United Nations CAT/C/NZL/CO/5/Add.1

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Distr.: General
3 March 2011

Original: English

Committee against Torture

Consideration of reports submitted by States parties under article 19 of the Convention

Follow-up responses by New Zealand to the concluding observations of the Committee against Torture (CAT/C/NZL/CO/5)*

[19 May 2010]

* In accordance with the information transmitted to States parties regarding the processing of their reports, the present document was not formally edited before being sent to the United Nations translation services.

1. On 14 May 2009, the Committee against Torture adopted concluding observations on New Zealand's fifth periodic report (CAT/C/NZL/CO/5). The Committee requested further information within one year on four of its recommendations related to: the insufficiency of prison facilities in New Zealand (recommendation 9); the allegations of historic abuse (recommendation 11); the withdrawal of the reservation to article 14 (recommendation 14); and the use of taser weapons (recommendation 16). This paper provides further information and outlines recent developments on these issues over the past 12 months.

Paragraph 9 of the concluding observations

In order to improve the arrangements for the custody of persons deprived of their liberty, the State party should undertake measures to reduce overcrowding, including consideration of noncustodial forms of detention in line with the United Nations Standard Minimum Rules for Non-custodial Measures (The Tokyo Rules), and in the case of children in conflict with the law ensure that detention is only used as a measure of last resort. It should also provide adequate mental health care and legal services for all persons deprived of their liberty, particularly to inmates suffering from mental illnesses. The State party should keep under constant review the use of instruments of restraint that may cause unnecessary pain and humiliation, and ensure that they are used only when necessary, and that their use is appropriately recorded.

Overcrowding

2. The Committee expressed the view that the number of prison facilities will be limited in light of the forecast growth in prisoner numbers and expressed concern that overcrowding may lead to violence between prisoners. The Government is aware of this risk and has taken steps to ensure that there will be sufficient prison beds available to meet projected future demand. These steps include building additional facilities and decreasing imprisonment rates through initiatives to reduce rates of offending.

3. The Department of Corrections has a plan for the development of additional capacity which dynamically responds to changes in the forecast growth in the prison population. The Department's planning takes into account initiatives to reduce the length of time prisoners are held in custody on remand, changes in policing and sentencing practice and changes in the number of offences being committed following the introduction of measures designed to reduce offending.

4. In the short term, additional capacity will be provided by increased use of shared cells (double-bunking), where appropriate, and the use of modular accommodation units to supplement prison buildings. To meet longer term demand the Government has also announced its intention to build additional prison facilities.

5. In order to reduce offending, the Government is progressing a new approach known as "Addressing the Drivers of Crime". This approach includes early prevention, treatment for specific needs related to offending, and justice sector responses that reduce re-offending. Cross-government action is under way in four priority areas:

- Improving the quantity, quality and effectiveness of maternity and early parenting support services in the community, particularly for those most at risk.
- Developing and implementing programmes that treat and manage behavioural problems in children at risk and young people.

- Reducing the harm from alcohol and improving the availability and accessibility of alcohol and drug treatment services.
- Identifying alternative approaches to manage low-level offenders and offering pathways out of offending.

6. Effective early intervention to address the underlying causes of crime and victimisation should reduce offending and, over time, decrease the prison population.

Detention as a measure of last resort for young offenders

7. In order to improve the arrangements for the custody of persons deprived of their liberty, the Committee also recommended that detention measures are used as a last resort for young offenders. The Children, Young Persons and Their Families Act 1989 requires that a child or young person (16 years or under) who commits an offence should be kept in the community so far as is practicable and consonant with the need to ensure the safety of the public. In practice detention in custody is used as a last resort and the vast majority of young people are dealt with in the community. For example of the 4,271 children between 14 and 16 years old prosecuted in the Youth Court in 2008 only 152 were given a custodial sentence.

Mental health

8. The Committee expressed concern over what it regarded as the inadequate provision of mental health care to mentally ill inmates in prisons. The Government recognises that more forensic beds are needed to accommodate mentally unwell prisoners and that assistance needs to be provided to more prisoners with mild to moderate mental health issues. A number of initiatives are in place and others are developing to address these issues.

Mental health assessment on arrival

9. The mental health status of all prisoners is assessed by a registered nurse during their first 24 hours in prison. In addition, custodial staff screen prisoners to identify those at high risk of suicide or self harm. All prisoners identified with serious mental health needs are referred to the relevant District Health Board (DHB) Regional Forensic Psychiatry Service for further assessment and treatment. Secondary level services for prisoners who suffer from severe mental illnesses are provided either in prison or in secure inpatient care by the DHB Regional Forensic Psychiatry Service. Any prisoner who is assessed as being at risk of self harm or suicide is placed in an At Risk Unit and a management plan is developed. The policies governing the treatment of these patients are under review with the aim of strengthening a multi-disciplinary approach and a focus on well-being.

The mental health screening tool

10. The Department of Corrections and the Ministry of Health jointly funded the development, piloting and validation of a mental health screening tool for use by primary health nurses in prisons. A National Reference Committee of forensic psychiatrists guided the development of the tool based on international best practice and research.[1] Psychotic

[1] In 2007 the screening tool was piloted at Christchurch Men's Prison and Auckland Central Remand Prison. The pilot found that: 30 per cent of new male receptions required a referral to forensic psychiatric services for further assessment; following the clinical assessment by a forensic mental health nurse, approximately 18 per cent of new male receptions were referred to a forensic

disorders were diagnosed at a rate several times higher than expected in community settings. The rates found in the pilot confirm rates noted in the research on prison populations and the screening tool has been recommended for implementation.

