Oranga Tamariki Residence Visit

(OPCAT monitoring)

Korowai Manaaki Youth Justice Residence

Visit date: s 9(2)(a) OIA 2020

Report date: 18 December 2020

Contents

Introduction

Purpose of visit

The purpose of this visit was to fulfil the international monitoring mandate of the Office of the Children's Commissioner (OCC), to monitor the safety and wellbeing of children and young people detained in secure locked facilities. On s 9(2)(a) OIA 2020, s 9(2)(a) OIA carried out an announced monitoring visit to Korowai Manaaki Youth Justice Residence. s9(2)(a) OIA .

The Children's Commissioner is designated as a National Preventive Mechanism (NPM) under the Crimes of Torture Act (1989)[1]. The role of his office is to visit youth justice and care and protection residences 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. Appendix 1 provides more details on the legislative background of our visits.

Context

Korowai Manaaki is a youth justice residence, located in Wiri, South Auckland. The residence sits within a semi-industrial area. Korowai Manaaki has 46 beds across five units.

Since our last OPCAT visit in s 9(2)(a) OIA 2019, there have been structural changes that apply nationally across youth justice residences. These include:

- A national increase in the number of Team Leader Operations (TLOs).
- A change in the roster to enable TLOs to spend more time on shift with Care Teams and young people
- Creation of Manager Residence Operations (MRO) and Quality Lead positions in each residence.

On 4 July 2020, s9(2)(a) O weeks before this visit, two young people absconded from the residence. The incident triggered a significant review of the processes and practices at Korowai Manaaki.

There have been significant staff changes as a result of the incident:

- An interim Residence Manager was appointed to the residence for six months. They had been in this role for five weeks at the time of our visit.
- Three TLOs have left the residence.
- Four care staff members have left the residence.

Young people at Korowai Manaaki

Young people can be detained at Korowai Manaaki under:

- Oranga Tamariki Act 1989 s311 and s238(1)(d).

[1] 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/

- Corrections Act 2004, s34A.
- Criminal Procedure Act 2011, s175.

At the time of our visit, there were 25 young men living at Korowai Manaaki. Three of the five units were open. A six bed and an eight bed unit had been closed including the girls unit. The young people ranged in age from 15 to 18. The legal status of these young people was as follows:

Status	**Number of young people**
Oranga Tamariki Act s.311 (Supervision with Residence)	s9(2)(a) OIA [redacted]
Oranga Tamariki Act s.238(1)(d) (Remand)	19
Criminal Procedure Act s.175 (Remand)	s9(2)(a) OIA [redacted]
Corrections Act s.34A (Detention of child or young person)	
Total young people	**25**

Our monitoring processes

We were interested in hearing about the experiences of young people and we also wanted to understand the group dynamics at the residence. We used several methods to engage with young people and staff.

We ran focus groups with young people in two out of the three units. All the young people present in each of their units at the time participated in the group discussion. Some young people were in secure and were not able to participate. One unit had another programme running at the time the focus group was initially scheduled. A focus group was planned for this unit on the last day of the visit but could not be held because the visit had to be cut short.

We spent time observing in the units, including eating and having conversations with young people and staff. This enabled us to see and experience after-school and evening routines.

As well as interviewing individual young people, we interviewed residence staff and external stakeholders, and reviewed relevant documentation.

For more information about our interviews and other information gathering processes see Appendix Two.

Our evaluation processes

In the past, the majority of our OPCAT reports have included a five or four-point scale. We used this scale to rate each OPCAT domain and to provide an overall rating for each residence.

We are currently reviewing our evaluation processes and are temporarily suspending the use of rating scales. Instead we will use key descriptors – harmful, poor, good and very good – to describe our overall findings in relation to:

- the treatment of young people at the residence
- the conditions at the residence

Our reports will also provide summaries of the strengths and areas for development according to each of the OPCAT domains.

The table below lists the new descriptors used in our findings, describing their impact and our expectations for further action.

