "*I'm not the same person*". She had "*changed due to isolation*". She feels "*weary*" and "*distrusts staff as a result*".

456.2 Ms C said being on her own changed her a lot. She has started "*acting out*" and has "*mistrust in Corrections*". She said that being in "*a wing of people overwhelms me*". The words she used to describe herself after being at ARWCF were "*paranoia, no trust, made me violent, PTSD, head injury – head concussions team, flashbacks – shields and helmets, non-sociable, strip me of dignity, mana*". *She said she "wasn't like this before.*"

The number of staff attending when use of force was deployed

457. The wāhine raised issues about the number and attitude of staff attending during planned and spontaneous uses of force. In Ms B's evidence in the District Court, she said staff "*came ready for war*", "*they were hostile, we were hostile*", "*there would always be six plus*". Ms A said in a meeting with the Residential Manager "*when she sees SERT, it doesn't scare her, it makes her go into defence mode*".

458. The footage reviewed as part of this allegation demonstrates that staff did make sustained attempts to encourage the wāhine to comply with instructions before using force. However, the footage does show a pattern of excessive numbers of staff attending emergencies. There was also a lack of leadership, for example in some footage of the wāhine being escorted. Where extra officers are not needed, they should have been directed to return to the guard room, and there should have been one officer clearly in charge directing the other officers what to do.

459. The excessive number of officers is concerning for two reasons:

459.1 When there is an emergency in a prison unit, it puts staff at risk if all staff immediately attend the emergency because this can create an opportunity for prisoners to create a false emergency in one part of the prison to distract attention from elsewhere.

459.2 Many of the wāhine in New Zealand's prisons have experienced trauma. While it is important to have an appropriate number of officers to ensure staff safety, deploying more staff than necessary may escalate tensions unnecessarily. As Ms B observed, "*they were hostile, we were hostile*".

Clothing, toilet paper and access to toiletries

460. In addition to the restrictive conditions imposed through the management plans, the following aspects of the management regime for the wāhine require comment:

460.1 The wāhine were only provided their clothing one piece at a time, and had to undress and hand over their underwear before they were given replacement clothing.

460.2 The toiletries of the wāhine were dispensed in small pottles.

460.3 Limited toilet paper was dispensed.

461. The Corrections Regulations require that "*every prisoner must keep his or her person, cell or self-care unit, furniture, clothing, and property clean and tidy*" and that "*[t]he manager of a prison must ensure that the means to comply [with this obligation] are available to every prisoner*".[494]

462. The prisoners complained about these aspects of their management. For example [redacted] Ms A submitted complaints in early August and at the end of October that "*im being given little amounts of toilet paper*", and that they had been "*DRIP FED TOILET PAPER, NO SOAP OR SHAMPOO*", and on 6 September Ms C requested that she have all her property all at once. On 6 October a complaint from Ms C was registered that the wāhine were "*having our own personal toiletries Drip fed to us in pottles … We have had toilet paper drip fed, Been Refused Sanitary things and had to Beg for clean clothing and clean towels … this is all degrading unhumane*". In her interview for this investigation, Ms A said she covered the cell camera and windows and washed her clothes to avoid having to exchange them, but the toilet paper fell off the camera while she had no top on.

463. In Ms Hill's 17 February 2020 letter (in Appendix A) she states that "*[o]n at least one occasion a male Corrections Officer has been present when [a prisoner was required to strip out of their clothing before being provided with fresh clothing]*". This may relate to video footage the Inspectorate viewed where staff including a male officer were delivering a meal when Ms A removed her clothing from inside her cell, possibly assuming staff had arrived to provide fresh clothing.[495] The incident reinforces my view that the policy was not appropriate.

464. On 20 November offender notes record a decision to dispense toilet paper to [redacted] Ms C, because she had been using it to set off the sprinklers. Later that evening, Ms C was seen lying on the floor, [redacted] outside her door. She had [redacted] after not receiving toilet paper, [redacted] On 3 December staff Ms C requested toilet paper but the officer had dispensed toilet paper to her 90 minutes previously and told Ms C to wait. When the officer later arrived to Ms C's cell with toilet paper, there was a [redacted] and Ms C [redacted] No toilet paper was dispensed.

465. I do not accept that restricting prisoners to one set of underwear at a time or restricting their access to toilet paper is appropriate. I recognise that these wāhine were known to misuse items provided to them, however there were issues of basic human dignity at stake. These decisions do not appear to have been part of the management plans, even though there is a separate place in the management plan templates for clothing. The rationale for the decision to restrict underwear is unclear, and the limit on toilet paper is disproportionate to the risk to which it responded.

