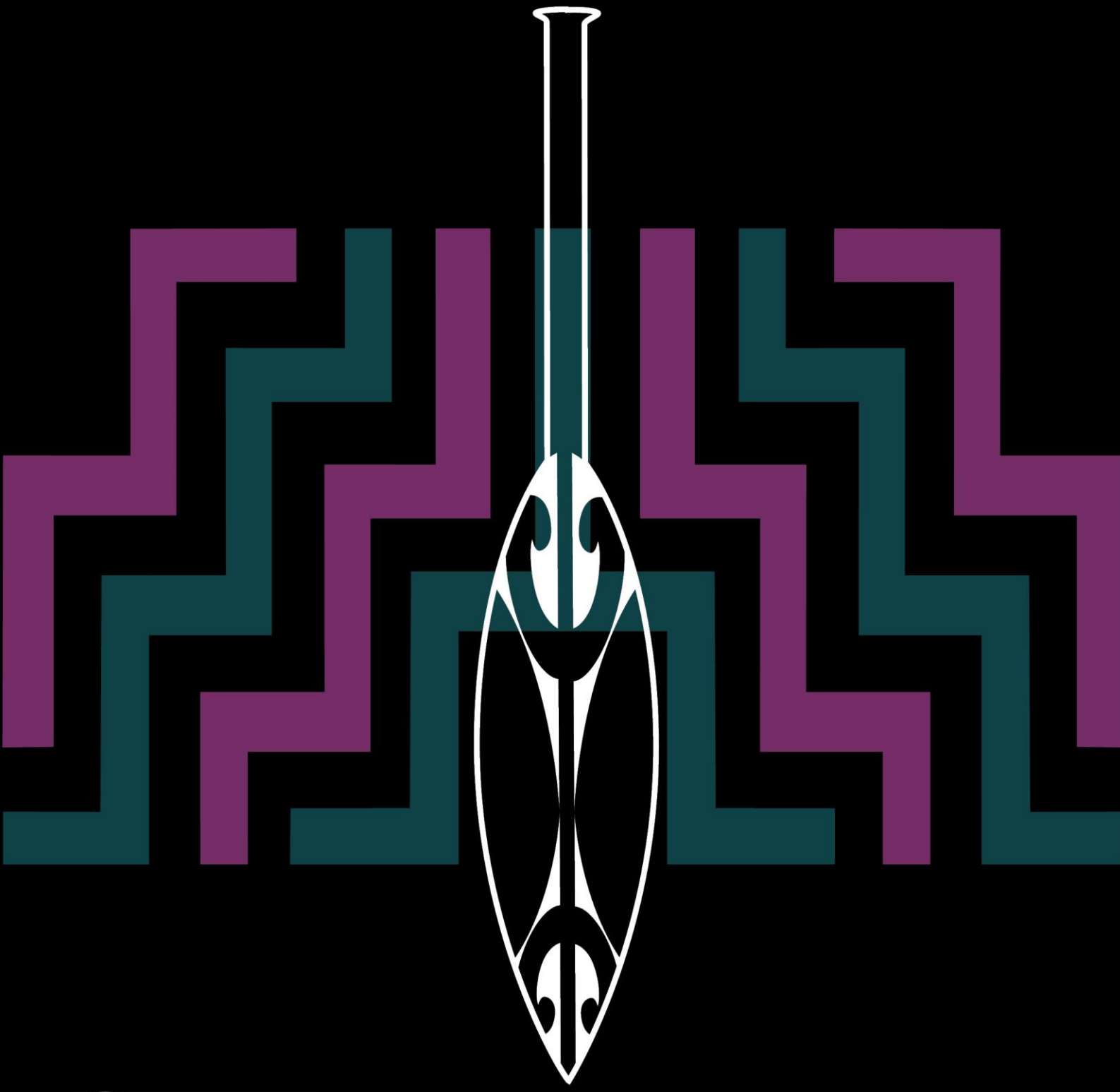

MANAAKITIA Ā TĀTOU TAMARIKI
Children's Commissioner

Te Maioha o Parekarangi

OPCAT Monitoring Report

Visit date: October 2022

Report date: November 2022

Contents

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 wellbeing, at every stage of their lives.

Executive Summary

Who we are

The Children's Commissioner is a National Preventive Mechanism (NPM) under the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman, Degrading Treatment or Punishment (OPCAT).

The New Zealand legislation relating to OPCAT and the role of the NPM is contained in the Crimes of Torture Act (1989). Our role as a NPM is to visit places of detention, including residences run by Oranga Tamariki, to:

- 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.

Judge Frances Eivers

Children's Commissioner

About this report

This report shares the findings from our monitoring visit and recommends actions to address the issues identified. We describe the quality of the experience of mokopuna at the facility and provide evidence of our findings based on information gathered before, during and after the visit. This includes assessing the progress in addressing previous recommendations.

