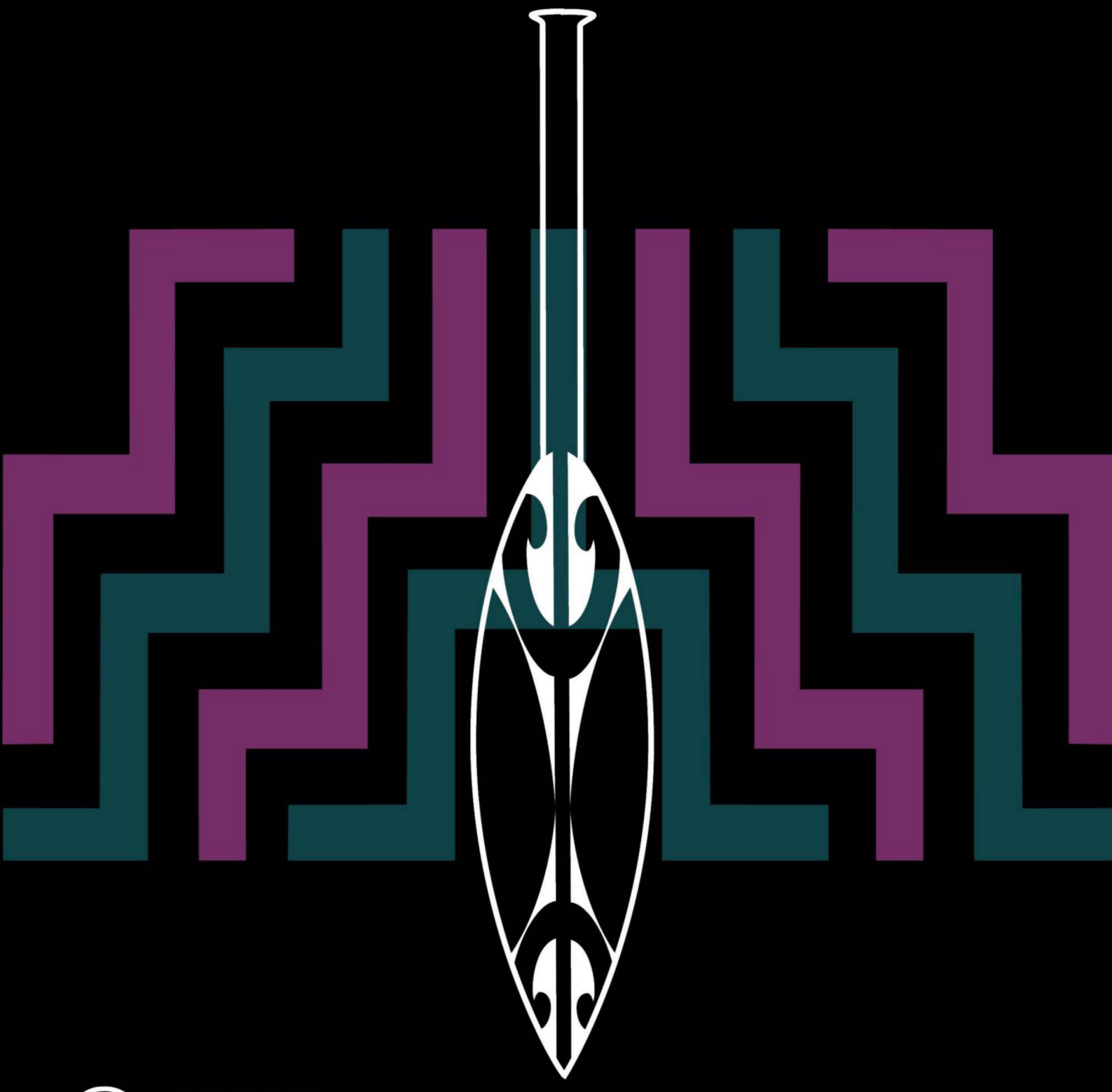

MANAAKITIA Ā TĀTOU TAMARIKI
Children's Commissioner

Te Oranga

OPCAT Monitoring Report

October 2021

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.

