Aroturuki Tamariki | Independent Children's Monitor

Towards a stronger safety net to prevent abuse of children

A review of the implementation of the recommendations of Dame Karen Poutasi following the death of Malachi Subecz.

IN-DEPTH REVIEW | MAY 2024

Me he tākapu matakana
He tākapu ruku hōhonu
He tākapu tohatoha hua

Like a sharp eyed tākapu
A deep diving tākapu
A tākapu who shares

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Te Kāwanatanga o Aotearoa
New Zealand Government

Foreword

This report looks at the implementation of the recommendations made by Dame Karen Poutasi in her review of the children's sector identification and response to suspected abuse following the death of Malachi Subecz.

Dame Karen's review was not the first to look into the failure of state agencies to keep a child safe from abuse. She quotes from other reviews dating back more than two decades. One of her recommendations was that we, in our new system-wide role, monitor the implementation of the recommendations made in her report after 12 months.

This is our first in-depth review to be commissioned by request. It is perhaps also the most important, addressing the fundamental question of whether tamariki are being kept safe from harm. The progress to date was disappointing.

The lack of urgency, and what appears to be a lack of priority given to addressing child abuse in New Zealand, is hard to understand. While it is important not to make hasty decisions that may have unintended consequences, it is concerning that there has not been greater progress.

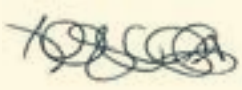
Sadly, the death of Malachi is not an isolated incident. Data from Child Matters shows that on average, one child in New Zealand dies because of abuse every five weeks[1]. Most of these children are under five years of age, and the largest group is under one year old. This is one of the highest rates in the OECD.

It is imperative that change occurs. Reviews of deaths of children from abuse going back more than two decades have made similar recommendations to the Poutasi review. This suggests that any changes made in response to earlier reviews have not addressed the root causes of why the system is failing to respond to harm at the earliest possible opportunity.

In her 2022 review, Dame Karen noted Mel Smith's words from his 2011 review of a case of serious abuse: "this is a heinous crime" and "whatever needs to be done must be done". Regrettably, as Dame Karen found in 2022, these words still need repeating.

As a country, we have shown we can make significant change when needed. Notably the response to Covid-19, which required responses across agencies and a number of legislative changes. When a matter is identified as a national priority, action can happen quickly.

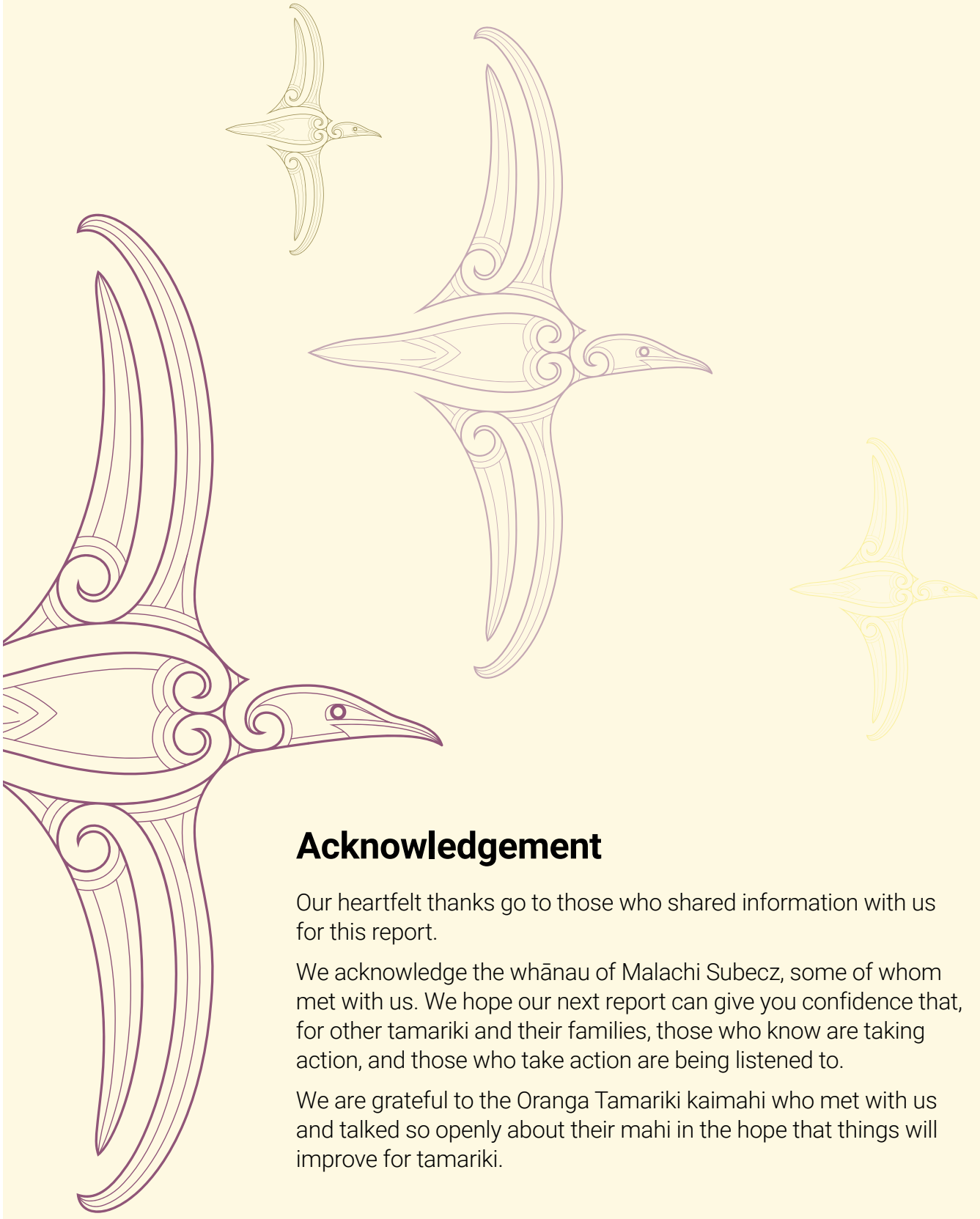
We will continue to monitor implementation of Dame Karen's recommendations, and of the actions outlined in agency reviews, and report on this again in another 12 months.



Arran Jones
Chief Executive

Nova Banaghan
Chief Monitor

1 https://www.childmatters.org.nz/insights/nz-statistics/



Acknowledgement

Our heartfelt thanks go to those who shared information with us for this report.

We acknowledge the whānau of Malachi Subecz, some of whom met with us. We hope our next report can give you confidence that, for other tamariki and their families, those who know are taking action, and those who take action are being listened to.

We are grateful to the Oranga Tamariki kaimahi who met with us and talked so openly about their mahi in the hope that things will improve for tamariki.

Contents

Key findings

Tamariki are no safer now than when Malachi died

Having completed our review, we are not confident that tamariki in similar situations to Malachi are any more likely to be seen, or kept safe by the system, than they were when Malachi died. There are several contributing factors we have considered in reaching this key finding, as set out below.

Across the children's system, agencies are not adequately prioritising child protection

Eighteen months on from the publication of Dame Karen Poutasi's review (Poutasi review) and two and a half years since the death of Malachi, there has been little progress.

Despite provisions in legislation placing responsibilities on children's agencies to prioritise child protection, including the Oranga Tamariki Action Plan (OTAP), there remains limited collaboration and child protection is still largely seen as an issue for the Police or Oranga Tamariki to respond to.

Many professionals appear to hold a view that simply referring concerns to Oranga Tamariki covers off their responsibilities as a children's agency. Some still do not report concerns when they should. Others have given up reporting to Oranga Tamariki because of a perceived lack of action and a resulting loss of trust and confidence.

Recommendations of the Poutasi review have not been implemented

Some of these recommendations require decisions to be made by government and some also require legislative change. These are still to be progressed.

Other recommendations are within the control of chief executives. These include adding the health sector as a partner to the Child Protection Protocol between NZ Police and Oranga Tamariki, building on existing multi-agency teams working in communities in partnership with iwi and Non-Government Organisations (NGOs), improving the understanding of when information can be shared, and educating and training the children's workforce on when to report abuse. While discussions continue, we are yet to see any implementation.

Individual agency reviews have made limited progress, and what has been done addresses symptoms and not underlying causes

We heard that agencies have made slightly more progress in response to their own internal reviews. Even so, many of these actions, which agencies set themselves and which are within their own mandate to progress, have still not been achieved.

Oranga Tamariki has taken specific actions following a review by the Chief Social Worker. Much of the Chief Social Worker's review focused on practice at site level. Despite Oranga Tamariki advising that initial planned actions have been completed, practice at the sites we visited has not yet substantively changed. Actions taken were largely focused on addressing symptoms, such as reminding staff about using practice guidance, one-off training opportunities and reviewing tools on performance development. While these are useful to a degree, if the root causes of practice issues are not addressed, only limited change can occur. Oranga Tamariki is working towards a 'practice shift', but our observation is that it is yet to make a difference.

When people report concerns, the response from Oranga Tamariki is not sufficiently focused on the safety of the child

Most initial reports of concern are assessed by the Oranga Tamariki National Contact Centre (NCC) which sends those requiring further action to local sites. Around half of NCC decisions referred to sites for further action are overturned by the site. When the site decides to take no further action, the child is not seen by Oranga Tamariki. There are a number of reasons a site may overturn the NCC decision, however, we heard staff capacity was having an undue impact on decision making. We also observed time spent reworking NCC assessments when this time could have been used to see tamariki.

We also heard there had been a shift in Oranga Tamariki practice to give greater weight to the voice of whānau, with the needs and safety of tamariki secondary. Oranga Tamariki senior leadership told us this was not the intent of the practice shift. It also explained that "the journey to fully introduce and embed this approach is not yet complete".

We note that the Ministerial Advisory Board's report in 2021, *Kahu Aroha*, reported similar concerns about the disconnect between what national office understood practice to be and what social workers were experiencing at the frontline.

Irrespective of whether this is a widely held misinterpretation, or is limited to specific regions or sites, it is something that OT needs to consider as it continues to implement its practice shift. Involving and working with whānau is critical, but the safety of the child must remain paramount.

The Poutasi review called for system change, but this has not happened

Actions progressed are not contributing to the system wide change envisaged by the Poutasi review. There continues to be a lack of clarity about the statutory role of Oranga Tamariki and the appropriate threshold for its intervention.

Government agencies have not implemented a nationally consistent, collaborative way of working where each agency prioritises its own role in keeping tamariki safe, and in working together. Working together must also include local iwi and NGO partners, who can be called upon to support whānau where early intervention may be more appropriate. If this is to be achieved, an iwi/community sector must be sufficiently resourced to work alongside whānau, in an enduring and meaningful way.

Introduction

This review is undertaken in accordance with section 26 of the Oversight of Oranga Tamariki System Act 2022. It is the result of Recommendation 14 of the independent review undertaken by Dame Karen Poutasi *Ensuring strong and effective safety nets to prevent abuse of children* (Poutasi review), which was published on 1 December 2022. Recommendation 14 asked that Aroturuki Tamariki – the Independent Children's Monitor review the Government's progress against the 13 other recommendations in the report, one year on from its publication.

The Poutasi review was commissioned by the chief executives of six government agencies[2] following the death of Malachi Subecz. Its purpose was to improve the children's sector identification of, and response to, abuse of children and young people. It looked across the interactions that six government agencies had with Malachi Subecz, his whānau, and his caregiver, identified where the system failed to protect Malachi, and made recommendations to address those failures to prevent abuse of tamariki in similar situations to Malachi in the future.

While the Poutasi review drew on the reviews undertaken by agencies as a source of information, it deliberately looked across the system to see what improvements could be made at that level, rather than focusing on individual agency changes. It considered this in terms of layers within the system to protect tamariki. In the report, Dame Karen Poutasi notes that:

> *"Throughout this review, I have envisaged a children's playground climbing frame with layers of safety nets so that if a child falls through the first net they are caught by the second or third safety net. A system of mutually reinforcing, purposefully structured safety nets is essential to offering the protection and care that children like Malachi are owed."*

2 Department of Corrections, Ministry of Education, Ministry of Health, Ministry of Social Development, New Zealand Police and Oranga Tamariki – Ministry for Children.

Who was Malachi?

Malachi Rain Subecz was born on 28 September 2016. He was in his mother's care until she was remanded into custody at Auckland Region Women's Corrections Facility on 21 June 2021. At this time Malachi's mother placed him in the care of Michaela Barriball.

Malachi suffered abuse inflicted by Ms Barriball. Reports of concern were made by Malachi's whānau to Oranga Tamariki, as well as contacting NZ Police and Malachi's daycare. Oranga Tamariki determined there were no care and protection concerns for Malachi and that no further action was required by Oranga Tamariki. Crucially this decision was made without anyone from Oranga Tamariki going to see Malachi. In July 2021, a Probation Officer from the Department of Corrections also contacted an Oranga Tamariki social worker with concerns. Oranga Tamariki determined that the concerns were beyond its scope to respond to, as it had already determined that there were no care and protection concerns. No other agency working with Malachi or Michaela Barriball raised concerns with Oranga Tamariki, although it was later found that Malachi's daycare had concerns but did not notify Oranga Tamariki.

On 1 November 2021 Malachi was taken by ambulance to Tauranga Hospital and then airlifted to Starship Children's hospital. His medical presentation was consistent with having suffered a traumatic brain injury. That same day, a hospital staff member made a report of concern to Oranga Tamariki. That report of concern said that Malachi had been admitted to Starship Children's Hospital and there were indications that he had suffered non-accidental injuries. The report of concern was allocated to an Oranga Tamariki social worker the following day.

On 2 November, in direct response to the report of concern from the hospital, a multi-agency professionals meeting took place. This involved health professionals, NZ Police and Oranga Tamariki. A multi-agency safety plan was created for Malachi, which considered how Malachi's safety needs would be addressed.

On 12 November 2021, Malachi died from the non-accidental injuries which he was hospitalised for on 1 November. He was five years old.

Scope

We chose to review and report both on the response to the recommendations of the Poutasi review, and the implementation by the six agencies of the recommendations in their own internal reviews. We have taken both a system and agency focus, looking at the extent to which agencies, either individually or collectively with others, are contributing to the overall system to ensure strong and effective safety nets to prevent abuse of children.

We reviewed all agencies with responsibilities for implementing actions from the Poutasi review as follows, those in bold are the six agencies that commissioned the review.

- **Oranga Tamariki - Ministry for Children**
- **Department of Corrections – Ara Poutama Aotearoa**
- The Ministry of Justice
- **Ministry of Social Development - Te Manatū Whakahiato Ora**
- **Ministry of Education - Te Tāhuhu o te Mātauranga**
- The Education Review Office (ERO)[3]
- **New Zealand Police - Ngā Pirihimana o Aotearoa**
- **Ministry of Health - Manatū Hauora**
- Health New Zealand – Te Whatu Ora

3 Aroturuki Tamariki - Independent Children's Monitor is a Departmental Agency hosted by, but operationally independent from, ERO.

The objective of our review was to understand:

- what actions agencies have committed to in response to the system recommendations in the Poutasi review, and in response to their own reviews, as well as the outcomes they expect to achieve from these actions
- what progress agencies have made in implementing their committed actions
- how agencies are or will measure the impact of their actions, including to what extent the actions of agencies address the underlying issues
- to what extent agencies' commitments and actions reflect obligations to te Tiriti o Waitangi
- whether and how agencies are working differently with parents who have been incarcerated.

We were also interested in whether the actions undertaken by agencies, individually and together, are making a difference for tamariki and their whānau. In undertaking this review we found that work has not yet progressed to a point where this is able to be measured, so we have not been able to meaningfully report on any impact. However, what our report does do is highlight what has been done, whether actions address the recommendations, and what more needs to be done.

Our approach

The Poutasi review made recommendations that require actions across agencies. In a December 2023 meeting with agencies, we heard that progress has been slow with no real implementation of actions to respond to the recommendations yet. Agencies also had internal reviews to respond to.

We requested information and data from all agencies with responsibilities for implementing recommendations arising from the Poutasi review[4]. We also requested data and information from the six agencies that completed internal reviews, about progress with respect to those reviews.

We focused our in-person engagement on frontline kaimahi from Oranga Tamariki because of its fundamental statutory role in addressing reports of concern. Oranga Tamariki also advised it had completed all initial actions in response to its internal review, whereas other agencies advised that their implementation was not as complete. We had intended in-person engagement with other agencies, however, their lack of progress means we would have learned little more than Dame Karen Poutasi did through her review.

It was important to us to understand the impact of the practice changes resulting from the Oranga Tamariki internal review. We wanted to understand if the changes are achieving the desired intent, particularly in responding to reports of concern. In addition, most of the recommendations of the Poutasi review, if implemented as outlined, will impact on Oranga Tamariki. We further wanted to understand how work in response to the Oranga Tamariki review may support implementation of the system-focused recommendations.

We intended to include voices of tamariki and their whānau in our review, to help understand what might be different for them because of the across-agency response to the recommendations. However, after hearing from agencies that work to respond to the Poutasi review was not yet at a point of implementation, this is not the right time. We will conduct a further review in twelve months, and will look to include the voices of tamariki and whānau in our monitoring at that time. We will also gather qualitative data from other agencies in our next review, to help determine how those agencies are implementing their responsibilities to protect tamariki.

4 Oranga Tamariki informed us that the quantitative data they provided on reports of concern may vary slightly from their externally published figures. This is because the level of detail required that they use a different data source than usual.

Our next review will also consider objectives that we could not address in this review, because work was not yet at a point to be able to measure progress. We will assess how agencies are measuring the impact of their actions, and the extent to which those actions address the underlying issues and reflect their te Tiriti o Waitangi obligations.