About this visit

OCC staff carried out an unannounced monitoring visit to Te Maioha o Parekarangi Youth Justice Residence in October 2022. The facility providing these services is known as Te Maioha and will be described as such in this report.

The purpose of this visit was to fulfil our responsibilities under OPCAT to monitor the safety and wellbeing of mokopuna in places of detention.

About this facility

Facility Name: Te Maioha o Parekarangi

Region: Rotorua

Operating capacity: 20. Te Maioha is a 3 bed unit (10 beds per unit). One unit (Te Rā) was closed at time of visit due to staffing levels.

Status under which mokopuna are detained: s238(1)(d), s311 of the Oranga Tamariki Act 1989, s34A of the Corrections Act 2004 or s173, s175 of the Criminal Procedure Act 2011.

Key Findings

Key findings are addressed in our recommendations with other issues relating to the prevention of torture and other cruel, inhuman, or degrading treatment or punishment (ill-treatment), identified in our analysis.

We found no evidence mokopuna had been subjected to torture, or ill-treatment. However, there is one area of considerable concern and that relates to the use of the observation room within the Secure Care Unit. We believe the use of this room should cease immediately until it is fully renovated and fit for mokopuna to use. We will follow-up on this recommendation in three months-time.

Our key findings for the visit are outlined:

- There is high capability amongst kaimahi Māori to integrate kaupapa Māori approaches, speak te reo, and bring in external providers or mentors.
- Low staffing numbers and staff retention is a significant concern.
- The use of restraint holds, searches, and admissions to secure care are high.
- The ongoing use of the observation room in secure care is inappropriate.
- The secure care unit in general is in very poor condition.
- Medication dispensation practices are unsafe and there is an unacceptably high number of medication errors.
- Not all mokopuna are receiving admission medical and well-being checks within the regulated[1] seven day timeframe.
- Infrastructure maintenance is an issue. Fences require maintenance and radios do not always work.
- There is a lack of meaningful or purposeful activity or programmes, including vocational opportunities, for mokopuna.
- Education is a highlight for mokopuna, and the classroom provides a warm and welcoming space.

[1] 14(2) of the Residential Care Regulations 1996

Recommendations

Our recommendations are based on:

- Key findings from our monitoring and analysis
- Any issues relating to ill-treatment

OCC staff identify systemic issues that impact on the effective functioning of the facility and make recommendations to address these. Action to address the facility recommendations should occur within 12 months after the date of our visit.

We will monitor progress against our recommendations at a follow up visit.

Oranga Tamariki has committed[2] to moving away from residences towards smaller, community-based youth justice and remand homes, operated alongside community partners including iwi and NGOs. While we expect to see progress on our recommendations in all residences, our overarching priority is the closure of these facilities, and we will continue to monitor this closely.

Systemic Recommendations

1	Revise the Individual Care Plan templates to ensure they are functional, youth-friendly, and available in other accessible formats and languages.
2	Develop a nationwide package of training programmes that sits alongside the Oranga Tamariki Te Waharoa Induction programme. Training programmes should include: • criminogenic risk factors • alcohol and drug support • mental health needs • intellectual disability • neuro-diversity • life skills • cultural development/ capacity building.
3	Review the grievance process. It should be independent and impartial and provide a clear mechanism for keeping mokopuna informed of progress.
4	Develop a national strategy to address recruitment and retention issues for staff across all residences.
5	Urgently roll out the National Medication Training for all staff.

[2] Oranga Tamariki. Youth Justice Community Homes | Oranga Tamariki — Ministry for Children

Facility Recommendations

1	Address the high use of secure care, restraint holds, and searches. Secure Care should only be used as a last resort and not as a place to hold surplus admissions.
2	Immediately decommission the observation room in the Secure Care Unit. The room is not fit for use and requires urgent refurbishment.
3	Ensure all reviews and record keeping meets national standards, in particular, for secure care admissions, use of force, and Whāia te Maramatanga. CCTV footage should not be deleted until the review has taken place.
4	Address maintenance issues as a matter of urgency. Priority must be given to the secure care unit, temperature control issues, and fencing repairs.
5	Develop programmes of activity specifically for after-school hours and during school holidays.
6	Reinstate Te Ara Tikanga and other meaningful, vocationally focused programmes for mokopuna.
7	Increase access to cultural programmes and invest in the cultural capability of kaimahi Māori.
8	Ensure staff are aware of the Code of Conduct and provide guidance on best-practice engagement strategies with mokopuna.
9	Ensure all staff receive the Te Waharoa Induction Programme in its entirety before working in open units.
10	Address the high number of medication errors.

Progress on previous recommendations

Progress on the recommendations from the previous Te Maioha report dated October 2019, are assessed to have made good, limited or no progress.

