Aroturuki Tamariki | Independent Children's Monitor

Towards a **stronger safety net** to prevent abuse of children

A second review of the implementation of the recommendations of Dame Karen Poutasi following the death of Malachi Subecz and a review of actions identified by government agencies to prevent abuse of children at the hands of their carers.

IN DEPTH REVIEW | DECEMBER 2025

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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He whakamihi
Acknowledgement

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

We acknowledge the whānau of Malachi Subecz. We hope in the near future you can have confidence that, for other tamariki (children) and their families, those who know are taking action, and those who take action are being listened to.

We acknowledge the whānau of the 24 tamariki who died at the hands of people who were supposed to be caring for them between December 2021 and June 2025 and whose death reviews were provided to us for the purposes of this review. Our heart goes out to everyone who bears the grief of losing a child.

We are grateful to the kaimahi (staff) from Oranga Tamariki, Corrections and early childhood education (ECE) providers and to those working in the community who met with us and talked so openly about their mahi in the hope that things will improve for tamariki.

Dame Karen Poutasi passed away shortly after we finalised this report. We are grateful that we had the opportunity to brief her on our draft report a few months prior. She was determined to ensure that her 2022 report *Ensuring strong and effective safety nets to prevent abuse of children* resulted in the improvement of New Zealand's child protection system. Dame Karen's care, kindness and determination for the State to serve our children better was always at the forefront of our discussions with her. We are committed to carrying her work forward.

Dame Karen Poutasi, kua ngaro koe ki te ao kikokiko, kua riro koe ki te pō. Haere ki te okiokinga i o koutou tūpuna e tatari ana mōu. Moe mai rā e te Rangatira, okioki ai.

Kupu Whakataki

I te 2024, i tāia e mātou te arotakenga o ngā tūtohu a Kahurangi Karen Poutasi i tana pūrongo i te 2022 i runga anō i ngā urupare a te rāngai tamariki ki te tūkino tamariki, nō te matenga o Malachi Subecz. Ehara ko te pūrongo a Kahurangi Karen te tuatahi ki te titiro ki ngā mūhore a ngā tari kāwanatanga i te matenga o tētahi tamaiti engari ko ia te tuatahi ki te tono arotake ki te whakatinanatanga o ngā panoni i tūtohua e tana pūrongo.

He matekiri, ā, he patu wairua ngā kitenga o tā mātou arotake i te 2024. Tē mārama mātou ki te hauarea o te whakatau i te tūkino tamariki i Aotearoa. Kāore hoki ētahi o ngā tūtohu māmā i whakatinanahia. Ko te hua o tērā, ko tā mātou kite ake, kāore i haumaru ake ngā tamariki mai anō i te wā i oti i a Kahurangi Karen tana pūrongo. Nā tēnei pōturitanga, i ū mātou ki te tirotiro anō i tēnei take i muri i te 12 marama, kia kite mēnā rā i panoni ētahi āhuatanga.

Ki te titiro whānui tātou, he pērā anō te āhua. Engari i te Ōketopa 2025 - i a mātou e whakaoti haere ana i tēnei arotake - i whakatau te Kāwanatanga kia whakamanahia ngā tūtohu katoa a Kahurangi Karen, ā, kia tīmataria he hōtaka mahi whiti-tari, hei whakatinana i ēnei.

Koinei te mahi tuatahi. Ko te mahi mō nāianei, ko te whakatinanatanga i runga i te tūpato me te whai whakaaro. Kia kitea rā anō ngā panoni i roto i ngā hapori, e kore e noho haumaru ake ngā tamariki. Ko ngā kitenga o tēnei arotake, kāore anō kia kapi noa ngā āputa i tautohua e Kahurangi Karen, ā, e taka tonu nei ngā tamariki i te kupenga haumaru.

I tua atu i te urupare ki ngā tūtohu a Kahurangi Karen, me wawe te rapu whakapainga ki te pūnaha tiaki tamariki kia pai ai te urupare tika ki ngā pūrongo āwangawanga. Ka whakatakoto tēnei arotake i ngā mahi hei whai. Ka tohu hoki ki ngā tauira o te panoni pai hei ārahi i a tātou.

He mea hirahira ki a mōhio koe, e noho haumaru ana te nuinga o ngā tamariki i Aotearoa, ā, ka urupare ngā kaitauwhiro a Oranga Tamariki ki te nuinga o ngā pūrongo āwangawanga. Engari kāore e tae atu rātou i ngā wā katoa ki te kite ā-kanohi i ngā tamariki katoa e māharaharatia nei e te tangata, tae atu ki ngā kaimahi tauwhiro, ngā pirihimana, ngā kaiako me ngā kaimahi hauora. Ahakoa ka tohe tū tētahi e ngākaurua ana ki te haumaru o tētahi tamaiti, kei te mōhio rānei he haumaru-kore tētahi tamaiti, kāore e tāea e mātou te kī taurangi ka urupare ake a Oranga Tamariki.

Ko te hunga e mate nui ana i ngā ringa o ngā kaitiaki ko ngā tamariki kei raro i te kotahi tau. Ko ēnei pēpi te hunga kāore i te tino kitea atu o tō tātou motu, ā, ko te aro ki a rātou, ā-kanohi nei, me noho hei whakaarotau. He tīmatanga pai ngā whakataunga i whakaputaina e te Kāwanatanga i te Ōketopa. Heoi ko tā tātou ināianei me kite rawa he whakatinanatanga.

Arran Jones
Tumu Whakarae

Foreword

In 2024, we published our review of the recommendations of Dame Karen Poutasi in her 2022 report on the children's sector response to abuse following the death of Malachi Subecz. Dame Karen's report was not the first to look at the failure of state agencies following the death of a child, but she was the first to request a review of the implementation of changes her report had recommended.

The findings of our 2024 review were disappointing and disheartening. We found the lack of priority given to addressing child abuse in Aotearoa New Zealand hard to understand. Even some of the simple recommendations had not been progressed. As a result, we concluded that tamariki (children) were no safer than when Dame Karen completed her report. Because of this lack of progress, we committed to come back after another 12 months and see what, if anything, had changed.

Overall, the story is much the same. However, in October 2025 – as we were finalising this review – the Government made the decision to accept all of Dame Karen's recommendations and to get a cross-agency work programme underway to implement them.

This was a first step. What is now needed is careful and thoughtful implementation. Until change happens on the ground and in communities, tamariki will continue to be no safer. As this review finds, the gaps identified by Dame Karen have not closed and tamariki continue to fall through the safety net.

Beyond responding to Dame Karen's recommendations, we need urgent improvements to the child protection system so it is able to respond effectively to reports of concern. This review sets out what is needed. It also points to examples of positive change that can guide the way.

It is important to note that the majority of tamariki in Aotearoa are safe and Oranga Tamariki social workers respond to many reports of concern. But the fact remains that they are simply not always able to get in the car to see with their own eyes all the tamariki that others are concerned about, including social workers, police officers, teachers and health staff. Even if those who are uncertain about a child's safety, or know a child is unsafe choose to act, we cannot say with confidence that Oranga Tamariki will respond.

The highest number of deaths at the hands of carers are tamariki aged under 1. These babies are some of the least visible in our country and checking on them, in person, must be a priority. The decisions announced by the Government in October are a good start. Now we need to see some action.

Arran Jones
Chief Executive

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Key findings

The care and protection system keeps many tamariki in Aotearoa safe, yet gaps in the safety net remain and tamariki continue to fall through these. Malachi died in November 2021. Between December 2021 and June 2025, 24 tamariki in Aotearoa were killed at the hands of the people who were meant to be caring for them.

Tamariki are still no safer than when Malachi died

The overall key finding of this report is that tamariki are still no safer than when Malachi died. The gaps in the system – as identified in the Poutasi report – have not closed, and Oranga Tamariki is not always able to respond when it needs to. The result is that tamariki are being harmed and killed.

The Government has announced that it will prioritise this work by accepting all recommendations in the Poutasi report and put a plan in place to implement them. This is a start, but this review identifies that, in addition to implementing the recommendations from the Poutasi report, the Government must further prioritise the safety of tamariki by ensuring that the statutory care and protection system – Oranga Tamariki – is resourced and equipped to respond when needed.

Social workers need to be able to see tamariki in person when reports of concern are assessed as requiring further action. Funding and resourcing community organisations to respond to reports of concern that do not require a statutory response could help to alleviate some of the pressure on Oranga Tamariki so it can act to keep tamariki safe.

Critical gaps identified in the Poutasi report remain

The critical gaps identified in the Poutasi report were not new. The report showed that, over the previous 30 years, there had been 33 reviews and reports about child abuse and deaths. Of the 33, eight identified similar practice and system gaps as the Poutasi report. Those eight included high-profile deaths of tamariki killed by those who were supposed to be caring for them.

Our analysis of death reviews since December 2021 found that tamariki at risk of harm can remain invisible. Reviews are mostly fragmented, not child focused and tend to look at an agency's own practice rather than across multiple agencies or at systemic issues. That means opportunities to close gaps and improve collaboration across government are being missed.

In addition, some of the recommendations that government agencies are working on from their own reviews following Malachi's death are focused on symptoms rather than underlying causes. This narrow approach is also taken in the 24 death reviews we looked at. This means the oranga tamariki system is not learning or improving in ways that will result in meaningful change.

Three years on from the Poutasi report, progress on implementing the recommendations has been very slow. This work will help to better identify tamariki and rangatahi (young people) at risk of harm or who are being harmed. What is also needed is improvement to a child protection system that is not always able to respond when called upon.

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

Recommendations in the Poutasi report sought to address the gaps around visibility of tamariki in the system, collaboration and sharing of information by agencies, and reporting of concerns by professionals and the public to make tamariki safer. Through our monitoring, we have also identified that changes are needed to how Oranga Tamariki responds to reports of concern. Even if the gaps identified in the Poutasi report are closed, tamariki will not be safer until Oranga Tamariki is able to respond to reports of concern when it must.

In the four years since Malachi died, very little has changed in how reports of concern are responded to. Like Malachi, some of the tamariki who have since died at the hands of those supposed to be caring for them were also known to Oranga Tamariki through reports of concern, but sufficient action was not taken to keep them safe.

While the number of reports of concern has increased, the number progressed for further action by Oranga Tamariki has not. This is not because the reported concerns are low risk. Rather, the static level of action is indicative of Oranga Tamariki sites working to the level of resource they have available. This results in a varied risk threshold between sites and regions. Data shows this, and the voices of community providers, government agency kaimahi, and frontline kaimahi from Oranga Tamariki confirms it. Put simply, Oranga Tamariki social workers are not always able to get in the car and visit tamariki when needed.

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

Oranga Tamariki needs the support of a well-funded and well-resourced community sector. The sector could then provide the first line of response to reports of concern that are lower risk and not assessed as requiring a statutory response. These are issues such as school attendance, food, housing or clothing. Iwi, Māori and community providers are better placed to provide this support, with the help of government agencies. Visits by community organisations could also provide an opportunity to assess any safety risks and escalate any reports of concern back to Oranga Tamariki in the knowledge that it will respond. Providing whānau with support at the earliest opportunity is consistent with an investment approach and can also prevent harm from occurring and further notifications to Oranga Tamariki.

This kind of collaboration is being trialled in reports of concern tables – where multiple organisations sit around the same table to determine the appropriate response. These provide an early intervention that may lead to a reduction in harm and in further reports of concern. But these can only go so far. When a statutory response is needed to keep a child safe, action from Oranga Tamariki is required.

Kaimahi working with these community-led tables tell us that, when they have exhausted options for support and consider a child is in need of statutory care and protection, Oranga Tamariki isn't always able to respond. It also doesn't always provide updates to the tables about whether it has visited and checked the child is safe.

In addition, the funding model does not support the establishment of consistent, robust community-based solutions. For example, Oranga Tamariki is rolling over pilot programmes in six-month increments rather than committing to a medium-term or long-term funding stream. The operating model for the tables is not consistent from one community to the next – and these tables are not available in all communities.

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

While the Government announced in October 2025 that it has now accepted all recommendations in the Poutasi report and is committed to taking action to respond, the critical gaps have still not been closed. Work has only just started.

Training in child safety and information sharing is welcomed. It is essential to better identification of harm and to reducing the risk of overwhelming the system with reports of concern – something that could happen as a result of mandatory reporting.

Oranga Tamariki is already struggling to manage the volume of reports of concern. Any increase due to mandatory reporting will not improve the safety of tamariki if social workers are unable to get out and check on those who may require care and protection. This is why we are highlighting the need to not only address the recommendations in the Poutasi report but also to improve the capacity and ability for the child protection system to respond.

Prioritising child protection must be the collective responsibility of all government agencies that support our tamariki, rangatahi and whānau. While other agencies must step up and play their part, Oranga Tamariki must always act when needed, using its statutory responsibilities and powers to protect children and keep them safe. It should not require repeated alarm bells for Oranga Tamariki to respond.

Scope

This review is undertaken in accordance with section 26 of the Oversight of Oranga Tamariki System Act 2022 as a review carried out on our own initiative.

It is our second review stemming from recommendation 14 of the report by Dame Karen Poutasi ***Ensuring strong and effective safety nets to prevent abuse of children***[1] (Poutasi report). Recommendation 14 was that Aroturuki Tamariki | Independent Children's Monitor review the Government's progress against the 13 other recommendations in the Poutasi report, one year on from its publication.

On 1 August 2024, we published ***Towards a stronger safety net to prevent abuse of children.***[2] We found that none of the recommendations made in the Poutasi report had been achieved at that time and that tamariki were no safer than when Malachi died. Recommendations that agencies had set themselves in response to their own internal reports were at various stages of implementation.

As work had not progressed to a point where it could be measured and we were unable to report meaningfully on the impact of any changes, we advised a second review would be completed. This is that second review.

As with our first review, we have looked both at responses to the recommendations of the Poutasi report and at the implementation of actions agencies set for themselves. We looked at both the system and at individual agencies and the extent to which agencies, individually or collectively, are contributing to ensuring strong and effective safety nets to prevent the abuse of children.

1 Poutasi, K. (2022). Ensuring strong and effective safety nets to prevent abuse of children. Oranga Tamariki. orangatamariki.govt.nz/assets/Uploads/About-us/Performance-and-monitoring/Reviews-and-Inquiries/System-review-Dame-Karen-Poutasi/Final-report-Joint-Review-into-the-Childrens-Sector.pdf

2 Aroturuki Tamariki | Independent Children's Monitor. (2024). *Towards a stronger safety net to prevent abuse of children.* aroturuki.govt.nz/assets/Reports/poutasi/Review-of-implementation-of-Poutasi-recommendations.pdf

The agencies that have a lead or supporting responsibility for the recommendations in the Poutasi report and have contributed to this review are listed below. The first six agencies commissioned the Poutasi report and also completed their own reports.

- Oranga Tamariki | Ministry for Children
- Department of Corrections | Ara Poutama Aotearoa
- New Zealand Police | Ngā Pirihimana o Aotearoa
- Ministry of Social Development | Te Manatū Whakahiato Ora
- Ministry of Education | Te Tāhuhu o te Mātauranga
- Ministry of Health | Manatū Hauora
- Ministry of Justice | Te Tāhū o te Ture
- Education Review Office | Te Tari Arotake Mātauranga
- Health New Zealand | Te Whatu Ora
- Executive Board for the Elimination of Family Violence and Sexual Violence[3]

Our objective is to assess whether the actions undertaken by agencies, individually and collectively, are making tamariki safer. To do this, we have sought to understand:

- the progress agencies have made in responding to the Poutasi recommendations and in implementing actions from their own reports
- the outcomes they aim to achieve from these actions and how they will measure the impacts
- the extent to which agencies' individual and collective actions address the underlying issues and critical gaps identified in the Poutasi report.

3 The interdepartmental Executive Board for the Elimination of Family Violence and Sexual Violence includes Accident Compensation Corporation, Department of Corrections, Ministry of Education, Ministry of Health, Ministry of Justice, Ministry of Social Development, Police, Oranga Tamariki and Te Puni Kōkiri. There are four associate agencies – Department of the Prime Minister and Cabinet, Ministry for Women, Ministry for Pacific Peoples and Ministry for Ethnic Communities.

Our approach

This review focuses on the five critical gaps within the system that the Poutasi report identified, whether those gaps are closing and whether tamariki are safer as a result.

As with our last review, we requested information and data from all agencies with responsibilities for implementing recommendations from the Poutasi report. We also requested data and information from agencies about their progress in completing actions arising from their own internal reports.[4]

In our information requests, we asked agencies about the recommendations they are responsible for, including what work has been completed since our last review and whether the impact of any change is being measured.

For this second review, we engaged with a wider range of agencies, including Corrections, ECE providers and representatives from several government agencies and non-government organisations (NGOs) who are part of multi-agency response teams responding to either Police callouts for family violence or to reports of concern made to Oranga Tamariki across the motu.[5] These engagements included kaimahi from Police, other government agencies, NGOs and iwi/Māori services.

We spoke with kaimahi from Oranga Tamariki to understand if their response to reports of concern had changed in any way. This included the Oranga Tamariki National Contact Centre.

We also surveyed some frontline kaimahi in the Ministry of Social Development (MSD).

4 We have used the most recent data provided to us by Oranga Tamariki. As this is operational data, in some cases, the figures reported differ slightly to data in our 2024 review. Where the most recent dataset did not contain the data we required, we have used older datasets that do not reflect recent updates to the operational data.

5 Our previous review included qualitative information from engagements with Oranga Tamariki kaimahi only. This was because only Oranga Tamariki had progressed changes sufficiently for us to seek information about the impacts they were having.

Our 2024 review noted our intention to look at whether the system's response when a sole parent of a dependent child is incarcerated has changed in response to the Poutasi report. For this review, we heard from some sole parents in prison faced with the decision of deciding who would care for their dependent tamariki when they received a prison sentence.

In our 2024 review, we found the Poutasi report recommendations had not been implemented and the system change called for had not happened. Given this lack of progress, we wanted to understand how agencies are applying findings from other reviews of child deaths to make the system safer for other tamariki.

To provide context about child death reviews in Aotearoa, we requested information from five of the children's agencies: Ministry of Education, Ministry of Health, Ministry of Justice, Police and Oranga Tamariki. In addition, we requested information from the Health Quality & Safety Commission | Te Tāhū Hauora. All six agencies responded to our request. Information was not requested from the Coroners Court | Te Kōti Kaitirotiro Matewhawhati.

Police and Oranga Tamariki provided data and information, including copies of the child death reviews they had undertaken between December 2021 and June 2025.

An overview of the status of agency responses to recommendations in the Poutasi report is set out in Appendix A. A similar overview of the status of agency responses to their own recommendations is provided in Appendix B.

Timeline for this review

April

April 2025 we requested information from agencies with responsibilities for responding to the actions in the Poutasi report on progress and, where relevant, what actions they have undertaken in response to their own agency reviews.

May

June

May and June 2025, we spoke directly with sole parents in prison with dependent children being cared for by someone other than a parent, and to kaimahi and leadership from across ECE services, Corrections kaimahi, and multi-agency teams responding to family violence. We also surveyed some Ministry of Social Development frontline kaimahi and spoke with leadership at NZ Customs Service.

Aug

August 2025, we spoke with six members of the leadership team from the Oranga Tamariki National Contact Centre (NCC) to hear more about how the process of the NCC triaging reports of concern is working.

Sept

September 2025, we provided a draft report to the agencies.

Dec

December 2025, we submitted the final report to the Minister for Children, and to agencies for formal response (under legislation, agencies that are the subject of this report have 35 working days to provide a written response).

In addition to the more than 1,200 people we engaged with in our regular monitoring in 2024/25, for this review we also heard from

13 mothers

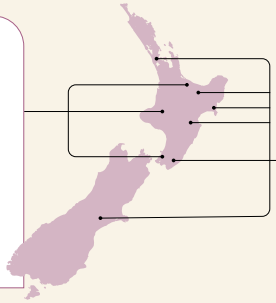
52 ECE kaimahi

19 Corrections kaimahi

46 Ministry of Social Development kaimahi

6 kaimahi from the Oranga Tamariki NCC

Oranga Tamariki kaimahi as part of our community monitoring in the Bay of Plenty, Greater Wellington and Te Tai Tokerau



32 kaimahi who are part of local multi-agency responses (for either family violence or reports of concern) in their rohe from five different localities – Auckland, Bay of Plenty, Hastings, Gisborne and Canterbury.

We selected communities to visit based on the numbers of reports of concern made to Oranga Tamariki in 2024 by ECE services and Police.[6] The communities we visited included some with high numbers and some with fewer numbers of reports of concern from ECE services and Police. We worked with the Education Review Office (ERO) to identify a range of ECE providers in each area that had not been subject to review by ERO in the past year (so providers were not overburdened). We engaged with ECE kaimahi from a range of provider types, including larger organisational structures, independently owned services and kōhanga reo.

6 Police reports of concern that were specific to family violence.

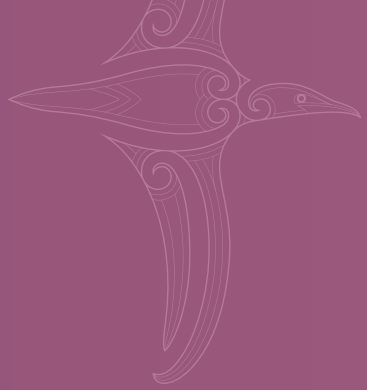
Police helped us connect with multi-agency teams responding to family violence[7] that are operating in the same communities so we could look at how those responses are working in practice.

We worked with Corrections to identify and engage with mothers in Christchurch Women's Prison and Arohata Prison who had dependent tamariki being cared for by someone other than a parent. We also spoke with Corrections kaimahi in these prisons and Christchurch Men's Prison about how they work with parents in prison and Corrections' responsibilities relating to child protection.

The table below explains how we use terms in our reviews when referring to what we heard.

Quantity	Term used
One, used as an example of a theme	For example, a
Two	A couple
Three 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

7 Multi-agency responses were recommended by Dame Karen Poutasi in recommendation 3 of her report. Our last review identified the models that were operating, but we did not speak with any for our last report.



Introduction

Aotearoa has one of the highest rates of child deaths by abuse in the OECD. Most of the children who die from abuse are aged under 5, and the largest group is aged under 1.[8] This is something the Poutasi report highlighted.

The Poutasi report showed that, over the previous 30 years, there had been 33 reviews and reports about child abuse and deaths, a mix of coronial inquests, reviews by past Children's Commissioners and reports by independent reviewers as well as by the Family Violence Death Review Committee.[9]

Eight of the 33 reports[10] identified similar practice and systems gaps as the Poutasi report. These eight included high-profile cases of tamariki killed by those who were supposed to be caring for them. The similarity of the findings – and lack of change as a result – was noted by Dame Karen.

> ***"I find it unacceptable that I need to once again make similar findings about how the system is – or is not – interacting. The majority of my recommendations are not new."*** [11]

8 Child Matters. (2025). New Zealand child abuse statistics. childmatters.org.nz/insights/nz-statistics/

9 In 2023, the Health Quality & Safety Commission made changes to the mortality review committees. The Family Violence Death Review Committee is now the Family Violence Death Review Subject Matter Experts, who report to the National Mortality Review Committee. The new national mortality review function is outlined in Appendix D.

10 See (pp. 29–31, 55–56) of report at footnote 1.

11 See (p. 31) of report at footnote 1.

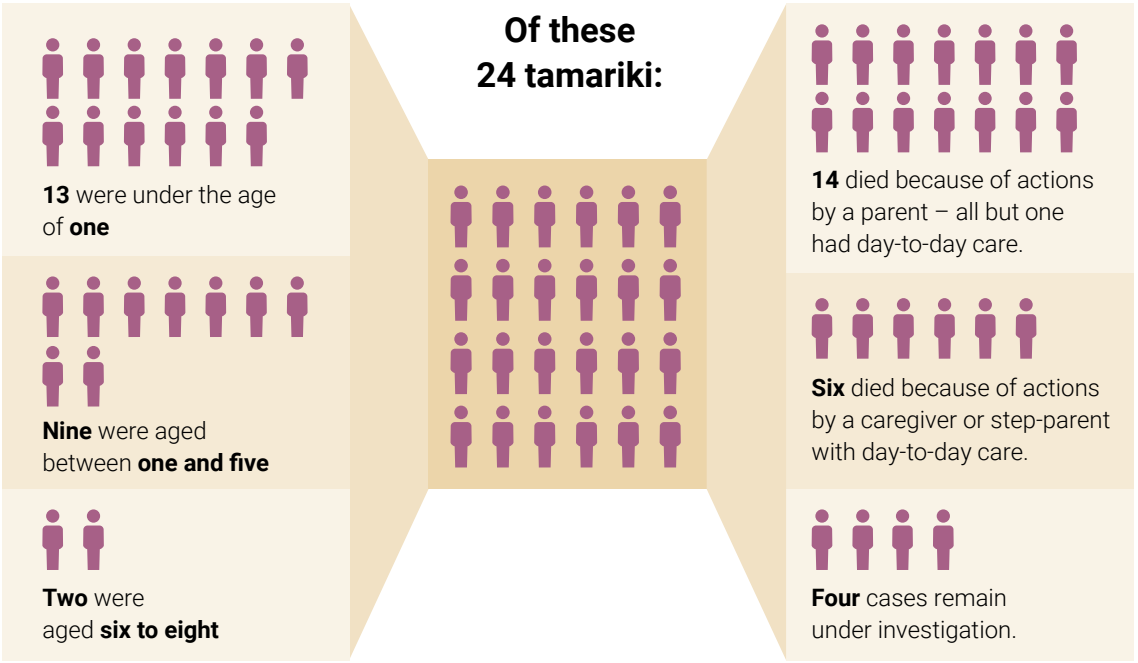
Since Malachi's death, a further 24 tamariki have been killed by someone who was supposed to be caring for them

Using data provided by Police and Oranga Tamariki, we identified that, between December 2021 and June 2025, 24 tamariki in Aotearoa died because of confirmed or suspected abuse, homicide, non-accidental injury or maltreatment by a person who was supposed to be caring for them. We are aware that, since June 2025, more tamariki have died in similar circumstances, and we acknowledge that these tamariki are not reflected in this review.

There is significant sensitivity in this information, and we respectfully note we have not reviewed the specifics of the lives and circumstances of these tamariki or the nature of their deaths. For example, we have not focused on the ethnicity of tamariki because Oranga Tamariki and Police have different ways of collecting ethnicity information, which makes reporting on ethnicity across these agencies problematic.[12] Potentially, this is a gap for children's agencies. A 2021 report[13] found that "mortality is not evenly distributed in the population: rates are higher in Māori and Pacific children and young people than in other ethnic groups".

12 Oranga Tamariki records multiple ethnicities and follows the Stats NZ ethnicity classifications and standards while Police does not. Police records one ethnicity for each individual despite guidance from Stats NZ that individuals should be able to identify with multiple ethnicities. Information about the approaches of Oranga Tamariki and Police to ethnicity data collection can be found in *Ethnicity data collection by justice sector agencies: Prepared for Te Rau o te Tika – the Justice System Kaupapa Inquiry (WAI 3060) – June 2024*.