Availability of secure hospital facilities for acutely unwell prisoners

11. There are frequently a greater number of acutely mentally unwell prisoners than can be accommodated by the DHB forensic inpatient beds. Historically, this has mainly been an issue in the greater Auckland region and has resulted in a number of prisoners waiting extended periods of time to be transferred to a secure inpatient bed. Although the waiting list numbers have decreased since July 2008 and prisoners do continue to receive treatment while in prison facilities, this issue remains a concern to the Government because these prisoners' needs are best met in a health facility.

12. The Department of Corrections copes with this shortfall in forensic inpatient beds under a memorandum of understanding with the Ministry of Health, which sets out the roles and responsibilities for the management and treatment of acutely mentally unwell prisoners awaiting a forensic inpatient bed. The DHB Regional Forensic Psychiatry Service has clinical responsibility for the assessment, treatment and care planning of waitlisted prisoners and leads the development of a care and management plan for each prisoner in consultation with the Department of Corrections.

Legal advice

13. The Committee expressed concern over what it regarded as inadequate provision of legal services to all persons deprived of their liberty, particularly to inmates suffering from mental illnesses.

14. People in detention, including those subject to orders on mental health grounds, have the same rights to legal advice and representation as other citizens and have readily available telephone and mail access to their legal advisers, as well as to the Office of the Ombudsmen and other review and complaint bodies. Prisoners are generally responsible for engaging their own legal advisers and, where they are unable to afford legal assistance, are eligible for public funding for their legal advisers through the Legal Services Agency.

15. In addition to appeals or reviews of sentences and other custodial orders, people in detention regularly bring other proceedings, including claims for breaches of human rights and privacy protections, and challenges to prison and parole decisions.

Mechanical restraints

16. The Committee recommended that New Zealand should keep under constant review the use of instruments of restraint that may cause unnecessary pain and humiliation, and ensure that they are used only when necessary, and that their use is appropriately recorded.

17. The Corrections Act 2004, Corrections Regulations and Prison Services Policy and Procedure Manual comprehensively regulate the types of physical restraints and circumstances in which they may be used, and impose conditions limiting the use of specified restraints and provide that the use of such restraints must be recorded.

18. The use of instruments of restraint is regularly reviewed by Prison Services' internal assurance function and any complaints, incidents or issues are referred to the Prison

psychiatrist and 9 per cent of all new male receptions were diagnosed as having a psychiatric disorder.

Inspectorate for investigation. Prisoners may themselves also pursue internal or external complaints or legal proceedings over any allegation of the unauthorised use of instruments of restraint.

Paragraph 11 of the concluding observations

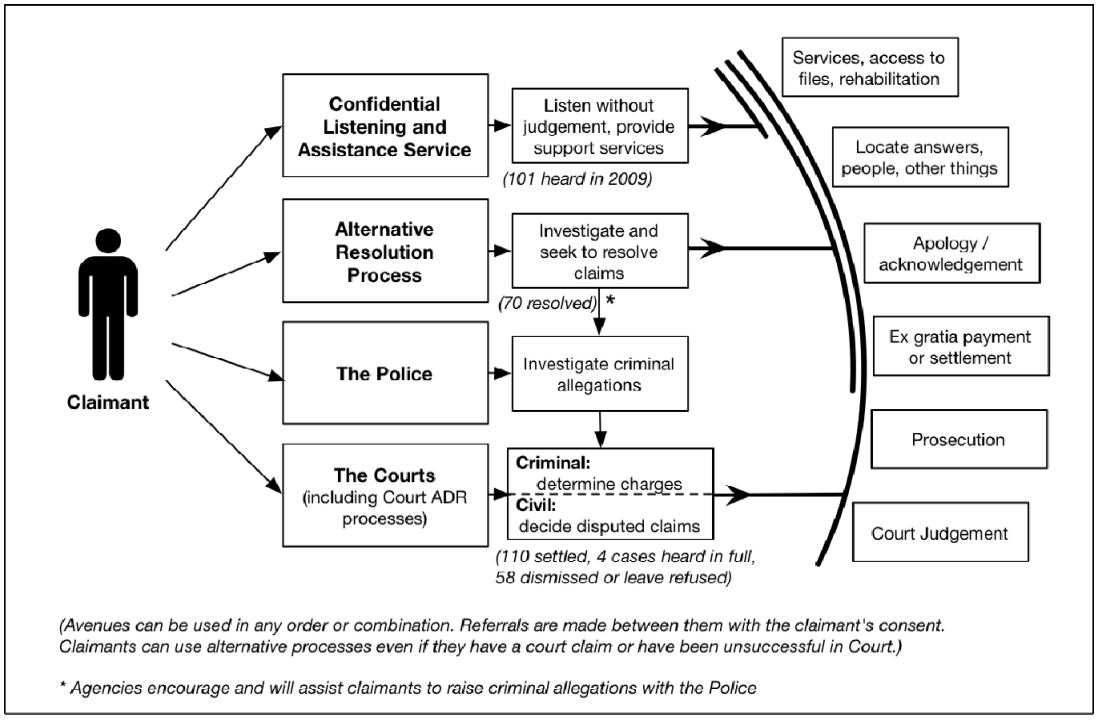
The State party should take appropriate measures to ensure that allegations of cruel, inhuman or degrading treatment in the "historic cases" are investigated promptly and impartially, perpetrators duly prosecuted, and the victims accorded redress, including adequate compensation and rehabilitation.

