Oranga Tamariki Residence Visit

(OPCAT monitoring under COVID-19 Alert Level 4)

Korowai Manaaki Youth Justice Residence

Virtual visit date: s 9(2)(a) OIA

Report date: 1 July 2020

MANAAKITIA Ā TĀTOU TAMARIKI
Children's Commissioner

Context

This brief report describes the information collected during the virtual monitoring 'visit' undertaken by the Office of the Childrens Commissioner (OCC) to Korowai Manaaki Youth Justice Residence during the COVID – 19 epidemic. This visit was undertaken by s 9(2)(a) OIA [redacted] from the Office of the Children's Commissioner.

The first New Zealand case of this virus was reported on 28 February 2020. The government subsequently announced four alert levels designed to reduce the spread of COVID-19, with increased restrictions on travel, work and services at each level[1]. On 23 March 2020, the Prime Minister announced New Zealand was moving to level three immediately and to level four within 48 hours. Level four, commonly described as a 'lockdown', was to extend for at least four weeks. This decision had particular implications for children and young people in secure residences.

Under the lockdown, almost everyone has been confined to their homes almost all the time. The exceptions have been essential workers who can leave their homes to go to work and essential travel which is limited to visits to the supermarket or pharmacy, and exercise close to home. Everyone except for essential workers has been required to stay inside their personal 'bubble' which consists of the people who make up their individual household.

For most people, opportunities for face-to-face contact with people outside their bubble have been extremely limited. For children and young people living in a secure residence, the residence as a whole, or their unit within the residence, has become their bubble.

Purpose of this monitoring visit

The purpose of this visit was to fulfil the international monitoring mandate of the Office of the Children's Commissioner to monitor the safety and wellbeing of children and young people detained in secure locked facilities during this period of lockdown. Visits to places of detention are particularly important in situations where civil liberties have been severely restricted because of serious health risks.

The Children's Commissioner is a National Preventive Mechanism (NPM) under the Crimes of Torture Act (1989)[2]. The role of OCC is to visit youth justice and care and protection residences, which are places of detention. The purpose of each visit is to examine the conditions and treatment of children and young people, identify any improvements required or problems needing to be addressed, and make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing ill treatment.

This visit was undertaken for the specific purpose of monitoring the safety and wellbeing of children and young people living in secure residences, and ensuring their rights were being upheld.

[1] See https://covid19.govt.nz/assets/resources/tables/COVID-19-alert-levels-summary.pdf

[2] This Act contains New Zealand's practical mechanisms under the United Nations Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (OPCAT). https://www.occ.org.nz/our-work/monitoring/monitoring-work/why-we-monitor/

Given the 'virtual' nature of these visits and the significant pressures on residence staff at this time, our primary focus was on interviewing children and young people and understanding their experience of the lock down environment. In contrast to our usual practice, we did not interview the full range of Oranga Tamariki staff and stakeholders. For this reason, no ratings have been given, although it is our usual practice to do so.

Our monitoring approach

In response to the level four announcement, OCC developed areas of inquiry specifically relating to COVID-19 using the domains for OPCAT monitoring[3]. An infographic on how we monitored during this time can be found in Appendix One.

This work was informed by advice provided to NPMs by local and international organisations[4]. Relevant advice for places of detention, provided by the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, is attached as Appendix Two.

Questions for children and young people, residence managers and health workers were developed against each OPCAT area of inquiry. We then designed a series of 'virtual' monitoring engagements to offer children and young people the opportunity to talk about their experiences in secure residences.

We were particularly interested in children and young people's:

- understanding of and reaction to pandemic plans
- access to health care and hygiene equipment
- contact with staff, whānau and other people who are important to them
- access to activities and programmes, and
- understanding of plans for any transitions in and out of residence.

We also wanted to hear from residence managers about how practice is developing in the new lockdown environment, emerging challenges and strategies to address these.

Following the development of our questions, we worked with residences to adapt our engagement processes to best suit the needs of children and young people using the available communication equipment. As well as talking with children and young people, we also interviewed the residence manager and a member of the health team to understand their systems, practices and planning around COVID-19.

