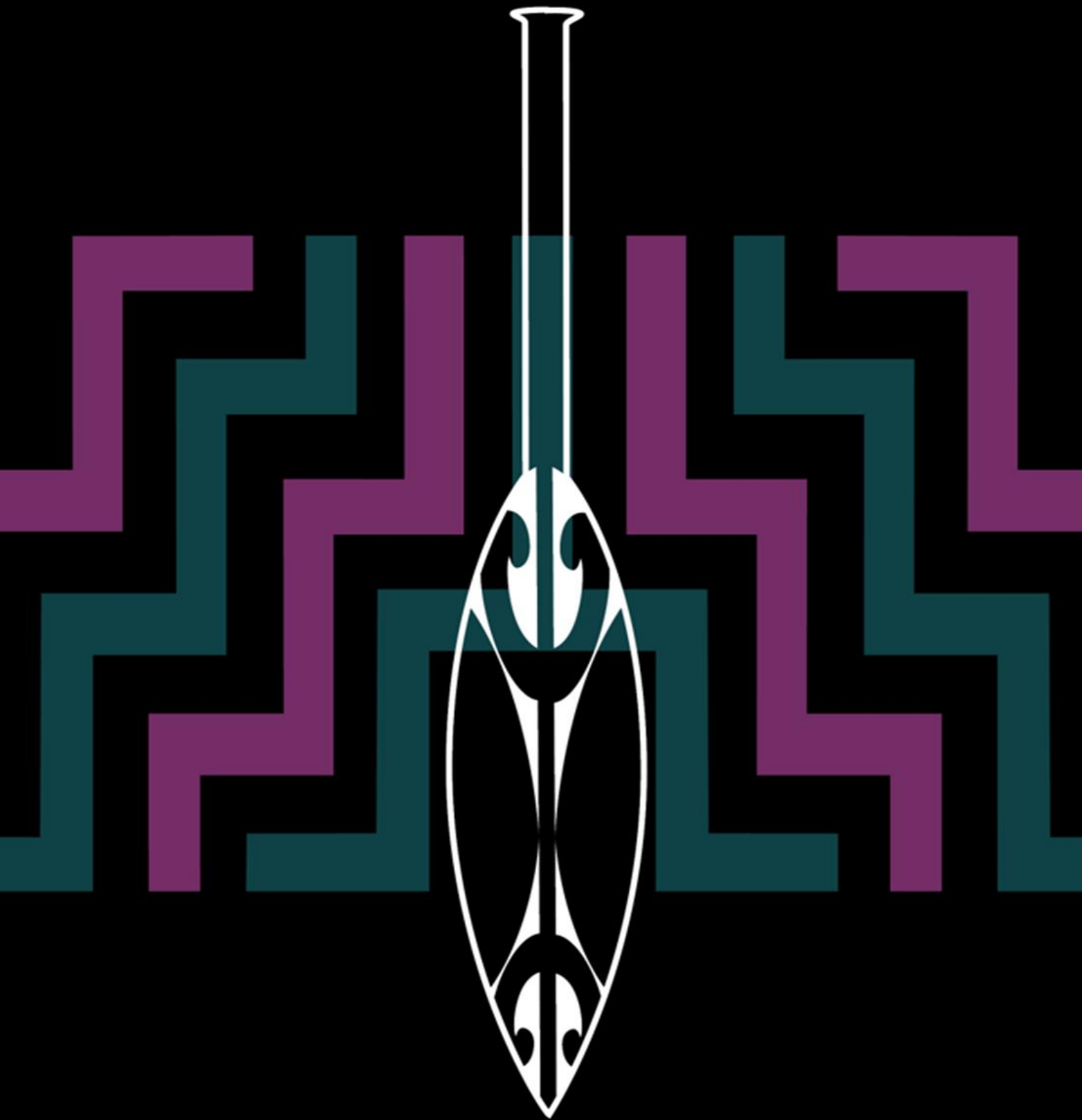




Korowai Manaaki – Youth Justice Residence

OPCAT Monitoring Report

Visit date: 30 June – 2 July 2025

Report date: October 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.



Contents

The role of Mana Mokopuna – Children and Young People’s Commission	4
About this Visit	4
About this Report	4
About this Facility	5
Key Findings	5
Recommendations	8
Concluding Observations from the United Nations	9
Report findings by domain	10
Appendix One – Progress on previous recommendations	35
Appendix Two – Gathering information	38



Introduction

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

Mana Mokopuna - Children and Young People's Commission is an 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. We note that as of 01 August 2025 due to legislative change, Mana Mokopuna – Children and Young People's Commission became Mana Mokopuna – Childre's Commissioner. We maintain the same OPCAT designation. Given this OPCAT Monitoring visit took place prior to the change to our legislation, we do refer to Mana Mokopuna – Children and Young People's Commission in this report.

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.

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:

- 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 torture, cruel, inhuman, degrading treatment or punishment.

About this visit

Mana Mokopuna conducted a full unannounced visit to Korowai Manaaki Youth Justice Residence (Korowai) between 30 June and 2 July 2025 as part of its NPM monitoring visit programme. The objective of our OPCAT Monitoring as the 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

This report shares the findings from the monitoring visit and recommends actions to address any issues identified. The report outlines the quality of mokopuna experience at the facility and provides evidence of the findings based on information gathered before, during, and after the visit. As with all of our OPCAT Monitoring visits, the findings of our visit were shared in real-time with the relevant detaining agency (in this instance, Oranga Tamariki).

About this facility

Facility Name:	Korowai Manaaki Youth Justice Residence, operated by Oranga Tamariki
Region:	Tāmaki Makaurau (Auckland)
Operating capacity:	46 bed capacity. Korowai Manaaki is made up of five secure units, where mokopuna live. These contain, bedrooms, bathrooms, dining area, kitchen, television room and rooms for mokopuna to regulate and have phone calls. There is one further unit designated to Secure Care. There were 32 mokopuna on-site at the time of our previous November 2024 OPCAT monitoring visit. By comparison, there were 36 mokopuna onsite at the time of this June 2025 OPCAT Monitoring visit. 92% of the mokopuna were on remand (both Youth and District/ High Court jurisdictions). 86% of mokopuna resident in the facility at the time of this June 2025 visit whakapapa Māori.
Status under which mokopuna are detained: Oranga Tamariki Act 1989 – s235, s238(1)(d) and s311, Criminal Procedure Act 2011 – s173 and s175, sentenced under the Corrections Act 2004 – s34A.	

Key Findings

Mana Mokopuna found no evidence of cruel, inhumane, degrading treatment or punishment (ill-treatment) during the visit to Korowai Manaaki. However, there is a negative culture at Korowai Manaaki that is resistant to change and does pose an issue in terms of operational transparency and a willingness to constantly review processes to enable proactive harm prevention.

Areas of concern:

- There is instability in the residence leadership group with the Manager Residence Operations recently resigning, an interim Acting Manager Resident Operations (MRO) appointment and a still relatively new Residence Manager.



- Communications and organisational direction are still reported by kaimahi as unclear.
- At the time of this June 2025 visit, staffing numbers at the residence were critically low.
 - Kaimahi report being overwhelmed, tired, burnt-out and losing hope in terms of being able to contribute to positive impact for mokopuna living in the residence.
 - Practice is variable with Mana Mokopuna witnessing a lack of line of sight and kaimahi calling mokopuna derogatory names. Multiple kaimahi also report that contraband is being brought into the residence to enable easy shifts and compliant mokopuna.
 - Mokopuna are missing out on medical appointments due to a lack of kaimahi available to escort them.
- Mokopuna are limited in their access to the protective systems available to ensure their rights, are upheld and their safety and wellbeing supported and protected.
 - Whilst there is increased access to advocates like VOYCE Whakarongo Mai¹ and the Grievance Panel², there is a strong “no snitching” culture at Korowai Manaaki that makes it hard for all mokopuna to engage with these services when they are experiencing circumstances where they would like to access such support and systems. This “no snitching” culture is perpetuated by kaimahi and mokopuna alike.
- There are significant deficiencies in documentation and record-keeping practice at Korowai Manaaki.
 - Unit daily logbooks and the Secure Care register were often incomplete and lacking detail.
 - Secure care is being used as a behaviour management tool. The grounds for admission of mokopuna into secure care were vague and therefore potentially unlawful.
 - The use of Regulation 48³ to confine mokopuna to bedrooms was used regularly and some mokopuna did not come out of their rooms on their hourly rotations. When Secure Care is full, mokopuna can spend up to 22 hours a day in their bedrooms.
 - Use of Force reviews had not been completed for over two months.
- Mokopuna Māori remain disconnected from identity and whakapapa.
 - Many kaimahi said that there is nothing at Korowai Manaaki for mokopuna who whakapapa Māori. This relates to pro-social role-modelling, support to grow knowledge of te ao Māori, and participate in culturally inclusive programmes.
 - Programmes are generally centred around ‘passive recreation’ which includes listening to music, playing cards or chess, and watching TV.

¹ [Home - VOYCE - WHAKARONGO MAI](#)

² Whaia te Maramatanga is the grievance and complaint process used in all youth justice residences.

³ Residential Care Regulations 1996



- Mokopuna are taking advantage of tired kaimahi.
 - Assaults are occurring between mokopuna regularly, particularly against tamaiti who other mokopuna do not want in their unit.
- Mokopuna are sharing clothes including underwear and drinking from shared drink bottles and jugs without cups.
- Repairs need to be conducted in a timely manner to ensure safety of mokopuna in the facility.
 - There was a boarded up window at the end of one wing at the time of our unannounced OPCAT Monitoring visit, and the secure care bedrooms require urgent refurbishment.
 - Heavy tagging and etching on Perspex windows is a safety hazard as it obscures kaimahi line of sight of each other and of mokopuna.