13 Te Rōpū Arotake Auau Mate o te Hunga Tamariki, Taiohi | Child and Youth Mortality Review Committee. (2021). 15th data report: 2015–19 Health Quality & Safety Commission (p. 4). hqsc.govt.nz/assets/Our-work/Mortality-review-committee/CYMRC/Publications-resources/CYMRC-15th-data-report2015-19_final_2.pdf



We have focused on these tamariki because of some of the circumstances they share with Malachi. Almost half (11) of the children were known to Oranga Tamariki before their death. Two further children aged under 1 had had siblings involved with Oranga Tamariki. Most of the alleged perpetrators (19) were known to the Police in varying ways. However, most of the children were not known to the Police.

Our 2024 review referenced a Child Matters statistic that one child dies every five weeks from abuse. This cannot be compared with the statistics in this year's review because our focus is on where a child is killed by the person who was supposed to be caring for them. The average figure in our 2024 review was from Child Matters, and was based on any death resulting from abuse. This will include deaths caused by a wider group of people than we have focused on in this review.

Almost all 24 deaths have been, or will be, reviewed by Police and one-third reviewed by Oranga Tamariki

A death review had already been completed by one or both agencies for 14 of the tamariki. In addition to data, Police provided 10 completed Police family violence death reviews (PFVDRs) and told us a further 12 were in progress. Oranga Tamariki provided seven completed child death reviews and told us two more were in progress.

In Aotearoa, there are several different ways that non-accidental deaths of tamariki and rangatahi are reviewed. Each of the six agencies we requested information from about child death reviews has a different focus and may or may not choose to undertake a review of a child death. The only agency that confirmed it does not have a formal agency review role was the Ministry of Education. However, any of these six agencies may participate in a review at the request of the National Mortality Review Committee | He Mutunga Kore,[14] provide information for a coronial process or contribute to a multi-agency review. A more detailed overview of the mechanisms that may review tamariki deaths is provided in Appendix D.

Agency reviews are often conducted in isolation, do not always look at systemic issues and do not lead to change across the system

The literature and research around child death reviews often points to child deaths being hard to predict and notes reviews that focus too heavily on trying to find blame can lead to recommendations that have the wrong focus.[15] Research has found recommendations of reviews often give undue weight to readily

14 The Health Quality & Safety Commission has established a national mortality review function to review and report on mortality through the collection, analysis and review of mortality data on specific classes of death with the aim of preventing future premature death and promoting continuous quality improvement.

15 Connolly, M., & Doolan, M. (2007). *Lives cut short: Child death by maltreatment*. Office of the Children's Commissioner. manamokopuna.org.nz/publications/reports/lives-cut-short-child-death-by-maltreatment-marie-connolly-and-mike-doolan-published-for-the-office-of-the-childrens-commissioner-2007-/

measurable aspects of practice rather than the more complex understanding of how the system did not prevent the death and what changes are needed at a system level.[16]

> *"When a child dies violently, New Zealand has closely followed other countries in adopting recommendations that emerge from the child death review process. But this has often been done uncritically, using a bureaucratic rather than a professionally focused approach, with the introduction of more protocols and the revision of procedures for social workers and allied professionals, as well as concurrent demands for greater compliance. This response assumes, incorrectly, that the often idiosyncratic circumstances surrounding a single child's death can necessarily be generalised across other cases within the statutory child protection system, and that the specific professional responses that might have saved that particular child will necessarily be useful if applied more widely."*[17]

From the child death reviews provided to us by Police and Oranga Tamariki, we note the following.

- Police and Oranga Tamariki, for the most part, undertake reviews in isolation from other agencies. Their reviews focus on internal practices rather than broader systemic issues.[18]

16 Munro, E. (2011). *The Munro review of child protection: Final report – a child-centred system*. Department for Education. gov.uk/government/publications/munro-review-of-child-protection-final-report-a-child-centred-system

17 See (p. 68) of report at footnote 16.

18 Police confirmed this is consistent with Police policy and the intent of PFVDRs. It noted that broader system issues are reviewed by the Family Violence Death Review Subject Matter Experts through the National Mortality Review Committee – Appendix D refers in more detail.

- Most of the PFVDRs do not make specific recommendations and do not introduce new or systemic changes to existing Police practice – meaning that Police does not make any recommendations for itself.[19] Some PFVDRs included findings and/or recommendations for Oranga Tamariki and the Ministry of Health. As reviews are undertaken in isolation from other agencies, it is unclear whether the recommendations or reviews that made recommendations for other agencies were given to those agencies to learn from. Some PFVDRs have a finding that no government agency held information that, if acted upon, could have prevented the death.[20]
- Some of the reviews undertaken by Oranga Tamariki appear comprehensive, make multiple findings, identify areas for improved practice and make recommendations. Some include a plan in response to the review that shows that actions were completed but provide no detail or explanation of how or whether it led to any change. Actions did not appear to align with the level of risk identified in the reviews.
- Reviews by Police and Oranga Tamariki focused on addressing symptoms contributing to harm but not the underlying causes.

Police told us that PFVDRs consistently highlight areas for improvement that align with recommendations made by the Poutasi report and that these areas are already being addressed by Police's continuous improvement efforts. For example, Police has invested in frontline training and interagency co-ordination initiatives to support early identification and response to family harm.

Oranga Tamariki told us it makes changes to address specific findings of child death reviews. As an example, it said what has been learned has been incorporated into practice improvements and in implementing its new Practice Approach.

19 Police told us that, for many child death reviews, Police's first engagement is at the point of notification of serious injury or death. It told us that, in these cases, there are often few or no recommendations for Police action that would have changed the outcome. It explained that PFVDRs tend to generate more recommendations in cases where an adult has died as a result of intimate partner violence, where Police may have had prior involvement.

20 Police guidance outlines the scope of PFVDRs in relation to other agencies as follows: "The review will also consider the interaction of Police with external agencies. However, it must not examine the practices of those other agencies apart from their engagement with [Police] and their known interaction with the parties involved, if relevant."

This main part of the review begins with the five critical gaps identified in the Poutasi report, what agencies are doing to respond to the critical gaps and our assessment of whether these gaps are closing.

The second part of the review looks at the front door of the child protection system and how current reports of concern are handled. Even if the critical gaps identified by the Poutasi report are closed, Aotearoa does not yet have a child protection system that is fit for purpose and that is always able protect tamariki and rangatahi when called upon.

We finish with a look at how child deaths are reviewed in Aotearoa and if and how learnings from these reviews inform improvements to policies and practices to keep tamariki safe.

Closing the critical gaps

The Poutasi report found five critical gaps

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

The Poutasi report was published in December 2022 and echoed themes from previous child death reviews in Aotearoa dating back 30 years. Those 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.

Findings of our 2024 review indicated little progress in closing critical gaps

Our 2024 review found that recommendations from the Poutasi report had not been implemented and there had been limited progress on actions identified in agencies' own reviews. Furthermore, what had been done addressed symptoms rather than underlying root causes. The critical gaps identified in the Poutasi report remained.

We found the Oranga Tamariki response to reports of concern was not always sufficiently focused on the safety of tamariki and rangatahi. Oranga Tamariki was not making the best use of its resources to respond to reports of concern. Site decision making on reports of concern was unduly influenced by resourcing and workload, and the threshold for statutory intervention seemed to differ across Oranga Tamariki sites as a result.

We reported there was a lack of trust across the sector about whether Oranga Tamariki would respond appropriately to reports of concern – and noted this trust would need to be rebuilt. We noted that, in tandem with this, the NGO sector would need to be resourced and supported to pick up and respond to reports of concern that do not meet the threshold for statutory intervention – such as early intervention support for whānau. Alongside work to educate professionals on when to report concerns, this might improve the capacity of Oranga Tamariki to investigate reports of concern more fully.

Our 2024 review concluded that the system-level change called for in the Poutasi report had not been realised. We noted that other agencies, particularly children's agencies, need to respond to wider needs of whānau earlier – including health, education, employment and housing needs – to prevent the escalation of harm to tamariki wherever possible. Expectations that Oranga Tamariki will be able to solve it all need to change.

The Government has now formally accepted all the recommendations in the Poutasi report

Following our 2024 review, the Government started to track this work, with a standing agenda item on the recommendations included on the agenda for Child and Youth Ministers.

In early October 2025, while we were writing this review, the Government announced it formally accepted all the recommendations of the Poutasi report. It agreed to take an integrated, all-of-government approach focused on safeguarding children to implement the recommendations with urgency.

Critical gap 1

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

The Poutasi report identified 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 noted the children 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 report found that, when a sole parent is facing a custodial sentence, it should be a red flag for risk.

The Poutasi report made two recommendations aimed at closing this critical gap. They were focused on vetting the carers of tamariki whose sole parent has been arrested and/or taken into custody, regular follow-up checks of those carers to ensure ongoing safety of tamariki and providing support for carers to meet the needs of these tamariki.

Also relevant to this critical gap is the report by the Office of the Inspectorate | Te Tari Tirohia on Corrections' management of Malachi's mother. That report noted that Malachi was not recorded as a dependant when his mother arrived at prison.

While some work has progressed towards closing this critical gap, vetting caregivers of tamariki whose sole parent is arrested and/or taken into custody is not yet in place and this critical gap remains

Ensuring the needs of dependent tamariki whose sole parent is imprisoned are identified and met will help to close this critical gap. To do this, the system must first identify these tamariki and rangatahi.

Some work has progressed. Oranga Tamariki and Corrections have taken steps to understand the number of parents with dependent tamariki and rangatahi who come before the courts, and judges are now more likely to receive information about dependent tamariki and rangatahi of people being sentenced. As part of the decision to accept all the recommendations in the Poutasi report, Cabinet agreed to make enhancements to the existing report of concern process to ensure that tamariki and rangatahi of sole parents who are incarcerated are identified and their needs met. We were told that agencies are working together on a dedicated interagency response to identify and respond to the needs of these tamariki and that this will include assessing the safety of alternative carer arrangements.

Through our monitoring, we heard that work by Corrections is ongoing to ensure information about dependent children is recorded. However, prisoners and Corrections kaimahi told us about challenges and why Corrections is not always made aware of parental responsibility. Some of these reasons are outside of Corrections' control such as parents not being willing to provide relevant information and other agencies not sharing it. It is important, however, that Corrections does record information about the dependent tamariki of parents in prison and that prison social workers take opportunities to keep parents connected with their tamariki and rangatahi. Regular connection can make parents aware of safety and wellbeing issues for their tamariki and rangatahi in the community, and prison social workers (currently in women's prisons only) can help parents to respond to concerns, including by working with Oranga Tamariki.

Child death reviews that we looked at reveal that another child whose parents were in prison was killed by a person meant to be caring for them, just two months after Malachi died.

Despite the work that has progressed, this critical gap remains.

Understanding of the number of sole parents or caregivers coming before the courts is improving

In our previous review, we noted that, to fix a problem, it is important to understand the extent of it. At the time, the Ministry of Justice could not tell us how often a sole parent or carer had been in court on charges that could lead to a sentence of imprisonment.

A recent Oranga Tamariki published evidence brief[21] used data from the Integrated Data Infrastructure (IDI) to identify for research purposes how many parents (including sole parents) in prison in 2021 had tamariki and rangatahi aged under 18. It showed that more fathers of tamariki and rangatahi aged under 18 are imprisoned than mothers of tamariki and rangatahi aged under 18 (Table 1).

Table 1: Number of parents in prison who had tamariki aged under 18 in 2021.

Fathers	**3,522**
Mothers	**399**

Data from the IDI further shows that, as at 31 March 2025, 41,610 tamariki and rangatahi aged under 18 have a parent who is either in prison or has been in prison at some point in the last five years. It also shows that, as at 31 March 2025, 3,465 tamariki aged 0–4 had a parent who had been in prison or on remand in the past 12 months. This was 1.2 percent of this age group in Aotearoa. For those aged 5–14, the number and proportion increased to 9,630 tamariki or 1.4 percent of this age group.[22]

Corrections told us it began collecting information in March 2024 and, as at May 2025, had completed 7,184 pre-sentencing reports that identified dependants in respect of 6,010 individuals. It could not provide information on whether the dependants recorded were tamariki and rangatahi or other dependants or how many of these individuals received a custodial sentence. Corrections was later

21 Ning, B., Faasen, K., Jackson, G., & Jenkin, G. (2024). Evidence brief: Care of children of incarcerated sole caregivers. Oranga Tamariki | Ministry for Children. ot.govt.nz/assets/Uploads/About-us/Research/Latest-research/Youth-Justice-research/Evidence-Brief-Care-of-Children-of-Incarcerated-Sole-Caregivers.pdf

22 Age-specific data was drawn from publicly available data online at sia.govt.nz/what-we-do/regional-data-explorer

able to advise that, between March 2024 and 11 September 2025, 582 males, 106 females and 13 people of unknown gender were recorded in their pre-sentencing report as having dependants[23] and were subsequently documented as being in prison custody. This suggests that most people with dependants for whom a pre-sentencing report is prepared do not receive a custodial sentence.

We also asked Police how many people it had taken into custody who identified themselves as a primary carer. Police advised it does not currently collect this information, but changes are being made to the Electronic Custody Module (ECM) within the National Intelligence Application to include a prompt to ask about dependants. It told us the ECM prompt is to improve identification of dependants and that concerns are referred to the appropriate agency. Police guidance is to forward concerns about tamariki and rangatahi to Oranga Tamariki. While it was not able to provide data for this review Police confirmed that, in future, it will be able to report on how many people it has taken into custody who identified they have dependants. However, it will not be able to report on how many of those dependants were tamariki and rangatahi.

23 Corrections advised that it does not collect information on whether the dependant recorded is a child or young person or if the individual is a sole parent.

Some progress has been made on identifying parents or carers appearing in court

The Ministry of Justice provided an update on the cross-agency work led by Judge John Walker to ensure judges receive information about the dependent tamariki and rangatahi of defendants. It advised that the Making Children Visible in the Court operational process was introduced in March 2025. It said the process strengthens existing court mechanisms such as oral submissions to identify for judges when a defendant has dependent tamariki and rangatahi. However, the Ministry of Justice could not tell us how many times judges had been made aware of the existence of dependent tamariki and rangatahi since the introduction of this process, as the court case management system does not record this.

Police told us that the Police prosecution report was updated as part of Making Children Visible in the Court. It now prompts Police kaimahi to include childcare arrangements so the prosecutor can provide the information to the Court if appropriate. The report now includes a section to note the details of applicable childcare arrangements at the time of arrest, including how many tamariki and rangatahi they relate to and whether Oranga Tamariki was contacted.

Corrections told us it includes whether someone has a dependant on its Provision of Advice to Courts form along with other information relating to the individual's sentencing or relevant court matters. This is to better inform sentence pathways and consideration of support needs. Support needs could include a report of concern to Oranga Tamariki or to make sure the parent has the support they need to stay in touch with their tamariki and rangatahi while in prison. While this change is positive, Corrections noted its impact is limited by its reliance on self-disclosure.

Identifying dependent tamariki and rangatahi is just the first step. It is important that, once they are identified, the needs of these tamariki and rangatahi are understood so they can be supported and kept safe.

Enhancements are being made to the report of concern process to ensure that tamariki whose sole parent is arrested and/or taken into custody are identified, their safety assessed and their needs met

The Poutasi report recommended that Oranga Tamariki should be engaged in vetting a child's carer when a sole parent is arrested and/or taken into custody. It said that Police (or the relevant prosecuting agency) in the first instance, and the Court in the second, would need to build time into their processes for this to occur. The report further recommended that Oranga Tamariki do regular follow-up checks and provide support for vetted carers while the sole parent remains in custody. It identified that resourcing must be addressed to enable this to occur.

It made this recommendation because no part of the system considered whether Michaela Barriball was a safe caregiver for Malachi, if she was able to meet his needs while his mother was in prison or if she needed specific supports to do this.

A December 2025 Cabinet paper noted that agencies are working together to enhance the existing report of concern process to ensure that tamariki whose sole parent is arrested and/or taken into custody are identified and their needs met. In January 2026 an in-person interagency hub will be established including Oranga Tamariki, Corrections, the Ministry of Education, MSD, Police and the Ministry of Justice. At the time of drafting, Health NZ was considering its appropriate level of involvement in the hub. The hub will be based in the Oranga Tamariki NCC.

From February 2026, Police, Corrections and MSD will identify tamariki whose sole parent is remanded in custody and/or sentenced to a term of imprisonment. They will make a report of concern to Oranga Tamariki at the following points:

- opposition to bail – if Police oppose bail for the first Court appearance
- Immediate Needs Assessment – when Corrections assesses a prisoner's needs upon arrival at prison
- Corrections data match – used to identify MSD clients who have been imprisoned and are receiving financial assistance from MSD[24]

24 Generally financial assistance from MSD ceases when a person is imprisoned

- application for, or change to, assistance – when MSD receives an application from a caregiver for a benefit or other financial assistance in respect of, or to include, a child, where the applicant is not the lawful guardian of that child, and where the parent(s) of that child is in prison.

The interagency hub will then help to identify and respond to the safety, wellbeing and adequacy of care needs of these tamariki within 48 hours of the report of concern being received. It will do this by gathering and sharing information that the agencies in the hub hold about the circumstances and care arrangements for these tamariki. This is enabled through existing provisions in the Oranga Tamariki Act.[25]

We recognise the progress made in getting to this point. It provides an opportunity to not only check on a child's safety, but to put support in place for tamariki, rangatahi and their carers. As we outline later in this section, tamariki and rangatahi who have a parent or parents imprisoned may need a wide range of support and information. The hub is an opportunity for agencies to step in and help ensure those needs are met. Bearing in mind the challenges tamariki and rangatahi with parents in prison face, there is also an opportunity for the interagency hub to consider support for, and to see all these tamariki, not just those assessed as being at risk of harm. This wider focus would link with the priorities of the Social Investment Fund and could be delivered through community partners.

However, we are concerned that if the hub is not sufficiently resourced, the response may not achieve what Dame Karen envisaged when she made this recommendation. At worst, it could divert existing resources at the expense of seeing other tamariki for whom concerns have been raised.

More can be done to identify dependent tamariki and rangatahi, but often, it will still require parents to tell agencies about their tamariki

In our 2024 review, we said we would look at whether and how agencies are routinely identifying and responding to the needs of dependent tamariki and rangatahi whose parent or carer is arrested and/or taken into custody. In our engagements for this review, we found that opportunities to identify these tamariki were sometimes missed.

25 Sections 15, 66 and 66C

While the enhanced report of concern process is expected to help identify and respond to these dependent tamariki and rangatahi, we note that it will rely on a number of existing processes as well as individual discretion on whether to make a report of concern. We are pleased to see that additional processes, such as data matching, will also be used and we hope that identification of tamariki and rangatahi will be improved.

In our engagements, we heard about the barriers and enablers to identifying tamariki and rangatahi whose sole parent has been arrested and/or taken into custody. These are set out below.

Mothers were not always asked if they have tamariki and rangatahi when taken into police custody or in prison

We met with mothers in prison who had dependent tamariki and rangatahi being cared for by someone other than a parent – either because their mother was their sole parent or because both parents were in prison. They told us about a range of experiences of when they were asked whether they had dependent tamariki and rangatahi.

A couple of mothers told us police ensured that their tamariki were looked after during their arrest. One mother told us police asked her "who could look after your baby?", and after she called a friend, the police went and picked her friend up and brought her to the mother's house to look after her baby.

Other mothers told us that, either at the time of arrest or when in custody, police did not ask them whether they had tamariki and/or did not listen when they were told about dependent tamariki.

> *"With my last arrest, my son was at home with me. I was dragged from the house. I yelled at the neighbour to go into the house and get my son who was aged 2 years. Police physically removed me from the house. I tried to tell [police] then and after I had been arrested [about my child]."*
> MOTHER IN PRISON

> *"You should get asked [whether you have dependent tamariki] when you are at the [police] station getting processed. But from experience, [police] don't listen."* MOTHER IN PRISON

Another mother told us she would not tell police about her dependent tamariki because "I don't trust police".

Police told us its People in Police Custody Policy sets out considerations for police officers regarding dependants of those taken into custody. It advised the policy is being updated to include additional considerations such as that police must ensure appropriate due diligence is undertaken when arranging for the care and protection of a detainee's child/dependant, including assessing the immediate environment the child/dependant will be placed in and any local and reliable knowledge.

The mothers we met with recounted various experiences of being asked about dependent tamariki when arriving at prison. One mother told us she was "asked about the ages of [her] children, but not much other than that". Another said she was asked about her tamariki "and if they were safe". A third mother said only her family had asked her about her child and that no professionals or case managers had, but "the prison social worker got involved when I started to talk about [my child]".

There is little support for parents to find a suitable carer prior to being imprisoned – and many receive no advance notice of a custodial sentence

Corrections told us a probation officer completing a pre-sentence report for someone with dependent tamariki and rangatahi should ensure the individual is aware of all sentencing options so they can make arrangements for the care of their tamariki accordingly. We were told there is guidance for Corrections kaimahi to have these conversations and prepare parents for the possibility of a custodial sentence. While this should happen, it is not clear that it must happen. This may explain why some of the mothers we met with had not been prepared for the possibility of a custodial sentence.

> *"I was on bail at home for [over a year]. No warning, end of trial and that was it. Dropped my kids to school and that was it."* MOTHER IN PRISON

> *"I was on electronic monitoring bail for [nearly 200] days – full carer for our … kids. Went to court and my lawyer said, 'We're sending you to jail today'. I went to court expecting to go home. I had jail time before my sentence, which hopefully would let me go [on home detention]."* MOTHER IN PRISON

> *"I didn't know until on the day [that I would be sentenced to imprisonment]."* MOTHER IN PRISON

Only one mother told us about proactively asking for a sentencing indication, which meant she was able to make calls and arrange for her tamariki to be cared for before she went to prison.

> *"Once I was given a sentencing indication, I called as many agencies as I could to help me sort the kids. Especially around the safety aspect of things for me."* MOTHER IN PRISON

When we met with mothers in prison, we asked about their current experiences within the last 12 months. While it is possible that some mothers also spoke about prior experiences with police and Corrections, it was clear from what we heard that not all mothers were asked about their tamariki or informed about a possible custodial sentence. We hope that the experiences of mothers who are imprisoned are now getting better – in line with what we heard from agencies around improving processes to identify dependent tamariki of parents being imprisoned.

Once in prison, further efforts are made to identify dependent tamariki but improved information sharing would help

Prison kaimahi told us they ask for information about dependent tamariki so they can help ensure tamariki and rangatahi are being cared for. Kaimahi told us parents who indicate they need to arrange childcare as part of their immediate needs assessment are given the opportunity to do so. In response to our information request, Corrections told us parents who need to arrange childcare can make phone calls until they are satisfied their tamariki are cared for. If appropriate arrangements cannot be put in place, prison kaimahi will contact Oranga Tamariki via a dedicated 0800 number, which alerts the Oranga Tamariki call centre that the call is coming from a prison.

Prison kaimahi told us that, when people are brought into Corrections custody, the immediate needs assessment process collects information about dependent tamariki, but people will not always disclose that they are parents because of a lack of trust.

> *"[It] can be hard to establish that [women coming to prison] have kids … Women are scared of Oranga Tamariki involvement."* PRISON KAIMAHI

> *"We know with some women that they do have kids and that some don't tell us, but we are responsible to find out."* PRISON KAIMAHI

We heard Corrections receives limited information from other agencies about dependent tamariki. We heard from prison kaimahi that information about dependent tamariki and rangatahi is sometimes recorded on paperwork from the courts, but information about dependent tamariki and rangatahi is generally not shared with them by Police.

> *"If [prisoners] have been in police cells prior to coming out here [to the prison], you get [no information]."* PRISON KAIMAHI

Police told us that a prisoner transit sheet accompanies the individual to court and, if they are remanded in custody, to the prison. It confirmed that the prisoner transit sheet does not include information about dependants. It further confirmed that Police guidance states to forward any concerns about dependants to Oranga Tamariki.

Corrections informed us that its immediate needs assessment process is still being refined. It told us specialist advice is being provided on the collection and storage of personal information about dependent tamariki of people in prison.

Tamariki and rangatahi whose parent(s) are imprisoned need support and information

Pillars[26] helped us understand the needs of rangatahi who had had a parent or parents go to prison. Pillars met with six rangatahi, some of whom were younger when their parent(s) went to prison, to help inform our review.

Three rangatahi had either their sole parent or both parents go to prison. The remaining three had their fathers imprisoned whilst they remained cared for by their mothers.

The responses from all the rangatahi suggest that, even when a parent remains available to care for them day-to-day, tamariki and rangatahi whose parents go to prison have a number of needs that are not always addressed. For them the need for support was not limited to just those who had a sole parent who was imprisoned.

Almost all (five) of the rangatahi had a change in living circumstances. In some cases, tamariki and rangatahi were cared for in their home but by another relative who moved in. Others had to move out of their homes to be cared for by someone else.

26 Pillars | Ka Pou Whakahou is a national charity that works with tamariki and whānau of people in prison. It provides wraparound social work, mentoring programmes and youth advocacy.

> *"I was in and out of different homes all the time at first. I had one interview about who I wanted to live with – that was the only time I felt the system actually cared."* **RANGATAHI**

> *"We often didn't go to the doctor or dentist coz Nana wasn't able to do that for us on her own."* **RANGATAHI**

Some rangatahi who continued to be cared for by their mother also had changes in their living circumstances. In the most extreme situation, a rangatahi said they experienced homelessness for a while as a direct result of their parent going to prison.

> *"I was homeless, constantly changing schools, couldn't make any long-term friends – I didn't make friends until I went to college. Figuring out who I was was so hard – lying about my dad's identity."* **RANGATAHI**

> *"Dad was in and out of prison, and we were living in cars homelessness. Lots of different houses, different schools, transience was the norm. There was like a year that went by when we couldn't go to school."* **RANGATAHI**

> *"Food parcels in times of need really helped – we are a big whānau and when you're hungry everything stops."* **RANGATAHI**

Half of the rangatahi said they felt safe with the person caring for them. The other half either did not feel safe or only felt safe some of the time. Most were not involved with Oranga Tamariki as a result of their parent going to prison, but some had prior involvement. Sometimes the involvement was for a sibling or siblings.

> *"Most of the time [I felt safe], but we lived a free will kind of life doing whatever we wanted. It was also terrifying at times too. Like when my dad got out of prison and brought drama home – I had to stay awake for days to keep myself and my siblings safe."* **RANGATAHI**

> *"No matter how old they are, involve little kids as well – as long as there are trusted adults around to do that. Not the people who are hurting them."* **RANGATAHI**

> *"I wish I'd been communicated with. I would've felt safer with more assurance – knowing that my family is OK. Understanding why this was happening."* **RANGATAHI**

The rangatahi were affected in a variety of ways. Most talked about disruptions to friendships and relationships, some had had interruptions to their schooling and some spoke of feeling isolated. The rangatahi all felt that better communication is needed with tamariki and rangatahi. Things they wanted to help to understand include what will happen and why – such as who they will live with, and how court processes work.