Findings	**Impact for young people**	**OCC expectation**
Harmful	Treatment and/or conditions that are damaging or hurtful for children and young people	Must be urgently addressed
Poor	Treatment and/or conditions that are not sufficient to meet the needs of children and young people	Requires improvement in the near future
Good	Treatment and/or conditions that are sufficient to meet the needs of children and young people	Must be reviewed regularly to ensure the standard is maintained and improved if possible
Very good	Treatment and/or conditions that work well to meet the needs of children and young people	Should continue subject to effectiveness. May also be beneficial in other residential contexts

Overall findings and recommendations

Overall finding

We have serious concerns about Korowai Manaaki. We found that five key areas must be urgently addressed. These areas were identified as 'harmful' and have a significant impact on the safety and wellbeing of children and young people and impact across the seven OPCAT domains. The areas are:

- Young people do not have regular access to engaging activities and programmes.
- Young people have concerns that have not been listened to and say there is no point speaking up about issues that are important to them.
- The units are unclean.
- Staff do not have regular communication with each other, and staff teams are working in silos.
- Staff members do not have consistent or clear understandings of staff roles in the residence.

We would like to acknowledge that staff talked openly about the challenges they had experienced and the dilemmas that many of them had faced while working at Korowai Manaaki. Staff we spoke with were hopeful the changes currently underway would enable them to provide better services for young people in the future.

While it is encouraging that an extensive review is being carried out by the acting Residence Manager and the residence is being supported to make significant changes, we continue to have serious concerns for young people at Korowai Manaaki. We will conduct a follow-up visit in early 2021 to evaluate progress. We would like the Residence Manager and Oranga Tamariki National Office to regularly update us on progress with our three month recommendations.

Recommendations

The recommendations have been prioritised by timeframe, in relation to our planned follow-up visit. We do not expect formal written response to these recommendations from Oranga Tamariki given there will be an additional report in early 2021. The next report will include our updates as to progress against these recommendations and any further recommendations from our findings.

Within three months of this report

We recommend the Korowai Manaaki leadership team, with support from the DCE Youth Justice Services:	
Rec 1:	Continues to ensure all staff have consistent understanding of their roles and practice expectations at Korowai Manaaki (ref. page 11) *(Ref. State of Care, 2017, Action 1)*
Rec 2:	Changes the BMS 'buy-ups' to be items that are motivating but do not include rewards young people should receive routinely, such as time talking with whānau and haircuts (ref. page 11)
Rec 3:	Ensures that all staff have access to, and are familiar with, young people's plans so they can support young people to know and understand what their plans are (ref. page 10)
Rec 4:	Reviews the scheduling and running of Multi-Agency Team Meetings so individual plans are regularly reviewed by all relevant professionals and the young person (ref. page 11)
Rec 5:	Develops processes that enable young people to safely have time alone when they need to, in the units (ref. page 12)
Rec 6:	Provides a range of activities, to encourage calmness and reflection while young people are in the secure unit (ref. page 13)
Rec 7:	Reinstates and resources the Youth Council as a mechanism for young people to have a voice (ref. page 14 and page 27)
Rec 8:	Works with the Grievance Panel to re-establish monthly meetings between the Grievance Panel and the Grievance Coordinator as well as quarterly meetings between the Panel Chair and the Residence Manager (ref. page 15)
Rec 9	Works with VOYCE Whakarongo Mai to encourage more frequent and longer visits from VOYCE Kaiwhakamana (ref. page 15)
Rec 10:	Ensures the units are urgently cleaned and kept hygienic (ref. page 16)
Rec 11:	Prioritise hygiene matters, including consistent availability of soap. (Ref. page 17)
Rec 12:	Continues to make resources available to support care teams to plan and implement programmes (ref. page 18)
Rec 13:	Continues to work with young people and the clinical team to ensure that young people have phone calls at times of the day when their whānau are available (ref. page 19)

Rec 14:	Increases the level of collaborative communication and information sharing between all the professional groups working to support young people in the residence, as per our previous recommendation in Appendix 3 (ref. pages 23 and 27)
Rec 15:	Establishes regular lines of communication with external providers, and supports them to coordinate their services with each other (ref page 23)
Rec 16:	Supports Māori staff to re-establish Te Rōpū by ensuring they have time and resources to do so (ref. page 24).

