MANA MOKOPUNA
Children & Young People's Commission

Te Poutama Ārahi Rangatahi

OPCAT Monitoring Follow-Up Report
Visit Date: 30 July – 1 August 2024
Report Date: May 2025

Kia kuru pounamu te rongo
All mokopuna* live their best lives

* Drawing from the wisdom of Te Ao Māori, we have adopted the term mokopuna to describe all children and young people we advocate for, aged under 18 years of age in Aotearoa New Zealand. This acknowledges the special status held by mokopuna in their families, whānau, hapū and iwi and reflects that in all we do. Referring to the people we advocate for as mokopuna draws them closer to us and reminds us that who they are, and where they come from matters for their identity, belonging and well-being, at every stage of their lives.

  Please note for clarity, in this report, we use the term 'mokopuna' to describe a group of children and young people, and 'tamaiti' for a specific child or young person.

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Introduction

The role of Mana Mokopuna – Children and Young People's Commission

Mana Mokopuna - Children and Young People's Commission (Mana Mokopuna) is the independent advocate for all children and young people (mokopuna) under the age of 18 and for those who are care-experienced, up to the age of 25. Mana Mokopuna advocates for children's rights to be recognised and upheld, provides advice and guidance to government and other agencies, advocates for system-level changes, and ensures children's voices are heard in decisions that affect them.

Under the UN Convention on the Rights of the Child, all children have specific rights that must be protected, respected, and fulfilled at all times, in all circumstances. One of these specific rights is the right to be free from all forms of torture or tother cruel, inhuman or degrading treatment or punishment (Article 37).

Our organisation is a designated National Preventive Mechanism (NPM) as per the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman, Degrading Treatment or Punishment (OPCAT).

The New Zealand legislation relating to OPCAT is contained in the Crimes of Torture Act (1989). The role of the NPM function at Mana Mokopuna is to visit places where mokopuna are detained, and:

- Examine the conditions and treatment of mokopuna
- Identify any improvements required or problems needing to be addressed
- Make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing ill-treatment.

About this visit

Mana Mokopuna conducted an unannounced follow-up visit to Te Poutama Ārahi Rangatahi (Te Poutama) between 30 July and 1 August 2024 as part of its NPM monitoring visit programme. The objective of our OPCAT Monitoring as a NPM is to prevent ill-treatment in all places where mokopuna are deprived of their liberty by regularly monitoring and assessing the standard of care experienced in these facilities.

About this report

The report captures a snapshot of the residence at the time of the visit through highlighting any presenting issues and concerns, as well as areas of strength and good practice observed

during the visit. The report also outlines the progress made against the recommendations from our last full OPCAT Monitoring visit in February 2023 as detailed in Appendix Two.

About this facility

Facility Name: Te Poutama Ārahi Rangatahi This facility is a special purpose care and protection facility for mokopuna assessed as displaying harmful sexual behaviour (HSB). The facility is run by Barnardos Aotearoa, a national non-government organisation approved to deliver care services under section 396 of the Oranga Tamariki Act 1989 on behalf of Oranga Tamariki.
Region: National Service located in Christchurch operated by Barnardos Aotearoa (Barnardos).
Operating capacity: Currently the facility operates with 8 beds. The residence is made up of a communal living area containing a dining area and full kitchen. There are also separate rooms for watching TV. There are two bedroom wings off the main living area. There is a separate room as a dedicated education space and a separate therapy wing. The therapy wing contains a large group therapy room and a smaller individual therapy area. There is also a music room with various instruments and an area to record music. There is a separate area off the admin block designated for whanau visits.
Status under which mokopuna are detained: s.78 and s.101 of the Oranga Tamariki Act 1989.

On arrival

Overall, Te Poutama provides an excellent service to treat mokopuna who have been assessed with displaying Harmful Sexual Behaviour. The model of care is trauma-informed and is led by dedicated, therapeutically trained leaders. Mokopuna plans are tailored to meet individual needs and mokopuna themselves told Mana Mokopuna that the service and kaimahi are good.

Seclusion event for one tamaiti

On arrival into the facility, the OPCAT Monitoring team were alerted by Barnardos kaimahi to a situation where a tamaiti was being housed in the main therapy wing, separated from their peers. Te tamaiti was wholly being cared for in this wing by themself and this living arrangement was entering into its fourth week. The situation was unique and had not been seen by the Mana Mokopuna OPCAT Monitoring team before. Oranga Tamariki National Office were aware of the current situation and the placement breakdown and were working to source another placement that could meet the needs of te tamaiti.

Over the course of the next three days that Mana Mokopuna were onsite at Te Poutama, the OPCAT Monitoring team took the time to understand the circumstances that led to te tamaiti being separated and secluded away from the majority of kaimahi and all other mokopuna, what the current plan was for them, and what could be done to expedite their removal from the situation they found themselves in. Detailed findings regarding this situation for te

tamaiti are contained in the body of this report and they support our overall finding of ill-treatment for this particular tamaiti and their seclusion event.

It is worth reiterating that the finding of ill-treatment solely relates to te tamaiti who was secluded. In contrast to the treatment of te tamaiti who was secluded, the mokopuna in the main facility told Mana Mokopuna that they generally felt safe, could identify kaimahi they trusted to confide in, and were engaged in the therapeutic programme. There were no findings of ill-treatment for those mokopuna living in the main area of the residence.

Immediate actions

Mana Mokopuna OPCAT Monitoring Team was made aware of numerous avenues of correspondence (emails as well as hui) from Barnardos Aotearoa alerting Oranga Tamariki National Office of the behavioural challenges, inappropriateness of the placement, the impending placement breakdown and then the decision to separate one tamaiti from their peers due to significant safety concerns. From the information presented to the OPCAT Monitoring team, there appears to be a lack of urgency from Oranga Tamariki to transition te tamaiti out of Te Poutama and out of their seclusion-like environment. As a result, te tamaiti had been living in this setting for just over four weeks when the Mana Mokopuna visit commenced.

The OPCAT Monitoring team's concerns for the wellbeing, dignity, and rights of te tamaiti in this instance were immediately raised with the Chief Children's Commissioner who subsequently raised the concerns to the Chief Executive of Oranga Tamariki.

A Report of Concern was sent by Mana Mokopuna to the Oranga Tamariki National Contact centre on 9 August 2024 to formally log the concerns of Mana Mokopuna regarding the treatment experienced by this tamaiti in real time.

International consultation

Attached as Appendix One is our rationale for using the words seclusion, seclusion event, or seclusion-like environment to describe the situation we found te tamaiti in when Mana Mokopuna arrived at Te Poutama to complete an OPCAT monitoring visit. We have added this appendix to provide context to the use of the words to describe the situation, and the extent to which we sought external advice from the Association for the Prevention of Torture and from other National Preventive Mechanisms internationally to test our approach and ensure accurate description of the situation for this tamaiti.

Key Findings

The main findings from the follow-up visit are listed below. We have separated out the key findings for te tamaiti who experienced the seclusion event and the rest of the mokopuna living in the residence. As noted above, there was a finding of ill-treatment solely relating to the seclusion event involving one tamaiti.