Contents

Introduction

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.

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 Oranga Care and Protection Residence in October 2021.

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

The announced closure of Te Oranga

On 1 July 2021 the Chief Executive of Oranga Tamariki announced the closure of Te Oranga following the release of video footage to mainstream media on 28 June 2021 in relation to a serious event at the residence.

Te Oranga staff were placed on special leave and staff from other residences were brought in to maintain operations at Te Oranga. Plans to transition mokopuna out of the residence into alternative placements was implemented with immediate effect.

OCC received an escalated grievance from mokopuna at Te Oranga relating to the effect of the closure on their health and wellbeing.

These factors all contributed to the timing of the monitoring visit from OCC staff. It was important to meet with and hear from mokopuna before the residence closed, to understand the impact on them before, during and after the event that led to the decision to close, and their transition out of the residence.

The residence was at operating capacity prior to the announcement. At the time of our visit most of the mokopuna had either been transitioned out of the residence or were in the process of transitioning out.

About this facility

Facility Name: Te Oranga

Region: Christchurch (Otautahi)

Operating capacity: 10

Status under which mokopuna are detained: Section 78 and 101 of the Oranga Tamariki Act 1989

OPCAT definitions

The main objective of OPCAT is to prevent torture and ill treatment.[1] In order to:

- Establish a system of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment
- Provide constructive recommendations aimed at improving the conditions and treatment of detained persons.
- Mitigate risks of ill treatment and build an environment where torture is unlikely to occur

We have adopted the following definitions of torture, cruel, inhuman, or degrading treatment or punishment in accordance with international human rights practice relating to mokopuna in places of detention.

Torture

Severe physical or mental pain or suffering, intentionally inflicted to obtain a confession, punish a child or young person for something they or someone else committed or is suspected of committing, or intimidating or coercing a child or young person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

Cruel, inhuman, or degrading treatment

Any treatment which offends a child or young person's dignity may be considered cruel, inhuman or degrading treatment, regardless of whether it causes pain or suffering.

Cruel, inhuman or degrading punishment

Any punishment intended to cause pain or discomfort. This includes non-physical punishment that belittles, humiliates, denigrates, scapegoats, threatens, scares or ridicules a child or young person.

[1] OPCAT in New Zealand 2007-2012, *A Review of OPCAT Implementation by New Zealand's National Preventive Mechanisms* (2013) Opcat-2013_web.pdf (hrc.co.nz)

Monitoring Framework

Our monitoring is conducted under seven domains, six of which are defined by the Association for the Prevention of Torture[2]. The seventh domain, 'Improving Outcomes for Mokopuna Māori' was developed for the Aotearoa New Zealand context by OCC to assess how mokopuna Māori are supported to have a positive connection to their identity and whakapapa.

The domains are:

- Treatment
- Protection Systems
- Material Conditions
- Activities and access to others
- Medical services and care
- Personnel
- Improving outcomes for mokopuna Māori

How OPCAT is reflected in the way we monitor

Using the seven domains as a framework we:

- Rigorously examine the treatment and conditions using a range of methods and information sources
- Describe these treatment and conditions in terms of their impact on mokopuna
- Clearly identify anything that constitutes torture or other cruel, inhuman, or degrading treatment or punishment
- Clearly identify any problems to be addressed and improvements required, along with our expectations for action
- Make recommendations aimed at improving treatment and conditions and preventing future ill-treatment

[2] Association for the Prevention of Torture (2004) *Monitoring places of detention: A practical guide.*

How we work

Methodology

We use several methods to engage with mokopuna, whānau and staff to hear about their experiences. We also want to understand the group dynamics at the facility.