To ensure the experiences of young people could inform practice, we provided the residence leadership with verbal feedback after our visit and prior to the report.

[3] https://www.occ.org.nz/our-work/monitoring/monitoring-work/why-we-monitor/

[4] These include, among others, the New Zealand Human Rights Commission in their role as the Central NPM for New Zealand, the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), and the Association for the Prevention of Torture (APT).

Structure of this report

This report starts with a brief description of Korowai Manaaki youth justice residence, the number of young people living there and the circumstances surrounding our visit.

The next section lists our areas of enquiry then describes what we heard from various sources – the Residence Manager, a member of the health team and young people. To provide context, each area of enquiry begins with the information provided by the residence manager and a member of the health team about operational changes and the rationale for decisions made under lockdown. This is followed with descriptions of what we heard from young people. To preserve the confidentiality of the small number of young people interviewed s 9(2)(a) out of a total of 36 in residence at the time) we have not used direct quotes. Following the visit, we engaged with the Quality Lead for the residence to investigate possible ways to increase future uptake of interviews with OCC by young people. These included ensuring the residence had sufficient time to prepare for the visit, and increasing awareness of OCC's profile with staff and young people between visits. Some constraints for this virtual visit are discussed throughout this report, including access to video calling technology at the residence. These access issues restricted the type and amount of our engagement with the residence before the visit and also meant that interviews with young people had to be carried out in the AVL room away from the units.

We are looking forward to engaging with a wider range of young people when we do a full OPCAT monitoring visit mid year.

The final section describes issues that came up during our monitoring visit along with our actions in response.

About Korowai Manaaki Youth Justice Residence

Korowai Manaaki is a 46 bed secure residence located in South Auckland.

At the time of our visit, there were 36 young people placed in the residence. Their ages ranged from 15 to 18. The number of young people had been reduced in order to make a unit available to be used as an isolation unit for new admissions and to manage any potential COVID-19 illness.

We explored the possibility of using video calling using platforms like Zoom to talk with young people. The residence advised that most of their staff had not been upgraded to the digital workplace which meant there were at most 6 devices in the residence capable of being used for video calling. On advice from the residence we opted to use the residence Audio Visual Link (AVL) so that young people could see who they were speaking with. Prior to the interviews, we asked if young people could see a video prepared by OCC staff to introduce themselves and the nature of the interviews. We were told that this would not be possible for the same reasons as video calling, therefore we settled on a letter to give the young people some idea about who we are and what we do.

Initially 13 young people indicated they wanted to talk with us. On the day, a total of s 9(2)(a) young people participated in the interviews.

Pandemic plans

The Residence Manager told us the focus from the beginning was on keeping young people and staff safe. We heard that the residence and health team worked together to share information about pandemic planning and to implement guidance in the residence setting. One example is that the isolation unit needed to be set up early. Initially this was set up in the secure unit because it had the facilities to keep young people separated from each other, but with support from the health team, the isolation unit was moved to another unit. The move involved hiring portable showers and bathrooms for staff working in the unit and the staff having separate entry and exit points to other staff in the residence.

Each unit was also it's own 'bubble'. Young people were not able to mix with young people from other units. Staff were also only able to work in one unit to reduce the risk of illness spreading between units.

The Residence Manager also contacted staff who had previously worked at Korowai Manaaki and were still employed by Oranga Tamariki, to arrange a contingency workforce. The initial worry was making sure there were enough staff on the floor, should staff become unwell or need to self-isolate.

What we heard from young people

Young people we spoke with had heard about COVID-19 and knew that it was a virus. They understood that changes in staff practice, such as washing hands frequently and staff only working in one unit, were to keep everyone in the residence healthy.

We heard from young people that they knew there was an isolation unit, 'the Coronavirus Unit', and that was where new admissions went before coming to the units and where young people would go if they were unwell.

Voices of children and young people

We heard from the Residence Manager that the Youth Council was not continuing under Alert Level 4 because young people and staff were not able to mix with others outside of their unit. Each unit was having community meetings each morning to talk about issues coming up for young people in their respective units. Young people could also talk with their Case Leaders or staff as well as having the usual access to the grievance process.