Positive findings:

- Newly recruited kaimahi have the opportunity to breathe fresh life into the residence, and to build a culture within the residence that focuses on therapeutic, trauma-informed care of mokopuna, as long as this is appropriately resourced and supported at a systemic level by Oranga Tamariki.
 - Many new kaimahi said they are confident in what they have been taught and were not afraid to question practice that ran contrary to their training.
- A new admission booklet has been produced and is being used. The booklet is mokopuna-friendly and clearly outlines how the residence operates, what mokopuna can expect, and how to access support.
- The general areas where mokopuna spend most of their time were clean and tidy.



Recommendations

2025 Systemic and Oranga Tamariki National Office focused Recommendations

As a result of the findings of our OPCAT monitoring visit in June 2025, Mana Mokopuna makes the following recommendations:

	Recommendation
1	Direct the appointment at Korowai Manaaki of a specifically designated kaimahi to be responsible for the regular review of all Use of Force events on mokopuna, so that those reviews are timely and in line with practice guidance expectations.
2	Audit the use of secure care across the Oranga Tamariki Youth Justice Residences and Care and Protection Residences to understand the common themes for admission into secure care, and to identify practice gaps where grounds have not been met for a mokopuna to be in secure care or where documentation is lacking detail.
3	Ensure site social workers are providing robust remand reviews for all mokopuna on remand in Oranga Tamariki Youth Justice Residences to limit the time that mokopuna are held on pre-trial detention and within custodial settings.
4	Refurbish the secure care bedrooms and systematically replace the heavily tagged and etched Perspex windows across Korowai Manaaki Youth Justice Residence to help ensure mokopuna and kaimahi safety.

2025 Facility Recommendations for Korowai Manaaki Youth Justice Residence

	Recommendation
1	Provide training to all relevant kaimahi to raise the standard and consistency of documentation detail including entries into unit logbooks, secure care registers and forms such as Serious Event Notifications, MySafety reports, Reports of Concern, and Use of Force reviews.
2	Ensure all kaimahi have access to cultural and clinical supervision to foster the growth of good practice across the residence and to help kaimahi identify areas they require professional development.
3	Provide training to all relevant kaimahi on the importance of independent advocates for mokopuna and the ways that they as residence kaimahi can positively support engagement with advocates for mokopuna.
4	Provide training to all relevant kaimahi to limit medication administration errors to prevent harm to mokopuna (noting that medication administration errors are enabling attempted overdoses by mokopuna).



	Recommendation
5	Provide enhanced Whakamana Tangata training to ensure all kaimahi are confident in the application of restorative, trauma-informed practice.
6	Regularly monitor programme and activity implementation against what is scheduled to encourage kaimahi not to default to passive recreation activities, and transparently report on the outcomes of this monitoring across the residence to encourage continued improved implementation against scheduled programming and activities for mokopuna.

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 Observations⁴ for New Zealand's sixth periodic review on its implementation of the Children's Convention⁵ 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 Observations⁶ for New Zealand's seventh periodic review regarding the implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment⁷.

Both of these sets of concluding observations included recommendations to New Zealand relating to upholding the rights of mokopuna Māori.

Many of the recommendations from both sets of Concluding Observations are directly relevant to aspects of treatment experienced by mokopuna at Korowai Manaaki which Mana Mokopuna has found during this monitoring visit in June 2025. Where relevant, these are highlighted throughout the body of the report.

⁴ Refer CRC/C/NZL/CO/6 [G2302344 \(3\).pdf](#)

⁵ [Convention on the Rights of the Child | OHCHR](#)

⁶ Refer CAT/C/NZL/CO/7 [G2315464.pdf](#)

⁷ [Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment | OHCHR](#)



Report findings by domain

Protection Systems

This domain examines how well-informed mokopuna are upon entering a facility. We also assess measures that protect and uphold the rights and dignity of mokopuna, including complaints procedures and recording systems.

Mokopuna have few safety mechanisms at Korowai Manaaki

Mokopuna residing at Korowai Manaaki are limited in the protective systems available to ensure their rights, safety, and wellbeing is upheld. While advocacy support from VOYCE Whakarongo Mai and the residence Grievance Panel is available to mokopuna, these advocacy mechanisms are undermined by the strong presence of a “no snitching” culture. Through interviews and observations, both mokopuna and kaimahi indicated to Mana Mokopuna that raising concerns through the grievance process exposes mokopuna to intimidation, bullying, and physical retaliation from peers. This culture is elevated by the behaviour of some kaimahi, who the Mana Mokopuna team heard during this OPCAT Monitoring visit making dismissive comments about “snitching” in the presence of mokopuna, regarding kōrero or interviews they participated in with us as OPCAT monitors. In many cases this was said by residence kaimahi in a joking manner. However, kaimahi saying this kind of thing to them underlined to mokopuna that speaking with OPCAT monitors and external providers of oversight and/or of services and support is noticed by all in the unit. As a result of this kaimahi behaviour, the residence is not an environment in which mokopuna can freely raise legitimate complaints about their treatment and advocate for themselves and their rights, even where their safety is at risk.

This raises high concern for Mana Mokopuna as it undermines the purpose of independent advocacy and grievance systems for mokopuna which exist to safeguard the rights of all mokopuna in the facility. This is also contradictory to Article 12 of the UN Convention on the Rights of the Child which guarantees mokopuna the right to express their views freely in all matters affecting them.

A fundamental shift in attitude and behaviour is required to create an environment where mokopuna are supported, encouraged, and protected when voicing concerns about their care and treatment. Without such safeguards, there is potential for harm and ill-treatment to occur, and for this to remain hidden and unaddressed.

Information used to ensure safety is not being accurately recorded

Accurate and timely documentation is critical in any youth justice facility, as it provides a record of mokopuna care, informs kaimahi practice, and ensures accountability. However, as part of



this OPCAT Monitoring visit, Mana Mokopuna found significant deficiencies in documentation and record-keeping practice at Korowai Manaaki.

Unit daily logbooks were often incomplete and lacking detail about unit dynamics that inform incoming shift kaimahi. Secure care registers also lacked detail and admissions to secure care were frequently justified with vague references to legislation, without clear explanation of how and why mokopuna meet the threshold⁸ to utilise the most restrictive practice available in a youth justice residence (secure care). Some mokopuna also had extended stays⁹ in secure care without the appropriate retention orders applied for via the Youth Court.

Our monitoring also found a lack of rationale as to why Regulation 48¹⁰ (confining to bedrooms) was being imposed on mokopuna, again with a lack of detail regarding the behaviours or risks in allowing mokopuna to mix in the units and what plans were being put in place to mitigate those risks so that mokopuna could remain in the units.

When secure care is full at Korowai Manaaki, mokopuna may only be let out of their bedrooms for around seven to eight minutes in every hour. The lack of detail in the secure care register fails to give kaimahi the information they need to understand mokopuna triggers, de-escalation strategies, and care needs going forward. As one kaimahi told us, the system is a “f**king mess,” with poor documentation leading to repeated reliance on secure care to manage mokopuna behaviour, rather than learning from mokopuna patterns and adopting preventative approaches.

Concerningly in both April and May 2025 there were approximately 150 occasions in both months with some mokopuna not being let out of their bedroom for their allocated rotations,¹¹ therefore spending extended periods of time alone without contact with others.

Furthermore, Use of Force reviews had not been completed for over two months (from 16 April to 30 June 2025), which inevitably results in potential harm to mokopuna going unnoticed and kaimahi practice not being corrected in a timely manner. Anecdotally, more than one kaimahi made the correlation between low staffing numbers and force being used on mokopuna. This practice highlights the critical need for immediate Use of Force reviews for all Youth Justice Residences and especially at Korowai Manaaki given the review backlog. Mana Mokopuna was told that whilst there is a qualified reviewer onsite, the preference for the facility management team was to have the National STAR¹² trainer review force for the residence which came with a time delay.

Mana Mokopuna is concerned that documentation standards at Korowai Manaaki are not improving. This issue is regularly reported by Mana Mokopuna as a result of our OPCAT

⁸ Grounds for secure care admissions are set out in s368 of the Oranga Tamariki Act 1989.

⁹ Mokopuna can only be held in secure care for a maximum of 72 continuous hours without an application for retention being made to the Youth Court as per s371 of the Oranga Tamariki Act 1989.

¹⁰ Regulation 48 of the Residential Care Regulations 1996 states mokopuna can be kept in their bedroom whilst in secure care.