Recommendations from 2019 report for **National Office (All YJ Residences):**

1	works with the residence manager to ensure that young people at Te Maioha have access to grievance advocates.	**Good Progress**
2	works with the residence leadership team to prioritise developing the courtyard and completing the refurbishment in the family group conference rooms.	**No progress**
3	supports the ongoing cultural development the residence is engaging in (see rec 9) through access to regular cultural supervision	**No progress**
4	supports existing staff to have access to Te Waharoa and follow-on modules to refresh and cover a range of practice issues.	**Limited progress**
5	ensures that the units are maintained at a comfortable temperature for young people.	**No progress**

Recommendations from 2019 report for **Te Maioha Leadership Team:**

6	continues to work with the grievance panel and support the grievance panel meeting with all young people to keep building understanding and engagement with the grievance process	**Good progress**
7	continues to ensure that all staff keep receiving regular training on the grievance process and young people's rights.	**Limited progress**
8	supports young people to have access to their preferred activities and programmes.	**Limited progress**
9	continues to support staff and young people to learn te reo Māori and engage in a wider range of cultural activities.	**Limited progress**

Treatment

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

The regular use of the observation is not appropriate

The observation room is located in the secure care unit and is in a deplorable condition. This room is being used to hold mokopuna that have destroyed property in the open unit and secure care rooms.

Our review of documentation and interviews with staff shows the use of this room has become common practice. Holding mokopuna in this room, due to inadequate facilities, is inappropriate and the use of the observation room to hold mokopuna who are being destructive must cease immediately.

We will seek an update on this within three months of this report's publication.

Restraints, searches and secure care are used frequently

There was a high number of searches, use of restraint holds, and secure care admissions at Te Maioha. We attribute this to emotional dysregulation, staff shortages, and inadequate staff training. Mokopuna also said that the lack of activities and boredom are contributing factors.

In September 2022, there were 50 pat-searches, 58 scan-searches, 20 restraints, and 75 secure admissions. This is high given Te Maioha is only operating a 20 bed capacity.

We heard that searches had increased due to building infrastructure issues leading to safety concerns. This included mokopuna pulling out wiring from walls, metal rods from fencing, and making shanks out of various materials. Whilst safety and security is a focus, searches can be traumatising and unpleasant for mokopuna.

Lack of staff training as well as short staffing suggests that staff were often unable to de-escalate or diffuse situations effectively. This has a knock-on effect resulting in high admissions to secure care.

Secure Care and searching mokopuna should be used as a last resort and de-escalation should be the initial strategy.

Record keeping and review processes are not up to standard

Staff told us use of restraint holds were not always reviewed and mokopuna are not seen by nurses in a timely manner. Staff told us that CCTV footage was being deleted after three months despite reviews lagging behind timeframe.

We also saw medication logs that were partially filled out, left blank and un-used medication was left in the staff room without any documentation.

A recent Regulations Audit by Oranga Tamariki highlighted a range of concerns, including reviews around the use of force, secure care, Whāia te Maramatanga, and medication dispensation. We urge Te Maioha to action the findings of this audit immediately.

We were told staff are either untrained or too busy to complete proper documentation and recommend that this is addressed.

Good documentation and robust oversight are critical to prevent ill treatment and ensure Te Maioha is meeting its legal requirements.

Relationships between mokopuna are varied

Mokopuna we spoke to said they got on well with most of the other mokopuna in their units. Mokopuna were mostly friendly with each other and we observed laughing and banter.

However, dynamics in the units can change quickly. We saw this happen during evening observations where mokopuna were kept in their room while staff conducted a room search for a concealed piece of metal. Mokopuna continually came out of their rooms despite being asked not to, kicked at their doors and swore at staff for delaying dinner time. During dinner, mokopuna were heightened, cups were thrown at walls, food was thrown on the ceiling and food was taken off other people's plates.

We also heard about a calculated assault from behind on a mokopuna who was at Te Maioha on a temporary status when he was admitted to the open unit.

The units were described by many staff as 'bubbly' reflecting how fast relationships can change between mokopuna and how dynamics change with new admissions.

Some staff do not role model pro-social behaviours

Mokopuna said they got on well with most staff and there are staff at the residence they can trust and talk to. We observed friendly banter between staff and mokopuna.

However, many staff did not role model appropriate behaviour or relationships. Poor behaviour choices by mokopuna were not checked by staff. We heard mokopuna asking inappropriate questions and staff either answered the question or fuelled further discussion about topics that were inappropriate. Some staff we observed did not act professionally and crossed boundaries talking about topics that should not be discussed in a professional setting.

There was a lack of therapeutic intervention

We did not see evidence of a therapeutic model of care at Te Maioha. Staffing shortages mean there is an inability to provide training for staff as there is not enough staff to then backfill shifts. Unit staff also have limited opportunity to implement the trauma-informed elements in care plans developed by the Case Leaders. The focus of the residence is purely on operational safety and security rather than therapeutic care.