What we heard from young people

Young people we spoke with said there are staff they can talk with about any issues that they have.

Young people also said that even with a cohort of new staff starting just prior to lockdown, there are staff that they have a good relationship with and can trust.

Personal hygiene, cleaning and health

We heard from the Residence Manager that the message from before the lockdown for staff and young people was that hand washing and physical distancing is the best defence against COVID-19. Each unit had soap and disposable paper towels available in the bathrooms. When all the young people needed to wash their hands at the same time, such as when they have finished an activity outside or before meals, there are sinks available in the kitchen and laundry of each unit. The sinks in the kitchen and laundry are separate to where food is prepared and clothes are washed and they also have soap and disposable towels.

The residence has increased the cleaning schedule. Every weekday, two cleaners clean all the rooms on-site. One cleaner comes at 5am and the other in the afternoon. This is double the usual amount of cleaning.

We heard there is a health team member on-site daily. Health consultations are being carried out via phone consulation with the onsite nurse. The nurse meets with all new admissions in the isolation unit as part of their initial assessment and to begin building a relationship with them before moving to phone consultation. Young people need to ask a staff member in order to phone the nurse. During lockdown there were three young people who needed to go off-site for appointments and all of these young people were able to access specialist health support. The health team will also come on-site to carry out COVID-19 testing, reducing the risks associated with transporting a potentially unwell young person on new admission to a testing centre.

At the time of our visit the health team were looking to establish Zoom consultations instead of relying on the phone. The barrier had been the technology available to residence staff. Following up after our visit, we heard that this was still not able to be consistently implemented, due to a lack of resources like laptops. The lack of access to equipment meant that if a Case Leader was going to support a young person to have a Zoom consultation, the Case Leader had to use their own laptop or phone. This posed a tension between giving the young person privacy during their consultation and monitoring the young person's use and access to information while using the Case Leader's device.

Young people maintained contact with specialist health providers, such as Taiohi Tu Taiohi Ora (TTTO) via telephone.

What we heard from young people

All young people we talked with spoke about washing hands before kai and during activities throughout the day.

One young person told us their unit has a big clean in the weekends.

We heard that young people knew they could access the nurse or doctor by phone for a range of issues.

Young people we spoke with said they could contact people who were important to their care, such as their social worker and other health providers if they wanted to.

Contact with whānau and significant others

Young people continued to have access to whānau via the telephone. We heard that residence staff were making extra calls available for young people who:

- were worried about whānau,
- had older whānau members,
- had whānau who visited regularly but were not able to during lockdown, or
- were being bailed to a whānau member that they had not met before or did not know well.

If young people were having trouble getting hold of their whānau or were worried, Case Leaders could let young people use their office, to make calls at different times to the usual schedule. We also heard the care teams were facilitating more phone calls in the weekends.

Some Case Leaders were able to use Facetime on their phone for young people to have video contact whānau but not all Case Leaders had phones that were able to do this. We heard that all case leaders will soon have access to phones that can use FaceTime. However, ongoing use of video calls is still being considered as it may take a Case Leader away from other parts of their role.

We also heard that one unit had a broken phone. A new one has now been purchased.

What we heard from young people

We heard genuine concern amongst young people about whānau wellbeing, especially their older family members. We heard that young people were not able to keep up with news and updates about numbers and statistics, especially as case numbers were reducing at the time of our visit.

All young people we spoke with were getting standard phone calls in the morning and evening.

There were inconsistent levels of understanding from young people about being able to keep in touch with whānau. Some young people thought there were extra phone calls available, some thought phone calls had extra time, and some thought that only the usual schedule was available.

Activities and programmes

All off-site visits and external providers needed to be cancelled due to the lockdown. Because of this, the residence increased its internal programmes team in order to schedule activities for young people throughout the day. The variety of activities on the programmes schedule was limited. A further constraint was that activities could not involve mixing young people from different units as this would break their 'bubbles'.

Staff were running literacy and numeracy programmes while school was not available. Initially staff were compiling the content for the education programme but more recently the school had started providing books.

There were also physical activity programmes such as going to the gym, playing rugby and games on the back field and in the courtyard area of each unit and a four week inter-unit kapa haka challenge. The escort staff helped to run programmes as they had increased availability, due to there being less movement around the residence.