Timeline for this review

- December 2023 meeting with agencies to inform them about our approach to this review.
- February 2024 request for information from agencies with responsibilities for responding to the actions in the Poutasi review on progress and where relevant, what actions they have undertaken in response to their own agency reviews.
- March and April 2024 we spoke directly with frontline kaimahi and leadership from across Oranga Tamariki, including national office staff.
- April 2024 a draft was provided to the agencies.
- May 2024 a final draft was provided to the agencies.
- June 2024 the final version was submitted to the Minister for Children and to agencies for formal response (under legislation they have 35 working days to respond).

In March and April 2024 we heard from:

85 kaimahi

Across 16 Oranga Tamariki sites

From 3 regions

(Auckland, Bay of Plenty and Canterbury)

+ Oranga Tamariki National Contact Centre, and national office.

The purpose of these engagements was to understand the impact of practice changes at the frontline. Given the focus of this review it was important that we visited and spoke with kaimahi from the two Tauranga sites in the Bay of Plenty region, and specifically Te Āhuru Mōwai site which was the site that assessed the reports of concern for Malachi. We included Auckland and Canterbury as the timing coincided with our monitoring schedule and provided a geographical spread.

In addition, where relevant we have drawn on findings from other engagements undertaken over the 2023/24 year as part of our core monitoring responsibilities. This includes visits to the Upper South Island (including the West Coast), and Taranaki and Manawatū regions. This enabled us to test whether what we heard in the monitoring for this review also came up elsewhere.

The table below explains how we have used terms in this review.

Quantity	Term used
1, used as an example of a theme	For example, a
2	A couple
3 or more, but less than half	Some
Around 50% (where this is more accurate than some or most)	Many/Around half
More than half	Most
90%+	Almost all
100%	All

Response to the Poutasi review

Findings of the Poutasi review

The review found five critical gaps as follows:

- the needs of a dependent child when charging and prosecuting sole parents through the court system are not formally identified
- the process for assessing the risk of harm to a child is too narrow and one-dimensional
- agencies and services do not proactively share information, despite enabling provisions
- there is a lack of reporting of risk of abuse by some professionals and services
- the system's settings enabled Malachi to be unseen at key moments when he needed to be visible.

The findings were reported in December 2022, and echoed similar themes from previous child death reviews in Aotearoa New Zealand. Similar themes included a need for greater collaboration across agencies, better information sharing, and the need to build awareness and knowledge to better inform identification and reporting of child abuse at both a community and professional level.

Approach to the recommendations

At the time the Poutasi review was published, the Government accepted nine of the recommendations and committed to considering the remaining five[5]. A November 2022 Cabinet paper[6] noted that the recommendations could be categorised as:

- operational, or within the authority of Chief Executives to support and progress (recommendations 3, 4, 5, 7 and 13)
- requiring Ministerial and Cabinet approval and subsequent legislative amendments (recommendations 10, 11 and 12)
- subject to further consideration because of significant consequences that could arise from implementation (recommendations 1, 2, 6, 8 and 9).

The Cabinet paper invited the Minister for Children or other relevant Ministers to report back to Cabinet in 2023 on the recommendations that require Cabinet approval.

5 https://www.beehive.govt.nz/release/government-address-child-abuse-system-failings

6 https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Performance-and-monitoring/Reviews-and-Inquiries/System-review-Dame-Karen-Poutasi/CAB-22-MIN-0540-Final-report-by-Dame-Karen-Poutasi-on-the-death-of-Malachi-Subecz.pdf

The subsequent 2023 report to Cabinet [CAB 23 MIN 0398 refers][7] noted that eight of the 13 recommendations were more substantive because they involve a range of complexities, and/or may lead to significant change in the children's system. Oranga Tamariki established four across-agency working groups in early 2023 to prepare advice on these recommendations including:

- vetting and supporting caregivers (recommendations one, two and six)
- information sharing (recommendation seven)
- mandatory reporting (recommendations eight and nine)
- the children's system (recommendations 11 and 12).

Oranga Tamariki is also working with lead and supporting agencies to consider or progress the remaining five recommendations.

Although not all recommendations were accepted, the 2023 Cabinet paper directed agencies to continue to prioritise progressing each of the recommendations outlined in the Poutasi review, to ensure that the children's system responds with the speed and urgency required.

Oranga Tamariki co-ordinates updates on this work for the Minister for Children every six months. These updates are published on its website here: https://www.orangatamariki.govt.nz/about-us/performance-and-monitoring/reviews-and-inquiries/malachi-subecz-system-review/.

Closing the critical gaps

At the time of writing, none of the recommendations made by the Poutasi review had been fully implemented, although there was evidence of detailed planning underway in respect of most of the recommendations.

When we spoke with Oranga Tamariki national office, they told us that "work has not moved as quickly as Oranga Tamariki would have liked. An election and a change of government have impacted decision making processes". Oranga Tamariki also said that there is "significant complexity" behind some of the recommendations, which may appear straightforward, but have several potential unintended implications that require complex consideration and assessment before making policy decisions. Oranga Tamariki national office told us how important it is to get ministerial support across portfolios to achieve progress. In response to our information request, all agencies mentioned the need to get policy decisions in order for them to implement change.

7 CAB-23-MIN-0398-Report-to-Cabinet-on-the-progress-made-against-the-recommendations-of-the-Dame-Karen-Poutasi-system.pdf (orangatamariki.govt.nz)

Critical gap one

The needs of a dependent child when charging and prosecuting sole parents through the court system are not formally identified

The Poutasi review identified that tamariki of imprisoned sole caregivers can be in the care of another person without formal authority. This can be for long periods, without consideration for the child's safety or wellbeing. It notes that tamariki of people in prison are among our most vulnerable citizens. An imprisoned parent has very little real ability to check up on a child's care, or to follow up on a caregiver's ongoing suitability or treatment of the tamariki.

The Poutasi review found that when a sole parent is facing a custodial sentence it should be a red flag for risk.

Recommendation one

Oranga Tamariki should be engaged in vetting a carer when a sole parent of a child is arrested and/or taken into custody. NZ Police (or other prosecuting agency) in the first instance, and the Court in the second, will need to build into their processes time for this to occur.

Recommendation two

Oranga Tamariki should be engaged in regular follow-up checks and support for such an approved carer while the sole parent remains in custody. Resourcing must be addressed to enable this to occur.

The lead agency for both recommendation one and recommendation two is Oranga Tamariki, supported by the Department of Corrections, Ministry of Justice, and the NZ Police.

These recommendations were noted by Cabinet in 2022 as being subject to further advice because significant consequences could arise from implementation. Legislative change would be required.

Status: Not achieved

There has been little progress in vetting carers

NZ Police advised that its ***People in Police Custody*** policy already includes a section on "detainees with the responsibility for children or young persons". In relation to Malachi, NZ Police advised that as Malachi's mother had made arrangements for Malachi's care, there was no further role for the NZ Police in this instance[8].

Policy discussions over the past 14 months have focused on the appropriateness of vetting a carer chosen by the guardian of the child, and what happens if the checks produce information of concern. Work has also included consideration of whether follow up checks are required and what types of support are available for tamariki, caregivers, parent(s) in prison, and whānau. We were advised that this work is significant and complex and, depending on the approach taken, could take several years to progress.

We were told that agencies have engaged with whānau care partners, national care providers, members of the judiciary and the legal profession, young people with care experience and/or who have had a parent in prison, Pillars Ka Pou Whakahou (an organisation that supports tamariki and whānau who have a parent in prison) and caregivers of tamariki in and outside of state care. The purpose of the engagement was both to help inform the response, as well as to determine whether recommendations one and two should be implemented. What it highlighted is that there are a range of views on whether and how to implement these recommendations.

To fix a problem it is important to first understand the extent of it, however this remains unknown and progress to understand the number of carers in scope is slow.

We asked the Ministry of Justice how many times a sole parent or caregiver has been before the District Court on charges that could lead to a sentence of imprisonment since the review. The Ministry of Justice advised it could not provide this information because it is not recorded and there are no plans to change or update the case management system to record this.

The Department of Corrections was not able to tell us how many times a pre-sentencing report had been required for a sole parent requiring care for their tamariki since the review, or about any reports of concern to Oranga Tamariki as a result. It does not differentiate reports by whether they are for a sole parent. However, Corrections advised that the week before providing its response to us it made changes to its technology, which will enable it to record and report this information in future.

8 The investigation and prosecution was undertaken by the NZ Customs Service.

From our perspective efforts could have been made to understand the size of this issue. For example, as a first step Corrections could have sampled the current women's prison population to understand how many have children, and of those how many are satisfied with their children's care arrangements. The women's prison population is smaller than the men's prison population, so this would provide a starting point. Steps could then be taken to also understand this across the men's prison population to give an indication of the overall size of the issue.

We also asked the Ministry of Justice for an update on any process changes for sentencing of sole parents or caregivers. It told us that in late 2022 Judge John Walker formed the Primary Caregivers in Custody with Dependent Children working group. This cross-agency working group comprises members of the judiciary, the Ministry of Justice, the Department of Corrections, NZ Police, Oranga Tamariki, Public Defence Service, Crown Law, and the New Zealand Law Society.

Although not a direct response to the recommendations of the Poutasi review, the working group operates in parallel, and has identified several opportunities where, with consent from the defendant, judges can be made aware of the existence of dependent children. This could provide an additional opportunity to check on tamariki. As of February 2024, the Public Defence Service, Legal Aid Service and NZ Police had either updated or were in the process of updating forms to include a field asking about the existence of dependent children.

Agencies advise further analysis and policy decisions are required to progress recommendations one and two.

What we'll look for in another 12 months on critical gap one

When we next review progress we will be looking at whether, and how, agencies are routinely identifying and responding to the needs of dependent tamariki whose parent(s)/guardian(s) are arrested and/or taken into custody. This will include looking at the data that the Department of Corrections has recently started to collect, and how it is being used to keep tamariki safe.

Critical gap two

The process for assessing the risk of harm to a child is too narrow and one-dimensional

The Poutasi review found that at various points, the views of other agencies, as well as those of Malachi's whānau and community, should have been sought or shared by agencies so they could be considered in assessing and responding to Malachi's needs. This may have resulted in a decision by Oranga Tamariki to go and see Malachi.

Recommendation three

Multi-agency teams working in communities in partnership with iwi and NGOs, resourced and supported throughout the country to prevent and respond to harm. There are examples of this happening already across the country. Implementation in all localities must be a priority so that relevant local teams can help assess, respond to the risk to a child, and provide support.

The lead agency for recommendation three is Oranga Tamariki, supported by NZ Police, Ministry of Social Development, Ministry of Health, Health NZ – Te Whatu Ora, and Te Puna Aonui[9].

This recommendation was noted by Cabinet in 2022 as already being implemented. It is operational in nature or within the authority of Chief Executives to progress.

Status: Not achieved

9 Te Puna Aonui is an interdepartmental board which includes the Accident Compensation Corporation, Department of Corrections, Ministries of Education, Health, Justice, and Social Development, New Zealand Police, Oranga Tamariki and Te Puni Kōkiri. There are four associate agencies – the Department of Prime Minister and Cabinet, and the Ministries for Women, Pacific Peoples, and Ethnic Communities.

Multi-agency teams are not in place in all communities

Multi-agency teams as described in this recommendation are not in place in every community. Examples of existing or emerging multi-agency programmes are listed below. While it is important to have models of practice that fit individual communities, it is not yet known what the collective impact of these different models is having on child safety.

- *Te Aorerekura – National Strategy and Cross Agency Action Plan to Eliminate Family Violence and Sexual Violence,* hosted by Te Puna Aonui. Te Puna Aonui works in partnership with specialist sector, communities and iwi to systematically look at ways to improve coordination and enable a collective response to family and sexual violence.
- *The Integrated Community Response (ICR) Programme* is an essential part of delivering on Te Aorerekura and has supported localities to grow their infrastructure, capacity, and capability to run local multi-agency tables and responses. So far the ICR programme has supported eight locations with funding, advice and a co-learning support network. Further roll out will continue.
- *The Integrated Safety Response (ISR)*, hosted by NZ Police on behalf of Te Puna Aonui and *Whāngaia Ngā Pā Harakeke*, a partnership between NZ Police and local iwi Māori to respond to family harm, which are initiatives that reflect collaboration and collective responsibility that work to prevent and respond to harm.
- *The Enabling Communities programme* delivered under the Oranga Tamariki Future Direction Plan, which is working to restore and empower iwi and communities to lead the prevention of harm for tamariki, rangatahi and whānau.

NZ Police advised us that it has a network of Māori, Pasifika and ethnic teams across the country working in partnership with communities to address issues as they arise. NZ Police further advised that its Child Protection Teams work in partnership with partner agencies when responding to harm, with the Child Protection Protocol (CPP) as an example.

Recommendation four

Medical records held in different parts of the health sector should be linked to enable health professionals to view a complete picture of a child's medical history.

The lead agency for recommendation four is Health NZ – Te Whatu Ora.

This recommendation was noted by Cabinet in 2022 as already being implemented. It is operational in nature or within the authority of Chief Executives to progress.

Status: Not achieved

Linking of medical records is expected in 2026

Health NZ – Te Whatu Ora advised that the Hira programme[10] will give approved whānau and health providers a comprehensive view of a child's medical history and health system interactions. The new system will help health providers to monitor wellbeing indicators over time, regardless of where healthcare is accessed. It will give them secure, easy access to a child's 'real time' information when needed. This is still some years away.

Health NZ advised us that Hira is on track to have patient summaries available to individuals and their healthcare providers via My Health Record by mid-2024. While this technology will enable individuals, families, and whānau to view their information, including community dispensed medicines, vaccination status, entitlements (initially Community Services Card and High Use Health Card), laboratory results (initially Covid-19), and other data (for example allergies and conditions), it does not provide the linking of medical records recommended in the Poutasi review.

Work is also underway to provide a single national approach for sharing health information between authorised healthcare providers. This will enable consistent nationwide access to a child's primary care medical records. In her review, Dame Karen Poutasi noted:

> *"Medical records should be joined up, and whilst there are current health data and digital initiatives to do so, these should be expedited. Emergency departments, hospital, primary care and preschool Well Child Check records should be linked to facilitate the opportunity to detect child abuse and neglect. Malachi was seen at a health centre while he was carrying signs of abuse (albeit these were not visible through his clothes) and had experienced significant weight loss since his last Well Child Check".*

Development of a business case began in early 2021, before the recommendations of the Poutasi review. However, funding is only confirmed to complete tranche one of the business case by the end of June 2024. In order to complete tranches two and three, which will deliver on the intent of recommendation four, further funding will need to be approved. Assuming funding is confirmed, this work is then not expected to be implemented before 2026. It has not been expedited as recommended by the Poutasi review.

10 https://www.tewhatuora.govt.nz/our-health-system/digital-health/hira-connecting-health-information/

Recommendation five

The health sector should be added as a partner to the Child Protection Protocol between NZ Police and Oranga Tamariki to enable access to health professionals experienced in the identification of child abuse, and to facilitate regular joint training.

The lead agencies for recommendation five are the Ministry of Health and Health NZ – Te Whatu Ora, supported by Oranga Tamariki and the NZ Police.

This recommendation was noted by Cabinet in 2022 as supported in principle. It is operational in nature or within the authority of Chief Executives to progress.

Status: Not achieved

No decision has been reached on health involvement in the Child Protection Protocol

The Child Protection Protocol (CPP) is the agreement between NZ Police and Oranga Tamariki to work together where abuse or neglect is suspected. A regular review of the CPP that is currently underway has included targeted engagement with NZ Police and Oranga Tamariki kaimahi. This has provided information about the strengths and opportunities for improving the CPP, including experiences of accessing health expertise in child protection matters. It revealed that agencies felt able to access paediatric assessments and advice in urgent circumstances and when working under the CPP. Issues were identified with delays, and challenges at times accessing follow-up support.

The Poutasi review also identifies that the CPP requires joint annual training between Oranga Tamariki and NZ Police. Police told us that the existing training for Police investigators is supported by health providers. If Health were added to the CPP and all three agencies were to regularly train together, this could more formally ensure a shared understanding of how to draw on each other's strengths when responding to reports of concern about abuse of children.

We were advised that the review of the CPP is ongoing with an interim decision on how the health sector can be involved yet to be made. Options include full operational membership of the CPP, partial membership in areas such as governance, participation in review and training, and not joining in lieu of other measures that would support access to health expertise and services in the context of the CPP. Decisions are expected to be made by Chief Executives.

What we'll look for in another 12 months on critical gap two

When we next review progress we will be looking for evidence that a more holistic approach to assessing risk to tamariki has been implemented across the children's system, and to understand whether and what difference this is making for tamariki and their whānau.

Critical gap three

Agencies and services do not proactively share information, despite enabling provisions

The Poutasi review found that there was an urgent need to consolidate a whole picture of the risks for Malachi. Each agency had part of Malachi's reality, but none registered the red flags to bring it to each other.

The Oranga Tamariki Act 1989 already allows agencies and persons considered to be "child welfare and protection agencies, and independent persons" under the Act to share information to prevent or reduce the risk of harm to a child, or to assess risk. However, agencies and their services did not proactively share information.

Recommendation six

The Ministry of Social Development should notify Oranga Tamariki when a caregiver who is not a lawful guardian, and who has not been reviewed by Oranga Tamariki or authorised through the Family Court, requests a sole parent benefit or other assistance, including emergency housing support, for a child whose caregiver is in prison.