19. The Government is committed to the investigation and resolution of allegations of torture or ill-treatment by the State. Such allegations can be pursued through civil claims against the Government or against individuals, through criminal complaint to the New Zealand Police and through a range of other and more specialised procedures, including the Office of the Ombudsmen and Independent Police Conduct Authority, which are designated as national preventive mechanisms under the Optional Protocol to the Convention against Torture.

20. In respect of the current "historic abuse" cases, which encompass a broad range of allegations of ill-treatment while in children's homes, psychiatric institutions and other forms of State care in periods ranging from 1950 to 1992, the Government has engaged with the claims both systemically and in each individual case.

21. At a systemic level, allegations of ill-treatment in a given institution are thoroughly investigated.

22. For individuals who raise such allegations, court and Police procedures have been supplemented with a Confidential Listening and Assistance Service (CLAS), which can provide support and other assistance, and with an Alternative Resolution Process, which can provide compensation, apologies and other remedies. The result is an integrated and comprehensive approach to addressing such allegations (see figure below).



23. The Government has instituted these specific procedures in keeping with its commitment to seek, where possible, satisfactory engagement with and resolution of such allegations without requiring claimants to pursue civil proceedings through the courts. Many of the present claimants have chosen to conduct civil proceedings, frequently with public funding provided through the independent Legal Services Agency. In some cases, however, legal proceedings do not provide a comprehensive or appropriate response:

- Court claims must satisfy normal standards of proof. While a number of the historic claims have proceeded to trial, these have to date failed to establish the allegations advanced.
- Court claims must also comply with standard procedural requirements, including, so far as applicable, standard limitation periods. The Crown seeks to resolve claims based on their facts, without regard to statutory defences and puts limitation periods to one side and has settled with 110 claims on this basis. Where a claim cannot be resolved in this way and proceeds through the courts, these defences, which are widely recognised as acceptable,[2] are applied. In particular, as the present claims relate to events between twenty and sixty years ago, limitation restrictions do bar some claims.

24. The provision of public funding for such proceedings is subject to a continuing and independent assessment of whether funding is warranted by the prospect of success in each individual case.[3] Where, as has occurred in a number of the present historic claims, the claim is determined to have no sufficient prospect of success, funding may not be provided or may be withdrawn.

25. In recognition of such difficulties, the Alternative Resolution Process instituted by the Government follows more flexible and less formal procedures that focus on ensuring that the substance of claims is carefully assessed and an appropriate outcome reached. As noted, however, pursuit of the Alternative Resolution Process or the other mechanisms outlined above does not preclude claimants from continuing with court proceedings. Neither does an unfavourable decision from the courts prevent claimants from choosing to use the Alternative Resolution Process.

26. All affected agencies have commissioned research, as well as looking at individual claims, in order to satisfy themselves that there is no evidence of systemic failure as there was with the Lake Alice psychiatric hospital claims. The Ministry of Social Development (MSD) has recently received results of a year-long research project into a residence that is the focus of a large proportion of claims. The Crown Health Financing Agency (CHFA) has

[2] See, for example, *Stubbings v United Kingdom* (1996) 23 EHRR 213, commenting that limitation periods [51] address "... stale claims which might be difficult to counter and prevent the injustice which might arise if courts were required to decide upon events which took place in the distant past on the basis of evidence which might have become unreliable and incomplete because of the passage of time."
Similarly, the Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law observe that, in such cases, "time limitations applicable to civil claims and other procedures ... should not be unduly restrictive".

[3] The New Zealand Legal Services Agency acts independently in administering public funding for legal assistance in accordance with criteria prescribed by law. Agency decisions are subject to oversight by a specialised and independent tribunal, the Legal Assistance Review Panel, and by the New Zealand courts. The suggestion of partiality (see the Shadow Report to the Committee of Ms Sonja Cooper, 4) is, for these reasons, untenable.

carried out investigations of three psychiatric hospitals to date - Porirua, Ngawhatu (Nelson) and Cherry Farm (Dunedin). No systemic issues have been identified.

27. The Government has also considered whether a broader procedure, such as the general compensation scheme provided for former patients of the Lake Alice Hospital in 2001, could be adopted here. However, as the claims generally do not involve claims of broad systemic or institutional failure but are, predominantly, concerned with particular incidents and experiences of individuals, such an approach is not feasible here. The Government has also determined that, for the same reasons, a public inquiry is not an appropriate mechanism.

28. The Government is continuing to review its approach to the resolution of claims, including contributions to legal and counselling or related costs.

Claims involving child welfare treatment

29. In respect of children formerly in care as Wards of the State, the Government has adopted an approach of acknowledging and apologising where it has failed people, and helping them get on with their lives.