494 Clause 69.

495 This may also relate to an offender note dated 2 November, which states "*Prisoner shouting out to staff stating 'You pervert!' or words to that effect*" at [A1060].

Keeping wāhine in wet cells or failing to provide dry clothing

466. It appears likely that the wāhine were at times relocated to Separates cells after sprinkler activations, initially in order to remove the water from the wāhine's own cell and to reactivate the sprinkler. The wāhine needed to be relocated to a different cell, at least temporarily, for their own welfare because their cell was wet. However, there are a number of occasions where it appears that the wāhine were left in their wet cells for extended periods, or were relocated to a Separates cell but there is no evidence that they were given dry clothing:

466.1 On 24 September Ms C activated her sprinkler at approximately 10.00am and was transferred at 1.36pm to a Separates cell. She submitted a PC.01 complaint that she had been "*left in wet clothing for 8 hours*". There is no record in the offender notes or incident reports of Ms C being given dry clothing; the response to the complaint, on 12 November, was that Ms C "*has been spoken to and it has been agreed to move forward in a more positive path*".

466.2 On 2 October Ms B activated her sprinkler at approximately 9.22am, and was relocated at approximately 3.47pm after Cell Buster pepper spray was used. She had been in a wet cell for approximately six hours 47 minutes.

466.3 On 20 November all three wāhine activated their sprinklers at 3.25am. They were relocated to different cells over ten hours later. An incident report records that at approximately 10.30am, staff observed that Ms C [redacted] Staff removed it. At that stage, Ms C would still have been in a wet cell. Ms C 's electronic health file records that she was "*Seen in cell lying on the floor.* [redacted] *Did not want to get up and show herself to the writer as she* [redacted] *Was asking for toilet paper, had not been given this so* [redacted].

467. From the information in the offender notes and incident reports, it appears that more should have been done to ensure that prisoners were relocated out of wet cells promptly and provided with a change of clothing (dry clothing should have been available as the prisoners were only able to keep one set of clothing in their cells).

Cell cameras

468. There are a number of references in the offender notes and incident reports to the wāhine covering the cameras in their cells with wet toilet paper. While cameras are permitted within ISU cells because of the concern that at-risk prisoners in ISU might self-harm, there was no reason for the cameras in the Separates cells to be on. The live footage from the cameras can potentially be seen by officers on the unit's guard room and master control monitors. Even if the footage is not viewed live, requests can be made within a limited timeframe for the footage to be saved and viewed.

469. In the MDT meeting minutes for 24 October, there is a note "*Camera in cell: Is not so much of an issue, due to privacy cameras can remain covered. But most definitely they cannot cover the yard camera*".[496] On 29 October Ms C was asked to remove wet toilet paper from the cameras, suggesting that at that time staff were using the cameras. The wāhine did cover the observation windows at times, but the cameras

496 At [0].

should not have been used as an alternative, especially as the wāhine also appear to have put paper on the cameras.

470. The 5 November incident report describes a search of Ms B 's cell: "*also the cell camera was covered. All obstructions were removed*". The 21 November offender note that Ms C "*will not to get a whole toilet paper because staff witnessed her used it to cover her observation window and also cover her camera*".

471. To the extent the cameras were not kept on, it appears that the wāhine may not have been advised of this. Ms A submitted a PC.01 complaint on 1 December that said, among other things, that "*I don't like that the camera can see us strip our clothes of in order to get clean uniforms. I feel paranoid*".[497]

472. There were no safety concerns as with an at-risk prisoner in the ISU that would have justified keeping the cameras on. To the extent that the prisoners assumed the cameras were on (and they were asked to remove paper from the cameras, so it was a reasonable assumption), the feeling of being constantly watched by staff while being prevented from associating with other prisoners would have heightened the feeling of vulnerability and powerlessness.

Staff issues

473. The issues identified in this investigation do not stem from a lack of processes or regulation. Rather, the existing regulations and processes were not followed.

474. When interviewing staff as part of this investigation, there were a number of comments about the dysfunctional culture among the staff. There were comments from staff at all levels on a lack of leadership, and some blamed staff for resisting management.

475. A number of staff commented on divisions or cliques among the officers, whether because of union membership, length of time at the site or between day and night staff. There were divisions as to how the wāhine should be treated. Some staff misunderstood their role and took an overly punitive approach. Some staff disagreed with aspects of the management plan and took a more sympathetic approach with the wāhine, which made others who were keeping to the plan feel undermined. There was a general lack of knowledge of POM. Many officers described the verbal abuse from the wāhine as taking a toll, and mentioned the abusive pictures displayed by the wāhine on 4 November 2019 as having a particularly lasting impact.