> *"That's what this place is for, so like, not to make sure that we behave ourselves. It's to like, a place to help us recover."*

Adding to this, mokopuna have few de-escalation options when they need to self-regulate. Mokopuna can meet individually with the psychologist who is based full-time at the residence but if they are not available, going for a walk around the internal courtyard, sitting in a chair, or going to in the unit courtyard/ basketball court are the only options to self-regulate.

There is currently no plan to address or mitigate escalating behaviours in the units.

Mokopuna and whānau are involved in their plans

Case Leaders regularly involved mokopuna and whānau in their plans. Case Leaders meet with other stakeholders at multi-disciplinary team (MDT) meetings. Whānau and mokopuna are also included in these meetings. If they are not available, the meetings do not happen. These meetings occur monthly for about 15-20 minutes for each mokopuna.

Regular custodial status reviews were occurring, however custodial remands remain long

Social Workers are obligated under s242(1A) of the Oranga Tamariki Act 1989 to review the custodial status of mokopuna on statuses such as s238(1)(d). We were told these reviews are happening regularly, which is a positive.

However, the length of stay on remand is high and some mokopuna have been on a custodial remand status for over 100 days.

Long periods on remand creates uncertainty for mokopuna. It is also worth noting that remand within the youth jurisdiction does not count towards 'time served'. The remand period can therefore be the same as, if not more than, a sentence under s311 of the Oranga Tamariki Act 1989.

Protection Systems

This 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.

The admission process is working well

The admission process is straightforward for mokopuna. All mokopuna receive medical checks, as well as mental health, and alcohol and drug screening upon arrival. However, these were not always carried out within the required seven day timeframe.

Mokopuna were given an admission pack on arrival with information about the rules, their rights, VOYCE Whakarongomai, the Behaviour Management System (BMS), and Whāia te Māramatanga (the grievance process).

We found the information booklet was comprehensive, child-friendly and detailed. Mokopuna we spoke to understood their rights as well as the rules and regulations of the residence.

The admission room was, however, dark and grim and had a walk-through x-ray scanner. Staff told us this was rarely used as staff do not automatically conduct searches upon admission.

The personal safety of mokopuna was a concern for them

Some mokopuna told us they felt safe on the unit, while others did not.

Poor unit infrastructure has meant that recently a high number of weapons and shanks are found on the units. These range from mental wire from fences and contraband such as vapes being fashioned into shanks.

> *"This is supposed to be a safe place but you never know, someone could come up behind you and punch you, stab you."*

Staff radios do not always work

Staff told us that on more than one occasion, certain radio channels have not transmitted correctly and 'code' calls have not been responded to in a timely way.

This poses a high safety risk for staff and mokopuna and needs be addressed urgently.

Age mixing exacerbates safety concerns

The OCC is concerned regarding the age mixing of mokopuna in youth justice residences. While on our visit to Te Maioha there were 13 year olds housed in the same units as 17 year olds. The dynamic of the units was described as volatile and staff expressed concern for younger mokopuna who are more impressionable, easily influenced, and desperate to 'fit-in'.

This can result in younger mokopuna 'looking up' to the older cohort and adopting copy-cat type behaviours.

> *"I think residence is like, it's not a good thing aye. It's like good but it's not good, 'cos the relationships you make through, go on the outs and then just tee-up with each other and then just do the same things you done to get in here."*

Transitions can be improved

Some mokopuna knew they were coming to Te Maioha and what the plan is for them moving forward, while others did not. Mokopuna from other residences did not always have all the necessary documentation with them, so it was unclear whether their well-being needs were being met. The lack of information sharing can hamper smooth, and effective transitions.

One mokopuna said their social worker did not help them fill out forms to get back on the benefit. They said having money from the benefit would help prevent them from offending, as then they would no longer need to steal.

The Life Skills Units were not open at the time of our visit. Again, the lack of available staff meant that the open units were prioritised rather than the independent living spaces. Staff acknowledge that the Life Skills Units are a good way to transition out of residence and it is unfortunate that they have temporarily fallen victim to the staff shortage.

Transition plans need to be comprehensive to ensure mokopuna do not keep coming back into residence. Residences and partner agencies need to work together to provide wrap around support for mokopuna and their whānau returning into the community.

There is no local remand home available for mokopuna

Due to short staffing at Te Maioha, staff from Te Kohanga (the local remand home) were re-deployed help bolster staff in the residence. This means the local remand home is not currently operational. Mokopuna on remand whose risk profile allowed for a community remand placement therefore do not have this option. The only local option for mokopuna is Te Maioha or a community placement outside of their home area (somewhat defeating the purpose of community-based options).

Mokopuna were well supported by external advocates, however the Whāia te Maramatanga process could be improved

There was a strong presence on the units from VOYCE Whakarongomai and members of the grievance panel. These advocates met regularly with mokopuna and maintain a close relationship so they can better understand the issues when they need to advocate for mokopuna. They are often invited to cultural events, such as language weeks, hāngī and Matariki.

Te Maioha encourage a culture of reporting concerns via the grievance processes. Mokopuna said they felt

comfortable making grievances, however they did not feel their grievances were responded to fast enough.