Over the next 12 months of this report

National Office **We recommend the DCE Youth Justice Services:**	
Rec 17:	Establishes an integrated approach to transition from Korowai Manaaki so that Oranga Tamariki sites and the residence are able to link with appropriate stakeholders in a timely way (ref. page 13).
Rec 18:	Strengthens care of young people who are in joint care of Oranga Tamariki and the Department of Corrections by: a. Ensuring residential staff have access to clear operational and practice guidance b. Reviewing the Memorandum of Understanding between the Department of Corrections and Oranga Tamariki (ref. page 13).
Rec 19:	Works in partnership with relevant residential staff and external specialists to establish a therapeutic model and appropriate therapeutic environment for youth justice residences. The model needs to be supported by staff training in a range of areas, including supporting young people with mental health needs (ref. page 20) *(ref. State of Care, 2017, Action 2, 10, 13)*
Rec 20:	Amends the supervision policy to: a. include the provision of cultural supervision b. require one on one supervision for staff (ref. page 22) *(Ref. State of Care, 2017, Action 1, 17)*
Korowai Manaaki leadership **We recommend the Korowai Manaaki leadership team:**	
Rec 21:	Finds a drainage solution so the playing field is able to be consistently available for young people to use (ref. page 17)
Rec 22:	Develops staff cultural capacity so tikanga is embedded into daily routines and young people have increased opportunities to connect with their whakapapa and speak te reo Māori (ref. page 12)
Rec 23:	Works with the clinical team and stakeholders to review the process for gathering information on admission so that young people have coordinated, timely and meaningful plans (ref. page 14)

Rec 24:	Continues to work strategically to build partnerships with Māori stakeholders, as per our previous recommendation in Appendix 3 (ref. pages 24 and 27) *(Ref. State of Care, 2017, Recommendation 2 and Action 18)*

Of our recommendations from our OPCAT report of 27 August 2019, four had limited progress and five had no progress. There was one recommendation we did not monitor progress during this visit. For further detail, see Appendix Three.

Findings by domain

Domain 1: Treatment

Our monitoring of the Treatment domain includes examining the relationships between children and staff, models of therapeutic care and behaviour management, and the quality of planning and interventions tailored to individual children and young people's needs.

Findings from our last reports:

In our last OPCAT report dated 27 August 2019 we said:

- Young people had variable experiences of staff practice.
- Information gathering for individual care plans was not efficient.
- The Behaviour Management System was not individually tailored for young people.
- Restorative practice was not understood.

In our COVID-19 report dated 1 July 2020 we said:

- Young people had staff members they trusted to talk with.
- A new cohort of staff had started before lockdown and there was a focus on building relationships with young people.

Findings from this visit

Strengths

Staff are focused on building relationships with young people

Young people trusted many of the staff and felt some staff members held aspirations for them. We observed staff who knew the young people well and engaged warmly and proactively with them. One young person expressed his respect for the care team by describing how he would like to work in residence when he is older. The residence leadership and clinical teams have regular contact with young people and were familiar with each unit.

"The staff is all good in here, they can protect myself, they can help me."

Young people generally have positive relationships with each other

Young people felt safe with most other young people in the residence. We heard that young people help each other with grievances and suggestions, when there are difficulties with staff members, when conflict resolution is needed. The Case Leader team, Team Leader Operations (TLOs) and the residence leadership team were aware of some difficult dynamics among young people and factored them in to operational decisions.

Areas for development

Young people had variable experiences due to inconsistent staff practice expectations

Staff told us that before the acting Residence Manager came to the residence, many core practice processes were not being implemented consistently, such as line of sight and resource lists. The varying understanding that staff have of their roles and practice expectations impacted on young people regarding access to equipment and consistent professional relationships as well as interactions with staff.

One impact on young people is that they are no longer able to access sensory boxes as a therapeutic tool. This is because the sensory boxes were not thoroughly and consistently checked after they had been used by young people. Young people then used the boxes to conceal items that could pose a risk or be used in tagging. The sensory boxes were discontinued until risks associated with young people having access to the equipment could be managed appropriately by staff.

We observed different team processes between units and different practice between staff within teams. One example was that each unit had different expectations on young people for showers and preparing for the evening meal.

Young people also had variable experiences when staff restrained them. Young people talked about differences in the way they were restrained, with some staff restraining them hard. Young people also talked about needing to know staff so they could predict how a staff member might react.

> *"Some staff are really hardcore with restraints, coz I've seen really hardcore restraints and I've seen like real soft restraints that like I dunno, like the restraints are alright."*

The Behaviour Management System (BMS) includes 'buy-ups' that should be available to all young people

We heard that young people needed to be on BMS level three to get a haircut. It is detrimental that some young people cannot access a service that is a normal part of their hygiene and grooming, especially during adolescence.

We heard from young people that those on BMS levels one and two have one 10-minute phone call a day. They said young people on level three can have a 20-minute phone call. We have received clarification from the residence leadership team that BMS is not linked with phone calls, however some young people worried they would not get a phone call to their family if they did not complete their duties.