The lead agencies for recommendation six are Oranga Tamariki and the Ministry of Social Development, supported by the Department of Corrections, Ministry of Justice, and the NZ Police.

This recommendation was noted by Cabinet in 2022 as subject to further advice because significant consequences could arise from implementation. Legislative change would be required.

Status: Not achieved

Progress on recommendation six will first require decisions on recommendations one and two

Agencies advise that implementation of this recommendation is contingent on the policy decisions that are yet to be made in respect of recommendations one and two.

The Ministry of Social Development told us it can (and does) tell Oranga Tamariki when it considers tamariki to be in need of care and protection, and the law provides for this. However, application for a sole parent benefit, in itself, is not sufficient grounds to notify Oranga Tamariki. Therefore, it would need to have a clear purpose for sharing information, which may be provided through policy decisions in respect of recommendations one and two.

No change or progress has been made towards recommendation six.

Recommendation seven

The enhancement of understanding of the information sharing regime in the Oranga Tamariki Act 1989, to educate and encourage child welfare and protection agencies and individuals in the sector to share information with other child welfare and protection agencies on an ongoing basis.

The lead agencies for recommendation seven are Oranga Tamariki, the Department of Corrections, Ministry of Justice, NZ Police, Ministry of Social Development, Ministry of Health, Health NZ – Te Whatu Ora, and the Ministry of Education (the Information Sharing Working Group).

This recommendation was noted by Cabinet in 2022 as supported in principle. It is operational in nature or within the authority of Chief Executives to progress.

Status: Not achieved

Information sharing between agencies remains an issue

We know that reports of concern from government agencies to Oranga Tamariki are already high, and this is a form of information sharing. Of the approximately 80,000 reports of concern received annually across all notifier types, around 20,000, or a quarter of these are made by the NZ Police[11]. In addition, health agencies and schools make around a further 10,000 reports respectively each year. However, we also know that not all of these reports are progressed for further action by Oranga Tamariki. This raises two questions. First, is the level of reporting enough? Improved education and training across the sector could help provide confidence in this regard. We discuss this further under critical gap four. Second, is Oranga Tamariki making the right decision on which cases require them to engage with tamariki and their whānau to assess their safety? We address this question later in our report.

However, we also know from our ongoing monitoring that information sharing between agencies is a problem more broadly. Agencies advise the legal basis to share information is not at issue, but rather it is a lack of clarity at the frontline. All agencies leading the response to recommendation seven are child welfare and protection agencies that are able to share information under section 66C of the Oranga Tamariki Act 1989, to support the safety and wellbeing of tamariki and rangatahi.

11 This does not include reports of concern from the NZ Police related to family violence, which are recorded separately by Oranga Tamariki.

The Information Sharing Working Group has agreed to, but not yet implemented, a range of actions to ensure frontline staff at relevant agencies understand and use the information sharing provisions through:

- delivering updated information sharing guidance, communication, and other resources to frontline staff so that there is shared advice and clear understanding about information sharing. For example, ongoing learning and development opportunities for professional groups
- highlighting information sharing work in regional leadership meetings that reach a range of stakeholders, convened by Regional Public Service Commissioners. Oranga Tamariki is working with the Regional Public Service office to support this action by providing communications through their regular newsletter, attending monthly hui, and linking resources.

In addition, in March 2024, the Government Chief Privacy Officer released guidance on the development of information sharing agreements. This guidance could support an improved understanding by agencies of how to share information to better protect tamariki.

What we'll look for in another 12 months on critical gap three

When we next review progress we will look to see how information is shared between agencies at the frontline, and whether and what difference this is making to improve the safety of tamariki. This is also something that we consider as part of our annual reporting on compliance with the National Care Standards.

Critical gap four

There is a lack of reporting of the risk of abuse by some professionals and services

The Poutasi review noted that the childcare centre Malachi attended had a policy requiring the reporting of child abuse, but they did not follow this despite having and documenting concerns for him. The review further noted that across professional groups the reporting and feedback process is not well understood and it is therefore likely that harm and abuse is under-reported.

Recommendation eight

Professionals who work with children should be **mandated to report suspected abuse to Oranga Tamariki**. This should be legislated by defining the professionals and service providers who are to be classed as 'mandatory reporters', to remove any uncertainty around their obligations to report.

Recommendation nine

The introduction of mandatory reporting should be supported by a **package approach that includes**:

- **a mandatory reporting guide** with **a clear definition of the red flags** that make up a high-risk Report of Concern, together with the creation of a 'High Report of Concern' category similar to New South Wales 'Risk of Significant Harm' definition
- **defining mandatory reporters,** all of whom should receive regular training
- **in addition, for professionals deemed to be mandatory reporters, there should be:**
    - **undergraduate courses teaching risks and signs of child abuse**
    - **mandatory regular updated training** regarding their responsibilities and the detection of child abuse, with practising certificates conditional on training and refreshers.

The lead agency for both recommendation eight and recommendation nine is Oranga Tamariki, supported by the Department of Corrections, Ministry of Justice, NZ Police, Ministry of Social Development, Ministry of Health, Health NZ – Te Whatu Ora, Te Aka Whai Ora, the Ministry of Education and the Education Review Office (the Mandatory Reporting and Training Working Group).

These recommendations were noted by Cabinet in 2022 as subject to further advice because significant consequences could arise from implementation. Legislative change would be required.

Status: Not Achieved

It is not clear what impact mandatory reporting would have in Aotearoa New Zealand

Introduction of mandatory reporting would require legislative change. The Mandatory Reporting Working Group undertook targeted engagement from July to September 2023. The engagement tested initial responses to the recommendations in the Poutasi review. It sought to identify what a mandatory reporting regime could look like and identify other options to support professionals to recognise and respond to abuse.

Oranga Tamariki advised that there are strong views both for and against mandatory reporting, with limited consistency in those views within and across sectors. Feedback to date indicates that a broad and systemwide response is required to raise awareness and respond to child abuse. Mandatory reporting, if pursued, must be only one part of a broader national strategy.

We have heard of concerns about what mandatory reporting may mean. They include potential over-surveillance of Māori and Pacific tamariki and whānau. We also heard that it could risk over-reporting. The Poutasi review considered these risks, and recommended that if implemented, mandatory reporting should be supported by regular training and a mandatory reporting guide as ways to mitigate the risks.

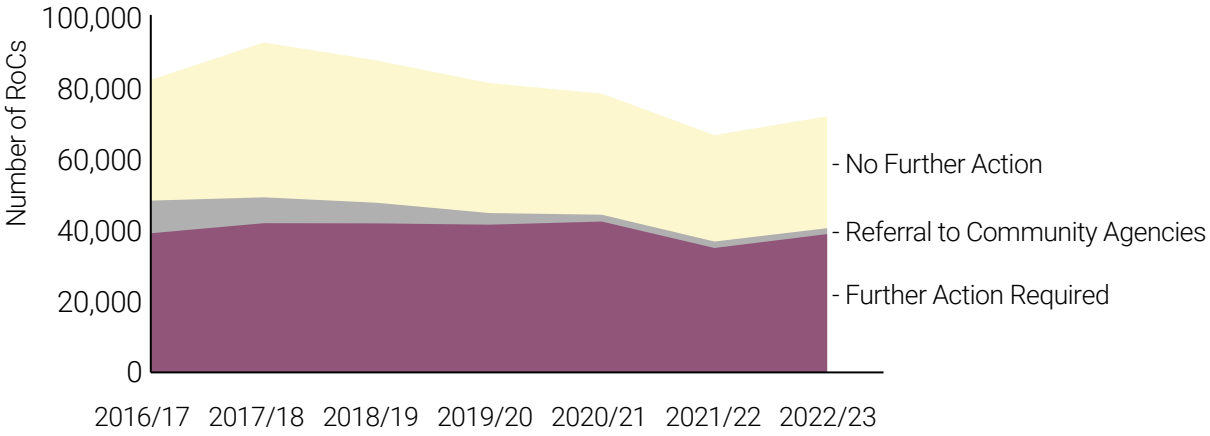
While the response from Oranga Tamariki shows significant thought has gone into considering recommendation eight, there is little detail on the response to recommendation nine around training and what to look for when determining whether to make a report of concern.

To help us put this work in context, we asked Oranga Tamariki to provide data on reports of concern it received, by notifier type, from across financial years from 2016/2017 to 2022/2023. The data shows that since 2016/2017, around 80,000 reports of concern have been received each year for around 58,000 tamariki. This equates to reports of concern for approximately 5 percent of the current child and youth population, with 1.2 million people aged 18 and under in Aotearoa[12].

12 This figure is based on the 2018 New Zealand census from data available on the Stats NZ website, (stats.govt.nz)

Graph 1: Annual Reports of Concern and Oranga Tamariki response

While there is variation in the number of reports of concern, consistently around 40,000 per year result in further investigation.



Reporting had been decreasing since 2017/18, with the lowest number of reports made during 2021/22. In 2022/23 the number of reports increased again towards the reporting numbers seen before the Covid-19 pandemic. Across this time, regardless of changes in reporting frequency, the number of cases that Oranga Tamariki progresses to assessment or investigation (where the child should be sighted) remains largely the same. Each year from 2016/17 to 2022/23, around 40,000 reports of concern were progressed to an assessment or investigation[13].

Recent analysis by Oranga Tamariki[14] shows that the largest decreases in the numbers of reports of concern made to Oranga Tamariki are those from professional/government notifiers. Although the analysis cannot pinpoint why this is, it does not attribute it to a reduction in need. However, it notes that a reduction in child poverty rates may have improved wellbeing of tamariki. The Oranga Tamariki report noted that decreasing trust among some professionals that Oranga Tamariki will respond, and long response times at the National Contact Centre, were contributing to the decrease in reports of concern being made. This is a further challenge to overcome to improve reporting of child protection concerns.

13 Throughout this report, unless specifically stated otherwise, we refer to the number of reports of concern progressing to assessment or investigation (Further Action Required; FAR) based on the final decision made by Oranga Tamariki sites. This final site decision is subsequent to the much higher number of initial FARs made at the National Contact Centre.

14 https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Research/Latest-research/Analysis-of-the-decrease-of-Reports-of-Concern/Analysis-of-the-decrease-in-Reports-of-Concern.pdf

While undertaking this review, we spoke with officials in Australia, to better understand the experiences with mandatory reporting there. At the time of the Poutasi review, New South Wales Child Protection Services had recently introduced mandatory reporting and this was held up as a success. When we spoke with officials in New South Wales we heard that things have changed since then. While reports of concern initially decreased after the introduction of mandatory reporting, they have subsequently increased year on year, to the point where officials describe themselves as "drowning". They told us they have too many reports of concern coming in the door that do not require a statutory response and this is placing pressure on their resources and making it harder to see the "wood for the trees".

Similarly, in Victoria which also has mandatory reporting, we heard that their Child Protection Services have a similar challenge in managing workloads.

We heard that Oranga Tamariki is already struggling to address the number of reports of concern it receives. In the context of the recommendation to introduce mandatory reporting, this leaves two apparent options:

- further resource/reprioritise existing funding within Oranga Tamariki (as well as take opportunities to streamline processes and remove duplication) along with improved funding for community organisations, and/or
- improve education and training for professionals and service providers around the identification and reporting of child abuse.

Recommendation 10

There should be active monitoring of implementation by early childhood education services of their required child protection policies to ensure they are providing effective protection for children. Therefore, the Ministry of Education and the Education Review Office should jointly design and administer a monitoring and review cycle for the implementation of child protection policies in Early Learning Services.

The lead agency for recommendation 10 is the Ministry of Education, supported by the Education Review Office.

This recommendation was noted by Cabinet in 2022 as accepted in principle, subject to Cabinet decisions and with further advice to be provided. It requires Ministerial and Cabinet approval and subsequent legislative amendments.

Status: Not achieved

Early learning services are already required to have child protection policies, and ERO check for this

The Ministry of Education confirmed that early learning services are required to have a written child protection policy that meets the requirements of the Children's Act 2014 when applying for a licence, and again when moving from a probationary licence to a full licence.

Early learning services are also required by the Ministry of Education to review their child protection policies every three years and the Education Review Office (ERO) checks compliance on a three-yearly cycle. This includes looking at how early learning services manage areas such as emotional and physical safety which have a potentially high impact on tamariki wellbeing.

There are working protocols in place that outline how ERO and the Ministry of Education work together when likely non-compliance is identified. Any shortfalls in compliance with child protection requirements are a serious risk and are escalated for a response by the Ministry of Education's front-line licensing teams.

ERO provided recent data on non-compliance in relation to child protection identified in early learning services in relation to:

- whether early learning services have a procedure for safety checking all children's workers, compliant with the Children's Act 2014
- whether early learning services have a written child protection policy which is compliant with the Children's Act 2014.

The data from ERO shows that it is identifying a slight increase in instances of non-compliance with these legislative requirements in early learning services. In the six months between July and December 2023, it found 108 instances of non-compliance with safety checking children's workers and home-based service families, and 17 instances where a centre did not have a written child protection policy compliant with the Children's Act. This compares with 160 and 40 non compliances respectively for the 12 months from July 2022 to June 2023. This suggests that some services do not have a comprehensive understanding of the requirements of a robust child protection policy. ERO also told us that its staff have all undertaken recent professional learning with a focus on safeguarding children, which has heightened awareness of these areas when evaluating early learning services.

Reports of concern from Early Childhood Education providers have increased, however barriers to reporting remain

While monitoring compliance of child protection polices is important, it is arguably more important that early learning services know when and how to raise concerns.

When we spoke with Oranga Tamariki kaimahi about any change in reporting practices from Early Childhood Education (ECE) providers, they said that the Poutasi and agency reviews have affected the attitudes of some ECE providers and other organisations, making some overly cautious and reactive, while others take a long time to report allegations of abuse or neglect.

We heard that some Oranga Tamariki sites are proactively engaging with and providing training to support ECE providers understanding of abuse and when to report concerns to Oranga Tamariki.

> *"I'm starting to make good connections; they call and ask for advice and information." – site kaimahi*

Some kaimahi talked about working with Child Matters to provide training for local ECE providers on child protection. While this is not the responsibility of Oranga Tamariki, we heard it has helped improve the quality of reports of concern received from ECE providers. However, we heard that attendance is based on ECE staffing capacity, with only some sessions having a good number of attendees.

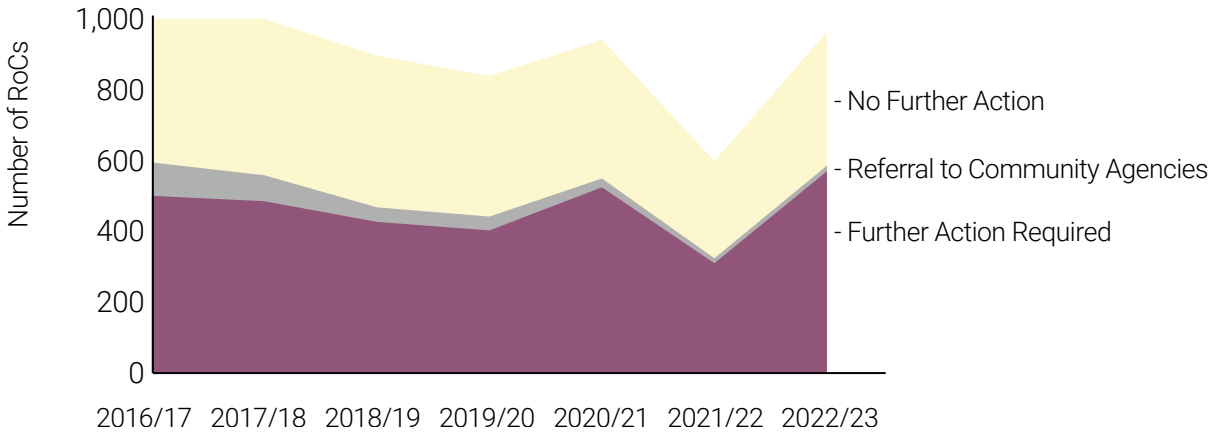
> *"The willingness is there but their staff are stretched too." - site leadership*

Despite these concerns, the number of reports of concern from the ECE sector has increased since Malachi died.

Data from Oranga Tamariki shows that the numbers of reports of concern from ECE providers were at their lowest at the time of Malachi's death in 2021/22 and have since increased towards the numbers seen in 2016/17. The proportion of reports where further action is taken remains largely the same, irrespective of the number of reports.

Graph 2: Annual reports of concern from the early childhood education sector and the Oranga Tamariki response

The proportion of reports where further action is taken remains steady, irrespective of the number of reports.



The Ministry of Education and ERO have taken steps to understand barriers to reporting, but work to address these barriers is still to be done

As a first step to understand this better, the Ministry of Education and ERO sought feedback from the ECE sector throughout 2023. This included teachers, service owners, and internal staff and helped both agencies understanding of the barriers to effective implementation of child protection policies. For example, there was consensus from the ECE sector that it would be helpful to understand the roles of the Ministry of Education, ERO and Oranga Tamariki in child protection, along with training as part of their qualification, and more practical information on how to talk with parents about their concerns and managing these difficult conversations.

In addition, the Ministry of Education and ERO have subsequently developed a work plan. This includes a strengthened review cycle and a range of other actions to enhance and support child protection in ECE. The work plan is subject to final approval and resourcing decisions which will be confirmed once the Ministry of Education has finalised its savings programme. Some of the recommended changes to strengthen the review cycle are also dependent on regulatory setting change. The Government has announced its intention to carry out an ECE regulation sector review this year, which may impact on this work.