Relevant documentation[3] confirmed a number of grievance response times were delayed and mokopuna were not always being communicated to about the outcome of their grievance. Some grievances included serious complaints against staff members and one complaint had not been responded to in over three months.

> *"If we have a fight in here or the staff hurt us, it is what it is. We can't do nothing about it, no one's even listening to us anyway."*

We also heard concerns about the Grievance Panel and lawyers being denied access to CCTV footage. The National Office legal team were consulted and access was provided. The Grievance Panel should be provided with this material when requested to undertake their investigations.

Mokopuna want their own voice

While mokopuna were good at raising concerns via the grievance process, they have been asking for a Kahurangatahi Youth Council forum for them to express their voices at a higher level. Nothing had been done to cater to this at the time of our visit.

Mokopuna need more support in having a say in residence operations and in decisions that affect them. Mokopuna want to be heard and listened to by decision makers.

[3] Documentation included the grievance panel quarterly reports and the internal grievance register and reporting system.

Material Conditions

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

The secure care unit was in poor condition

International human rights standards suggest the use of secure care (or seclusion) for mokopuna amounts to ill treatment.[4] The condition of the secure care unit at Te Maioha amplifies this concern. The Secure Care Unit was dirty and bordered on degrading.

There was tagging everywhere, paint peeling from the walls, and the shower smelt musty with mould on the ceilings. Mokopuna said they did not feel clean after using the showers in the secure care unit.

Secure Care overall lacked ventilation and is hot and stuffy. It is difficult for staff to maintain safe observations in the bedrooms due to the heavy tagging on the perspex observation windows.

The observation room in the secure care unit was in deplorable condition and, if not urgently addressed, could amount to ill-treatment if continually used for mokopuna. It was dirty, lacked any natural light, had no bathroom, and was falling apart. There was a mattress on the floor with no bed base. Mokopuna could also be viewed via CCTV even if they did not require constant observation. We were told it had become common practice to hold mokopuna in there who engage in property damage. Using this room for this purpose is completely inappropriate and this should stop immediately.

The open units are dirty and require maintenance

At the time of our visit, the units were in poor condition. The units were messy and dirty, and we found there was an overall lack of respect for the physical environment. Food, scraps, cloths, and other items had been thrown on walls and ceilings and they appeared to have been there for some time. Whilst dining in the open units we witnessed butter being thrown up walls and food scraps from tables just brushed onto the floor.

There was tagging on all the windows, making it difficult to maintain line of sight, and the units were sparsely decorated, and bleak looking.

Property damage was an issue

Te Maioha have been dealing with infrastructure issues and major property damage. Staff were finding it difficult to progress their requests via National Office.

The fences around the basketball courts attached to each unit had been kicked in

[4] Report of the Special Rapporteur on torture and other cruel, inhuman, or degrading treatment or punishment, U.N. Doc. A/63/175 Annex (28 July 2008) (Manfred Nowak).

by mokopuna and they would use the broken pieces of wire as weapons. Staff have to station themselves in front of the damaged fences so that mokopuna can continue to use the outdoor areas while they waited for repairs.

Face plates around the unit intercoms are dismantled by mokopuna, leaving the wires exposed and the metal face plates used to fashion shanks. There have been long waits for replacement items, leaving some rooms unusable for mokopuna due to the hazard of exposed wires. The wait for replacements has become desperate and items are now being used from the un-used unit to fix items in the units used by mokopuna.

The building infrastructure is failing, unsafe, and urgently needs to be addressed.

There was a lack of equipment for incentives as part of the Behaviour Management System

The Behaviour Management System (BMS) is based around rewarding good behaviour with additional privileges and equipment. For example, the use of the weights room in the gym, using the PlayStation and having access to portable music and DVD players.

At the time of our visit, access to equipment that worked such as DVD players was an issue. As a result, mokopuna were left with no rewards for their good behaviour. This left them feeling frustrated and feeling that their hard work had been in vain. This creates a lot of tension between mokopuna and has become a disincentive to behaving well.

The quality and quantity of kai has improved

Te Maioha have an on-site kitchen and new chef that provided their meals on a 28-day cycle. We saw forms that mokopuna fill out making suggestions about which kai they liked and disliked.

In the past there were numerous grievances about kai, particularly that the meals were not satisfying, and mokopuna still felt hungry after meals. The new chef has worked to increase the amount, variety, and quality of kai given to mokopuna. There is now good volume, more protein content, and mokopuna can go back for seconds if they chose.

Mokopuna could personalise their bedrooms

Mokopuna can personalise their bedrooms with photos and posters. Te Maioha is the only residence that has toilets in all the bedrooms. Mokopuna have mixed feelings about the toilets as some said it is good not to have to ask to leave your room at night, while others said it smelled bad and they did not like looking at the toilet whilst in their bed. They suggested a door or toilet lid would help alleviate the smell.

