



Korowai Manaaki Youth Justice Residence

OPCAT Monitoring Follow Up Report

Visit Date: May 2023

Report Date: June 2023



Kia kuru pounamu te rongō

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.

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Executive Summary

The role of OCC

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 is contained in the Crimes of Torture Act (1989). My 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
Ngāti Maniapoto, Waikato
Children's Commissioner

About this visit

OCC conducted an unannounced visit to Korowai Manaaki Youth Justice Residence (Korowai) as part of a follow-up visit work programme. This particular visit served a dual purpose. One was to assess progress against recommendations made as part of the last full visit conducted in October 2022. The second was to validate (or otherwise) concerns regarding transparency of operations at the residence raised with OCC directly from the public.

About this report

During the visit, it was apparent that the concerns raised by members of the public and other child advocate agencies about the safety of mokopuna, were valid. Therefore, the assessment of the progress of the recommendations became a secondary action. This report focuses on detailing the concerns raised to OCC and the evidence gathered by OCC to support the claims.

The Children's Commissioner places the safety and wellbeing of mokopuna in Korowai Manaaki as a priority, noting that unless mokopuna are safe it is a serious breach of the provisions of the Children's Convention and te Tiriti o Waitangi. These concerns have been raised directly with the Chief Executive, Oranga Tamariki.

About this facility

Facility Name: Korowai Manaaki YJ Residence

Region: Auckland

Operating capacity: 46

Status under which mokopuna are detained:

Oranga Tamariki Act 1989 – s235, s238(1)(d) and s311, the Criminal Procedure Act 2011 – s173, S175 and the Corrections Act 2004 – s34A.

Concluding Observations from the United Nations Committee on the Rights of the Child (2023)

In February 2023, the United Nations Committee on the Rights of the Child ('the UN Committee') released its Concluding Observations¹ for New Zealand's sixth periodic review on its implementation of the Children's Convention² and how the Government is protecting and advancing the rights of mokopuna in Aotearoa New Zealand.

There are multiple recommendations from the Concluding Observations that relate to the treatment of mokopuna in places of detention and many of them are relevant to Korowai Manaaki. These will be highlighted throughout the body of the report.

The Children's Commissioner considers that treatment of mokopuna at Korowai Manaaki contravenes both the Children's Convention in terms of ensuring the safety and rights of mokopuna³, rights and protections of mokopuna under Te Tiriti o Waitangi⁴, as well as meeting the threshold for ill-treatment under the OPCAT.⁵

Key Findings

The OCC found evidence of ill-treatment at Korowai Manaaki.

The OCC reports the following findings:

- Mokopuna do not feel safe at Korowai.
- Mokopuna are regularly assaulting each other and the attacks are often unexpected and unprovoked.
- There is a prison mentality in the facility with mokopuna operating in 'packs' and co-ordinating assaults on individuals. Some staff are complicit in allowing these attacks to happen.
- Mokopuna are regularly absconding onto the roof.
- There is a high use of secure care and restraint practice. Not all mokopuna are getting timely access to medical care especially after being restrained.
- Staff recruitment, training and retention remains a significant issue for the residence. Many new staff have no experience working with mokopuna which makes practice inconsistent across the facility.
- Staff use contraband to 'bribe' mokopuna into good behaviour.

¹ Refer CRC/C/NZL/CO/6. To see the Children's Commissioner report to the UN Committee, see: [NZ Children's Commissioner's Report to the UN Committee on the Rights of the Child - 2022 | Office of the Children's Commissioner \(occ.org.nz\)](#)

² [Convention on the Rights of the Child | OHCHR](#)

³ Article 3 [Convention on the Rights of the Child | OHCHR](#)

⁴ Specifically Articles 2 and 3 of Te Tiriti o Waitangi as they relate to mokopuna as taonga and the commitment to provide active protection to achieve equitable outcomes for mokopuna and their whānau, hāpu and iwi.

⁵ [Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment | OHCHR](#) and [Preventing Torture: The Role of National Preventive Mechanisms – A Practical Guide | OHCHR](#)

- Specifically, a significant number of vapes⁶ are coming into the residence, and these are often repurposed as 'shanks'.
- Staff are sharing personal information about mokopuna to other mokopuna in the units.
- There is a lack of communication between leadership and operations staff and between staff working in different units. Staff do not feel safe when incidents occur.
- There is a lack of transparency across the facility and independent advocates are regularly being denied access to units.