> *"School was hard because some people didn't want to be associated with us because of our parents. My sister lost friends, so I became silent and isolated myself coz I didn't want to lose friends like she did."* **RANGATAHI**

> *"The police told me on the spot when they came to get [Mum] that she was going to jail. I had no time to react or prepare."* **RANGATAHI**

> *"I do feel I was always last to know about everything, and [the] process was very long and draining."* **RANGATAHI**

> *"My school would have police turn up to interview me in uniform. My friends would know. The teachers knew. It messed up my relationships. It was like I always had to be in damage control mode. I grew up around it, so it was normalised in a way which isn't right. I know now that none of it was OK."* **RANGATAHI**

All the rangatahi spoke of a lack of support from people and agencies at the time their parent(s) went to prison and while they remained in prison. However, four of the six rangatahi specifically mentioned what a positive difference the support they received, and continue to receive, from Pillars has made.

> *"When it first happened, no one supported me. My mum got no support either."* **RANGATAHI**

> *"We just had to go to our Mum's court cases to find out if she was coming out or not. There was no communication or support."* **RANGATAHI**[i]

> *"Due to the court case, we weren't allowed to discuss anything in relation to the case so that was difficult."* **RANGATAHI**

> *"All I had was my family and all I could do was live day-to-day until the sentencing. I couldn't imagine how terrible it would have been if I hadn't had the support I did."* **RANGATAHI**

> *"I never talked about what my happened with my Dad to anybody. It's just something that you just don't talk about."* **RANGATAHI**

These experiences demonstrate that those who care for tamariki and rangatahi whose parent(s) are imprisoned need a wide range of supports, irrespective of any concerns for their safety. They also show that tamariki and rangatahi in this situation may need specific support provided directly to them.

> *"I want support to be there ready to go – like the KWKW [Kaiwhatu Kura Whānau – whānau navigators in the criminal District Court] idea needs to happen. I think the BoR [Pillars Youth Advisory Panel Bill of Rights] would make a big difference to other families – as long as they had support to be walked through it. I gave up some of my childhood to get through it all. I can't imagine what my older sister had to give up."* **RANGATAHI**

> *"I would change everything to be honest … we need someone there to support the kids because I know there's heaps of kids out there that just get left and the police don't really worry about the families … yeah, I would change the support system."* **RANGATAHI**

In November 2025, the Social Investment Agency announced its first round of funding. A total of $50 million will go towards programmes reaching more than 1,600 tamariki and rangatahi. Ministers decided the priority cohorts for the first round of the Social Investment Fund would include tamariki and rangatahi with parents who are, or have recently been, in jail.

Having identified tamariki and rangatahi whose parents are in prison as a priority for funding, there is an opportunity to put in place the support these rangatahi are asking for.

The interagency hub that is being established may be a vehicle to achieve this. Its role is to gather and share information about the circumstances and care arrangements for tamariki and rangatahi whose parent(s) are remanded in custody awaiting court appearances or sentenced to imprisonment.

At the time we drafted this review, it was unclear what role agencies such as the Ministries of Health and Education may have in delivering supports via the interagency hub. It is also unclear whether there is an intention for all tamariki and rangatahi to receive a welfare visit, or whether the response will only be where concerns for safety are apparent. We encourage all government agencies to consider how to deliver a wide range of support.

By listening to those rangatahi who are experiencing the system today, government agencies can close the gaps in the safety net for tamariki and rangatahi in the future.

Prison social workers support mothers in prison but there is less support for fathers in prison

The Poutasi report identified that an imprisoned parent has very little real ability to check up on their child's care or to follow up on a carer's ongoing suitability or treatment of their tamariki and rangatahi. The prison social worker role is important in helping to keep parents connected with their tamariki and rangatahi. It is through regular connection that parents can become aware of any emerging safety or wellbeing issues.

We heard that, in women's prisons, a prison social worker would be notified about dependent tamariki so they could support mothers in prison.

In prison, working with a social worker is voluntary. The mothers we met with told us that prison social workers help maintain connections with their whānau, including dependent tamariki and rangatahi, while they are in prison.

> *"… My prison social worker was there [next to me on the audio-visual link for the family group conference]. She supported me in there."* MOTHER IN PRISON

> *"I asked the [prison] social worker if I could have my baby [with me] here. The social worker worked really hard for my baby to be here."* MOTHER IN PRISON

We also heard prison social workers are someone mothers can talk to if they are concerned about their tamariki and rangatahi.

> *"I would go to my [prison] social worker, the one here. Because I have built up a relationship with her."* MOTHER IN PRISON

> *"I would tell my prison social worker. She is quite busy, but she could help me. She is the reason why I decided my ex-partner isn't safe. She is awesome."* MOTHER IN PRISON

The support for fathers in prison is not the same. Kaimahi at Christchurch Men's Prison told us there was no social worker. When we asked if there was a need for one, we were told "[it] would be a benefit if we had one. We had a team of them 15 years ago."

Child death reviews reveal that another child of parents in prison was killed just two months after Malachi

Two of the 17 child death reviews we looked at were for the same child, who was killed by a person who was meant to be caring for them while their parents were in prison. The reviews identified that, when this child's mother was imprisoned, they were placed in Oranga Tamariki custody by Police under section 48 of the Oranga Tamariki Act, 1989.[27]

After an initial short stay with an approved Oranga Tamariki caregiver, the child was placed into the care of a whānau member. This whānau member had other tamariki in their care, and Oranga Tamariki did not complete a caregiver assessment as a senior practitioner from another Oranga Tamariki site "vouched" for them. What is most concerning about this case is that, despite the parents being previously known to Oranga Tamariki, a multitude of family violence reports made to Oranga Tamariki and reports of concern about abuse to other tamariki, the section 48 custody order was allowed to lapse with no assessment of the safety or the needs of the child or consideration of a further custody order.

Soon after the child was placed with this whānau member and after the custody order had lapsed, the child was taken by another whānau member without Oranga Tamariki knowledge or follow-up. Less than six weeks later, the child had been killed by a person meant to be caring for them. The child was not seen by Oranga Tamariki after they were with their whānau caregiver, and their needs were not assessed. The social work practice was adult-centric, with little consideration of the child's vulnerability or what they needed.

> *"When [the child] was placed in [the whānau member's] care, [the child] was not seen there and the impact on the [whānau member] and the other tamariki [they] cared for was not considered."*
>
> **ORANGA TAMARIKI CHILD DEATH REVIEW**

When this child's experience is considered alongside the experience of Malachi, it further highlights the vulnerability of tamariki whose parent is imprisoned and the need for the system to provide greater protection for them.

27 Section 48 gives custody to the Chief Executive of Oranga Tamariki for up to five days. This is to allow Oranga Tamariki to determine the necessary steps and whether and what custody orders are necessary.

Critical gap 2

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

The Poutasi report 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 might have resulted in a decision by Oranga Tamariki to go and see Malachi.

The Poutasi report made three recommendations to try and close this critical gap. Those recommendations were focused on enabling decision making at a community level to address harm and the risk of harm before it escalates to needing a statutory response, on giving health practitioners a wider view of interactions a child has had with the health system and on using health practitioners to help assess harm and support training under the Child Protection Protocol (CPP).[28]

In its report following the death of Malachi, the Ministry of Health made a similar recommendation to the Poutasi report about joining up medical records. In addition, the report by the Chief Social Worker following Malachi's death noted a need to involve community agencies in decision-making processes.

28 The CPP is the agreement between Police and Oranga Tamariki to work together where abuse or neglect is expected

There has been little progress since our 2024 review – the Poutasi recommendations and agencies' own actions have not been addressed and this critical gap remains

There is still no consistent, structured process for considering perspectives from other agencies or community organisations when assessing the risk of harm to a child.

While there are models of multi-agency teams in place, these primarily focus either on responding to an incident of family violence where police have attended or where Oranga Tamariki has assessed a report of concern as not requiring its involvement. The issue of inconsistent risk assessment for family violence and sexual violence victim-survivors, including tamariki and rangatahi, is a recognised gap within family violence and sexual violence responses.

Reports of concern tables triaging notifications that Oranga Tamariki has assessed as requiring no further action are promising, but they are not in every community and there is no consistent approach to how they operate. We could not identify any multi-agency models where professionals discuss concerns or worries about tamariki and rangatahi before the point of making a report of concern. If they did, and had resources to act, it would be a useful preventive measure – to provide help before harm occurs or escalates.

The Centre for Family Violence and Sexual Violence Prevention told us that, while this is mostly accurate, practice and capacity vary widely across Aotearoa and some multi-agency responses consider risks to tamariki prior to a formal report of concern being made. It told us that some multi-agency responses will bring whānau to the table even if a family harm incident or report of concern has not occurred. This is because community providers sitting around the table often have knowledge of whānau within the community who are experiencing harm but are not known to Police or other statutory agencies.

The Centre for Family Violence and Sexual Violence Prevention also told us it has identified the need to strengthen the visibility of tamariki within multi-agency responses and ensure a more consistent approach and will be progressing this as part of work to respond to the recommendations of the Poutasi report. It told us that the Executive Board for the Elimination of Family Violence and Sexual Violence approved a target operating model in August 2025.

Models that have greater visibility of tamariki and can discuss concerns prior to lodging a report of concern could help to determine what whānau may need and how they can be supported by iwi/Māori or community agencies before harm occurs.

Work in Health NZ to give health practitioners a wider view of a child's interactions with the health system has not advanced since our 2024 review. Implementation of the Shared Digital Health Record is at such an early stage, it is not possible to measure its impact. Approval of a business case is still needed to progress work to deliver on the full intent of this work.

A decision has been reached for Health NZ to join the CPP, but this is yet to be implemented. Until we can see how this is working in practice, we cannot measure whether and how this will contribute to closing this critical gap.

Child death reviews suggest that, even when tamariki are known to Oranga Tamariki and Police, they can still fall through gaps in the safety net. Since Malachi's death, at least five further tamariki who were known to Oranga Tamariki and/or Police have also been killed by someone who was meant to be caring for them.

Widening the agencies that are involved in assessing risk to tamariki and rangatahi with a view to supporting earlier interventions to prevent harm may help to close this critical gap. More needs to be done to achieve this.

Later in this review, we look at the ability of the child protection system to respond to reports of concern and why they are not necessarily acted upon.

The Poutasi report recommended setting up multi-agency teams in all communities to prevent and respond to harm

The Poutasi report recommended that multi-agency teams should be working in communities in partnership with iwi/Māori and other NGOs, resourced and supported throughout the country to prevent and respond to harm.

It noted that there are examples of this happening already across the country, but implementation in all communities must be a priority so relevant local teams can help assess, respond to the risks to tamariki and rangatahi and provide support.

This recommendation was made with a view to widening how risk is assessed and supporting earlier interventions to prevent harm occurring. While assessing the risk of harm is an inexact science and assessments may not always identify this risk, bringing in more perspectives to help assess risk, including earlier assessments and community responses to address harm, would go some way towards closing this gap.

Our 2024 review noted that, while there were several multi-agency programmes in place across the country, they were not in place in every community. The multi-agency programmes identified in our 2024 review were focused on responding to incidents of family violence, but they did not all operate or assess risk in the same way. We concluded that the collective impact these models were having on child safety was unknown.

There are reports of concern tables and family violence tables operating across Aotearoa

Oranga Tamariki told us that, since our 2024 review, it has worked with several community partners through its Enabling Communities approach to establish community responses to reports of concern. These tables receive reports of concern from Oranga Tamariki where it has already made a decision that the concerns raised do not require further action on its part. The term tables is used to describe the group of organisations that sit around the same table to discuss the response.

In communities where this approach has been set up, all reports of concern where Oranga Tamariki determines that a statutory response is not required will be referred to these tables. We heard about two examples of these tables during our recent community monitoring visit to Te Tai Tokerau – Te Kahu Oranga Whānau in Kaitaia and Te Tēpu in Whangārei.

In addition, we again heard about the network of multi-agency teams that respond to incidents of family violence. These teams are also often referred to as tables.

Most referrals to the family violence tables come from Police following a family harm incident that police officers have attended. The table collectively determines the appropriate response for whānau, which can include making a report of concern to Oranga Tamariki to assess whether further action is needed to support tamariki and rangatahi. The family violence tables do not usually consider cases where tamariki and rangatahi have been directly harmed, as allegations of abuse against tamariki and rangatahi are managed under the CPP between Oranga Tamariki and Police and require a direct report of concern to Oranga Tamariki.

To help inform this review, we met with two examples of these multi-agency teams – Integrated Safety Response (ISR) hosted by Police and multi-agency tables called Safety Assessment Meetings (SAMs).

While these initiatives are making a difference in the communities where they are operating, they are not yet closing the critical gap identified in the Poutasi report.

Neither reports of concern tables nor family violence tables are present in all communities, although the family violence tables do cover every Police district. Oranga Tamariki further told us that it was not feasible or desirable to set these up in all communities.

There is no consistent operating model or approach to assessing risk for either reports of concern tables or family violence tables. This is because they have been developed to respond to local needs and conditions. It means that responses to harm vary across communities – what might be assessed in one community as needing a response might be assessed in another as not requiring a response.

For the most part, reports of concern tables and family violence tables respond to address harm that has already occurred. There is no consistent forum across communities for agencies to collaborate at an earlier stage, share information and prevent harm occurring. The vision of the Poutasi report was that multi-agency teams would be set up to assess risk identified by agencies before needing to make a report of concern in order to help prevent harm from occurring.

Oranga Tamariki is piloting working more closely with strategic and community partners to respond to reports of concern

Oranga Tamariki told us Ngāti Kahungunu Iwi Incorporated is leading two multi-agency initiatives – Te Ara Hanganga and Te Kura. Te Ara Hanganga is a new programme operating in two Hawke's Bay locations, with four community organisations and Oranga Tamariki collaboratively assessing reports of concern. Te Kura co-ordinates the assessment and response to family harm incidents across Napier and Hastings, involving approximately 20 government agencies and NGOs.

Te Kahu Oranga Whānau and Te Tēpu in Te Tai Tokerau are also multi-agency response tables that triage reports of concern, referring those that need early support to community organisations and escalating those that require statutory intervention back to Oranga Tamariki. Some community kaimahi felt that all reports of concern should be sent to the tables for triage as they saw inconsistency in the threshold for action at Oranga Tamariki.

Many kaimahi from these tables, from community agencies and Oranga Tamariki, emphasised that communication between them enables good outcomes for tamariki, rangatahi and whānau referred to the table. However, we heard that there is not consistent feedback between Oranga Tamariki and the tables about whether reports of concern have been closed or actioned.

Neither Oranga Tamariki nor the community agencies from these tables routinely hear what has happened once whānau have been referred to a community organisation for community response or back to Oranga Tamariki for a statutory response. This leads to concern about whether anyone has visited and if tamariki are safe.

The Whangārei community table, Te Tēpu, told us about several areas of concern in their interaction with Oranga Tamariki. They said there can be weeklong delays in referrals being sent to their table from sites, due to delays in sites receiving the reports of concern from the NCC.

Police and Te Tēpu kaimahi were also concerned that multiple reports of concern about the same child are not always linked in CYRAS, the Oranga Tamariki administrative database. They said that Oranga Tamariki does not consider the safety of siblings and whānau when responding to a report of concern, instead focusing only on the child the concerns were about.

We also heard that, once a report of concern is referred to a table for community response, it is closed in CYRAS as no further action. If the table determines further intervention is needed such as a statutory response from Oranga Tamariki, it needs to make a new report of concern.

In addition, we heard that, when cases are referred to some of the tables for follow-up, whānau may not consent to working with the community agency. In those situations, a new report of concern must be made as the community agency does not have a mandate to work with the whānau.

We further heard that Oranga Tamariki does not advise the table of the action it has taken on reports of concern referred to it by the table. The practice of prematurely closing the report of concern creates additional bureaucracy and potential delay. Tamariki would be better served if Oranga Tamariki kept the report of concern open until the community table advises the appropriate action has been taken and that tamariki are safe.

In Greater Wellington, we heard about the Hapori Community Intake and Assessment table. One regional leader said that Hapori went further than previous initiatives at Oranga Tamariki because Oranga Tamariki is "not at the head of the table". The five community agencies[29] that make up the table are given reports of concern received by Oranga Tamariki and collectively triage reports of concern and make intake decisions.

> *"Without the Hapori response, this [Oranga Tamariki site] would fall over. We don't do it by ourselves, we do it all together."* **ORANGA TAMARIKI KAIMAHI**

We heard from Oranga Tamariki kaimahi that whānau are more willing to engage with community organisations, and at one site, this has reduced entries into care. However, we understand that not having secure funding makes it difficult to recruit kaimahi and that the table does not have all the resources it needs. At the time of writing, Oranga Tamariki is contracting the Hapori model on a rolling six-month basis as a pilot initiative.

29 Ngāti Toa, Wesley Community Centre, Taeaomanino Trust, Porirua Whānau Centre and ASK – A Safe Kapiti.

Practice and resourcing across the family violence tables is also variable

Family harm tables are more common than reports of concern tables and exist in most communities. They are commonly made up of Police, Oranga Tamariki and NGOs, with some including iwi/Māori agencies.

The tables meet at varying levels of regularity to discuss recent incidents of family violence. Mostly, the representatives jointly decide the appropriate action based on the nature of the incident but we were told there is significant variation across the tables, and in some cases, the risk and action is decided by a single person in one organisation.

We heard from kaimahi from both SAM and ISR family harm tables about the importance of building relationships and the information sharing that happens in these meetings.

> *"I get phone calls [from professionals at the table] all the time. It's always an open door, always an open line between agencies. They don't hesitate to ask. We don't have all the answers, we [as differing agencies] do think differently, we do have good relationships with other agencies."* **POLICE KAIMAHI**

However, we heard levels of resourcing created challenges across the different tables. For example, we heard that ISR tables were better resourced than SAM tables, and in practice, this can limit which iwi/Māori and NGO agencies the SAM tables can afford to contract.

> *"[The SAM table is] totally different to ISR where they get tonnes of money. We sort of run on faith and hope, which is a challenge."*
> **COMMUNITY AGENCY KAIMAHI**

We also heard that, at the SAM tables, each government agency is responsible for funding its own representation, and this can have an impact on which agencies attend and how frequently. We heard that Police put more funding and resourcing into the SAM tables than other agencies in terms of the kaimahi allocated to the SAM tables.

The Centre for Family Violence and Sexual Violence Prevention explained that ISR is an example of a multi-agency response model whereas a SAM table is a meeting and they are funded differently, with ISR receiving the most dedicated funding. ISR directly contracts NGOs and iwi organisations to pick up cases from its SAM table and work with whānau.

All other models do not receive direct funding for NGOs or iwi organisations to pick up cases. However, NGOs receive funding from MSD to respond to family violence in their community more generally.

These different funding models lead to a variation in responses and services available in communities. There is also a lack of visibility of what happens with referrals, as agencies are not funded to enter outcome data across systems.

Kaimahi also told us about the lack of thorough induction for new agency professionals at the table and that they were often left to teach themselves new processes and systems. In some cases, agency representatives had received their own agency-specific induction, but this did not always cover the work of the table.

> *"The induction programme is not well distributed. It most definitely has not been made available to the SAM agencies. I have heard mixed things in the community about it."* **COMMUNITY AGENCY KAIMAHI**

The Centre for Family Violence and Sexual Violence Prevention explained that induction practices vary across the sites and that some sites have training and induction as a pre-requisite for participation.

We also heard that sometimes iwi and NGO agencies did not have the capacity to support the tables.

> *"… It was about capacity. [The iwi] had so many different contracts, and a lot of being in this space is tedious, it can be very 'same shit different day' … [It's] not for a lack of trying and not to say they weren't willing."*
>
> **COMMUNITY AGENCY KAIMAHI**

Work is happening at a national level to strengthen family violence responses

We heard from the Centre for Family Violence and Sexual Violence Prevention about the work it is doing under the second Te Aorerekura Action Plan[30] to strengthen existing multi-agency responses to family violence. In its initial

30 Centre for Family Violence and Sexual Violence Prevention. (2024). *Te Aorerekura | Action Plan 2025–2030: Breaking the cycle of violence*. preventfvsv.govt.nz/assets/Uploads/Second-Te-Aorerekura-Action-Plan.pdf

report,[31] it summarised key insights, including enablers and barriers to multi-agency responses. The themes we heard from the multi-agency tables we spoke with align with these insights such as how the membership of the table impacts its success but that membership varies across the tables, in part due to funding and available resourcing.

The Centre for Family Violence and Sexual Violence Prevention is working with tables in 12 localities to develop system improvement plans that will identify actions to improve multi-agency responses to family violence at the national, regional and local level.

Linking medical records would give medical practitioners a complete view of a child's medical history and could support a more complete assessment of risk

As well as setting up multi-agency teams in communities, the Poutasi report recommended 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. This would further widen the view of the risk of harm to tamariki and rangatahi and could support medical practitioners to make reports of concern at an earlier stage and with more information to support an assessment of the risk of harm.

Our 2024 review noted the linking of medical records was expected in 2026. We reported that Health NZ advised the Hira programme will give approved whānau and health providers a comprehensive view of a child's medical history and health system interactions. We were told the new system will help health providers monitor wellbeing indicators over time regardless of where healthcare is accessed and will give them secure, easy access to a child's real-time information when needed but that this was still some years away from being realised.

31 Te Puna Aonui Business Unit. (2024). Understanding the current state of family violence: Multi-agency responses. Centre for Family Violence and Sexual Violence Prevention. preventfvsv.govt.nz/assets/Resources/Data-and-Insights/Te-Puna-Aonui-Understanding-the-current-state-of-family-violence-multi-agency-responses-2024.pdf

We further noted that development of the business case for Hira began in early 2021. At the time of our last review, funding had only been confirmed for tranche one of the business case, which would make patient summaries available to individuals and their healthcare providers via My Health Record by mid-2024. Tranches two and three of the business case would enable consistent nationwide access to a child's primary care medical records, but funding still needed to be confirmed for those tranches.

Limited progress has been made towards linking medical records since our last review

The Ministry of Health and Health NZ have been working to link medical records across the health sector since early 2021. This was also recommended in the Poutasi report and in the Ministry of Health's own report following Malachi's death. The intent of this work is to enable health professionals to view a complete picture of a child's medical history, which in turn will allow for a greater assessment of risk.

We asked Health NZ about progress on this work. In response, it told us that this initiative is part of a multi-year programme to link medical records across relevant healthcare settings. Some regions already have record sharing between general practitioner and hospital providers, and functionality. Over the next year, Health NZ will progressively deliver integrated access to hospital and primary care records through existing systems, connected nationally.

Health NZ has limited involvement in the CPP but is assessing the impact of it joining fully

The Poutasi report recommended that the health sector should be added as a partner to the CPP between Police and Oranga Tamariki to enable access to health professionals experienced in the identification of child abuse and to facilitate regular joint training.

Our 2024 review noted that the CPP was under review and that a decision had not been reached on health sector involvement in it. Options included full operational membership of the CPP, partial membership in areas such as governance, participation in review and training, and not joining but adopting other measures to enable access to health expertise and services in the context of the CPP.

We were told that a phased approach will be taken to Health NZ joining the CPP. Health NZ told us that its Board agreed in mid-October 2025 to it joining the CPP in a leadership and governance capacity as an initial step.

Health NZ also advised that an updated draft CPP that includes Health NZ is being developed by Oranga Tamariki, Police and Health NZ. However, it cannot confirm when or if full partnership will happen until it fully understands the likely resourcing implications for its frontline staff as part of the next phase.

It noted that, in some regions, additional clinical staff are likely to be required. In this next phase, Health NZ would also consult with clinicians about which tamariki and rangatahi require health involvement and how to implement this practically. Subject to the outcomes of the scoping for this next phase and approval to proceed to full partnership, Health NZ anticipates fully joining the CPP from 1 July 2026.

In his evidence to the Coroner's inquest into the death of Malachi Subecz, Dr Patrick Kelly, consultant paediatrician at Te Puaruruhau,[32] said he supported Health NZ joining the CPP, stating that "in my view, it is the only way we have to work to eliminate the variability in practice shown by both the police and Oranga Tamariki, when it comes to deciding which children should be referred for a health assessment". However, he raised concerns about the current ability of Health NZ to respond to the need for child abuse assessments.

Dr Kelly noted that there are no dedicated resources for these assessments, despite requests for regional centres with child protection expertise. Starship is the only hospital to have a dedicated, multi-disciplinary child protection team in the country. In areas outside Auckland, when acute assessments of injuries are sought by Oranga Tamariki or Police, they must be "somehow squeezed into the busy inpatient and outpatient clinical workload of general paediatricians or join the queue in equally busy emergency departments".

Dr Kelly raised concerns about the limited training many frontline health professionals receive in interpreting childhood injuries. He noted that the only national standardised training is provided through the Violence Intervention Programme. However, he also noted that, while this training is mandatory for all Health NZ kaimahi, almost no doctors attend. Similar training for GPs was almost entirely voluntary.

32 Te Puaruruhau (Starship Child Protection), Te Toka Tumai (Health NZ) Auckland, Te Hā Oranga (a kaupapa Māori organisation), Police and Oranga Tamariki are co-located at Puāwaitahi – the first multi-agency service dedicated to child protection in Aotearoa.

Within his evidence, Dr Kelly raised concerns about Oranga Tamariki practice in relation to the identification of physical injury. Dr Kelly described Oranga Tamariki social workers receiving photographs and making decisions about the safety of tamariki, without any input from experienced health professionals. He also noted that this practice is embedded within the culture of Police.

The Poutasi report noted that a cousin of Malachi emailed Oranga Tamariki and included a photograph of what was thought to be bruising around Malachi's eye. This photograph was only reviewed by Oranga Tamariki social workers, and the report of concern was closed.

> *"Oranga Tamariki and the police routinely make their own decisions about the significance of injuries observed in children. Decisions about which children are referred for a medical opinion are arbitrary and widely variable and largely made by statutory officers with little or no training in injury interpretation … One simple and achievable change to information sharing that might make a difference right now, is this. That every time Oranga Tamariki or the police receive a notification which involves an allegation that a child has visible physical injuries, that information (including any photographs of the injuries or possible injuries that the police or Oranga Tamariki receive) must be shared with a health professional with expertise in the assessment of injuries in children".* **DR PATRICK KELLY**

To achieve this, Health NZ would need to put considerably more resource into training of health professionals and providing adequate child protection expertise in all parts of Aotearoa. It was for this reason that Dr Kelly asked the Coroner to broaden the terms of reference for their inquest into Malachi's death to ask "whether actions taken by the health system … are sufficient to reduce the likelihood of further deaths occurring in similar circumstances in the future".

Until Health NZ provides child protection expertise in all parts of Aotearoa, the risks associated with Oranga Tamariki and the Police making health decisions in isolation remains.

The importance of working closely with health professionals was commented on in an Oranga Tamariki child death review.