The classroom provided a warm and welcoming space

The condition of the units contrasted with the look of the classrooms. There was artwork by the mokopuna on the walls, their awards were visible, and school-work displayed. The classrooms were colourful and bright and they appeared clean and tidy with lots of resources available.

The outside environment required shelter

Mokopuna were required to walk through the central courtyard area any time they needed to leave their unit. The lack of shade in the courtyard was raised as a concern in our previous report and continues to be an issue. Poles were installed, but no shade sails to keep mokopuna cool in the summer or dry when it rains.

Te Maioha is one of the few residences that does not have a pool. Mokopuna and staff have requested a pool to mitigate the hot summer temperatures and provide another option for mokopuna to self-regulate. The lack of pool and outside shade and shelter is a health and well-being issue and needs to be addressed.

Missing clothing was an issue for mokopuna

Mokopuna can wear their own clothing and there are spares provided by the residence. The management of mokopuna property and clothing on admission had been an issue for mokopuna. Mokopuna have made several recent complaints about the property claim process. Their feedback was that the process was not clear to them and their concerns had been met with lack of action.

Activities and access to others

This 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.

Mokopuna were engaged in education

Kingslea School provided education support and have a 1:5 ratio of teachers to mokopuna. Kingslea also have teacher aides available to assist mokopuna with learning difficulties.

Mokopuna said they enjoy their education and we observed them engaged in school. The classrooms are well decorated and are good spaces that promote learning.

Teachers make learning fun

Teachers tailor the curriculum content to make it interesting and relevant for mokopuna. For example, there were projects on the effects of methamphetamine use and assessments based on favourite rappers such as Tupac.

Mokopuna were awarded student of the week, which was based on completing their work, behaviour, or not going into secure care. Multiple awards were given out each week. If mokopuna get an award, they can choose posters of their favourite artists or musicians to hang in their rooms.

Focused programmes are delivered as part of the structured day

Alcohol and drug group sessions are delivered as part of the school programme. The education tutor also runs practical vocational courses in agriculture, horticulture, fencing, construction, and motorbike and rural safety. However, due to staffing constraints only one mokopuna can do these courses at a time.

Mokopuna told us they also wanted more science based and sexual education courses and that some of the programmes are too easy for them.

Meaningful activities are severely impacted by staffing shortages

Our previous report detailed successful vocationally focused programmes run at Te Maioha. These included agricultural programmes, using the Life Skills Units and the 'Going Home' programme where mokopuna could experience supported independent living situations before leaving residence. Other activities included going to the community gym and mowing lawns at the local marae or church.

These programmes were now not available. Vocational activity was limited to what could be delivered by Kingslea School. Mokopuna said a highlight was being able to work in the Kai Café. Here, they could gain experience in baking, cooking and also barista qualifications.

There was a woodwork, art, and music programme running at the time of our visit. Mokopuna were having a

competition to see who could make the best Christmas tree decorations made from wood and a laser cutter.

Te Maioha had also arranged a member of the community come and host beauty programmes such as face masks, eyebrow plucking, and bracelet making. Mokopuna seemed to enjoy this, and we observed one of the mokopuna with a colour braid in their hair.

There is a lack of activity outside of school hours

Mokopuna told us there is a lack of activity during the school holidays or after school hours. Mokopuna get bored manifests in increased negative behaviours in the units. The saying around the residence is that mokopuna "watch the carpet grow." Mokopuna said the lack of activities was a trigger for the well documented riot that occurred in November 2021.[5]

Undertaking meaningful, vocational programmes is important for mokopuna to develop necessary life skills to support them on release. They also give them hope for the future. Mokopuna said they would like to do courses in scaffolding, plumbing, mechanics, and barbering.

> *"There was a staff that worked here and he was a barber and he used to like, every Saturday and Sunday he used to like, cut hair and we could cut hair with him, but he's gone now."*

Mokopuna had regular contact with whānau

Mokopuna said they had regular contact with whānau, receiving two 10-minute phone calls a day, which mokopuna said was mostly enough for them. Whānau could also visit mokopuna at the residence. Staff said that whānau are encouraged to come and visit mokopuna and are able to participate in events such as language weeks.

Language weeks create opportunity to connect to community

Te Maioha provide good opportunity for mokopuna to connect with the community and be exposed to and celebrate other cultures. We heard that Te Maioha create events that celebrate not only Māori culture but also Tongan and Samoan cultures. Members of the community and whānau members are invited into the residence to share their knowledge with mokopuna. During Tongan language week whānau members came in, spoke Tongan, and shared Tongan music.

[5] Group tried to escape Rotorua youth justice facility last night (1news.co.nz)

Medical services and care

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

Mokopuna waited long periods for medical appointments

There were five health related grievances in the last quarter (July- September 2022) and 31 ACC claims for injury in the month of September. Mokopuna told us they often have long wait times for medical care.