The Ministry of Education and ERO advise that, while developing the work programme, they have:

- publicised the Ministry of Education's child protection training module to the sector through different channels and networks, including the Ministry of Education's He Pānui Kōhungahunga | Early Learning Bulletin, leading to an 85% increase in the number of people completing the module in 2023 (7,291 people)
- promoted and supported greater awareness about how to report child protection and safety concerns, along with developing and sharing a clearer understanding of the roles and responsibilities of key agencies in this.

The Ministry of Education and ERO advise they will continue raising awareness of the training module and how to report concerns as other work progresses in 2024.

We asked Oranga Tamariki national office if it had a national plan or strategy for working with ECE providers on policies, practice, and when to report concerns, or if it had given any advice to sites on working with ECE providers.

National office kaimahi told us that this was not something that had been identified as part of its work plan and that they were not aware of a consistent approach to working with ECE providers around the country. We were told that engagement with ECE providers was not something that had been identified as a key prevention mechanism.

What we'll look for in another 12 months on critical gap four

When we next review progress against the recommendations, we will look for evidence of how children's agencies are working together to identify cases that need to be referred to Oranga Tamariki. This will include how agencies are working together to proactively respond to whānau to prevent needs escalating to require a statutory response. We will also look for progress on the proposed regulatory changes by the Ministry of Education and Ministry of Regulation, and the impact this has on reviews undertaken by ERO. In particular, if reviews undertaken by ERO show reduced issues with compliance related to child protection.

Critical gap five

The system's settings enabled Malachi to be unseen at key moments when he needed to be visible

The Poutasi review found that the system settings allowed Malachi to be invisible. He did not have a voice and was not seen or focused on by professionals working within the children's system. It notes that there were those who tried to act but were not listened to, those who were uncertain and did not act, and those who knew and chose not to act.

Recommendation 11

The agencies that make up the formal Government's children's system **should be specifically defined in legislation.**

Recommendation 12

These agencies should have a specific **responsibility included in their founding legislation** to make clear that they share responsibility for checking the safety of children.

The lead agency for both recommendations 11 and 12 is Oranga Tamariki, supported by the Department of Corrections, Ministry of Justice, NZ Police, Ministry of Social Development, Ministry of Health, Health NZ – Te Whatu Ora, and the Ministry of Education (the Children's System Working Group).

These recommendations were noted by Cabinet in 2022 as accepted in principle, subject to Cabinet decisions and with further advice to be provided. They require Ministerial and Cabinet approval and subsequent legislative amendments.

Status: Not achieved

Responsibilities of children's system agencies are clear, but may not be being routinely implemented

We were advised that the Children's System Working Group produced a report clarifying the existing children's system in Aotearoa New Zealand, including statutory accountabilities relating to child wellbeing and protection. It concluded that the existing formal children's system has a range of opportunities to improve child safety, including:

- reviewing the membership of the formal children's system, including children's agencies, agencies required to have child protection policies, agencies required to conduct safety checks of children's workers, and child welfare and protection agencies
- strengthening cross-agency practice of how these statutory obligations, particularly child protection policies, are implemented
- exploring options for what a cross-system responsibility to check on the safety of children could look like in practice (and the corresponding legislative options)
- strengthening practice in how the system provides early intervention support to children and young people before the point of involvement with Oranga Tamariki.

The Children's System Working Group is now preparing a report on potential activities to address the identified gaps in the children's system to better prevent, recognise, report and respond to child abuse.

Under the Children's Act 2014, agencies that deliver children's services have a range of statutory accountabilities to ensure, support and improve the safety and wellbeing of tamariki. In particular, prescribed agencies are required to have a child protection policy. A child protection policy is a document describing the process that the organisation uses to identify and report child abuse.

Under the legislation, these child protection policies must be available on agencies' websites and must be reviewed every three years.

We were interested in whether and how children's agencies are meeting their statutory responsibilities to identify and report child abuse. To this end we asked the agencies we reviewed if they have a current child protection policy that is compliant with the Children's Act. Only two of the agencies we reviewed have a current child protection policy. The other agencies advised that their policies are currently under review, despite planned reviews being overdue, in some cases by many years. The table at Appendix A sets out agencies' compliance in more detail. While not having a current child protection policy does not mean agencies are not fulfilling their responsibilities to identify and report on child abuse, it does suggest that this may not be a priority for those agencies whose policies are not up to date.

Recommendation 13

Regular public awareness campaigns should be undertaken so the public is attuned to the signs and red flags that can signal abuse and are confident in knowing how to report this so children can be helped. Aotearoa society needs to hear the message 'don't look away'.

The lead agency for recommendation 13 is Oranga Tamariki, although it is acknowledged that it needs to be supported by a multi-agency approach.

This recommendation was noted by Cabinet in 2022 as accepted. It is operational in nature or within the authority of Chief Executives to progress.

Status: Not achieved

A public awareness campaign has not yet been developed

Oranga Tamariki advised that public awareness campaigns will be an ongoing programme of work, and ideally become part of business-as-usual operations. It noted that budget constraints pose a risk for this recommendation and accordingly it is exploring other opportunities to advance child abuse prevention messaging. Oranga Tamariki is developing an awareness-building content stream on its external platforms where it can utilise existing content that may have been developed by sector and/or community partners. Despite accepting this recommendation in 2022 and being within the authority of the Chief Executive to progress, no public messaging or awareness has been progressed in response to this recommendation.

What we'll look for in another 12 months on critical gap five

We will be looking to see how the system is responding to put the needs of tamariki front and centre, and what impact this is having for tamariki and their whānau. This will include how children's system agencies are working together and fulfilling their responsibilities. Ultimately, we will be looking to see how the system prioritises the needs of tamariki and makes them more visible.

Agency reviews

The six agencies that commissioned the Poutasi review each also completed their own reports into their interactions – direct and indirect – with Malachi, his mother, wider whānau, and Ms Barriball. In this section we look at each of those agency reviews, the recommendations arising from them, what has been done in response, and what has changed as a result. This is set out in broadly the chronological order in which each agency was involved, although we note there were overlaps in when agencies were respectively engaged.

Oranga Tamariki

Reports of concern

How Oranga Tamariki receives, records and responds to reports of concern is important context for understanding its response to Malachi, and the subsequent changes it implemented.

When agencies or members of the public have concerns for the safety and/or wellbeing of tamariki, they can either call, or email/fax/mail the Oranga Tamariki National Contact Centre (NCC) or go into an Oranga Tamariki site to discuss their concerns. They can also contact NZ Police. These become reports of concern when the information is assessed to meet the definition under section 15 of the Oranga Tamariki Act.

If a report is not considered by Oranga Tamariki to meet the definition under section 15, it may instead be recorded as a contact record. Information may also be added as a case note for open cases, including where there is additional information relating to concerns that are already being assessed or investigated.[15]

Oranga Tamariki carries out an "initial assessment" on all reports of concern. This is to determine what response is required.

In response to our information request, Oranga Tamariki told us that since late 2021, it has gradually centralised responsibility for initial assessments. It told us that most initial assessments are now completed by the NCC (approximately 75 to 80 percent of all initial assessments, across 42 of the 60 Oranga Tamariki sites nationwide)[16]. However, cases where it is clear that tamariki require further assessment, such as critical or very urgent reports of concern (48- or 24-hour timeframes) and those cases that require an investigation under the CPP go directly to sites with little work done on the initial assessment.

An initial assessment can include contacting the person making the report of concern, as well as others, to develop an understanding of the needs and vulnerability of the tamariki, and to develop a chronology.

15 https://practice.orangatamariki.govt.nz/core-practice/practice-tools/intake-decision-response-tool/recording-decision-responses/

16 In response to our information request, Oranga Tamariki advised that sites who complete their own assessments are: Kaitaia, Whangārei, Rotorua, Taupō, Whakatāne, Gisborne, Taumarunui, Tararua, Porirua/Kāpiti, Lower Hutt, Wellington, Blenheim, Nelson, Rangiora, Ashburton, Timaru, and Oamaru.

Decisions on initial assessments may be that no further action is required, to refer the child to a community agency, or that either a child and family assessment or an investigation under the CPP is needed. The phase of assessment that further investigates a report of concern after initial assessment is called "core assessment". The site may subsequently decide to overturn an initial assessment decision made by the NCC and instead refer the child to a community agency or determine that no further action is required.

Reports of concern to Oranga Tamariki about Malachi

On 21 June 2021, Malachi's mother asked Michaela Barriball to have care of Malachi.

On 22 June 2021 Malachi's cousin went into an Oranga Tamariki site to make a report of concern about Malachi. The site entered the information and transferred it to Te Āhuru Mōwai site for initial assessment. The next day, after Malachi's cousin called the social worker back with further information, a case note was added to the report of concern to note the additional information provided. On 28 June, Malachi's cousin contacted the duty social worker at Te Āhuru Mōwai site to provide further information, including that she had a photo that she thought showed bruising around Malachi's eye. On the advice of the social worker, Malachi's cousin emailed the photo to the NCC and asked for it to be attached to the report of concern.

On 29 June, the report of concern was allocated to a social worker at Te Āhuru Mōwai site to complete the initial assessment. The social worker allocated was the same social worker who had spoken to Malachi's cousin the day before. In reviewing the information in the report of concern, the social worker determined that while Malachi had unmet needs, there were no care and protection concerns for him and determined no further action was required by Oranga Tamariki. The following day, this decision was signed-off by a supervisor.

The social worker contacted Malachi's cousin to advise of the decision and recorded a case note on CYRAS.

At the time of making the initial assessment decision, it was not standard practice for Te Āhuru Mōwai site to make referrals to agencies for support as part of an initial assessment. Accordingly, there was no referral, and the report of concern was closed with no further action.

Following Malachi's death, the Office of the Chief Social Worker in Oranga Tamariki undertook a practice review looking at how Oranga Tamariki responded to the reports of concern made for Malachi.

What the Chief Social Worker's review found

The Chief Social Worker's review identified four areas which contributed to Oranga Tamariki failing to provide Malachi and his whānau with the right response. Those four areas are:

- the practice guidance, professional development, and inter-agency processes which require strengthening to support social workers to consistently recognise and respond to the complex needs of tamariki and whānau
- practice decision making that fell short of what was required to deliver a quality service to Malachi and his whānau, including the decision not to progress the initial assessment to an assessment that involved seeing Malachi
- the wider community and system which did not communicate or respond in a connected way using a locally-led, partnered approach to the initial report of concern
- the site environment, support and leadership which impacted on the ability of social workers to deliver best practice.

In response to the Chief Social Worker's practice review, in November 2022 the Oranga Tamariki Leadership Team – Te Riu published a response that outlined what had already been done, and what more would be done over the next six months. The response included 30 recommendations to address immediate issues, 11 which had already been addressed, and 19 which were to be completed between December 2022 and May 2023. At the time of our review, Oranga Tamariki advised that all 30 recommendations in the initial response were complete, and that broader issues would continue to be taken forward through the Future Direction Plan and broader change programme.

We wanted to understand if the changes made in response to the Chief Social Worker's practice review are achieving the intended impact. To this end we engaged with kaimahi from Oranga Tamariki in the NCC, sites across the Auckland, Bay of Plenty and Canterbury regions, and in national office. Much of what we heard, aligned with what the Ministerial Advisory Board heard and reported on in its 2021 report *Kahu Aroha.*[17]

Most of the Chief Social Worker's review focused on practice at site. Despite Oranga Tamariki advising that initial planned actions to implement it have been completed, we heard that practice at the sites of the social workers we spoke with, has not yet substantively changed for them. This is because some of the planned actions are focused on addressing symptoms such as reminding staff about using practice guidance, one-off training opportunities and reviewing tools on performance development. While these are important ways to improve practice, if the root causes of practice issues are not addressed, only limited change can occur. Oranga Tamariki told us it is also trying to create broader change through the practice shift. We discuss this further below.

17 SWRB082-OT-Report-FA-ENG-WEB.PDF (beehive.govt.nz)

Practice guidance, professional development and interagency processes

The practice guidance, professional development, and inter-agency processes which require strengthening to support social workers to consistently recognise and respond to the complex needs of tamariki and whānau.

Status of response: Oranga Tamariki advise this is complete

The Chief Social Worker's review identified some gaps in existing practice guidance, professional development, and processes for working with partner agencies about responding to reports of concern. The review found that it is likely these gaps contributed to limited engagement with others (including Malachi and his whānau) during the initial assessment, a failure to recognise underlying factors which may have impacted on Malachi's care, and a lack of consultation with other professionals, particularly around the possibility of physical abuse.

Changes to practice guidance may be minimising child safety

Oranga Tamariki told us that in response to this finding it undertook reviews of policy and guidance and made several changes to strengthen practice. The intent of the changes was to ensure there is clear direction about recording and assessment of photographs and other 'additional information' received following an initial report of concern. This was to ensure that Oranga Tamariki responds to reports in a way that is consistent with legislation and best practice expectations.

Changes were made to the initial assessment phase guidance, including broadening who can be contacted at this point, to determine whether a core assessment is required. Current guidance on the Oranga Tamariki Practice Centre now says:

> *…in some circumstances it may be appropriate to speak directly with tamariki, whānau or family as part of our initial assessment. Understanding how whānau or family see the situation for te tamaiti, whether they have concerns or are stepping in to provide support, can help us reach a decision about the appropriate response.*

> *It may also be appropriate to gather information related to the notifier's concerns from other agencies (such as schools, early childhood educators, health professionals, NGO providers and iwi) who know te tamaiti and their whānau or family. We may also receive information from the notifier or another concerned person who proactively contacts us after the initial report of concern with information they believe is important. This may include visual information such as photographs.*

The purpose of this change was to allow social workers to gather more information during the initial assessment. This change could improve decision making, provided risks associated with contacting parents and whānau at this stage are managed. However, there does not appear to be any further guidance around assessing the risk of doing this. We also heard from Oranga Tamariki kaimahi in sites that although in many cases parents are now contacted during an initial assessment, tamariki are not spoken to or seen. While the practice change may have increased engagement with parents, feedback from kaimahi we spoke with suggests it has not increased the visibility of the child in the decision-making process.

A consistent concern we heard from the social workers and supervisors we spoke with was that tamariki are not at the centre of decision making. We heard how the practice shift, while positive in some respects, seems to conflict with the child protection lens. We also heard that those working for Oranga Tamariki and their colleagues in community and government agencies are not clear about the role of Oranga Tamariki.

> *"There is also a lack of basic understanding of our statutory role. We have great social workers that have come from community, but they don't get the statutory part of the job." - site leadership*

Kaimahi recognised the importance of whānau, and including them in decision making, but they felt that Oranga Tamariki had "gone too far", and there is no longer a sufficient focus on the safety of the child and keeping the holistic needs of the child at the centre of decisions. They felt that their role as statutory social workers was less clear, and this was reflected in training they receive. This was a concern raised in 2021, by the Ministerial Advisory Board's report *Kahu Aroha*.[18]

> *"When we are talking about the new learning courses, it's had a focus on see and engage, whakawhanaungatanga. It took away from the core statutory focus. People say whānau-led, whānau-led, you can be whānau-led but you still have to assess safety and risk, what is your statutory role, what is it we have to do? While all this learning has been good, it's taken away the purpose of statutory work." – site kaimahi*

The Poutasi review was clear that for government sector agencies, tamariki are not always at the centre of the identification of and response to child abuse. This includes Oranga Tamariki (the agency at the heart of child abuse identification and response) which also failed to detect red flags and prioritise Malachi's safety.

18 SWRB082-OT-Report-FA-ENG-WEB.PDF (beehive.govt.nz) pp 31

> *"Malachi did not have a voice: he was not seen or focused on. We should have a child protection system that, across multiple agencies and our society, looks at and listens directly to the needs of the child themselves rather than just the adults around them. Children must be given a voice across the system that is intended to support their needs and that seeks to describe itself as child centred. We need to turn this aspiration into a reality." - Poutasi review*

This issue is not new. The Poutasi review identified eight previous reviews that were particularly relevant, that highlighted similar circumstances and gaps in the system. Of particular relevance is a Chief Social Worker Review into the deaths of Olympia Jetson and Saliel Aplin which found a lack of focus on the child and decisions to work through adults and parents when determining whether a child was at risk.

> *"Whenever a notification of abuse is received, the first step is to secure the safety of the child, before beginning any investigation. This recognises that the very process of investigation, making enquiries and gathering information, may endanger a child. The process of inquiry, the asking of a question, conveys the issue at the heart of the inquiry. Care must be exercised when communicating the reason for the inquiry." - Review 2003*[19]

What we heard in our engagements, particularly in the Bay of Plenty region, is that the invisibility of tamariki in the system has not changed:

> *"It's a flash in a pan, everything comes out then we forget about it. Wheels keep on turning, then we lose focus on all the reports. Tamariki should be at the centre of everything. Currently, I don't see tamariki at the centre, they're not even on the table. I got some practice notes, they come out, but we should be living them, but we've drifted away from tamariki."*
> *– site leadership*

Overall, what we heard from kaimahi was that they felt best practice has shifted towards emphasising organisational values, and relationship building.

Oranga Tamariki national office told us that while it is aware that in some areas, interpretations of the practice shift suggest it is defaulting to entirely whānau-led decisions with a reduced emphasis on safety or risk, this is not an accurate reflection of the practice shift, or training.

