



MANAAKITIA Ā TĀTOU TAMARIKI

**Children's  
Commissioner**

## **Te Puna Wai ō Tuhinapo Youth Justice Residence**

OPCAT Monitoring Follow Up Report

Visit Date: June 2023

Report Date: August 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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## Our Role

**At the time of this visit to Te Puna Wai o Tuhinapo, The Children's Commissioner was 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 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
- Report and 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

The Office of the Children's Commissioner (OCC) conducted an unannounced visit to Te Puna Wai o Tuhinapo Youth Justice Residence (Te Puna Wai) in June 2023, as part of a follow-up visit work programme. The visit served a dual purpose. One was to assess progress against recommendations made as part of the last full visit conducted in November 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

It became apparent to OCC that there were issues of safety for mokopuna living in the facility. Therefore, monitoring and reporting of the safety concerns became paramount and the assessment of the progress of the recommendations became a secondary action. This report focuses on detailing the safety concerns reported to OCC.

During the visit, OCC provided an oral report to the Children's Commissioner regarding the safety and perceived ill-treatment of mokopuna. The Children's Commissioner then spoke directly to the Chief Executive, Oranga Tamariki about these concerns. A report of concern was also made. This written report formalises the oral report and the concerns communicated via the Report of Concern notification process.

## About this facility

**Facility Name:** Te Puna Wai o Tuhinapo Youth Justice Residence

**Region:** Ōtautahi, Christchurch

**Operating capacity:** 40

**Status under which mokopuna are detained:**

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

Corrections Act 2004 – s34A.

## Transition phase to Children and Young People's Commission – Mana Mokopuna

Until 1 July 2023, the Children's Commissioner was a National Preventive Mechanism (NPM) under the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman, Degrading Treatment or Punishment (OPCAT).

From 1 July 2023, the Children and Young People's Commission ("Mana Mokopuna") was established, replacing the Children's Commissioner, and it now has the NPM designation.

The visit reported herein was undertaken in June 2023 by the Office of the Children's Commissioner, but the report was not finalised until August 2023. For consistency and accuracy during this transition phase, this report references the monitoring work done by the Office of the Children's Commissioner in June.

## 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 Observations<sup>1</sup> for New Zealand's sixth periodic review on its implementation of the Children's Convention<sup>2</sup> 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 Te Puna Wai ō Tuhinapo. These will be highlighted throughout the body of the report.

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<sup>1</sup> 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 \(occ.org.nz\)](#)

<sup>2</sup> [Convention on the Rights of the Child | OHCHR](#)

## Issues and concerns raised to the Children's Commissioner

During the visit staff behaviour was highlighted as a significant concern. This specifically related to allegations of sexually inappropriate behaviour by staff, staff having inappropriate relationships with mokopuna and contraband being supplied to mokopuna.

Oranga Tamariki Senior Leadership were notified immediately of these concerns and a Report of Concern was made.

The Children's Commissioner considers that treatment of mokopuna at Te Puna Wai o Tuhinapo:

- Contravenes the Children's Convention ensuring the safety and rights of mokopuna<sup>3</sup>
- Breaches the rights and protections of mokopuna under Te Tiriti o Waitangi<sup>4</sup>
- Meets the threshold for ill-treatment under OPCAT.<sup>5</sup>

Additionally, the following issues and concerns were raised regarding the facility and the safety of mokopuna:

## Key Findings

The OCC reports the following findings:

- There were allegations of sexually inappropriate behaviour by staff.
- The safety of mokopuna residing in Te Puna Wai o Tuhinapo cannot be guaranteed. Violent acts between mokopuna are frequent and unprovoked.
- There are high levels of contraband entering the residence and some of this is being brought in by staff. Mokopuna are making weapons out of everyday items.
- Staff practice by those working directly with mokopuna in the units is unprofessional and unsafe.
- There continues to be a high use of secure care and restraint holds which are resulting in injury to mokopuna. The legal grounds for admission into secure care are not clearly documented in unit logbooks.

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<sup>3</sup> See in particular Article 3(3) of the Children's Convention which provides that States Parties ensure institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision [Convention on the Rights of the Child | OHCHR](#)

<sup>4</sup> 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.