Issues and concerns raised to the Children's Commissioner

Prior to this unannounced visit to Korowai Manaaki, the OCC received information from a variety of sources that operations at the residence were not transparent nor was the environment safe for mokopuna. Staffing practice was highlighted as a significant concern. This specifically related to:

- the lack of experience of new staff to work with vulnerable mokopuna
- staff ability to engage with and therefore safely manage mokopuna behaviour
- the number of assaults between mokopuna
- the amount of contraband entering the residence
- the use of secure care as a behaviour management tool
- the lack of transparency across residence operations. This includes the lack of detail in some Serious Event Notification (SEN) reports, and the lack of access given to independent advocates when they visit the residence.

These concerns provided lines of enquiry for the visit and information was gathered that substantiated them as accurate.

High use of Secure Care

The use of secure care is a breach of international and national Children's rights.

Admissions into secure care and restraint practice continue to be used regularly at Korowai Manaaki. It is a breach of Article 2 of Te Tiriti o Waitangi as mokopuna are taonga and should not be treated in a way that so significantly diminishes their mana.

⁶ 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).

Secure care or seclusion runs contrary to international human rights law which prohibits its use on those under 18 years of age⁷. In addition, the United Nations expressed serious concern in its Concluding Observations of New Zealand's sixth period review of the implementation of the Children's Convention regarding restraint practice. The Concluding Observations drew specific attention to "allegations that children in secure residential care facilities [...] experience injuries from the use of restraints by staff, are subjected to bullying and unsanitary conditions and lack access to a fair and effective complaints procedure".⁸

The Children's Commissioner continues to call for an immediate cessation in the use of secure care and for alternative therapeutic measures to be used to manage challenging behaviour. Secure care adds to mokopuna experience of trauma.

At Korowai Manaaki, the OCC reviewed data which shows an increase in secure care admissions in the six months prior to the visit.⁹ Staff are not actively managing and de-escalating mokopuna behaviour and the result is admission to secure care. Secure care is being used as a behaviour management tool.

At the time of the visit, mokopuna in the Secure Care Unit were on 15-20 minute rotations out of their rooms¹⁰, meaning that mokopuna spend a very large amount of time in secure care confined to their bedroom. Staff also said that mokopuna do not always have access to water when confined to their rooms.

Information recorded in unit logbooks often does not detail the grounds for the secure care admission nor the reason for instigating the regulation 48. Simply quoting the legislation in the 'grounds' section of the logbooks is not sufficient.

Mokopuna having limited time out of their bedrooms is a challenge for professionals visiting mokopuna. These staff are having to wait for mokopuna to come out on their rotations before they can engage. This can be multiple hours depending on how many mokopuna are in secure care. OCC were told this includes medical staff wanting to check mokopuna for injuries after restraints and social work staff wanting to work on individual care or treatment plans.

There is also an issue with confidentiality as professionals have to have conversations in the wing hallways of the secure care unit when mokopuna are confined to their rooms. Other mokopuna and staff can hear these conversations. OCC staff experienced this when trying to engage one on one with mokopuna and the conversation being overheard and then added to by other mokopuna from a different bedroom.

⁷ 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).

⁸ Refer CRC/C/NZL/CO/6. 27(b)

⁹ Monthly data supplied to OCC from Oranga Tamariki.

¹⁰ Regulation 48 of the Residential Care Regulations 1996

Staff said there is no specific activity programme for mokopuna while they are in secure. The reason given for this is due to current dynamics between certain mokopuna, and the lack of available staff to effectively manage multiple and often complex behaviours.

Mokopuna are taonga under Article 2 of Te Tiriti o Waitangi and the practice of secure care breaches this Article. The seclusion of mokopuna also runs contrary to international human rights law which prohibits its use on those under 18 years of age¹¹ and restraint practice was highlighted as a serious concern in New Zealand's sixth periodic review on its implementation of the Children's Convention¹².