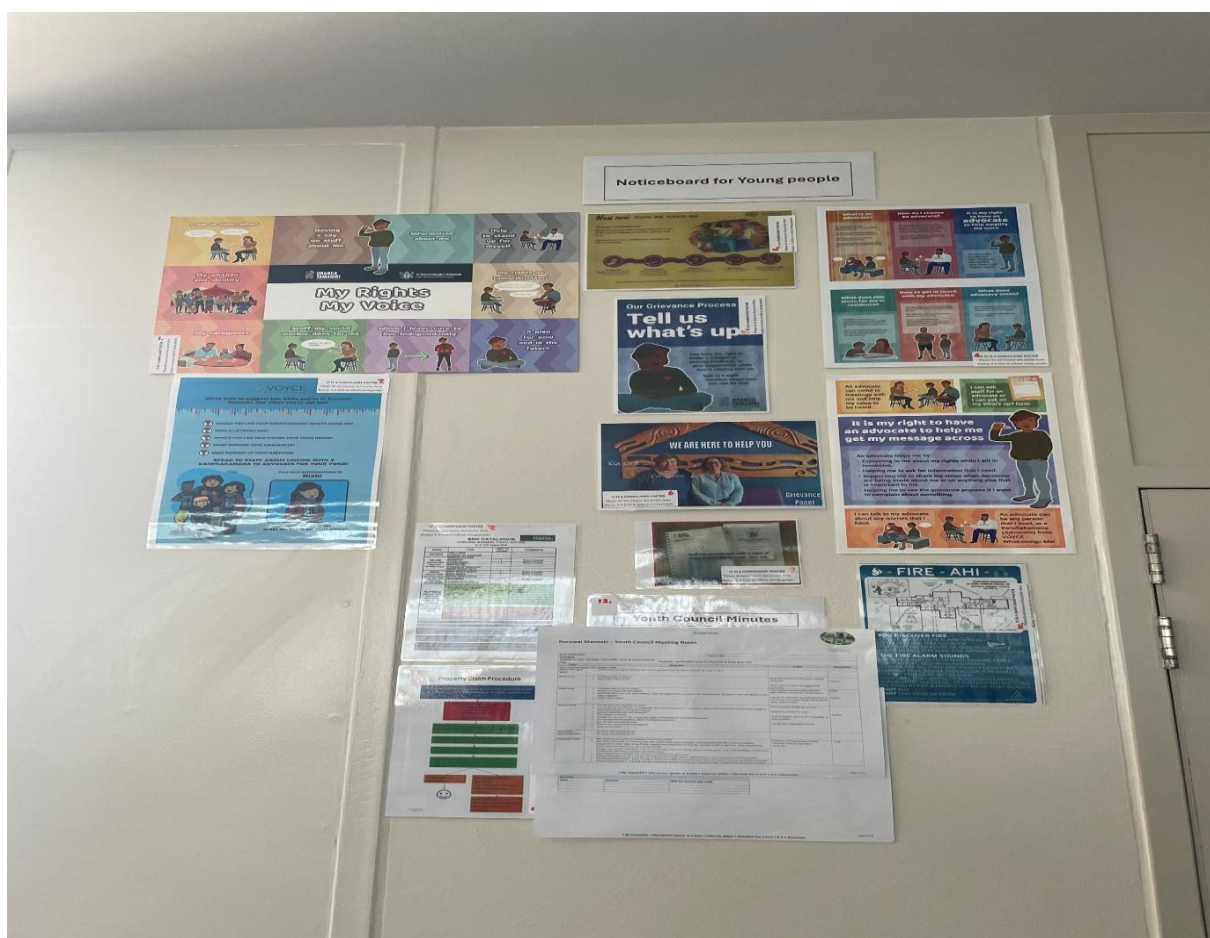
¹¹ Data obtained onsite at the residence.

¹² Safe Tactical Approach Response (STAR) is the use of force training used across all youth justice residences.

Monitoring of this facility, and little seems to be done at a residence level to improve kaimahi practice in this area. Mana Mokopuna recommends urgent training for all relevant kaimahi so they are clear on what details need to be documented in logbooks and registers, and that regular quality assurance checks are carried out to track improvements in this aspect of practice across the residence.

Advocates are regularly at Korowai Manaaki

Independent advocates are a vital protection system for mokopuna within youth justice facilities. VOYCE Whakarongo Mai (VOYCE) kaimahi conduct regular weekly visits to Korowai Manaaki and are working to build trust with mokopuna and kaimahi alike. There has been a vast improvement in the relationship between VOYCE and Korowai Manaaki kaimahi as was acknowledged by VOYCE Kaiwhakamana (VOYCE kaimahi who work directly to support mokopuna with independent advocacy). This has meant VOYCE involvement in mokopuna independent advocacy has increased at Korowai Manaaki and allowed them to create meaningful relationships with mokopuna and kaimahi, as well as developing and delivering meaningful mokopuna rights and advocacy workshops at the facility. Posters with their contact details are displayed prominently in every unit, and new kaimahi are introduced to the independent advocates from VOYCE through the Te Waharoa induction training.



(Notice board for mokopuna with rights information)



The Grievance Panel also visits at Korowai Manaaki regularly, providing oversight of the Whaia te Maramatanga¹³ process. These are positive developments that demonstrate the importance of external advocacy mechanisms in upholding mokopuna rights in the facility. They form key protective systems for mokopuna and their rights that must be supported and integrated into Korowai Manaaki on an ongoing basis.

However, despite these improvements and an increased presence of independent advocates/complaints mechanisms at Korowai Manaaki, mokopuna in the residence largely remain reluctant to use advocates and to access the grievance process. They told us that grievances often take too long to resolve, that outcomes are rarely communicated, and that they have little faith their concerns will be addressed. Many grievances over the last few quarters of the year were about issues such as food, clothing, and furniture, rather than deeper concerns about mokopuna treatment. This reflects both a lack of trust in the process and the influence of the “no snitch” culture – mokopuna still refer to the Grievance post box in units as “snitch boxes”. Mokopuna also said they have withdrawn grievances in the past because they believed “nothing will happen anyway.” Unless kaimahi actively support mokopuna to use these systems safely and confidentially, the potential of independent advocacy to protect mokopuna will not be realised.

Oranga Tamariki is bound by the Children’s Convention and Article 3 of Te Tiriti o Waitangi to ensure the safety of all mokopuna in State Care, at all times. The failure of the State to ensure safety for all mokopuna in care was noted by the UN Committee on the Rights of the Child in its most recent Concluding Observations on New Zealand, with reference to the need to address a ‘bullying culture’ in places where mokopuna are detained.¹⁴

There have been improvements in the admission process with the development of a child-friendly information booklet

Mana Mokopuna noted a positive development at Korowai Manaaki with the introduction of a new mokopuna-friendly admission booklet. This resource explains, in mokopuna-friendly language, how the residence operates, what mokopuna can expect, and how to access support. Both mokopuna and kaimahi described it as helpful in informing mokopuna who may be new to the facility or youth justice residences in general which can help to reduce stress for mokopuna during the admission process.

However, admission processes themselves still lack depth. All About Me Plans (AAMPs) and medical information were frequently incomplete, leaving kaimahi without a full picture of mokopuna health needs, educational background, personal aspirations, or cultural identity. This is not only a safety concern for mokopuna particularly when health information may be missing, but also a cultural concern, as mokopuna can lose connection to whakapapa and

¹³ Whaia te Maramatanga is the grievance and complaint process used in all youth justice residences.

¹⁴ CRC/C/NZL/CO/6 para 27(b)



whānau that help keep them grounded. Admissions of mokopuna into the residence should always set the foundation for safe, individualised care, but at present they fall short of this standard, meaning significant opportunities are being missed and gaps are presenting in the care of mokopuna to meet their specific needs and uphold their rights in action.

Admissions are a critical transition period for mokopuna and the initial experiences they have when being admitted into the residence heavily shape the experience that mokopuna have in the residence. Many arrive directly from Court or Police cells, feeling anxious, angry, scared and/or unsafe. First impressions are therefore vital for building trust and ensuring mokopuna understand their rights and feel that they are able to ask questions and have a voice in their treatment and decisions that are made about them. Consistent processes and systems for admission of mokopuna into the residence should set the foundation for their safety and care while in Korowai Manaaki.

Mokopuna are entitled to the highest standard of care when they are in the custody of the State. Oranga Tamariki is bound by the duties and obligations set down in the UN Convention on the Rights of the Child, and Te Tiriti o Waitangi. We specifically draw Oranga Tamariki's attention to by Articles 19, 20 and 27 of the Children's Convention, and Article 3¹⁵ of Te Tiriti o Waitangi, to actively protect and treat as taonga the mokopuna in its care.

¹⁵ [The three articles of the Treaty of Waitangi – Nation and government – Te Ara Encyclopedia of New Zealand](#)



Treatment

This domain focuses on any allegations of torture or ill-treatment, use of seclusion, use of restraint and use of force. We also examine models of therapeutic care provided to mokopuna to understand their experience.

Low staffing has an impact on unit dynamics

High kaimahi ratios in residences are not a luxury – rather, they are a critical foundation for mokopuna safety, effective rehabilitation, and trauma-informed care. At the time of this June 2025 OPCAT Monitoring visit, staffing numbers at the residence were critically low. Kaimahi told us they are regularly working double shifts, with many feeling fatigued and burnt-out. Some kaimahi expressed that this results in the increase of restrictive practice methods being employed, like Secure Care, to manage mokopuna.

Exhausted kaimahi have less capacity and patience to manage mokopuna behaviour, complete critical tasks like paperwork, and deal with day-to-day challenges within units. For example, one unit had their PlayStation removed as an activity option because they were flippant about introducing themselves to the Mana Mokopuna OPCAT Monitoring visit team. The imposition of this consequence on the mokopuna created on-going heightened dynamics amongst the mokopuna within that unit for the remainder of our onsite unannounced visit. Kaimahi are also less able to plan or deliver meaningful programmes and instead allow mokopuna to remain idle and bored which can also contribute to unsafe dynamics within the units.

*"It's about being professional and human. We need more people."
(Mokopuna)*

Low staffing numbers can also impact on kaimahi practice, creating inconsistencies in approaches and expectations for mokopuna.

Mana Mokopuna noted the following practice issues:

- A lack of line of sight by kaimahi in relation to mokopuna in the residence
- Calling mokopuna names. An example noted during the visit was a kaimahi calling te tamaiti "ol' stoney" when referring to their cannabis use.
- Multiple kaimahi gave examples of colleagues going easy on contraband being possessed and used by mokopuna in the residence, in order have an easier shift due to the impact on mokopuna behaviour (see page 17 regarding contraband entering the residence).
- Some kaimahi lacking professional boundaries – especially young female kaimahi allowing mokopuna to drape arms around them and acting in ways that other kaimahi describe as "flirtatious".