We also heard from the residence manager that the residence was preparing for upcoming language weeks and had done an ANZAC day challenge where young people decorated their units.

What we heard from young people

Young people we talked with were enjoying kapa haka challenge. Young people liked the inter-unit component of this challenge.

Young people enjoyed having regular access to gym.

Young people we spoke with had a variety of experiences with the programmes during lockdown. Some young people were feeling bored and some young people were feeling good about the activities and programmes available.

Young people enjoyed playing sports like rugby but were limited to playing with those in their own unit.

Staffing and staff relationships with children and young people

In mid March, just prior to lockdown, a new cohort of staff completed Te Waharoa induction programme. The timing meant these staff had already accessed the initial training they needed before going on the floor but they would need to have continued coaching and support in their new roles. The Team Leader Operations (TLOs) have been keeping in touch with their teams, including the new staff, to provide this support.

The new cohort meant that staff levels were higher than usual. The residence manager needed to balance staffing levels to ensure that a contingency workforce was available if staff needed to self-isolate and staff in the units were not mixing to reduce the risk of cross infection. The residence manager did this through the deployment of staff throughout the residence, for example increasing the programmes team and having escort staff give support by running activities.

Staff adjusted their expectations and practices to help young people adapt to COVID-19 changes. Staff put in place appropriate boundaries around handshaking between young people and staff and encouraged washing hands. Staff were consistently told that boundaries were in place to keep young people safe from staff. Staff also emphasised with young people that staff are the risk to them, not the other way round.

What we heard from young people

Young people identified that there were a lot of new staff and that some of the staff had come from 'next door' (Corrections officers). They said they felt they could get along with the new staff as well as exisitng staff.

Young people that we spoke with said they had good relationships with at least some staff on each shift.

Responsiveness to mokopuna Māori

The only Māori programme running at the time of our visit was the kapa haka challenge. The Residence Manager acknowledged responsiveness to mokopuna Māori is an area that needs more focus. The Residence Manager is interested in external supports to facilitate revitalising Te Rōpu Māori at the residence. This is an area that needs attention as our previous OPCAT report recommendation was that the residence continue to build partnerships with Māori stakeholders.

What we heard from young people

One young person we spoke with enjoyed taking a leadership role in the kapa haka challenge. Another young person was considering their iwi and their prior experiences in deciding which haka to do.

Transitions in and out of the residence

We heard that six young people had been admitted to Korowai Manaaki during Alert Level 4 lockdown. All of these young people went through the isolation unit and at one point all six were isolating at the same time. The number was manageable but made it difficult to keep young people separate, and the Residence Manager said that four would be a more manageable number for the size and capacity of the unit.

Oranga Tamariki National Office developed a screening tool for new admissions. The health team provided the residence with the most up-to-date information on case definitions from the Ministry of Health and the District Health Board, as these changed continuously throughout the lockdown.

Court dates and Family Group Conferences were continuing to run using AVL. This meant there was at times pressure on the AVL room. Residence staff wanted to get young people back to their community as soon as possible.

What we heard from young people

The young people that we spoke with had varied levels of understanding about their plans for when they left Korowai Manaaki.

Some young people we talked with knew what the plan was for when they left the residence.

One young person we spoke with knew where they wanted to live and what course they wanted to take but was not sure whether this was part of their plan.

Follow-up actions

This section outlines issues identified during our monitoring visit - what we did and what happened in response.

Individual matters

We followed up on several individual matters for young people including stress relating to dynamics in the unit and with other young people and worries relating to confidentiality when sharing information with the case leader team. These matters were raised with the Residence Manager, and the Team Leader Clinical Practice and followed up by the Case Leader. The residence response satisfactorly resolved these issues.

Broken phone

We heard that the phone in one unit was unable to be used by young people because it was broken. We were advised on s9(2)(a) OIA 2020 that a new one had been purchased.

We look forward to carrying out a full face to face OPCAT visit in mid 2020 to follow-up on this report and to carry out a comprehensive follow-up to this virtual visit. Our next OPCAT visit will have a particular focus on identifying tangible actions the residence is undertaking to improve outcomes for mokopuna Māori.