Issues and concerns for te tamaiti in seclusion:

- *Seclusion-event of te tamaiti*
    - Tamaiti who do not meet the admission criteria have been inappropriately placed at Te Poutama. Inappropriate placements, such as te tamaiti living in a wing by themself, have had a significant negative impact on all mokopuna living at Te Poutama as well as the kaimahi caring for them.
    - Barnardos Aotearoa had requested from Oranga Tamariki additional transition supports with regard to the specialist needs of this tamaiti. Whilst agreement to provide support had been approved, at the time of the visit none of these had been provided by Oranga Tamariki.
    - Te Poutama does not have a designated Secure Care unit[1], however, a tamaiti had been secluded in makeshift 'secure care' or seclusion areas for prolonged periods of time. This practice has breached mokopuna rights as per s368 of the Oranga Tamariki Act as there are no legal grounds for mokopuna to be held in this setting. This treatment has also breached tamaiti rights under the UN Convention for the Rights of the Child.[2]
        - This tamaiti is entitled to a high Standard of care. Living in a large therapy room with a mattress on the floor for a bed, clothes at times scattered on shelving, no free access to a bathroom or shower, a lack of structured, appropriate education, no access to peers, and describing being lonely, does not meet the expected standard.

General issues and concerns:

- Mokopuna who are admitted into the residence who do not meet admission criteria have a significant negative impact on other mokopuna treatment plans and kaimahi wellbeing.
- Not having a permanently appointed residence manager has had a significant impact on how the residence is run. Many kaimahi said not have a permanent manger in place has contributed to some instances of siloed and inconsistent practice.
- Induction needs to be strengthened to ensure kaimahi are well prepared for working with mokopuna within this specialist setting.
- Kaimahi require on-going specialist training to ensure they have the skills and knowledge to work within a highly therapeutic model. Some kaimahi spoke to knowing how to

[1] All Oranga Tamariki Care and Protection and Youth Justice residences have a unit dedicated for Secure Care. Mokopuna treatment when they are admitted into secure care is governed by Part 5 of the Residential Care Regulations 1996.

[2] Article 37 Convention on the Rights of the Child

operate with a therapeutic lens but lacked the understanding of why this mattered or how it affected mokopuna care experiences – they knew the 'how' but not the 'why'.

- Kaimahi require regular external clinical supervision to support their wellbeing to ensure they can uphold practice which is reflective and responsive to mokopuna needs.
- A lack of community support and placements can negatively impact on mokopuna transitions out of Te Poutama with mokopuna sometimes staying longer than necessary in the facility.

Visit and facility positives:

- Te Poutama has the potential to provide excellent therapeutic care which has proven positive outcomes and success for mokopuna assessed as displaying harmful sexual behaviour. Many success stories were shared by kaimahi. It is important the admission process is carefully managed by all relevant stakeholders to ensure this success can continue.
- Mokopuna generally feel safe and cared for and have good access to advocacy and were supported to express their views and opinions.
- Mokopuna could identify safe adults in the residence that they trusted and had good relationships with.
- Mokopuna have access to support to get their cultural needs met and the residence has cultural aspects woven throughout their operations.
- There is good access to quality education, whānau, transition support, and interest-centred programmes for mokopuna at Te Poutama.

Recommendations

Additional recommendations resulting from findings from this 2024 follow-up visit.

2024 Systemic recommendations for Oranga Tamariki

	Recommendation
1	Conduct a practice review of Oranga Tamariki actions and rationale regarding mokopuna held in seclusion whilst in Te Poutama.
2	Develop a clear escalation plan to appropriately transition mokopuna out of placements when those placements are deemed no longer suitable.
3	Review the admission criteria for mokopuna referral to Te Poutama and ensure mokopuna who can participate in the treatment programme are the only mokopuna referred to the service. This includes ensuring mokopuna have the appropriate assessments completed before entering the therapeutic programme.
4	Continue to work with external stakeholders to ensure there are suitable transition support options available to mokopuna and their whānau in the community.

2024 Facility Recommendations for Barnardos New Zealand

	Recommendation
1	As soon as a permanent manager is employed, provide time for a full residence re-set that includes thorough debrief of recent seclusion events, ascertain training requirements from kaimahi, and develop a regular schedule of training to meet these needs.
2	Revise the induction programme to ensure kaimahi are well prepared to work with mokopuna in the facility that aligns to the specialist treatment model.
3	Implement regular clinical supervision for all kaimahi working directly with mokopuna.
4	Continue the excellent education provision that is tailored to individual need.

Concluding Observations from the United Nations

In February 2023, the United Nations Committee on the Rights of the Child ('the UN Committee') released its Concluding Observations[3] for New Zealand's sixth periodic review on its implementation of the Children's Convention[4] and how the Government is protecting and advancing the rights of mokopuna in Aotearoa New Zealand.

In August 2023, the United Nations Committee Against Torture also released Concluding Observations[5] for New Zealand's seventh periodic review regarding the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[6].

Many of the recommendations from both sets of Concluding Observations are directly relevant to aspects of treatment experienced by mokopuna at Te Poutama which Mana Mokopuna has found during this OPCAT monitoring visit in August 2024. Where relevant, these are highlighted throughout the body of the report.

[3] Refer CRC/C/NZL/CO/6 G2302344 (3).pdf
[4] Convention on the Rights of the Child | OHCHR
[5] Refer CAT/C/NZL/CO/7 G2315464.pdf
[6] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment | OHCHR

Issues and Concerns

The Isolation of Mokopuna Breaches their Human Rights

Upon arrival at Te Poutama, Mana Mokopuna was made aware that one tamaiti was being held in a seclusion-like environment and had been in this situation for several weeks. An area within the facility which is typically used for individual, group, and music therapy had been locked off to all other mokopuna and was being used to solely house a single tamaiti. This tamaiti had high and very complex needs and Mana Mokopuna was told by clinical staff that they did not meet the admission criteria into the residence. The reasons given for the admission to be deemed inappropriate was:

- An AIM3 assessment[7] was last completed over three years prior to admission into Te Poutama. Therefore, at the time of admission, te tamaiti did not have an adequate assessment recommending secure care.
- Te tamaiti did not have the ability or mental capacity[8] to fully engage in the therapeutic programme, and
- Te tamaiti displayed destructive behaviours, that included significant property damage,
- Early on into te tamaiti stay in the residence, assaults on kaimahi and other mokopuna had occurred and these behaviours could not be appropriately managed by Te Poutama kaimahi.

It is worth noting that Mana Mokopuna was informed that another tamaiti had also previously experienced a seclusion event in the same area of the facility in late 2023 also due to unmanageable behaviours. Te Poutama senior kaimahi were clear that the seclusion of mokopuna was a very last resort action, and for te tamaiti in seclusion during this 2024 OPCAT monitoring visit, a significant contributing factor was Oranga Tamariki failing to secure an alternative placement in a timely manner. Despite this, the practice of seclusion severely infringes on mokopuna right to a high standard of care that can fully meet their needs.[9]

The isolation and seclusion of mokopuna goes against their human rights.[10] There is strong international advocacy for the seclusion of all mokopuna in all settings to cease immediately.