- Mokopuna can easily identify tired kaimahi and know which kaimahi are working double shifts. Incident reviews indicate a recent hub rush (where mokopuna rush into the kaimahi-only unit control hub) occurred with tired kaimahi.

The 'survival mode' approach adopted by kaimahi undermines trauma-informed, therapeutic care, and leaves both mokopuna and kaimahi at risk of harm. Mana Mokopuna recommends that Oranga Tamariki reviews minimum unit staffing numbers for Korowai Manaaki and ensures via recruitment processes, induction, and on-going training that kaimahi have the tools to appropriately manage a unit and the right mindset and attitudes to continually support mokopuna in ways that uphold their safety and rights.

*"If one child comes out of here okay, it will be a miracle, we haven't done our best for them."
(Kaimahi)*

Mokopuna are running the units

Mana Mokopuna observations and interviews with kaimahi during this OPCAT Monitoring visit found that mokopuna, rather than kaimahi, "ran the units". An example was when kaimahi were directed by the leadership team to maintain safe practice and protocols in regard to music within the units. This included not letting mokopuna control the speaker. However, in observations made by Mana Mokopuna, a select few mokopuna were able to dictate music being played and the volume it was played at, even when kaimahi had just received instructions that this should not be happening.

Mana Mokopuna also noted mokopuna dictating who entered units when new admissions arrived at the facility. Mokopuna were observed isolating individual tamaiti who they did not want in their unit, and kaimahi confirmed there were cases of tamaiti being assaulted to force their admission into Secure Care when their presence in a unit was not wanted by other mokopuna.

This happened during the course of this June 2025 OPCAT Monitoring visit, with one tamaiti being released from Secure Care to their open unit after an assault, only to return to Secure Care again a few hours later due to threats to their safety. The other mokopuna in the unit had made it clear to kaimahi that they did not want that particular tamaiti in their unit and were forcing kaimahi to consider a change in unit for that tamaiti. Mana Mokopuna was also told by kaimahi as they were walking another tamaiti over to Secure Care that they had no grounds under legislation to admit the tamaiti into Secure Care but were doing it anyway as they didn't feel they could keep him safe. Many kaimahi are not equipped to manage the unit dynamics and therefore were allowing mokopuna to rule the units with fear.

*"It's unpredictable, you don't know what is going to happen [...] you don't know if someone or the staff are telling YP [young people] to beat someone up. Its straight 100% one of the most corrupt places, all the corruption in this space."
(Mokopuna)*



"It's either me first or just let them beat me up. I'm not going to do that. I'm just going to be straight in there as soon as I walk in."

(Mokopuna)

Contraband is regularly brought into the residence

Contraband continues to be an issue at Korowai Manaaki. This is not the first time Mana Mokopuna has been told that mokopuna have ready and regular access to cannabis and vapes. The OPCAT Monitoring visit team was told by multiple kaimahi in the residence that the contraband is brought into the residence by both whānau members visiting mokopuna, and by kaimahi themselves. Supplying cannabis or vapes to children under 18 is illegal¹⁶ and its presence, let alone its prevalence in a State-run facility is unacceptable.

Mokopuna are creating paraphernalia made from rubbish, fruit, toilet rolls and playing cards to consume the cannabis in the residence. They also make ignition devices from wires and batteries as well as having access to matches and a striker strip from a matchbox. Mana Mokopuna noted one tamaiti in Secure Care who had been admitted due to a belief by kaimahi that they had cannabis on their person. This tamaiti was brought out of their bedroom on rotation whilst Mana Mokopuna was present monitoring in the Secure Care unit. Open conversation between this tamaiti and kaimahi confirmed the tamaiti was smoking cannabis in their bedroom and the comment from kaimahi was to "hurry up and smoke it all", as the knowledge of the availability of cannabis had spread to the other mokopuna in the unit and there was unrest as this tamaiti said they "don't want to share." Not once did this kaimahi offer amnesty to hand in the contraband or outline a room or pat-down search. Instead, the kaimahi simply joked and laughed and told the tamaiti to smoke what they had quickly, effectively encouraging the mokopuna to use this contraband.

Mana Mokopuna was also made aware by multiple kaimahi in the residence of a particular room in Secure Care where mokopuna were storing contraband behind the in-built wall intercom. The intercom had been tampered with and contraband was being stored in the wall cavity behind it. Kaimahi told Mana Mokopuna that some mokopuna were purposely crafting their admission into Secure Care and requesting a particular room, as the rumour had spread across the residence that this room was where contraband was being made available. Across the board, kaimahi in the residence who Mana Mokopuna spoke with said that the majority of contraband is being brought in by kaimahi, rather than by visitors, as visit logs are not correlating to when particular tamaiti are found to be under the influence of substances.

Article 33 of the Children's Convention requires Oranga Tamariki to take all appropriate measures to protect children in its care in Youth Justice residences from the illicit use of narcotic drugs.¹⁷

¹⁶ It is illegal to supply vapes both directly and indirectly to mokopuna under the age of 18 (Smokefree Environments and Regulated Products (Vaping) Amendment Act 2020) and S6(d) Misuse of Drugs Act 1975.

¹⁷ [Convention on the Rights of the Child | OHCHR](#)



The presence of cannabis in Korowai Manaaki is particularly concerning especially for mokopuna on regular medication or with mental health diagnoses, as cannabis is known to negatively interact with prescription medication by increasing side effects and altering medication concentration.¹⁸ There are also general health and safety risks for mokopuna that arise from using cannabis, as well as a serious risk of fire within the residence as a result of mokopuna lighting joints.

Having cannabis in residences represents both a systemic failure and a missed opportunity to uphold the rights and mana of mokopuna in the Youth Justice system. The State has a non-negotiable duty of care to protect mokopuna in its custody from harm, including harm caused by drugs. Condoning and supporting contraband use is a direct failure of this responsibility and arguably a breach by the State of Articles 19, 24, 33 and 40 of the UN Convention on the Rights of the Child and the State's obligations under Te Tiriti o Waitangi to keep mokopuna safe.

At the time of this OPCAT Monitoring visit there was a distinct lack of therapeutic support available to mokopuna in Korowai Manaaki by way of addiction support and rehabilitation. This is concerning given the prevalence of cannabis use, how it can interact with prescribed medication and the negative effects it has on developing minds and bodies. Mana Mokopuna encourages Korowai Manaaki to increase the use of existing supports established through Odyssey¹⁹ to support mokopuna therapeutically with their drug addictions and challenges.

Secure Care is used to control mokopuna behaviour

Mana Mokopuna found the use of Secure Care to be high and sometimes used inappropriately at Korowai Manaaki. As detailed in the previous domain, information regarding legal grounds for Secure Care admissions was lacking and inconsistent across the residence. In March, April and May 2025 there were over 140 admissions recorded at an average of around 45 per month.²⁰

The isolation and seclusion of mokopuna goes against their human rights. The UN Committee Against Torture, the UN Subcommittee on the Prevention of Torture and the UN Committee on the Rights of the Child note that the use of solitary confinement, of any duration, on children, constitutes cruel, inhuman or degrading treatment or punishment or even torture. There is strong international advocacy for the seclusion of all mokopuna in all settings to cease immediately. The Concluding Observations on New Zealand released by the UN Committee Against Torture on 26 July 2023 recommend New Zealand should immediately end the practice of solitary confinement for children in detention. Mana Mokopuna supports zero seclusion practices. We have seen that this is achievable as demonstrated by some of the other

¹⁸ There is significant research regarding the negative health impacts of cannabis. An example: [CBD and other medications: Proceed with caution - Harvard Health](#)

¹⁹ [Odyssey](#)

²⁰ Data obtained onsite at the residence.



places of deprivation of liberty of mokopuna that we monitor as an OPCAT National Preventative Mechanism.

Kaimahi at Korowai Manaaki confirmed to Mana Mokopuna that Secure Care is used as a behaviour management tool when kaimahi can no longer manage the behaviour of individual tamaiti, and to address dynamics in the open units. During the OPCAT Monitoring visit, Mana Mokopuna heard over the internal radio communication system within Korowai Manaaki a direction by a member of the residence leadership team to unit kaimahi that if mokopuna do not comply with instruction to “just put them in secure.” Secure Care must not be used as a punishment. Mokopuna should instead be supported through relational guidance, supported self-regulation as well as meaningful activities to ensure the least restrictive methods of behaviour management are the default way of working, not Secure Care as the default.

In addition, vulnerable mokopuna told Mana Mokopuna that they at times request to be taken to Secure Care or intentionally do not comply with rules so they can be admitted into Secure Care, due to feeling unsafe in open units. Secure Care should not be the unit of choice for any mokopuna, especially given the amount of time they spend alone in their bedroom, which runs counter to their rights as mokopuna.

*“Secure Care is a mockery”
(Kaimahi)*

The excessive use of Secure Care within Korowai Manaaki is a red flag for deeper systemic issues in the residence. It harms mokopuna emotionally and developmentally, undermines human rights obligations, and contradicts the values of rehabilitation, equity, and care. Addressing this requires urgent action: increased kaimahi training, better ratios, and a firm commitment to trauma-informed, relationship-based practice like Whakamana Tangata. Secure Care must be the exception, not the rule. Mana Mokopuna strongly urges that Korowai Manaaki decrease its use of Secure Care and moves towards zero seclusion practices. This will require a systematic re-set of the residence culture and a mindset and behavioural shift by kaimahi.