Appendix One

MANAAKITIA Ā TĀTOU TAMARIKI
Children's Commissioner

OPCAT 'virtual' monitoring under COVID-19 Alert Level 4

secure residences

What we did

- Undertook 'virtual' monitoring visits to 4 secure care and protection residences and 4 secure youth justice residences
- Interviewed 63 children and young people
- Interviewed 10 residence managers and team leaders
- Interviewed 8 health staff

Pre-visit engagement

- Liaised with national office and residence managers to plan the visits
- Created short videos for children and young people, introducing ourselves and explaining our processes
- Provided written information sheets for children and young people

What we asked children and young people about

- Understanding of, and reaction to, pandemic plans
- Access to healthcare and hygiene equipment
- Contact with staff, whānau, and significant others
- Access to activities and programmes
- Understanding of plans for transitions in and out of residence

Interview processes

- Each residence had different technological capabilities
- Some interviews undertaken via video, others via phone
- Sought verbal consent from children and young people
- Made sure children and young people had a private space to talk

After the visits

- Provided oral and written feedback to each residence manager
- Provided brief formal monitoring reports
- Followed up children and young people's concerns and requests

Highlights

- Ability to connect with children and young people despite lockdown
- Ability to advocate for children and young people during this period
- Ability to learn what worked and where to make changes
- Support and advice, from residence managers and national office staff, in the development of these processes

Appendix Two

30/4/2020

United Nations CAT/OP/10

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

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Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Advice of the Subcommittee to States parties and national preventive mechanisms relating to the coronavirus disease (COVID-19) pandemic*

I. Introduction

1. Within the space of a few short weeks, coronavirus disease (COVID-19) has had a profound impact on daily life, with many impositions of severe restrictions upon personal movement and personal freedoms, aimed at enabling the authorities to better combat the pandemic through public health emergency measures.

2. Persons deprived of their liberty comprise a particularly vulnerable group, owing to the nature of the restrictions that are already placed upon them and their limited capacity to take precautionary measures. Within prisons and other detention settings, many of which are severely overcrowded and insanitary, there are also increasingly acute problems.

3. In several countries measures taken to combat the pandemic in places of deprivation of liberty have already led to disturbances both inside and outside of detention facilities and to the loss of life. Against this background, it is essential that State authorities take full account of all the rights of persons deprived of liberty and their families, as well as of all staff and personnel working in detention facilities, including health-care staff, when taking measures to combat the pandemic.

4. Measures taken to help address the risk to detainees and to staff in places of detention should reflect the approaches set out in the present advice, and in particular the principles of "do no harm" and "equivalence of care". It is also important that there be transparent communication to all persons deprived of liberty, their families and the media concerning the measures being taken and the reasons for them.

5. The prohibition of torture and other cruel, inhuman or degrading treatment or punishment cannot be derogated from, even during exceptional circumstances and

* Adopted by the Subcommittee on 25 March 2020, pursuant to article 11 (b) of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

emergencies that threaten the life of the nation.[5] The Subcommittee has already issued guidance confirming that formal places of quarantine fall within the mandate of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT/OP/9). It inexorably follows that all other places from which persons are prevented from leaving for similar purposes fall within the scope of the mandate of the Optional Protocol and thus within the sphere of oversight of both the Subcommittee and of the national preventive mechanisms established within the framework of the Optional Protocol.

6. Numerous national preventive mechanisms have asked the Subcommittee for further advice regarding their response to this situation. Naturally, as autonomous bodies, national preventive mechanisms are free to determine how best to respond to the challenges posed by the pandemic within their respective jurisdictions. The Subcommittee remains available to respond to any specific request for guidance that it may be asked to give. The Subcommittee is aware that a number of valuable statements have already been issued by various global and regional organizations, which it commends to the consideration of States parties and national preventive mechanisms.[6] The purpose of the present advice is also to offer general guidance within the framework of the Optional Protocol for all those responsible for, and undertaking preventive visits to, places of deprivation of liberty.