Investigation

30. An investigative unit, the Care Claims and Resolution Team (CCRT), has been established separately from current day services for State Wards. The CCRT investigates all historic claims, with priority being given to cases where allegations are made in respect of people who are still working for the Government in positions of trust with children and young people.

31. The CCRT investigates claims, works with claimants to seek resolution and help them get on with their lives, and looks into the meaning of the claims collectively. To date, it has found no evidence of systemic failure, and the total known claims make up less than 1 per cent of former State Wards. For this reason, claims are predominantly investigated as individual matters.

32. Where claims include allegations of criminal offending the CCRT encourages and supports the complainant to refer their complaint to the Police for criminal investigation and prosecution. Where such complaints are made, MSD gives all possible assistance to the Police. The investigation process also takes proper account of the natural justice rights of those against whom the allegations are made.

Court and alternative processes

33. Many claims have been filed in the courts, which provide an independent, well-tested means of hearing and responding to serious allegations. The Government acknowledges that the Court process can be difficult for claimants in particular, and can be time consuming. Since 2007, an optional, alternative process to the courts has operated for resolving historic claims by former State Wards. The alternative process through the CCRT is available to any person, including those who have filed a claim in the Courts. The process uses investigation resources that also support Court claims.

34. This process works with the individual and assesses claims to a broadly similar standard of evidence as the Courts, though it does so in consultation with the individual and involves more flexible investigation practices, in part because it can work from the individual's own account of their experience. The process relies on meeting with the applicant, hearing their grievance and understanding the issues they would like resolved for them to be able to move on in their life.

35. This alternative process centres on the needs of the claimant by:

- Making sure they and their family are receiving the help they should
- Investigating their allegations about past care
- Assisting them with other matters that may help them put their experiences behind them and move on in their life.

The help offered to claimants includes:

- Assistance in approaching authorities with formal complaints about an alleged perpetrator (and co-operating fully with subsequent investigations)
- Investigating allegations, including looking at contemporaneous evidence, locating and questioning other former residents and staff, and commissioning research
- Providing access to information and files, and answering claimants' questions
- Providing a personal apology or acknowledgement
- Offering assistance such as counselling, health or other personal services, and locating lost family members or possessions
- Offering financial payment.

36. Some of this assistance is provided to claimants regardless of whether their allegations can be substantiated.

Resolution

37. About 80 per cent of allegations or claims looked at by MSD in this way have been resolved. The majority of these have not started out as claims filed in Court; though people may go on to file a claim if it cannot be resolved. MSD has had 165 such applications in total, of which 95 are outstanding at present. The number of claims currently outstanding reflects a more than four-fold increase in applications since mid-2009 following media publicity.

38. While monetary compensation is a priority for some claimants, more than half of those who have approached the Government directly have sought other means to resolve their claim. This can include an explanation to assist their understanding as to why they were originally taken into care; locating photographs, pocket money or other possessions; or receiving a personal apology.

39. Financial payments are offered based on the facts of the claim. The level of payment offered is consistent with what would likely be awarded by the Courts. It takes into account the nature of the State's responsibility to the person, what happened in respect of any failing by the State in its responsibility, and what the impact on the person has been. In contrast to court claims, where cases are subject to time limits and other restrictions, compensation payments through this alternative process are not subject to such limits.

40. The alternative process operates as a complementary avenue to the CLAS. The CLAS provides a service for people who would like to have their experiences listened to without judgement, whereas the alternative process offers an option for those who would like an apology, compensation, or other help. People can be referred between these avenues depending on their individual needs or preferences.

41. It takes 11 months on average for full consideration of a claim to be completed outside of the Courts. This is about one-third the average length of the Court process. This time frame reflects the investigation undertaken to establish the facts of a claim and meet

the needs of the individual claimant. The pace of investigation is accelerating as more information is gathered, and the Government estimates that all currently known claims could be resolved within five years.

Claims involving psychiatric hospital treatment

42. Currently there are approximately 252 claims against CHFA. This number is approximate because many claimants are currently discontinuing claims as a consequence of a recent Supreme Court decision on the application of a statutory provision (for more information see below under "Court Process").

43. Most claims involve allegations that, while in State psychiatric institutions, the care people received was not of an acceptable standard or that they were subjected to treatment as punishment, or given treatment that they did not require. In particular, many claimants allege they were subjected to electro-convulsive therapy (ECT) not because it was required by their mental condition but in order to punish them for perceived wrong behaviour. Many claimants also plead physical or sexual assaults by staff, or other patients, or both.

Investigation

44. CHFA has taken a number of steps to investigate the claims. The purpose of such investigation was to determine whether there was, as alleged, systemic physical and sexual assaults on patients by staff or widespread misuse of treatment. As most of the claims come from Porirua Psychiatric Hospital, CHFA instructed its counsel to investigate those claims. In doing so, a number of former hospital staff were interviewed, and as a result CHFA is satisfied that there is no evidence to show any systemic approach to mistreatment of patients.

45. CHFA also commissioned an investigation into specific complaints made in respect of Cherry Farm Hospital. The interviews undertaken of a number of former staff show a view different to the allegations in the claims.