> *"While Health is not currently a partner in the CPP, inviting Health to CPP consultations with Police about [the child] could have provided an opportunity to develop a more holistic understanding of the safety risks and wellbeing needs of [the child] at each point in the site's work with [the child], his family … and to make more informed decisions about [the child's] future safety."* ORANGA TAMARIKI CHILD DEATH REVIEW

Understanding of current CPP requirements is mixed, with inconsistent responses from Oranga Tamariki kaimahi and stretched Police

We heard concerns from some Oranga Tamariki and Police kaimahi about how the current CPP requirements are functioning on the ground.

Police kaimahi were concerned that some Oranga Tamariki social workers lack understanding of the CPP process and their role and there is inconsistency in responses from the sites. For example, we heard initial joint investigation plans are not always recorded in CYRAS or actioned by Oranga Tamariki kaimahi while the police are conducting their investigations under the protocol. Police kaimahi said that this can result in delays and unaddressed risk to tamariki and rangatahi, particularly when Oranga Tamariki closes cases during delays.

Police kaimahi in one region we visited also noted their own delays, telling us that they too are "swamped" by many CPP investigations.

> *"The timeliness and the delay in investigation causes kids stress. Kids have disclosed, and six months later, we are still having conversations."* POLICE KAIMAHI

We were told by a few Police kaimahi that individual Oranga Tamariki sites appear to have shifting priorities, with different demands, funding and resourcing that affect how they prioritise serious allegations that require a joint CPP response. We heard that some sites have more understanding of what the Police Child Protection Team does, and some Oranga Tamariki site leaders are more willing to attend meetings and work together than others.

> *"Some site managers have no idea what CPT is – and they're ultimately in charge. We have quarterly meetings where we want the site managers and district managers [to attend]. We'll be there but getting [Oranga Tamariki site managers] there is a struggle."* POLICE KAIMAHI

Child death reviews reveal that, even when tamariki are known to Police and Oranga Tamariki, they can fall through gaps in the safety net

There is a similar picture in some child death reviews that shows interaction between Police and Oranga Tamariki regarding the CPP.

Five of the 24 tamariki who have died since Malachi because of confirmed or suspected abuse by a person who was supposed to be caring for them had reports of concern made prior to the incident that led to their death and resulted in a referral to the Police under the CPP. One of these cases did not meet the threshold for an investigation under the CPP.

For another child aged under 2 who was killed only a few months after Malachi, the CPP was not followed by Police. The PFVDR found that "a report of concern should have been submitted by the Detective or [Child Protection Team and] this would likely have triggered a follow-up response from Oranga Tamariki". Nonetheless, this death review had no specific recommendations for Police.

> *"While there is clear evidence of working under the CPP, there were opportunities to work more closely with the Police and Health at key decision points. There was a lack of clarity about Oranga Tamariki's [sic] role within the CPP which may have influenced our decision about ongoing involvement with [the child] based on the initial Police decision to close their investigation."* **ORANGA TAMARIKI CHILD DEATH REVIEW**

Critical gap 3

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

The Poutasi report found 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 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. Despite this, agencies and their services did not proactively share information about Malachi.

The Poutasi report made two recommendations focused on closing this critical gap. The recommendations were focused on improving information sharing between agencies, with one specifically focused on MSD sharing information with Oranga Tamariki when financial assistance is sought for a child whose parents or sole caregiver is in prison.

Also relevant to this critical gap is a finding from the Chief Social Worker's report following Malachi's death that, if agencies had been more co-ordinated, it would have strengthened the response Malachi and his whānau received. In addition, the report of the Office of the Inspectorate[33] recommended the relationship agreement between Corrections and Oranga Tamariki be reviewed. Among other things, the relationship agreement sets out how the agencies work together and protocols for sharing information.

33 Office of the Inspectorate. (2022). Summary of the Office of Inspectorate's review. inspectorate.corrections.govt.nz/__data/assets/pdf_file/0018/49113/summary_-_final.pdf

Information is not yet being shared or connected more effectively

Our 2024 review found that information sharing was an ongoing issue. While the legal basis to share information was not at issue, there was a lack of clarity about whether information sharing was permitted by agencies, particularly for frontline kaimahi. As a result, information was not always shared across agencies as envisaged by legislation.

We noted that many professionals appeared to hold a view that simply referring concerns to Oranga Tamariki covers off their responsibilities as a children's agency, and this view remains. However, children's agencies' information-sharing responsibilities are more than just making a report of concern. Agencies need to work collaboratively so there is a better understanding of risk. Although the number of reports of concern from professionals has increased, which we discuss in more detail later in this report, there is nothing to suggest that information is being shared and connected more effectively now than when we last reported.

In our monitoring engagements, we continued to hear that information sharing remains a barrier. We heard this from the multi-agency response tables we spoke with, and Corrections kaimahi told us they need Oranga Tamariki to share more information with them. Oranga Tamariki told us it has developed guidance for children's agencies around the information-sharing provisions in the Oranga Tamariki Act. Despite this, there is nothing to suggest that information is being shared more routinely by frontline kaimahi now than when we last reported.

Government announcements in October 2025 accepting the recommendations of the Poutasi report stated that it was reinforcing a clear expectation that children's agencies share information where there are safety and wellbeing concerns for tamariki. It noted that the Privacy Commissioner would work alongside agencies to achieve this. We were told that, as well as reinforcing this message, the Privacy Commissioner will participate in workshops and lead proactive messaging.

The action for Oranga Tamariki and Corrections to review their relationship agreement has not been completed but is now underway.

The longstanding issue of information not being shared to keep tamariki and rangatahi safe is frequently cited in child death reviews as missed opportunities.

Shared training is required to be developed and delivered across agencies and community providers to close this critical gap. This will also require an ongoing focus to avoid repeating problems with understanding when to share information and the practice of doing that.

A new interagency hub will notify Oranga Tamariki of applications for financial assistance by caregivers of a child whose parent is in prison

The Poutasi report recommended that MSD 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 Poutasi report was clear that this is not about assessing whether a caregiver is entitled to financial assistance but that this is an opportunity for Oranga Tamariki to assess whether tamariki and rangatahi in this situation are at risk.

Our 2024 review noted that implementing this recommendation depended on decisions being made about recommendations to vet caregivers. MSD also told us that it reports concerns to Oranga Tamariki where it considers tamariki to be in need of care and protection. But MSD does not consider that application for a sole parent benefit or other support is, in itself, sufficient grounds for it to notify Oranga Tamariki. It told us that a clear purpose for sharing information in this context would need to be established through decisions on recommendations on vetting caregivers in the Poutasi report.

As noted in critical gap one, an interagency hub is being established to identify and respond to the needs of tamariki whose sole parent is remanded in custody and/or sentenced to imprisonment. MSD will make a report of concern to Oranga Tamariki when it receives an application for a benefit or other assistance from a caregiver that is for, or includes, a child the applicant is not the legal guardian of and where the parent(s) of that child is in prison. Information would then be shared through the hub as set out under critical gap one, to help triage the report of concern and determine the most appropriate response.

The interagency hub is expected to be established in January 2026, and MSD intends to update processes and begin to identify and share information with the hub from February 2026 onwards.

Guidance on information sharing has not led to improved practice but the Privacy Commissioner will work with children's agencies to reinforce expectations around information sharing

The Poutasi report also recommended improving understanding of the information-sharing regime in the Oranga Tamariki Act 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. Sharing information is one way agencies can pull together a fuller picture of risk for tamariki and rangatahi.

Appropriate sharing of information has also been repeatedly recommended in previous child death reviews.

Oranga Tamariki advised it had recently developed guidance on the information-sharing regime in the Oranga Tamariki Act and had given this guidance to other children's agencies. Child and Youth Ministers subsequently asked the agencies for an update on their information-sharing policies and how they are giving effect to them in practice.

Several agencies gave us a copy of the information they had respectively given to the Child and Youth Ministers detailing how information is being shared. This primarily identified the specific legislation and mechanisms able to be used to share information and, at a high level, how information sharing should happen in practice. It did not include any data that measured changes to how or how often information is shared or any assurances that frontline kaimahi are more aware of when and how to share information than they were when we last reported. It is also not clear what the expectations of Child and Youth Ministers were or whether the information provided met their expectations.

Advice to Ministers set out expectations for when kaimahi would share information, with a particular focus on information sharing with Oranga Tamariki. Some agencies stated that information sharing happens at the frontline regularly.

The Ministry of Education advised that it has provided information-sharing guidance and its Information Management team offers information-sharing training. The Ministry of Education provides training to schools, ECE services and Ministry kaimahi on request. However, due to resourcing, it is not able to deliver training on a wide scale. Where training is provided, it is intended to support the sharing of information for the wellbeing and safety of tamariki, particularly at the frontline.

The Ministry of Education noted that it does not have oversight of whether or how the education sector is using the information-sharing provisions in section 66C of the Oranga Tamariki Act between education providers or with other child welfare and protection agencies.

MSD advised that its information sharing with Oranga Tamariki is primarily reactive – responding to requests for information – rather than proactive sharing on its own initiative. It also noted that sharing information about child wellbeing is more complex. Specific guidance for MSD Kaimahi on when it would be helpful for Oranga Tamariki to have information from MSD on child wellbeing could be of assistance.

Police noted that agencies need to continuously ensure staff are educated on when to share information and what information they are entitled to share.

Health NZ noted that clinical staff complete an eight-hour Violence Intervention Programme core training session followed by refresher training every two years. This training includes information-sharing provisions and references to relevant internal and external policies and legislation. However, as noted earlier in this report, Dr Kelly questions whether doctors routinely attend this training.

We asked Oranga Tamariki if it had any information or context that shows information is being shared more routinely by frontline professionals now. It told us information sharing is encouraged by its frontline professionals and that it has a lot of information readily available to support how and when this can occur.

There is no evidence that the guidance provided by Oranga Tamariki to children's agencies on how information can be shared under the Oranga Tamariki Act has led to improved information-sharing practices. It is unclear whether it is understood why information is not being shared by frontline professionals across the sector.

However, announcements the Government made in October 2025 after accepting the recommendations of the Poutasi report stated that the Privacy Commissioner would work alongside children's agencies to reinforce expectations of information sharing.

In November 2025, the Privacy Commissioner issued a statement reinforcing that children's safety and wellbeing comes first, and there are no legislative barriers to sharing information where there are concerns about this. The Privacy Commissioner also issued new guidance about sharing information for child wellbeing and safety purposes.[34] They met with regional public service leadership groups to communicate clear expectations for information sharing and provide guidance on doing so safely. These groups intend to communicate this to their regional networks.

We will be looking to understand whether the work of the Privacy Commissioner leads to improved information sharing practice in our future monitoring.

Issuing guidance alone is unlikely to shift decades of differences in practice and understanding across the oranga tamariki system. If this is to be overcome, shared training developed and delivered across agencies and community providers is likely to be needed. It may be that the work led by the Privacy Commissioner will deliver on this.

However, even if improvements are made, turnover in the sector and roles with rotations mean that ongoing focus will be needed to avoid the repetition of problems with the understanding and practice of sharing information.

34 privacy.org.nz/resources-and-learning/a-z-topics/information-sharing-childrens-wellbeing-and-safety/

Even multi-agency response tables often struggle to share information

The multi-agency response tables we met with told us sharing information is fundamental to how the tables work. We heard that multiple legislative mechanisms enable information to be shared but not all agencies represented at the tables co-operated in sharing information – in one region, Oranga Tamariki was not participating, and in another region, it was not sharing information it held to support a multi-agency approach to meet tamariki and rangatahi needs.

Two family violence tables we met with said the Ministry of Education was not represented and that it was difficult to connect with the right parts of the Ministry. This is partly due to the Ministry of Education's structure, as information from the table goes to a regional contact who is then responsible for passing it on to individual schools.

The benefit of having the Ministry of Education at the table was evident in one region in relation to tamariki who had been exposed to family violence. We heard the shared information meant schools were able to respond to behaviours from these tamariki and rangatahi with an understanding of what was happening for them – helping meet their needs and preventing several suspensions and exclusions.

In contrast, a multi-agency table we met with in another region told us that information sharing with the Ministry of Education was not working so well and that similar needs of tamariki and rangatahi in their region were not being met.

In Hastings, kaimahi from the multi-agency table Te Kura have an arrangement where they hot desk in the offices of other agencies from the table. They said this helps to keep the agencies connected and aware of contracts that other agencies have – as well as what services have been cut – so the table knows what services are available to refer tamariki, rangatahi and whānau to for support. We were told whānau are aware that Te Kura agencies are sharing information and that sharing information enables a wider picture of the safety of whānau.

Corrections kaimahi need more information from Oranga Tamariki

In our engagements with Corrections kaimahi, we heard that information sharing with Oranga Tamariki is a barrier.

> *"Sharing of information [with Oranga Tamariki] is not great. If a case has an allocated social worker, then [Corrections kaimahi] would get informed but there is a lag and some serious cases are unallocated, but because the woman is here, [the cases] don't get allocated [to an Oranga Tamariki social worker] and then we don't know what is happening."* CORRECTIONS KAIMAHI

> *"From a custody perspective, the women may not be involved with our prison social worker, but then suddenly their kids get uplifted, and we then have to manage that and try and contact Oranga Tamariki while the mums are freaking out. Would be great if Oranga Tamariki let us know as soon as they can and also let the mum know where their kids have gone to. They don't know. Also, these mums [then] can't call their kids as [they] are no longer on their phone list [due to moving and not having current contact details]."* CORRECTIONS KAIMAHI

Despite these issues with information sharing between agencies, as we discuss later under critical gap four, reports of concern from Corrections kaimahi to Oranga Tamariki have increased. In addition, Corrections provides notifications to Oranga Tamariki about some prisoners prior to their discharge from prison.

Notifications about prisoners being discharged are not intended to be reports of concern, as Corrections does not have sufficient information to determine if the release of the prisoner is a concern for tamariki. Instead, it shares this information so that Oranga Tamariki can assess the risk. However, Oranga Tamariki records all notifications as reports of concern.

Data from Oranga Tamariki shows it is taking further action in response to both reports of concern and notifications it receives from Corrections. This is because it progresses more reports for further action than Corrections makes as reports of concern. Because Oranga Tamariki does not distinguish between reports of concern and notifications, we cannot be sure of the breakdown of how many notifications are progressed for further action relative to the reports of concern, but we know it is resulting in some action being taken to keep tamariki safe.

While Corrections is passing regular information to Oranga Tamariki, improving two-way communication between the two agencies could further improve safety and outcomes for tamariki who have a parent or parents in prison or being released from prison.

Corrections and Oranga Tamariki have still not reviewed their relationship agreement

In 2022, Corrections set itself an action to review the relationship agreement it has with Oranga Tamariki and thereafter ensure a review is undertaken every two years. This remains incomplete.

Corrections advised the current relationship agreement between it and Oranga Tamariki was signed in 2018. Corrections noted that it and Oranga Tamariki have been working on reviewing and updating several schedules to the relationship agreement. The focus has been on schedules relating to information sharing, placement of young people, electronic monitoring and the operational protocol on victim notification. Although the relationship agreement has not been reviewed, the agreement remains in place until it is withdrawn or superseded by a new agreement.

Corrections noted that it and Oranga Tamariki have both been through organisational change processes. It said these contributed to resourcing pressures that have had a significant impact on both agencies' ability to progress work on the relationship agreement and its schedules. It confirmed the agencies are now working collaboratively to progress this. The overarching relationship agreement is undergoing internal review by Corrections, with an Oranga Tamariki review expected to be sought shortly.

This suggests that policy directions to cut back-office functions have had an adverse impact on agencies' ability to deliver on this important work programme.

Child death reviews often point out the importance of information sharing by agencies to keep tamariki safe

Information sharing by agencies to keep tamariki safe is an enduring issue. The Poutasi report noted that improved information sharing had been called for multiple times in 30 years of reviews. It remains an issue in the child death reviews we looked at.

Reviews by both Police and Oranga Tamariki point out it is critical that information is shared but opportunities for professionals to do this are not being taken up.

> *"… The sharing of information between agencies is critical to establishing any insight as to risk around individuals and or family."*
> **POLICE CHILD DEATH REVIEW**

> *"Overall, the assessment lacks depth and breadth and does not acknowledge the seriousness of the injuries to [the child] or the suspicion that the injuries are inflicted. There is no documented consultation with any other professionals, limited family members and no information is triangulated."* **ORANGA TAMARIKI CHILD DEATH REVIEW**

Critical gap 4

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

The Poutasi report noted the childcare centre Malachi attended had a policy requiring the reporting of child abuse but did not follow it although it had documented concerns about him. It said 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.

The Poutasi report made three recommendations aimed at closing this critical gap. Two recommendations focused on the introduction of mandatory reporting and on training to support professionals mandated to report concerns. The third recommendation focused on monitoring how well ECE services are implementing their required child protection policies to ensure they are providing effective protection for tamariki.

Also relevant to this critical gap are findings from the reports by MSD and the Office of the Inspectorate for Corrections. The MSD report recommended that it deliver training on its child protection policy to its kaimahi.[35] The Office of the Inspectorate recommended that Corrections review and refresh its processes in cases where there is a report of concern about a child and that, as part of this, it engages with key agencies, including Oranga Tamariki and Police.[36]

35 msd.govt.nz/documents/about-msd-and-our-work/publications-resources/information-releases/msd-child-protection-policy-practice.pdf

36 See footnote 33.

Reports of concern from professionals have increased and work is underway to address this critical gap

At the time of the Poutasi report, reporting by professionals was at one of its lowest points.

In our 2024 review, we stated that around 80,000 reports of concern were received annually for around 58,000 tamariki – approximately 5 percent of the population aged under 18 in Aotearoa. We referenced analysis by Oranga Tamariki that showed reports of concern had been decreasing since 2017/18, particularly from professional and government notifiers. Our 2024 review noted that this showed signs of increasing again from 2022/23 – after the publication of the Poutasi report.

The Government recently announced that it will progress towards a mandatory reporting regime with a stepped approach. As a first step, it will introduce mandatory child protection training for designated workforces. This is to ensure that those workforces have the knowledge and capability required to report suspected abuse of tamariki and rangatahi.

In the meantime, some children's agencies have already provided training for their kaimahi working with tamariki and rangatahi on when to report concerns. Accordingly, reports of concern from professionals have increased. The work that the Government is planning will further support and strengthen reporting, but the gap that needs to be addressed is how Oranga Tamariki responds to the reports of concern it receives, which we discuss later in this report.

As part of the stepped approach the Government announced, it noted that children's agencies' systems and Corrections' systems will need to be bolstered so that, when mandatory reporting comes into effect, those systems are ready and able to respond in a timely way.

Since our 2024 review, the ECE regulatory sector review[37] has been completed. One of its recommendations was to amend ECE licensing criteria to strengthen how services must evidence how they have implemented their child protection policies and procedures. These changes will enable ERO and the Ministry of Education to assess whether ECE kaimahi are prepared and able to respond to child protection policy-related matters.

37 Ministry for Regulation. (2025). *Early Childhood Education (ECE) regulatory sector review.* regulation.govt.nz/regulatory-reviews/early-childhood-education-ece-regulatory-sector-review/

The revised licensing criteria are expected to be implemented in April 2026. The Ministry of Education and ERO told us they have been working with the ECE sector to promote a greater awareness and understanding of child protection requirements. This may be having a positive impact as fewer instances of non-compliance with child protection requirements were identified in 2024. Our engagements with ECE services also identified a consistently good understanding of their child protection policies and how to make a report of concern to Oranga Tamariki.

Some child death reviews reinforce the need for more knowledge and education about child abuse and reporting

Some reviews of child deaths by both Oranga Tamariki and Police point to a need for more knowledge and education about child abuse and reporting. PFVDRs, in particular, identify a need for more and better education for agencies and the public.

> *"Enhanced education of the community, other agencies, and Police regarding the effects of mental health, family violence, identifying warning signs and how to report and where to report this information is imperative for prevention."* **POLICE CHILD DEATH REVIEW**

One of the PFVDRs for a child aged under 1 identified that several people were concerned about the safety of the child. Two people, on two separate occasions, witnessed the child being shaken by their parent. Neither person made a report of concern or disclosed their concerns to any agency. This child died of a traumatic head injury, and their parent was charged with their murder. The PFVDR notes that one person who saw the child being shaken said that reporting to Oranga Tamariki is "pointless", as they had previously made a report of concern (about the child's sibling) and "no action was taken".

Oranga Tamariki has not been proactively educating the public and professionals about when to make a report of concern

Existing provisions in the Oranga Tamariki Act in section 7(2)(ba)(i) and (ii) place duties on the Chief Executive of Oranga Tamariki to:

- educate both the public, and professional and occupational groups, on how to identify, prevent and report cases of child abuse
- develop and implement protocols for government agencies and NGOs and professional groups related to reporting child abuse.

We asked Oranga Tamariki if it had a strategy for fulfilling these requirements and what groups, if any, it had worked with since 1 July 2024 to do that. Oranga Tamariki told us it does not have a strategy for regular public campaigns to raise awareness of child abuse. It did not tell us whether it had worked with any professional groups over this period. It noted it regularly publishes research, evaluation and insights reports related to the wellbeing of tamariki, rangatahi and whānau and the social services sector on its website.

When we asked Oranga Tamariki how it worked with ECE services as part of our last review, it told us this was not its responsibility.

In October 2025, the Government told us that it has committed to a public campaign to increase awareness of the signs of abuse. This will directly respond to a recommendation in the Poutasi report that 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 tamariki can be helped.

The impact of not educating professionals and the public about when to make reports of concern can be seen on the ground. Oranga Tamariki social workers told us they are frustrated that Oranga Tamariki is viewed as the default agency to provide support to tamariki, rangatahi and their whānau and that reports of concern from other agencies do not always meet the threshold for statutory intervention.

> *"I found many [reports of concern from a community reports of concern table] don't require [a family group conference], so we pile up [Oranga Tamariki] social work caseloads. The perception [from the table] is it sounds too hectic – for example, meth use or family harm – then it becomes [Oranga Tamariki] work … I've been here 14 years, that mahi could sit with community."* ORANGA TAMARIKI KAIMAHI

Some Oranga Tamariki kaimahi said other agencies could sometimes do more to support tamariki, rangatahi and whānau instead of making a report of concern.

> *"Sometimes [mental health agencies] know we have the power [to uplift]. For tamariki/rangatahi with mental health that is out the gate, they know we can uplift the children. We get that side, but we are not mental health professionals."* ORANGA TAMARIKI KAIMAHI

We heard from some health kaimahi that the Oranga Tamariki hospital liaison helps them to make reports of concern by ensuring complex health information is presented clearly and simply. It is not clear, however, whether this approach supports an improved Oranga Tamariki response to these reports of concern.

The Government is also working to improve child protection knowledge, skills and training for professionals who work with tamariki and rangatahi

The Poutasi report made two recommendations focused on improving the reporting of concerns about tamariki by professionals. In particular, it recommended that professionals who work with tamariki and rangatahi should be mandated to report suspected abuse to Oranga Tamariki. It said that 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.

In addition, the Poutasi report recommended that 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 the New South Wales 'risk of significant harm' definition
- defining mandatory reporters, all of whom should receive regular training
- for professionals deemed to be mandatory reporters, undergraduate courses teaching risks and signs of child abuse and mandatory regular updated training regarding their responsibilities and the detection of child abuse, with practising certificates conditional on training and refreshers.

Our 2024 review noted it is not clear what impact mandatory reporting would have in Aotearoa. We noted that child protection systems in the similar Australian jurisdictions of New South Wales and Victoria had become overwhelmed following the introduction of mandatory reporting. We further noted that we had heard Oranga Tamariki was struggling to address the number of reports of concern it received.

We concluded that, in the context of the recommendation to introduce mandatory reporting, we saw two apparent options:

- Further resource/reprioritise existing funding within Oranga Tamariki (and take opportunities to streamline processes and remove duplication) and improve funding for community organisations.
- Improve education and training for professionals and service providers around the identification and reporting of child abuse.

In October 2025, the Government announced that it would progress towards a mandatory reporting regime with a stepped approach. First, mandatory child protection training will be introduced for designated workforces to ensure that those designated workforces have the knowledge and capability required to report suspected abuse of tamariki and rangatahi. Concurrently, the Government intends to better resource the systems of children's agencies and Corrections so that, when mandatory reporting comes into effect, those systems are ready and able to respond in a timely way.

As we detail below, professionals are reporting concerns to Oranga Tamariki. We welcome additional training and resource for the child protection system, and if implemented well, this should help keep tamariki safe. It should also reduce some of the unintended consequences associated with mandatory reporting. Additionally, increased reporting also requires Oranga Tamariki to be in a position to respond when needed. Later in this review, we note that Oranga Tamariki is struggling to respond to the current demand.

A relationship with Oranga Tamariki would help ECE services identify signs of abuse and know when – and how – to report concerns

ECE services have a crucial role in identifying suspected abuse or neglect of tamariki. For this review, we were interested in how well ECE services understand when and how to report concerns and what processes they have in place to help them do this.

ECE kaimahi had a limited understanding of the Oranga Tamariki role and when it would intervene. The ECE services we heard from rarely had a relationship with their local Oranga Tamariki site. Where there was a relationship, it appeared to have arisen as a result of ECE kaimahi working with Oranga Tamariki social workers to support particular tamariki rather than intentional relationship building.

> *"Certain [Oranga Tamariki] sites are better than others. Not even just the site – it could be that one social worker. If you get a great social worker then you are in, you can work collaboratively, then other times no."* **ECE LEADER**

Some ECE kaimahi told us they appreciated receiving guidance when they contacted Oranga Tamariki about whether an immediate report of concern was warranted.

Based on what we heard from ECE kaimahi, it is clear they would value having a relationship with their local Oranga Tamariki site that could support them with decisions on whether to make a report of concern.

Kaimahi in ECE services receive training and have processes in place to report concerns for tamariki

All ECE kaimahi we met with told us about training they had within the ECE sector to help them identify child abuse. All of them described the requirements of their centre's child protection policy and when they would make a report of concern.

All ECE kaimahi we heard from talked about using collective decision making to determine whether to lodge a report of concern with Oranga Tamariki. They told us this included having ways to raise concerns within their organisational structure to leadership and governing bodies. For example, kaimahi from kōhanga reo and kindergartens spoke about referring cases to governing bodies if it was not clear whether a report of concern to Oranga Tamariki was warranted.

Kaimahi from the independent ECE services we met with talked less about their organisational support networks than others but still told us that the decision to make a report of concern would be made between ECE kaimahi and leadership.

In a couple of ECE services, we heard that staffing ratios were problematic if kaimahi need to lodge a report of concern.

> *"Because we work to ratio, we can't leave the floor during the day when the tamariki are here. This means we can't call Oranga Tamariki to make a report of concern until after the tamariki have left. This is worrying for us as they may be returning to where there is harm occurring, but our policy is that we can't go below ratio."* **ECE KAIMAHI**

> *"There's only one number to call [Oranga Tamariki] and that can be crazy busy."* **ECE KAIMAHI**

However, kaimahi from one ECE service said that, if required, they would go under ratio to lodge a report of concern.