19 Report into the involvement of the Department of Child, Youth and Family Services with Olympia Jetson and Saliel Aplin, 2 April 2003

National office leadership advised us *"the scale of change required is significant, as was identified in the Ministerial Advisory Board's 2021 report Hipokingia ki te Kahu Aroha Hipokingia ki te Katoa and the journey to fully introduce and embed this approach is not yet complete. Some sites and regions are at different stages in their learning and understanding and more work is needed to ensure all staff understand how to apply the practice approach within the context of their statutory role. However, most staff are seeing the value in the practice approach, including that it is enabling them to respond differently and more comprehensively to issues of child safety and risk in their practice whilst also working in ways that build strengthened relationships with whānau".*

National office assured us that assessment and practice places a view of risk within the broader context of the child's wellbeing. It explained that some of the sites and regions we visited have not implemented training to support the new "oranga framing" to the same extent as others. We did hear from the sites we visited that they do work to the practice standards and the oranga framing, as much of it is "what social workers already do", and it is just re-packaged.

Despite this explanation from Oranga Tamariki national office, it was apparent that the views of the kaimahi in the sites we visited were that practice had shifted to a whānau focused rather than whānau informed approach. Regardless of the intent behind the policy or guidance, if this is not understood by the frontline, it results in a failure of implementation.

We heard induction and training are not adequately supporting some social workers

Oranga Tamariki told us its Puāwai induction training and Leaders in Practice professional development programmes were launched in January 2023. In addition, work was undertaken to develop additional learning resources for all practice staff, ensuring that the critical learning needs identified in the Chief Social Worker's practice review are embedded within the core curriculum. The intent of this work was to support social workers to consistently recognise and respond to the complex needs of tamariki and whānau.

Oranga Tamariki national office leadership told us that *"the introduction of the new practice approach has been coupled with a focus on strengthening our learning and professional development offer through programmes such as Pūawai induction for new social workers, a leaders in practice programme, the postgraduate kaitiakitanga bicultural supervision programme, fortnightly site based learning referred to as He Akoranga and a range of additional learning opportunities supported through the Chief Social Worker's development fund."*

National office advised us it has received extensive feedback from kaimahi who have completed learning cycles, who have provided compelling feedback about the benefit of the training to their work.

We were told that as Oranga Tamariki *"reset a learning and development culture within the organisation, some kaimahi have indicated that it is difficult to find the time and space to participate fully in all learning and some may feel there are still gaps in the learning offer. Overwhelmingly, most of those who have participated in these learning opportunities across the country are seeing them as valuable, have acknowledged an increased investment in their development and can describe clearly how their approach to practice is changing as a result of new learning"*.

However, across sites in the Auckland and Bay of Plenty regions, most of the social workers and site leadership we spoke with told us that the induction and training does not adequately prepare or support social workers for the work they need to do. We heard that previous induction programmes better prepared kaimahi for the realities of the job.

One kaimahi said they liked how the induction training let them meet kaimahi from other sites and see other sites' different practices.

Another kaimahi told us their high workload makes it hard for them to be invested in training, especially when they don't feel the training is relevant to their mahi. One leader told us that kaimahi spend too much time on training and personal improvement when they should be focusing on their work in the community. They felt there is currently too much focus on the kaimahi themselves, rather than on those they work with.

We heard positive feedback about fortnightly practice forums led by practice leaders and based on site need or reviews. We were told that most of the sessions are topics on tamariki in care, with very little about intake and assessment. One kaimahi suspected this is because there are not many reviews about the intake and assessment process.

NCC kaimahi have their own induction programme and NCC staff often rely on others throughout the organisation to share learning. In some instances, they have created their own tools to support practice.

> *"Since I've come on board, we been looking at our NCC induction because our social workers don't go to our national [Oranga Tamariki] induction program." – NCC leadership*

> *"With national office, we almost have to make our own process systems and induction. We look at how they are run. There are gaps, building those relationships but again have you considered us, we are specialist with after hours, but you don't even have us sitting at the table." – NCC leadership*

We asked kaimahi how they had been made aware of the practice standards, how they are being implemented and how they know they are achieving them. The kaimahi we spoke with about the practice standards were aware of them. Some felt that they naturally implemented the practice standards into their work.

> *"The practice standards are common sense and basic social work."*
> *- site leadership*

> *"We are starting to incorporate those [practice standards] concepts. The differences between the office is not much anyway, because the work is still being done. If we applied the practice framework to a lot of the cases we worked, a lot of the work is being done [as per the practice standards]."*
> *– site leadership*

We were told that sites receive regular training on the practice standards, but this was not universally considered helpful. Some kaimahi told us they would rather have training on specific practices relevant to their work and incorporate the principles into those trainings.

We heard that communication from Oranga Tamariki regional and national leadership is not always clear and can get lost. Some site leadership kaimahi told us that there are "so many comms" that it is hard to keep up and that communication on practice changes were not clear.

> *"It [the practice changes] just appears [on the Practice Centre]. I don't know where they come from." – site leadership*

Some leaders knew to share these changes with their team, while others either do not know to share it, or find it gets lost due to their workload.

What we see again is the difference between what we heard when we spoke with kaimahi in sites compared to what Oranga Tamariki national office tells us it understands. In summary, we heard Oranga Tamariki has developed and is part way through delivering training on the practice shift. There are mixed views from the sites on the value and impact of the delivery of the various training requirements. Those we spoke with stated they learn more from practical training that has clear messages on how they are supposed to work in a statutory context.

Practice decision making

Practice decision making that fell short of what was required to deliver a quality service to Malachi and his whānau, including the decision not to progress the initial assessments to a core assessment.

Status of response: Oranga Tamariki advise this is complete

The Chief Social Worker's review found that Oranga Tamariki did not meet its obligations to Malachi or his whānau. Members of Malachi's whānau made repeated, sincere and considered efforts to raise their concerns about the care, safety and wellbeing of Malachi, and the response of Oranga Tamariki was inadequate. It noted that correct practice was not followed to reach the decision to take no further action in response to the reports of concern made by Malachi's cousin. A decision should have been made to undertake a core assessment and Malachi should have been seen as part of this.

Oranga Tamariki told us that in response to this finding, on 30 November 2022 the Chief Executive sent a letter of practice expectations to senior leaders with responsibilities for the delivery of services to tamariki and whānau. The letter set out that:

- only social workers with more than 12 months experience as a registered and practicing social worker will complete initial assessments, and that new social workers will be supported to complete their practice induction and focus on their learning
- the practice standards are minimum standards and his expectation is for managers and leaders to support social workers to understand and apply the practice standards in their work
- channels are available to staff to share concerns, and his expectation on managers to work with their teams in a way that creates a safe space for open and honest dialogue and where concerns can be raised, including anonymously if needed.

In addition, we were advised that on 5 December 2022, the Chief Social Worker issued a practice note about case recording. This noted that issues had been identified with inconsistent recording of all relevant contacts and information obtained from people involved with tamariki or whānau. On 20 February 2023, a message was sent to all Practice Leaders which included a slide pack presentation and discussion notes on the Practice Standard to 'Keep Accurate Records', for delivery to all frontline kaimahi.

Most initial assessments are made by the National Contact Centre

We wanted to understand how the changes made have influenced decision making both at the NCC and sites, particularly around reports of concern.

In response to our information request, Oranga Tamariki told us that:

- the NCC has embedded systems and allocated staffing to promote consistency in decision making across the country. This ensures that those completing initial assessments are sufficiently experienced. We were advised that the sites who continue to complete their own initial assessments are smaller sites, or sites who have a partnered assessment approach with key community and/or iwi/Māori partners.
- the NCC has moved to a regional team structure. This allows them to become more familiar with tamariki and whānau in the particular region they service, as well as the community support agencies that are available.

When we visited the NCC, almost all kaimahi told us about the benefit in the shift from a centralised approach to regionally focused teams.

> *"It's broken heaps of barriers with sites in [region], having face to face conversations really helped. [We are] getting to know our community better and community agencies. [It is a] totally different way of working that seems to be working." - NCC kaimahi*

> *"[It is a] far more collaborative approach, we keep close eyes on renotification intakes, we can have a joint consult for the best way forward for this tamariki or rangatahi, we can have this conversation in the after-hours space too. It is a far more collaborative approach in getting the best outcome for our whānau. We often have social workers who work for NCC [National Contact Centre] who are based in Christchurch and the Hawkes Bay for example, and they develop that local knowledge, and it assists them to have that relationship with local whānau." - NCC leadership*

However, we were also told that within the regional teams there are different approaches to practice and intake social workers can be responsive to the needs of the local site.

> *"It depends on where you live and the service you get, but if we [NCC] were doing [all] initial assessments, we will have more consistency." [NCC leadership]*

When we asked Oranga Tamariki sites how the process with the NCC completing initial assessments was working, we heard that communication and consultation between the NCC and sites makes a difference. In one region a supervisor spoke of an increase in consultation around timeframes:

> *"That has been a change, I have noticed it's different from previous years. The calls from the NCC to site from social workers has increased. There is a lot more consultation. They are asking us now what time frame should this [report of concern] be – it's useful at times." – site leadership*

But we also heard about how delays and a lack of communication from the NCC impacts on site workloads:

> *"Sometimes they [NCC] upload [the intake] so late so we are already behind the 8-ball. We still have a full caseload, we drop that to meet the 10 day timeframe. They sort of, I feel that their expectations are a bit unrealistic. They make those decisions in isolation." - site kaimahi*

> *"Sometimes they've [NCC] had it for 10 days before they give it [to site] and there's no communication around that." – site leadership*

We heard across regions that records from the NCC were sometimes inaccurate or incomplete. Although this could be corrected with a few phone calls, when this was done at site, it took time away from other casework.

The National Contact Centre is taking steps to improve quality assurance

We also looked at the checks in place to support quality decision making over reports of concern and initial assessments, at both NCC and in sites.

Overall, we heard that NCC staff had site experience, and were able to describe an environment where they had regular access to supervisors to support decision making. NCC leadership told us there is a greater level of oversight of the decisions made by new social workers and that these decisions are not made in isolation.

> *"For the new kaimahi, it is always a 100 percent sign off… Compared to site, our supervisors are sitting on the floor so there's always that capacity for checking every piece of work." - NCC leadership*

Supervisors sign off on all decisions, and case sampling by the Practice Leader also supports good decision-making. It is important that the new Quality Practice Tool (QPT) is implemented to provide additional assurance and oversight to both the NCC leadership and national office.

National office advised that while the NCC does not currently complete quality assurance reports for national office, these are to be implemented in late 2024. To support this a QPT is being developed, led by the NCC leadership team. The QPT contains a set of questions used by practice leaders to review randomly selected cases and determine if the quality of practice aligns with expectations in the practice policy, guidance and standards.

We were told that once implemented, the QPT will enable data to be generated on the NCC's initial assessment practice. This will be able to support national level reporting if desired, as well as NCC-led continuous practice improvement activities.

The NCC leadership team told us that the impacts of practice changes were not always considered within the unique context of the NCC.

> *"… It was like NCC was here on this island and OT [Oranga Tamariki] national office was here on another island. There was a practice note that come out in 2022, saying basically by the way the Practice Centre has been updated, and by the way you can talk to whānau now, but it was treated as a minor change but actually that was a major change for us ... It was a big change that was minimised." – NCC leadership*

Sites use different quality assurance processes to check their decisions

In accordance with the Chief Social Worker's practice review, we heard that sites were ensuring that decisions on initial assessments were not being made by social workers with less than 12 months experience. Where we heard about exceptions, we were assured that they never worked alone, and that there was adequate supervision and oversight of their work.

While almost all sites we spoke to over the three regions now use some form of collective review of initial assessments,[20] the process used varied across the sites we spoke with. Two out of the three regions used the same decision response tool as the NCC to inform their decision, as required in policy. The other relied on the professional judgment of staff members. Sign-off of the final decision also varied. In some sites a single supervisor was responsible for the decision, while others used collective decision making.

Staff from Oranga Tamariki national office told us the expectation was that all sites should use the decision response tool to inform their intake and assessment decisions.

When we asked about whether quality assurance changes made as a result of the Chief Social Worker's practice review are making a difference, all sites mentioned QPT. The results of QPT are used by sites to understand where they need to work on practice, and what they can do better.

20 Sites receive reports of concern from the NCC with an initial decision of Further Action Required, but do not receive reports assessed by the NCC as no further action.

While QPT has been focused on core assessment, Oranga Tamariki is currently using it to assess the quality of initial assessment decisions where the initial assessment decision is no further action. This is a positive step, as understanding whether the correct decision is being made at this stage is critical to keeping children safe.

In our interviews with kaimahi, we heard that the latest QPT checks, undertaken shortly before we spoke with sites, was focused on intake and assessment practice. We were told by frontline kaimahi that this was the first time QPT had focused on intake and assessment. At the time of drafting this report, the results from the QPT had not been fully analysed to be shared with us.

However, Oranga Tamariki national office advised that its approach to quality assurance is to ensure it is routinely reviewing and considering all aspects of practice, from initial assessment to care, over the course of the year. It further advised that case file analysis provides a second line of assurance. This is undertaken by Oranga Tamariki as part of its self-monitoring system.

The wider community and system

The wider community and system which did not communicate or respond in a connected way using a locally-led, partnered approach to the initial report of concern.

Status of response: Oranga Tamariki advise this is complete

The Chief Social Worker's review found that the operating model for responding to reports of concern can result in isolated decision-making and is vulnerable to being used as a means of managing workload. It noted there was a lack of partnered decision making, resourcing, wider community and cross-government collaboration and information sharing when responding to reports of concern. It also noted that had agencies been more coordinated, it would likely have strengthened the response that Malachi and his whānau received.

Both the Poutasi review and the Chief Social Worker's practice review noted the need to involve community agencies in decision making processes. The success of strategies to do this is varied. In some sites we heard that there were strong connections, and decision making envisaged in the Poutasi review is occurring. However, other sites felt they were unable to progress this area due to delays in approval from national office.

> *"…we're not sure where it goes, it just gets lost. It's the layers, the bureaucracy. We don't get any autonomy." – site leadership*

Some also felt that the model of having the NCC complete initial assessments was a barrier to community involvement at the early stage.

> *"We get asked to be strategic, then get out there, then be told we can't. We pull out the [Poutasi] report. We still can't do it." – site leadership*

Kaimahi told us that communication is not always clear and that the messages they are getting are sometimes inconsistent.

> *"It's great what is being said at the top, but by the time it gets to us we get the bare minimum at the bottom … People talk about hitting a glass ceiling, but we are hitting a brick ceiling, we can't see what is on the other side. I get inspired by what Chappie [Chief Executive] and the leaders said at the top, but then we get the remixed version at the bottom. We need to be hearing the same message." – site kaimahi*

Given this feedback, we were interested in the views of other agencies, particularly around making reports of concern. We looked at what we had heard from agencies through our regular monitoring programme. Of note was that most agencies have told us they do not hear back about the outcome when they have made a report of concern, and this can affect their confidence that the right decision is being made.

> *"As a frontline [Police] officer we never hear what's happening with a report of concern, we don't know if it is being dealt with or not." - police officer*

Professionals in other agencies and NGOs we spoke with told us that they do not feel that their reports of concern are taken seriously enough or acted upon by Oranga Tamariki, that they do not hear back about the outcome of the assessment of the report, and that they feel discouraged from making reports of concern as a result of this.

> *"As I have become a more experienced social worker, I found that I didn't want to put in a ROC [report of concern] because OT [Oranga Tamariki] don't take them seriously and it goes nowhere but it wrecks my relationship with the family I work with." – Barnardos kaimahi*

> *"What are the scenarios where OT would pick it up? What are the likely RoC [report of concern] that will hit OT [Oranga Tamariki] buttons, is there a word we can use? Well, if we don't hear back, what's the point. We're not going to stop putting them in, it's a duty of care of course, but it's frustrating." - school principal*

Recent research[21] has also identified that the process of deciding to report concerns to Oranga Tamariki is influenced by the threshold within Oranga Tamariki for accepting reports. That research found that "as the Oranga Tamariki threshold rises and its criteria change, it slowly, yet unevenly and with instances of resistance, affects the NGO heuristic and threshold".

We also heard that in some regions, professionals in other agencies are making reports of concern to the NZ Police, rather than Oranga Tamariki, as they feel the NZ Police are more responsive to their concerns. While this is consistent with section 15 of the Oranga Tamariki Act, which states that a report of concern may be made to either the Chief Executive of Oranga Tamariki or a constable of the NZ Police, reports of concern are most relevant to NZ Police if there is potential criminal activity (such as abuse). If the concern prompting the report is solely around care and protection, it must be assessed by Oranga Tamariki in the first instance. We also understand that as per the relationship agreement between the NZ Police and Oranga Tamariki, concerns raised with the NZ Police that are solely of a care and protection rather than a criminal nature are meant to be referred directly to Oranga Tamariki.

Report of concern data does not necessarily reflect need

Having heard from professionals in other agencies that multiple reports of concern are required for Oranga Tamariki to act, we wanted to understand whether this was reflected in the data on reports of concern. In particular, whether multiple reports of concern needed to be made before reports of concern were progressed to investigation, and whether this differed by the notifying agency. However, data on reports of concern did not necessarily show this was the case.

Data provided to us by Oranga Tamariki shows that in 2022/23, for all the tamariki for whom a report of concern was made, 75% of them had only one report recorded for them, and 92.5% of tamariki had up to two reports recorded for them. Oranga Tamariki could not yet tell us how many of these tamariki had contact records as well as reports of concern. This would give us a better understanding of the number of times Oranga Tamariki had been contacted about tamariki it had recorded reports of concern for. Oranga Tamariki advised that it is looking at understanding this further as part of case file analysis is has underway.