7. The Subcommittee would emphasize that while the manner in which preventive visiting is conducted will almost certainly be affected by necessary measures taken in the interests of public health, this does not mean that preventive visiting should cease. On the contrary, the potential exposure to the risk of ill-treatment faced by those in places of detention may be heightened as a consequence of such public health measures taken. The Subcommittee considers that national preventive mechanisms should continue to undertake visits of a preventive nature, respecting necessary limitations on the manner in which their visits are undertaken. It is particularly important at this time that national preventive mechanisms ensure that effective measures are taken to reduce the possibility of detainees suffering forms of inhuman and degrading treatment as a result of the very real pressures that detention systems and those responsible for them now face.

II. Measures to be taken by authorities concerning all places of deprivation of liberty, including detention facilities, immigration detention centres, closed refugee camps, psychiatric hospitals and other medical settings

8. It is axiomatic that the State is responsible for the health care of those whom it holds in custody, and that it has a duty of care to its staff and personnel working in detention facilities, including health-care staff. As set out in rule 24 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.

9. Given the heightened risk of contagion among those in custodial and other detention settings, the Subcommittee urges all States to:

(a) Conduct urgent assessments to identify those individuals most at risk within the detained populations, taking account of all particular vulnerable groups;

(b) Reduce prison populations and other detention populations, wherever possible, by implementing schemes of early, provisional or temporary release for those detainees for whom it is safe to do so, taking full account of the non-custodial

[5] See article 2 (2) of the Convention against Torture and articles 4 and 7 of the International Covenant on Civil and Political Rights.

[6] See, for example, World Health Organization, "Preparedness, prevention and control of COVID-19 in prisons and other places of detention: interim guidance", 15 March 2020; and European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, "Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (COVID-19) pandemic", CPT/Inf(2020)13, 20 March 2020. Available at https://rm.coe.int/16809cfa4b.

measures indicated, as provided for in the United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules);

(c) Place particular emphasis on places of detention where occupancy exceeds the official capacity, and where the official capacity is based on a calculation of square metreage per person that does not permit social distancing in accordance with the standard guidance given to the general population as a whole;

(d) Review all cases of pretrial detention in order to determine whether it is strictly necessary in the light of the prevailing public health emergency and to extend the use of bail for all but the most serious of cases;

(e) Review the use of immigration detention centres and closed refugee camps with a view to reducing their populations to the lowest possible level;

(f) Consider that release from detention should be subject to screening in order to ensure that appropriate measures are put in place for those who are either positive for COVID-19 virus or are particularly vulnerable to infection;

(g) Ensure that any restrictions on existing regimes are minimized, proportionate to the nature of the health emergency, and in accordance with law;

(h) Ensure that the existing complaints mechanisms remain functioning and effective;

(i) Respect the minimum requirements for daily outdoor exercise, while also taking account of the measures necessary to tackle the current pandemic;

(j) Ensure that sufficient facilities and supplies are provided free of charge to all who remain in detention, in order to allow detainees the same level of personal hygiene as is to be followed by the population as a whole;

(k) Provide sufficient compensatory alternative methods, where visiting regimes are restricted for health-related reasons, for detainees to maintain contact with families and the outside world, including telephone, Internet and email, video communication and other appropriate electronic means. Such methods of contact should be both facilitated and encouraged, as well as frequent and provided free of charge;

(l) Enable family members or relatives to continue to provide food and other supplies for the detainees, in accordance with local practices and with due respect for necessary protective measures;

(m) Accommodate those who are a greatest risk within the remaining detained populations in ways that reflect that enhanced risk, while fully respecting their rights within the detention setting;

(n) Prevent the use of medical isolation taking the form of disciplinary solitary confinement; medical isolation must be on the basis of an independent medical evaluation, proportionate, limited in time and subject to procedural safeguards;

(o) Provide medical care to detainees who are in need of it, outside of the detention facility, whenever possible;

(p) Ensure that fundamental safeguards against ill-treatment, including the right of access to independent medical advice, the right to legal assistance and the right to ensure that third parties are notified of detention, remain available and operable, restrictions on access notwithstanding;

(q) Ensure that all detainees and staff receive reliable, accurate and up-to-date information concerning all measures being taken, their duration and the reasons for them;

(r) Ensure that appropriate measures are taken to protect the health of staff and personnel working in detention facilities, including health-care staff, and that they are properly equipped and supported while undertaking their duties;

(s) Make available appropriate psychological support to all detainees and staff who are affected by these measures;

(t) Ensure that, if applicable, all the above considerations are taken into account with regard to patients who are involuntarily admitted to psychiatric hospitals.