> *"If a child was in immediate danger and teacher had to leave, we just throw the ratios out the window. Then we talk to the [Ministry of Education] on why we did that."* **ECE LEADERSHIP**

We heard that, when ECE kaimahi make a report of concern, they are also thinking about maintaining relationships with whānau. However, ECE kaimahi acknowledged that the safety of tamariki outweighed worries about how whānau would react if they knew the ECE had made a report of concern. They worry that, if the whānau remove their child from the centre, not only is that child's safety now less visible but the whānau may have lost an important support and become more vulnerable.

> *"In one case we reported, the family realised what was happening so they dropped everything and moved to another country. When we think about it, we get sad about that and those children."* **ECE LEADER**

> *"The biggest worry is that we lose the child [the child will be taken away by whānau or won't return to the centre] and we have to put that [idea] aside because safety is more important than losing a child."* **ECE LEADER**

> *"If you ring Oranga Tamariki, you have got to be sure as you don't want to upset the family as they need support from somewhere."* **ECE LEADER**

Reports of concern from ECE kaimahi have increased in the past two years

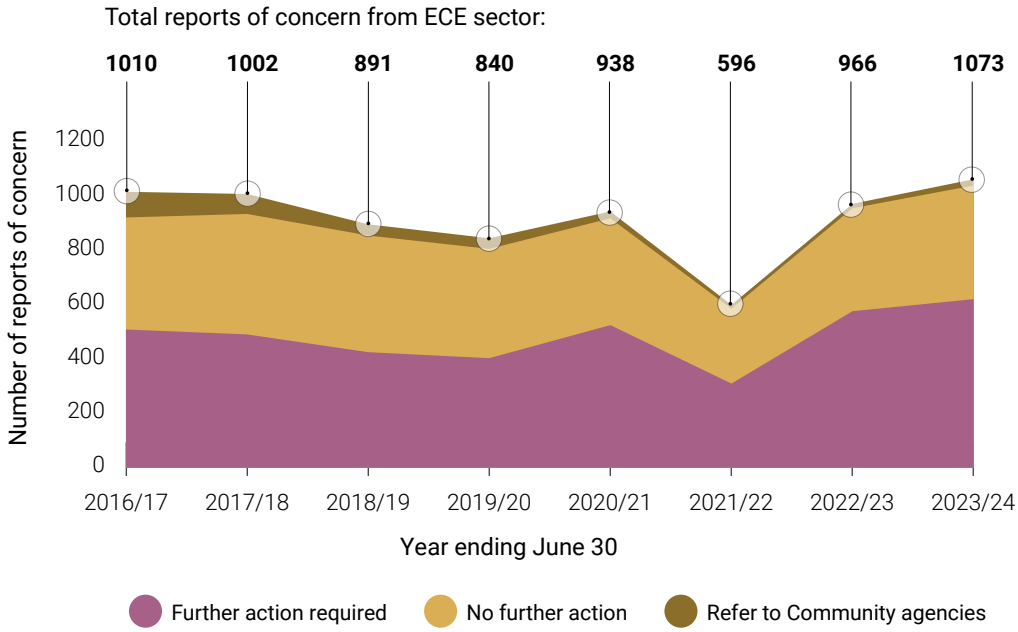
All ECE services told us their practice was to report concerns to Oranga Tamariki where they felt the concern met the threshold. The ECE services who told us they had not made a report of concern recently said it was because they were confident there had not been a need.

Our 2024 review noted that reports of concern from kaimahi at ECE services were at their lowest at the time of Malachi's death but were starting to increase.

The Ministry of Education and ERO told us they had publicised the Ministry of Education's child protection training module to the sector, and this had led to an 85 percent increase in the number of people completing the module in 2023. They said they promoted and supported greater awareness about how to report child protection and safety concerns and had developed and shared a clearer understanding of the roles and responsibilities of key agencies in this.

While a higher number of reports of concern from ECE services are being progressed for further action by Oranga Tamariki than in previous years, the proportion of reports of concern where further action is taken has not changed (Figure 1). It is unclear whether this is because there has been no change in the understanding of when to make a report of concern, despite the training, or if it is because of Oranga Tamariki resourcing and decision making.

Figure 1: Despite the number of reports of concern from ECEs fluctuating, the proportion where Oranga Tamariki takes further action has not



MSD kaimahi have received training on recognising and reporting child abuse

MSD told us it has completed three actions it set for itself that were designed to improve the knowledge of its kaimahi around how to recognise and report child abuse. As well as ensuring information available on child protection is clear, relevant and current and increasing the visibility of its child protection policy and related resources, MSD has delivered its ChildSafe online learning module to kaimahi.

MSD told us that, as of 3 June 2025, 98 percent of its kaimahi[38] had completed the ChildSafe online learning module, which covers how to recognise and report child abuse and includes content about the information-sharing provisions in the Oranga Tamariki Act.

To determine whether the training was helping MSD kaimahi identify and report potential child abuse, we surveyed 65 MSD integrated services case managers in five regions (Northland, Bay of Plenty, Central, Canterbury and Southern) in June 2025. The survey targeted this frontline role as it supports clients with complex needs who may be more vulnerable and at risk of harm and therefore more likely to make reports of concern to Oranga Tamariki. We received responses from 46 of the 65 MSD kaimahi.

The survey responses indicate that the training has been helpful and is being used by MSD integrated services case managers in their work. Full results from the survey can be found at Appendix C.

Data from Oranga Tamariki on reports of concern shows a slight increase in the number of reports of concern made by MSD over the last two years that resulted in a further action decision (Table 2).

While we cannot say whether this increase is related to the rollout of the MSD ChildSafe training, the survey results indicate that a higher proportion of respondents who had completed this training had made a report of concern compared to respondents who had not done the training (or were unsure if they had). As the difference is not statistically significant and the number of MSD kaimahi surveyed is small, it is not clear whether the training and education about child protection has increased awareness and reporting of concerns.

38 This percentage represents 8,921 kaimahi having completed the training out of a total 9,089.

Table 2: Reports of concern from MSD kaimahi resulting in further action decisions have increased.

	2021/22	2022/23	2023/24
Reports of concern from MSD kaimahi that resulted in a further action decision	122	132	140

MSD told us insights from the survey would inform future training modules and content aimed at keeping tamariki safe

Corrections kaimahi received training on their child protection obligations and how to recognise and report suspected abuse

Corrections advised that the Prison Operations Manual includes guidance on making reports of concern. It told us it updated the learning pathway for probation officers in January 2025, which includes a module on Corrections' child protection policy, child protection obligations for probation officers, types of abuse and the process to make a report of concern.

Corrections said that, from January 2025, all probation officers who join the agency would be required to complete this module. Corrections is also creating an all-of-organisation learning module on its child protection policy and kaimahi responsibilities.

Corrections has used REFER online since 2021/22 to send reports of concern. Because of this, Corrections is the only agency other than Oranga Tamariki that has a centrally held record of when a report of concern has been made, by whom and the site. Corrections told us that most of its reports of concern are made by probation officers. The number of reports of concern made by prison-based kaimahi is low, peaking at only 12 in the 2024/25 year.[39]

Corrections data shows an increase in the number of reports of concern made and suggested that this increase may indicate improved awareness following the training and information it has disseminated to its frontline kaimahi (Table 3).

39 This data is for the nine-month period from 1 July 2024 to 31 March 2025. It was also the highest number of reports of concern from Corrections kaimahi across the four years of data that Corrections provided us.

Table 3: Reports of concern made by Corrections kaimahi have increased.

	2021/22	2022/23	2023/24	2024/25*
Total reports of concern recorded by Corrections as being made by Corrections kaimahi	202	278	470	605
Total reports of concern recorded by Oranga Tamariki as being made by Corrections	1,382	1,177	1,095	1,254

* The data for 2024/25 is for the nine-month period from 1 July 2024 to 31 March 2025 so is an incomplete year.

Data also shows that a greater number and larger proportion of reports of concern recorded by Oranga Tamariki as from Corrections were progressed to further action in 2023/24 compared to 2022/23 (Table 4). We cannot say for certain whether this increase is due to the training, but it may indicate that the training has enabled Corrections kaimahi to better identify and report on the cases requiring action.

Table 4: Reports of concern from Corrections kaimahi resulting in further action decisions have increased.

	2021/22	2022/23	2023/24
Reports of concern recorded by Oranga Tamariki from Corrections kaimahi that resulted in a further action decision	473	476	490

Data provided by Oranga Tamariki shows a higher number of reports of concern made by Corrections kaimahi than indicated by Corrections. When we asked about this discrepancy, Corrections told us its kaimahi use REFER online to send both reports of concern and information-sharing notifications when people leave prison. Oranga Tamariki records all of these notifications as reports of concern, which is why the data is different. Corrections confirmed that it does not count information-sharing notifications as reports of concern.

Corrections and Oranga Tamariki further advised that a small number of reports of concern from Corrections kaimahi are made by phone, with 10 recorded by Oranga Tamariki between 1 January and 2 October 2025. Corrections said it is possible there could also be other reports of concern that have not been captured in its data and that it plans to look into this further.

Corrections also told us about work it has been doing to progress the recommendation of the Office of the Inspectorate to review and refresh processes in cases where there is a report of concern about a child. It told us that all material on its intranet on child protection has been reviewed. Updates are being made to ensure the information is easy for kaimahi to find and clear to follow.

Guidance is being developed for kaimahi on what a good-quality report of concern looks like and what information to include. Corrections has worked with Police and Oranga Tamariki regarding the processes for reporting concerns and this is informing the development of updated material and guidance, which is expected to be available to kaimahi by December 2025. The updated materials and guidance are intended to support Corrections kaimahi who are concerned about the safety of a child to know how to make a report of concern and what information to provide.

In our 2024 review, we noted that Corrections was considering undertaking a thematic review of reports of concern made to Oranga Tamariki. For this review, Corrections advised that this has not been progressed but will be reconsidered once the updated guidance and all-of-organisation child protection policy learning module has been implemented.

Revised licensing criteria for ECE services will be implemented in 2026

The Poutasi report recommended that there should be active monitoring of implementation by ECE services of their required child protection policies to ensure they are providing effective protection for tamariki. It said the Ministry of Education and ERO should jointly design and administer a monitoring and review cycle for the implementation of child protection policies in ECE services.

Our 2024 review identified that ECE services are required to have a written child protection policy,[40] review their policy every three years and have a procedure for safety checking all children's workers.[41] Data provided by ERO for our 2024 review showed it had identified an increase in non-compliance with these legislative requirements between July 2022 and December 2023.

40 For most licensed services, the requirement is: "There is a written child protection policy that meets the requirements of the Children's Act 2014. The policy contains provisions for the identification and reporting of child abuse and neglect, and information about how the service will keep children safe from abuse and neglect, and how it will respond to suspected child abuse and neglect. The policy must be reviewed every three years." Ministry of Education. (2024). Child protection. education.govt.nz/education-professionals/early-learning/licensing-and-certification/licensing-criteria-for-centre-based-ece-services/health-and-safety/child-protection

41 Children's workers are defined in the Children's Act.

We reported that the Ministry of Education and ERO told us they were finalising a work plan to strengthen the review cycle and enhance and support child protection in ECE. We noted that the Ministry of Education and ERO had undertaken work to understand barriers to the ECE sector making reports of concern. The Ministry of Education's child protection training module had been promoted, which had led to an increase in the number of ECE kaimahi completing the module.

Our 2024 review noted that some of the changes to strengthen ERO's review cycle were dependent on regulatory change, which was being progressed through the ECE regulatory sector review. The ECE regulatory sector review has since been completed.

One of the recommendations of the regulatory review was to amend ECE licensing criteria to strengthen how services must evidence implementation of their child protection policies and procedures. The changes will enable ERO and the Ministry of Education to assess whether ECE kaimahi are prepared and able to respond to child protection policy-related matters.

The Ministry of Education consulted with the ECE sector on the proposed amendments in June and July 2025, with the changes progressing through the introduction of the Education and Training (Early Childhood Education Reform) Amendment Bill in July 2025. The revised licensing criteria were gazetted on 28 November 2025 and are expected to be implemented in April 2026. This lead-in time gives the ECE sector and the Ministry of Education time to prepare and train kaimahi on the changes.

Compliance with ECE child protection requirements may have improved

Recent data from ERO and the Ministry of Education suggests compliance with ECE child protection requirements may have improved between 2023/24 and 2024/25. Data from ERO shows a significant decrease in non-compliance related to safety checking in ECE services in the 2024/25 year compared to 2023/24 (Table 5). There was also a more modest decrease in concerns about compliance with child protection policies.

Table 5: Compliance with licensing criteria related to child protection appears to have improved.

	2023/24	2024/25
Safety checking non-compliance	173	46
Child protection policy non-compliance	33	24

ERO told us that, throughout 2024, it helped services understand their obligations and improve their practice in relation to child protection requirements. This included clarifying requirements, supporting services' implementation of child protection policies and introducing a new reporting format for English-medium licensed ECE services in July 2024. It has also continued to focus on training and supporting staff with guidance and resources to understand their role in relation to child protection.

While not directly comparable,[42] data from the Ministry of Education also shows a decrease in non-compliance relating to child protection in licensed ECE services between 2023 and 2024. Table 6 shows the decrease in the number of provisional licences[43] issued because of non-compliance with child protection requirements.

42 The Ministry of Education and ERO data cannot be directly compared as it does not relate to the same services. and the actions taken by the Ministry of Education may be in subsequent years to ERO's reviews. For this reason, the numbers do not align and should not be directly compared

43 The Ministry of Education has the statutory powers to intervene when services breach the regulated standard. If services are non-compliant with child protection requirements, the Secretary for Education is able to decide depending on the level of risk to children to issue a provisional licence or a suspension notice. A provisional licence allows a service to continue operating while remedying the non-compliance as opposed to suspension, which stops the service from operating from an effective date.

Table 6: The number of provisional licences issued for non-compliance with child protection requirements has decreased.

	2023	2024
Provisional licence for non-compliance with safety checking	79	25
Provisional licence for non-compliance with child protection policies	56	18

Similarly, from 2023 to 2024, there was a decrease from three to one for licence suspensions for non-compliance with child protection policies and a decrease from 38 to 16 for suspensions for non-compliance with safety checking.

The Ministry of Education told us it has continued to promote awareness of resources and training on child protection to the ECE sector. It told us that there had been a further increase in the number of ECE kaimahi who completed the Ministry's child protection training last year – from 7,291 in 2023 to 8,319 in 2024. ECE kaimahi also told us they were accessing the Ministry of Education training.

Larger ECE service providers with multiple licensed services told us they had created and delivered their own child protection training in addition to the Ministry training.

The actions taken by ERO and the Ministry of Education may be contributing to improved compliance in the ECE sector. As we only have data and information to compare between 2022 and 2024 and most ECE services are reviewed by ERO on a three yearly cycle, it is too early to comment on whether this is a sustained shift in the sector – but it is promising.

Critical gap 5

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

The Poutasi report found system settings allowed Malachi to be invisible. He was not seen or focused on by professionals working within the children's system and did not have a voice. It noted 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.

The Poutasi report made four recommendations to make tamariki like Malachi more visible to professionals working within the children's system. It included recommendations to more explicitly state which agencies are children's agencies and what responsibilities those agencies have as well as a recommendation for regular public awareness campaigns to be undertaken.

The final recommendation was for the Independent Children's Monitor to review the Government's progress against the recommendations in the Poutasi report a year on from its publication. We fulfilled that requirement with our 2024 review.

Responsibility for child protection sits across the children's system but roles have not been clarified

The Poutasi report made recommendations aimed at clarifying the responsibilities of children's system agencies regarding child protection. This included a recommendation that the agencies that make up the "formal Government's children's system" should be specifically defined in legislation.

The Poutasi report went further to recommend that specific responsibilities be included in children's agencies' founding legislation so it is clearer that they share the responsibility for checking the safety of tamariki and rangatahi.

For this review, we were informed that the recommendation to define the agencies that make up the "formal Government's children's system" in legislation is complete. While no legislative changes were made, the Minister for Children agreed in May 2024 that existing legislation meets the requirements of this recommendation. This is despite the Poutasi report noting it was not clear enough.

We note there are groups of agencies with statutory responsibilities making up the formal Government's children's system, but as these cross several different pieces of legislation, it is complex. For example, the Children's Act sets out children's agencies in section 5, defines which agencies must have a child protection policy in sections 14 and 15 and specifies which agencies and organisations are required to safety check children's workers in section 24. The Oranga Tamariki Act specifies which agencies are child welfare and protection agencies in section 2. Across these Acts and sections of Acts, there is considerable variation in the agencies listed, and it remains unclear which agencies constitute the "formal Government's children's system".[44]

44 The children's system is focused on all children in Aotearoa and is therefore wider than the Oranga Tamariki system, which is focused on tamariki, rangatahi and whānau who are at risk of, currently receiving or have received services or support under or in connection with the Oranga Tamariki Act.

Specific responsibilities of children's agencies have not been clarified in founding legislation as set out in the recommendation, and the Government has advised that it will not be possible to do this as envisaged by the Poutasi report as not all children's agencies have founding legislation.[45]

In its decisions to accept the recommendations of the Poutasi report, the Government noted that it is important to consider the recommendation to clarify the responsibilities of children's agencies in founding legislation in the context of other changes being implemented that will strengthen agency accountability for checking child safety. It noted that checking the safety of tamariki already exists in Part 2 of the Children's Act and that agencies will take immediate steps to ensure that all children's agencies are complying with these provisions. Officials will also assess whether there are any gaps and consider what further legislative change may be required to fully implement the intent of this recommendation.[46]

The lack of progress to date on recommendations focused on the responsibilities of children's agencies is a missed opportunity for Government to ensure agencies across the system can focus on and be held to account for their roles in keeping children safe. Through our future monitoring, we will be looking to understand how recent commitments the Government has made to address these recommendations are making a difference.

Work to respond to these recommendations has not clarified roles and responsibilities for child protection across the children's system.

45 Paragraph 30 refers: msd.govt.nz/documents/about-msd-and-our-work/publications-resources/information-releases/cabinet-papers/2025/update-on-government-response-to-the-dame-karen-poutasi-review/paper-update-on-government-response-to-the-dame-karen-poutasi-review.pdf

46 ibid

All agencies we reviewed that are required to, now have up-to-date child protection policies

The Children's Act requires prescribed agencies to have a child protection policy that sets out how the organisation identifies and reports child abuse and neglect.[47]

At the time of our last review, only two of the agencies we reviewed had a child protection policy that met the requirements under the Children's Act. Positively, for this review, all of the agencies we reviewed that were required to have a child protection policy had an up-to-date policy, with most agencies having updated their policy since our 2024 review.

For this review, seven[48] of the eight agencies we reviewed advised they have up-to-date child protection policies. Six had updated their child protection policy since our 2024 review.

Oranga Tamariki updated its policy in late November 2025, just prior to the finalisation of this review. It had not reviewed its policy since November 2020 so was well overdue.

ERO does not have a child protection policy and is not currently required to under the Children's Act, but it told us that its Manual of Standard Procedure and associated resources provides its kaimahi with clear guidance on practices, which helps ensure child protection.

Corrections told us it has elected to have a child protection policy although it is not required to under the legislation.

The table at Appendix E sets out agencies' compliance with child protection policies in more detail.

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

48 Corrections, Police, Ministry of Health, Ministry of Justice, Ministry of Education and MSD.

No progress has been made on developing a public awareness campaign

In 2024, Oranga Tamariki told us that public awareness campaigns will be an ongoing programme of work and ideally become part of its business-as-usual operations.

Despite this, no observable progress has been made since we last reported. In response to our information request, Oranga Tamariki noted this work was delayed.

A December 2025 Cabinet paper noted that two separate campaigns are planned by Mana Mokopuna – Children's Commissioner and Accident Compensation Corporation (ACC). The campaigns are respectively focused on child maltreatment and child sexual abuse prevention. The paper notes that as implementation of these campaigns progress, the agencies responding to the Poutasi recommendations will consider whether a broader campaign is needed.

We note that both Mana Mokopuna and ACC are Crown entities that were not tasked with responding to the Poutasi recommendations. While the campaigns seek to fill gaps in public awareness, government agencies should not fully rely on these campaigns to address their responsibilities. As noted in critical gap four, there remains a responsibility in the Oranga Tamariki Act for the Chief Executive to educate the public, and professional and occupational groups, on how to identify, prevent and report cases of child abuse.

Child death reviews highlight the invisibility of tamariki

Child death reviews continue to highlight the invisibility of tamariki and rangatahi to the system. More must be done if this critical gap is to be closed.

Of the 17 child death reviews provided by Police and Oranga Tamariki, at least seven highlight that tamariki were not visible to the system that needed to protect them.

> *"[The child] is not visible in the case work. The case work became very adult focused, and [the child] got lost in the adult issues. [The child] was a vulnerable child who was unable to speak for themselves, their voice is missing from the assessment."* **ORANGA TAMARIKI CHILD DEATH REVIEW**

Responding to reports of concern

The child protection system is not currently able to respond when needed

The primary focus of the Poutasi report was on how to better identify harm or the risk of harm and to make sure that Oranga Tamariki and other agencies had access to the best information to keep tamariki safe.

The Poutasi report looked at the circumstances surrounding the death of Malachi and considered previous child death reviews. However, it did not specifically look at the ability of the care and protection system to respond once a report of concern is made.

Our 2024 review found that, when people report concerns, the response from Oranga Tamariki was not sufficiently focused on the safety of the child. Decisions of Oranga Tamariki social workers were unduly influenced by available resource, with differing thresholds for intervention between regions and sites. At times, decision making gave greater weight to the voice of whānau, with the need and safety of tamariki secondary.

Overall, we found that Aotearoa did not yet have a comprehensive child protection system that consistently responds in a way to either keep tamariki safe or to support whānau to prevent harm from occurring.

This review shows that little has changed. There continues to be a high proportion of reports of concern from professionals that do not result in further action by Oranga Tamariki and where tamariki and rangatahi are not seen. Kaimahi from agencies and services, including Oranga Tamariki, continue to tell us they are concerned about the risk to tamariki and rangatahi.

System settings have not changed, gaps remain and tamariki and rangatahi are still no more likely to be seen by Oranga Tamariki now than when Malachi was killed.

Implementing the Poutasi recommendations may make tamariki and rangatahi at risk more visible, but to make them safer, Oranga Tamariki and the wider child protection system must be able to respond when needed.

Oranga Tamariki is looking for reasons not to intervene rather than getting in the car to visit tamariki when serious concerns are raised

In our 2024 review, we found that actions taken had not contributed to the system-wide change envisaged by the Poutasi report. There was a lack of clarity about the statutory role of Oranga Tamariki, the appropriate threshold for its intervention and its ability to respond to reports of concern.

Progress with the Poutasi recommendations is slow. Better visibility and reporting of concerns are important but can only go so far. Even once all the recommendations have been implemented, it would not solve the fundamental problem – Aotearoa does not yet have a child protection system that is always able to respond when needed. In fact, increased reports of concern may have the unintended consequence of placing more pressure on a system already struggling to respond.

Social workers want to keep tamariki and rangatahi safe – and they often do – but the current child protection system is not always keeping children safe. There are several reasons.

- Oranga Tamariki is overwhelmed by the high numbers of reports of concern it needs to assess and respond to.
- People who have made a report of concern do not hear back from Oranga Tamariki and remain concerned about those tamariki and rangatahi. This can result in additional reports of concern being made, which further overwhelms the system.
- Despite a standardised approach to assessing reports of concern and quality assurance processes, Oranga Tamariki decisions on whether to intervene are unduly influenced by site resources. As a result, thresholds for intervention vary across sites and regions.
- Decisions by Oranga Tamariki sites on whether to intervene are not always child-centred.

- Social workers do not all have the skills they need to assess risk, and induction and training are not meeting this need.
- There is not always the resource or capability within Health NZ to help social workers assess risk and harm.
- The threshold for Oranga Tamariki to take action is too high.
- Oranga Tamariki is continuing to refer tamariki and rangatahi to stretched community providers although it knows they have limited capacity to provide the support needed.

Significant numbers of reports of concern are already being made and the number is increasing

Oranga Tamariki data shows the number of reports of concern is increasing, although this is not necessarily indicative of increased harm in our communities.

Oranga Tamariki notes that changes in public awareness and reporting behaviours are driving some of this increase. It suggests that increases in actual harm and wellbeing concerns driven by social and economic issues are also a factor.[49]

Changes in the way that Oranga Tamariki records reports of concern and an increase in renotifications for tamariki and rangatahi already known to Oranga Tamariki also explain some of the increase, as we discuss below.

Between 2017/18 and 2021/22, total yearly reports of concern decreased by 28 percent to 66,400 reports of concern about 49,300 tamariki and rangatahi. However, the most recent data provided to us by Oranga Tamariki shows total yearly reports of concern increased by 44 percent between 2023/24 and 2024/25 to 108,100. The number of tamariki and rangatahi who had reports of concern made about them also increased by 17 percent – from 53,100 in 2023/24 to 62,400 in 2024/25.

All notifier types recorded by Oranga Tamariki made more reports of concern in 2024/25 than in 2023/24. In both years, the greatest number of notifications were made by Police and kaimahi in the health and education sectors.

49 Oranga Tamariki. (2025, June 30). Understanding the increase in reports of concern. orangatamariki.govt.nz/about-us/research/our-research/understanding-the-increase-in-reports-of-concern/

Changes in how Oranga Tamariki records reports of concern and renotifications have contributed to the increase

In the first half of 2024, Oranga Tamariki changed how it records calls to the NCC in response to a recommendation from the Ombudsman.[50]

All calls that meet the definition of a report of concern are now recorded as a separate report of concern, even if there is already an open report of concern for the same tamariki and rangatahi or if it does not meet the threshold for assessment or investigation. Previously, some of these calls were entered as a contact record or were added as case notes to the existing case file and the social worker notified.

A proportion of the increase can also be attributed to renotifications – where Oranga Tamariki receives more than one notification for the same child about the same concerns.

The Oranga Tamariki analysis shows renotifications have increased over time, but it only looks at renotifications received within a month of the initial report of concern. Given that some professionals may allow much longer than a month for Oranga Tamariki to take action before making a second report of concern about a child, only looking at renotifications made within a month may not show the full picture.

The approach taken to the analysis by Oranga Tamariki makes it difficult to see the extent to which renotifications and the change in recording practices are together driving the increase in total reports of concern.

When considered alongside what we heard in every region we visited and with professionals telling us they are making repeated reports of concern because Oranga Tamariki does not act or does not inform them of any action taken, it is likely that the number of renotifications is being underestimated by Oranga Tamariki.

50 Ombudsman. (2020, October 24). Failure by Oranga Tamariki to investigate reports of concern and complaints. ombudsman.parliament.nz/resources/failure-oranga-tamariki-investigate-reports-concern-and-complaints

People who make a report of concern do not always hear back from Oranga Tamariki, resulting in repeated reports of concern and continued worry about the child's safety

In our monitoring visits we consistently heard from professionals, including health and education kaimahi and police officers, that they are not hearing back from Oranga Tamariki on the outcome of reports of concern they have made. They don't know whether any action has been taken or if the child is safe. This is despite section 17(1)(c) of the Oranga Tamariki Act requiring Oranga Tamariki to inform the notifier of the outcome of a report of concern.[51]

> *"We just don't know what we're going to get. You might get no action, you might get a big response."* HEALTH KAIMAHI

This is leading to frustration from kaimahi at government agencies and community organisations.