Young people are not familiar with their plans

We saw plans that indicated Case Leaders had worked with young people to find out about them and their goals. Some young people signed the plans to say they had read them. Despite this, not all young people were aware they had a plan, what the plan was, and how it factored into what they were doing at Korowai Manaaki and what they would do when they left.

Young people's plans are not regularly reviewed with their team

Multi Agency Team (MAT) meetings are held at the residence once a week and include the Case Leader, site Social Worker, forensic mental health, alcohol and other drug support, and any other agency involved with each young person. However, the weekly meetings only cover new admissions and only review existing plans if there has been an incident. The meetings do not proactively review and update individual care plans.

Young people are not supported to learn about their identity

Young people want more help from Oranga Tamariki residence staff to learn about their whakapapa, have more opportunities to speak te reo Māori and have tikanga observed as part of daily routines.

Through our review of grievance register and through interviews with staff, s9(2)(a) OIA [redacted]

Young people need opportunities for time alone

Young people told us it was important to have time to themselves in their rooms, especially when they were upset or angry. They said they could not go to their rooms during the day. Young people called this 'reg 24' as explained below:

> *"So regs 24 is basically if you're feeling sick or heightened you have the right to go to your room to calm down or relax or sleep if you're sick."*

Young people wanted time in their rooms under 'reg 24' but they were no longer allowed to go to their rooms during the day, since the recent absconding incident. One impact of this was that some young people told us that they liked going to secure to have time away from the unit.

For clarity, s24 of Oranga Tamariki (Residential Care) Regulations 1996 prevents young people being confined in their rooms for more than one hour between 7am and 8pm. This section from the Regulations seems to have been confused by young people with having the right to be in their room.

Young people in the secure unit do not have access to activities

We heard young people in secure care had limited time out of their rooms and limited access to activities. Some young people found this was challenging and not helpful for them on their return to the unit.

> *"Everyone here has a different experience [in the secure unit]. Mine was unpleasant in secure only coz of my thinking… Aw I just think too much when it's too quiet…like, I don't recommend it because it's kinda a place like a punishment place."*

Transition from residence is not consistently supported

Many young people do not know where they are going when they leave Korowai Manaaki. This is a barrier to meaningful plans being made while young people are in the residence and continuity of care being provided when they leave. Health and education providers are given limited information about timeframes for when young people are due to be released. Some opportunities for offsite work experience have been declined despite businesses being willing to have them. We also heard about one young person whose belongings were packed into a rubbish bag when they left.

Lack of clarity about requirements for young people in 'Corrections Beds'

Staff were unclear about operational decisions for young people who were either sentenced or remanded to Korowai Manaaki under the Corrections Act or the Criminal Procedure Act. Since these young people were not subject to the Oranga Tamariki Act, staff were unclear about whether they could go to secure and mix with other young people in Korowai Manaaki. Offsite activities needed to be approved by Case Managers from the Department of Corrections. This meant young people were limited in their activities. Staff were unsure about how to prepare these young people to transition to prison rather than their community.

Domain 2: Protection system

Our monitoring of the Protection System domain includes assessment of the safety of children and young people, and how well their rights are upheld.

Findings from our last reports:

In our last OPCAT report dated 27 August 2019 we said:

- An on-going 'snitch' culture was a barrier to young people using the grievance system.
- The residence had a sound process for admission.
- The grievance process was administered well.

In our COVID-19 report dated 1 July 2020 we said:

- The Youth Council had been stopped to prevent units mixing.
- Units had meetings every day.

Findings from this visit

Strengths

Whaia te Māramatanga is used by young people to make suggestions

Young people use Whaia te Māramatanga to make suggestions and some young people use it to make grievances. The grievance register indicated there are a range of issues being raised by young people. Young people knew about the grievance process even if they had not used it to make a grievance. The units had signs on the walls showing the process and photos of the grievance panel. Boxes for completed forms were on the walls in every unit.

Areas for development

Admission processes do not result in integrated plans

The admission process requires information to be gathered within a seven-day timeframe to form the individual care plans, risk plans, education plans and health plans. The case leader, health team, and education team all gather information to make plans and this results in information being gathered from different sources that is not integrated into a comprehensive plan for young people.

Young people do not see changes as a result of their feedback

Young people said it was only worth using their voice about small things because if they raised larger issues, even as a group, there would be no change. Young people said some staff were barriers to change and would minimise issues, which had the effect of preventing young people raising issues. Young people wanted the Youth Council to start again as a way of having a voice.