<sup>5</sup> [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](#)

- Mokopuna Māori are disproportionately represented, and their cultural needs are not met.
- Material conditions within the residence are inadequate.
- Many mokopuna are refusing to go to school and there is a lack of pro-social activity available for mokopuna.
- There is a communication breakdown between professionals in the residence and site social workers which is resulting in inconsistent social work practice.

## Safety of mokopuna compromised

### Allegations of sexually inappropriate behaviour

A situation was disclosed to OCC that involved a staff member and alleged sexually inappropriate behaviour. This was immediately raised with residence management, the Children's Commissioner, and the Chief Executive of Oranga Tamariki. A Report of Concern was logged with the Oranga Tamariki National Contact Centre on 15 June 2023.

### Violence between mokopuna has intensified

The violence between individual mokopuna has increased significantly since the last visit by OCC in November 2022. Documentation reviewed<sup>6</sup> for the six months prior to this visit detail a total of 155 assaults, some of them serious and which required hospital treatment. Staff across the facility advise that the nature of assaults has increased in severity and are often unprovoked and without warning. Mokopuna are targeting the head area, including kicking the face, which has resulted in mokopuna being knocked unconscious and sustaining multiple concussions sometimes in quick succession.

OCC reviewed multiple Serious Event Notification forms that detailed diagnosed concussions and the requirement for mokopuna to receive off-site medical treatment. During the visit, OCC saw a mokopuna with a black eye, and were told this was the result of an assault from another mokopuna the day before.

Staff raised the following concerns:

- The long-term impact and potential brain injuries mokopuna could sustain because of the nature of the assaults.
- Certain mokopuna are continuously targeted and experience multiple assaults. For example, one mokopuna was knocked unconscious and then two weeks later was assaulted again.

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<sup>6</sup> Monthly operational or working data supplied to OCC from Oranga Tamariki. Data includes instances of serious threats to kill or harm, serious assaults requiring hospital treatment and assaults with minor injuries.

- The increase in weapons being made by mokopuna is a contributing factor to the increase in violence. Nine weapons or 'shanks' were recovered from one unit just prior to the visit from OCC. Mokopuna are co-ordinating attacks on staff to gain access to out of bound areas and in one instance ripped out metal shelving from cupboards to create sharpened weapons and 'tag' the facility.

## Faulty radios compromise safety

Across the facility the radios do not work properly causing significant safety concerns for staff. Radios are the main form of communication for staff. The concerns were also experienced by OCC staff who wore radios throughout the visit. OCC experiences with radios were:

- There are '*black spots*' throughout the residence where the radio does not have coverage.
- The case leader's office in one of the units does not get reception and staff stand in the corner between a door and cupboard to get signal.
- Considerable static occurs, preventing staff communicating and hearing each other.

Many staff said they are particularly concerned when codes<sup>7</sup> are called in a unit or from the key room<sup>8</sup>, requiring a rapid response team. Personnel responses are sometimes not occurring due to the radios not working. An example of this was once again documented in Serious Event Notification reports where a mokopuna was assaulting a staff member with multiple punches to the head. Staff were calling a code over the radio, and no response team arrived.

## Contraband is readily available and accessible

Contraband being brought into the facility consists of vapes, cigarettes and on occasions cannabis. OCC was informed directly by mokopuna and staff that contraband is being brought in by staff and being used to bribe mokopuna to behave and for staff to get mokopuna to like them. Mokopuna would not disclose who the staff members are due to the '*snitch*' culture and an inability to feel safe enough to speak the truth<sup>9</sup>.

There has been an increase in incidents where mokopuna are escaping out of units, climbing onto the roof, and are given vapes and fast food as part of negotiations to come down. OCC was informed that during the roof incident in April 2023, facility management and senior Oranga Tamariki leadership gave approval for nicotine based vapes to be given to mokopuna.

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<sup>7</sup> Code is the terminology used when an incident occurs and requires a rapid response.

<sup>8</sup> Key room is where a staff monitors the CCTV footage of the facility.

<sup>9</sup> [Oranga Tamariki \(Residential Care\) Regulations 1996 \(SR 1996/354\) \(as at 01 July 2023\) 21 Torture, cruelty, and inhuman, humiliating, or degrading discipline and treatment prohibited – New Zealand Legislation](#) – Mokopuna do not feel safe and are anxious to disclose.



This is inappropriate and illegal. It is illegal to supply mokopuna under the age of eighteen with nicotine<sup>10</sup> and some of those involved in this April incident were under that age threshold.