Observing

We spend time in facilities seeing how mokopuna and staff interact and what their daily routines are

Joining In

We join in activities and mealtimes to experience what access mokopuna have to good food and meaningful activities

Informal Conversations

We have informal chats with mokopuna and staff who tell us about their thoughts and experiences

Interviews

We conduct formal interviews with mokopuna and staff who are happy to speak with us confidentially

Our analysis

We analyse information we have gathered by coding it according to each of the OPCAT domains. We identify themes within each domain in relation to the treatment and conditions experienced by mokopuna. We then identify any treatment or conditions that constitute ill-treatment as well as any areas where preventions could be strengthened.

Finally, we review the recommendations made in the previous OPCAT report and formulate new recommendations based on our findings in relation to current treatment and conditions.

Our findings

Findings are categorised under each of the seven OPCAT domains. Some findings relate to two or more domains – for the purposes of reporting, they are placed in the most significant domain.

Key Findings

Key findings are addressed in our recommendations along 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 that mokopuna had been subjected to torture, or cruel or degrading punishment.

However, we identified the following areas of significant concern which may constitute ill-treatment:

Change management

The closure of the residence was poorly managed and had a significant impact on the mental and emotional health and wellbeing of mokopuna and the staff responsible for their care.

Communication

Poor communication between management and residence staff was identified as a real concern prior to the event that initiated the announced closure. We heard from mokopuna and staff how the announcement went badly and was traumatising for them.

Transitions out of residence

The length of time some mokopuna had been in the residence is unacceptable. Equally concerning is the transition process post announcement which appeared to have been rushed and reactive. The relationships that had been formed with staff and with other mokopuna were not given the consideration needed in transition planning, to provide a suitable, long term placement for mokopuna.

The inappropriate use of secure

The use of secure as an ongoing solution to managing mokopuna with mental health needs is inappropriate and may constitute ill-treatment. Staff must be appropriately trained to manage mokopuna with complex mental health needs without resorting to the use of secure as a way of managing.

Summary of findings

These findings, and the limited or no progress on our previous recommendations are an indication of systemic problems that existed within the operating model of the residence prior to the serious event in June 2021 and the announcement of closure.

Our team were informed by residence staff on their last day that the residence was to remain open. An independent review of Te Oranga is therefore recommended so that any learnings could inform the future of this residence and others.

Recommendations

Our recommendations are based on:

- Key findings from our monitoring and analysis
- Any issues relating to ill-treatment
- Progress against recommendations from the previous monitoring visit

We identify systemic issues that impact on the effective functioning of the facility and make recommendations to address these. Our recommendation is that action to address the facility recommendations occurs within twelve months after the date of our visit. We will monitor progress against those and the systemic recommendations at our next monitoring visit.

Systemic Recommendations

1	Commission an independent review of Te Oranga to inform the future of this residence and others.
2	Develop a change management process for future residence restructure or closure that has mokopuna at the core of planning.
3	Develop and implement a workforce strategy to address appropriate staffing levels, recruitment and training in all residences.
4	Develop a robust strategy to transition mokopuna from residence to include a range of suitable specialist placements – particularly for those with complex needs.
5	Develop a process whereby kaimahi can safely raise concerns.
6	Review the grievance process to ensure independence and impartiality.

Facility Recommendations

1	Strengthen the relationship with mana whenua to help build the cultural competency of staff and support mokopuna Māori to connect with their whakapapa.
2	Consult with mokopuna on the renovation and rejuvenation of the residence.

3	Provide regular supervision for all residence staff, including cultural supervision.
4	Develop and implement an induction package that includes specialist training for example trauma informed practice and mental health.
5	Establish a relationship with community mental health services to provide clinical input, consultation and treatment for mokopuna with complex mental health needs.

Progress on previous recommendations

Progress on the recommendations from the previous Te Oranga Care and Protection Residence OPCAT report dated 11 December 2020 are assessed to have made good, limited or no progress.