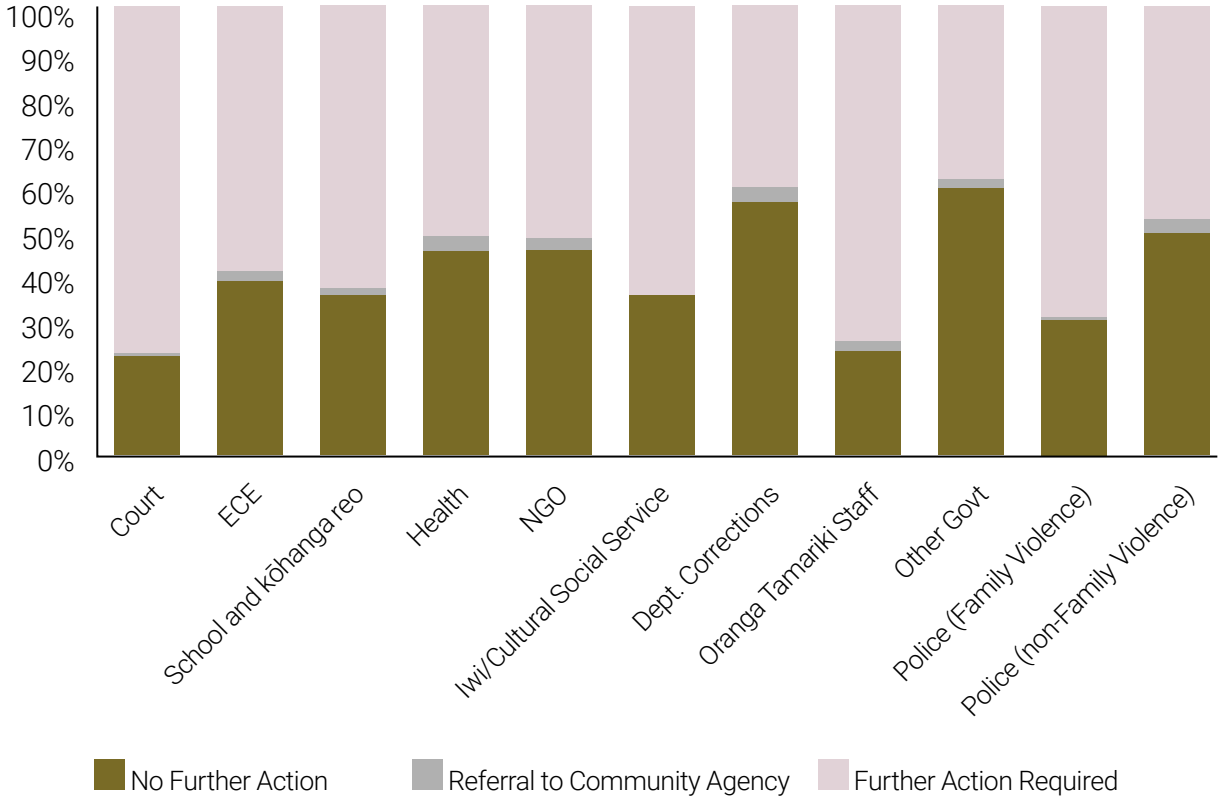
Oranga Tamariki data also shows that for all their investigation or assessment decisions in 2023, in 81% of these cases only one report of concern was made prior to the decision, with up to two reports being made in 96% of these decisions. There has been little change in these figures since 2016.

21 Keddell, E, Colhoun S, Norris P and Willing E, 2024 The heuristic divergence between community reporters and child protection agencies: Negotiating risk amidst shifting sands - ScienceDirect

The graph below shows the report of concern decisions made by Oranga Tamariki in 2023, broken down by the notifying agency. The percentage of reports resulting in further action required varies by notifier type.[22] Decisions to take further action were made in a lower proportion - around 40-50% - of reports of concern received from NGOs, Health, Department of Corrections, Other Government, and NZ Police non-family violence.

Graph 3: Oranga Tamariki response to Reports of Concern by notifier type in 2022/23

A high proportion of reports of concern from professionals do not result in further action by Oranga Tamariki



Based on this, we conclude that looking at data on reports of concern in isolation does not necessarily provide an accurate view. It is evident from the data and in what we have heard, that those who do make reports of concern to Oranga Tamariki may be operating on different thresholds for when to report. Additionally, the data does not account for contact by agencies that was recorded as a contact record or additional information instead of a report of concern. There is also a possible issue of trust in Oranga Tamariki and lack of confidence that it will respond to address need in response to reports of concern.

22 Due to variation in the number of reports between agencies it is not certain whether this difference can be said to be statistically significant, and as such should be interpreted with caution

We also heard in our wider community monitoring that NGOs will try to work with families for as long as they can before making a report of concern. They told us that when they do report concerns it is because they are serious enough for Oranga Tamariki to become involved, however, nearly half of all reports of concern are assessed by Oranga Tamariki as requiring no further action.

Site environment, support and leadership

The site environment, support and leadership which impacted on the ability of social workers to deliver best practice.

Status of response: Oranga Tamariki advise this is complete

The Chief Social Worker's review found that at the time of their involvement with Malachi and his whānau, social work staff at Te Āhuru Mōwai site were experiencing workload and resourcing issues that were having a direct impact on their practice. In addition, a broader range of known process, culture, leadership, and stakeholder relationship issues were also present, had not been addressed and likely contributed to decisions made about Malachi.

Oranga Tamariki national office told us that it considers that it has implemented a comprehensive plan for the Bay of Plenty region that addresses the broader workload, leadership, development, stakeholder relationship, practice and cultural issues identified by the review.

Having visited the site, these issues have not been completely resolved. Further, kaimahi across all sites we visited talked about not feeling supported, not being listened to or asked what they needed in order to do their job. The experience of Te Āhuru Mōwai is reflective of this.

Staff we spoke to wanted more support from regional and national leadership

We were told at Te Āhuru Mōwai that there was an initial response after Malachi's death, with additional staff coming in from other sites from March 2022. This provided short term relief. This support focused on managing workloads and issues that arose but did not address staff wellbeing to the extent required. Staff told us they were not asked what help they needed, that this was a site in crisis prior to Malachi's death, and that their physical environment was not supporting good practice and physical wellbeing. This impacted on staff retention and recruitment, and the site continues to feel unsupported by its community, government partners and its own organisation.

We heard in the Bay of Plenty region that when social workers are working in the community, it is not uncommon for Malachi to be mentioned as an acknowledgement that they are not trusted to make the right decision.

Despite this kaimahi spoke positively about their current site manager, and the difference he is making, in spite of the challenges that remain.

What appears to have occurred is that focus and resources were deployed at the time of Malachi's death. Steps were taken to address immediate needs, and it was assumed that the problems had been resolved. However, from speaking with staff and leadership at the site it appears that short term solutions were applied, and symptoms addressed but not underlying causes. As a result, staff lack confidence in the organisation and their own practice.

We were told that in the Bay of Plenty there is now more consultation with (and between) supervisors, because staff now lack confidence in their decision-making and skills. This was thought to be a result of the lack of support, as well as the community response.

> *"I spend a huge portion of my day going over cases with social workers." – site leadership*

It was also acknowledged that the confidence of supervisors at Te Āhuru Mōwai has been negatively impacted since the review, but that the leadership team is more transparent and willing to discuss issues, which is a positive shift. We heard that Oranga Tamariki made sweeping changes to the site's leadership after the practice review, and the new leadership is invested in their mahi and helps to break down silos.

We were also told how frontline staff at Te Āhuru Mōwai support each other. There was a view that they are lucky to have the kaimahi they do, but also a realisation that this could change at any time. There was concern about public sector budget cuts and the impact of this on tamariki, rangatahi and their whānau. We heard the region is not allowed to access fee for service arrangements[23] or resource workers. This meant that social workers have to do additional work such as staying overnight with tamariki and rangatahi in motels and taking tamariki and rangatahi to see their parents for access arrangements in the weekend. Kaimahi across all regions described lacking confidence in, and support from, regional and national leadership.

Oranga Tamariki national office disagreed with this perspective. It told us it could provide numerous examples of supporting and enabling the region with care arrangements from a national perspective, including the approval to employ resource workers, fee for service arrangements, and the creation of care contracts in the region.

23 Fee for service arrangements include any arrangement for the provision of social sector services where an alternative contracting arrangement is not in place.

Barriers to recruitment are affecting practice

The Chief Social Worker's practice review noted that when workload pressures are high, a greater tolerance for risk may occur and reasons may be found to close an open case rather than exploring the best response to what may be occurring within or needed by the whānau. The review was also clear that the work of Oranga Tamariki must always be based on responding to the safety and wellbeing needs of tamariki and whānau. It stated that "effective leadership strategies are needed to ensure this focus is not compromised by high workload and demand". It further noted that high demand, workload and case complexity is a known feature that is impacting on the social work workforce within Oranga Tamariki and more broadly across the sector. Oranga Tamariki noted it has work underway as part of the Future Direction Plan to address this.

However, we heard in sites that very little has changed, despite actions taken as a result of the practice review.

Leadership in the Bay of Plenty region understood that they were subject to a staffing freeze and this has affected staff capacity to manage workload. We heard that while some roles can be hired, information sent from national office about the full-time hours for each region meant they could not hire as many people as they need. In the Bay of Plenty region we were told:

> *"It's all driven to save money. I'm tracking towards seven vacancies; I was told last night I can take on two social workers." – site leadership*

The issue with recruitment was not limited to the Bay of Plenty. We also heard in Auckland and Canterbury that they have been understaffed for a long time. Their high caseloads mean their outputs are not as high quality and they may miss deadlines.

> *"Until we have reasonable caseloads, like 10 – 14 tamariki [per social worker], we are never going to do good enough work." – site leadership*

Oranga Tamariki national office told us there was no staffing freeze on social work roles. It told us that recruitment is a sector-wide challenge and it has approximately 160 social worker vacancies across the country at present.

In one region we were told that high caseloads cause kaimahi to quit, leading to a low staff retention rate and an increase of inexperienced staff.

We also heard that staff capacity was an issue in some sites because some social workers were leaving to take regionally based roles with the NCC. We were told that these roles are considered more attractive as kaimahi can be based anywhere in the country, work from home and also not have to undertake after hours duties. However, national office advised that, aside from a few exceptions, NCC kaimahi are required to work from a site and that latest recruitment rounds include an expectation of after hours work.

Oranga Tamariki is struggling with the volume of reports of concern it receives. Decisions on which cases to intervene in are often made based on capacity. A recent report from Oranga Tamariki suggests that the volume of reports of concern may be decreasing, although it cannot say that this correlates to a reduction in need[24].

We heard about the lack of clarity of the statutory role of Oranga Tamariki, and not enough education on how to identify signs of abuse or neglect for professionals, particularly when studying or training for their roles as NZ Police, doctors, or pre-school teachers. In parallel, work is needed to rebuild trust that Oranga Tamariki will respond to those reports of concern in the manner required.

We asked national office how it identifies when a site is potentially in crisis. In response they told us about heat maps across the regions, and that these indicated more support was needed across most of the country. We were told that the heat maps involve structured data from a range of sources being analysed across all sites. This supports Oranga Tamariki national office to understand current capacity across sites to carry out initial and core assessment work. They are designed to identify sites that may need additional assistance or support, or where there may be pressure points impacting on practice.

When we asked what Oranga Tamariki does to respond to this need, we were told that addressing the challenges faced by sites is difficult. As an example, they told us social workers' contracts are often site based and do not always allow for social workers to be moved between sites to address need. National office told us there are practical interventions for sites such as providing site coaching and support. It also told us that during periods such as Christmas, it also deploys experienced social workers from national office out to sites.

Resourcing is impacting on decisions to intervene and take further action

A consistent theme we heard from all sites was that decisions about the need for an assessment are often made based on resourcing and workload, and this increases the risk that cases requiring follow-up are missed.

> *"If we were to allocate every report of concern from the contact centre, oh lord, our social workers would burn out." – site leadership*

> *"My understanding is that we [sites] are to accept everything [as it is assessed by the NCC] but sites don't because of workload. NCC has always been way more cautious than sites. There is no consequences [for NCC staff], no flow on effects for pressures on staff. Sites go we can't possibly look into these concerns because we have other work." – site leadership*

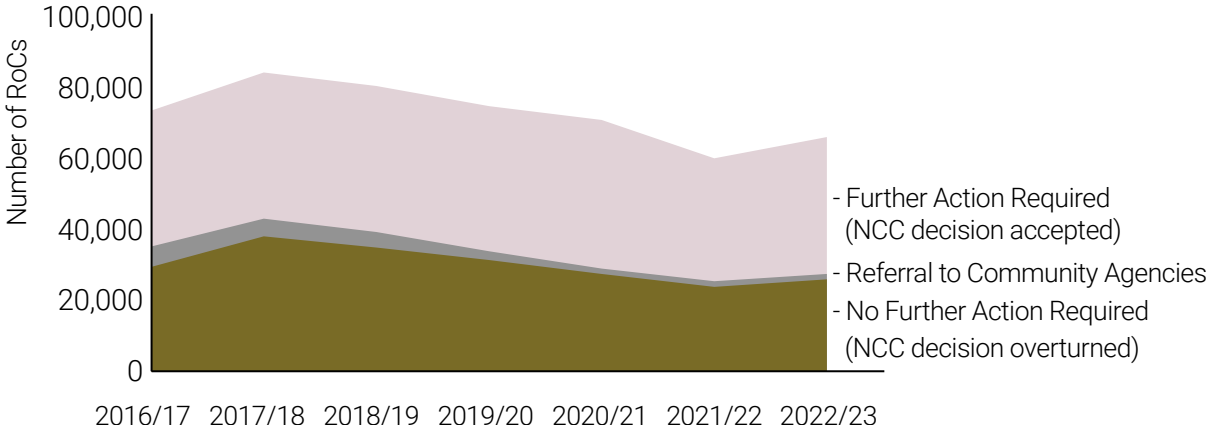
24 https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Research/Latest-research/Analysis-of-the-decrease-of-Reports-of-Concern/Analysis-of-the-decrease-in-Reports-of-Concern.pdf

Some kaimahi told us that despite the regional approach, there is still a disconnect between the NCC and local sites and that NCC decisions are not always accepted by sites.

In trying to understand the size of this issue we looked at the number of initial assessments that are amended at site from further action to no further action. Oranga Tamariki data shows that around half of all initial assessments forwarded to sites from the NCC for further action are overturned (see graph below) and that the number of accepted decisions for further action is fairly stable, regardless of the overall number of reports.

Graph 4: Site response to Further Action required decisions at the National Contact Centre over time

Further action decisions by the National Contact Centre are re-worked by sites and around half are overturned

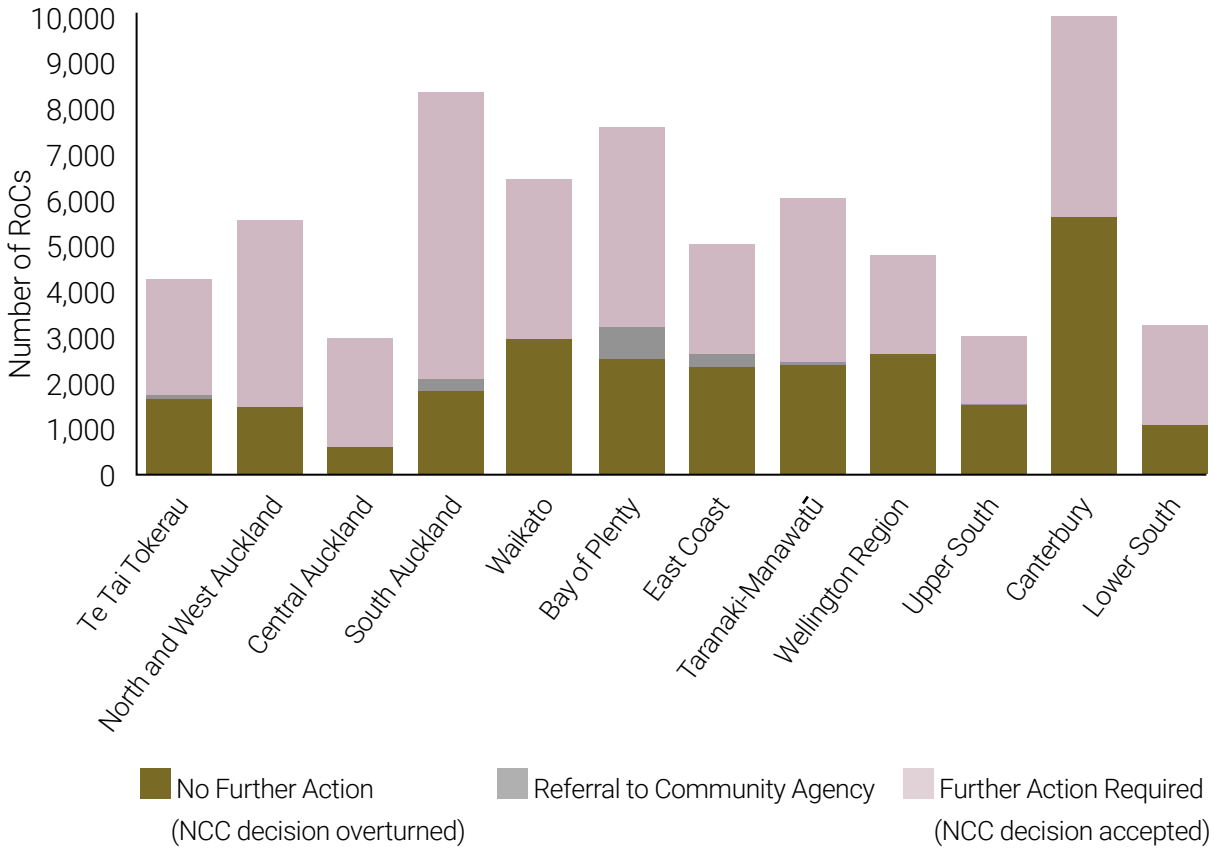


We then looked at the difference across regions, which shows variation in acceptance rates of NCC decisions. In particular, the Auckland sites had higher acceptance rates of NCC decisions, with the reverse in Canterbury. We note that as well as having a lower acceptance rate of NCC decisions, the Canterbury region receives a larger volume of reports of concern than other regions.