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**Oranga Tamariki is bound by Article 3 of the Children’s Convention<sup>11</sup> and Article 3 of Te Tiriti ō Waitangi to ensure the safety of mokopuna in state care.**

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## Unprofessional staff practice

### Leadership is inconsistent

The consensus amongst staff is the new leadership is well respected and a welcome change. Staff said that leadership is more transparent and is working hard towards getting the residence back on track. However, facility wide change and practice improvements have not had time to be embedded. Whilst there have been pockets of change, there is inconsistent practice amongst staff, exacerbated by many experienced practitioners leaving the job. Staff are anxious about previous leaders returning, as staff said they did not feel heard, operations were not transparent and the residence focused on the containment of mokopuna rather than providing a positive and therapeutic environment.

### Staff is overworked, overwhelmed, and overstretched

There are a select few permanent staff within the facility who display good practice and engagement strategies with mokopuna. These staff are passionate about mokopuna and want to see the facility performing better. However, there is a critical shortage of staff. Just prior to the visit, there had been a mass exodus of permanent staff who were burnt out, resulting in an increase in contracted services being used.

Staff are contracted from security companies (Allied Security, October Protection) and non-government organisations (Mana Services and Hapū Ora). Permanent staff consistently spoke about the lack of experience of new staff and a lack of understanding on how to work with mokopuna, especially vulnerable mokopuna. This has led to inconsistencies in the care and treatment of mokopuna, and a lack of structure and stability. What is allowed by one group of staff, is not allowed by the next group. The focus has become quantity of staff rostered to units rather than providing quality care.

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<sup>10</sup> 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).

<sup>11</sup> [Convention on the Rights of the Child | OHCHR](#) . See also [section 5\(1\)\(b\)\(i\), Oranga Tamariki Act 1989](#)

## Practice is unprofessional and inappropriate

Due to the issues with staff detailed above mokopuna undermine staff, gain control, and believe:

*“Staff are the boss, but only when we let them be”.*

The shortage of experienced staff has contributed to unprofessional practice, role modelled to mokopuna.

Behaviours observed by OCC include:

- **Inability or unwillingness of staff to redirect and address poor and disrespectful behaviour.** Instead, staff participate in the behaviour calling mokopuna disrespectful names and laughing when mokopuna use vulgar language towards other staff.
- **Conversations between staff and mokopuna are not appropriate.** An example of this was when mokopuna were in a circle with a staff member having a conversation about methamphetamine use and being ‘cooked’. Staff did not redirect these conversations, rather they laughed at this and by default validated the conversation.
- **Staff swearing at mokopuna.**
- **Lack of line of sight.** OCC staff had to provide their own line of sight and witnessed a female staff member in the TV room with five mokopuna and no line of sight from her colleagues<sup>12</sup>.
- **Inappropriate movies.** R rated movies are prohibited in residences<sup>13</sup>. Mokopuna are watching R rated movies such as *The Grudge* and *Power with 50cent*. Mokopuna were exposed to content of a sexualised nature.
- **Inappropriate use of electronic devices and streaming services.** Mokopuna are watching *Smash or Pass*<sup>14</sup> consistently on YouTube instead of attending school. A staff member told OCC that the content watched on YouTube is the best they can offer tāne mokopuna in terms of seeing attractive females whilst in residence. The same staff member went on to say that the mokopuna like seeing the pretty girls on the screens.
- **Inappropriate behaviour by staff** – OCC observed an overall lack of engagement with mokopuna and included staff falling asleep and doing their own yoga stretches away from the group of mokopuna.
- **Inappropriate dynamics between female staff and mokopuna.** OCC saw the following:

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<sup>12</sup> [Line of sight | Practice Centre | Oranga Tamariki](#)

<sup>13</sup> [Use of electronic communication in residences | Practice Centre | Oranga Tamariki](#)

<sup>14</sup> Smash or Pass is a YouTube series based on a game where players evaluate the sexual desirability of an individual and declare whether they would want to “smash” them (have sex with them) or “pass” (choose not to).

- A female staff member playing contact sport with mokopuna falling onto her.
- A female staff member trying to get a jandal from a mokopuna who had positioned this between his legs, near his genitals. The female staff member proceeded to stand over the legs of the mokopuna and make multiple attempts to grab the jandal (before eventually being successful).
- A female staff member bending over in a compromising position in tight clothing, and mokopuna were staring at her body. The positions drew inappropriate comments from mokopuna which were not sanctioned by staff.