46. CHFA has instructed an independent psychiatrist to review a number of claims where the allegation is that the institution used ECT either as a threat, or as a punishment, when its use was not medically indicated. Each of the reviews has revealed sufficient evidence to refute these allegations.

47. Further, CHFA has instructed its counsel to talk with a number of psychiatrists and medical practitioners who were in the institutions at the relevant times about the allegations made. There is no evidence confirming the claimants' allegations of routine or systemic mistreatment of patients in these institutions.

Court process

48. There have been two proceedings in the High Court relating to these claims, one in respect of allegations about Porirua Hospital and the other in respect of allegations about Ngawhatu Hospital. In both cases the claims were unsuccessful. The Ngawhatu claim failed to meet the evidential burden, while in the Porirua claim, the Judge found it was more likely than not a small number of relatively minor physical assaults by unnamed nurses on the plaintiff, which, except for the bar against such claims in the Accident Compensation legislation, might have resulted in a modest damages award. The factual findings in this case do not support that there was torture, cruel, degrading, or disproportionately severe treatment or punishment.

49. Since 2005, the claims against CHFA have primarily focussed on the applicability of statutory restrictions on many of these claims, with representative claims proceeding through the courts until a decision of the Supreme Court in September 2009, which clarified

the application of a leave and immunity provision in the Mental Health Act 1969 to many of the psychiatric claims. The Court confirmed that allegations of sexual and physical assaults by staff do not require leave. However, other allegations relating to the care, treatment and control of patients do require leave. The effect of this decision is that a large proportion of claims, particularly those relating to events prior to 1972, can no longer be pursued through the courts, although they remain open to resolution through the alternative procedure.

Alternative process

50. CHFA is willing to meet with claimants to discuss their claims, although most current claimants have to date chosen not to do so, apparently on legal advice. One claim has been settled following such discussions between the claimant and the representative of CHFA.

51. In 2004 the Government established a Confidential Forum for former psychiatric patients. Its purpose was to provide an accessible, confidential environment where former patients and/or their family members could describe their experiences in a psychiatric hospital, in confidence, to an informed, caring, receptive and non-critical panel. The panel was able to provide information on available services and refer the person to appropriate services and agencies which might be able to provide counselling or other assistance. The panel was empowered to assist, where appropriate, with some costs associated with counselling.

52. The Forum heard from 493 people (82 per cent were former patients, 12 per cent former patients' family members, and 6 per cent former staff). The panel advised the Government that most people attending the Forum found it a useful process, though there was criticism of its inability to award compensation.

53. The Government has since established a similar forum with a wider reach (CLAS), which offers an opportunity to those people who were in State care prior to 1992 to talk about their experiences and/or concerns with a panel of suitably qualified people, with a focus on their current needs. The panel can assist with seeking assistance from existing social services for these people and their families, and accessing information held about them by the State, in an environment where they can ask questions and seek corrections to information held.

Settlement process followed in earlier claims arising from treatment at Lake Alice Hospital

54. As noted above, the Government does not consider that the claims are amenable to a broader settlement procedure of the kind that it has followed in the past. One recent such procedure related to 95 claimants who, during the course of the 1990s, had filed proceedings against the Government in respect of treatment they received as inpatients of the Child and Adolescent Unit at Lake Alice Hospital in the period between 1972 and 1977.

55. In 2000, the Government decided to negotiate a confidential settlement with the claimants, which was finalised in 2001. Following this first settlement round, Cabinet agreed to a further confidential settlement process to include people who had not filed claims but were in the same factual situation as the first round claimants.

56. The Government did not require individual claimants to prove their cases. Rather, the Government was able to reach a view that the claimants' personal statements and the medical records demonstrated that there had been improper treatment. Compensation was paid from an allocated fund according to an independent assessment (by a former senior judge, Sir Rodney Gallen) of the harm each person had suffered.

57. The settlement process followed for Lake Alice is that:

- The eligibility criteria are that a person was a resident (inpatient) in the Child and Adolescent Unit at Lake Alice Hospital between 1972 and 1977.
- A claimant submits a claim to a co-ordinator in the Mental Health team within the Ministry of Health.
- The claims are assessed as to whether they meet the eligibility criteria by an independent assessor (currently a District Inspector under the Mental Health (Compulsory Assessment and Treatment) Act 1992), who carries out any further inquiries as to whether or not the applicant meets the eligibility criteria.
- The claims are then referred to a retired High Court Judge, who confirms whether the eligibility criteria are met and if so, the appropriate level of compensation.
- The matter is then submitted to the Ministry of Health, to prepare a letter of apology and payment of compensation to the claimant.

58. This settlement process is basically complete. The Ministry of Health is currently contacted by an additional 2-3 people per year who claim eligibility, and this settlement process continues to operate where those claims are received.

Distinctions between Lake Alice and current historic claims

59. There are two key differences between the current psychiatric hospital claims and the Lake Alice claims which explain the different approach taken by the Government in addressing them. Firstly, the Lake Alice claimants' allegations were factually clearly established. In the current claims, the factual allegations are generally contested. Second, the Lake Alice claimants' allegations were substantially the same in that they related to treatment conditions in the Child and Adolescent ward at Lake Alice, during the period 1972-1977 under the care of one particular doctor.