[7] The AIM3 Assessment Model is used to assess adolescents who are displaying harmful sexual behaviours and where there are corresponding risks of harm to others and themselves.
[8] The mokopuna in seclusion had a variety of diagnoses including intellectual disability.
[9] Oranga Tamariki (Residential Care) Regulations 1996 (SR 1996/354) (as at 01 July 2023) 3 Right to professional and planned standards of care
[10] A/ HRC/28/68, para 44

International research[11] labels the seclusion of mokopuna as harmful and a practice the New Zealand government has been questioned about during numerous formal reviews by various United Nations treaty bodies.

The Committee against Torture, the Subcommittee on the Prevention of Torture and the Committee on the Rights of the Child note that the imposition of solitary confinement, of any duration, on children constitutes cruel, inhuman or degrading treatment or punishment or even torture.[12]

The Concluding Observations released by the United Nations Committee Against Torture on 26 July 2023 recommends New Zealand should immediately end the practice of solitary confinement for children in detention.[13]

The OPCAT Monitoring team immediately raised concerns to the Chief Children's Commissioner who then alerted the Chief Executive of Oranga Tamariki to the seclusion of this tamaiti living at Te Poutama at the time of the monitoring visit. Shortly after completing the on-site monitoring visit, te tamaiti was removed from seclusion at Te Poutama and placed into an Oranga Tamariki run Care and Protection facility.

Makeshift seclusion areas do not provide tamaiti with legislated rights and protections

There is no designated secure care unit[14] at Te Poutama as seclusion and highly restrictive practices do not fit within their therapeutic model of care. Therefore, when all other avenues to manage te tamaiti had been exhausted, a makeshift 'secure care' or seclusion area was set up as the behavioural challenges of this tamaiti became dangerously unmanageable.

However, any mokopuna in this situation is then not protected by a legal framework that governs how care should look in this temporary setting. When this occurred for a tamaiti at Te Poutama, their seclusion event had been prolonged and without structure, and resulted in breaches of their human rights as a child.

For a tamaiti held in a seclusion area at Te Poutama, the following breaches of the Oranga Tamariki Act 1989 and the Children's Convention were evidenced:

- Te tamaiti was placed in a seclusion area for over a month.[15] There was no break in the seclusion event due to a risk to self and others.

[11] Examples include: Seclusion - an overview Nowak, M. (2019). *The United Nations global study on children deprived of liberty-online version*. United Nations, Hales, H., White, O., Deshpande, M., & Kingsley, D. (2018). Use of solitary confinement in children and young people. *Crim. Behav. & Mental Health*, *28*, 443.
[12] A/ HRC/28/68, para 44
[13] CAT/C/NZL/CO/7 para 38(h)
[14] Oranga Tamariki Residential Care Regulations 1996, reg46
[15] Breach of CRC article 3, 4, 19, 23, 24, 25, 27, 37

- There is no legal paperwork documenting the seclusion event as would normally be required under ss368-383 of the Oranga Tamariki Act. These include:
    - The length of time exceeding 72 hours (s370).
    - No application to the Family Court to hold te tamaiti for longer than 72 hours (ss371, 376).
    - No legal representation in regard to the seclusion event (ss373, 374).
    - The ability to have the decision to seclude reviewed (s379).
- Te tamaiti did not have access to a bedroom and was placed in a large therapy room with a mattress and blankets on the floor.[16]
- Te tamaiti did not have access to education tailored to meet their specific needs.[17]
- Te tamaiti did not have access to peers, as other mokopuna in the residence declined invitations to join him for meals and free time in the seclusion area.[18]
- Te tamaiti care plans sighted during the on-site visit were ad hoc and unclear and did not cater to their intellectual disability needs.[19]
- Te tamaiti did not have access to advocates such as VOYCE Whakarongo Mai (VOYCE)[20] or the Grievance Panel[21] (an oversight admitted to by kaimahi at Te Poutama) and there was no evidence that they had access to age appropriate information that could explain the rationale for their care situation.

When speaking with te tamaiti, they expressed that they would like access to VOYCE, and that they did not know what was happening for them in terms of next steps in their care journey. Te tamaiti emphasised that they were lonely and just wanted to be with the other boys in the facility. Whilst this tamaiti had a dedicated 24/7 care team of specialist adults arranged by Oranga Tamariki, this did not fulfil te tamaiti need for peer interaction and socialisation.

Mana Mokopuna advocates and supports zero seclusions practices in line with international children's rights recommendations and guidelines.[22]

Communication breakdown has put mokopuna at risk of harm

Systemic pressures around a lack of appropriate placements for mokopuna with high and complex needs has fuelled pressure on service providers like Barnardos Aotearoa to accept mokopuna who do not necessarily meet admission criteria, in order to provide places of care

[16] Breach of CRC article 23, 24, 26, 27
[17] Breach of CRC article 23, 26, 27, 28, 29
[18] Breach of CRC article 23, 26, 27, 31, 39
[19] Breach of (UN CRPD) article 03, 04, 07
[20] Breach of CRC Article 12 and 13. VOYCE Whakarongo Mai are contracted by Oranga Tamariki to provide independent advocacy for mokopuna in care.
[21] The Grievance Panel are those who work with mokopuna when they make complaints using the residence Whaia te Maramatanga complaints process.
[22] A/ HRC/28/68, para 44, CAT/C/NZL/CO/7 para 38(h)

for mokopuna. In this case, te tamaiti had multiple diagnoses of ADHD, FASD, frontal lobe damage and intellectual disability. Te tamaiti was assessed as not displaying HSB at a level that required secure care. However, as Barnardos Aotearoa is a contracted service provider with Oranga Tamariki, and had bed availability at the time of admission, Oranga Tamariki pushed for te tamaiti to be placed into this secure facility regardless of not meeting a secure care threshold.

Tamaiti who do not meet the referral and admission criteria for Te Poutama put other mokopuna and kaimahi at risk of harm. Barnardos Aotearoa reluctantly accepted the referral on the basis that agreed mitigation plans with additional supports were identified and supplied by Oranga Tamariki to help plug identified service delivery gaps. However, kaimahi said that many of these promised supports (additional staffing, resources for targeted education) did not eventuate to the detriment of te tamaiti care, disruption and risk to other mokopuna in the facility, and unreasonable pressure on kaimahi to work with te tamaiti who should not have been placed in the facility in the first place.

As issues regarding te tamaiti placement began to escalate, Te Poutama senior kaimahi arranged on-going meetings with Oranga Tamariki to highlight what was happening, requesting immediate removal of te tamaiti. Both kaimahi at Te Poutama and those working for Barnardos Aotearoa National Office expressed their concerns to Mana Mokopuna immediately as this visit began as it appeared very little was being done by Oranga Tamariki to expedite an alternative placement for te tamaiti. Due to this lack of action, Te Poutama kaimahi made the decision to set up a seclusion area for te tamaiti. Following notification to Oranga Tamariki of this now complete placement breakdown at Te Poutama, Mana Mokopuna was told during this visit the only option Oranga Tamariki put forward as an interim measure until a more stable placement within the residence network could be found, was a motel room with care staff. All kaimahi interviewed by Mana Mokopuna consistently said they did not believe a motel placement was an appropriate response to the needs of this tamaiti. This seclusion event lasted over four weeks.