Mokopuna Plans lack important information

All mokopuna should be entering the facility with an All About Me Plan (AAMP), filled in by their Oranga Tamariki site social worker. Kaimahi said mokopuna AAMPs are often incomplete when mokopuna arrive for admission, which can make it challenging for the on-site clinical team to find the information they need to provide the best care possible for mokopuna whilst they are in residence. It is essential for mokopuna plans to be completed, with input from mokopuna and their whānau, and to be updated regularly by their social worker. This right was not being realised for mokopuna at Korowai Manaaki at the time of this OPCAT Monitoring visit.



Mokopuna are required to have input into their plans, consistent with Article 12 of the UN Convention on the Rights of the Child. Essential details such as the services provided to them, personal objectives, whānau contact details, and information regarding their education, recreation, and welfare needs are also required under section 3(3) of the Oranga Tamariki (Residential Care) Regulations 1996²¹. Mokopuna at Korowai Manaaki did not have this right upheld.

Mana Mokopuna also remains concerned about the amount of mokopuna in all youth justice residences on remand. Custodial remand statuses should be reviewed every 14 days as per s242(1A) of the Oranga Tamariki Act 1989. However, Mana Mokopuna consistently finds remand review documentation substandard and lacking detail as to the reasons why a custodial setting is still required for some mokopuna. 92% of the mokopuna living at Korowai Manaaki at the time of this June 2025 visit were on remand and the sample of remand reviews scrutinised were also substandard and described as tick-box.

Mana Mokopuna recommends Oranga Tamariki ensures site social workers are completing robust remand reviews to limit the time that mokopuna are held on pre-trial detention and within custodial settings.

²¹ [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](#)



Personnel

This domain focuses on the relationships between staff and mokopuna, and the recruitment, training, support and supervision offered to the staff team. In order for facilities to provide therapeutic care and a safe environment for mokopuna, staff must be highly skilled, trained and supported.

Culture and communications require urgent attention

There is a longstanding culture at Korowai Manaaki that lacks transparency and where substandard practice is accepted. Unethical behaviours by kaimahi have sometimes gone unchallenged, and kaimahi who do raise concerns report a fear of retaliation. Kaimahi describe low morale and disengagement, which in turn weakens teamwork and has a significant effect on kaimahi turnover rates. For some time now, Mana Mokopuna has been reporting these findings through our independent OPCAT reporting. However, Korowai Manaaki seems to persistently hold on to a culture that is resistant to change, which is in turn compromising the quality of mokopuna care in the residence.

In addition to an embedded culture that is overall inconsistent with the rights and quality care of mokopuna, there is instability in the residence leadership group, with the Manager Residence Operations (MRO) recently resigning, an interim Acting MRO appointment and a still relatively new Residence Manager. There is still a sense from some long standing kaimahi that the 'old ways' are better, and there is a clear division in the leadership group between those who want to change the perception of the residence and how it operates, with those who remain staunchly committed to keeping things as they have always been.

Many kaimahi who spoke to Mana Mokopuna during this OPCAT Monitoring visit used the word "corrupt" to describe the operations of some kaimahi, and others expressed to us that the residence had got worse in terms of culture since our last January 2024 visit. Both kaimahi and mokopuna were unaware of the interim Acting MRO being onsite or what their name was, and said they rarely see the Residence Manager in the units. Some kaimahi told Mana Mokopuna that they did not know what the Residence Manager looks like. This speaks to a communication breakdown between the leadership team and those working directly with mokopuna in the units, and a perceived lack of visibility of the Residence Manager to role-model leadership in a visible way.

*"I have lost hope, I think I have done all I can here and am looking for other jobs."
(Kaimahi)*



Some kaimahi do not feel safe working at Korowai Manaaki

Mana Mokopuna found that many kaimahi reported they do not feel safe or confident working in units especially when shift numbers are low. In one instance, Mana Mokopuna observed unplanned leave had taken place where 10 kaimahi and one Team Leader Operations did not turn up for their shift. This then put remaining kaimahi under immense pressure to cover shifts by either staying on later or working a whole additional shift.

Several kaimahi also said they avoid speaking up about issues such as poor practice or further escalating issues out of fear of being mistreated or outcast by their colleagues. In some instances, kaimahi have felt some colleagues use mokopuna to put pressure on other kaimahi by encouraging mokopuna to target or 'green light' kaimahi that speak up. Some kaimahi said they can only rely on a small group of trusted kaimahi to "have their backs" and uphold professional practice standards. Generally, issues, even when they are raised, go unaddressed and not dealt with. This is perpetuating a culture that operates with fear and intimidation. Many kaimahi said their sole focus is on getting through shifts unharmed.

It is imperative that all kaimahi feel safe working in the residence and that there are clear avenues for them to be heard, provide both positive and negative feedback and suggestions, and for the leadership team to work with kaimahi who can lead the residence into a positive direction of change.

Strengthening practice through collaboration between new and experienced kaimahi

Despite challenges experienced by kaimahi, newly recruited kaimahi have the opportunity to breathe fresh life into the residence. Many new kaimahi that Mana Mokopuna spoke with said they are confident in what they have been taught and were not afraid to question practice that ran contrary to their training. These kaimahi expressed enthusiasm, confidence, and a willingness to ask 'why' and dig deeper into how things should be run in a unit that is focused on caring for mokopuna in the youth justice system.

Several kaimahi, both newly recruited and longstanding, said they were committed to making changes and working towards mokopuna rehabilitation and wellbeing. Many of these kaimahi gave tangible solutions to site wide problems and were willing to have conversations with managers regarding poor practice. There are still some kaimahi willing to take on personal risk and name kaimahi who have questionable practice, with the aim of improving care experiences for mokopuna. These are the people the leadership team need to listen to in order to turn the tide on ingrained ways of working in Korowai Manaaki, to re-set the residence in a significant way that puts the safe and rehabilitative care of mokopuna at the absolute centre of all that happens in the residence.

New kaimahi bring fresh perspectives, and when teamed up with skilled and experienced youth practitioners who have a high standard of practice, this group of kaimahi have the potential to steer a re-set of the residence culture. However, all kaimahi require supervision and strong



leadership support to sustain their practice. Without effective guidance, there is a risk they will either leave or be absorbed into entrenched negative ways of working in the residence.

Training and supervision are essential to promote good practice

In order to continually upskill all kaimahi and grow their confidence and experience in navigating complex unit dynamics and mokopuna behaviours, an intense training programme needs to be developed and delivered. Effective kaimahi practice also relies on kaimahi being well-supported through ongoing and high-quality clinical and cultural supervision.

Kaimahi, in particular residential youth workers, are tasked with managing mokopuna with high and complex needs, repeatedly addressing behaviours, and upholding Oranga Tamariki care regulations in their daily interactions. Kaimahi identified gaps in knowledge around basic operational processes such as shower routines and maintaining line of sight and knew that both of these processes carry significant safety risks if not managed well. They also expressed concern over their limited access to reflective, trauma-informed supervision which they said does not help them keep safe in terms of good practice, continued professional learning, and driving consistent routines and expectations with mokopuna.

Regular, high-quality supervision and consistent trauma-informed practice training and guidance is a safeguard for both kaimahi and mokopuna. By embedding strong support systems and kaimahi practice, this should better ensure that trauma-informed care is sustained and can ultimately lead to safer facilities for both kaimahi and mokopuna.



Medical services and care

This domain focuses on how the physical and mental health rights and needs of mokopuna are met, in order to uphold their wellbeing, privacy and dignity.

Article 24 of the UN Convention on the Rights of the Child outlines that all mokopuna have the right to timely, high quality health care. Not all mokopuna have this right realised at Korowai Manaaki.

Communications between residence and medical kaimahi needs to be improved

Communication and cohesion between external stakeholders providing services in the residence and the residence leadership team was raised as an issue in our previous OPCAT monitoring report (detailing the October 2024 (full unannounced) and January 2025 (drop-in) visits). As a result, the Residence Manager made a commitment to meet with all external parties, including the medical team, on a regular basis. At the time of this June 2025 visit, no scheduled hui had taken place and a number of external stakeholders providing services in the residence communicated to Mana Mokopuna that communications with the residence were no better, maybe even worse. Examples of poor communication were provided by kaimahi and evidenced through our review of mokopuna documentation from the residence. These examples include:

- A tamaiti undergoing a process to be sectioned under the Mental Health Act for assessment, however, residence and clinical kaimahi are unsure who is responsible for providing updates about the process and when te tamaiti can expect to leave the residence. Clarity was lacking around:
 - A psychiatrist update regarding mental state, risk mitigations and plans for admission into adolescent mental health services.
 - What the safety plan updates are (tamaiti was still in Korowai Manaaki at the time of the visit)
 - Transport details for te tamaiti to the next placement.
- An undiagnosed medical issue for a tamaiti who came into the residence. This issue was apparent in the community placement prior to te tamaiti entering Korowai Manaaki. When te tamaiti then came into residence the condition was picked up by the medical team who suggested hospital review.
 - Oranga Tamariki site social workers did not pass on any concerns and the medical team did not receive timely information before seeing te tamaiti themselves.



- The hospital review took place at the request of residence onsite nurses and te tamaiti was diagnosed with a serious virus and admitted for a hospital stay.
- Generally, and from a medical perspective, mokopuna are entering the residence with a lack of information which is impacting how mokopuna receive timely medical intervention.

Good, clear communications across all operations of residences and across the systemic network supporting mokopuna is essential to ensure appropriate services are available in a timely manner, in order to meet mokopuna needs and uphold their rights in practice. Mana Mokopuna recommends that the Residence Manager convene ongoing hui with external stakeholders to re-set relationships and in an effort to make an agreement to working openly and transparently putting mokopuna at the centre across all operations at Korowai Manaaki.