"You don't really got a say in this place, here to do the time."

There is a breakdown between the grievance panel and the residence

The grievance panel has not been meeting monthly with key staff at the residence nor has the panel had quarterly meetings with the residence. The quarterly reports have been late for the previous three quarters. There is a disagreement between the panel and the residence over whether the panel is provided with sufficient information to complete the quarterly reports. These issues are currently being followed up by the residence and Oranga Tamariki National Office.

VOYCE kaiwhakamana visits are severely time limited

VOYCE Whakarongo Mai provides advocacy and support for young people at the residence through their kaiwhakamana. The kaiwhakamana for Korowai Manaaki visits once a week for an hour. This is not enough time to engage with young people and follow up on issues. The relationship between VOYCE and Korowai Manaaki is in it's early stages and both residence leadership and VOYCE believe more engagement will benefit the young people. Young people enjoyed their engagement with VOYCE but were unsure when they would have another chance to talk with the kaiwhakamana.

Domain 3: Material conditions

Our monitoring of the Material Conditions domain includes assessment of how the living conditions in secure residences (e.g. accommodation, internal and external environments, hygiene facilities, bedding and food) contribute to children and young people's wellbeing.

Findings from our last reports

In our last OPCAT report dated 27 August 2019 we said:

- The material conditions were pleasant and youth friendly following a refurbishment at Korowai Manaaki.
- Young people sometimes had difficulty hearing people on the phones
- There was variable satisfaction with the food.

In our COVID-19 report dated 1 July 2020 we said:

- Each unit had a soap dispenser and paper towels available.
- Young people were being encouraged to frequently wash their hands.
- The cleaning schedule had been doubled with cleaning contractors coming onsite twice a day.

Findings from this visit

Strengths

Many young people liked the food

Young people liked having a menu available to see what was coming up. They also liked having the choice of a lighter meal on the menu. We also saw that young people had access to a range of other food through cooking programmes and as part of programmes like the "Boys to Men" that involved eating together.

"I think the food is awesome, enough to eat, it's good in here, better than no food to eat."

Areas for development

The living conditions in the units are harmful

The units have not been maintained since the refurbishment discussed in our 2019 report. The units had etchings and tagging throughout them. Some staff felt unsafe addressing tagging because it could lead young people to escalate. Fleas jumped onto our flipchart on the floor during focus groups and young people told us that they got insect bites that would swell into boils and become painful. Young people also showed us that the air vents were clogged with dust.

The units are not maintained hygienically for the COVID-19 pandemic context

We heard that the cleaning contractors had focused on the administration block and young people and casual staff were cleaning the units, even during COVID-19 lockdown. When we asked about cleaning during our COVID-19 monitoring we were not given a full and correct answer from the previous Residence Manager. We are extremely disappointed that we were misled about the cleaning schedule and state of the units during a global pandemic.

Young people do not have access to soap in the bathrooms and need to go to the kitchen to wash their hands. Young people and staff are encouraged to wash their hands frequently.

We are alarmed to find that young people have been living in these conditions. The acting Residence Manager is addressing this urgently and we expect new safe and hygienic arrangements to be embedded before our next visit.

Young people are unable to access outside spaces

As noted in our 2019 report, the outside space is pleasant and well maintained. However, young people are rarely able to access the space and spend much of their time in the units or the courtyards attached to each unit. Young people would like to have more time outside, including on the playing field, which is currently unable to be used due to being waterlogged. We heard the field had been drained multiple times but the drainage issue has not been resolved and the field remains unusable.

Domain 4: Activities and contact with others

Our monitoring of the Activities and Contact with Others domain assesses the opportunities available to children and young people to engage in quality, youth friendly activities inside and outside secure residences.

Findings from our last reports

In our last OPCAT report dated 27 August 2019 we said:

- The programme team had been expanded.
- Care Teams were inconsistent in their implementation of after school activities.
- Young people wanted more contact with whānau through longer phone calls or support for whānau visits.

In our COVID-19 report dated 1 July 2020 we said:

- Young people were worried about their whānau.
- Extra phone calls are available when young people were worried or had vulnerable family members.
- Some case leaders had access to video calling and made it available for young people to see whānau. Young people were unsure of how much contact they could have and whether they could video call.
- We also heard that young people wanted more things to do during the day, while school was not running.