Once te tamaiti was secluded, and Te Poutama kaimahi expressed they were no longer able to provide appropriate care, Oranga Tamariki arranged for contracted external staffing cover. However, the lack of clear and consistent communication between Oranga Tamariki, Te Poutama, and the external contracted care staff assigned to look after te tamaiti in seclusion, has left this tamaiti susceptible to harm because there was no clear understanding of the plan for them. Te tamaiti continuity and quality of care was therefore impacted due to:

- **Lack of information and understanding regarding presentation, care needs, and behaviour management**

  Some of the external care team expressed feeling unsafe when they first started caring for te tamaiti as they were not provided with an orientation to the facility or paperwork detailing the care expected for te tamaiti. Some kaimahi said they did not

know they were coming to a "jail" where they would need a key for every door and that made them feel uneasy.

Externally contracted kaimahi described feeling completely left to their own devices at Te Poutama and needing to figure out te tamaiti care on their own. Kaimahi said it was difficult to provide continuity in care across their shift teams and identify the most appropriate behaviour management plan for when te tamaiti was dysregulated and damaging property. One management strategy was to retreat to a separate room when aggressive behaviour by te tamaiti was displayed, and simply monitor the situation as it unfolded. Kaimahi said this was their only option as there was no clear plan or support in place to ensure their safety.

- **Lack of structured routine and understanding of process**:
  Without cohesive information-sharing around te tamaiti care plans, needs, and prior routines, the external care team were expected to try and establish a routine for a tamaiti whilst at the same time identifying what their needs were, and what they could and could not do to effectively to support them.

  Externally contracted staff said there was limited engagement from the Te Poutama team and it had been confusing in terms of what was expected of them when they worked with te tamaiti. Examples of the confusion were observed during the visit when there were periods Te Poutama kaimahi were not aware where te tamaiti was as externally contracted kaimahi had not communicated they were leaving the facility with te tamaiti. Te Poutama kaimahi did not know where the outing was to or how long te tamaiti was expected to be off-site. These types of communication breakdowns created a health and safety risk as duty of care remained with Te Poutama and yet kaimahi had no idea where one of their tamaiti was for multiple hours in the day.

In subsequent discussions with Oranga Tamariki National Office post the on-site visit, to understand why there were significant delays in finding an alternative placement, it was explained to Mana Mokopuna that a funding request was needed to progress any bespoke placement. This had not been progressed in the over thirty days te tamaiti had spent in seclusion at Te Poutama. Due to this, the only other option was a secure care and protection facility, for which there was a waitlist.

Mana Mokopuna was also told on two separate occasions both during an interview at the time of the onsite visit and during post-visit follow up interviews that assistance had been offered from a local Christchurch organisation who specialises in intellectual disability support and placement, however this had not been pursued by Oranga Tamariki during or post the prolonged seclusion event.

Mokopuna are entitled to a high standard of care.[23] Treatment goals and care plans should be documented and implemented with consistency. When multiple adults have different ideas regarding mokopuna care, gaps in treatment can occur and mokopuna can be susceptible to harm.[24]

Mokopuna wellbeing and dignity has not been kept at the centre of decision-making

Mokopuna with very high and complex needs who do not meet the criteria threshold for Te Poutama cannot not have their needs met, as kaimahi do not have the relevant expertise or training to work with them. Kaimahi role competencies are specific to the needs of the therapeutic HSB programme. The lack of residential kaimahi experience in working with tamaiti with the specific needs presented by this tamaiti was to but be mitigated with the provisions that Oranga Tamariki said they would put in place. These included two externally contracted care workers on site, seven days a week for 12 hours per day to support te tamaiti on a one to one basis. This included education support, off site activity, and disability training for Te Poutama kaimahi. As previously stated, this support from Oranga Tamariki was not provided at the point of admission. Mana Mokopuna kaimahi saw incontinence pads dotted around the therapy wing and at times the makeshift bedroom had a distinct smell of urine. Contracted care staff employed to look after te tamaiti now in seclusion, explained that bedding had to be commercially washed daily and there was regularly faeces smeared on walls.

In addition, te tamaiti has a diagnosed intellectual disability which inhibits their full engagement in the treatment, activity and education programme. Again, this evidences how this placement was not aligned to the best interests of te tamaiti given their inability to engage in the specific therapy offered at Te Poutama – therapy targeted at a diagnosis they do not have. Many Te Poutama kaimahi who Mana Mokopuna spoke to also explained the significant risk of disruption to other mokopuna treatment journeys when there are tamaiti who lack the ability to participate.

Ultimately the absence of a child-centred care approach was evidenced by the lack of urgency from Oranga Tamariki to move this tamaiti to a more appropriate placement that could meet their very specific needs. Oranga Tamariki was fully aware of the conditions te tamaiti was being held in, which breached their human rights as a child, yet Oranga Tamariki did not find an immediate alternative placement until Mana Mokopuna completed their

[23] Oranga Tamariki (Residential Care) Regulations 1996 (SR 1996/354) (as at 01 July 2023) 3 Right to professional and planned standards of care – New Zealand Legislation

[24] For example - Frederick J., Spratt T., Devaney J. (2021) 'Adverse childhood experiences and social work: Relationship-based practice responses', *The British Journal of Social Work*, 51(8), pp. 3018–34. And Lester S., Khatwa M., Sutcliffe K. (2020) 'Service needs of young people affected by adverse childhood experiences (ACEs): A systematic review of UK qualitative evidence', *Children and Youth Services Review*, 118, p. 105429.

OPCAT Monitoring visit and made a Report of Concern. Te tamaiti was moved to an alternative placement less than five working days after the OPCAT visit concluded.

All kaimahi, both employed by Barnardos Aotearoa and externally contracted, who spoke with the Mana Mokopuna OPCAT Monitoring Team during and post this monitoring visit, agreed the seclusion of this tamaiti was inappropriate. Kaimahi at Te Poutama were disappointed Oranga Tamariki did not assist in a more timely manner, in accordance with the General Principles of the Oranga Tamariki Act 1989, particularly with regards to the child's sense of time,[25]to find a placement that could appropriately meet their needs.

Inappropriate admissions have a negative impact residence-wide

During the visit, it became apparent to Mana Mokopuna that the impacts of inappropriate admissions were felt residence-wide, with a significant negative well-being impact on mokopuna and kaimahi alike. A number of kaimahi resigned during and just after being required to care for a tamaiti whose needs and behaviours were beyond their training to manage.

There was also significant property damage caused by a very high and complex tamaiti (subsequently held in seclusion), much of which had yet to be repaired. Property maintenance and repairs must be approved externally through Oranga Tamariki and during a tour of the facility, kaimahi pointed out various areas of the facility that required repair, including a door frame with exposed screws that posed a health and safety risk.

The treatment and care experience of other mokopuna are severely disrupted by inappropriate admissions

A direct consequence when tamaiti are admitted who are not suitable for the therapy programme in this residence is that there is significant disruption to the treatment plans of other mokopuna in the facility. Kaimahi said that for some mokopuna, they were only just now getting back on track with their treatment plans due to the disruptive behaviours of the other tamaiti.