60. The current claims are highly diverse and allege a range of specific instances of mistreatment and abuse across a range of institutions by a wide range of other people. As such, individual consideration and investigation of the claim is necessary and a Lake Alice type settlement process would not be feasible.

Paragraph 14 of the concluding observations

The State party should consider withdrawing its reservation to article 14 of the Convention and ensure the provision of fair and adequate compensation through its civil jurisdiction to all victims of torture.

61. As indicated in paragraphs 231 to 244 of New Zealand's fifth periodic report, New Zealand makes broad provision for compensation and other redress to victims of torture through the New Zealand Bill of Rights Act 1990, the provision for compensation for criminal injury under the Accident Compensation Act 2001, tort law, the provision for discretionary payments under the Crimes of Torture Act 1991 and several other, more specialised legal regimes.

62. As those schemes do not or at least may not in practice, provide for comprehensive compensation, New Zealand is continuing to review the further steps, if any, necessary to withdraw its reservation. Such steps may follow from two current reform projects relating to the victims of crime:

- The Government has recently introduced a number of initiatives that will offer additional support to victims of serious crime, including providing additional support to families of homicide victims and help to victims of sexual violence. The Ministry of Justice has also been directed to undertake a review of victims' rights and access to support services, which includes reviewing the legislative, policy, and operational issues associated with the implementation of the Victims' Rights Act 2002 (which was described in paragraphs 239 to 241 of New Zealand's fifth periodic report). That review is expected to be completed in 2011.
- The Law Commission – which is an independent, Government-funded organisation, which reviews areas of New Zealand law that need updating, reforming or developing – has also been directed to conduct a complete independent review of New Zealand's system for compensating victims of crime. The review will consider the adequacy of New Zealand's mechanisms for compensating victims of crime and identify priorities for reform. An issues paper has been published and public submissions have been sought. The Law Commission will soon make recommendations to the Government for changes to domestic law. The Government will consider the Law Commission's report and respond publicly.

Paragraph 16 of the concluding observations

The State party should consider relinquishing the use of electric taser weapons, the impact of which on the physical and mental state of targeted persons would appear to violate articles 2 and 16 of the Convention

63. The Government does not consider the use of Tasers to constitute torture, cruel, inhuman or degrading treatment. The Police are committed to ensuring a safer community for all involved, and in accordance with articles 2 and 16 have ensured that the Taser is subject to strict safeguards. The Police conducted a trial and completed an extensive literature review, developing an international best practice for Taser use. Consequently there is a set of Standard Operating Procedures, a training programme, and a set of first aid procedures all of which govern how Tasers are to be used.

64. Safeguards include restricting Taser use to specially trained constables who are also certified in tactical safety and first aid, imposing strict conditions on when Taser use can be justified, ensuring that there is a medical assessment and aftercare of the affected subject, and the use of automatic video recording and follow-up reporting when a Taser is used.

65. In particular, and noting the Committee's concerns, a certified constable may only use a Taser in accordance with Police instructions and in proportion to the threat posed by the subject. Notably, Tasers must not be used against a subject who is uncooperative but not aggressive. In addition, there is a range of circumstances in which the use of Tasers is prohibited, for example, where particular hazards exist, or in response to demonstrations or protests. Unauthorised use would entail disciplinary or criminal consequences for the constable concerned, and the prospect of civil proceedings by the affected person.

66. In the context of these safeguards, Tasers are an important additional tool to ensure the safety of the public. This includes the safety of persons subject to Taser use, particularly as New Zealand is one of only six countries in the Organisation for Economic Co-operation and Development (OECD) where police do not routinely carry firearms.[4] Since 1990 there

[4] The others being Iceland, Ireland, Norway, South Korea and the United Kingdom.

have been 29 shootings by the New Zealand Police, three being in 2009, two of which were fatal. In an effort to reduce the likelihood of injuries or fatalities inherent in the use of firearms, there has been a desire to find a less-lethal alternative. The availability of Tasers will reduce the need for the Police to use firearms in violent situations. This will therefore reduce the risk of fatalities. Tasers will also provide officers with increased safety, as they allow officers to maintain a safer distance from violent individuals. While the use of Tasers does, in the Government's view, require thorough safeguards, they are strongly preferable to the alternative of broader use of firearms.

67. For these reasons, the Government does not plan to relinquish the use of Tasers and is confident that the procedures and processes that the New Zealand Police have put in place are sufficient to meet any concerns. These procedures and processes are described in detail below, along with a summary of the trial and an update on the progress of the subsequent roll-out.

Safeguards

68. One of the major concerns put forward in opposition to the introduction of the Taser is the potential for it to be used excessively. This is a valid concern which the Police take seriously.

69. In accordance with articles 2 and 16 of the Convention a number of safeguards which are regularly reviewed and revised have been put in place in order to reduce the risk of any form of abuse of the use of Tasers, including any use which would amount to torture.

70. Firstly, Tasers are only to be issued to trained and certified staff. These staff members are selected by the District Commander and approved by the National Manager: Professional Standards. These staff members must:

- Have a minimum of two years of relevant Police service
- Hold a current New Zealand Police First Aid Certification
- Hold a current New Zealand Police Electro Muscular Incapacitation device operators or instructors certification
- Hold a current Staff Safety Tactical Training certification
- Go through a Staff Safety Tactical Training course prior to be being issued with a device. This will consist of eight hours of training. Operator recertification will then be conducted annually.