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**Mokopuna are entitled to a high standard of care<sup>15</sup> and the relationship between staff and mokopuna should be always professional and have due regard for the well-being, culture and needs of mokopuna residing in the facility.<sup>16</sup>**

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## High use of secure care

### Secure care is in breach of the Children’s Convention and UNCAT

Mokopuna and staff emphasised the need for OCC to look at the conditions in secure care. The state of secure care had deteriorated considerably since the last visit in November 2022. The showers were in a disgusting state and in need of repair. A staff member said, “*I wouldn’t want to shower in there*”. There was scrunched toilet paper that had been thrown on the ceilings, and marks on the walls that resembled faeces. The bedrooms were full of tagging, the floors were filthy, and the communal rooms are generally in poor condition.



*Conditions of secure care.*

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<sup>15</sup> [S3 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](#)

<sup>16</sup> [S27 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](#)

## Staff dictate the rules of secure care

Admissions into secure care and restraint practice continue to be used regularly at Te Puna Wai. OCC reviewed data, which showed an increase in secure care admissions and in the six months prior to the visit.<sup>17</sup> Between December 2022 and May 2023 there was an average of 32 admissions per month into secure care, compared to a monthly average of 23 between the period June 2022 and November 2022.

OCC were advised that there is a low staff ratio within secure care impacting on the quality of care provided. OCC witnessed one mokopuna banging and screaming on the walls from inside their bedroom. Staff, after some time and prompting by OCC, completed a check by opening the observation window asking, “are you all good?” before abruptly shutting it and walking back to the open area without having received an answer from the mokopuna.

Staff cannot provide adequate support or properly work through strategies to address behaviours and prevent the cyclic nature of re-admission into secure care<sup>18</sup>. Information entered into logbooks showed that mokopuna are re-admitted for the same unaddressed behaviour multiple times.

The low staff ratio is also impacting on when and for how long mokopuna can come out of their bedrooms. As per information in the logbooks, mokopuna are almost always admitted into secure with additional restrictions under regulation 48<sup>19</sup> of the Oranga Tamariki Residential Care Regulations 1996. Staff across multiple shift groups were vague when asked about rotations out of bedrooms and why it was (or otherwise) necessary. Some staff said that decisions were made based on how they felt at the time, what activities mokopuna had completed whilst in secure care, and whether staff could manage mokopuna together in the communal areas. These are not valid grounds<sup>20</sup> to hold mokopuna for long, continuous amounts of time alone, locked in their bedrooms.

OCC noted that Regulation 24 of the Oranga Tamariki Residential Care Regulations 1996 is used for mokopuna in the open units. This regulation enables mokopuna to be locked in their bedrooms.

## There are regular applications made to the Youth Court to hold mokopuna in secure care for longer than 72 hours

There are on average two to three retention orders being filed in the youth court per week for mokopuna, so that the residence can hold them in secure care for up to seven days. Staff are not actively managing and de-escalating mokopuna behaviour and the result is that secure

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<sup>17</sup> Monthly data supplied to OCC from Oranga Tamariki.

<sup>18</sup> [Use of secure care in care and protection and youth justice residences | Practice Centre | Oranga Tamariki](#)

<sup>19</sup> [Oranga Tamariki \(Residential Care\) Regulations 1996 \(SR 1996/354\) \(as at 01 July 2023\) 48 Confinement to rooms of children and young persons in secure care – New Zealand Legislation](#)

<sup>20</sup> As stipulated under s368 of the Oranga Tamariki Act 1989

care is often being used as a punishment. Reasons for secure care retention orders ranged from behaviours still heightened to mokopuna not completing 'reflection' work.

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**The Committee against Torture, the Subcommittee on the Prevention of Torture and the Committee on the Rights of the Child, note that the imposition of solitary confinement, of any duration, on children constitutes cruel, inhuman or degrading treatment or punishment or even torture – Special Rapporteur on Torture 2015.<sup>21</sup>**

**The Concluding Observations released by the United Nations Committee Against Torture on 26 July 2023 records that the State party should immediately end the practice of solitary confinement for children in detention.**

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### Information recorded in logbooks is inaccurate

Information recorded in logbooks is substandard and lacks detail. This includes logbooks for the secure care unit. Simply quoting the legislation in the 'grounds' section of the logbooks is not sufficient<sup>22</sup>. Staff advised that at times mokopuna are admitted into secure care for inappropriate reasons such as banging on the unit windows. There are significant gaps in what information is recorded and staff told OCC the logbooks are "*really, really bad*".