Mokopuna are not safe at Korowai Manaaki

Increased levels of aggression and violence in all units

Violent assaults: Documentation reviewed by the OCC indicate that there is - on average - one violent assault on mokopuna (from other mokopuna) every week. In the six months prior to the OCC visit, there were a total of 34 assaults¹³. One of these incidents included a mass fight between seventeen mokopuna from different units. One mokopuna was taken to hospital to treat facial and neck wounds inflicted by a 'shank' made from a plastic vape casing. In the three months prior to the visit there were 37 serious threats to kill or harm.¹⁴

Pack mentality and bullying behaviour: The OCC is concerned with the prison or 'pack' mentality many mokopuna currently display. Across all units of the residence there is a mokopuna code named 'green light'. This is when mokopuna in a unit identify one mokopuna who is targeted for assault. The OCC witnessed the heightened behaviours of mokopuna in a unit and staff told OCC there was a 'green light' on one mokopuna. Facility staff knew the situation was unfolding and despite there being additional staff allocated to the unit for the afternoon shift, staff did little to de-escalate behaviours. Mokopuna were seen standing on furniture, posturing and becoming unruly. Facility staff were observant of the behaviour and there was minimal interaction to de-escalate the situation. The 'green light' target stayed close to OCC staff, was visibly nervous, and refused to go to the gym as per the afternoon schedule (the scene of a previous assault and location of potential assault for him). It is worth noting that the 'green light' assault occurred the day after OCC left the facility.

¹¹ 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).

¹² Refer CRC/C/NZL/CO/6. 27(b)

¹³ This number is the number of assaults between mokopuna gained from data supplied to OCC on a monthly basis for all Oranga Tamariki run residences.

¹⁴ Data supplied to OCC on a monthly basis for all Oranga Tamariki run residences.

These attacks can be co-ordinated as noted above or opportunistic. For example, mokopuna passing each other entering the kitchen and one hitting the other with no prior warning or in other cases mokopuna re-entering a unit to be greeted by handshakes and an unprovoked punch to the head. There have also been assaults using unit furniture, including vacuum cleaner poles.

At the time of the OCC visit, there were five staff on ACC leave due to injuries obtained at work.

The units within Korowai Manaaki are breeding grounds for bullying behaviour due to the violent assaults. Mokopuna face a choice of be part of the pack or be the target. Some staff describe Korowai Manaaki as a 'half-way' place between a youth justice residence and a youth wing in a Corrections facility.

The Children's Commissioner notes that Oranga Tamariki is bound by Article 3 of the Children's Convention and Article 3 of Te Tiriti o Waitangi to ensure the safety of mokopuna in state care. The failing of the state party to ensure safety was noted in the Concluding Observations Article 27(b) with reference to resolving a 'bullying culture' in places where mokopuna are detained.

Units are run by 'king pin' mokopuna

There are a number of serious issues around the training and calibre of staff which is enabling a "king pin" culture:

- There are a few staff whose presence has a positive effect on the mauri of the unit however, there are simply not enough of these staff working in the residence.
- Many staff lack experience working with vulnerable and complex mokopuna.
- A considerable number of the new staff have been recruited via external agencies including security companies.
- The OCC heard from multiple sources, including staff, that some staff bribe mokopuna using contraband to ensure mokopuna behave well or to use mokopuna influence in the unit to manage the behaviour of other mokopuna¹⁵.
- Staff have obvious favourites with some mokopuna being greeted with hugs and handshakes but not for others.
- Some staff were seeking to direct the OCC from having unmonitored conversations and unfettered access with mokopuna. Korowai Manaaki staff remained vigilant when

¹⁵ Items include food, personal hygiene products, vapes and the use of cell phones.

OCC conversations were not with mokopuna they had suggested, and often interjected in conversations the OCC was having with mokopuna.

- Key mokopuna are dictating activity in the unit. Mokopuna are requesting, and staff are allowing, mokopuna to access media such as YouTube. OCC saw mokopuna watching clips of Police 10/7 (and criminalised behaviours) and music videos with sexualised content. On one occasion, this was at the expense of participating in a programme aimed at gaining a forklift licence. Staff did not facilitate attending the vocational programme and the tutor left the unit with only two mokopuna signing up to finish the second part of their course. The OCC was made aware of other incidents where key mokopuna were refusing education, and others in the unit then followed suit.