This aligns with what we heard about the closeness of the relationship with the NCC and sites. The thresholds for intervention also seem to vary by site. For example, we heard that a site with few reports of concern was accepting all NCC recommendations and progressing every case to core assessment. In other sites, where the numbers of reports of concern were much higher, sites were using different approaches to review NCC recommendations. Sites should have enough resource to investigate and address cases of concern, but we heard that generally they do not. The graph to the right shows the variation in acceptance of NCC decisions across regions.

Graph 5: Site response by region to further action required decisions at the National Contact Centre in 2022/23

Acceptance of National Contact Centre further action decisions varies significantly across regions.



Where the site decides not to progress a report of concern to a core assessment, it is possible that it is referred to a community agency and this provides an opportunity for tamariki to be seen. Some of these referrals are reflected in the data, but Oranga Tamariki accepts that referrals to community agencies are underreported. The kaimahi we engaged with stated it is not standard practice for Oranga Tamariki to record referrals to community agencies. As a result, most referrals to community agencies appear as no further action decisions and there is no tracking of how many reports of concern are being addressed by the community and how many result in no action at all.

We heard from frontline Oranga Tamariki kaimahi that in some communities the capacity to respond to reports of concern at a community level is stretched. We heard that despite this, there is still a practice within Oranga Tamariki to refer cases to community agencies, regardless of the capacity of those agencies to respond to the need.

Tamariki are no more likely to be seen now than when Malachi died

Based on what we have heard from kaimahi and what we see from the data, we cannot be confident that tamariki in similar situations to Malachi are any more likely to be seen or kept safe than when Malachi died.

Overall, Oranga Tamariki is not making the best use of the resources it has to respond to the number of reports of concern for tamariki, and sites are spending time re-assessing further action required decisions made by the NCC. We also heard from Oranga Tamariki kaimahi that their interpretation of the practice shift placed greater emphasis on relationship building with whānau, even when there are situations where there may be safety concerns for tamariki. This is impacting on site decision making, and other agencies and NGOs are saying the threshold for statutory intervention to keep tamariki safe remains too high and unclear.

As a result, trust and confidence of agencies and NGOs is eroding, with a decline in the number of professionals making reports of concern.

While there are many community and iwi/Māori agencies in Aotearoa New Zealand, they often struggle with a lack of funding and uncertainty about contracts being continued, and sometimes do not have enough capacity to meet the demands of families in need. The gap between a community response and a statutory one also appears to be widening. We heard that many agencies will work with families to try to keep them out of the statutory system, but when they do need to make a report of concern there is no action from Oranga Tamariki, or it is referred directly back to the community.

We heard about lack of clarity about the statutory role of Oranga Tamariki, and that there is not enough education on how to identify signs of abuse or neglect for professionals, particularly when studying or training for their roles as NZ Police officers, doctors, or pre-school teachers. If this was addressed it would help ensure that those tamariki who need to be, are reported to Oranga Tamariki. In parallel, work is needed to rebuild trust that Oranga Tamariki will respond to those reports of concern in the manner required.

As already noted in our review, around half of all initial assessments referred from the NCC to sites for further action are overturned to become no further action by the site. Community and iwi/Māori agencies need to be supported to respond to tamariki and whānau needs, leaving Oranga Tamariki to focus on those tamariki and whānau who require statutory intervention. This requires a well-funded and -resourced NGO sector. If this is not achieved, tamariki and whānau needs will remain unaddressed, and over time are likely to worsen. Ultimately this will lead to further notifications to Oranga Tamariki, but with more entrenched needs that are harder and potentially more costly to address.

Aotearoa New Zealand has a way to go. Oranga Tamariki is trying to achieve this vision through its Future Direction and Enabling Communities approach, but it is not there yet. It also requires support from across government, and particularly the children's agencies. In our monitoring we heard how, when other government agencies make decisions in isolation that impact on the wellbeing of tamariki and whānau, it has a flow on impact on reports of concern to Oranga Tamariki. Examples we heard were Kainga Ora evicting tenants, or NZ Police pulling back from family harm. Rather than working together as children's agencies to collectively make decisions that benefit tamariki, agencies remain in silos.

In order for the system to be able to respond to meet need, these gaps must first be addressed, before considering additional demands and changes such as mandatory reporting.

Department of Corrections

The Department of Corrections undertook a review of its management of Malachi's mother. We have considered the condensed, publicly available summary of the review, as this review covers the aspects that relate to Malachi.

The overall review made twelve recommendations, eight of which were included in the summary review as being of relevance to ensuring the safety of dependent children. Corrections advised us that as of 29 February 2024, five of these eight recommendations were complete. Below is a summary of the recommendations and what remains outstanding.

Recommendation one

Corrections must undertake a review of the Relationship Agreement with Oranga Tamariki, and thereafter ensure a review is undertaken every two years.

Status: Not achieved

Corrections advise that work has commenced to update the current agreement and update/consolidate the schedules (such as the information sharing schedule). Once this is complete, it will update the guidance for reports of concern and information requests. Corrections further advised that it has an ongoing relationship with Oranga Tamariki and the agencies continue to work together on emerging issues.

We asked Corrections why they have been unable to review their relationship agreement with Oranga Tamariki. Corrections told us that while it has resource available to progress this work, Oranga Tamariki has not yet resourced this work. Given the recommendation proposes the relationship agreement be reviewed every two years, there are implications for future reviews if those reviews also take as long to progress.

Recommendation two

Corrections must review and refresh its induction processes to ensure that information about a prisoner's dependent children in the community is identified and recorded. Corrections must consider the Bangkok Rules[25] and the Inspection Standards as it refreshes its induction processes.

Status: Not achieved

While considerable work has been undertaken, this action is not yet fully achieved.

Corrections advised it has reviewed and updated the Immediate Needs Assessment (which forms part of the reception into custody process) to include more open-ended questions with the purpose of strengthening the quality of information being provided to ensure Corrections can offer a more supportive response to individuals. The question regarding childcare arrangements has been updated with the intention to provide for further discussion with those coming into prison regarding any dependents they may have. Corrections is also trialing asking an additional question on whether women were breastfeeding/lactating prior to entering custody, in order to ensure these women have access to their immediate health care needs. Corrections advised it is also working through the process to make changes to incorporate questions about women who have tamariki aged under 2-years, to ensure they are getting timely information and access to Mothers and Babies Units and/or Feeding and Bonding facilities.

Corrections further advised that in August 2023, it tested an updated Immediate Needs Assessment at Auckland Prison, Mt Eden Corrections Facility, Auckland Region Women's Corrections Facility and Spring Hill Corrections Facility. These sites were chosen for He Ara Whānau – A Pathway for Whānau, which seeks to support Māori who have been sentenced to imprisonment or remanded into custody, to put their affairs in order when coming into the Corrections system. The goal is to improve the wellbeing of whānau. When a person is received at these sites, they are now offered a referral option for their whānau to Te Pā. This is a kaupapa Māori organisation responding to community needs and providing reintegration and social services for whānau who are either in the justice system or exiting the system.

Corrections told us examples of how Te Pā has supported whānau by providing food parcels, clothing, nappies, hygiene and care packs, dental work, registering tamariki with doctors and supporting whānau to attend these appointments. Te Pā has also supported whānau with getting Well Child Tamariki Ora checks completed for tamariki, and enrolling whānau in training courses and obtaining driver licences.

25 The Bangkok Rules is a set of 70 rules focused on the treatment of female offenders and prisoners, adopted by the United National General Assembly on 22 December 2010. The Bangkok Rules address the issue of women prisoners with children, and seek to minimise negative impacts on these children.

In addition, Te Pā Navigators have supported whānau to maintain contact with the individual in prison. They have provided financial assistance through their child travel fund for whānau to visit, and obtain birth certificates to support prison visitor applications.

Recommendation three

Corrections must review its processes for approving telephone numbers, particularly for prisoners with dependent children in the community.

Recommendation four

Corrections must remind staff of the requirement to follow practice guidance for video calls at all times.

Recommendation six

Corrections must remind staff of the responsibility to ensure that prisoner information is appropriately recorded and stored.

Recommendation seven

Corrections must remind staff of best practice when correcting errors in official documents.

Recommendation eight

Corrections must ensure that review risk assessments are completed in accordance with the Prison Operations Manual.

Status: Corrections advise these actions are complete

Corrections advised that as a result of the internal review, a lessons learned process was undertaken in February 2023. This was chaired by the Chief Custodial Officer and attended by all General Managers. All General Managers were advised to share the recommendations at site level and encourage discussion to remind staff of practice guidance. The Chief Custodial Officer followed up to ensure that all matters had been addressed on site.

Recommendation five

Corrections must review and refresh its processes in cases where there is a report of concern about a child. As part of this review, Corrections must engage with key agencies, including Oranga Tamariki and NZ Police.

Status: Not achieved

Corrections advised that work to review and refresh its processes in cases where there is a report of concern about a child is ongoing. In 2021 Corrections added the report of concern process to its Online Refer system, which is technology developed to replace paper-based referrals to external providers. This system allows Corrections to capture practice and quality, so that a review on this is possible. Internal discussions are currently underway around a thematic review of reports of concern sent to Oranga Tamariki.

What this means in practice and what we'll look for in another 12 months

When we next review progress we will look to understand how changes to the relationship agreement are facilitating better working between the agencies and better outcomes for tamariki and whānau. We will also look to understand what changes Corrections has seen as a result of the revised Immediate Needs Assessment forms, and how this information is being used to support better outcomes for tamariki and whānau. Lastly, we will look to understand trends in the data captured by Corrections around reports of concern and how this is being used.

Ministry of Social Development

The Ministry of Social Development (MSD) review primarily focused on its interactions with Ms Barriball. This included the provision of both main benefit assistance and emergency housing support.

The review identified that Ms Barriball was receiving a type of case management targeted at families who have high and complex needs, such as family violence, drug and alcohol abuse, debt, health problems, criminal activity, unemployment, housing and education. It noted that all required documentation was provided to meet the criteria for the assistance MSD provided. The review also notes that Malachi was seen by MSD staff in the Tauranga Work and Income office with Ms Barriball, but there were no indications of safety concerns on these occasions. This is why MSD did not contact Oranga Tamariki in relation to Malachi.

The review, dated October 2023, identified initiatives that MSD planned to undertake to improve child protection practices, in line with its Child Protection Policy.

Initiative one

A review and refresh of MSD's existing MAP (Manuals and Procedures[26]) and its Doogle (intranet) pages to ensure the information available to staff is clear, relevant and current.

Status: Not achieved

26 https://www.workandincome.govt.nz/map/index.html

Initiative two

Delivering existing training on MSD's Child Protection Policy to staff in the next year, and frontline-focused training to be adapted for non-frontline staff.

Status: Not achieved

Initiative three

Increasing the visibility of the Child Protection policy and all the related resources through the various staff platforms on the MSD intranet.

Status: The Ministry of Social Development advise this action is complete

Although work is underway, two of the three initiatives the Ministry of Social Development set for itself are not yet achieved.

MSD told us it has recently refreshed its 'Child Safe' online learning module for staff. This covers topics of child abuse and how to recognise and report abuse. The training now covers high-level information about information sharing provisions as set out in section 66C of the Oranga Tamariki Act 1989. The 'Child Safe' online learning module is part of MSD's induction programme, and sets out expectations of how MSD staff should respond when they have concerns about the safety and wellbeing of children. While MSD considers this action is complete, it acknowledges the need to regularly revisit this to ensure that all MSD staff are up to date. It plans to roll out this training as a refresher for all MSD staff later in 2024.

MSD also advised that it continues to improve its operational practices guided by its child protection policy. As part of its commitment to building staff capability in this area, all client facing managers will be undertaking a half-day Family Violence Awareness training between March and July 2024, facilitated by a specialist Family Violence response provider. These training sessions will be made available to all MSD staff throughout the country, later in 2024.

The MSD review also identified that process improvements could be made regarding the report of concern pathway. MSD has discussed with Oranga Tamariki officials the importance of Oranga Tamariki staff 'closing the loop' with MSD as frontline staff do not always know whether any action has been taken when a report of concern is lodged. The review noted that understanding the outcome of a report of concern may help encourage frontline MSD staff to be more proactive in raising concerns. This is also consistent with section 17(1)(c) of the Oranga Tamariki Act 1989, which notes that:

unless it is impracticable or undesirable to do so, as soon as practicable after a decision is made not to investigate or the investigation has concluded, inform the person who made the report—

i. whether the report has been investigated; and

ii. if so, whether any further action has been taken.

What this means in practice and what we'll look for in another 12 months

In our next review, we will be looking to understand from frontline MSD staff, whether the training and information provided to them is helping them to identify and respond to potential child abuse.

Ministry of Education

The Ministry of Education commenced a review in May 2022, focused on the actions of Abbey's Place Childcare Centre while Malachi was in its care.

The review found that the child protection policy in place at Abbey's Place met the requirements under the Children's Act 2014, and that there was a procedure that set out how the service would identify and respond to suspected child abuse and/or neglect. However, the review found that Abbey's Place had not followed its policy or procedure and did not take reasonable steps to consider whether the information available to it indicated there was a risk to Malachi's safety. Further, effective governance and good management practices were not demonstrated in relation to this.

A provisional licence was issued to Abbey's Place in May 2022 with conditions the centre needed to meet outlined in a plan. The centre was given until 22 July 2022 to provide evidence of meeting the conditions of the plan. After considering the evidence provided by the centre, a preliminary decision was made to issue a Notice of Intention to Cancel (NIC) the centre's licence. This was because two of the conditions specified in the provisional licence had not been complied with by the date specified.

In September 2022, the Ministry of Education made recommendations for how it could use lessons from its review of Abbey's Place, as follows.

Recommendation one

Change Ministry of Education internal processes for decision making on cases where a child has experienced serious harm so that decisions are passed through and approved by the relevant Hautū (Deputy Secretary) of each region, in consultation with the Hautū of Te Pae Aronui (Operations and Integration).

Status: Not achieved

Work on improving processes has started but approval of the draft *Framework for managing incident notifications* has been delayed due to the changes within the Ministry of Education and the development of Te Mahau[27]. Before final approval the Ministry of Education needs to consult with persons within the regions who have the delegations to make decisions. The Ministry of Education was not able to confirm when the framework is expected to be finalised.

The Ministry of Education provided information on how its staff manage incident notifications from an ECE service. While this does not incorporate a pathway of notifying the Secretary for Education, we were advised that employees exercise discretion based on a risk assessment to escalate matters on a case-by-case basis. Escalation can go as far as the Secretary for Education when considered necessary.

The Ministry of Education advised that it is monitoring incidents logged on its Takiwā (regions) work management systems to ensure any high-risk situations are escalated to the appropriate Deputy Secretary.

Recommendation two

The Early learning Operations Group within Te Pae Aronui[28], in conjunction with Takiwā Hautū (Deputy Secretary Regions), uses what it has learned through the review of Abbey's Place Childcare Centre following the death of Malachi Subecz to inform regulatory work, including:

i. a current state assessment of how it monitors safety checking and child protection policies to make recommendations for change

Status: The Ministry of Education advise this action is complete

ii. the delivery of a blueprint for being a modern regulator as part of the Te Mahau work programme, including the development of specific recommendations for ECE regulator practice

iii. the establishment of an education sector regulatory group for agencies with regulatory accountabilities for education.

Status: Not achieved

A current state assessment of safety checking in the schooling and early learning sectors (in response to (i.)) was completed in September 2022. The assessment covered the regulatory framework for safety checking and the Ministry of Education's current practice within the safety checking system. It also identified risks and opportunities for improvement. The intention at the time was to establish a working group that would review the current state assessment and make any recommendations.

27 Te Mahau is part of the Ministry of Education. It provides services and support for schools, kura and early learning services, from curriculum leadership, to learning support, teaching resources, services design and delivery. It was previously known as the Education Service Agency.

28 Operations and Integration Group

In response to (ii.) the Ministry of Education advised that a design team from within Te Pae Aronui have worked to develop a first iteration of a Te Mahau modern regulator approach roadmap. However, this work needs to be developed further with more regulatory rigour before it can be progressed. This work sits within the broader context of the child protection work across the Ministry of Education. The Ministry further advised us that there is no fixed timeframe for this work, which has been affected by its savings programme, and may be further impacted by the Government's planned ECE regulation sector review.

In response to (iii.) the Ministry of Education advised that staff from Te Pae Aronui completed a stocktake of child protection related responsibilities and activities across the Ministry. This has informed a process to identify gaps and better align and co-ordinate this work.

The Ministry of Education advised that the network and regulatory team within Te Pae Aronui have been working on a strategic plan that will support teams to work together to modernise tools and approaches to regulation in both the schooling and early learning sectors. While work is underway, there is more to be done before the Ministry can commit to the education sector regulatory group.

There are also currently multiple cross-agency groups that meet regularly to progress child protection issues, such as Te Kāhui Kāhu group working on Core Worker Exemptions. This work has led to increased awareness of gaps in the system and has since resulted in the Ministry of Education's first investigation into a situation where a worker did not have a core worker exemption.

What this means in practice and what we'll look for in another 12 months

There has been little progress made towards the recommendations. Changes to internal processes so that where a child has experienced serious harm, licensing and other decisions are overseen by a deputy secretary have not been finalised, and consultation on the draft process still needs to occur. We asked the Ministry of Education when this was expected. On 30 April 2024 it replied that this is in progress and due to be presented to deputy secretaries in April 2024.