Several mokopuna told us of tooth aches, chipped teeth, and that they have not been able to see the dentist since being admitted into Te Maioha. Some mokopuna also said they have waited several weeks before being seen by a doctor following injuries. One mokopuna told us they had not been taken for an x-ray for over a week despite being in pain and eventually a broken bone being diagnosed.

Appointments with on-site medical professionals have been prone to delay due to the lack of staff available to escort mokopuna to the medical rooms.

Medication dispensing was an issue

Staff are not properly trained to dispense medication and the process currently in place is unsafe. Youth Workers are responsible for dispensing medication on the unit. New National Medication Standard Operating Procedures and Training has been developed by Oranga Tamariki however training had not occurred at the time of our visit.

Our review of medication logs found that nearly all medication was not dispensed correctly. This includes medications being missed or not signed out. We also saw a box of refused medications on the kitchen table in the staff room without any other information beside it.

There was one instance where controlled medication (quetiapine) was found on the floor and taken by another mokopuna who was not prescribed that medication.

Mistakes with medicines are being made regularly and record keeping is not at an acceptable level. This poses risk of harm to mokopuna. Training on how to dispense medication correctly is urgently required.

Not all restraints were followed up with the health team

The health team are not regularly informed of incidents or restraints. Nurses need to be aware of all restraints as soon as they happen so they can schedule in health or injury checks. We heard that staff used to receive updates via daily meetings, however these no longer occur. Mokopuna told us they had been hurt after being restrained and were not seen by the doctor afterwards.

Te Maioha had their own Clinical Psychologists

Te Maioha employ their own Clinical Psychologist who meets with mokopuna regularly. The psychologist had a small case load and was on the units regularly, allowing them to build rapport with mokopuna. Mokopuna said they enjoyed

speaking to the psychologist and wanted to see them more often.

To support the psychologist, Te Maioha also have access to a mental health team contracted to deliver services via Ngā Ringa Awhina (part of the Waikato District Health Board).

Personnel

This 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.

Staffing levels are unsafe and unsustainable

Staffing levels are at a critical level nationwide. Many staff are working double shifts and has led to Te Maioha operating in a 'safety and security' model rather than with a therapeutic focus. Recent leadership changes have also created some instability for staff.

The lack of adequate staffing negatively impacts almost all areas of mokopuna care. The residence regularly struggles to meet minimum safe staffing levels on the units. The residence is trying to recruit more staff with local recruitment events but for the mean time staff are being denied annual leave, as there is not enough people to cover shifts. Te Maioha is already running at reduced capacity to cater for low staff numbers.

Recruitment and retention need improvement

There were 25 staff vacancies at the time of our visit. Staff retention had become critical at Te Maioha, with many staff leaving after only a short period of time, with an average 8-month turnover rate. Staff told us that Oranga Tamariki did not conduct exit interviews with those leaving however staff told us it was largely due to poor renumeration, unmanageable rosters, limited career opportunities, unsafe environments, lack of supervision or focus on staff wellbeing, and lack of training. These concerns need to be explored and addressed by Oranga Tamariki.

Not all staff are receiving a full induction

The initial induction training, the first stage of Te Waharoa[6], is not being completed by all new staff. Instead, staff are receiving a condensed version of Te Waharoa that primarily focusses on restraint training.

There are many new, inexperienced staff in the open units with minimal training. Part of Te Waharoa requires new staff to 'buddy up' with more experienced staff to continue their induction. This is also not happening.

Staff told us that due to a lack of experience, staff are making mistakes, required processes are not being followed, and staff are not de-escalating mokopuna behaviours. This is leading to heightened units and inappropriate behaviour by mokopuna is going un-checked.

Professional development is not happening

[6] The national professional development pathway for Oranga Tamariki residences.

Staff outlined that previously there was training on therapeutic interventions including, relationship building with mokopuna, trauma-informed care, tikanga training, as well as training in mental health and health promotion. There was also regular clinical supervision. Professional development and supervision has not been a focus for approximately six months.

Clinical supervision only occurred after a critical incident rather than as a way to promote good consistent practice across teams.

Staff behaviour was inappropriate at times

While we observed some positive interactions between staff and mokopuna during our visit, we also saw inappropriate behaviour from staff. Examples included staff disclosing personal details about themselves or others, swearing, not setting boundaries, or role modelling good interactions. We heard that these behaviours often reflected their lack of training.

Other examples included mokopuna not following staff instructions when asked to stay in their room during searches. During one meal, we observed cups and food being thrown at the walls, swearing, mokopuna eating food off other's plates, and snorting salt. There was a complete lack of respect for each other and the rules of the residence. Staff did nothing to check this behaviour and joked that the butter on the roof will melt off in summertime. We also heard that new staff were more susceptible to being influenced by mokopuna to break the rules, such as allowing phone calls with people not on their approved contact lists.

There was no evidence that a tikanga model was operating in the residence.