71. Secondly, the use of Tasers is governed by Standard Operating Procedures. Tasers are not to be routinely carried by Police constables. Tasers are acquired by trained and qualified constables at the beginning of their shift and placed in a locked metal box bolted to the floor of their patrol vehicle. Tasers can only be removed from the box following an assessment (and with a supervisor's authority) that an incident is likely to pose a threat of assault to the public or Police, and are returned to secure storage at the conclusion of a shift.

72. When considering whether to use a Taser, the officer must have an honest belief that the subject (by age, size, apparent physical ability, threats made, or a combination of these) is capable of carrying out the threat posed. The Taser can then only be used in situations within or beyond the assaultive range (which is outlined in the Tactical Options Framework). The device must never be used to induce compliance with an uncooperative but otherwise non-aggressive person.

73. Police instructions outline various restrictions on the use of Tasers. Use is restricted in circumstances:

- Where the subject is offering passive resistance

- Involving crowd situations (Tasers must not be carried by constables policing demonstrations)
- Where there are flammable objects or explosives nearby
- Against a female who is known to be or believed to be pregnant
- To incapacitate persons using multiple cycles of Taser discharge[5] (if the Taser is ineffective after the first cycle then operators must utilise alternative tactical options).

74. Care should also be taken where subjects are in an elevated position or near water. There are also restrictions on how the Taser can be used. In laser painting mode[6] the laser must not be intentionally aimed at the eyes of the subject. In discharge or contact-stun mode[7] the head, face, neck and groin area should not be targeted. The chest area must also be avoided.

Criminal responsibility

75. Members of New Zealand Police are individually criminally responsible by virtue of section 762 of the Crimes Act 1961 for the use of any excess force during the course of their duties. They may also be subject to internal disciplinary action.

76. Independent mechanisms to receive complaints of police misconduct are available through the Independent Police Conduct Authority.

Vulnerable groups

77. Race and sex are not factors relevant in the decision to use any particular tactical option available to the Police. As noted above, one of the ways in which the Police ensure that Tasers are not used improperly, including discriminatorily, is to restrict the circumstances in which a Taser may be carried.

78. The trial (which is discussed below) identified Māori and Pacific peoples, and people affected with mental health issues as vulnerable groups. The Police will continue to engage with Māori, Pacific peoples and mental health stakeholders to work together to address the underlying causes as to why these groups were over-represented during the trial.

Young persons

79. The operating procedures do not specifically restrict the use of Tasers by age, as age is no barrier to violent behaviour. Young people can be as capable of violent behaviour as adults. However, the constable must ensure that the use of the Taser is a proportionate response to the threat posed by the young person.

Monitoring

80. Each Taser has a video and audio recorder on board to record each time it is used. This camera automatically records audio and video of an incident when the Taser is

[5] Discharge with probes fired: probes make physical contact with subject, an electrical current is delivered to the subject by means of probes attached to insulated wires.

[6] Laser painting mode: no physical contact with subject, directing red laser light over subject's body as a deterrent.

[7] Contact-stun mode: device makes physical contact with subject, an electrical current passes through the subject by means of subject-device contact.

removed from the holster. This ensures that Police use the device fairly and according to the operating procedures.

81. Every time the Taser is switched on, discharged, used in contact-stun mode, arching[8] or pre-operational spark testing, the details of the date, time, duration, number of activations and member involved is recorded by the Taser's on-board computer. The Police log each deployment of a Taser and record the serial number of each Taser cartridge.

82. Information recorded by the Taser's internal computer and the video and audio recorder information is uploaded to Police computer systems every time a Taser is acquired. This information is retained for evidential purposes, training, and ensuring the Taser has been used appropriately in accordance with standard procedures. It also allows any use of a Taser to be traced back to an individual constable.

Transparent process

83. In order to ensure transparency and oversight of Taser use, the New Zealand Police continue to work with the Human Rights Commission and various non-governmental organizations, and publish Police instructions for Taser use, summary of reports on incidents involving Tasers and the findings of an external medical advisory group.

Taser deployment in practice including post-treatment

84. The Standard Operating Procedures require that unless it is impractical or unsafe to do so a verbal warning be given in conjunction with the deployment of the Taser in order to encourage peaceful compliance and to warn others nearby. A further verbal warning is also given in conjunction with discharge or contact-stun mode.

Aftercare

85. The Standard Operating Procedures outline the required aftercare procedures. Where a person is exposed to the Taser device it is the responsibility of the deploying member to ensure that the individual is assessed for injuries, and is constantly monitored and provided with the appropriate level of aftercare. Normal First Aid procedures (as per Police Training) must be adopted and appropriate measures, including cardiopulmonary resuscitation (CPR) where applicable, should be instigated. Where the individual’s safety is at risk, medical assistance must be sought.

86. Medical practitioners must examine all people who are exposed to the Taser device as soon as practicable. Medical attention is essential where the subject does not recover within a reasonable time, complains of a medical condition, asks for medical attention, the Police are informed/believe that the subject has a cardiac pacemaker or other implanted medical device, or where in the Police opinion the subject appears to be suffering from a medical condition, pre-existing or otherwise.