476. Management sought to implement changes in the culture, especially around the divisions between staff who had good relationships with the wāhine and those who did not and felt undermined by other staff. Several management staff also said that when they were appointed to their roles, they considered that prisoner management was too informal and the wāhine had too much say in their own management. A number of staff commented that they were encouraged not to engage with the wāhine. This may have been the result of an overcorrection to a different problem, or a misunderstanding of an instruction not to undermine other staff in front of the wāhine. When interviewed as part of this investigation, Ms A said that there was a sign in the unit instructing staff not to interact with the wāhine. Whether or not such a sign existed, some staff were under a similar understanding, and some were uncomfortable with it.

497 In response to a draft copy of this report, Ms B advised that she could sometimes see the screens showing footage from inside cells running in the staff base when she was taken past this area.

Overall effect on both staff and other wāhine

477. Staff reported being fatigued from the daily abuse and challenges from these wāhine. Some staff were affected by working with the wāhine and requested to be transferred to another unit. A Corrections Officer stated "*abuse, incidents, names calling, racial slurs, assaults became daily incidents*". A Principal Corrections Officer stated "*PCO's were burnt out by* [redacted] *and* [redacted] *who had the intention to burn them out. They were very manipuluative and had an influence over other prisoners". "Staff were physically and mentally drained. We tried to swap some staff and there was an increase in staff sickness".*

478. The collective behaviour of the wāhine deteriorated to the point that other wāhine in the unit were relocated to different units.

479. The behaviour of these three wāhine impacted heavily on the day to day operation of the unit, and also the wider site, often resulting in other wāhine being denied their entitlements and/or appropriate care due to additional staff being redeployed in response to incidents.

Record-keeping

480. Record-keeping was generally poor. This is obvious from the issues to do with the complaints and the use of force discussed above, but it was a general theme across the review period, and created a lack of transparency that at times hampered the Special Investigation.

481. For example, staff did not record in IOMS when prisoners commenced periods of cell confinement. Cell movements were recorded, and where a prisoner moved to D Wing to serve a cell confinement sentence the commencement date of the sentence can be easily inferred. However, sometimes cell confinement penalties were served in the prisoner's own cell, and therefore it often not possible to conclude with certainty when a prisoner commenced a sentence of cell confinement. For example, on 31 May 2019 [redacted] was moved to D Wing, where she stayed until 6 June. It is possible that this included a five day sentence of cell confinement that had been imposed on 21 May 2019 if [redacted] had appealed that sentence and withdrawn the appeal after she was moved on 31 May 2019, but it is also possible that she had already completed the 21 May 2019 sentence without moving cells, and that the 31 May-6 June 2019 period in Separates cells did not relate to a disciplinary penalty.

482. The prisoner movements do not appear to have been always recorded. On 24 May 2019 an offender note recorded that [redacted] was placed in a Separates cell after she activated her sprinkler. Yet when the Inspectorate obtained the records of prisoner movements there was no record of [redacted] being moved to D Wing. This suggests that the move was temporary, but the failure to record the movement is a serious health and safety issue. During an emergency staff must be able to locate prisoners, especially if they need to be evacuated.

483. ARWCF does not keep (and nor is it common practice across the prison network to keep) records of when each prisoner is unlocked (although keeping such records was common practice previously). Therefore, it is not possible to obtain an accurate understanding of how long the maximum security prisoners at ARWCF were on unlock each day. Given the rolling unlocks it is possible that prisoners had limited time on unlocks, but there is no way of obtaining an accurate picture of this. As discussed in the complaints section, [redacted] submitted a formal complaint that she had been in her cell for 48 hours

without being unlocked. The records do not assist in ascertaining whether this occurred, or whether this was a systemic issue.

484. In a further example of record-keeping issues, Ms C alleged that she was not provided with underwear in the ISU [redacted] When the ISU was approached, it claimed that it had no record of Ms A being at the ISU during the relevant period, although the prisoner cell movement records showed that she was.

OFFICE OF THE INSPECTORATE
Te Tari Tirohia

Appendix B. National Commissioner response

DEPARTMENT OF CORRECTIONS
ARA POUTAMA AOTEAROA

12 April 2021

Janis Adair
Chief Inspector
Department of Corrections

By email: janis.adair@corrections.govt.nz

Tēnā koe Janis

Re: Draft report of investigation into the management of three women at Auckland Region Women's Corrections Facility

Thank you for your letter of 31 March 2021 providing a copy of your draft report into the above matter, and for the opportunity to respond.