Additionally, the therapeutic wing was not available for mokopuna to undertake their treatment sessions in the typical setting as it was being used as a seclusion area for one tamaiti. This meant individual and group therapy had to be held elsewhere, and the music room, also located in the therapy wing, was only available for mokopuna to use when the secluded tamaiti was not on-site. Not being able to use therapy areas dysregulates

[25] s5 Oranga Tamariki Act 1989.

mokopuna who are engaging in a therapeutic journey and, as kaimahi said, it can take some mokopuna a long time to get back on track after regressions in their treatment plans.

Mokopuna also commented that they could not access off-site activity as they had in the past due to a lack of kaimahi. At times, multiple kaimahi were needed to manage a single tamaiti which did not leave the required number of kaimahi available to supervise other mokopuna on off-site activity. Mokopuna in Te Poutama were acutely aware of the impact inappropriate admissions have on their care experiences in the facility.

Management of inappropriate admissions has had a significant impact on kaimahi morale and retention

The widespread impact of inappropriate admissions was particularly apparent to a significant degree amongst most kaimahi. Many kaimahi described the need for a reset after the latest occurrence of seclusion ended and te tamaiti was able to be placed in a more appropriate setting. However, the fact that this was not the first time this had occurred and there were no guarantees it would not happen again, was also raised as a concern by multiple kaimahi.

Kaimahi described being burnt out and morale significantly impacted following a series of events late 2023 involving another tamaiti where Te Poutama was not the right placement for them and where kaimahi were subject to a series of assaults. Kaimahi described the incessant occurrence of incidents over the two months this tamaiti was in their care, which included threatening behaviour, both physically and sexually, toward kaimahi and other mokopuna. These behaviours were also present with the current tamaiti in seclusion which brought back feelings of dread for many kaimahi.

Due to this, Mana Mokopuna were told that several kaimahi resigned because of the events that surrounded the two secluded mokopuna and there were some kaimahi on special ACC approved leave. For the kaimahi who remained, they said they need more constructive and practical support when they are struggling to help mokopuna. Kaimahi described a lack of support when caring for mokopuna who are, for example, incontinent with some kaimahi saying they were simply asked to be “more resilient”.

Kaimahi working in this environment should have access to external clinical supervision. The current support systems rely on peer supervision, Employee Assistance Programme[26] and event debriefs with the clinical team. However, kaimahi need confidential, regular and on-going clinical supervision with trained experts to reduce burn-out, provide a safe place for kaimahi to reflect on practice and develop skills to enhance mokopuna care experiences.

Mana Mokopuna recommends Barnardos Aotearoa implements regular clinical supervision for all kaimahi working directly with mokopuna.

[26] EAP Services Limited

Leadership direction and experienced kaimahi are critical to the success of the therapeutic model of care at Te Poutama

At the time of this monitoring visit, there had not been a permanent residence manager at Te Poutama for some time. Some kaimahi said not having consistent and stable management for the facility has sometimes resulted in lack of clear decision-making, communication breakdowns, and siloed practice[27]. Multiple kaimahi said there was a lack of cohesion with decision making and communications to those who work with mokopuna, described as ad hoc. An example discussed during this OPCAT monitoring visit was kaimahi believed they were short staffed on shifts, however, Mana Mokopuna was told that staffing ratios had been reduced due to funding restraint. Inconsistencies like this create uncertainty for kaimahi and can often create consistencies in the practice and treatment mokopuna receive in the facility.

Many kaimahi also said that the lack of clear leadership has impacted on how the therapeutic model of care has been applied when caring for mokopuna. Kaimahi said that a lot of the experienced kaimahi have now left which has placed significant pressure on those with knowledge to quickly upskill new kaimahi. Kaimahi said clinical staff are stretched thin and said that clinical practice is often not aligned to the therapeutic model. Examples centred around kaimahi working with mokopuna who do not have the skills to successfully continue learnings from individual or group therapy outside of those sessions, meaning gains made in therapy sessions are often not carried over and imbedded into everyday living. Clinical staff need to provide constant reminders around basic therapeutic practice and behaviour management and some Clinical staff said that they could not always rely on kaimahi to reinforce therapeutic decisions regarding individual treatment goals. Examples of inconsistences:

- Some kaimahi allow mokopuna to stay up late watching movies in their rooms. Some mokopuna were not going to bed until the early hours of the morning.
- Some kaimahi were allowing mokopuna to sleep-in well into the morning. This was disrupting morning routine and it was a rush to get ready for education.
- There were occasions where some kaimahi did not correct questionable conversations and allowed mokopuna to talk about inappropriate topics that had been identified as risky subjects in mokopuna treatment plans.
- Line of sight was not always kept and mokopuna who were not allowed to be alone together had opportunities for private conversation. In these cases, individual safety plans were not followed.

[27] Within the Te Poutama there were three different teams which feed into silos – Residence Operations, Clinical and Education, alongside a disconnect between leadership and kaimahi working on the floor of the residence.

- Most mokopuna knew what the rules of the residence were however, mokopuna would take advantage of kaimahi not having the same level of knowledge and would manipulate kaimahi into bending the rules. Kaimahi often knew this had happened and many used the phrase “getting got” when reflecting on their interactions with mokopuna.

Kaimahi working directly with mokopuna often said they know what the therapeutic model is, but not always the ‘why’ things are done the way they are. Not knowing the ‘why’ is therefore reflected in inconsistencies in practice approach.

The overarching theme when discussing the therapeutic model of care with a range of kaimahi at Te Poutama was that the bones and theory of the model are really good, however, the facility does not currently have the staff and stability to make it great and holistically effective for mokopuna. There was, however, hope that once the residence was able to re-set, the strength of therapeutic practice would return.

Mana Mokopuna recommends that Barnardos Aotearoa instigate a full re-set once a permanent manager is appointed. The re-set must address workplace culture, address communication breakdowns, and provide time for in-depth training on all aspects of the therapeutic model of care.

Facility Positives

Te Poutama has the potential to provide excellent therapeutic care

"I actually love it here. If I'm honest, I get routine here, its structured. I'm sleeping and detoxing off vapes and weed."

(Mokopuna)

All mokopuna Mana Mokopuna spoke to who were living in the main area of the residence, said they felt good and safe engaging with kaimahi and in the Te Poutama therapy programme. Te Poutama have an excellent therapeutic care model which utilises a holistic approach toward gathering comprehensive information around mokopuna needs and incorporates the AIM-3[28] assessment framework. The information gathered is then used to identify therapeutic needs and inform individualised care, intervention, treatment, and learning plans in order to address the harmful sexual behaviours mokopuna are diagnosed with. When this works well, mokopuna are able to reach a point of being safe to transition back into the community.

During our visit, different kaimahi shared with Mana Mokopuna the various success stories of mokopuna who had previously gone through and completed the therapeutic intervention programme at Te Poutama. The therapy offered at Te Poutama works and it is therefore critical that the right kaimahi with the right training are working for and with the right mokopuna on their therapeutic journey.

Te Poutama provides comprehensive wrap-around transition planning

Te Poutama has an excellent transition phase to their programme and dedicated kaimahi working with mokopuna and whānau to prepare for mokopuna return to the community. The Whakamana Mokopuna (transition worker) is pivotal to keeping whānau and mokopuna well involved and informed of the transition plan whilst also working in tandem with the residence social work team to ensure continuity of care is established and set up as soon as possible. It was emphasised that "transitioning out starts at the point of admission" and that transition work is also important prior to admission in order to ready mokopuna and whānau for the treatment programme within the facility. Transition support both into and out of the facility was held in high regard by mokopuna, whānau, and kaimahi working in the facility.

