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| Complaint from a young person in a Care and Protection Residence |
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| Legislation Ombudsmen Act 1975Agency Oranga TamarikiOmbudsman Chief Ombudsman Peter BoshierCase number(s) 523061Date June 2020 |

*Complaint from young person in Care and Protection Residence—Planning for placement outside Residence and communication about this unreasonable—Placement in Residence to be a last resort and for as short a time as possible—Placement found during investigation and apology made—Ombudsman recommended continued updates and acknowledgement of the time spent in Residence*

# Background

The Chief Ombudsman received a complaint from a young person in a Care and Protection Residence. The young person had previously been in the Residence for 18 months, and this was now her second time there. By June 2020, she had been in the Residence for around another 10 months. When she entered the Residence for a second time, the young person was told that it would be for a short amount of time – hopefully only a matter of weeks. She was immediately worried that she might spend another extended amount of time there.

The young person needed a placement outside of the Residence, as she could not return home. Towards the end of 2019, it looked like a placement had been found. The young person met the provider involved, and discussions about cost were underway. Staff at Oranga Tamariki believed placement would be successful, and they waited to hear the outcome.

After more than a month of waiting, the young person made a complaint to the Residence Grievance Panel, as she was concerned about how long it was taking to hear back. Her grievance was upheld, and Oranga Tamariki made further enquiries of the provider to try and speed the process up.

Just before Christmas, the provider advised Oranga Tamariki and the young person that they had declined the placement. She was very upset by this. She had been led to believe that placement was very likely, had understood that she would leave the Residence either before Christmas or just after, and she did not understand what had gone wrong.

The young person then asked the Children’s Commissioner to review her grievance. He agreed that the complaint was justified, and talked to both the provider and Oranga Tamariki. The Children’s Commissioner recommended that Oranga Tamariki make sure that she continued to be updated, that planning continue for a placement, and that she be put in touch with Voyce Whakarongomai (an advocacy and support group for children and young people who are, or have been in care).

However, the young person was still dissatisfied with the amount of time that was passing, and felt that she wanted further consideration of her complaints. The Children’s Commissioner helped her to make a complaint to the Ombudsman.

The young person explained that she was upset by the length of time spent in the Residence, especially as this was her second time there. She watched others come and go, and felt as though she was losing her teenage years. She felt that the environment was bad for her mental health, and her medical professionals agreed.

She was depressed and angry, but scared to show this in case it meant that she would have to stay at the Residence for longer. She wanted to be trusted to return home while Oranga Tamariki organised a placement for her.

# Investigation

The Chief Ombudsman notified Oranga Tamariki that he was investigating the young person’s complaint. In particular, the Chief Ombudsman wanted to know:

* What Oranga Tamariki had done to ensure that the young person’s time in Residence was as short as possible.
* Whether, given the circumstances of a previously lengthy stay at the Residence, there had been a sufficiently high level of oversight over the case.
* How Oranga Tamariki had worked with service providers to ensure timely assessment, and how it worked with providers when a young person felt that they had been treated poorly.
* What kind of updates the young person was receiving about progress in finding a placement.

Oranga Tamariki explained that it had been difficult to find a placement option because when the young person first returned to the Residence, the youth justice system had been involved. Oranga Tamariki had hoped that she could return home until a placement was found, but this was not approved by the Court. Once youth justice issues were resolved, returning home became a possibility, but Oranga Tamariki were concerned that this option was unsafe.

When the placement fell through, the young person’s social worker and other Oranga Tamariki staff were disappointed too. They believed that they had found a viable option. Oranga Tamariki worked with the provider to learn what had gone wrong, and changes that could be made to ensure that if a placement wasn’t going to be offered, the young person and Oranga Tamariki would know this as early as possible.

Oranga Tamariki also explained that the young person’s social worker, and their supervisor, thought very carefully about how best to give updates. After the placement fell through, they were worried about providing too much information, too early, in case new options also fell through, and created further stress and unmet hopes for her.

The Chief Ombudsman reviewed the entire file of the young person, noting all of the actions that had been taken to find a placement for her. It appeared that Oranga Tamariki had not always acted as urgently as it could have, and that it was recognised very early on that a bespoke placement would be required, yet this wasn’t immediately pursued.

The detrimental effects of residence in a secure care facility are well known. Young people should only enter a Care and Protection Residence if there is no other option, and should be there for the shortest amount of time possible. In total, this young person had spent nearly two and a half years in the Residence, and was suffering because of this.

The Chief Ombudsman considered that Oranga Tamariki may have been prioritising the ease of ensuring the young person’s safety at the Residence, without properly considering her views and the detrimental effects of spending so long in the Residence.

The Chief Ombudsman acknowledged that positive changes had been made by both the provider and Oranga Tamariki. Processes and guidance had been updated to ensure that in future cases, similar misunderstandings would not occur, and matters would progress more efficiently. Oranga Tamariki had started these changes quickly, before the young person made her complaint to the Chief Ombudsman.

However, the Chief Ombudsman did consider that Oranga Tamariki should have maintained a higher level of oversight and been more proactive in how they monitored things. Although it was possible to escalate issues to a Deputy Chief Executive, this was not the same as proactive monitoring. This is not necessary in all cases, but would have been appropriate here given that the young person was on her second stay, had already spent 18 months there on her previous stay, and frequent updates were being sought by the Court. Proactive monitoring and follow-up could have emphasised the urgency of the situation.

Finally, while the Chief Ombudsman understood the concerns around providing updates to the young person, this remained important and had been recommended by the Children’s Commissioner and the Grievance Panel. The young person, more than anything, wanted a commitment to timeframes or an understanding of the steps that were needed to secure placement. She had expressed to the Chief Ombudsman’s staff that regularly waiting for updates led to confusion and fear about what might happen. Although she had been upset when the placement fell through, it was not her fault that she had been given such strong signals that the placement was going ahead. Continued updates needed to take place.

# Outcome

The Chief Ombudsman formed the final opinion that Oranga Tamariki had acted unreasonably. The young person had remained in the Residence for too long, and at times Oranga Tamariki had not taken action as quickly as it could have. There should have been better, higher-level oversight of the young person’s circumstances, and communication could have been improved.

During the Chief Ombudsman’s investigation, Oranga Tamariki advised that it had been able to secure a bespoke placement for the young person, and planning for this had begun. Oranga Tamariki had also spoken to the provider again, and an apology had been made to the young person.

Because of this, and because the young person’s planning was frequently being reviewed by the Family Court, the Chief Ombudsman could not make recommendations about reassessing where the young person should reside while waiting for the bespoke placement to commence.

Instead, the Chief Ombudsman recommended that:

* Regular updates were to be provided to the young person on the progress of the placement that had been secured. Necessary steps were to be set out for her in an appropriate way.
* Fortnightly reports be made to his office on the progress of the placement, so that he could determine whether further intervention was required.
* When the young person left the Residence, she received an acknowledgment that the length of time she spent there was undesirable.

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