> *"We complete [reports of concern]. Go back to families and we can see zero impact, no reach in from Oranga Tamariki."* POLICE LEADER

> *"We send another report of concern. It's on repeat, repeat, repeat."* POLICE LEADER

> *"[Reports of concern] have not been addressed though [by Oranga Tamariki], we just keep advocating."* COMMUNITY AGENCY LEADER

In particularly serious cases, Police and one community organisation told us they escalated follow-ups on their reports of concern to increasingly senior kaimahi in Oranga Tamariki to find out what was happening.

> *"Kids are running away all the time, and kids are being sexually assaulted every week. And we don't hear back from Oranga Tamariki. It's huge work and it's heartbreaking."* HEALTH KAIMAHI

> *"We don't get any feedback from our reports of concern, and we're not doing it for fun. We keep rolling it through and we don't hear anything from Oranga Tamariki."* POLICE KAIMAHI

> *"For [reports of concern] that are severe [and already known to Oranga Tamariki], you get nothing [no communication]. I continuously send things."* POLICE KAIMAHI

51 Section 17(1)(c) states: "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."

We heard health kaimahi often have to "chase up" to find out what action has been taken in response to their reports of concern, and the Oranga Tamariki hospital liaison will help them do this. We heard waiting for Oranga Tamariki is frustrating for whānau, and health kaimahi feel responsible for ensuring tamariki and rangatahi remain safe.

One health kaimahi said they operate on the assumption that making a report of concern acts as a protection. However, when they don't hear back from Oranga Tamariki, they are unsure what, if anything, has happened, and whether it did provide protection. This lack of communication compounds the worry many organisations have about making reports of concern and how that could impact their relationship with whānau.

> *"We make a [report of concern], then [Oranga Tamariki] don't let us know. We think we have provided a bit of safety by reporting this but then we don't know what happens."* HEALTH KAIMAHI

> *"There is still an awful amount of concern about making reports of concern and who makes it, and what that means for our relationships, and even what difference will it make, and also what is the outcome that will occur?"* HEALTH KAIMAHI

Oranga Tamariki has a two-stage approach in deciding whether to respond to a report of concern

When Oranga Tamariki receives a report of concern, it makes an initial assessment. The NCC completes almost all initial assessments, with a small number made by specific sites.

The 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 child and to develop a chronology. Decisions made on initial assessments may be:

- that no further action is required
- to refer the child to a community agency for support
- that further action is needed by way of either a child and family assessment or an investigation under the CPP.

Where the initial assessment is made by the NCC and results in a decision that further action is needed, this is sent by the NCC to the Oranga Tamariki site responsible for the area where the child lives for the site to undertake a core assessment.

A core assessment builds on the initial assessment to understand the risk and needs for tamariki, rangatahi and their whānau.

Sites are not bound by the decision of the NCC to take further action. Sometimes, the sites know the tamariki and whānau that the report of concern relates to and have local knowledge that the NCC did not have when making its initial assessment. Accordingly, sites may subsequently decide to overturn a decision made by the NCC and instead refer the child to a community agency or determine that no further action is required.

The NCC uses a standardised approach for initially assessing reports of concern and now has quality assurance processes over decision making

Our 2024 review noted that most initial assessments were completed by the NCC and that this was mostly working well. However, we also noted that, at the time, the NCC did not make quality assurance reports to national office, so there was a lack of assurance over whether its decisions were correct. Also, a small number of sites were completing initial assessments, rather than the NCC, and across these sites, there were different quality assurance processes to check their decisions.

For this review, we asked Oranga Tamariki whether any work had been done to confirm that initial assessment decisions in response to reports of concern are being made correctly. We specifically asked whether there had been any improvements to quality assurance of decision making on initial assessments by both the NCC and sites.

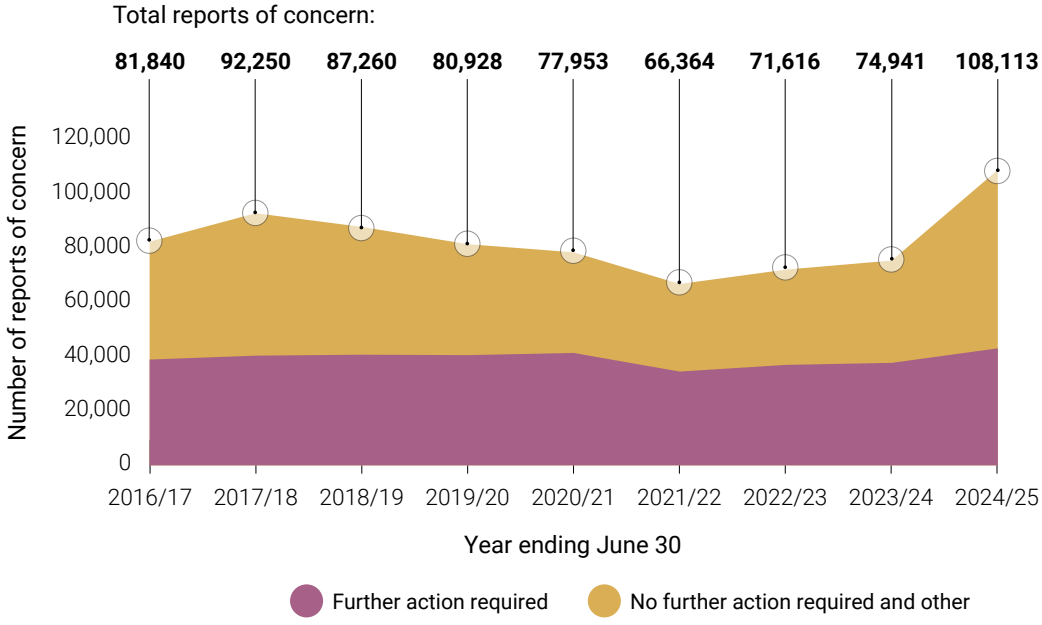
Oranga Tamariki told us that there are now quality assurance processes over initial assessment decisions by the NCC. It told us both the NCC and sites use the Decision Response Tool to support consistent and objective decisions on the appropriate response pathways for reports of concern. Oranga Tamariki said that, while there is a degree of professional judgement in any quality assurance process, it is not aware of any decisions being made on professional judgement alone.

Decisions on whether to act on a report of concern are also unduly influenced by site resources

In our 2024 review, we referenced data from 2016/17 to 2022/23 and noted that, of the reports of concern considered by sites, the number of reports of concern that result in further action has remained consistent at around 40,000 each year.

The number of reports of concern that resulted in further action in 2023/24 and 2024/25 appears similar to previous years at 42,800 in 2024/25, despite the increase in total reports of concern (Figure 2). This indicates that site decision making on whether to take action is closely linked to organisational capacity to respond.

Figure 2: Though the total number of reports of concern varies over time, the number resulting in further action has remained steady.



Because of resourcing limitations, a significant number of tamariki for whom concerns are reported are not visited. Kaimahi from Oranga Tamariki and Police as well as other professionals tell us the risk to tamariki and rangatahi is high as a result.

> *"What has happened is that Oranga Tamariki won't uplift kids as to bring the statistics down. Oranga Tamariki won't uplift kids in grave danger … [because of] the perception of Oranga Tamariki in the media, pressure from management. I have been doing Oranga Tamariki work for 30 years, it is more difficult now than ever."* **COMMUNITY PROFESSIONAL**

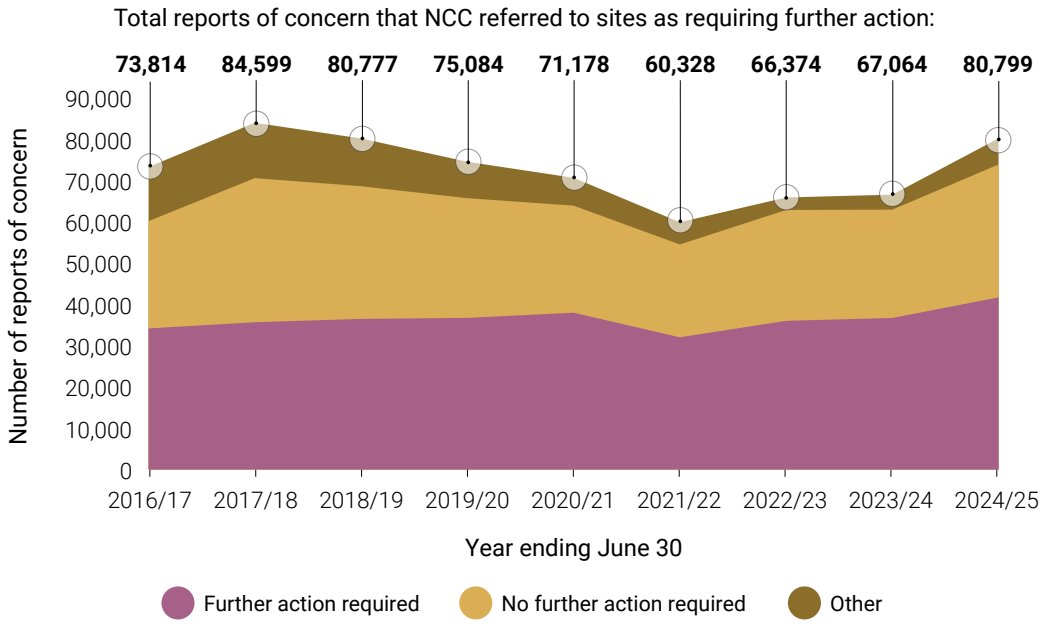
> *"Oranga Tamariki are very quick to surprise lots of police officers. How can you close this [family's case] from what the police officer has seen? What's happening?"* **POLICE LEADER**

> *"If [Oranga Tamariki leadership] had made some of these [restructuring] decisions to keep [tamariki and rangatahi] safer, we could work with that. I know there's going to be preventable deaths. What annoys me is that social workers will be pinpointed and their supervisors. I can accept when there's mistakes and poor practice, but [in] the review of the next baby's death, they won't be looking at the restructure."* **ORANGA TAMARIKI KAIMAHI**

Sites continue to overturn around half of NCC decisions that further action is required

As in our 2024 review, we looked at Oranga Tamariki data on the proportion of NCC further action decisions accepted by sites (Figure 3). Patterns are much the same, with around half of reports of concern referred from the NCC to sites for further action progressing to further action. This means half of the reports of concern that the NCC determined required further action were overturned at site and no further action was taken.

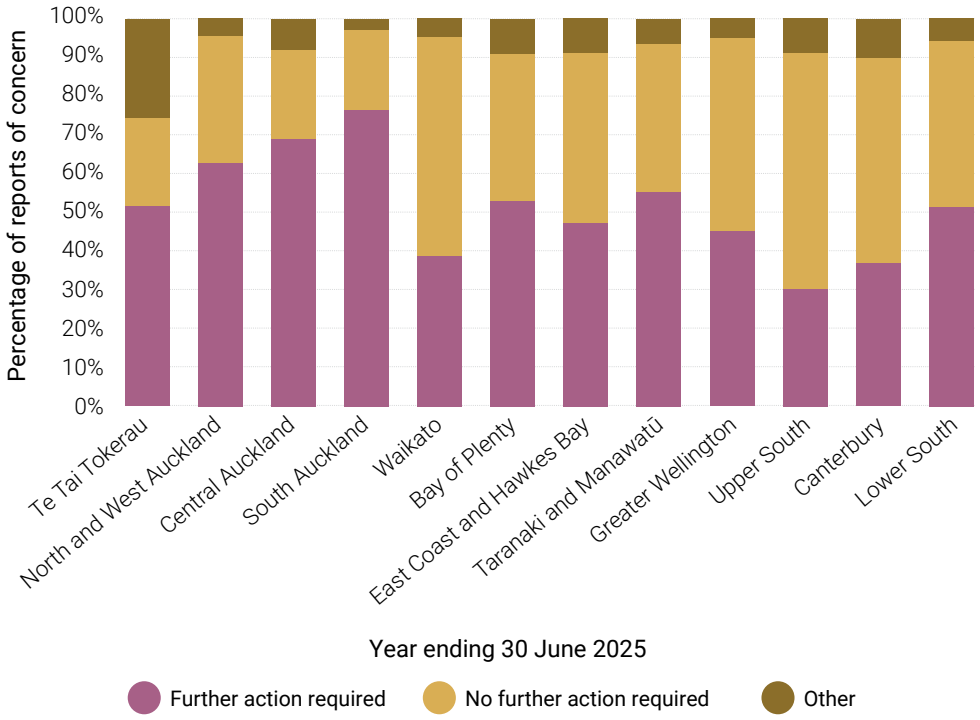
Figure 3: NCC decisions that further action is required on a report of concern continue to be overturned by sites.



The overturning of NCC decisions results in regional and site variations on the threshold for intervention

Regional variations also mirror what we saw in our last report, with NCC decisions more likely to be accepted in Auckland than in Canterbury and the Upper South (Figure 4).

Figure 4: Regional variation in responding to reports of concern referred by the NCC for further action.



While we acknowledge that Oranga Tamariki cannot control the volume of reports of concern it receives, it can improve processes to better manage the response to those concerns.

For this review, we asked Oranga Tamariki how it ensures sites have the capacity and resources they need to respond to reports of concern and whether it has a strategy for addressing capacity issues. Oranga Tamariki explained that:

- although the increased volumes have made it more difficult to respond quickly and have added to pressure on kaimahi and support systems, it has multiple systems to ensure tamariki and rangatahi with the greatest need are prioritised
- calls to the NCC are screened promptly, so even in periods of high volume, urgent matters are put through to a social worker almost immediately
- it initially assesses urgency, and cases with high urgency, those that involve babies or infants and those that require a joint CPP response with Police are allocated quickly
- roles are sometimes reoriented to support teams or sites under the greatest pressure, and this sometimes includes redeploying kaimahi from other sites in the region or nationally if necessary
- reports of concern with lower risk are not always allocated immediately to avoid placing social workers under undue pressure, and it also has a protocol to review social worker workloads that exceed a set level.

Reports of concern are sometimes delayed getting to sites

In our monitoring engagements with Oranga Tamariki kaimahi, we heard the process of the NCC completing initial assessments was not always working well. We heard that delays in the NCC completing initial assessments and sending reports of concern to sites were limiting sites' ability to respond due to the age of the reports of concern.

Some Oranga Tamariki site leaders told us there had been significant delays in reports of concern being sent to sites from the NCC, with "over 100 [reports of concern] that were over 22 days old".

We heard that lack of capacity combined with high workloads was further exacerbating the delays and reducing the ability of social workers to respond appropriately.

Oranga Tamariki continues to not make the best use of the resources it has

Leaders at NCC told us little has improved since we last reported. We heard that changes in recording practice and what they described as "the increasing complexity of reports of concern" has made their work more resource intensive. They explained they are "all fighting for resources" across the organisation.

Leaders at NCC wanted Oranga Tamariki leadership to better define roles and responsibilities between the NCC, sites and multi-agency tables, as this would remove some of the existing confusion and duplication of effort. They also spoke of the need to better resource the "front door" so time can be taken to do thorough initial assessments.

In our 2024 review, we noted "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 reassessing further action required decisions made by the NCC".[52] This has not changed.

Even if the initial assessment process is improved, unless frontline social workers are able to properly assess safety by getting eyes on the child, risks will remain

In one region, we heard that, despite public assurances that frontline services would not be affected, the Oranga Tamariki restructure had reduced frontline staffing and resourcing.

We heard some site leaders were carrying caseloads, that youth justice kaimahi were picking up work for care and protection kaimahi and that there was a freeze on hiring new staff. Oranga Tamariki kaimahi told us they must choose which cases to work on and which to leave.

> *"As leaders, we take a workload as well. There's nothing that you can't stop. There is that much work coming through the door, [and] when you see that [staff] are at capacity, you take over to support them, but then you can't do your job."* **ORANGA TAMARIKI SITE LEADER**

> *"At some point, you have no choice [but to take on a caseload]."*
> **ORANGA TAMARIKI SITE LEADER**

52 See footnote 2 (p. 60).

We also heard that social workers were making decisions on whether to act not on individual circumstances and risk to the child but in comparison to other cases in front of them. This creates a threshold for action that is based on neither risk to the child alone nor the assessment tools but based on capacity.

In Bay of Plenty, we heard that issues highlighted in our 2024 review remained unresolved. We heard the Oranga Tamariki restructure, cuts to resources and what kaimahi told us was a hiring freeze have led to increased workloads for frontline social workers.

In one site we visited in another region, we heard that there are a significant number of unallocated cases. We heard examples of social workers at this site making critical decisions, only for cases to not be allocated and "go into the abyss". There were concerns from social workers about this practice not "servicing whānau" well because it delays social workers engaging with whānau, and high caseloads make it difficult to provide adequate support or visit tamariki.

More recently, we heard that a push to reduce the number of unallocated cases has led to unintended consequences. Rather than allocate cases, sites have simply closed unallocated reports of concern.

Accepting that not all reports of concern require a statutory response, we have not seen any evidence that Oranga Tamariki is any more likely to follow up a report of concern now than when we last reported. It continues to make decisions that are unduly influenced by the available resource. If anything, things may be worse than we found in 2024.

Oranga Tamariki site decisions on whether to take action do not always put the child in the centre

In our 2024 review, we noted Oranga Tamariki had made changes to its guidance on initial assessments. This included broadening who can be contacted during an initial assessment to determine whether a core assessment[53] is required.

We noted that, rather than strengthening practice, this change may sometimes increase risk to tamariki and rangatahi by placing greater weight on the views of some individuals – who may be the perpetrator or afraid of or protecting the perpetrator – rather than focusing on the safety of tamariki and rangatahi. There was a lack of guidance for kaimahi about when – and how – to balance the views of whānau with the safety needs of tamariki and rangatahi.

Many community professionals shared concerns about the decision making of Oranga Tamariki social workers when the safety of tamariki and rangatahi is at risk. We heard from some community kaimahi that Oranga Tamariki social workers ask them what they should do. They felt that many Oranga Tamariki social workers lack confidence and understanding of their statutory role and responsibilities.

Some community kaimahi told us of times they have had serious concerns about the safety and risk of abuse to tamariki and rangatahi, considering decisions made by Oranga Tamariki kaimahi.

> *"I think a lot of social workers don't see the actual danger to tamariki – I get you can't remove kids willy-nilly as it impacts psychologically on tamariki, but at the same time, some social workers don't appear to have the ability to identify high risk."* **COMMUNITY AGENCY KAIMAHI**

53 If an initial assessment determines further action is required, this subsequent phase of investigation into the report of concern is known as a core assessment.

A couple of whānau members also shared examples of times they felt decisions from Oranga Tamariki social workers were not sufficiently focused on the safety and risk to their tamariki and rangatahi.

> *"[Oranga Tamariki] let me down. Baby was being neglected, which was what I said was going to happen if they took that route [of not applying for custody orders]. They said they were trying to give [the mother of the child] an opportunity to sort her shit out, but I was like our main concern was that baby was safe – wasn't that their job?"* **WHĀNAU**

Some community professionals told us they felt Oranga Tamariki lacked strategic direction, transparency and consistent guidance to support its kaimahi. They questioned how much risk drives decision making, noting that sudden changes seemed to reflect resource availability and media attention rather than any clear rationale.

> *"We find some [Oranga Tamariki] decisions made are in a knee-jerk way. The whole plan changes and you're [the] last to know. I think it's practice that's a means to an end and not trauma informed."* **COMMUNITY AGENCY KAIMAHI**

Oranga Tamariki site leaders and frontline kaimahi we met with in 2025 told us that the practice shift messaging tells them to follow a relational and holistic practice framework. We heard that there was a disconnect between how sites want to respond to tamariki and whānau – in relational ways – and the expectations from national and regional offices, which was more transactional.

> *"[Regional office] need to get on board with some of our relational ways of working because [not being on board] can be a barrier … [children] are waiting cos we can't get internal processes in line. In the last three years, there's been lots of training but that comes from the top. They're not on the same page. We're told this and that, but the thing is young people are still sitting in limbo not knowing what the next steps are. We see lots of anxiety for kids, young people not feeling safe and feeling unsettled. We are needing to get better at that."* **ORANGA TAMARIKI KAIMAHI**

In addition, we heard concerns about the capability of some Oranga Tamariki kaimahi to make the right decisions. Some site leaders told us how the capability and skills of some social workers impacts their practice and that some social workers lack capability and confidence when undertaking assessments. This means assessments are not always carried out, and site leaders sometimes need to step in to support social workers to do them.

> *"We are multi-tasking here … We are switching between practice lead, social worker and supervisor. We are having to step in and do social work because our social workers don't have the capability to make practice decisions."*
>
> ORANGA TAMARIKI KAIMAHI

Tamariki aged under 5 are the most at risk but they are no more likely to be seen

Although data on child deaths in Aotearoa shows that tamariki under 5 are at higher risk, the response from Oranga Tamariki to reports of concern does not prioritise seeing these very young tamariki.

Data from the last nine years[54] shows the proportion of reports of concern that resulted in further action – where Oranga Tamariki visited the tamariki for whom safety concerns were raised – was around 30 percent for tamariki of all ages up to 14.

Reports of concern about rangatahi aged 15 and older were less likely to result in further action responses from Oranga Tamariki at around 11 percent.

Induction and training are not adequately preparing social workers to assess risk

We asked Oranga Tamariki if it had made any changes to social worker induction and training since our last review and if it knew what impact those changes were having.

In response, Oranga Tamariki told us that the structure of its induction and training programme has been improved since our last review to create flexibility for social workers to meet their induction requirements. It told us there are now two or three opportunities for social workers to complete each module and attend face-to-face wānanga. Previously, the schedule was prescribed, so a missed event was difficult to catch up and caused delays in completion. Oranga Tamariki told us this new approach is helping social workers schedule their learning around work and other commitments.

54 This refers to data provided by Oranga Tamariki on reports of concern covering the period July 2016 to June 2025. This data was grouped annually and broken down into age bands for tamariki for whom reports were made.

However, what we heard from Oranga Tamariki kaimahi tells us a different story. Some Oranga Tamariki site leaders and kaimahi told us their compulsory training is a "one-size-fits-all" and "tick box" activity.

We heard that the training does not teach the specific skills needed for different roles, and cultural training is not specialised to the different needs of each community. In addition, we heard that new kaimahi do not receive training for a long time after they start, which delays them understanding and applying the legislation in their work.

We heard from some Oranga Tamariki kaimahi that there is not enough training and support for social workers, including a lack of induction training for new social workers. As an example, one kaimahi said that, while the practice centre is a useful resource, it can be difficult to use effectively as there is an overwhelming amount of information for newer kaimahi to "trawl" through.

> *"I think the organisation lacks training for new social workers. I have seen too many times where new social workers are just given things and told 'here go, do it' but then they get into trouble because they didn't follow the right practices."* **ORANGA TAMARIKI KAIMAHI**

We heard the organisation has a "sink or swim" mentality that affects staff retention.

A few kaimahi told us organisational expectations do not allow sufficient time for training, and valuable training becomes "a pressure" that is "overshadowed" by their workload.

Some Oranga Tamariki kaimahi told us there is a lack of support from leaders to implement training they have received on practice frameworks and legislation. We heard that some kaimahi put training into practice themselves without support from practice leads and supervisors. For example, a couple of kaimahi told us they had not received any training on Tiaki Oranga, the recently launched new assessment framework, and one kaimahi described feeling as though the training "has just been left behind".

Our review this year suggests that the issues we identified in 2024 are persisting.

We have continued to hear that inconsistent messaging about the practice shift and how to apply it may be placing tamariki and rangatahi at greater risk. We again heard that training and induction is not meeting social workers' needs, although it may be too soon to see the impacts of changes Oranga Tamariki has made. We will continue to look at this as part of our regular monitoring practice.

Health NZ also has a role. As highlighted in critical gap two, expertise from Health NZ professionals could assist Oranga Tamariki social workers to assess harm and the risk of harm. However, the capacity and capability of Health NZ to provide this support is currently limited.

Professionals who make reports of concern tell us the threshold for Oranga Tamariki to act is too high

We continue to hear concern from professionals in other agencies and NGOs about the high threshold for Oranga Tamariki to take action in response to their reports of concern.

> *"[The Oranga Tamariki] threshold seems to be climbing because of their inability to stay on top of things. I know that they can't handle it all because of the amount of [reports of concern] that are coming through. When people fill that [report of concern], the expectation is that [Oranga Tamariki] will do something about it sooner rather than later."* **POLICE KAIMAHI**

> *"With the [child aged under 2] who was reported [with more than a dozen hospital admissions], however many [reports of concern], no intervention from Oranga Tamariki."* **POLICE KAIMAHI**

> *"There is a big gap in the antenatal space – we have a woman who is about to be released who is not allocated anyone [within Oranga Tamariki]. I advised Oranga Tamariki and they have done nothing about it. Oranga Tamariki social workers miss the opportunity to engage with pregnant women here before they are released. Women are more open to engaging here."* **CORRECTIONS KAIMAHI**

> *"If they are nearing [age] 17, they don't really get any help. It doesn't matter how many complaints we do."* **HEALTH KAIMAHI**

> *"How bad does it have to get, really?"* **HEALTH KAIMAHI**

A couple of Police kaimahi told us they thought the threshold for response from Oranga Tamariki had risen, especially in cases relating to family harm. They felt there was sometimes a lack of action in response to tamariki, rangatahi and whānau involved in family harm.

> *"Exposure to family harm isn't generally enough [for Oranga Tamariki to take action]. Family harm doesn't meet the threshold. These kids are going to grow up, they would be saying 'You were at my house every week and you didn't do anything', only because they didn't meet the threshold."*
> POLICE KAIMAHI

Child death reviews echo the view that the threshold for action is too high

Concerns that the threshold for action is too high are reinforced by two Oranga Tamariki child death reviews that found health professionals had made reports of concern to Oranga Tamariki months before the deaths of the two tamariki.

The reports of concern noted that the significant injuries of the tamariki were inconsistent with the explanations given.

The death reviews show that Oranga Tamariki and Police responses to the reports of concern may not have adequately addressed the risk for these tamariki, especially considering the information from health professionals.

