ORANGA TAMARIKI
Ministry for Children

New Zealand Government

Response: *Towards a stronger safety net to prevent abuse of children 2025*

Response from Oranga Tamariki—Ministry for Children to the Aroturuki Tamariki | Independent Children's Monitor's second review of the implementation of the recommendations of Dame Karen Poutasi following the death of Malachi Subecz

February 2026

Overview

Oranga Tamariki—Ministry for Children (Oranga Tamariki) acknowledges the report from Aroturuki Tamariki | Independent Children's Monitor (the Monitor) titled 'Towards a stronger safety net to prevent abuse of children' (the report). This is the Monitor's second review of progress to implement recommendations made in the Poutasi report.

The death of Malachi Subecz was a tragedy. Malachi was five years old when he died on 12 November 2021 from injuries inflicted by his caregiver Michaela Barriball. Six agency Chief Executives jointly commissioned a review into the Children's sector, to better understand the children's system and understand any improvements that could be made. That review was completed by Dame Karen Poutasi and on 23 November 2022 she published her findings in a report titled *Ensuring strong and effective safety nets to prevent abuse of children* (the Poutasi report). The Poutasi report made 14 recommendations to facilitate the closing of the gaps in the children's system that did not catch identifiable risks to Malachi from his carer.

Special acknowledgement

We acknowledge the sudden and sad passing of Dame Karen Poutasi on 1 January 2026. Dame Karen was an exemplary leader in the public service and will be remembered for her immense contribution to health and education, and her humility, commitment to equity, and leadership during significant sector reforms. It is of the utmost importance to Oranga Tamariki to ensure her important legacy work is completed and that her views on child protection in Aotearoa are full realised.

Response

The Poutasi report looked at the children's system as a whole and how it failed Malachi. In October 2025, the Government accepted all 14 recommendations made in the Poutasi report and set up an integrated response led by the Ministry of Social Development (MSD) to work at pace in strengthening the children's system to better protect children from harm. Therefore, considering the integrated response, we are not committing to any additional new work to address the findings in the report and rely predominantly on the cross-agency response to the report. Where there are matters raised in the report specific to Oranga Tamariki, we make comment below.

Response to key findings

Tamariki are still no safer than when Malachi died

Whilst we agree there is much more work to do to ensure we address the issues of child abuse in this country, we do not agree with this finding.

We share the Monitor's deep concern that in the period since 21 November 2021 when Malachi died, 24 more children died at the hands of the person responsible for their care (most of whom were not known to Oranga Tamariki). This is powerful evidence that as individuals, communities, agencies and as a country more must be done. Protecting these children is a task for all New Zealanders to undertake.

Understanding the prevalence of child harm, including child homicides is complex and no one agency currently holds a true picture of whether more children are being harmed now than in the past. There are a wide number of socio-economic factors that affect the safety of tamariki, and it is difficult to accurately measure safety over time. Single measures such as the number of child homicides or numbers of reports of concern to Oranga Tamariki give us some indication of whether the amount of harm that *is visible* in our communities is changing,

however it cannot create a definitive statement about whether harm to children is increasing or reducing.

In her review Dame Poutasi found 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". What the data does tell us clearly is that in the year ending June 2025 we have seen more people taking action to protect children than in previous years. People reported concerns for approximately 9,000 more children this year than the previous reporting year. This included more reports of concern being made by members of the community as well as professional notifiers. Community agencies and partners provided new and different responses aimed at keeping children safer. Oranga Tamariki took slightly more children into care than the previous reporting year to protect them and keep them safe.

This suggests that the system is making early changes that are enabling people to be better able to notice and act on harm to children than in the past and therefore is likely contributing to improving safety for children overall. In addition to the collective agency work that is being driven as part of the response to the Poutasi review, Oranga Tamariki have made steady and important progress in a number of key areas including through the embedding of our practice approach, strengthened training for staff, the introduction of new assessment tools and frameworks and progressing important partnership work through our Enabling Communities prototypes.

Critical gaps identified in the Poutasi report remain

We agree with this finding.

Building the system protections Dame Karen envisaged will take co-ordinated and deliberate action by agencies over time. This work began prior to Government's acceptance of the review's recommendations and has accelerated since. This includes practice improvements, strengthened interagency arrangements, and the Chief Social Worker's review and subsequent policy changes following Malachi's death.

A key step forward in addressing the gaps identified in the Poutasi Report which Oranga Tamariki is leading with the support of our partner agencies is the new inter-agency (in person) hub based in our National Contact Centre in Grey Lynn, Auckland. The new in-person hub will provide an improved safety net for around 2,000 children each year whose sole parent (or sole carer) is remanded in custody or sentenced to a term of imprisonment. Sitting alongside our social work team in the hub will be representatives from MSD, Health NZ, Ministry of Education, Department of Corrections, and Police.

Please refer to the cross-agency response for further detail of the collective actions agencies are taking as part of an MSD led integrated work programme.

Oranga Tamariki is not always able to respond when it needs to

We agree with this finding in part. We acknowledge that unprecedented demand for our services and support, and increasing reports of concern presents new challenges for Oranga Tamariki, the wider children's system and our iwi, Māori and community partners in being able to respond. However, we do not agree that this means that child safety concerns are being ignored, as could be inferred from the report.