Your report specifically highlights the management of three women at Auckland Region Women's Corrections Facility (ARWCF), while also acknowledging the complex and challenging combination of factors involved in their management.

We acknowledge the significant failures that led to these women being managed in line with an increasingly restrictive regime in response to their escalating challenging behaviours. This did not meet our expected standards and those set out in the Prison Operations Manual and the Corrections Regulations.

As you are aware Corrections have already had an initial meeting with the three women involved, led by the Northern Regional Commissioner where we acknowledged the failings, the trauma they suffered and verbally apologised for the way they were managed during their time at ARWCF. Upon receipt of your final report, we intend to formalise this apology in writing as well as offering a package of care to go some way to remediate the situation. We are committed to continuing to work with the women to address their specific needs, provide any support they may require and to seek their input to improve our policies and procedures.

You made an overall recommendation within your report, seeking confirmation that no prisoners are subject to a similar regime throughout the prison network. You considered that a review of the way in which women across the prison network were managed should be reviewed and this should include:

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i. *A consideration of the staffing, management and oversight of ARWCF in order to provide assurance that no other systemic issues persist. Given the broad range of findings, staff competency should be addressed at every level, including custodial and health staff.*

ii. *A review of the use of maximum security classification for women.*

iii. *A review of the use of management plans across the prison network.*

iv. *A review of the management of Corrections Regulations 2005 cl.55 (Health centre manager to be notified of certain segregation directions) across the prison network.*

v. *A consideration of developing a national guideline for staff to support meaningful management of Corrections Regulations 2005 cl.76 (Certain prisoners at risk or seriously ill) (a) and (b).*

vi. *A consideration of how the Department can better support staff to manage women (including those who present with complex and challenging behaviour) in a culturally appropriate, gender-responsive and trauma-informed manner.*

All recommendations are accepted.

I can advise that assurance has been provided from all prison directors that every prisoner at their sites who is subject to maximum security or directed segregation, are being managed in accordance with appropriate and individualised management plans. Further ongoing assurances will occur.

A programme of work has been established to drive the transformation of our three women's prisons into a cohesive network, underpinned by a trauma informed operating model, tailored specifically to the needs of women. This will involve developing a programme for the Women's Prison Network focusing on the design, implementation and embedding of a gender responsive operating model, including reviewing the maximum security classification for women. Corrections expects to produce a systemic plan for change across all three of the women's prisons before the end of June 2021.

A plan has already been developed to address the immediate issues at ARWCF and a number of changes are already being or have been progressed including the appointment of a permanent Prison Director and the management team, a $12 million work programme to establish additional recreation yards, for more recreation time in the fresh air, increased oversight of unlock hours, increased prioritisation of monitoring and responding to the complaints of people in prison in a timely manner and the embedding of a new multi-disciplinary team approach to developing plans to guide progress and rehabilitation.

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Staffing in the Health Centre has improved and has included the appointment of a permanent Health Centre Manager (mid 2020) and a Nurse Practitioner (June 2020). Since November 2020 we have had two Enrolled Nurses (EN) and a Health Care Assistant (HCA) on a three-month fixed term secondment. Due to the success of this pilot the secondments have been extended while the business case is approved to make this permanent. The addition of EN's into the service at ARWCF has had a significant impact on service delivery and has ensured the right staff are doing the right work at the right time.

Resources to support the development of Asthma Management Plans have been provided to staff, and three staff are undertaking the required training for cervical screening. The HCM is driving a strong focus on quality improvement, new ways of working and strengthening relationships between the health and custodial teams to support the delivery of health services. A new Panadol alert mechanism has been put in place to prompt assessment by the health team when there is frequent use of Panadol.

The Regional Operations Director (ROD) has supported the reinstatement of the Daily Segregation Report (DSEG) being sent to the HCM who will commence weekly visits to ensure health and wellbeing is being maintained for Women who are 'non-associating'.

Nationally, the Health Centre Manager Responsibilities Policy and the Health Care Pathway Policy are under review and will provide clarity on the Welfare Check process, the management of segregated people and escalation pathways to ensure the appropriate level of health care is provided. The processes for referral and access to mental health services will be considered as part of the policy review as we focus on at risk women and those who require ongoing assessment and mental health support, and coordination of access to services.

We understand that the role of Principal Assurance Inspector, Women, has been established to provide assurance oversight of ARWCF, and will report directly to you as Chief Inspector once appointed. We welcome this in order to enable us to enhance transparency and ensure overall process and performance improvement. We undertake to report to you quarterly against the progress of your recommendations.

I trust that you are satisfied with our response. Please advise me in the first instance if you have any concerns.

Ngā mihi nui

Rachel Leota
National Commissioner

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