Action taken varies across different groups of professionals

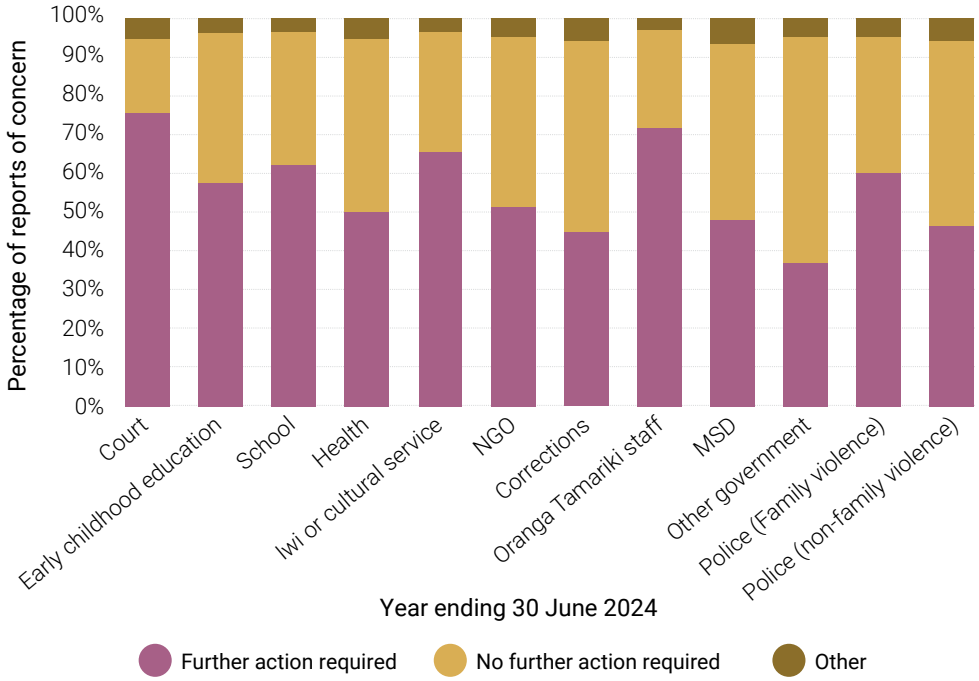
Oranga Tamariki decisions to take further action on reports of concern vary across notifier types. For this review, we looked at reports of concern from 2023/24 to see what had changed since our 2024 review (Figure 5).

As our 2024 review identified, Oranga Tamariki decided to progress only 40–50 percent of reports of concern from professional notifiers. This indicates that the assessment of risk by professionals when making a report of concern does not always align with how Oranga Tamariki assesses its need to intervene.

Across all reports of concern, Oranga Tamariki made a decision to take further action for 51 percent (36,400) of reports of concern in 2022/23, 50 percent (37,100) in 2023/24 and 40 percent (42,400) in 2024/25.[55] While the proportion of reports of concern where action is taken appears to be decreasing, the actual number of reports of concern that progress has remained consistent (around 40,000 are progressed each year).

What the data cannot tell us, however, is whether the threshold for intervention is getting higher, as was perceived by the professionals we heard from.

Figure 5: While there was variation across groups, a high proportion of reports of concern made by professionals continued to receive no further action by Oranga Tamariki.



Oranga Tamariki death reviews we looked at also identified that reports of concern are an opportunity for Oranga Tamariki to intervene to prevent harm, but this opportunity is not always taken.

> *"There was no consideration of the cumulative harm the children were experiencing. There were many [reports of concern] received that gave us the opportunity to look at the issues with fresh eyes however some of these were closed with no further action. The new concerns were also not considered in the context of the considerable history and intergenerational concerns."* **ORANGA TAMARIKI CHILD DEATH REVIEW**

55 Data was provided for Oranga Tamariki decisions on reports of concern for 2024/25 but we do not have this data broken down by notifier type for 2024/25.

Oranga Tamariki is continuing to refer tamariki and whānau to community providers despite contract cuts, loss of resources and limited capacity

We heard that Oranga Tamariki is continuing to refer tamariki and whānau to community providers, but funding and contracting cuts mean many of them are under pressure and cannot deliver the services needed. The Oranga Tamariki kaimahi we met with were concerned about the impact of this.

> *"We're encouraged to lean on the community, but all our community [providers] have had multiple contracts taken. We need them [community providers] but the powers that be decided 'nah'."* ORANGA TAMARIKI KAIMAHI

Many community organisations told us that cuts in their contracts mean they are having to be "creative" to fund their work. Some are working without funding, some are working above and beyond their funding and others are facing cuts and scaling back their services. Months into the 2024/25 financial year, some were still unclear about proposed changes and timeframes and were working without funding.

> *"Our contract and funding expired on 30 June 2024. We have been currently running for two months without funding … We are told 'yes' to more funding but not when, so we have no timeframe. We have no one to contact at Oranga Tamariki any more … We are not a provider who had pūtea [money] to tie us over … We contact [Oranga Tamariki] every other day and there is no new information. The government tell us to fill the beds but haven't given us funding."* MĀORI SERVICES KAIMAHI

We heard there is an expectation that services will continue to be provided even though funding has been reduced.

> *"I think if you give [Oranga Tamariki] an inch and they take a mile. They are very quick to ask us different things, pile on [work] outside of the contracts we are working."* COMMUNITY AGENCY LEADER

> *"Yeah contracts, there's a lot less wiggle room. We will see a need and take a look into what we might be able to do but then it's like, 'oh no, we can't with the funding we have' … It's just getting really tight or cut completely. How do you see the same number of clients if you only have this [gestures to a small amount]? We have waitlists as long as our arms."*
> **COMMUNITY AGENCY LEADER**

Oranga Tamariki kaimahi also told us the contract changes are impacting on their local relationships and having a negative impact.

> *"I do worry about our ability to sustain our social structure when so much of our ability is taken away from our community. We're the ambulance at the bottom of the cliff and it is now on fire. We can't go to the community because they don't have the capacity any more."* **ORANGA TAMARIKI LEADER**

In October 2025, Oranga Tamariki announced it would extend contracts due to expire on 31 December 2025 through to March 2027. This gives community providers greater certainty to enable them to deliver services and supports to tamariki, rangatahi and their whānau.

A resourced and capable community sector could help Oranga Tamariki focus on where a statutory response is most needed and reduce harm

For Oranga Tamariki to respond appropriately to reports of concern that require a statutory response, a resourced and capable community sector that meets basic social needs is required.

Community agencies are able to engage with whānau and help them access resources such as food and housing and supports such as for parenting, mental health and drug and alcohol addictions. In turn, this may help prevent harm and further reports of concern. In working with whānau, community agencies provide safety in that they have eyes on tamariki and can escalate serious concerns to Oranga Tamariki for a statutory response.

Te Reo Karanga, a community-led contact centre in Whakatāne, is an example of what is possible

Oranga Tamariki is trying to achieve this vision through its Enabling Communities approach, and one example of this is Te Pūkāea o te Waiora in Whakatāne – an initiative launched by Te Tohu o Te Ora o Ngāti Awa and Eastern Bay of Plenty Iwi Provider Alliance in 2024. It includes Te Reo Karanga, a tikanga-focused and community-led contact centre in Whakatāne.

Calls made to the Oranga Tamariki NCC that fall within the Whakatāne site catchment are redirected to Te Reo Karanga, which triages the calls and helps whānau to access community information and services. We heard the triage process and provision of support by Te Reo Karanga to tamariki, rangatahi and their whānau is working well. Two agencies spoke positively about it, noting that reports of concern are responded to quickly and tamariki, rangatahi and whānau can access a range of services in the community to support their needs.

All reports of concern that go through Te Reo Karanga are referred to Oranga Tamariki for a statutory response or those that might normally receive a no further action response are allocated to whānau navigators. Whānau navigators assess the needs of whānau and provide the services needed or refer to other community agencies. This allows tamariki, rangatahi and whānau whose needs do not meet the threshold for statutory intervention by Oranga Tamariki to access support and have their needs addressed holistically.

> *"One of the things that we're committed to is no case gets closed. There will be a visit. Every referral that we get through Te Reo Karanga, there will be a home visit to discuss what the concerns are and offer assistance. They can decline the service, but part of our assessment is, if there are risks still existing, we can go back into [Oranga Tamariki] and escalate it back to [Oranga Tamariki]."* **TE REO KARANGA KAIMAHI**

Te Tohu o Te Ora o Ngāti Awa shared information and data with us that shows some promising early results. Alongside data from Oranga Tamariki, there are indications that early responses to whānau by the community can be an effective way to manage some reports of concern.

A local Oranga Tamariki leader told us that triage by Te Reo Karanga has been working well for reports of concern from Infant, Child and Adolescent Mental Health Service that do not meet the statutory threshold. They said an understanding has developed that "Oranga Tamariki don't need to be the ones to do something first".

Te Reo Karanga has enabled the local Oranga Tamariki site to focus its resource where it is most needed. Crucially, although Te Reo Karanga relieved the local Whakatāne site of the work of responding to reports of concern, Oranga Tamariki decided not to reduce the number of social workers at the site. This meant Oranga Tamariki could focus on carrying out its statutory role. However, more recently, we heard this could be at risk, with Oranga Tamariki social workers from the Whakatāne site being required to cover vacancies at other sites.

Te Reo Karanga is an example of what can be done. Not only does it provide a more comprehensive response to the needs that may underlie a report of concern, but it also addresses those needs early to prevent further notifications, reduce potential harm and limit increased involvement in the oranga tamariki system. Doing this well requires the right help and support, including from other government agencies, to be involved from the earliest stage and not only in the most serious cases.

Resourcing the broader system and communities to respond to needs that do not require statutory intervention would enable Oranga Tamariki to direct its focus to responding to reports of concern that do require a statutory response. Without this, it will continue to struggle to respond to the number of reports of concern it will inevitably receive and to ensure the tamariki at the centre of them are safe.

Child death reviews

Child death reviews are not leading to the systemic change needed to prevent further harm

The death of a child is a tragedy in any circumstance, let alone when the cause is abuse. Literature on child deaths from abuse says that it is difficult to predict and impossible to prevent all deaths. However, putting support around tamariki, rangatahi and whānau at risk can reduce the likelihood of serious harm and death. Thorough reviews of what led to the death of tamariki, involving multiple agencies and using a robust systems framework, are also opportunities to make changes to the system to prevent serious harm in the future.

Malachi died in November 2021. Between December 2021 and June 2025, Police and Oranga Tamariki completed 17 reviews into the deaths of 14 tamariki who died from abuse by a person meant to be caring for them. These 17 reviews are opportunities to help close the critical gaps identified in the Poutasi report. They are 17 missed opportunities to deliver systemic change.

While not every review was robust or followed a systemic framework and not every gap was evident in every review, we found that, before their death:

- one child was moved by whānau to an unsafe environment after their parents were imprisoned and processes were not followed by Oranga Tamariki, which also did not sight the child or assess their needs
- three tamariki had had reports of concern from health professionals where their risk of future harm may not have been adequately addressed
- the CPP was not followed by Police for one child
- one child had a "significant but unknown number of reports of concern" incorrectly entered by Oranga Tamariki
- two tamariki had caregivers that were not adequately checked by Oranga Tamariki
- for four tamariki, Oranga Tamariki did not effectively sight them, where practice guidance indicated they should have

- for at least four tamariki who were sighted by either Police or Oranga Tamariki, the agencies did not share information to understand the overall, and potentially increasing, risks to the child.[56]

Notwithstanding the limitations of current child death review processes, areas needing improvement are well documented. As we outline in this review, action is needed, and there is a long way to go before the gaps in the safety net are closed to prevent child abuse occurring.

Death reviews further demonstrate the critical gaps identified in the Poutasi report

The way child death reviews are conducted also reflects the critical gaps in child safety. For example, across the 17 child death reviews, we saw the following.

- Reviews are not child-centred so do not consider what the child needed but instead look at how the agency responded.
- Agencies are not collaborating on child death reviews to learn from each other and make changes that improve the system. Reviews are focused on the agency's requirements rather than an assessment of the risk to the child and putting what the child needed to be kept safe at the centre of analysis.
- While some child death reviews include information from other agencies, suggesting information was shared to help inform the death review, others do not. We only saw limited evidence of information sharing between the Police and Oranga Tamariki to inform the child death reviews they undertake.
- Findings and recommendations of child death reviews do not appear to be shared with relevant agencies. This means agencies may not be aware that findings or recommendations have been made for them to action.

56 Police advised that this is based on the PVFDRs and, where cases were investigated under the CPP, additional information about interagency information sharing is held in the respective case files. It told us that, in this respect, the statement that "agencies did not share information to understand the overall, and potentially increasing, risks to the child" may not reflect the full extent of information sharing in CPP cases. Police did not explain why this information would not be reflected in the PFVDR if it exists.

- Even when agencies are deciding whether to review the deaths of tamariki, some tamariki seem to be invisible. This is evident in decisions by Oranga Tamariki not to undertake reviews of some deaths, even where the PFVDR appears to show a clear opportunity for Oranga Tamariki to address systemic issues when a child dies.

In completing death reviews, kaimahi follow the policies and guidance set by their agency. However, the actions required by those policies do not necessarily equate to the actions that are necessary to achieve systemic change. For example, Police advised that PFVDRs are not specifically designed to be child-centred but instead to assess Police's response to family violence concerns. Police told us that assessing the broader needs of children is not within the subject matter expertise or statutory function of Police.

This is just one example of how the policies do not always support systemic change. If policies are not designed to help bring about system change, we cannot be surprised that death reviews are not achieving this.

Oranga Tamariki may be missing opportunities to identify, learn from and address risks

Oranga Tamariki does not undertake reviews of all deaths of tamariki and rangatahi known to it. Decisions on whether or not to undertake a review are made by the Decision-Making Forum (DMF), a group of Oranga Tamariki senior leaders. Sometimes, particularly if the DMF considers Oranga Tamariki had little involvement with the child and their whānau, a decision is made not to undertake a review.

Tamariki aged under 1 were the largest group to die from abuse by a person who was meant to be taking care of them. Considering their short lifetime and the relatively fewer opportunities for others such as teachers and the public to suspect abuse, the decision not to review deaths where there was little or no previous involvement may be too narrow. We question how much involvement, in a life spanning less than 1 year, would be required for it not be considered "little". Oranga Tamariki is missing opportunities to identify, learn from and address risks, especially for babies.

We received information from Oranga Tamariki that included six deaths where its DMF had decided "a review is not required due to little or no previous

involvement" with Oranga Tamariki. However, information also provided by Oranga Tamariki identifies that five of these six tamariki or one of their siblings had had previous involvement with Oranga Tamariki.

In determining whether to undertake a child death review, Oranga Tamariki should give consideration to the wider risks the child faced, including their surrounding environment and notifications about siblings or other tamariki and rangatahi in the household.

PFVDRs for these same tamariki identify family violence notifications. Where Police attend family violence incidents, these are referred to a family violence multi-agency table. The table assesses whether a report of concern is required. When no action is required, this information is still passed to Oranga Tamariki to record, either as a contact record or a no further action report of concern. Either way, Oranga Tamariki should have a record of the incident or incidents. In cases such as these, an Oranga Tamariki review could consider whether it should have assessed the information in the way it did or if it missed an opportunity to intervene and provide support.

Where death reviews are completed by Oranga Tamariki, responses often do not address root causes

We asked Oranga Tamariki whether any recommendations, practice and/or policy changes were implemented as a result of the death reviews it had undertaken and whether any analysis had been done on the impact of any changes made.

In response, it provided a summary of changes made to respond to thematic insights. These included changes to how it records reports of concern at the NCC. It told us thematic insights had also informed updates to the CPP – but not what those updates were. It told us that insights had been used to embed the Practice Approach and Practice Systems – but again not what the changes were. It told us insights had informed the use of Practice Notes from the Chief Social Worker – but not what those Practice Notes were in relation to. It did not tell us whether it knew what impact these changes are having.

Oranga Tamariki further told us that the findings from reviews, reports and practice opinions are consistently shared with site and regional leaders, actions are agreed, including practice-focused discussions and planning with sites, and they are supported by the Office of the Chief Social Worker/Professional Practice regional and residential quality practice teams.

While Oranga Tamariki tells us it is applying learnings from reviews, as we have highlighted in this review, the critical gaps remain unaddressed. The problem may be that the learnings Oranga Tamariki is applying are not what is needed.

Our 2024 review identified that actions that had been taken by agencies – including but not limited to Oranga Tamariki – were addressing symptoms but not the underlying causes of the child protection system not keeping tamariki safe.

For example, after Malachi was killed, the Chief Social Worker issued a Practice Note to require that Oranga Tamariki social workers have at least 12 months' practising experience before undertaking initial assessments. This was because the Chief Social Worker's report identified that the social worker who assessed the report of concern for Malachi had less than 12 months' experience and the initial assessment should have resulted in a decision to undertake a core assessment rather than a no further action decision. However, a less-experienced social worker was doing the initial assessment on their own because the site was under-resourced for the volume of work it had to respond to. As we have seen in our review this year, this problem persists.

The action of issuing the Practice Note may have been measurable, but it did nothing to address the root cause of the issue.

Unless the root causes are addressed, the critical gaps are unlikely to close.

There is a lack of a well-resourced, independent death review mechanism supported by system-level accountability

As described above, agency death review processes are internally focused on the work of the agency rather than on understanding the systemic response that would have been required to prevent the death occurring. While there are independent, systemic, multi-agency mortality review processes such as those undertaken by the Family Violence Death Review Subject Matter Experts on behalf of the National Mortality Review Committee, they are not sufficiently resourced to ensure all deaths are reviewed.

Police told us it supports strengthened co-ordination and oversight of child death reviews to ensure system-wide learning and that PFVDRs are routinely provided to the Family Violence Death Review Subject Matter Experts to support this goal. However, restrictions on the use of the information collated for the purpose of reviews by the National Mortality Review Committee prevent the public release of findings. As a result, recommendations from individual reviews of the National Mortality Review Committee are collated at the national level and become the subject of substantive reports.

Recommendations from reviews are released by the National Mortality Review Committee to individual agencies. However, there is no accountability mechanism built into the review process and agencies are not required to report back to the National Mortality Review Committee on their progress in implementing recommendations made.

Oversight, potentially at ministerial level, of the findings and issues arising from national and agency death reviews could drive a more co-ordinated response across agencies to prioritise actions and address findings at a system level.

"There have been numerous reviews of previous cases of child abuse that have drawn very similar conclusions to mine. In reality, a number of the findings and recommendations of this review have largely been made before. Some recommendations have been implemented but fallen away as the spotlight moves on and the process defaults to what it knows; others have not been attempted because the environment was not seen as ready. As a society, we cannot continue to allow a cycle of abuse, review, outrage and distress – and then retreat from the difficult challenges. It is not acceptable we give up because it is too difficult. There must be sustained, determined and bold change. As difficulties arise in implementation, solutions focused on the protection of children and whānau must be found. This requires regular monitoring and accountability for change."

Dame Karen Poutasi on child abuse and death reviews conducted prior to the death of Malachi Subecz

Glossary

Case note	A case note is used by Oranga Tamariki 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 by Oranga Tamariki 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 violence reports deemed as no further action by the local interagency family violence tables.
CPP	The Child Protection Protocol: Joint Operating Procedures is an agreement between Police and Oranga Tamariki when responding to allegations of serious harm. It outlines each agency's responsibility and the process for investigation.
Child Protection Team	A Police team that provides specialist child assessment and investigation services for tamariki that have experienced sexual or physical harm.
CYRAS	The 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.
ECE services	Early childhood education services. For the purposes of this report, we use ECE services to mean the diverse range, including education and care centres, kindergartens, kōhanga reo, home-based services, and playgroups and playcentres. The Ministry of Education is the (current) lead regulator.

Enabling Communities	An Oranga Tamariki initiative to better support tamariki and their whānau. Oranga Tamariki is working with iwi, Māori and communities to develop prototypes to shift decision making and resources to communities.
Executive Board for the Elimination of Family Violence and Sexual Violence	Previously known by its gifted name Te Puna Aonui, which is the name used in our previous report.
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.
IDI	The Integrated Data Infrastructure is a large research database maintained by Stats NZ. It holds de-identified data about people and households in Aotearoa. Results from IDI analysis are not official statistics. They have been created for research purposes from the IDI, which is carefully managed by Stats NZ. For more information about the IDI, visit www.stats.govt.nz/integrated-data.
ISR (Integrated Safety Response)	A multi-agency intervention designed to ensure the immediate safety of victims and tamariki and to work with perpetrators to prevent further violence. ISR is hosted by Police as part of the broader government work on family violence and sexual violence.
Iwi	Tribe.
Kaimahi	Staff or staff member.
NCC	The Oranga Tamariki National Contact Centre provides a 24/7 phone and online service where anyone can report concerns about the safety and wellbeing of tamariki and rangatahi.
No further action	A decision on a report of concern that no further assessment or investigation is necessary.

Oranga Tamariki hospital liaison	The hospital liaison position provides interagency co-ordination and practice support between Oranga Tamariki and health.
PFVDR	Police family violence death review – undertaken by Police following a death from family violence.
Rangatahi	Defined by the Oranga Tamariki Act 1989 as a young person or young people aged 14 or over.
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.
Report of concern	Any concern reported to Oranga Tamariki or Police that meets the definition under section 15 of the Oranga Tamariki Act 1989.
SAM (Safety Assessment Meeting)	SAM tables are a multi-agency family harm intervention designed to respond to reported incidents of family harm.
Shared Digital Health Record	A Health NZ initiative that will enable a person's core health information to be securely accessed across health settings nationally.
SEN (Serious Event Notification)	Information collated by Oranga Tamariki about serious harm to a child or a child death.
Tamaiti	Oranga Tamariki uses tamaiti to refer to a singular child.
Tamariki Māori	Children of Māori descent.
Te Āhuru Mōwai	The Oranga Tamariki site that assessed the reports of concern received for Malachi.
Whānau	People who are biologically linked or share whakapapa. For the Independent Children's 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: Summary of agency progress on Poutasi recommendations

For each of the critical gaps identified in the Poutasi report, Dame Karen made a number of recommendations to address them. This table provides an overview of the status of each of the recommendations in the Poutasi report. It includes brief commentary on progress made. More detailed commentary is set out in the body of this review.

Recommendations of the Poutasi report

Critical gap 1: The needs of a dependent child when charging and prosecuting sole parents through the court system are not formally identified.

Recommendation 1: Oranga Tamariki should be engaged in vetting a carer when a sole parent of a child is arrested and/or taken into custody. 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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki, supported by Corrections, Ministry of Justice and Police	Not achieved.	Not achieved.	An interagency hub will be established in January 2026 to gather and share information to identify and respond to the needs of tamariki whose sole parent is remanded in custody and/or sentenced to imprisonment.

Recommendation 2: 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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki, supported by Corrections and Police	Not achieved.	Not achieved.	Agencies are working together to enhance the existing report of concern process to ensure that tamariki whose sole parent is arrested and/or taken into custody are identified and their needs met.

Critical gap 2: The process for assessing the risk of harm to a child is too narrow and one-dimensional.

Recommendation 3: 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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki, Police and the Executive Board for the Elimination of Family Violence and Sexual Violence	Not achieved.	Not achieved.	This is being progressed through Enabling Communities.

Recommendation 4: 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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Ministry of Health and Health NZ	Not achieved.	Not achieved.	Health NZ is undertaking a multi-year programme to link medical records across relevant healthcare settings to enable health professionals to view a picture of a child's medical history.

Recommendation 5: The health sector should be added as a partner to the Child Protection Protocol between Police and Oranga Tamariki to enable access to health professionals experienced in the identification of child abuse, and to facilitate regular joint training.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Ministry of Health and Health NZ, supported by Oranga Tamariki and Police	Not achieved.	Not achieved.	Health NZ is considering joining the CPP in a training and governance capacity while further work is undertaken to assess resourcing requirements of participating fully.

Critical gap 3: Agencies and services do not proactively share information, despite enabling provisions.

Recommendation 6: 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, from the agency for a child whose caregiver is in prison.

Lead agency	2024 status	2025 status	Progress made towards recommendations
MSD	Not achieved.	Not achieved.	From February 2026, MSD will make a report of concern when it receives an application from a caregiver for a benefit or other financial assistance in respect of, or to include, a child, where the applicant is not the lawful guardian of that child, and where the parent(s) of that child is in prison.

Recommendation 7: 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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki, Corrections, Ministry of Justice, Police, MSD, Ministry of Health, Health NZ, and Ministry of Education (Information Sharing Working Group)	Not achieved.	Not achieved.	The Privacy Commissioner is working alongside children's agencies to reinforce expectations of information sharing where there are safety and wellbeing concerns for tamariki.

Critical gap 4: There is a lack of reporting of the risk of abuse by some professionals and services.

Recommendation 8: 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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki, supported by Corrections, Ministry of Justice, Police, MSD, Ministry of Health, Health NZ, Ministry of Education and ERO	Not achieved.	Not achieved.	A staged approach will be taken to these recommendations, starting with mandatory education and training for designated workforces to improve child protection knowledge and skills.

Recommendation 9: 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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki, supported by Corrections, Ministry of Justice, Police, MSD, Ministry of Health, Health NZ, Ministry of Education and ERO	Not achieved.	Not achieved.	A staged approach will be taken to these recommendations, starting with mandatory education and training for designated workforces to improve child protection knowledge and skills.

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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Ministry of Education, supported by ERO	Not achieved.	Not achieved.	The revised ECE licensing criteria are expected to be implemented in April 2026.

Critical gap 5: The system's settings enabled Malachi to be unseen at key moments when he needed to be visible.

Recommendation 11: The agencies that make up the formal Government's children's system **should be specifically defined in legislation.**

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki, supported by Corrections, Ministry of Justice, Police, MSD, Ministry of Health, Health NZ and Ministry of Education (Children's System Working Group)	Not achieved.	Complete.	Agencies advise that this recommendation is complete.

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.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki, supported by Corrections, Ministry of Justice, Police, MSD, Ministry of Health, Health NZ and Ministry of Education (Children's System Working Group)	Not achieved.	Not achieved.	Progressing this recommendation is being considered in the context of other changes being implemented to strengthen agency accountability for checking child safety. Agencies are taking steps to ensure that all children's agencies are complying with provisions in Part 2 of the Children's Act for checking the safety of tamariki. Officials will also assess whether there are any gaps and consider what further legislative change may be required to fully implement the intent of this recommendation.

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'.

Lead agency	2024 status	2025 status	Progress made towards recommendations
Oranga Tamariki advised that the lead agency for this work is yet to be confirmed	Not achieved.	Not achieved.	A public awareness campaign will be progressed to help reinforce the mandatory training and education under recommendation 9.

Appendix B: Agencies' progress on own recommendations

In addition to commissioning the Poutasi report following the death of Malachi Subecz, agencies also completed their own reports and recommended actions for themselves. This table gives an overview of agencies' progress on the recommended actions they set themselves in their own reports. For actions that were not complete at the time of our 2024 review, we include an update (2025 status) on what agencies have done since to progress the recommendations. Where actions were noted as complete in our last review, no further updates are given beyond the 2024 status.

Oranga Tamariki

Recommendations	2024 status
Practice decision making	
That as a matter of urgency Oranga Tamariki resets the expectation that only experienced and capable social workers should complete initial assessments and takes steps to ensure this is occurring consistently.	Oranga Tamariki advised this action was complete.
That as a matter of urgency Oranga Tamariki reiterates to all staff the requirements of the case recording policy and the need to record and action the voices of whānau and any other people who make contact. This should be done immediately issuing a Practice Note from the Chief Social Worker.	Oranga Tamariki advised this action was complete.
That Oranga Tamariki establish and embed an accountability and reporting mechanism based on the core aspects of statutory social work – the eight Practice Standards. This framework will be used to measure and monitor the application of the Practice Standards, giving social workers, supervisors and managers greater visibility about the extent to which the Practice Standards are being met.	Oranga Tamariki advised this action was complete.
That Oranga Tamariki provides clarity to social workers about their responsibilities to meet the Practice Standards and implement responses when they are not met. These responses must balance the provision of development support and personal accountability and ensure that poor practice is not accepted.	Oranga Tamariki advised this action was complete.