Key 'king pin' mokopuna are managing the units – many staff are not re-directing negative behaviour, letting side conversations between mokopuna happen, and are essentially complicit in allowing behaviours to heighten.

There is a lack of programmed activity and mokopuna have restricted access to outside spaces

The general lack of activity outside of the structured school day (for those that attend) is contributing to negative unit dynamics and escalated mokopuna behaviours. Issues include:

- Mokopuna said they do not have access to their unit courtyard. Staff said this was because of non-compliant behaviour displayed by mokopuna and the lack of staff to provide appropriate line of sight. There is limited use of the grassed 'back field'. Mokopuna are therefore spending most of their time inside the unit. When the OCC asked mokopuna how they get fresh air they pointed to the inside air vents.
- During the past three months there have been several notable incidences where mokopuna have attempted to abscond. Many of these involve accessing the facility roof. Over the last five months, there have been 14 incidents where mokopuna have attempted to abscond. When the OCC asked mokopuna why they access the roof, they said it allows them to feel free.
- Staff told the OCC they believe the lack of activity has a direct correlation to negative unit behaviours. Not only do mokopuna have a right to access outside space and fresh air but programmes targeted at their interests, which are often sport based, have a positive impact on mokopuna wellbeing. As staff said, idle hands create unit mischief.

The Children's Commissioner considers that lack of programmes or pro-social activities for mokopuna is a breach of Articles 27 and 31 of the Children's Convention. Mokopuna need positive role-models, a therapeutic environment and access to programmes to help them build the skills necessary to move away from anti-social pathways.

Protection mechanisms are at an all-time low

Mokopuna are not accessing independent advocates

The grievance process at Korowai Manaaki has been compromised. Mokopuna have a right to be part of decisions that affect them however, facility staff actively discourage mokopuna from making complaints and a heavy "snitch" culture remains in the residence that prevents mokopuna from feeling comfortable using the Whaia te Maramatanga¹⁶ process.

This is not a new issue and has been documented on numerous occasions by the OCC¹⁷. The OCC saw this when a Korowai Manaaki staff member entered a unit and asked everyone if they still wanted to put in their complaint. Mokopuna were non-committal and the staff member responded that they would therefore withdraw it. This was an inappropriate way for staff to ascertain if mokopuna wanted their complaint worked through.¹⁸

Independent advocates, including VOYCE Whakaraongomai¹⁹, and the grievance panel, have also been unable to access units on several occasions due to a variety of reasons which include a lack of Korowai Manaaki staff available to escort advocates or that the units are too heightened for independent advocates to enter. It is also worth noting that many newer Korowai Manaaki staff did not know who VOYCE Whakarongomai were or what they offered mokopuna. This is despite VOYCE Whakarongomai attempting to make visits once per week.

The Children's Commissioner draws attention to the Concluding Observation 28(f) issued on 9 February 2023 by the United Nations Committee on the Rights of the Child. The Concluding Observations stipulate the importance of an independent complaints system being available for all mokopuna. This long-standing issue is an urgent priority across the national Oranga Tamariki residence system.

¹⁶ The complaint system used by all Oranga Tamariki run residences.

¹⁷ <https://www.occ.org.nz/publications/oia/opcat-youth-justice-residences/> - see Korowai Manaaki reports 2019 and 2022

¹⁸ Article 12 [Convention on the Rights of the Child | OHCHR](#), and Article 2 Te Tiriti o Waitangi

¹⁹ [VOYCE - Whakarongo Mai - advocacy for children with care experience](#)

There are breaches of confidentiality and mokopuna privacy

Mokopuna are aware of what is happening in units other than the one they are living in. For example, they are aware of which mokopuna are being admitted into secure care, which mokopuna are moving units, and which staff are on what shifts. Some staff members are also sharing personal information about other staff members and the OCC heard the sharing of individual mokopuna medical information openly on the units. This is a breach of the Privacy Act 2020 and article 16 of the Children's Convention²⁰.

All mokopuna have the right to privacy of their personal information. Disclosure of personal information puts mokopuna at risk of being targeted.

Mokopuna said there are few staff they can trust.