III. Measures to be taken by authorities in respect of those in official places of quarantine

10. The Subcommittee has already issued advice on the situation of those held in quarantine (CAT/OP/9). To that advice, the Subcommittee would further add that:

(a) Those individuals who are being temporarily held in quarantine are to be treated at all times as free agents, except for the limitations necessarily placed upon them in accordance with the law and on the basis of scientific evidence for quarantine purposes;

(b) Those being temporarily held in quarantine are not to be viewed or treated as if they were detainees;

(c) Quarantine facilities should be of a sufficient size and have sufficient facilities to permit internal freedom of movement and a range of purposive activities;

(d) Communication with families and friends through appropriate means should be encouraged and facilitated;

(e) Since quarantine facilities are a de facto form of deprivation of liberty, all those so held should be able to benefit from the fundamental safeguards against ill-treatment, including information of the reasons for their being quarantined, the right of access to independent medical advice, the right to legal assistance and the right to ensure that third parties are notified of their being in quarantine, in a manner consonant with their status and situation;

(f) All appropriate measures must be taken to ensure that those who are, or have been, in quarantine do not suffer from any form of marginalization or discrimination, including once they have returned to the community;

(g) Appropriate psychological support should be available for those who need it, both during and after their period of quarantine.

IV. Measures to be taken by national preventive mechanisms

11. National preventive mechanisms should continue exercising their visiting mandate during the COVID-19 pandemic; however, the manner in which they do so must take into account the legitimate restrictions currently imposed on social contact. National preventive mechanisms cannot be completely denied access to official places of detention, including places of quarantine, even if temporary restrictions are permissible in accordance with article 14 (2) of the Optional Protocol.

12. The objective of the Optional Protocol, as set out in article 1, is to establish a system of regular visits, whereas the purpose, as set out in the preamble, is the protection of persons deprived of their liberty against torture and other inhuman or degrading treatment or punishment, this being a non-derogable obligation under international law. In the current context, this suggests that it is incumbent on national preventive mechanisms to devise methods for fulfilling their preventive mandate in relation to places of detention that minimize the need for social contact but that nevertheless offer effective opportunities for preventive engagement.

13. Such measures might include:

(a) Discussing the implementation and operation of the measures outlined in sections II and III above with relevant national authorities;

(b) Increasing the collection and scrutiny of individual and collective data relating to places of detention;

(c) Using electronic forms of communication with those in places of detention;

(d) Establishing national prevention mechanism hotlines within places of detention, and providing secure email access and postal facilities;

(e) Tracking the setting up of new and temporary places of detention;

(f) Enhancing the distribution of information concerning the work of the national preventive mechanism within places of detention, and ensuring there are channels allowing prompt and confidential communication;

(g) Seeking to contact third parties (e.g., families and lawyers) who may be able to provide additional information concerning the situation within places of detention;

(h) Enhancing cooperation with non-governmental organizations and relief organizations working with those deprived of their liberty.

V. Conclusion

14. It is not possible to accurately predict how long the current pandemic will last, or what its full effects will be. What is clear is that it is already having a profound effect on all members of society and will continue to do so for a considerable time to come. The Subcommittee and national preventive mechanisms must be conscious of the "do no harm" principle as they undertake their work. This may mean that national preventive mechanisms should adapt their working methods to meet the situation caused by the pandemic in order to safeguard the public; staff and personnel working in detention facilities, including health-care staff; detainees; and themselves. The overriding criterion must be that of effectiveness in securing the prevention of ill-treatment of those subject to detaining measures. The parameters of prevention have been widened by the extraordinary measures that States have had to take. It is the responsibility of the Subcommittee and of national preventive mechanisms to respond in imaginative and creative ways to the novel challenges they face in the exercise of their mandates related to the Optional Protocol.