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**The use of secure care is a highly restrictive practice and the reasons for using it should be clear and well detailed. The use of secure care is in breach of Article 2 of Te Tiriti ō Waitangi as mokopuna are taonga and the practice diminishes their mana.**

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## Mokopuna Māori are disproportionately represented, and their cultural needs are not met

Documentation showed 69% of mokopuna in the facility were Māori. The practices and procedures of the facility do not reflect or honour principles of Te Tiriti ō Waitangi despite an

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<sup>21</sup> A/ HRC/28/68, para 44

<sup>22</sup> [Oranga Tamariki \(Residential Care\) Regulations 1996 \(SR 1996/354\) \(as at 01 July 2023\) 54 Daily log – New Zealand Legislation](#)

obligation by the Crown to do so.<sup>23</sup> OCC observed no effort in improving outcomes for mokopuna Māori. This is exacerbated by the Kaiwhakaue<sup>24</sup> being unable to fulfil their role due to shortage of staff.

The main issues are:

- No structured programmes or opportunities for mokopuna Māori to learn their whakapapa, develop meaningful connections, and engage in cultural practices.
- No consistency in the application of Whakamana Tangata<sup>25</sup>. Whakamana Tangata forms a cornerstone for Youth Justice residential (restorative) practice and provides the foundation to build a range of therapeutic, educational, health, and cultural interventions and supports.<sup>26</sup>

The United Nations Committee on the Rights of the Child and the United Nations Committee Against Torture have both called on greater state investment to address inequities for mokopuna Māori in (juvenile) youth justice. Both Committees remain concerned about the overrepresentation of mokopuna Māori in state care and the disproportionate rates of incarceration the Māori population face.<sup>27</sup> The Committees also call for strengthened duties of decision makers to uphold the right to identity of Māori children,<sup>28</sup> to develop an effective action plan aimed at eliminating disparity in rates of incarceration and survival in detention of Māori children, by addressing the risk factors associated with offending. This includes alienation from whānau, removal into state care and intergenerational issues such as trauma<sup>29</sup>. These calls for action align with the legislative duty of the Chief Executive under s 7AA of the Oranga Tamariki Act 1989.

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**Mokopuna are taonga and have the right to active protection and equitable outcomes. All mokopuna, especially those in State care, have the right to be safe.**

**Under section 7AA of the Oranga Tamariki Act 1989, the Chief Executive must ensure that policies, practices, and services meet the well-being needs of and reduce disparities for mokopuna Māori. Giving practical effect to this**

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<sup>23</sup> Oranga Tamariki has a responsibility to uphold Te Tiriti o Waitangi under section 7AA of the Oranga Tamariki Act 1989.

<sup>24</sup> A role specifically tagged to implement Whakamana Tangata within YJ Residences and increase the cultural capacity and capability of staff working in those facilities. [kaiwhakaue-position-description-june-2020.pdf \(msd.govt.nz\)](https://www.msd.govt.nz/kaiwhakaue-position-description-june-2020.pdf)

<sup>25</sup> The model of restorative practice used in all Youth Justice residences.

<sup>26</sup> [Oranga Tamariki Act 1989 No 24 \(as at 01 July 2023\), Public Act 7AA Duties of chief executive in relation to Treaty of Waitangi \(Tiriti o Waitangi\) – New Zealand Legislation and Section 7AA - What we do | Oranga Tamariki – Ministry for Children](#)

<sup>27</sup> CRC/C/NZL/CO/6 para 27(a), para 39 and CAT/C/NZL/CO/7 para 42(d)

<sup>28</sup> CAT/C/NZL/CO/7 para 40(b)

<sup>29</sup> CRC/C/NZL/CO/6 para 43(e),

**duty advances mokopuna rights under Te Tiriti o Waitangi and the Children's Convention. Not ensuring equitable experiences and outcomes, or safety, for mokopuna in state care is contrary to their rights under Article 3 of Te Tiriti o Waitangi and Articles 2, 3, 7-9 and 37 of the Children's Convention the Children's Convention.**

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## **Material conditions are inadequate**

### **Mokopuna are living in substandard conditions**

The units are in poor condition and are unfit for mokopuna. Graffiti is present on the walls, windows, and the ceilings. Units are dirty, wet tissue paper has been crunched up and thrown on the ceilings and many rooms in the residence smell damp. Bedrooms are dark with poor ventilation, and room temperatures range from extremely hot to freezing cold. The units are uninviting and as one mokopuna said *"it is depressing here"*.