Staffing capability

There is a lack of staff training and experience to care for mokopuna

The OCC has reported on the staffing crisis across all places where mokopuna are detained and Korowai Manaaki is no exception. Issues for Korowai Manaaki include:

- There are many staff working multiple shifts in a row, staying late to ensure minimal operating numbers, and team leaders and managers are covering unit shifts.
- New staff are being recruited from a variety of community-based NGOs and security companies. As a result, there is a significant lack of youth engagement expertise across all units of the residence which includes the new recruits.
- Beyond their induction training, many staff referenced a 'learning on the job' culture. All facility staff that OCC spoke to said training is lacking in key areas. These are:
 - de-escalation techniques (including regular STAR training refresher courses with certified trainers)
 - training in trauma informed practice
 - training to work with older mokopuna
 - the effects of drug and alcohol on mokopuna and how to safely detox
 - training in how to manage complex behaviours related to neurodiversity (FASD, ODD, traumatic brain injury and spectrum disorders)
 - training to effectively work with mokopuna who are experiencing mental health distress and trauma

²⁰ [Convention on the Rights of the Child | OHCHR](#)

- Few staff are role-modelling pro-social behaviours and many are not engaging with mokopuna at all. The OCC saw staff stationing themselves on chairs in corners of units watching mokopuna and not engaging with either mokopuna or OCC staff – even when asked questions directly.

Oranga Tamariki is obligated²¹ under Article 3 of the Children’s Convention to ensure residences are appropriately resourced to care for the mokopuna residing there.

Many staff lack professional boundaries

The OCC witnessed inappropriate staff behaviour in multiple units of the residence. The OCC saw the following from staff:

- playing with mokopuna hair
- lying on mokopuna and visa-versa
- calling mokopuna derogatory and offensive terms
- using inappropriate and foul language when speaking to other staff

The OCC were also told about staff hitting mokopuna with books, pulling their ears, taking food from them, and tagging with mokopuna on tables. OCC also heard from multiple sources that staff bribe mokopuna with, for example, lollies and additional BMS²² points and rewards and that some staff also bring contraband into the residence. Staff disclosing this information said it starts with cookies and drinks and ends in vapes.

The fragmented Staff work culture impacts on the care of mokopuna

The issues highlighted to OCC are as follows:

- Staff work in silos, communication is affected, and the safety of mokopuna is compromised as a result.
- Permanent staff are split between different shift teams in an attempt to spread experience and mentor new staff. Staff said that this is problematic as staff do not have a consistent shift team, and contracted staff are not committed to the kaupapa of the residence.
- Permanent staff feel pressure to ensure the safety of the unit and feel isolated when working with all new staff.
- Operations are firmly centred on security rather than therapeutic, mokopuna focussed activities. Staff who had worked in the residence for some time said the facility used to be creative with programmes aimed at enhancing the skills mokopuna

²¹ Article 3 [Convention on the Rights of the Child | OHCHR](#), [Preventing Torture: The Role of National Preventive Mechanisms – A Practical Guide | OHCHR](#) and Refer CRC/C/NZL/CO/6 28(e)

²² Behaviour Management System adopted in Korowai Manaaki. This is based on a levelled reward system and mokopuna earn points throughout the day to then ‘cash in’ for listed items.

have or designed activity around mokopuna interest areas. As a result, and not surprisingly, mokopuna say they are bored.

- Many staff that the OCC spoke to, do not know who management are, do not believe they come into the units, and do not feel well informed or supported especially when incidents are occurring.²³

Staff recruitment, training and retention remains a significant issue for the residence. Many new staff have no experience working with mokopuna who have experience of trauma and present with challenging behaviours.

²³ Teaching staff required assistance as they were in the options block with two mokopuna whilst an incident unfolded with mokopuna gaining access to the roof. Assistance did not arrive and Kingslea school were ordered off the property for their own safety by the school site manager.

Progress on 2022 recommendations

The assessment of the recommendations from the previous 2022 report became a secondary focus for this visit. Therefore, summary information is provided where it was discussed as part of a broader conversation regarding residence operations.