There are, however, transition barriers identified outside of the control of Barnardos and Te Poutama. These were identified as a lack of appropriate assessors to diagnose HSB in the

[28] Leonard, M & Hackett, S. (2019) The AIM3 Assessment Model – Assessment of Adolescents and Harmful Sexual Behaviour. https://tinyurl.com/AIM-3-Project

community, as well as a lack of suitable placements for mokopuna to utilise if they cannot return to the whānau home. The Clinical Manager at Te Poutama has been providing interim assessments for mokopuna when no community assessor was available to provide timely clinical input into mokopuna plans. In addition, some kaimahi outlined that the lack of community placement options have contributed to mokopuna staying in Te Poutama for an extended period of time.

Mana Mokopuna encourages Barnardos Aotearoa to continually work with specialist community providers to build the network of support for mokopuna and their whānau.

Well trained kaimahi are necessary for keeping therapeutic practice consistent and aligned to treatment plans

The need for thorough and consistent induction and training was consistently raised by kaimahi at all levels during the visit. There were many new kaimahi who were young and very few had previous experience working with mokopuna, particularly those with high and complex needs in the specialist area of harmful sexual behaviour. Most kaimahi said the induction training was not meeting their needs in terms of working effectively with mokopuna in the facility and this made it difficult for them to uphold the therapeutic standard of care. Kaimahi said that it was frustrating that Te Poutama kaimahi were resourcing other Oranga Tamariki residence induction programmes with their time to deliver trauma-informed specific sessions when their own induction programme requires work. As one kaimahi said it opened their eyes as to what was lacking at Te Poutama when comparing what was offered in terms of induction and training at the local Youth Justice Residence operated by Oranga Tamariki.

The management team acknowledged the induction and training package for kaimahi requires improvement. Kaimahi said that when training was offered, it was often very useful and well facilitated and they would simply like more of it to strengthen their practice.

Strengthening kaimahi knowledge and understanding and empowering them all to collectively uphold the therapeutic model offered at Te Poutama, will promote the consistent and treatment-aligned therapeutic practice that helps mokopuna succeed. Mana Mokopuna recommends that Barnardos Aotearoa prioritise the re-design of the induction programme and ensures a training schedule is developed and time is prioritised for kaimahi to attend training sessions.

Mokopuna generally feel safe and cared for and they feel comfortable voicing their concerns

Mokopuna were able to identify VOYCE Whakarongo Mai[29] as an advocacy avenue and were aware of the different options available to them to voice any concerns or complaints, including the Grievance process[30] or raising things directly with safe kaimahi within the residence. During the visit, mokopuna were able to name kaimahi who they trusted and felt cared for by and identified the kaimahi who they could reach out to if they needed to discuss issues that worried them.

"[The Acting Residence Manager] is the man! He's a stickler for the rules but has a lot of respect from me."
(Mokopuna)

The main areas mokopuna freely identified as issues for them were:

- The food served in residence. Various mokopuna described the food as:

"Oh, it's unhealthy […] There is no seasoning and the food is beige or grey or comes out of the freezer. There's pumpkin with every meal."

*"Food is sh*t. F**king disgusting. We were served raw chicken yesterday and left hungry. […] Food is getting worse and worse by the day."*

- The level of comfort of their bed and issues with their bedroom:

*"Mattresses are sh*t, bl*ody bricks and so hard. […] Pillows are also uncomfortable and room temperature is not ideal."*

"it's not nice having to use your bathroom [toilet in bedroom] and then stink your whole room."

- Some mokopuna also raised the lack of availability and minimal level of engagement of their residence social worker.

[My] social worker [here] is useless with a capital 'U'."

"Speechless. I haven't had time with her or seen her to be able to build a relationship."

Consistently, these were all also things that had been raised by mokopuna via the complaints process and were issues the residence leadership team were aware of. Mokopuna felt relaxed and safe identifying where aspects of everyday living could be improved which was a positive.

[29] Home - VOYCE - WHAKARONGO MAI
[30] All Oranga Tamariki residences including Te Poutama use the Whaia te Maramatanga complaints process to process mokopuna concerns. This includes mokopuna access to the Grievance Panel who are the main point of escalation if mokopuna do not agree with the outcome of their complaint.

There is opportunity for mokopuna to engage in cultural activity if they identify that is important to them

At Te Poutama, aspects of Te Ao Māori are woven throughout the facility feeding into its sense of mauri[31] – in both the physical art and designs around the residence including korowai, and the incorporation of Māori health models such as Te Whare Tapa Whā, and with mihi whakatau being prioritised when welcoming manuhiri (guests) including mokopuna when they first enter the residence.

This collectively feeds into a sense of tau (calm) for the facility. Mana Mokopuna did not observe structured cultural activities on a day-to-day basis which would be good to see, however there are certainly opportunities available for mokopuna if they identify a desire or need to engage in cultural activity and kōrero. There is a designated Kaumātua (Mātua) role and mokopuna collectively spoke positively about his presence within the residence. Mokopuna spoke to how he actively feeds into cultural care by identifying cultural needs alongside mokopuna and wrapping around his support to ensure these are addressed and met. Mokopuna said they felt empowered to ask Mātua to be a part of the mihi whakatau to welcome Mana Mokopuna into the residence, and Mana Mokopuna heard that Mātua had sat the mokopuna down and explained the process and mokopuna then felt comfortable sitting with Mātua on the paepae (front bench of speakers) during the mihi whakatau. Many kaimahi and mokopuna told Mana Mokopuna how Mātua goes out of his way to connect mokopuna to iwi and also provides education on the local mana whenua and the whakapapa of the residence. Mātua has a dual cultural advisory role with both kaimahi and mokopuna and was spoken of highly by all.

In accordance with Article 30 of the UN Convention on the Rights of the Child, and Article 11 of the UN Declaration on the Rights of Indigenous People,[32] Te Poutama provides support and activities that empower mokopuna Māori to practice their cultural traditions and customs if they wish.

Kaimahi also share their own backgrounds and knowledge of Te Ao Māori with mokopuna and incorporate aspects of this into their practice. Mokopuna spoke positively about kaimahi who shared korero with them and took them on activities such as eeling and using the whenua to ensure teachable moments are grounded within the understanding of Mātauranga and Ao Māori.

[31] Te Reo Word: (noun) life principle, life force, vital essence, special nature, a material symbol of a life principle, source of emotions - the essential quality and vitality of a being or entity. Also used for a physical object, individual, ecosystem or social group in which this essence is located.
[32] Convention on the Rights of the Child | OHCHR; United Nations Declaration on the Rights of Indigenous Peoples (A/RES/61/295)

The Whakamana Mokopuna at Te Poutama also provides a strong bridge and connecting role between mokopuna and the residence to whānau, hāpu and iwi of mokopuna.