Mokopuna miss medical appointments due to kaimahi shortages

Shortages of kaimahi on shift has an impact on when mokopuna can be escorted across the compound (internal courtyard area) to the medical room and team. When there are not enough kaimahi to run the units, mokopuna miss out on scheduled medical and dental appointments. Mana Mokopuna was told by kaimahi that this can include offsite appointments with specialists. While on-site nurses and visiting dental services provide some coverage, they cannot provide the comprehensive healthcare that mokopuna are entitled to. Kaimahi acknowledged these failures and openly admitted to Mana Mokopuna that even when there are enough kaimahi to manage movements from the units, a lack of motivation by kaimahi to work with mokopuna and kaimahi tiredness plays a part in whether mokopuna access services.

Mana Mokopuna saw first-hand the correlation between staffing shortages and mokopuna accessing adequate medical care. We recommend Oranga Tamariki address this urgently as there is risk of medical negligence if mokopuna are not seen by professionals in a timely manner.

A lack of care from kaimahi is resulting in medication errors

A review of documentation showed there had been multiple instances of mokopuna stockpiling medications and then using the excess medication to attempt overdose. Kaimahi told Mana Mokopuna they had explained to key residence kaimahi how to properly crush medications and give them to mokopuna on a spoon with yoghurt to avoid them stockpiling. However, kaimahi are not doing what has been advised, which is resulting in the overdoses or near misses. Documentation showed an overdose attempted by more than one mokopuna in each month across April, May and June 2025.



Medication errors also remain a serious concern. Despite clear instructions on how to track prescribed medications given to mokopuna from the medical team, kaimahi do not always follow these instructions often resulting in errors with dosage and timing. Mana Mokopuna found errors that included crushing medication incorrectly, giving melatonin hours before bedtime, or failing to provide doses altogether.

Medication errors and a laissez-faire approach to medicines by kaimahi within Korowai Manaaki poses significant health risks for mokopuna and reflects both training gaps and a lack of commitment to mokopuna health and wellbeing. These present failures to comply with Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018, which require safe and appropriate healthcare in care settings, and highlight the gaps in mokopuna experiencing their rights to the highest attainable standard of health under Article 24 of the UN Convention on the Rights of the Child.

Mana Mokopuna recommends a full and comprehensive review of kaimahi medicine administration training is undertaken at Korowai Manaaki to ensure mokopuna needs are met, and that the progress of improvement in this area continues to be monitored and reported on within the residence.



Improving outcomes for mokopuna Māori

This domain focuses on identity and belonging, which are fundamental for all mokopuna to thrive. We note commitment to Mātauranga Māori and the extent to which Māori values are upheld, cultural capacity is expanded and mokopuna are supported to explore their whakapapa.

Mokopuna Māori remain disconnected from identity and whakapapa

Mokopuna Māori continue to be over-represented at Korowai Manaaki, yet their cultural identity and wellbeing are not always being met or adequately supported. Kaimahi and mokopuna alike expressed concern at the lack of tikanga Māori, cultural programmes that support identity, and role models that embed Te Ao Māori within Korowai Manaaki.

Kaimahi Māori said there is an underlying negative attitude towards Māori culture held by some kaimahi working at the residence that creates a divide, and resistance to improving mokopuna cultural needs. They told us that this not only negates fostering cultural connectedness for mokopuna but undermines being able to implement therapeutic approaches outlined in Oranga Tamariki practice guidance and frameworks.²² Without strong te ao Māori approaches to building connections with culture, mokopuna Māori who are resident in Korowai Manaaki miss out on critical opportunities that should be provided to them to strengthen their sense of belonging and resilience. The absence of cultural foundation within the residence grounded in te ao Māori undermines Oranga Tamariki obligations under Te Tiriti o Waitangi, which requires practices that reduce cultural disparities and uphold whakapapa.

"There's nothing Māori in here...nothing!"
(Kaimahi)

Opportunities for change through Whakamana Tangata

Whakamana Tangata, the Māori-informed restorative model for Oranga Tamariki youth justice residences, is an untapped taonga that could transform mokopuna care at Korowai Manaaki and all youth justice facilities around the motu. At present, it is inconsistently applied and not embedded into everyday practice due to a lack of a permanent Kaiwhakaue. By embedding Whakamana Tangata into every interaction from leadership to frontline kaimahi, Korowai Manaaki can create an environment where not only mokopuna Māori, but all mokopuna, are not treated as problems to be managed but as taonga with identity, potential, and mana.

Mana Mokopuna have reviewed the model and undergone the foundational training and have found the practice model is well-informed, the training is exceptionally facilitated, as well as

²² [Our Māori Cultural Framework | Oranga Tamariki — Ministry for Children](#)



having had the privilege to see the model in practice at Te Maioha o Parekarangi Youth Justice Residence with positive outcomes.

Mana Mokopuna recommends that a robust implementation plan of Whakamana Tangata is embedded at Korowai Manaaki with a clear expectation that 100% of kaimahi complete the Whakamana Tangata training and are assessed to have a good level of practical understanding to enable implementation across the site.

There is a lack of cultural support and role models for mokopuna

Mokopuna Māori have limited access to te reo Māori, tikanga, and guidance that connect them to their whānau, hapū and Iwi. Kaimahi Māori reported feeling stretched thin when asked to fill these gaps, with many often wearing multiple pōtae (hats) to uphold tikanga for the facility, teach te reo Māori, provide education, and, for some kaimahi, provide cultural supervision in addition to their core duties. 86% of mokopuna in Korowai Manaaki at the time of our June 2025 visit whakapapa Māori. Mokopuna said they rarely see themselves reflected in kaimahi in the residence, which creates a further disconnect between formalising cultural values and embedding identity whilst navigating daily life in residence.

Korowai Manaaki does not currently have a Kaiwhakaue.²³ The Kaiwhakaue role is responsible for leading Whakamana Tangata in the residence, and the role works directly with all kaimahi to help embed the adoption of practices derived from Whakamana Tangata. The Kaiwhakaue role also works with the senior residential leadership team to help drive the Whakamana Tangata practice into residential systems, processes, policies and daily operations across Korowai Manaaki. The Kaiwhakaue is responsible for kaimahi training, mentoring and support, providing focused individual and group supervision. They also facilitate complex Hui Whakapiri and develop new practice approaches, particularly those involving whānau engagement, to share insights and lessons learnt, promoting continuous improvement to strengthen practice.²⁴

Mana Mokopuna suggests that a permanent Kaiwhakaue role is established at Korowai Manaaki to embed key practice frameworks to support kaimahi practice, and to enhance te ao Māori approaches and cultural understanding across the facility. Whilst there was a proposal for a current TLO to work with the Residence Manager on a strategy to improve outcomes for mokopuna Māori, this was in the early stages of scoping and not operational.

Mana Mokopuna believes there is also value in adopting a role that is specifically targeted at providing cultural guidance and supervision for kaimahi, and ensuring te reo me ona tikanga practice is upheld and present within Korowai Manaaki for both kaimahi and mokopuna, on a consistent basis.

*"I feel spread out and don't have a finger on the pulse."
(Kaimahi)*

²³ A tagged specialist Māori role focused on leading and developing cultural practice in Oranga Tamariki residences.

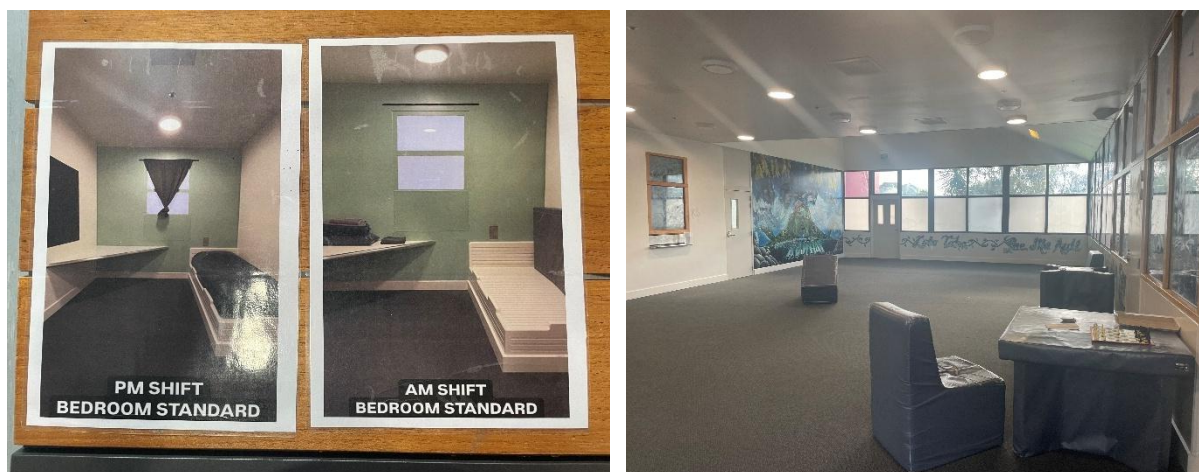
²⁴ [kaiwhakaue-position-description-june-2020.pdf](#)

Material Conditions

This domain assesses the quality and quantity of food, access to outside spaces, hygiene facilities, clothing, bedding, lighting and ventilation available to mokopuna. It focuses on understanding how the living conditions in secure facilities contribute to the well-being and dignity of mokopuna.

The units where mokopuna live were generally clean

Generally, units at Korowai Manaaki were observed to be cleaner than on previous visits with mokopuna bedrooms, bathrooms and general furniture and bedding to be adequate. This is an improvement. Mana Mokopuna observed kaimahi making efforts to maintain a clean standard in the units. Kaimahi and mokopuna were observed vacuuming and wiping down surfaces after meals and there was a clear 'bedroom expectation' in place for mokopuna.