Findings from this visit

Strengths

Young people enjoy being at school

Young people like the range of activities available through school, including vocational programmes such as 'Site Safe', scaffolding, forklift, and a hospitality programme. For the hospitality programme, young people baked every Monday to sell at the café on Tuesday. Young people also engaged in creative and art projects using a range of mediums. The school has a kapa haka teacher and three teachers who speak te reo Māori. All the teachers participate in weekly Māori lessons to improve their reo.

Areas for development

Young people are bored

We heard and observed that programming is inconsistent between teams in each unit. Cultural programmes are not embedded in the schedule aside from Matariki and various language week programmes Young people have limited access to programmes that develop life skills and opportunities that they would have in their community, such as gaining a driver's licence.

Residence processes and spaces have inhibited programme planning

Staff are encouraged to run programmes but unclear processes for approving programmes and resources is limiting. Staff did not want to talk with young people about programmes if they were not sure they would go ahead. However, we heard about a successful music programme over the school holidays. We encourage the residence manager and programmes coordinator to keep working with care teams to implement activities.

The spaces at Korowai Manaaki inhibit staff being able to offer a range of activities. The residence does not have areas where programmes can be run and this was one barrier to hands-on and creative programmes. We encourage a review of the space available for activities, alongside resourcing considerations.

Young people have inconsistent contact with their family

All young people have one, 10 minute phone call a day, in the evening. Young people might get longer calls if the unit was not full or if other young people did not want a phone call. This meant that young people were uncertain about how much time they could have. Additionally, some whānau were not consistently available in the evening and some whānau used other digital platforms for phone call, like Facebook or WhatsApp. The impact is some young people were not sure how long they would have and whether they could get hold of their whānau.

Young people also wanted reassurance about privacy during contact with family. For example young people wanted to know that their phone calls were not recorded. This particularly impacted young people who had been in Corrections facilities as they talked about phone calls in prison being recorded. Young people also wanted more privacy during whānau visits.

Domain 5: Medical Services and care

Our monitoring of the Medical Services and Care domain evaluates how well children and young people's health needs are assessed and met.

Findings from our last reports

In our last OPCAT report dated 27 August 2019 we said:

- Korowai Manaaki leadership and health professionals work well together to both promote young people's wellbeing and respond to health needs.

In our COVID-19 report dated 1 July 2020 we said:

- Oranga Tamariki and the health provider were working in partnership to respond to the changing pandemic situation and keep young people safe.

Findings from this visit

Strengths

Onsite health staff work well with young people

s9(2)(i) OIA continue to provide on-site primary health care. Young people know how to make an appointment with the nurse and are confident doing so. The health team does a comprehensive health assessment when young people come into residence. The assessment includes sexual health and immunisation history as well as background research to try and find as much information as possible to inform the health care in residence. The health team tries to enrol young people with health providers in the community prior to their transition from the residence but this isn't always possible.

Specialist health staff work hard to engage with young people

Young people can access mental health supports through the Regional Youth Forensic Service, Taiohi Tu Taiohi Ora (TTTO). Odyssey House provides alcohol and other drug programmes at an allocated time slot during school hours. The dental van visits every six weeks, however young people who are 18 years or older need to go offsite to see the dentist.

Areas for development

Lack of communication with health providers

External providers would like to coordinate and improve their services but are unable to make progress due to lack of communication with relevant staff within the residence. This has meant that providers have been unable to make some changes to tailor and improve their processes and they have been unable to align their services so that young people receive comprehensive care.

Referral system to the health team needs to be improved

Lack of technology means the residence uses outdated systems for referrals and medication management. Referrals to the health team are made through Case Leaders, care staff, or young people asking the nurse when she is in the unit. Referrals to mental health supports are made through the Case Leaders. The system means that staff must be involved in referrals and young people are not able to maintain a level of privacy around their health.

Domain 6: Personnel

Our monitoring of the Personnel domain assesses the quality, suitability and capacity of Oranga Tamariki staff to provide safe, secure, respectful care for children and young people, including processes for staff recruitment, selection, training, supervision and ongoing professional development.

Findings from our last reports

In our last OPCAT report dated 27 August 2019 we said:

- The induction programme for staff had improved
- Staff received ongoing training in core Oranga Tamariki topics.
- Communication between teams was lacking.
- There was a lack of uptake of supervision by the care team.