During the visit a unit was closed for refurbishments and mokopuna were moved into the other units. These unit's bedrooms have broken lights and intercoms. Mokopuna are not able to buzz staff if they require anything during the night and staff said that doors will sometimes have to be kept open, which is a safety risk.

The u are in dire need of refurbishment.

One mokopuna showed OCC staff their bedroom and pointed out that the slats on the bed base had blood on them. Due to this, the mokopuna was choosing to sleep on a mattress on the floor.

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**These conditions are in direct breach of article 27 of the Children's Convention<sup>30</sup> as the facility is not providing an adequate standard of living.**

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## **Lack of programmes for mokopuna enables anti-social behaviour**

Programmes are inappropriate

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<sup>30</sup> [Convention on the Rights of the Child | OHCHR](#)

The main structured programme in place for mokopuna is education provided through Kingslea School<sup>31</sup>. The mokopuna who were attending school have good relationships with teachers, feel supported to complete tasks and generally enjoy the challenge school offers. There are no other external providers coming into Te Puna Wai, such as Odyssey House, who have previously provided alcohol and drug counselling for mokopuna.

At the time of the visit, mokopuna in one unit were refusing to attend education. This was led by the older mokopuna in the unit and which influenced all mokopuna in the unit. There is significant pressure for younger mokopuna to conform and disengage from pro-social activity. Two younger mokopuna said prior to being moved to this unit, they had been engaging in education, but have now been influenced to stop.

Staff advised that the lack of internal programmes provided, results in mokopuna doing nothing and boredom, contributing to negative unit dynamics, escalates mokopuna behaviours and admissions into secure care.

To fill the gap, staff are creating activities. However, these are inappropriate and include poker tournaments, sparring (boxing) against each other, watching inappropriate movies and YouTube content that include sexual references and violence.

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**The lack of programmes and pro-social activities for mokopuna is a breach of Articles 27, 31 of the Children’s Convention and part two of the National Care Standards<sup>32</sup>. 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 and prevent reoffending.**

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## Social work practice is inconsistent

Mokopuna are frustrated about the lack of communication from social workers and involvement in their transition planning.

*“My social worker always focuses on what I am doing wrong, it is never good enough and I just want them to be proud of me”.*

This is evident in the All About Me Plans (AAMPs)<sup>33</sup>, as documentation sighted by OCC showed that over 50% of mokopuna detained in the facility did not have AAMPs. AAMP information is

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<sup>31</sup> [Kingslea School – Learning for Life](#)

<sup>32</sup> [National Care Standards | Oranga Tamariki — Ministry for Children](#)

<sup>33</sup> [All About Me plan | Practice Centre | Oranga Tamariki](#)



inconsistent. The Oranga Tamariki policy in line with the National Care standards states “*all tamariki and rangatahi in custody must have an AAMP that is reviewed regularly*”.

Staff told OCC there is a lack of communication from site social workers. Examples given were:

- Social workers not attending intake meetings
- Sites informing case leaders at short notice about Family Group Conferences
- Social workers giving little notice to the residence regarding court dates and times and
- Social workers not attending multi-agency meetings

A lack of connection with site social workers creates a tension for mokopuna and residence staff. Residence staff often must bear the brunt of mokopuna frustration and are blamed for the communication breakdown.

The lack of communication and inconsistent practice is also contributing to mokopuna spending excessive time on remand. The data reviewed indicated that there were at least six mokopuna who had been on remand for periods ranging from 75 to 93 days<sup>34</sup>. OCC evaluated the remand reviews and noted that they were often copy and pasted every two weeks, resulting in a tick box exercise not conducive to the needs of mokopuna<sup>35</sup>.

OCC is aware of the lack of appropriate community-based placements that often impact the remand period. However, mokopuna have a right to the least restrictive placement option.<sup>36</sup> Mokopuna should not be housed in places of detention purely because of a lack of community-based options. Oranga Tamariki leadership has an obligation to ensure mokopuna rights are upheld and provide appropriate places for them to live.