(Bedroom layout expectations for all mokopuna personal bedrooms (left) and a tidy common area (right))

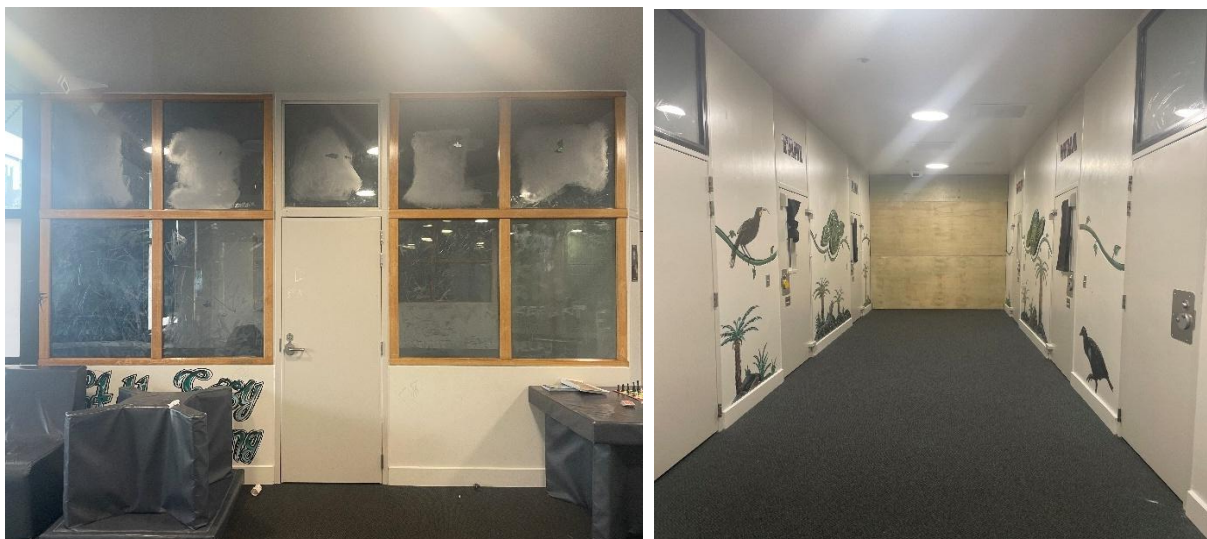
Of note, the Secure Care unit common areas were clean and had been refreshed, another improvement since our earlier monitoring visits. The bedrooms in Secure Care, where mokopuna can spend a considerable amount of their daytime, were, however, below standard and require urgent refurbishment.



(Bedroom and toilet area in Secure Care)

Tagging and property damage needs to be repaired in a timely manner

Mana Mokopuna saw that in some units there was significant tagging and etching on walls and Perspex windows. This is a safety concern as the Perspex is hard to see through and line of sight is obscured into especially TV rooms. This was a particular problem at night when lighting inside the room was low. To a lesser extent, there was also etching on most unit hubs, which again causes issues in terms of line of sight for kaimahi. Property damage to the end of one of the bedroom units was also noted with one of the window/ bench seat areas boarded up with plywood.



(view to the TV room in one of the open units and the boarded up bedroom wing area window)

Mana Mokopuna recommends systematically replacing the Perspex that is heavily damaged across the site in a timely manner to avoid undue risks to kaimahi and mokopuna safety.



Mokopuna share personal belongings

Mokopuna are issued with their own clothing on admission to Korowai Manaaki, which can be topped up during their residential stay. The laundry process involves each mokopuna having their own individual laundry bag, which is then placed in a larger bag for washing.

However, despite this process, mokopuna reported sharing clothes, underwear, and drink bottles, and Mana Mokopuna also observed this during the shower process conducted in one unit. Mokopuna were looking through a table of clothing that appeared to be communal. Once finishing their showers, mokopuna would look through the pile of clothing that included multiple pairs of underwear, pants and t-shirts to change into. When Mana Mokopuna asked if the pile of clothes all belonged to the specific tamaiti who was looking through the pile, the response was “no” and that the clothes were for everyone. Mana Mokopuna asked if this also related to the underwear, to which the mokopuna confirmed it did.

Mokopuna were also seen sharing drink bottles and drinking directly from a single jug of water located on the kitchen hatch shelf without individual cups.

Mokopuna must have access to and be encouraged to wear their own clothes, which are not shared with other mokopuna. It is not hygienic to have communal underwear and exposes mokopuna to unnecessary health risks,²⁵ and the same applies when sharing drink bottles or a single jug to drink from. Kaimahi should be upholding rules regarding own clothing to mitigate disagreements between mokopuna around particular items and brands and supporting mokopuna who may not wish to share clothing the ability to exercise that choice with mana and without being reprimanded by peers. Kaimahi should be encouraging the use of drink bottles that are provided and discouraging communal drinking to avoid the spread of illnesses amongst mokopuna.

As per Article 27 of the UN Convention on the Rights of the Child, mokopuna have the right to a good standard of living which includes a safe, warm and healthy home, nutritious food and appropriate clothing. Minimum expectations for clothing are further stipulated in the Mandela Rules,²⁶ in terms of using own clothing.

²⁵ Sharing drink bottles poses significant health risks for adolescents by transmitting bacteria and viruses through saliva, leading to infections like strep throat, mononucleosis (glandular fever), and potentially serious diseases like meningococcal disease and the flu.

²⁶ [The United Nations Standard Minimum Rules for the Treatment of Prisoners](#)



Activities and access to others

This domain focuses on the opportunities available to mokopuna to engage in quality, youth friendly activities inside and outside secure facilities, including education and vocational activities. It is concerned with how the personal development of mokopuna is supported, including contact with friends and whānau.

The Mana Mokopuna OPCAT Monitoring visit to Korowai Manaaki was conducted during the school holiday break and mokopuna were not attending education with Kingslea School during this time. A pilot involving community-based groups running programme blocks for mokopuna was also not running during the holiday period.

There was confusion around programme co-ordination for the school holidays

There is a concerted effort being made by Oranga Tamariki to increase the number and type of activities available for mokopuna when they are living in a residence. This is a positive development, as it is focused on upholding the right of mokopuna to education, development and recreation. As documented in past OPCAT monitoring reports for Korowai Manaaki, there has often been a heavy reliance in this residence on 'passive rec' which has involved listening to music, watching TV and playing cards or board games.

To address this, around the time of this June 2025 visit, a pilot was being tested over a 12 week period whereby community organisations were scheduled to come into the facility and run specific activities and programmes for the mokopuna in the residence. The pilot is being managed by Oranga Tamariki National Office and overseen onsite by the Programme Co-ordinator and residence leadership team. However, Mana Mokopuna was told that there had been little input into the programme schedule by Korowai Manaaki kaimahi or mokopuna living in the residence in terms of their preferences for activities. In addition, there was uncertainty among leadership team and kaimahi as to the parameters of the pilot programme, such as whether all time blocks in a day were covered by the pilot, and how it worked during the holidays. Kaimahi said there was some initial confusion as to who was running programmes in the holidays, with kaimahi being informed by the residence leadership that they were needing to do this a day prior to the holidays commencing, as some of the external providers had pulled out.

Despite the confusion, Mana Mokopuna observed some units participating in some of the programmes on offer during the school holiday break that consisted of rotating block activities. The schedule included a session on facility 'Rules and Regulations', video arcade games, burger making, dodgeball, using the indoor gym and weights room, and virtual reality



experiences. The Programme Co-ordinator was able to use personal connections in the community to bring in arcade style games into the facility for mokopuna to use.

Whilst it is an improvement for mokopuna at Korowai Manaaki to have access to different activity experiences run by community organisations, questions were raised by kaimahi regarding the over-taking of these activities of dedicated school time with Kingslea School. Mana Mokopuna will follow this up directly with Kingslea School during our next monitoring visit, in terms of ensuring mokopuna have access to education as is their right as per Articles 28 and 29 of the UN Convention on the Rights of the Child.

Kaimahi still rely on passive activities to pass the majority of the time for mokopuna within the residence

Despite a reasonably robust schedule being developed by the Programme Co-ordinator, few units were seen to be doing the outlined activities in their allocated unit time slots. Mana Mokopuna entered one unit during a scheduled 'Rules and Regulations' programme as per the schedule. Upon entering the unit, mokopuna were found to be spread across the unit engaged in their own conversations with no kaimahi facilitation of the prescribed programme. When asked if the programme was happening, mokopuna responded that they are just waiting for the next block and their time in the gym. Kaimahi confirmed they were not intending to run the 'Rules and Regulations' programme during that time that it had been scheduled.

During another unit observation period, Mana Mokopuna was told that the current activity was 'Shower Process', where mokopuna take turns to have their evening shower. This was at 3.30-4pm in the afternoon. This was a scheduled programme slot, however, the shower process was treated like the 'programme', instead of using the time to create meaningful activities that support mokopuna development. As some kaimahi said, shower time should be used as an effective de-escalation strategy in conjunction with dinner, medication and bed to set mokopuna up for a good night's rest.

*"There's not much to look forward to as YP [young person] here."
(Kaimahi)*

In some instances, kaimahi said staffing shortages meant that planned programmes were often cancelled, leaving kaimahi needing to come up with spare of the moment activities which often left mokopuna watching YouTube, playing cards or chess, or just handing out listening to music via a speaker – 'passive rec'.

These passive activities do little to build skills or support positive development for mokopuna, and in some cases risk negative behaviours escalating and putting mokopuna at risk of harm. Mana Mokopuna recommends the residence leadership team takes a more proactive approach in monitoring what is scheduled for mokopuna and what is actually being delivered



for mokopuna in the open units at Korowai Manaaki. The Programme Co-ordinator often has spent time developing schedules that are not followed, which impacts on mokopuna experiences and wellbeing in the residence.