1	Acknowledges the care and protection residence model of care, where vulnerable children with exceptionally high needs and challenging behaviours are placed together is not fit for purpose, and prioritises work creating smaller homes for children and young people in need of short-term stays in a secure environment. (Ref. page 8) (Ref. State of Care 2017, action 10)	No progress
2	Continues to prioritise the development of specialised placements suitable for children with complex needs, to minimise extended placements in care and protection residences. (Ref. page 9) (Ref. State of Care 2017, action 11)	No progress
3	Ensures full refurbishment of Te Oranga begins immediately. *(Ref. page 12) (Ref. State of Care 2017, action 8)*	No progress
4	Ensure staff receive training on understanding and awareness of LGBTQIA+ children and young people and how best to support them in a residential setting. (Ref. page 18)	No progress

5	Ensure staff receive the appropriate training and support to help them respond to children and young people with mental health needs. (Ref. page 8) (Ref. State of Care 2017, action 14)	Limited progress
6	Encourage and support staff to collaborate and share ideas for developing programmes that will meet the needs of all children and young people, including those with complex needs. (Ref. page 15) (Ref. State of Care 2017, action 12)	Good progress
7	Increase the number of care staff on the floor, to ensure staff and children and young people feel safe and supported and staff can focus on the individual needs of children and young people. (Ref. page 19) (Ref. State of Care 2017, action 15)	Limited progress
8	Continue to support Kingsley School to run the Taiohi programme so that children and young people can participate. (Ref. page 21)	Limited progress
9	Continue to prioritise regular supervision, including cultural supervision for all staff. (Ref. page 19) (Ref. State of Care 2017, action 17)	Limited progress

Treatment

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

Management of the closure had a negative impact on mokopuna

Mokopuna were upset and unsettled when they were told of the closure. Staff they had formed relationships with were put on special leave with immediate effect which limited their ability to prepare mokopuna. Some mokopuna said that they had lost their favourite staff member.

Mokopuna had to form new relationships with the staff brought in from other residences, and this took time.

The staff brought in were not provided with the appropriate information about the mokopuna and their complex needs to help them understand and manage their behaviours and maintain familiar routines.

This meant they had to form relationships and re-establish routines which was initially unsettling for mokopuna.

Staff told us that mokopuna would be re-traumatised when it was time for them to leave.

Transitions were poorly managed

There was a rush to find alternative placements for mokopuna, some of whom had been at the residence for over a year. They were anxious about the sudden change because they needed time to process the information and consider the decisions.

Staff were concerned that relationships and support with the new placement wasn't properly planned and established.

Finding appropriate placements for mokopuna with complex needs was difficult

Suitable, alternative long-term placements have been limited and taken a long time due to the complex needs of mokopuna and the varied levels of engagement with Oranga Tamariki sites.

The changes contributed to escalated behaviours for mokopuna

The impact of the pending closure left mokopuna dysregulated. One staff member said that this was the worst they had experienced in their time at Te Oranga, and after many years of experience in the sector.

We frequently observed conflict between mokopuna while we were there, but saw staff intervene quickly and effectively before it escalated further.

Mokopuna and whānau had some involvement in their plans

Some mokopuna contributed to their plans, for instance one mokopuna suggested a dysregulation activity that worked for them.

The complex needs of mokopuna in care require significant input from a broad range of services. Their plans are developed and discussed at multi agency meetings, attended by mokopuna and their whānau.

Teachers from the school attended and contributed to the plans. The school tried hard to understand the development needs of each mokopuna and tailored their individual educational plans to meet their needs.

Secure care is not an appropriate long-term solution

At the time of our visit the secure care facility was being used for a mokopuna with complex mental health needs.

This decision was made as the open unit was over stimulating for this mokopuna and contributed to anxieties that presented as violence and aggression towards peers and staff.

The physical location and condition of the secure unit was dark and dank. It was not conducive to a therapeutic environment.

The model of care in care and protection residences is different to youth justice

Staff brought in from other residences were unfamiliar with the Care and Protection operating model. There were differing opinions expressed by them about what model of care was best for mokopuna at Te Oranga. The different approaches and communication styles had an unsettling impact on mokopuna.