Regulatory change work is still at a preliminary stage, with only a current state assessment of safety checking in the schooling and early learning sectors complete to date. Furthermore, the Ministry of Education advised that regulatory change work in respect of child protection will be a continuing area of focus.

When we next review progress we will be looking to see whether the draft framework for managing incident notifications has been finalised and whether and what difference this is making to decision-making. We will also be looking to see if the changes to modernise tools and approaches to regulation have been progressed, and to understand whether and what difference those changes are making to how the early learning sector responds to identify and respond to abuse.

New Zealand Police

The Office of the Chief Social Worker's practice review identified that the NZ Police were involved following a 'breach of peace' incident that occurred between four adults on 15 October 2021, one of whom was Ms Barriball. The NZ Police then conducted a welfare check on Ms Barriball at her property. Ms Barriball spoke with the NZ Police outside of the cabin she lived in with Malachi, where she confirmed for NZ Police that she and her partner had argued. The curtains were closed and Police did not enter the cabin as they were not aware that Malachi was living there. Because of this the NZ Police did not check on him or provide any information about the incident to Oranga Tamariki. NZ Police later retrieved CCTV footage of the breach of peace incident and identified that Ms Barriball had been assaulted by her partner and recorded this as a family violence incident.

The NZ Police completed a Police Family Violence Death Review (PFVDR) following Malachi's death in November 2021. A PFVDR is completed following an unnatural death where the suspected perpetrator is a family or extended family member, caregiver, intimate partner, previous partner of the victim, or previous partner of the victim's current partner. The purpose of a PFVDR is ultimately to assist in the understanding and prevention of future family violence deaths and identify any required changes in policy, practices, and procedures. The PFVDR did not include information on the breach of peace incident they were involved in with Ms Barriball or any information on how this was managed by the NZ Police.

The PFVDR provides a chronological account of events from when Malachi's mother was arrested through to when Malachi died, including a list of the injuries found on Malachi by hospital staff.

The PFVDR did not make any explicit recommendations but did note that NZ Police and its partner agencies need to continue to promote the reporting of family harm, in all its forms, through media and anti-violence campaigns. It went on to note that in addition to timely reporting, facilitating training with ECE staff and providers to upskill them on the signs and symptoms of child abuse may help to prevent tragedies such as this occurring in the future. Lastly, it noted that there needs to be 'no wrong door' when identifying and reporting potential cases of child abuse.

As there were no explicit recommendations in the PFVDR, in its response to us, NZ Police instead provided comment on its role in the children's sector. This stated that NZ Police's main statutory functions, as they relate to the care and protection of children, are law enforcement and crime prevention. In performing those functions and interacting with tamariki and rangatahi, NZ Police assume a duty to ensure tamariki are in a safe environment. NZ Police engage with partner agencies (primarily Oranga Tamariki) on a case-by-case basis as required to ensure this is the case, and that appropriate support is in place.

The engagement between NZ Police and caregivers, and their dependent tamariki and rangatahi, is often brief. The key contribution of NZ Police is to ensure relevant information is shared with partner agencies to ensure appropriate visibility of relevant circumstances.

Ministry of Health

In July 2022, the Ministry of Health undertook a review into the points of contact Malachi had with health services. It found that, other than his final admission to hospital prior to his death, the multiple points of contact Malachi had with the health system were typical for a child of his age. Health records did not indicate any missed flags, cause for concern regarding a health professional's practice, or any deviation from child protection policies.

The review identified several system-level issues that could not have been addressed by health professionals at the time of presentation. It made five recommendations, some of which involve systems and processes that interact with the wider children's sector. In particular, the Ministry of Health review included a focus on access to information and how this could be improved.

Recommendation one

Endeavours towards joined up medical records with appropriate point of care access continue to be supported – noting that work to implement this was already underway through the Hira programme within Te Whatu Ora. It noted that priority should be given to joining up the medical records of children, particularly those in vulnerable situations given they often move between different services and geographical locations, which increases the risk of indicators being missed.

Status: Not achieved

By way of update, Health NZ– Te Whatu Ora noted that the first recommendation in the health review aligns with recommendation four in the independent review that *medical records held in different parts of the health sector should be linked to enable health professionals to view a complete picture of a child's medical history.* As per the response to the Poutasi review, work to join up health records is underway through the Hira programme, although funding to complete this work has not yet been approved. If funding is approved, it is not expected to be complete before late-2026.

Recommendation two

Consideration be given to extending Gateway Assessments to children who are placed into the care of others as a result of their parent(s) being imprisoned.

Status: Not achieved

The Ministry of Health and Health NZ advised that they, along with Oranga Tamariki are continuing to review the Gateway Assessment process as part of a commitment under the Oranga Tamariki Action Plan (OTAP). The review is considering who can get a Gateway Assessment, including where a parent is in prison. Advice is expected to go to Ministers on findings from the Gateway Assessment review shortly.

Recommendation three

Improvements be made to the report of concern process to incorporate multi-agency reviews of a report, to help determine an appropriate response.

Recommendation four

The findings of the review are shared with relevant agencies to inform opportunities for inter-agency working to identify response to abuse in future.

Status: Not achieved

The Ministry of Health and Health NZ advised that these recommendations are being considered in the context of the response to recommendation three of the Poutasi review and are being progressed through a commitment in OTAP. That action (action 11) commits relevant children's agencies to support a coordinated locally-led approach to prevention with community partners, with an initial focus on locally coordinated reports of concern. According to the Oranga Tamariki implementation plan, advice for Ministers on any recommendations for change to support community-based and locally-led responses to reports of concern was to be provided by the end of 2023[29].

29 https://www.orangatamarikiactionplan.govt.nz/assets/Action-Plan/Uploads/Resources/Publications/Oranga-Tamariki-Action-Plan-implementation-plan.pdf

Recommendation five

A cross-agency review be carried out for every case where a child dies from abuse, and actively monitor themes at a national leadership level.

Status: Not achieved

The Ministry of Health and Health NZ advised that work to respond to this recommendation is being considered as part of work on the Poutasi review in partnership with other relevant children's agencies.

What this means in practice and what we'll look for in another 12 months

Many of the recommendations set by the Ministry of Health have a system focus and are outside the Ministry of Health's sole control to influence.

The one recommendation that is within the Ministry of Health's operational control has not been expedited. It requires further funding to be approved and even then, is not expected to be complete before late-2026.

All work in response to the Ministry of Health recommendations is either being progressed as part of the response to the Poutasi review, or through OTAP, yet this still has not resulted in the work being prioritised enough for any of the recommendations in the Health review to have been achieved.

When we next review progress against the recommendations, we will look to understand whether and how the Hira technology is being used to identify and respond to signs of child abuse, noting that it is not expected that health records will be joined up at that point. We have asked to receive a copy of the advice being prepared on Gateway Assessments, and will be watching to see what progress is made on this over the next 12 months. As the other recommendations in the Health review are being progressed through the Poutasi review, we will consider progress on those as part of our next review of the system response.

Glossary

Case note	A case note is used to record information for open cases, including where there is additional information relating to concerns that are already being assessed or investigated.
Contact record	A contact record is used to record decisions where the social worker has determined that no further action is required by Oranga Tamariki. It can also be used to record interactions where advice has been given or information has been shared, and for family harm reports deemed as no further action by the local interagency family harm tables.
CYRAS	Oranga Tamariki administrative database (Care and Protection, Youth Justice, Residential and Adoption Services System).
Decision Response Tool	The practice tool used to decide on the appropriate report of concern response pathway.
Further Action Required	A decision on a report of concern that there are care and protection concerns that require further assessment or investigation.
Gateway assessment	An interagency process between health and education services and Oranga Tamariki to identify the health and education needs of tamariki in care, and how they will be supported.
ISR (Integrated Safety Response)	A multi-agency intervention designed to ensure the immediate safety of victims and children, and to work with perpetrators to prevent further violence. ISR is hosted by NZ Police as part of the broader government work on family violence and sexual violence.
Iwi	Tribe.
Kaimahi	Staff.
No Further Action	A decision on a report of concern that no further assessment or investigation is necessary.
Rangatahi	Defined by the Oranga Tamariki Act 1989 as a young person or young people aged 14 years or over.

Practice Leader	The role of the Practice Leader is to provide professional leadership, influence and direction in order to maintain and enhance the level of practice excellence and capability.
Practice standards	A set of eight standards for minimum practice that Oranga Tamariki social workers must meet. They include seeing and engaging with tamariki, ensuring safety and wellbeing of tamariki, and keeping accurate records, among others.
Quality Practice Tool (QPT)	The tool used by Practice Leaders to review randomly selected cases and determine if the quality of practice aligns with expectations in the practice policy, guidance and standards.
Report of concern	Any concern reported to Oranga Tamariki or the NZ Police that meets the definition under section 15 of the Oranga Tamariki Act 1989.
Tamaiti	Child.
Tamariki	Defined by the Oranga Tamariki Act 1989 as children aged under 14 years.
Tamariki Māori	Children of Māori descent.
Te ao Māori	The Māori world.
Te Āhuru Mowai	The Oranga Tamariki site that assessed the reports of concern received for Malachi.
Te Riu	The Oranga Tamariki leadership team.
Whakawhanaungatanga	Process of establishing relationships.
Whānau	People who are biologically linked or share whakapapa. For the Monitor's monitoring purposes, whānau includes parents, whānau members living with tamariki at the point they have come into care (this does not include whānau caregivers) or whānau who are close to, and/or involved with tamariki on a day-to-day basis (this does not include whānau caregivers) and who have been involved in decision making about their care.

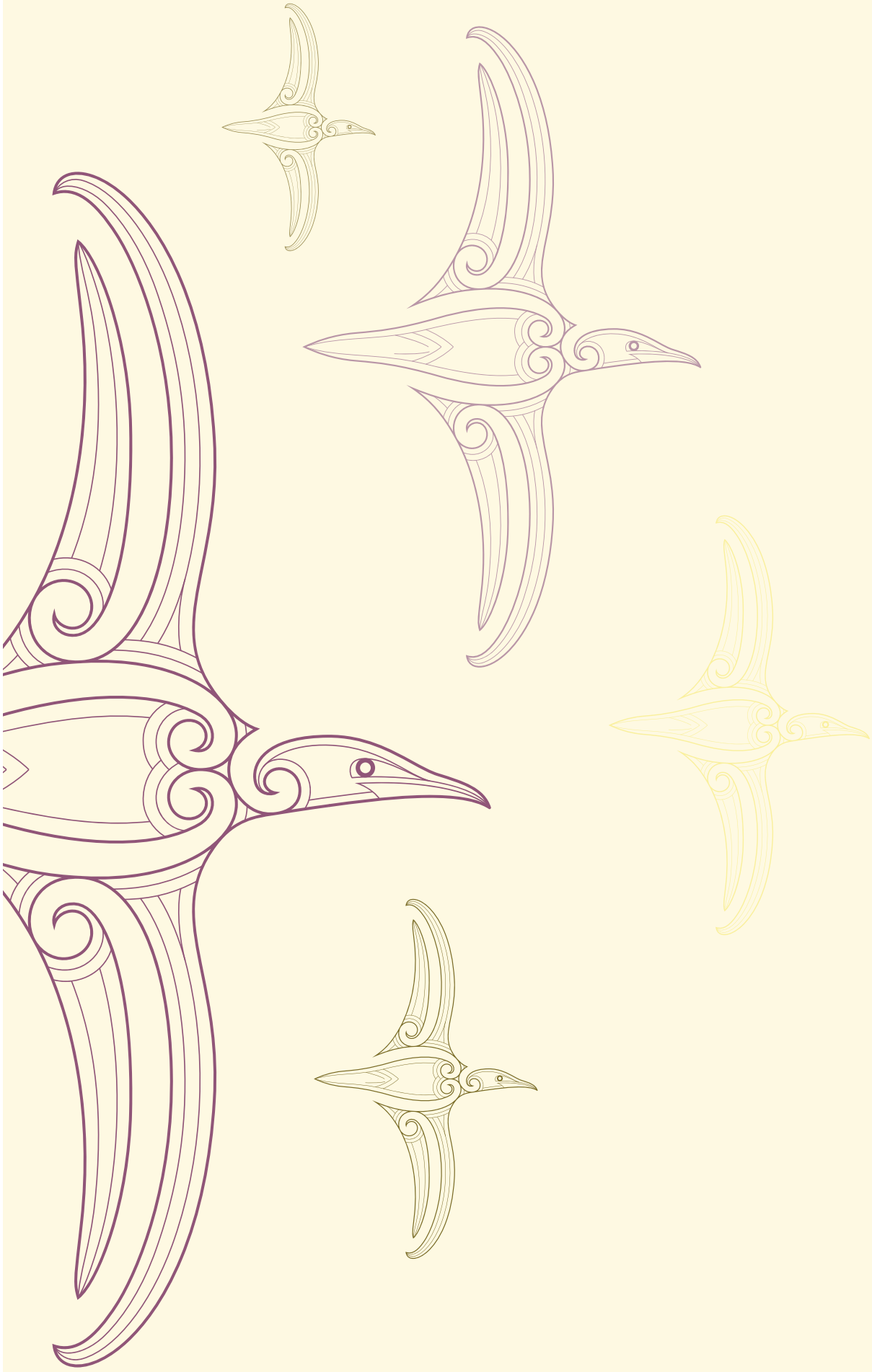
Appendix A: Child protection policy compliance

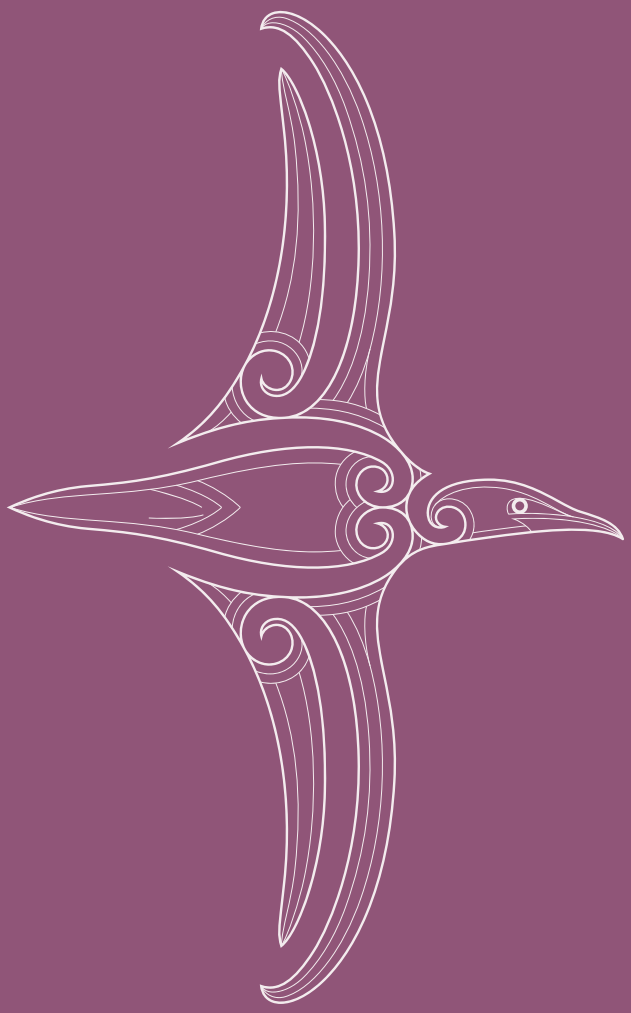
The table below shows agency compliance with requirement to have a child protection policy under the Children's Act 2014.

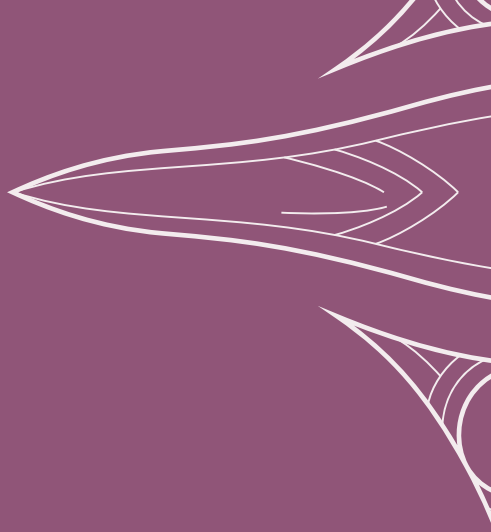
Agency	Required to have a child protection policy	Has a child protection policy	Is publicly available	Policy last reviewed	Policy next reviewed
Oranga Tamariki	Yes	Yes	Yes	November 2020	Not advised
Department of Corrections	No	Yes	Yes	June 2021	Currently under review
Ministry of Social Development	Yes	Yes	Yes	May 2023	May 2026
Ministry of Education	Yes	Yes	Yes	November 2019	Currently under review
Education Review Office	No	No	N/A	N/A	N/A
New Zealand Police30	Yes	Yes	Yes	June 2019	Currently under review (due for update by mid-year)
Ministry of Health / Te Whatu Ora	Yes	Yes	Yes	February 2017 (MOH)31	An overarching national child protection policy for all health agencies is in development
Ministry of Justice	Yes	Yes	Yes	August 2015	Not advised

30 In addition to the overarching child protection policy required under the Children's Act, Police advised it has a range of other child protection policies in place to support compliance and best practice.

31 District Health Boards were previously required to have a child protection policy. With the restructure to form Health NZ – Te Whatu Ora, a decision was made to create a national policy for all health agencies. The date of last review refers to when the Ministry of Health last reviewed its child protection policy.







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