Mokopuna are thriving in the education setting and have good access to both whānau and activities

Education formed a central part of mokopuna day-to-day routine and followed a very mokopuna-centric and needs-based approach which allowed mokopuna to flourish. Mokopuna were observed to be well-engaged and they all said they enjoyed school. Education plans were tailored to individual need and all opportunities were utilised for learning and gaining NCEA credits. For example, when mokopuna were taken through the consent process for an interview with the Mana Mokopuna team, the teachers asked to observe the process so that they could use mokopuna engagement as evidence toward gaining NCEA literacy credits. Mokopuna were also encouraged and supported to gain life skills through education which included through cooking and gaining their drivers or forklift licences.

"[teacher] is amazing. Never a dull day with [teacher]. [...] Teaching style meets you at your level."
(Mokopuna)

Mokopuna have a right to an education as per Articles 28 and 29 of the UN Convention on the Rights of the Child. Mokopuna living in Te Poutama are currently receiving this full entitlement due to a tailored education approach and relatable, well-suited educators.

Alongside education, Mokopuna had good opportunities to engage in activities aligned to their personal interests. It was clear that many kaimahi and mokopuna had built strong relationships and these kaimahi were influential in enabling mokopuna to access a variety of activities in the community. Mokopuna were being supported to play in sports teams outside the facility which included rugby and hockey, and to train with external specialists and work towards MMA[33] bouts. Mokopuna expressed that having access to outings and opportunities were important factors for maintaining their wellbeing and emotional regulation and said they were disappointed when a lack of kaimahi on shift sometimes meant these activities did not occur. Mokopuna also have access to a variety of board games, PS4 games, table tennis, basketball and music based activity within the residence. Speaking to and engaging with whānau was also important to mokopuna and this was scheduled into the daily routine for

[33] Mixed Martial Arts competition.

mokopuna with the use of phones and video calls as well as the ability for whānau to meet with mokopuna on-site.

Te Poutama have a behaviour management system that is not based on punitive practice

Te Poutama use a 'Te Meke' programme to help celebrate mokopuna engaging in the day-to-day programme in a positive manner. 'Tu Meke' places an emphasis on celebrating good behaviour amongst mokopuna through access to treats and entertainment opportunities and moves away from a punitive approach of losing access to privileges if, as kaimahi describe, mokopuna have a behaviour "wobble" at a point in the day. Mokopuna have the opportunity to correct their own behaviour and still maintain access to treats which encourages mokopuna to take responsibility for the management of their own behaviour without thinking they need to start back at square-one in the Te Meke programme. Mokopuna knew how the programme worked, what treats they could work towards and that kaimahi would be supportive, rather than punitive, in helping mokopuna maintain healthy behaviour expectations. Some kaimahi did note that Te Meke provisions in the form of sweet edible treats, high in sugar prior to bedtime could be disruptive to the bedtime routine for mokopuna and the type of treats offered at this time could be reviewed.

Mana Mokopuna encourage Barnardos and Te Poutama kaimahi to review they type of treats offered and when, to ensure mokopuna have healthier options that may be more appropriate, especially at nighttime.

Appendix One
Clarity on what constitutes seclusion

As a result of the unique situation the Mana Mokopuna OPCAT Monitoring team found during its onsite visit of Te Poutama, clarification regarding what constitutes seclusion, a seclusion event, or a seclusion-like environment when there is no area legally designated to house mokopuna in this way, was sought.

The Mana Mokopuna team first made contact with the Association for the Prevention of Torture (APT). This not-for-profit international organisation was set up at the time of the OPCAT to guide organisations designated National Preventive Mechanisms (NPMs) in administering the OPCAT in their country.[34]

Through the kōrero with the APT, the Mana Mokopuna team could determine that the environment te tamaiti was being held in at Te Poutama constituted seclusion. The seclusion event detailed in this report has been assessed as ill-treatment on the following basis:

- There was no area legally designated as secure care or a seclusion room in the facility.
- There was no legal framework that could govern how long te tamaiti could be held in such an environment or how to appeal the decision to seclude.
- There were no guidelines in what treatment should look like during the seclusion event. This includes:
    - Access to advocates and lawyers
    - Access to whānau
    - Access to peers
    - Standards of material conditions – what a bedroom should look like, how clothes and other personal care items should be arranged and where necessary disposed of.
    - Free access to water, the outside, a toilet and shower.
    - Standards of cleanliness
    - Access to appropriate education
    - Comprehensive daily plans that included activity, routine, and behaviour management strategies.

[34] | APT

The APT emphasised to Mana Mokopuna the existence of the Mandela Rules and the minimum requirements for people in detention like settings: The United Nations Standard Minimum Rules for the Treatment of Prisoners

In addition to sourcing guidance from the APT, Mana Mokopuna was also put in contact with NPMs in two other countries by the APT. The aim of these kōrero was to again discuss the situation at Te Poutama and seek guidance from those who may have experienced similar situations in their own OPCAT monitoring. One of the main aspects flowing out of these conversations was that mokopuna can still be considered to be in a seclusion setting when their only interactions are with adults. This was a point challenged by both Oranga Tamariki and Barnardos Aotearoa, however, the kōrero with other NPMs confirmed our correct and consistent use of the word seclusion for this particular report. The Ombudsman can also be a point of reference for our report when reading their expectations for the segregation of adults in the custody of the Department of Corrections, which state that "All forms of segregation, where people in custody are separated from the general prison population, is recognised as a highly restrictive practice." See: OPCAT Expectations – Corrections designed.pdf

Rationale for the use of the words seclusion or seclusion-like environment in this OPCAT Monitoring Report and the associated finding of ill-treatment has been provided to both Oranga Tamariki and Barnardos Aotearoa.

Appendix Two
Progress on 2023 recommendations

The below table provides an assessment of OPCAT Monitoring recommendations made in the previous February 2023 OPCAT monitoring report about Te Poutama Ārahi Rangatahi. Mana Mokopuna acknowledges that work on systemic recommendations is being led at a National Office level. The progress detailed here only relate to- the day-to-day operations of this particular facility that were reported, observed or evidence during the visit and are assessed to have made good, some, or no progress:

2023 System Recommendations

	2023 Recommendation	Progress as at August 2024
1	Streamline the property management process between Oranga Tamariki and Barnardos to ensure timely repair and refurbishment.	**Limited progress:** Communications with Oranga Tamariki have improved since the last visit, however repair timeframes still vary. Oranga Tamariki cite issues with funding as the main contributor to property maintenance delays. There is therefore still room for improvement in this area, and Barnardos acknowledged they can also improve timeliness in terms of logging repairs and alerting Oranga Tamariki National Office when things remain outstanding. The team at Te Poutama would like to be more involved in conversations for long term solutions to property issues.
2	Urgently refurbish the kitchen and finalise the instalment of outside water fountains and inside water coolers.	**Good progress – Completed.** Mana Mokopuna was informed that the kitchen was repaired and refurbished shortly after our last visit in 2023 and were able to observe it back in action. Mana Mokopuna was also able to observe that outside water fountains had been installed however these were unusable due to an issue with the water system and quality within the region. Consequently, there were portable inside water coolers being used in response to tap water being unsafe to consume, but it was unclear if these would remain beyond this issue. Mokopuna did however have good, unrestricted access to water, though it would be good to see the water system issues addressed and escalated to the appropriate stakeholders.
3	Review the grievance process to be independent and impartial.	**No progress** There was no significant updates or evidence around this process being reviewed. The team at Te Poutama had been informed that they would be welcoming two new Grievance panel members. It has been requested by the residence for Oranga Tamariki to provide training around grievance matters for kaimahi as it was identified by the panel last year there was a need for more kaimahi training around what the grievance panel does. At the time of the visit, there had been no follow-up to fulfil this training need. Te Poutama kaimahi reporting looking into running its own training program and introduce the Grievance Panel members to all kaimahi in the residence. The Grievance Panel members do however try to check folders and spend time with mokopuna every 6 weeks. The relationship between the Te Poutama team and the Grievance Panel members is good and both parties very responsive.
4	Only refer mokopuna that clearly meet the admission criteria and carefully consider the impact of placement on existing mokopuna in the facility.	**No progress** Since our last visit there had been additional inappropriate referrals and subsequent admissions that either did not meet the admission criteria, or mokopuna did not buy into the programme. Those placements then became detrimental to existing placements. The impact of inappropriate placements has been immense on both mokopuna but also the wider facility in terms of kaimahi morale, therapeutic practice, and kaimahi retention. It was acknowledged by the team at Te Poutama that significant pressure within a placement system that is in crisis, had fed into mokopuna not appropriate for the programme being admitted. Oranga Tamariki are struggling to find placements for mokopuna with very high and complex needs. On those occasions where mokopuna were not appropriate for the programme, Oranga Tamariki were struggling to place, and Te Poutama had bed availability.

		Additionally, due to a lack of resource in the community there has been an impact on assessments occurring prior to placement, with these assessments at times having to occur within the facility rather than before. Te Poutama provides a specialist programme for a specifically diagnosed mokopuna. It is not appropriate to place mokopuna who do not meet the admission criteria and who pose a risk to the treatment of other mokopuna at the residence. The continuation of such practice poses a great risk to mokopuna safety and the therapeutic outcomes that can be achieved at Te Poutama.
5	Source placement options for mokopuna in the community concurrent to their placement in Te Poutama to prevent the unnecessary detainment of mokopuna who have completed their treatment.	**Limited progress** Mana Mokopuna was pleased to hear that the mokopuna who had been spending an extended period at Te Poutama despite graduating the program had since found a successful placement in the community and that things were going well for them. There are some mokopuna who are still spending longer than necessary at Te Poutama because placements have not always been successfully identified or set-up by the time mokopuna are ready to transition out of the secure residence. This is beyond Barnardos control but has been identified as a barrier in the transition phase of mokopuna plans. However, Te Poutama has a dedicated transition worker who helps support mokopuna and whānau through the programme and works to establish connections and opportunities for placements during their stay. When mokopuna are 6-months out from transitioning, a transition plan involving the mokopuna and whānau is developed and then a second transitional plan is developed 3-months out from transitioning with more focused outreach and bringing things to a conclusion. In some instances where placement opportunities have been identified, funding has been declined by Oranga Tamariki. Kaimahi noted that it is difficult to find placements and funding declines sometime lack rationale. The team at Te Poutama has expressed it would be ideal to have a more established role in the placement process with Oranga Tamariki – there is work that can be done to be more collaborative in the placement approach.

2023 Facility Recommendations

	2023 Recommendation	Progress as at August 2024
1	Prioritise supervision that focuses on consistency of care and implementation of treatment plans	**Limited progress** Supervision is provided but kaimahi identified issues. The main issue is that individual supervision is sporadic. The clinical team co-runs a group supervision session every three weeks with Operation Team Leaders. In an effort to ensure more consistent access, there is a plan to introduce a supervision session on weekend days or providing two supervision sessions every three weeks. For kaimahi working on the floor with mokopuna, they can also reach out for support from their Operations Team Leader if the need any additional contact time. Kaimahi have described situations that require external clinical supervision. Mana Mokopuna is recommending all kaimahi who work directly with mokopuna (given the nature of behaviours) receive regular external clinical supervision.
2	Include practical components in the induction training so that new staff have the opportunity to put theory into practice before formally working with mokopuna.	**Limited progress** When speaking to kaimahi, a number of them identified not having a proper induction or that the induction had not fully prepared them for the necessities of the role. For some kaimahi, induction simply involved paper-based activities and then transition straight into the practical responsibilities of the role. Kaimahi described training as largely retrospective rather than prospective. Kaimahi expressed that it was not just needing a good induction alone, but also the necessity for ongoing high-quality training. It was identified by the management team at Te Poutama that this was an area that needed improvements and that they were actively working on developing and updating the induction training programme inclusive of engaging with kaimahi for feedback. To date, there has been an induction book for Senior Team Leaders produced which documents all the processes involved for the role and kaimahi describe this as a positive step.

	2023 Recommendation	Progress as at August 2024
3	Ensure staff professional development plans are completed and those who are promoted have access to appropriate training.	**Limited progress** This is still in progress, however communication has been sent out that all Professional Development Plans for kaimahi need to be noted down, with team leaders to have these all updated for their respective teams. Plans need to outline opportunities and pathways for kaimahi to progress in their roles. There has been a lot of interruptions toward residential staff accessing training due to a series of placements that have placed significant pressure on kaimahi.
4	Develop relationships with local education communities of practice to enable teaching staff access to relevant professional support, resources and information.	**No progress** Representatives from Te Poutama and Barnardos expressed that this is a systemic issue, in that the education system operating at this facility cannot be the same as Youth Justice or mainstream education. Te Poutama is classed as a Tertiary Education Provider so is not part of any local school Kaahui Ako.[35] However, it is important that efforts be made to address identified issues and that kaimahi within the education team are supported professionally and pastorally.
5	Amend assessments to include a stronger emphasis on the cultural identity and needs of mokopuna to inform their treatment and care plans.	**Good progress** Mana Mokopuna was pleased to see and observe the efforts and work being done to support mokopuna explore their culture and identity during their placements at Te Poutama. There is a designated Kaumātua role and mokopuna spoke positively about his presence within the residence, and that he actively feeds into cultural care. Care plans had cultural needs incorporated into them, with efforts also being made to identify and connect mokopuna with their whakapapa – different elements in mokopuna files included. • Mana Tamaiti • Whakapapa • Pepeha • Genogram • Pūrakau and Pūrakau iwi • Cultural assessments

[35] Communities of Learning | Kāhui Ako – Education in New Zealand

Appendix Three

Gathering information

Mana Mokopuna gathers a range of information and evidence to support our analysis and to develop findings for this report. Collectively, these form the basis of our recommendations.

Method	Role
Interviews and informal discussions with mokopuna (including informal focus groups).	
Interviews and informal discussions with staff	▪ Barnardos General Manager Child and Family Services ▪ Acting Residence Manager ▪ Manager Clinical Practice ▪ Kaumatua ▪ Operation Team Leaders ▪ Te Poutama Social Workers ▪ Residence kaimahi ▪ Whakamana Mokopuna transition worker ▪ Teachers
External stakeholders	▪ Grievance Panel members ▪ VOYCE Whakarongo Mai
Documentation	▪ Incident Reports ▪ Care Plans ▪ Communications between Oranga Tamariki and Barnardos kaimahi regarding mokopuna in seclusion.
Observations	▪ Daily Handovers ▪ Mokopuna Education ▪ Mokopuna day-to-day activities