We do not agree with the suggestion that decisions to take no further action are being made to manage demand. Decisions are made following assessment of the information available and in line with legislative requirements and practice guidance. Responding to Reports of Concern is our core business, and where indicators meet the Child Protection Protocol;

criteria, consultation with Police and consideration of joint investigation is expected. Our review of practice following Malachi's death has reinforced that clearer guidance, enhanced recording expectations, and stronger interagency processes have now been implemented.

It is not made clear in the Monitor's report that Oranga Tamariki has a legislative discretion under the Oranga Tamariki Act 1989 to undertake "such investigation as is necessary and desirable" section 17(2A). This recognises that whilst in many cases the appropriate response to a report of concern will be to complete an investigation (and take other statutory actions provided for in the Act) often there may be more appropriate responses which provide a legitimate response to a report of concern.

Each report of concern Oranga Tamariki receives is triaged, with an initial assessment completed to determine how best to respond depending on a range of factors including the child's previous history, whether there is new information since the concerns were reported, whether or not the child has safe and protective adults to support them and whether other agencies are already providing or could provide the support the child and their family need. A case file analysis of reports of concern completed at the beginning of 2024 showed that in 91 percent of cases (87 of 96) the rationale for the decision to take no further action was recorded in CYRAS[1]. In 28 percent of the cases where Oranga Tamariki deemed no further action was necessary, support from a partner agency was identified as the right option for the tamaiti and their whānau.

We acknowledge that there are significant opportunities to improve the Oranga Tamariki Intake and Assessment process, the 'front door' for Oranga Tamariki reports of concern. This work is critical, as we expect further increases as broader system work on mandatory reporting progresses. We have therefore established a work programme to identify and implement rapid improvements to strengthen the Intake and Assessment process. This work will be focused, actionable and grounded in frontline knowledge to ensure it is fit for purpose for those actioning these processes. Improvements will incorporate process, practice, system and technology.

Collaboration between Oranga Tamariki and community organisations could provide an early check on safety

We agree with this finding.

That is why we have invested heavily in codesigning new and innovative iwi, Māori and community led responses to reports of concern. In addition, across the country 27 sites have processes in place which directly involve iwi, Māori and community partners in triage and decision making about how best to respond to reports of concern[2]. This includes community partners providing direct support in response to the report of concern. Often it is our community partners who are better placed to offer the support children and families need in a way which will be accepted.

Enabling iwi, Māori and community responses by transferring decision making and resources is and remains a core part of our strategic plan. We are focused on building strong, locally led partnerships and relationships with iwi Māori, community groups and service providers, enabled by a nationally coordinated Children's System. Each year we invest around half of our operating budget (approximately $530 million dollars) on services provided by our iwi, Māori and community partners.

[1] For 71 percent of these (62 of 87) the rationale was considered robust. Where a robust rationale was not evidenced, this often reflected a lack of whānau history being considered alongside the current concerns, or a lack of sufficiently clear analysis of how the social worker had reached the decision.

[2] The nature of these partnerships and the scope of their work will vary.

Changes announced by Government in October 2025 are a start but greater priority must be given to keeping tamariki safe

We agree with this finding in part. The integrated cross-agency programme announced by the Government in October 2025 has accelerated progress, but the work to respond to the Poutasi report began in 2022. Children's agencies are not just starting this work now, as this finding implies.

Substantial work to strengthen our practice and improve interagency collaboration have been implemented since 2022. These improvements reflect work that has occurred over several years to strengthen child protection practice, some of it initiated prior to the publication of the Poutasi report. This work continues alongside the integrated cross-agency response.

We are committed to the work that has begun and remains ahead of us with our cross-agency partners to realise the system changes needed to create the mutually reinforcing safety nets envisaged by Dame Karen Poutasi.

Closing observations

Oranga Tamariki are disappointed that we were not given a greater opportunity to have direct input into the development of the Monitors' findings and insights, with the Monitor noting that most of the input from Oranga Tamariki staff was derived from previous engagements and not for the specific purposes of this report[3]. We therefore consider that that the Monitor has made some significant observations and criticisms of Oranga Tamariki which lack context, may be based on information which has changed with time and with which we do not fully agree. We nevertheless recognise and accept the challenge that more and faster progress is needed moving forward by Oranga Tamariki and our partner agencies to strengthen the systems which are intended to keep children safe.

The role that Oranga Tamariki has to play in the lives of children and families is significant. For this reason, it is essential that we are held to a high standard, that our actions and performance are robustly scrutinised and, where necessary, we are held to account when things go wrong. Systemic change requires a continuous improvement mindset which is supported by robust self-assurance alongside the strong, independent external scrutiny which our independent monitors provide.

[3] For the purposes of this report, the independent monitor spoke to 52 Early Childhood Education Kaimahi, 46 Ministry of Social Development Kaimahi, 32 kaimahi from various agencies who are part of multi-agency responses and 6 Oranga Tamariki kaimahi from the national contact centre.