Care and protection residences use MAPA[3] as a method of restraint and de-escalation techniques and strategies to prevent mokopuna from harming themselves or others. The staff that were brought in were not familiar with MAPA and only some staff had received the first phase of the training at the time we were there. Staff said that MAPA wasn't effective with mokopuna who escalated quickly. There were three restraints in the first night new staff arrived.

[3] MAPA® (Management of Actual or Potential Aggression) | Crisis Prevention Institute (CPI)

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.

Mokopuna are familiar with the grievance process

Mokopuna use the grievance process however, the process is not independent of kaimahi who may be subject to the grievance.

This may decrease the likelihood of mokopuna making grievances due to the lack of accessibility, independence, and impartiality. They may also perceive a risk of punishment, retribution, or sanction due to lack of anonymity.

The grievance panel is accessible to mokopuna

The grievance panel go into the unit every couple of weeks and are visible and available to mokopuna. Panel members try to get to know mokopuna by joining them for lunch.

After the incident, the grievance panel went to Te Oranga weekly to check in and be a consistent presence. These stopped when the Covid 19 Alert levels changed, and the national lockdown happened. During lockdown, the panel supplied their phone numbers but did not get any calls. The panel meet with the Residence Manager twice a quarter to check-in, go over quarterly reports and assess what is happening with recommendations from grievances.

There was valuable access to advocates, but this has been reduced

VOYCE Whakarongo Mai are good advocates for mokopuna and have supported them in making a number of grievances. Advocates from VOYCE come in regularly and build good relationships with mokopuna. However, some of their staff were not vaccinated and could not come into the residence.

Given all the change and uncertainty this has been a huge loss to mokopuna. A range of advocates are needed, for example when access to mental health services and support is needed for those on treatment orders.

Record keeping and documentation was poor

Hard copy files for mokopuna were incomplete or could not be readily viewed because they were only available on CYRAS which we don't have access to. There were no behaviour management plans or All About Me plans for mokopuna on file.

Recording in daily and secure logs was inconsistent and poor. The files did not have up to date documentation, such as Retention Orders.

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.

Not a mokopuna friendly space

The dining room and lounge were dated and looked tired. Staff said that the physical environment promoted bad practice as the staff can observe the mokopuna from the hub without having to engage with them.

The Secure Unit smelled and needed to be renovated.

Admission into Te Oranga is close to the Secure Unit and is not an inviting environment for mokopuna and their whānau when they first arrive.

The food and outside environment are good

The outdoor space and the pool are fully utilised by the school particularly in the summer. The school environment is well-resourced for learning and the classroom has lots of natural light and is spacious.

Residence staff support mokopuna for off-site school excursions.

Mokopuna said the food was good.

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.

Contact with whānau is supported

Many of the mokopuna are from different parts of the country so face to face contact is limited due to distance, the operational constraints of the residence and staff capacity to supervise access. Phone calls to whānau are available every day. Video calls were available every day during lockdown.

School provides stability and routine

The school provides good structure to the daily routine for mokopuna. The staff at the school provided stability during the transition process and mokopuna reacted well to this.

The school operated to the same timetable as mainstream schools and teachers worked one on one with mokopuna. They adopted a varied timetable with adventure-based activities that was fun for mokopuna and staff. One teacher told us that successful engagement with mokopuna in an educational setting, led to improved self-belief and relational skills when they transitioned into the community.

There is emphasis on off-site activities, doing things mokopuna enjoy

Staff know the inside environment is bleak and encourage mokopuna to be outside the unit as much as possible. There is a focus on activities that are educational and therapeutic and they make the most of the surrounding area when they can, for example surfing and caving.

Staff also brought their pets to work, which mokopuna really enjoyed.

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.

Primary health care is available on site

Nurses have a good relationships with mokopuna and are available on site. A doctor comes in once a week. The medical staff provided a familiar and reassuring face for mokopuna during the change process.