There was a lack of communication between teams

Since the change to an acting manager, staff said there were not as many staff meetings that had multidisciplinary input. Staff felt they didn't work collaboratively and there is little opportunity for staff on the floor to feedback to those in operations. This has led to teams operating in silos and a lack of consistency in practice.

Some staff also raised concerns that there was limited ability to escalate issues internally or to National Office. Staff said often concerns raised over email were not responded to or ignored. There were also some concerns that staff felt excluded and left out of decision making despite their significant experience working in the residence.

Improving outcomes for Mokopuna Māori

This focuses on identity and belonging, which are fundamental for all mokopuna to thrive. We asses 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.

Whakamana Tangata is not embedded

Whakamana Tangata is a Māori informed restorative practice approach to working with mokopuna in a restorative way based on forming good, positive relationships.[7] This work is essential to providing a restorative and strengths-based approach rather than punitive approach to youth justice.

However, we saw very little evidence that the principles of Whakamana Tangata were a 'way of being'. Staffing constraints and the residence being in 'survival mode' has meant a return to a more punitive way of running the residence.

Te Maioha had a high number of kaimahi Māori

There is a high percentage of kaimahi Māori at Te Maioha. Mokopuna māori are typically over-represented in places of detention, which makes a high number of kaimahi Māori all the more important as they can role model healthy pro-social relationships.

There were several mana whenua on staff with extensive connections to cultural resources in the community. There is high capability and willingness within the current staff members to provide cultural support, activities and connection to community for mokopuna. Staff need to be encouraged to share their knowledge to help mokopuna find their own connection to te ao Māori.

> *"I wanted to know my pepeha but no one wants to help me out."*

Local resources and connections can be used positively

Kaimahi who are mana whenua told us they have the connections and the willingness to tap into personal resource to help mokopuna grow their knowledge of te ao and matauranga Māori and increase their cultural connectedness. When programmes are sparse, connecting with community is a good way to expose mokopuna to resources and people with different skills and knowledge.

We heard kaimahi Māori speaking te reo to mokopuna. Kaimahi are encouraged to bring their whole being to their work, including their whakapapa. The majority of the operations team has a high degree of capability to operate in te ao Māori and

[7] Whakawhiti Moana: Whakamana Tangata, Kete Two, Oranga Tamariki – Ministry for Children, February 2020.

speak te reo. It is important te ao and reo Māori continues to be normalised and that in-house knowledge is used to its full potential.

Tikanga, cultural programmes and activities not happening

Tikanga programmes and activities that used to exist were not occurring at the time of our visit.

Outside of language weeks or events such as Matariki, there is very little available. There was no regular kapa haka or te reo lessons for mokopuna. Mokopuna said they would like to learn more about who they are and where they come from.

Staff and mokopuna told us that cultural assessments were available for mokopuna and mokopuna participate in completing them.

Putake-a-Nuku (2021 – 2022), the strategic plan for meeting the cultural needs of mokopuna Māori and complying with section 7AA of the Oranga Tamariki Act 1989, had finished. At the time of our visit, there was nothing to replace this strategy and staff said they had lost the drive and focus creating Putake-a-Nuku had provided. Te rōpū Māori is also not meeting regularly.

The OCC suggest reinvigorating this strategy and find new ways to make it relevant and operational.

Te Maioha has a good relationship with Parekarangi Trust

Te Maioha is built on the land of local iwi, Tūhourangi Ngāti Wāhiao. Parekarangi Trust and Oranga Tamariki established a memorandum of understanding at the time the residence was opened in 2010 that allows the Trust to have input into everything occurring at the governance level for the residence.

The Trust has oversight of recruitment and are informed when new staff are coming on board so they can be part of the pōwhiri or mihi whakatau. They also have quarterly catch ups with the residence leadership team.

Appendix

Gathering information

We gather a range of information and evidence to support our analysis and develop our findings in our report. These collectively form the basis of our recommendations.

Method	Role
Interviews and informal discussions with mokopuna (including informal focus groups) with mokopuna.	
Interviews and informal discussions with staff	• Acting Residence Manager • Quality Lead • Acting Residence Manager Operations • Health Coordinator • Shift leaders • Youth workers • Programmes/ Employment Coordinator • Team Leader Logistics, Operations, and Support • Mental Health Team (Ngā Ringā Awhina) • Clinical Psychologist • Kaiwhakaue • Parekarangi Trust Chairman • Teacher • Principal • Case Leader • Clinical practice lead
Interviews with external stakeholders	• Grievance Panel • Kaiwhakamana, VOYCE Whakarongo Mai
Documentation	• Grievance quarterly reports • Monthly Reporting (Jan – Sept 2022), on restraints, searches, staffing levels, training, grievances, and secure care • Medication log • Daily logbooks • Mokopuna Care Plans • Serious Event Notifications • SOSHI reports
Observations	• Morning, afternoon, and evening observation of unit routines • School • Dinner • Hospitality, art classes, gym time