2022 Systemic Recommendations

The OCC acknowledge that work on these recommendations is being led at a National Office level. The progress detailed here is a facility reflection as it affects day to day operation.

| | Recommendation | Progress |
|---|--|---|
| 1 | Develop a national strategy to address recruitment and retention issues for staff across all residences. Appropriate staffing levels and staff expertise must urgently be put in place in all residences to ensure the safety of both mokopuna and the staff working with them. | Limited progress. Staffing numbers have been increased by utilising staff contracted in from NGO partners which includes security companies. Approx. 40% of staff at Korowai Manaaki at the time of the visit were contract or casual staff. |
| 2 | Develop a nationwide package of training programmes that sits alongside the Oranga Tamariki Te Waharoa Induction programme. Training programmes should include: <ul style="list-style-type: none"> • criminogenic risk factors • alcohol and drug support • mental health needs • intellectual disability • neurodiversity • life skills • cultural development/ capacity building. | No progress. All new staff are receiving the standard induction programme before working on units. However, all staff spoken to said training outside of induction was not able to be completed on a regular basis. Staff continue to identify gaps in their knowledge regarding working with mokopuna with high and complex needs, neurodiversity and mental health distress. |
| 3 | Review the grievance process. It should be independent and impartial and provide a clear mechanism for keeping mokopuna informed of progress. | No progress. Whaia te Maramatanga is still used in the residence. Mokopuna are reluctant to use the complaints process as it is seen as 'snitching'. Whaia te Maramatanga is not impartial or independent of the residence. |

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| 4 | Regularly review s238(1)(d) custody statuses as per s242(1A) of the Oranga Tamariki Act 1989. The findings of each review should be shared with the residence to help inform transitions out of custody. | No progress. At the time of the visit, there were 9 mokopuna in Korowai who had been in the residence on s238(1)(d) remand longer than 70 days. Of these, 6 had been in for longer than 100 days. ²⁴ |
| 5 | Urgently roll out the National Medication Training for all staff. | No progress. No training has been rolled-out by National Office however, staff did say that with a change in health provider and their pro-active attitude in assisting dispensing staff, medication errors have reduced. |
| 6 | Investigate options to install a commercial kitchen to service Korowai Manaaki. | No progress. There is no immediate plan to install a kitchen. Staff said this was due to resource consent issues. |

2022 Facility Recommendations

| | Recommendation | Progress |
|---|--|---|
| 1 | Reduce the high use of secure care, restraint holds, and searches | No progress. The number of admissions into secure care remain a concern. This recommendation needs urgent attention at national leadership level. |
| 2 | Ensure all staff receive the full Te Waharoa Induction Programme before working in open units. | Good progress. All staff OCC spoke to said they had received the full induction programme before commencing work in the units. |
| 3 | Ensure mokopuna attend their medical appointments in a timely manner. Consent to receive treatment should be on individual care plans and accessible to medical staff. | Limited progress. Some mokopuna are still not receiving medical treatment in a timely manner especially after they have been involved in restraint holds. Good progress has been made in terms of obtaining consent to be |

²⁴ Residence list provided on day one of the visit

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| | | treated for mokopuna on s311 orders who are under 16 years old. OCC consider this part of the recommendation complete. |
| 4 | Increase access to cultural programmes and invest in the cultural capability of kaimahi Māori. Te Rōpū should be re-ignited. | No progress. Outside of language weeks and what is done via Kingslea School as part of the structured day, both staff and mokopuna said little is done in terms of cultural programmes. The Kaiwhakaue had recently left the facility and Te Roopu was not operating. |
| 5 | Multi-Disciplinary Team meetings should be held regularly with key staff from health, education, clinical and case work teams. | Not assessed. |

Appendix

Gathering information

The OCC gathers a range of information and evidence to support the analysis to develop findings for this report. These collectively form the basis of our recommendations.

| Method | Role |
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| Interviews and informal discussions with mokopuna (including informal focus groups) with mokopuna | |
| Interviews and informal discussions staff | <ul style="list-style-type: none"> • Residence Manager Operations • Quality Practice Lead • Team Leaders Operations • Kingslea School staff • Case Leaders • Shift Leader • Youth Workers |
| Documentation | <ul style="list-style-type: none"> • Serious Event Notifications • Health, Safety, Security and Incident reporting • Grievance Panel quarterly reports • Reports of Concerns • Unit Daily logbooks |
| Observations | <ul style="list-style-type: none"> • Unit routines • Activities and Education • Mokopuna engagement with staff and each other • Shift handovers • Internal and external environment |