In our COVID-19 report dated 1 July 2020 we said:

- A new group of staff had been recruited and finished their induction prior to the lockdown.

Findings from this visit

Strengths

Experienced staff are supporting newer staff

There have been a lot of changes recently with new positions across youth justice, such as the Manager Residence Operations (MRO) role, being filled by experienced staff members. Staff have also left the residence following the recent absconding incident. Due to these changes, there are a number of staff members learning new positions or in acting roles as well as new care staff members on the floor. Experienced staff members are supportive of those learning new roles and many have made themselves available in a coaching and mentoring capacity.

Staff levels are stabilising

Staff levels are beginning to stabilise with a reduction in sick leave. High numbers of staff on sick leave has meant that staff had to do double shifts. As a result, staff have not been available to support programmes, like the weekly Activity Based Learning at the school. This had to be cancelled due to inconsistency in staff available to support it. We also heard that when there are low staff levels, staff are not always available to escort young people to health appointments.

Areas for development

Staff do not receive adequate supervision

The current policy is that only registered social workers receive one-to-one professional supervision, as this is a requirement of the Social Workers Registration Board. Care teams can debrief with their team and their TLO for half an hour after each shift. TLOs are on the floor alongside teams and try to provide coaching. Group supervision is held as part of staff office

days which occurs once every three weeks. The amount of supervision available to care teams is insufficient, as they have one hour every three weeks to debrief as a group.

TLOs are available on the floor, to support care staff members in a coaching capacity. However TLOs themselves receive variable amounts of supervision and some have not had the chance to be trained in providing supervision. The TLOs are providing a large amount of practice guidance to care staff and need to be supported in this role.

Training does not upskill staff with the range of practice tools they need

Staff do not receive training in mental health and wellbeing, social development, trauma, and sensory modulation. This is partially because training has not been prioritised during the change period. Staff were due to have training in the youth justice restorative programme, Whakamana Tangata, however this needed to be postponed as implementing safe baseline practice first was the priority. Another barrier is that training in these more specific areas has not been resourced by Oranga Tamariki.

There is a lack of effective communication between staff in the residence

Staff teams within the residence do not communicate effectively with each other. Emails between teams are not consistently responded to, which is a barrier to implementing programmes and plans. One example from our visit was that the mihi whakatau to welcome us was unable to go ahead, because staff had not responded to emails that had been sent arranging it. Face to face conversations between teams is also limited. We heard that lack of communication has also compromised health and safety for external providers and young people, when relevant information, such as identified risks and management strategies, is not shared.

Domain 7: Improving Outcomes for Mokopuna Māori

Our monitoring of the Improving Outcomes for Mokopuna Maori domain assesses the residence's plans and progress for improving outcomes for mokopuna Māori, including the extent to which Māori values are embraced and upheld, and the relationships mokopuna are supported to have with their whānau, hapū and iwi.

Findings from our last reports

In our last OPCAT report dated 27 August 2019 we said:

- The residence leadership was working with Te Rōpu to build capacity amongst staff to support mokopuna Māori.
- The residence was reinstating the Māori strategic plan. Internal and external partnership relationships were in early stages.

In our COVID-19 report dated 1 July 2020 we said:

- The residence manager told us that they needed external support in order to progress responsiveness to mokopuna Māori.

Findings from this visit

Strengths

External providers are increasing their staff cultural competence

External providers such as health, education, and other community based providers have established their own cultural advisor roles within their organisations in order to understand, engage, and support mokopuna Māori in each of their specialist areas. We also heard that these providers were using cultural frameworks to improve their services to young people at Korowai Manaaki.

Areas for development

Oranga Tamariki staff are not supported to build their cultural capacity

We heard that some teams have limited support to build cultural capacity, depending on who was on their team and their ability to support staff. We heard that nothing had changed in relation to section 7AA of the Oranga Tamariki Act and some staff were embarrassed by the lack of cultural capacity or strategic vision for improving outcomes for mokopuna Māori.

Te Rōpu is small and relies on individual staff

There are two or three people who are driving the work of Te Rōpu across the residence. When kaimahi are given additional roles, they have to balance their role in Te Rōpu with other demands. This has limited the amount of time available for staff to participate in Te Rōpu and has also limited leadership opportunities.

Appendix One: Why we visit – legislative background

The Children's Commissioner has a statutory responsibility to monitor and assess the services provided under the Oranga Tamariki Act 1989. Specifically, section 13(1) (c) of the Children's Commissioner Act 2003, states that the Commissioner must monitor and assess the policies and practices of Oranga Tamariki and encourage the development of policies and services that are designed to promote the welfare of children and young people.