87. The probe must be removed from the subject with their consent at the earliest opportunity. If the subject asks for a medical practitioner to remove the probe then the Police must leave the probes in place, but still minimise the discomfort of the subject, and shall facilitate their request at the earliest opportunity.

88. The only Taser-related injuries or health issues to subjects was a minor probe wound reported in 2009.

[8] Arching: no physical contact with subject, causing device to emit a visible electrical arc in front of subject as a deterrent.

Medical Advisory Committee

89. An external medical advisory group reviews medical reports and provides a summary in annual reports. The professional make-up of the medical advisory group includes doctors, nurses, and academics who hold positions in the areas of mental health, emergency medicine ambulance medical services, nursing, university medical and health sciences, and general practitioner medical services.

90. Additionally, an independent reference group has been formed to provide independent and expert advice around Police use of force (including Tasers). This reference group includes doctors (including mental health professionals), researchers, lawyers (including human rights lawyers) and academics.

Post-incident procedures

91. Where the Taser has been deployed, the officer involved must ensure that a supervisor is notified as soon as practicable. This supervisor must attend the scene as soon as possible to ensure proper aftercare is administered, preserve and photograph the scene where necessary, and recover all evidence. They must also investigate the incident to determine whether the use of the Taser was in accordance with the Standard Operating Procedures, and make sure that the member completes a report of the incident. Post-incident information packs are accessible to all members who carry a Taser device in the course of their duty. This includes a copy of the Standard Operating Procedures, a guide for operators, information leaflet for the subject, medical personnel and for hospitals as well as evidence and exhibit bags, antiseptic wipes, surgical gloves and containers for the probes.

Summary of the trial and update on the progress of the subsequent roll-out

92. The Committee has been previously advised that the Police conducted a trial of the Taser device in four Police districts (Auckland, Waitematā, Counties Manukau and Wellington) from 1 September 2006 to 31 August 2007. The trial was conducted as part of a review to examine less-lethal weapon options for managing violent individuals to ensure that Police tactics and equipment are the most effective, and least likely to endanger the safety of Police, the public and offenders.

93. Prior to the trial, the Police conducted an extensive review of available literature on the use of Tasers by enforcement officers, as well as scientific and medical research. This evaluation ensured that Police were aware of and could take into account domestic and international concerns about the manner in which the device was used and led to the development of international best practice for the use of Tasers by the Police in New Zealand. An extensive evaluation report of the trial was completed and supported the Commissioner's decision to introduce the Taser nationwide.

94. In December 2008 phase one of the reintroduction began with the return of the devices to the same four districts that participated in the trial. The first post-trial employment of the Taser did not take place until late January 2009. During the first year (phase 1) of reintroduction, 32 Taser devices were available and approximately 300 staff members were authorised to deploy the device operationally.

Statistics: trial and reintroduction

95. The Taser was employed a total of 128 times during the Taser trial. The Taser has been employed 132 times during the reintroduction phase, which counts for less than 7 per

cent of the 2,026 Tactical Options Reports[9] ("TORs") in 2009 (not including "Dog Bite" or Armed Offenders Squad call-out reports). In the nine incidents where the Taser was deployed during 2009 (again, not including the dog), eight of the subjects were arrested and one was transported to a mental health hospital. Staff believed every subject was violent and had access to a weapon (weapons were recovered in eight of the incidents). The police did not receive any injuries.

96. At this stage the statistics available are too small to be considered as a valid statistical sample. The methods of employment are set out in the table below.

	Presentation mode	**Laser painting mode**	**Arching mode**	**Discharged with probes fired**	**Contact-stun mode**
Trial	11% (12)	69% (80)	3% (3)	16% (18)	1% (2)
Reintroduction	16% (21)	76% (100)	1% (1)	8% (10)	0

Weapons

97. During the Trial, weapons were present at 66 per cent of incidents, and believed to be present at a further 18 per cent. The majority (70 per cent) were cutting/stabbing weapons. Police reported alcohol or drug use in 51 per cent of incidents, and family violence was a factor in 39 per cent. Mental health issues were a factor in 21 per cent of incidents.

98. The most common subjects were between 25 and 29 years old (30), followed by 35-39 year olds (27), 20-24 year olds (21), and 14-16 year olds (5). New Zealand European/Pākehā subjects comprised 36 per cent, Māori comprised 32 per cent and Pacific Island peoples comprised 26 per cent.

99. During the reintroduction, weapons were present at 53 per cent of incidents, and believed to be present at a further 81 per cent. The majority (57 per cent) were cutting/stabbing weapons. Police reported alcohol or drug use in 54 per cent of incidents. In the 131 incidents (not including one dog), 32 per cent (42) involved mental illness or suicidal behaviour.

100. The most common subjects were between 31 and 50 years old (54), followed by 21-30 year olds (38), 17-20 year olds (21), 51-99 year olds (9) and 14-16 year olds (4). New Zealand European/Pākehā subjects comprised 36 per cent, Māori comprised 37 per cent and Pacific peoples comprised 21 per cent, followed by Asian (1.5 per cent), Indian (1.5 per cent), and unknown (1.5 per cent).

[9] Electronic reports that the Police use to notify deployment of tactical options during a use of force situation.