Having a variety of developmentally challenging and appropriate activities available to mokopuna is a right for mokopuna, as per Article 31 of the UN Convention on the Rights of the Child.



Appendix One

Progress on 2024 recommendations

The following table provides an assessment of the recommendations made by Mana Mokopuna for the previous full unannounced OPCAT Monitoring visit of Korowai Manaaki carried out by Mana Mokopuna in February 2024. Mana Mokopuna acknowledges that work on systemic recommendations is led at the Oranga Tamariki National Office level. The progress detailed here only relates 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**, **limited**, **some**, or **no** progress:

2024 Systemic Recommendations

	2024 Recommendation	Progress as at June 2025
1	Urgently implement practical ways to mitigate contraband such as cannabis and vapes entering secure residences.	Some Progress - Oranga Tamariki has progressed practical ways to limit the amount of contraband entering the facility with the use of clear bags for kaimahi and appointing specific kaimahi to manage whānau visits. There are reminders on sign-in for all people visiting the residence/being admitted to the residence regarding which items cannot be brought on-site, and an agreement with the Department of Corrections is in place to use search dogs for perimeter fence checks and common area checks (when mokopuna are not using these areas). A Professional Conduct Notice was issued to all kaimahi on 14 May 2024 outlining all unauthorised items and kaimahi signed an acknowledgement form. Despite these measures, contraband is still freely available in the residence. Mokopuna were seen who were under the influence and talking freely with kaimahi around smoking their bag of cannabis. Vapes were still regularly seized and kaimahi still believe the majority of contraband is being brought in by other kaimahi who work at the facility.
2	Provide suitable on-site resource ²⁷ to support mokopuna with high and complex mental health needs.	Limited progress – Mokopuna who have high and complex needs that cannot be managed in open units are often admitted into Secure Care to separate them from other mokopuna. Whilst onsite for this June 2025 visit, a tamaiti was being held in Secure Care pending a transfer once paperwork had been completed to admit them into a specialist facility under the Mental Health Act. The communications regarding this treatment and transfer were not handled well, and kaimahi said they did not know what was happening in terms of timeframes for this tamaiti. Vulnerable mokopuna were also being assaulted in open units and again, spending long periods of accumulated time in Secure Care.
3	Ensure mokopuna have access to a fit-for-purpose, independent complaints system, and ensure that mokopuna understand how to access it.	No progress - The Whaia te Maramatanga process still lacks independence and is not child-centred. Mokopuna refer to the grievance boxes as 'snitch boxes' and this is reinforced by kaimahi. Mokopuna were reminded on numerous occasions, albeit in a joking manner, not to 'snitch' when talking to Mana Mokopuna.
4	Review the residence recruitment strategy to ensure all kaimahi have the adequate skills and experience to work appropriately with high and complex needs mokopuna.	Some progress – Whilst we note many kaimahi who work with mokopuna in the open units are close in age, the new kaimahi Mana Mokopuna spoke with were enthusiastic, willing to challenge kaimahi practice and were confident in their training. As noted in the report, on-going training and regular supervision will be key to keeping these kaimahi on track and not subsumed into the embedded negative culture.
5	Review induction training to ensure new kaimahi are well prepared for the realities of working in a secure residence and that they have the skills to pro-socially engage with mokopuna and safely de-escalate situations involving mokopuna in their care.	Some progress – Some of the newer residence kaimahi who spoke with Mana Mokopuna during this visit said by and large the induction training was adequate, however, time on buddy shifts was important to 'learn the ropes' of working in a unit with experienced kaimahi. The problem was when those experienced kaimahi had worked

²⁷ This may include employing specialist kaimahi or providing intensive training for existing kaimahi who care for mokopuna with significant mental health needs.



	2024 Recommendation	Progress as at June 2025
		double shifts and were visibly tired and lacking patience. The new group were more learning from each other and questioning practice as they went. Mana Mokopuna did note to the leadership team that the newer kaimahi we spoke with were a breath of fresh air and have the potential to help turn the residence around in terms of a positive working culture. There were, however, some casual kaimahi who were identified by their colleagues as problematic and possibly bringing in contraband. Specific names were given to the leadership team to investigate as per Oranga Tamariki normal HR processes.
6	Ensure mokopuna are visited by their allocated social workers ²⁸ and that remand reviews are completed ²⁹ for individual mokopuna with a view to minimising pre-trial detention timeframes. ³⁰	Limited progress – We note that completing 14-day remand reviews is an organisational priority for Oranga Tamariki and something that is closely monitored by Oranga Tamariki National Office. However, we are seeing little movement in terms of mokopuna having their custodial remand status reviewed and least restrictive options being explored. The lack of meaningful remand reviews continue to be a concern as many are lacking detail or cut and pasted from the previous review. Mokopuna have the right to this review as per s242(1A) of the Oranga Tamariki Act 1989.

2024 Facility Recommendations

	2024 Recommendation	Progress as at June 2025
1	Complete an internal practice audit and ensure all kaimahi have an agreed understanding of professional practice expectations and have the skills to pro-socially engage with mokopuna and safely de-escalate situations involving mokopuna in their care.	Some progress – As noted above there were some very confident and engaging new kaimahi who expressed a desire to help mokopuna and be solid role model supports for their journey through their residential stay. However, there remain kaimahi working in the residence whose engagement approach is substandard and not in line with trauma-informed practice standards – particularly Whakamana Tangata. As noted in the report, tired kaimahi who are working with reduced shift numbers have little patience and are quick to escalate to restrictive practice such as admission into Secure Care.
2	Leadership team to create an action plan alongside the Kaiwhakaue to address the disparities of mokopuna Māori and set measurable outcomes as determined by Korowai Manaaki.	No progress – At the time of the visit there was no Kaiwhakaue in post at Korowai Manaaki. There was a proposal for a current TLO to work with the Residence Manager on a strategy to improve outcomes for mokopuna Māori. This was in the very early stages. Mokopuna Māori who spoke to Mana Mokopuna reiterated that there is not a lot happening for them and this was triangulated with kaimahi Māori and evidenced in programme schedules.
3	Provide training to all residence kaimahi outlining the importance of independent advocacy for mokopuna and how kaimahi can empower mokopuna to access independent advocates and have a voice in how they are cared for, as well as to raise any complaints or concerns they have about their care and treatment.	Limited progress – There is an increased presence both from VOYCE Whakarongo Mai and the Grievance Panel in the residence, which provides continued opportunity for mokopuna to raise concerns with advocates. However, the stigma still applies in terms of labelling complaints processes as ‘snitching’, and kaimahi were heard warning mokopuna about ‘snitching’ when talking to Mana Mokopuna OPCAT monitors during our visit. New kaimahi were very accommodating and knew who these advocates were and some kaimahi supported mokopuna being able to talk with the Mana Mokopuna team.

²⁸ Aligning to National Care Standards and practice advice as per [Assessing the frequency of visits to tamariki in care | Practice Centre | Oranga Tamariki](#)

²⁹ As per s242(1)(A) of the Oranga Tamariki Act 1989.

³⁰ CRC/C/NZL/CO/6, para 38(b)



	2024 Recommendation	Progress as at June 2025
4	Implement a schedule of meaningful, culturally inclusive activity programmes that can be delivered to mokopuna outside of the school structured day.	Some progress – There is a pilot in place to improve programmes in terms of variety and access to community-based organisations. This pilot runs for 12 weeks, and Mana Mokopuna will ask at the next visit how this has gone for mokopuna and kaimahi. The activity schedule for the holiday period (the time this monitoring visit took place) was limited, as there was confusion around who would be running these programmes from kaimahi. Kaimahi had to use their personal community connections to bring in activities like arcade games to provide some variety for mokopuna. There is still a reliance on ‘passive rec’ to fill in the time and Mana Mokopuna found that showers were also considered a programme.
5	Consider regularly changing shift teams to enable all kaimahi the opportunity to work with different people under different Team Leaders as a way to build a more positive, aligned, and collective culture of care for mokopuna amongst kaimahi.	No progress – Kaimahi shortages are a critical issue at the time of this visit. Kaimahi repeatedly said it is hard to commit to trainings and improvement when the facility is in survival mode. Kaimahi are tired, burnt out and losing hope that things will get better for them. Getting through a shift unharmed is their focus rather than building team cohesion with different rostering approaches.



Appendix Two

Gathering information

Mana Mokopuna gathered a range of information and evidence to support the analysis and develop findings for this report. These collectively form the basis of our recommendations.

Method	Role
Interviews and informal discussions with mokopuna.	
Interviews and informal discussions with kaimahi and external stakeholders	■ Mokopuna ■ Residence Manager ■ Acting Manager Residence Operations ■ Team Leader Operations ■ Residential Youth Workers and shift leaders ■ Team Leader Logistics ■ Team Leader Clinical Practice ■ Case Leaders ■ Quality Lead ■ Programme Co-Ordinator ■ VOYCE – Whakarongo Mai ■ Medical team
Documentation	■ Mokopuna list – legal status, ethnicity, admission date ■ All About Me Plans ■ Remand Reviews ■ Grievance quarterly reports ■ Serious Event Notifications ■ Incident reports ■ MySafety Incidents ■ Report of Concerns ■ Site Programme Schedule – Holidays ■ Pilot Programme weeks 5-9 schedule ■ Kaimahi roster ■ Secure care register ■ Secure care retention applications ■ Daily logbooks ■ Seized/Prohibited items register. ■ Monthly Quality Reports ■ Use of Force data and reviews
Observations and engagements with mokopuna	■ Unit routines and mokopuna engagement with each other and with kaimahi. ■ Activities on-site ■ Shift handovers ■ Morning, afternoon, and evening shifts