Recommendations	2024 status
Site environment, support and leadership	
That as a matter of urgency Oranga Tamariki works with Te Āhuru Mōwai site and the Bay of Plenty regional team to create a support plan to address the specific issues which have been identified in terms of leadership, site culture, professional development and engagement with community partners.	Oranga Tamariki advised this action was complete.
That Te Āhuru Mōwai site undertakes work in partnership with iwi, Māori, community and other government services in the re-design of a local approach to Reports of Concern which responds when worries are raised about the safety and wellbeing of tamariki.	Oranga Tamariki advised this action was complete.
Practice guidance, professional development and interagency processes	
That Oranga Tamariki ensures social workers have the opportunity to engage in professional development, training, coaching and mentoring relevant to their level of experience in order to respond confidently and capably in the areas of practice identified within the findings of this review.	Oranga Tamariki advised this action was complete.
That Oranga Tamariki progress the action within the Future Direction Plan to develop and implement a post-graduate professional practice course for statutory social workers.	Oranga Tamariki advised this action was complete.
That Oranga Tamariki ensures Supervisors have access to ongoing training, development, regular internal support, and external supervision. That Oranga Tamariki accelerates work currently underway to lift the capability and quality of supervision practice.	Oranga Tamariki advised this action was complete.
That Oranga Tamariki ensures all site and regionally based managers have access to appropriate training and professional development to carry out their role. This includes the provision and resourcing of professional development plans, leadership training, coaching and regular supervision.	Oranga Tamariki advised this action was complete.
Workload and Work Management	
That Oranga Tamariki develops a caseload sizing approach, which accounts for complexity and establishes a baseline for an acceptable workload in order for individual practitioners to undertake professional, reflective, and responsive practice. This approach must be able to be applied in relation to an individual practitioner and across team and sites as a whole.	Oranga Tamariki advised this action was complete.
That Oranga Tamariki progress the action within the Future Direction Plan to establish a national visibility model for caseload/workload management, that enables regular reporting and identifies gaps in capacity where additional workforce investment and wider resources may be required.	Oranga Tamariki advised this action was complete.

Recommendations	2024 status
Practice Guidance and Policy	
That as a matter of urgency Oranga Tamariki, involving the Office of the Chief Social Worker, completes a review of the legal position and policy underpinning initial assessment practice.	Oranga Tamariki advised this action was complete.
Child Protection Protocol	
That Oranga Tamariki and Police work with Te Whatu Ora (Health New Zealand) to consider their inclusion as a party to the Child Protection Protocol, and to ensure that the CPP provides for greater clarity, support and expertise from health when assessing potential signs and indicators of abuse and neglect.	Oranga Tamariki advised this action was complete.
Complaints Processes	
That work underway as part of the Future Direction Plan to develop a fit for tamariki and whānau complaint process takes into account the experiences and insights of Malachi's whānau, with particular regard to the need for greater independence and accessibility.	Oranga Tamariki advised this action was complete.
The wider community and system: a need for local and connected responses	
Collaborative decision making	
That work is accelerated as part of the Future Direction Plan to fundamentally shift how Oranga Tamariki assesses and response to reports of concern with our partner agencies to ensure collaborative decision-making and support. That this work should build on partnered approaches and processes already being used in some parts of the country. That careful consideration is given during design of this approach in order to understand and make provision for the resourcing requirements to enable this model to work effectively. That the following principles and elements should be considered in the development of this approach: • Tamariki are understood in the context of their whānau and whakapapa. • The expertise of iwi, local marae, Kaupapa Māori services and Kairaranga a-whānau, are recognised in understanding and strengthening cultural connection and identity for tamariki and whānau Māori. • Engagement with tamariki and whānau should occur at the earliest opportunity, based on a prevention response, to address unmet needs which impact on their oranga. • Joined up approaches with other agencies, are grounded in shared commitments, responsibilities, and clear accountabilities for tamariki.	Oranga Tamariki advised this action was complete.

Recommendations	2024 status
• Support options must be available and able to be readily activated whether through whānau, natural networks within communities, or through more formal support agencies. • Ensuring continuity of the relationship with a social worker, which (when required) is not disrupted. This will require allocating a social worker at the point where a report of concern is received. • Information sharing between professionals and agencies for the purpose of safety and wellbeing is utilised, and that this occurs as part of an established process agreed to between the children's agencies. • An analysis of the required resources will be needed to enable the implementation of the future model and must be a feature of the design approach.	
We [Oranga Tamariki] propose consideration of a review of the effectiveness of the Children's Act 2014. The purpose of this would be to clarify the responsibilities of children's agencies in supporting timely information-sharing and prioritisation of services for tamariki who come to the attention of Oranga Tamariki, with an emphasis on a collaborative approach to responding to report of concern.	Oranga Tamariki advised this action was complete.

Department of Corrections

Recommendations	2024 status	2025 status
Recommendation 1 Corrections must undertake a review of the Relationship Agreement with Oranga Tamariki, and thereafter ensure a review is undertaken every two years.	Not achieved.	Not achieved.
Update on recommendation 1 The Relationship Agreement is still being reviewed.		
Recommendation 2 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 and the Inspection Standards as it refreshes its induction processes.	Not achieved.	Not achieved.
Update on recommendation 2 Specialist advice is being sought on the collection and storage of personal information on dependent children of people in prison.		

Recommendations	2024 status	2025 status
Recommendation 3 Corrections must review its processes for approving telephone numbers, particularly for prisoners with dependent children in the community.	Corrections advised this action was complete.	
Recommendation 4 Corrections must remind staff of the requirement to follow practice guidance for video calls at all times.	Corrections advised this action was complete.	
Recommendation 5 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 Police.	Not achieved.	Not achieved.
Update on recommendation 5 Corrections has reviewed all material on its intranet on child protection and is updating this so that it is easy to fid and clear for kaimahi. It has worked with Police and Oranga Tamariki regarding the processes for reporting concerns and this is informing the development of updated materials and guidance. The updated materials and guidance are expected to be available to Corrections kaimahi by December 2025.		
Recommendation 6 Corrections must remind staff of the responsibility to ensure that prisoner information is appropriately recorded and stored.	Corrections advised this action was complete.	
Recommendation 7 Corrections must remind staff of best practice when correcting errors in official documents.	Corrections advised this action was complete.	
Recommendation 8 Corrections must ensure that review risk assessments are completed in accordance with the Prison Operations Manual.	Corrections advised this action was complete.	

Ministry of Social Development

Initiatives	2024 status	2025 status
Initiative 1 A review and refresh of MSD's existing MAP (Manuals and Procedures[57]) and its Doogle (intranet) pages to ensure the information available to staff is clear, relevant and current.	Not achieved.	MSD advises this action is complete.
Update on Initiative 1 MSD updated MAP and the relevant content on its intranet, Doogle, in December 2024.		
Initiative 2 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.	Not achieved.	MSD advises this action is complete.
Update on Initiative 2 MSD refreshed its ChildSafe online learning module and assigned it to all kaimahi to complete in November 2024.		
Initiative 3 Increasing the visibility of the Child Protection policy and all the related resources through the various staff platforms on the MSD intranet.	MSD advised this action was complete.	

57 workandincome.govt.nz/map/index.html

Ministry of Education

Recommendations	2024 status	2025 status
Recommendation 1 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).	Not achieved.	The Ministry of Education advises this action is complete.
Update on recommendation 1 Ministry of Education implemented its revised internal process for decision making on cases where a child has experienced serious harm in July 2024.		
Recommendation 2 The Early learning Operations Group within Te Pae Aronui[58], 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	i. Ministry of Education advised this action was complete	i.
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	ii. Not achieved	ii. Not achieved
iii. The establishment of an education sector regulatory group for agencies with regulatory accountabilities for education.	iii. Not achieved.	iii. Not achieved.
Update on recommendation 2 Ministry of Education advised that its report into Abbey's Place Childcare Centre has informed and been incorporated into the ECE regulatory sector review. It did not provide specific updates on sub-recommendations ii and iii.		

58 Operations and Integration Group

Ministry of Health

Recommendations	2024 status	2025 status
Recommendation 1 Endeavours towards joined up medical records with appropriate point of care access continue to be supported. 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.	Not achieved.	Not achieved.
Update on recommendation 1 Health NZ is progressing a programme of work to join up medical care records across the health system. In addition, Health NZ has been working with Oranga Tamariki to progress an initiative that would flag all tamariki under the care of Oranga Tamariki in primary care IT systems. Health NZ is in the final stages of approval for resourcing to progress the work.		
Recommendation 2 Consideration be given to extending Gateway assessments[59] to children who are placed into the care of others as a result of their parent(s) being imprisoned.	Not achieved.	Ministry of Health advises this action is complete.
Update on recommendation 2 Consideration was given to extending Gateway Assessments as part of the Gateway Assessment Review and redesign. A decision was made not to extend assessments. The current priority for agencies is on making national improvements to the Gateway service to enable earlier access to health, education and disability services for tamariki in the care of or at risk of being in the care of, Oranga Tamariki. A phased approach to progressing the improvements is planned.		

59 practice.orangatamariki.govt.nz/core-practice/practice-tools/other-practice-and-assessment-tools/gateway-assessments

Recommendation 3 Improvements be made to the report of concern process to incorporate multi-agency reviews of a report, to help determine an appropriate response.	Not achieved.	Not achieved.
Recommendation 4 The findings of the review are shared with relevant agencies to inform opportunities for inter-agency working to identify response to abuse in future.	Not achieved.	Not achieved.
Update on recommendations 3 and 4 The Ministry of Health advised that agencies are progressing this as part of overall work on improving the response to the report of concern process.		
Recommendation 5 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.	Not achieved.	Rejected.
Update on recommendation 5 The Ministry of Health confirmed that this action has now been rejected and will not be progressed by agencies at this stage.		

Appendix C: MSD survey results

Set out below are the results of the survey of MSD integrated services case managers. The survey was sent to 65 kaimahi and 46 responded.

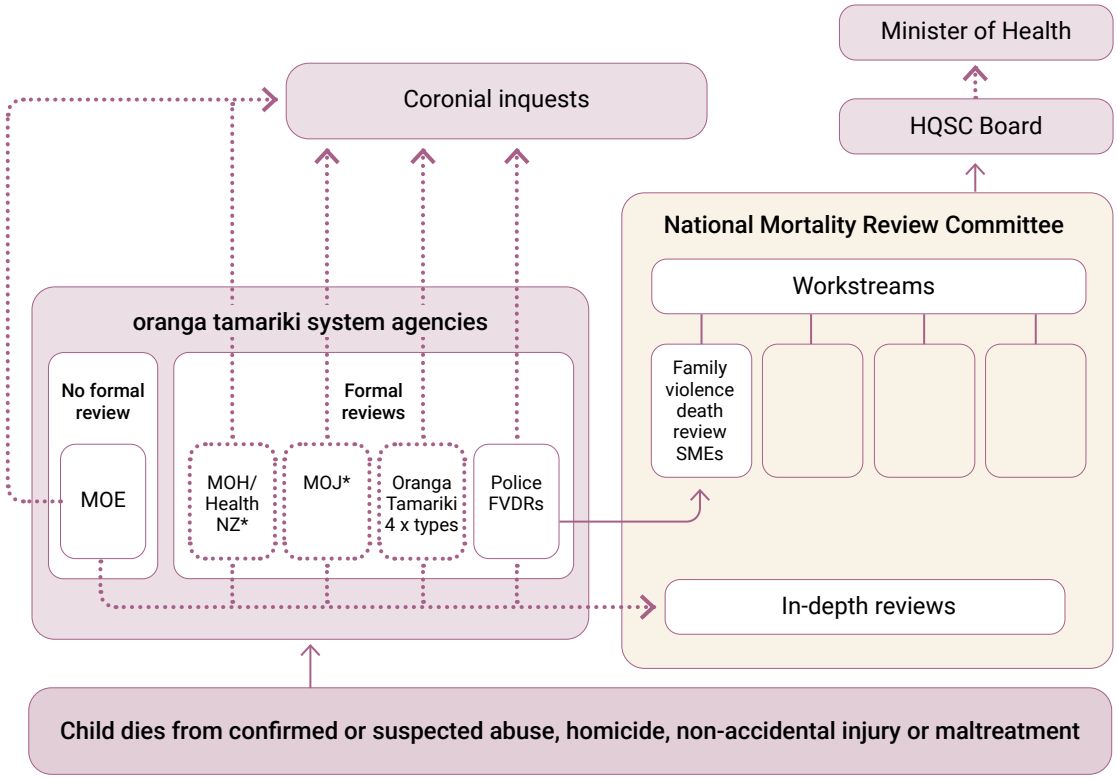
- Of the respondents we surveyed, 41 percent (19/46) told us they could recall completing the ChildSafe online learning module. MSD advised that its records show that, across the organisation, 98 percent of kaimahi had completed the training.
- Of those who completed the ChildSafe online learning module, 68 percent (13/19) said they felt more confident about how to make a report of concern after completing the learning module.
- Of those who completed the ChildSafe online learning module, 89 percent (17/19) found the module useful, 79 percent (15/19) reported their practice improved as a result of completing the module and 74 percent (14/19) said they feel more confident about what to look for to identify child abuse or neglect.
- Most of the respondents had made a report of concern (76% or 35/46), and of these, almost half of respondents (48% or 22/46) had made their most recent report of concern within the last 12 months.
- A higher percentage of respondents who had completed the ChildSafe online learning module had made a report of concern (84% or 16/19) compared to those who had not completed the training or were unsure if they had completed the training (70% or 19/27), but this difference is not statistically significant.
- Slightly more than half (59% or 20/34) of respondents who had made a report of concern had heard back from Oranga Tamariki on the outcome of that report of concern. This is relevant as the MSD report identified that 'closing the loop' on reports of concern is important, and if frontline MSD kaimahi know that the reports of concern they make are responded to, it may make them more likely to report future concerns. We were unable to compare the rate of response across time as the proportion of responses by timeframe are too small to make statistically significant conclusions (the difference could be due to random variation rather than a meaningful difference).

- Most respondents knew where to find MSD's child protection policy on the MSD intranet (89% or 39/44).
- All of those who told us they had completed the module, 100 percent (19/19) told us it explained what their specific responsibilities are under the MSD child protection policy.
- Of those who told us they had not completed or did not know if they had completed the module, most (89% or 24/27) told us it would be helpful to have training on the MSD child protection policy.
- Overall, the responses to this survey indicate that the training has been helpful and is being used by MSD integrated services case managers in their work.

Appendix D: Child death review mechanisms in Aotearoa

This section outlines the various mechanisms for reviewing child deaths from confirmed or suspected abuse, homicide, non-accidental injury or maltreatment in Aotearoa. Figure 6 gives an overview and more detailed information on the reviews that agencies complete is provided below this.

Figure 6: Process for review of child deaths from confirmed or suspected abuse, homicide, non-accidental injury or maltreatment.



* These agencies told us they do some reviews, but could not provide copies of what these reviews look like.
Agencies with a dotted line do not review all of these deaths.

Police process for reviewing some child deaths

All child deaths where abuse, homicide, non-accidental injury or maltreatment is suspected are investigated by Police. After the investigation, Police may also undertake a review of the death. Where the suspected perpetrator is a family member, partner or caregiver, Police should undertake a Police family violence death review (PFVDR).

The purpose of a PFVDR is to help prevent future family violence deaths by highlighting improvements that could have helped prevent the death and any changes that should be made to Police practices and procedures. The reviews look at Police's interaction with external agencies but do not examine the practices of other agencies apart from their engagement with Police and their known interaction with the parties involved, if relevant.

PFVDRs follow a set format and are completed by Police kaimahi in the district or area where the death occurred. PFVDRs are expected to be completed within 12 months of the death. As shown in Figure 6, all completed PFVDRs are provided to the Family Violence Death Review Subject Matter Experts of the National Mortality Review Committee to help inform its review function and reporting.

Oranga Tamariki process for reviewing the death of a child known to it

The death of a child who is known to Oranga Tamariki triggers the preparation of a Serious Event Notification (SEN). This is not a review of the death but a report prepared from CYRAS records. The SEN is provided to the Ombudsman under section 42(2) of the Oversight of Oranga Tamariki System Act, which requires Oranga Tamariki to provide information on all critical or serious events.[60]

If a child known to Oranga Tamariki or in its custody dies from any cause, Oranga Tamariki may also decide to undertake a review. The decision whether or not to undertake a review is made by the Decision-Making Forum (DMF), a group of Oranga Tamariki senior leaders.[61] Sometimes, particularly if the DMF feels that Oranga Tamariki had little involvement with the child and their whānau, a decision is made not to undertake a review.

If the Oranga Tamariki DMF decides a review is to be done, a decision will also be made about which of four types of review, with differing methodologies, will be done.

60 The Oversight of Oranga Tamariki System Act specifies what constitutes a critical or serious event. Among other events, it includes the death of a child or young person with current or recent involvement under the Oranga Tamariki Act.

61 Members include the Deputy Chief Executive of Service Delivery, Chief Social Worker, National Commissioners, Chief Legal Officer and other support functions such as General Manager of Practice.

- **Initial case assessment:** This is led by the site involved. It is described as an initial analysis to identify practice improvement opportunities and to understand operational risks. It is typically completed within two weeks.
- **Practice opinion:** This is led by the Office of the Chief Social Worker. It is described as an analytical review of practice, usually in relation to a set event or timeframe. The review uses information from CYRAS but may also involve some engagement with the site and/or region within Oranga Tamariki. It does not involve interviews with anyone outside of Oranga Tamariki to elicit further information. Terms of reference will provide a timeframe for completion, which is usually four to six weeks.
- **Rapid practice assessment:** This is led by the Office of the Chief Social Worker. It may be undertaken on request from a critical stakeholder[62] following a death of a child or rangatahi or significant event where Oranga Tamariki has current and relevant involvement or very recent and significant involvement. It is described as a holistic assessment of practice related to a specific event or time period. It is intended to provide an overview of the practice and the system context in which the practice has occurred. It may include phone calls and interviews with some external stakeholders to identify any relevant information in addition to what is held by Oranga Tamariki, but it does not include engagement with tamariki or their whānau. Terms of reference will provide a timeframe for completion, which is usually eight to 10 weeks. From the reviews we received from Oranga Tamariki, this is the process it most commonly uses for reviews of child deaths.
- **Practice review:** This is led by the Office of the Chief Social Worker. It is described as an in-depth review of the practice that occurred with te tamaiti or rangatahi and their whānau to understand what did happen as well as what should have occurred. Practice reviews can include engagement with other stakeholders outside of Oranga Tamariki, including children's system partners, iwi/NGOs and family and whānau. Practice reviews make findings of fact and recommendations for change (where appropriate). They are lengthier and may take longer than other types of review by Oranga Tamariki. They are not common – the last practice review undertaken by Oranga Tamariki was the review of Malachi's death in 2021.

The reviews appear to be used internally only. They do not appear to go to a central oversight body such as a ministerial group.

The DMF meets weekly to review and maintain oversight of workflow in relation to a death or significant event.[63]

62 Oranga Tamariki confirmed that a critical stakeholder for this purpose includes its Chief Executive, members of the DMF, National Commissioners, Chief Social Worker, Chief Legal Officer, General Manager of Practice and Child Protection Investigation Unit.

63 Oranga Tamariki defines a significant event as the death of a child who was in care, involved with Oranga Tamariki or recently involved with Oranga Tamariki or the death of another person by tamariki and rangatahi who are in care, involved with Oranga Tamariki or recently involved with Oranga Tamariki.

A new Child Protection Investigation Unit at Oranga Tamariki will also review child deaths

The Child Protection Investigation Unit (CPIU) was established at Oranga Tamariki on 22 November 2024. The CPIU was set up in part to respond to recommendations by the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions. When it was announced, the Minister for Children said the CPIU "reflects an unwavering commitment to learning from past failures and restoring trust in the Care System".[64]

The work of the CPIU is governed by a Charter that was updated in October 2025. Its primary purpose is to improve the safety of tamariki.

While situated within Oranga Tamariki, the CPIU is operationally independent and is not part of any Oranga Tamariki site, region or service line. It is separate from existing review processes or internal investigations and reports directly to the Chief Executive of Oranga Tamariki.

The objective of the CPIU is to enhance the capability of Oranga Tamariki to care for and protect tamariki in care or known to Oranga Tamariki. It does this by providing independent, objective assurance that Oranga Tamariki is responding appropriately and in a timely manner to matters of serious concern involving tamariki.

CPIU investigations and reviews may be case specific, thematic or systemic. CPIU reports will contain findings and may make recommendations to the Chief Executive aimed at improving practice, policy and processes. The CPIU will oversee the monitoring of Oranga Tamariki responses to its recommendations to ensure timely and purposeful implementation. Following an investigation, the CPIU will share its findings and recommendations with staff to promote continuous improvement.

The work of the CPIU includes, but is not limited to:

- investigating the deaths of tamariki in care or known to Oranga Tamariki
- investigating allegations of caregivers causing harm to tamariki in care or known to Oranga Tamariki
- investigating other matters that give rise to serious concerns or where there are complex or systemic issues that pose a risk to tamariki.

64 Chhour, K. (2024, November 22). *Child Protection Investigation Unit established*. beehive.govt.nz/release/child-protection-investigation-unit-established

The CPIU will look at whether Oranga Tamariki followed legislation, policies and practice standards correctly when it worked with a family. Its investigations will examine how Oranga Tamariki interacted with other agencies, including the operation of information-sharing protocols. The CPIU has no jurisdiction over other agencies and will not examine the actions of other agencies or make findings or recommendations in relation to them.

In our oversight role, we will watch the progress of the CPIU and its impact on strengthening the oranga tamariki system.

National mortality review functions

Health Quality & Safety Commission

The national mortality review function of the Health Quality & Safety Commission comprises:

- National Mortality Review Committee
- subject matter experts appointed to provide expert advice on the National Review Committee's mortality review workstreams[65]
- a National Mortality Review Function Management Group (a division of the Health Quality & Safety Commission).

The purpose of the national mortality review function is to review and report on avoidable mortality. Its aim is to prevent future premature deaths and to promote continuous quality improvement by collecting, analysing and reviewing mortality data on specific classes of death.

The Family Violence Death Review Subject Matter Experts undertake in-depth reviews of two to four deaths each year[66] on behalf of the National Mortality Review Committee. The in-depth reviews are independently facilitated and collate relevant information from across agencies, including PFVDRs. The in-depth reviews, including their recommendations, are not published. However, their findings and themes help inform substantive reports that are published by the National Mortality Review Committee.

65 The National Review Committee's mortality review workstreams include family violence death review, child and youth mortality review, perinatal and maternal mortality review, and perioperative mortality review.

66 There are only a few in-depth reviews undertaken each year because there is not resourcing available to complete an in-depth review for every death. Reviewing every death is also unlikely to furnish additional insights than a smaller number of reviews.

The National Mortality Review Committee reports on its reviews to the board of the Health Quality & Safety Commission, which in turn may report to the Minister of Health. Findings from in-depth reviews are also disseminated among the agencies that took part in the review process. Schedule 5 of the Pae Ora (Healthy Futures) Act 2022 prevents the release of this information more widely.

Coroners

Coroners have a role in reviewing certain deaths in Aotearoa. Their role is set out in the Coroners Act 2006, which states that its purpose is to help to prevent deaths and to promote justice through:

- investigating and identifying the causes and circumstances of sudden or unexplained deaths or deaths in special circumstances
- making recommendations or comments that, if drawn to public attention, may reduce the chances of further deaths occurring in circumstances similar to those in which the deaths occurred.

Among other things, coroners decide whether to open an inquiry and/or inquest into a death. If an inquiry is held, its purpose is to make recommendations or comments that may reduce the chances of other deaths in similar circumstances. The coroner's role is also to refer the death to other investigating authorities if it considers the public interest would be served by their investigation. The coroner does not determine civil, criminal or disciplinary liability.

We note that at the time of writing, the Coroner had an inquest underway into Malachi's death.

The Ombudsman

The Ombudsman is also able to investigate a child death if the child dies while in the custody or care of an agency it has authority over such as Oranga Tamariki residences, youth justice facilities, supervised care, and health and disability facilities.

We note that the Ombudsman also completed an opinion into Malachi's death.

Appendix E: Child protection policy compliance

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

Agency	Required to have a child protection policy	Has an up-to-date child protection policy[67]	Is publicly available	Policy last reviewed	Policy next reviewed
Oranga Tamariki	Yes	Yes	Yes	November 2025	November 2028
Department of Corrections	No	Yes	Yes	March 2024	April 2026
Ministry of Social Development	Yes	Yes	Yes	May 2023	May 2026
Ministry of Education	Yes	Yes	Yes	July 2024	July 2027
Education Review Office	No	No	N/A	N/A	N/A
New Zealand Police[68]	Yes	Yes	Yes	August 2024	February 2028 (unless required earlier)
Ministry of Health/ Health NZ	Yes	Yes	Yes	June 2025[69]	June 2028
Ministry of Justice	Yes	Yes	Yes	January 2025	January 2028

67 Under the Children's Act, child protection policies must be reviewed at least every three years.

68 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.

69 District health boards were previously required to have a child protection policy. With the restructure to form Health NZ, a decision was made to create a national policy for all health agencies.

Appendix F: Resources and support

This report includes data and information that may be distressing. Some options and resources for help are outlined below.

Talking to someone, like a family member or friend, can make a real difference if you are having a hard time or you are worried about someone else. If you need to talk about how you're feeling right now, trained counsellors are available free of charge at any time of the day or night – call or text **1737**.

You can also talk to a doctor, nurse, counsellor or other health professional. They are used to talking about personal things and not just about illnesses. School counsellors and school nurses are there to help too.

Helplines are free and private and can help with problems whether they are big or small. If a helpline you try is not the right one for you, they will often try to direct you to the right one.

- **Need to talk?** Free call or text anytime on 1737 or go to 1737.org.nz
- **WhatsUp:** call 0800 942 8787 or web chat whatsup.co.nz/contact-us
- **Youthline:** call 0800 376 633, free text 234 or web chat youthline.co.nz/get-help/helpline/
- **Healthline:** call 0800 611 116 for advice and information from a registered nurse.
- **Child Rights Line:** call 0800 224 453 for information and advice about your rights and how you should be treated.
- **VOYCE Whakarongo Mai:** call 0800 4 VOYCE / 0800 486 923 or email: contactus@voyce.org.nz for support for care-experienced tamariki and rangatahi. You can also look at what services are available in your area at familyservices.govt.nz/directory
- **Youth Law** help tamariki and rangatahi with legal issues. You can get free legal advice on lots of different issues from bullying at school or feeling safe at home, to police and youth justice: 0800 884 529 or email: nzyouthlaw@gmail.com.
- **Transition support services** help rangatahi who are leaving care or youth justice. Call 0800 55 89 89.

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aroturuki.govt.nz

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