There is inadequate access to specialist mental health care

There are inappropriate placements of mokopuna with complex mental health needs at Te Oranga. Youth Workers at Te Oranga are not trained in mental health. The impact of changes over the past few months was significant for mokopuna with an increase in medication for anxiety.

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.

Poor communication and decision making had a significant impact on everyone

There was extremely poor communication with the staff at the residence after the incident featured on national news and the announcement of the closure of Te Oranga. Staff were not sure of what was happening and mokopuna were the last to be told. Leadership was lacking.

Communication between teams, work groups, replacement staff from the different residences, management and National Office was extremely poor.

Staff were dealing with a changing environment, including constant changes in management and different management styles. This includes working with staff from different residences used to operating under different models of care.

Poor staff culture and communication was highlighted as an issue prior to the incident. Staff felt they weren't getting any support or being listened to. Te Oranga staff said they are dealing with a lot of guilt and shame for being made complicit in what happened and then placed on leave. All of this uncertainty, change and poor communication has a huge impact on mokopuna. They felt extremely unsettled, high uncertainty and guilt and responsibility for adults they had formed a relationship with, who then suddenly left.

There needs to be a safe feedback mechanism for staff to raise concerns

Staff said the reason for the announced closure was as a result of several factors.

Staff reported concerns to management and Oranga Tamariki National Office, about how unsafe the operational environment was at Te Oranga prior to the incident. 'What happened here is entirely predictable and entirely preventable'. This indicates there are no mechanisms for staff to raise concerns in a way where they are listened to or where they are acted on accordingly.

Staff felt unsupported and were not provided with the resource or training to manage the high and complex needs of the mokopuna at Te Oranga.

There is a lack of induction, training and supervision for staff

For staff coming from other residences there was no handover or introduction into how Te Oranga worked and there have been no inductions for new staff for 18 months.

Staff do not have personal development plans and training, for example mental health and LGBTQIA+ issues.

There was no supervision or de-briefing provided to staff prior to the incident, however it was re-introduced for Te Oranga staff as they returned to their roles. Staff that came in from the other residences did not receive any on-site supervision.

Staff levels were inappropriately low prior to the announced closure

Te Oranga staff raised issues with senior management about the lack of staff on some shifts.

Before the announced planned closure, the staff to young person ratio was dangerously low. Staff were also working unsafe amounts of overtime with inadequate space between shifts, leading to stress and burnout. This also affected professional development, as it meant staff could not be released for training.

The staff brought in from other residences said they had been doing extremely long shifts, and there was a lack of clarity around when Te Oranga staff were returning to the residence. At the time of our visit the staff to mokopuna ratio was high, although the number of mokopuna there at the time was significantly less than operating capacity.

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.

Lack of commitment to improving outcomes for mokopuna Māori

There was a lack of a national led strategy to meet the legislative requirements under section 7AA of the Oranga Tamariki Act, or to embed the principles of Te Tiriti o Waitangi.

We did not observe any practice that demonstrated a commitment to Te Ao Māori and improving outcomes for mokopuna Māori.

Kapa haka and harakeke were the only programmes available for mokopuna Māori.

Building cultural capability

There was no regular presence of mana whenua at the residence during the time of our visit.

Although we were told the relationship with mana whenua is there, it should be strengthened to help build the cultural competency of staff and support mokopuna Māori to connect with their whakapapa.

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	• Residence Manager • Acting Residence Managers • Manager Residence Operations • Case Leader • Team Leader Clinical • Acting Team Leader Operations • Team Leader Support Services • Case Workers • Youth Workers • School Principal • Teacher Aides • Nurses
Interviews with external stakeholders	• Grievance Panel • VOYCE - Whakarongo Mai
Documentation	• Grievance quarterly reports • Secure care register • Secure care logbook • Daily logbook • Care Plans and All About Me plans • Serious Event Notifications • SOSHI reports
Observations	• Classroom • Activities – on and off-site • Secure care • Dinner