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**The Children’s Commissioner continues to advocate for the phased closure of all Youth Justice residences and to replace them with smaller community-based options, devolving power and resources to iwi , hapū and whānau and community organisations, to develop tailored models.<sup>37</sup> This is in line with Article 2 of Te Tiriti ō Waitangi.**

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<sup>34</sup> Remand reviews provided by the facility.

<sup>35</sup> [14-day reviews of tamariki and rangatahi detained in a residence \(section 242\(1A\)\) or Corrections youth unit \(section 242\(2B\)\) | Practice Centre | Oranga Tamariki and Convention on the Rights of the Child | OHCHR](#)

<sup>36</sup> [Oranga Tamariki Act 1989 No 24 \(as at 01 July 2023\), Public Act 208 Principles – New Zealand Legislation](#)

<sup>37</sup> [New Zealand's 7th Periodic Review under the UN CAT Submission | Mana Mokopuna and investing-in-children-report.pdf \(msd.govt.nz\)](#) and article 37 of Convention on the Rights of the Child.

## 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.

1	Develop a national strategy to address recruitment and retention issues for floor staff across all residences. This should include researching reasons for retention issues by surveying staff on topics such as remuneration, rosters, training, and development opportunities. Address these reasons accordingly.	<p><b>Limited Progress</b></p> <p>There continues to be staff shortages at the facility and contracted NGO partners and security companies continue to be used.</p>
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## 2022 Facility Recommendations

1	Safeguard mokopuna rights by allowing more time outside of the rooms while in the Secure Care Unit.	<p><b>No Progress</b></p> <p>Mokopuna continue to be admitted to secure care and there is a high use of regulation 48 which means mokopuna have limited time out of their bedrooms.</p>
2	Plan programing that is age appropriate and offers suitable gender mixing opportunities.	<p><b>No Progress</b></p> <p>Many mokopuna are refusing to engage in the structured day activity (school) of the residence. Staff are attempting to fill the gap with activities however most of the activities are inappropriate. Activities</p>

		mainly consist of poker games, and R rated movies and YouTube programmes that have sexual content and violence.
<b>3</b>	<p>Improve kaimahi wellbeing by;</p> <ul style="list-style-type: none"> <li>• Having the right tools and skills to support escalated and potentially dangerous behavior.</li> <li>• Maintaining accurate numbers for safe staffing level.</li> </ul>	<p><b>No Progress</b></p> <p>There continues to be a shortage of experienced staff and overall staff practice in the units is inappropriate and unsafe. Mokopuna are being bribed to behave, staff join inappropriate conversations, swear at each other and mokopuna, and do not re-direct escalating behaviours.</p>
<b>4</b>	All kaimahi are trained in the full 6-week Te Waharoa training (this should include mental health, FASD, HSB, trauma informed training).	<p><b>No Progress</b></p> <p>Staff told OCC that they continue to not receive a full 6-week induction training.</p>
<b>5</b>	All kaimahi have opportunity to access team and individual supervision.	Not assessed.

# Appendix

## Information

The OCC collects 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
Interviews and informal discussions with mokopuna.	
Interviews and informal discussions staff	<ul style="list-style-type: none"> <li>• Residence Manager</li> <li>• Residence Manager Operations</li> <li>• Quality Practice Lead</li> <li>• Team Leaders Operations</li> <li>• Case Leaders</li> <li>• Shift Leader</li> <li>• Youth Workers</li> <li>• Kaiwhakaaue</li> <li>• Kingslea Staff</li> <li>• Nurses</li> <li>• VOYCE Whakarongo Mai</li> </ul>
Documentation	<ul style="list-style-type: none"> <li>• Serious Event Notifications</li> <li>• Health, Safety, Security and Incident reporting</li> <li>• Grievance Panel quarterly reports</li> <li>• Reports of Concern</li> <li>• Mokopuna All About Me Plans</li> <li>• Mokopuna Remand Reviews</li> <li>• Unit daily logbooks</li> </ul>
Observations	<ul style="list-style-type: none"> <li>• Unit routines</li> <li>• Activities and Education</li> <li>• Mokopuna engagement with staff and each other</li> <li>• Shift handovers</li> <li>• Internal and external environment</li> </ul>