In addition, the Office of the Children's Commissioner is designated as a National Preventive Mechanism (NPM) under the Crimes of Torture Act (1989). This Act contains New Zealand's practical mechanisms for ensuring compliance with the United Nations Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (OPCAT), which was itself ratified by New Zealand in 2007. Our role is to visit youth justice and care and protection residences to ensure compliance with OPCAT.

Appendix Two: Interviews conducted and information accessed

Method of engagement	Number of young people
Focus groups in two of the three units	s 9(2)(a) OIA [redacted]
Individual interviews onsite	
Phone interviews on return to Wellington	

Oranga Tamariki residence staff	• Interim Residence Manager • Manager Residence Operations • Quality Lead • Grievance Coordinator • Team Leader Clinical Practice (TLCP) • Team Leaders Operations (TLOs) • Case Leaders • Programme Coordinator
External stakeholders	• Voyce Whakarongomai • Kingslea School teachers and assistant principal • s9(2)(i) OIA [redacted] (onsite health providers) • Taiohi Tu Taiohi (TTO) Regional Youth Forensic team • Odyssey House (alcohol and other drug support) • Grievance Panel
Documentation	• SOSHI • Grievance register • Admission information and assessments • Individual Care Plans and Risk Plans (shared with consent from young people) • Menu • Training log • Programmes schedule
Observations	• Afternoon and evening observation of unit routines from school until before bed. • Observation during school time
Information we planned to gather but we were not able to because the visit was shortened	• Residential Psychologist • Care Staff interviews (discussions were had with care team members on the floor but a formal interview was not conducted.) • More individual interviews with young people • Observation in secure unit

Appendix 3: Recommendations from our 2019 OPCAT report.

We recommend that the Korowai Manaaki leadership team takes steps to:

Rec 1: Give young people more confidence that their voices are heard and responded to. For example:

a. Talk to young people about their ideas for enabling a youth led council
b. Ensure all young people are informed of the outcomes from youth council meetings.

There has been no progress toward this recommendation (ref. page 14)

Rec 2: Continue to support all staff to be aware of the 'snitch culture' as a barrier to the use of the grievance process and have strategies to encourage and support young people to use the grievance process. This recommendation relates to an ongoing issue that Korowai Manaaki and National Office is working to address. (as per action 7, *State of Care* 2017).

There has been limited progress toward this recommendation (ref. page 14)

Rec 3: Increase the level of collaborative communication and information sharing between all the professional groups working to support young people in the residence.

There has been no progress toward this recommendation (ref. page 23)

Rec 4: Until Oranga Tamariki national office has replaced the BMS with another system, continue to:

- more effectively tailor the BMS for different young people and find ways to help young people understand why other young people may receive points for different behaviours, for example setting behavioural goals that align with therapeutic plans. (as per action 1, *State of Care* 2017); and
- ensure staff use meaningful restorative practices following incidents between staff and young people or between different young people.
- Continue to use alternative approaches to model and reinforce positive behaviours for example through staff relationships and their responses to young people.

There has been no progress toward the recommendation that BMS is tailored to align with therapeutic plans (ref. page 11)

There has been limited progress toward the recommendation that staff use restorative practice. Whakamana Tangata has been re-scheduled (ref. page 23)

There has been limited progress toward the recommendation that staff model and reinforce positive behaviours. Staff practice is still inconsistent (ref. page 11)

Rec 5: Continue to work strategically to build partnerships with Māori stakeholders (as per action 18, *State of Care* 2017).

There has been no progress toward this recommendation (ref. page 24)

Rec 6: Continue to encourage care staff to participate in 1:1 professional supervision and address identified barriers to participation. (as per action 17, State of Care 2017).

There has been no progress toward this recommendation (ref. page 22)

For Oranga Tamariki National Office we recommend that:

Rec 7: The DCE Youth Justice Services updates the individual care plan templates to present information in youth friendly ways and enable better participation from young people in shaping their goals.

There has been limited progress toward this recommendation. The template has been updated but young people still have limited engagement in their plans (ref. page 11)

Rec 8: The DCE Youth Justice Services takes steps to strengthen policies relating to youth justice residence placement decisions so that whenever possible young people can be more consistently placed geographically close to their whānau.

We did not monitor against this recommendation on this visit.