



Reference: 23-OIAD-001

31 August 2023

Tēnā koe <sup>9(2)(a)</sup>

#### Response to your Official Information Act Request

Thank you for your email of 8 August 2023 requesting the following under the Official Information Act 1982 (the Act):

All information relating to monitoring undertaken to date or planned monitoring concerning the Oranga Tamariki System's performance and effectiveness in detecting child maltreatment in New Zealand

There are two documents in scope of your request.

a. Ensuring strong and effective safety nets to prevent abuse of children, a report by Dame Karen Poutasi. An independent review into the children's system response to abuse commissioned by the Chief Executives of six public sector agencies. This report is publicly available here: <a href="https://www.orangatamariki.govt.nz/about-us/performance-and-monitoring/reviews-and-inquiries/malachi-subecz-system-review">https://www.orangatamariki.govt.nz/about-us/performance-and-monitoring/reviews-and-inquiries/malachi-subecz-system-review</a>

Final Terms of Reference Dame Poutasi Review, the terms of reference developed to review the progress the agencies subject to Dame Poutasi's review have made in implementing the review recommendations. A copy of this document is provided in full. Please note that the planned monitoring activities are yet to be finally determined as firstly we need to understand from agencies if implementation of the recommendations has progressed to a stage where there is value in undertaking monitoring of the nature proposed.

Since 1 July 2019, our mandate has been limited to looking at the lives of tamariki and rangatahi in care and we have been reporting on Oranga Tamariki compliance with the Oranga Tamariki National Care Standards and Related Matters (NCS) Regulations 2018. As

part of our monitoring of the NCS Regulations we assess the performance of Oranga Tamariki in meeting their obligations under NCS Regulation 69, *Duties in relation to allegations of abuse or neglect*. Our workbook developed to support our monitoring teams when we visited Oranga Tamariki site staff included the prompts:

- What is your role regarding allegations of abuse or neglect in relation to children in care?
- How confident are you that staff are responding appropriately and consistently to allegations of abuse or neglect in relation to children custody?
  - o What do you base this assessment on?

Responses received from these questions are those most likely to indicate the performance and effectiveness of oranga tamariki system in detecting child maltreatment prior to our expanded monitoring role. We report on our findings related to NCS Regulation 69 in our monitoring reports which are available on our website <a href="https://aroturuki.govt.nz/reports/">https://aroturuki.govt.nz/reports/</a>.

With the commencement of the *Oversight of Oranga Tamariki System Act 2022* on 1 May 2023, our role expanded to include the monitoring of the oranga tamariki system. The oranga tamariki system includes agencies who are responsible for providing services or support to tamariki, rangatahi and whanau under, or in connection with, the Oranga Tamariki Act 1989.

In preparation for our expansion, we have developed a list of big questions which cover key areas of system performance to assess how outcomes for tamariki and rangatahi are being met. One of our big questions is *How, and how well, are agencies working to enhance the wellbeing, including safety, of tamariki and rangatahi?* which aims to assess how the system ensures that tamariki and rangatahi are kept physically and emotionally safe from harm. We expect that responses received from questions related to this are those most likely to indicate the performance and effectiveness of oranga tamariki system in detecting child maltreatment. If you would like to be added to our mail list to receive our future reports which will include our findings related to this, you can subscribe for updates on our website <a href="https://aroturuki.govt.nz/contact-us/">https://aroturuki.govt.nz/contact-us/</a>.

The primary mechanism for detecting maltreatment in the community within the oranga tamariki system is through a Report of Concern which, in most cases, are triaged by either the Oranga Tamariki National Contact Centre or the Police. The effectiveness and performance of these areas will be captured under our expanded monitoring scope.

Dame Karen Poutasi made a number of recommendations in her report, *Ensuring strong* and effective safety nets to prevent abuse of children that aim to close the gaps for detecting child maltreatment in the oranga tamariki system. Work is underway to review the progress agencies have made in implementing the report recommendations. Although the monitoring work isn't focused on the effectiveness or performance of the system in detecting child maltreatment, it will assess agencies progress against the implementation of the recommendations.

Aroturuki Tamariki has the option to carry out reviews of issues, themes, concerns, or areas of identified practice relating to the delivery of services or support through the oranga tamariki system. We may find that we identify through our monitoring that the oranga tamariki system's performance and effectiveness in detecting child maltreatment is an area that requires a focused review.

On 1 August 2023, the Roy McKenzie Centre for the Study of Families and Children & Oranga Tamariki jointly hosted a seminar where the findings of the Australian Child Maltreatment Study were shared. The seminar was shared with a number of our staff at the time. Learnings from the study will be factored into our ongoing development of monitoring policy and practice. You can access the seminar here <a href="https://www.wgtn.ac.nz/rmc/news/oranga-tamariki-and-roy-mackenzie-centre-australia-child-maltreatment-study-seminar">https://www.wgtn.ac.nz/rmc/news/oranga-tamariki-and-roy-mackenzie-centre-australia-child-maltreatment-study-seminar</a>.

You have the right to seek an investigation and review by the Office of the Ombudsman of my response to your request, in accordance with section 28(3) of the Act. The relevant details can be found on their website at: <a href="https://www.ombudsman.parliament.nz">www.ombudsman.parliament.nz</a>.

Please note that due to the public interest in our work, Aroturuki Tamariki publishes responses to requests for official information on our <u>website</u>. If you have any queries about this, please feel free to contact us on info@aroturuki.govt.nz.

Ngā mihi nui

Arran Jones

Chief Executive





### **Review Terms of Reference:**

# Monitoring Agency Progress in Responding to Dame Poutasi's Recommendations

Malachi Subecz was a five-year-old boy who was killed by his caregiver in November 2021. As part of the response to his death, the Chief Executives of six government agencies<sup>1</sup> commissioned Dame Karen Poutasi to investigate and report on gaps in the Children's Sector that contributed to the failure to prevent his death.

Dame Poutasi's report *Ensuring strong and effective safety nets to prevent abuse of children* was published in December 2022. This report identified five critical gaps within the Children's Sector and made fourteen recommendations for changes aiming to address those gaps. Recommendation 14 asks Aroturuki Tamariki/the Independent Children's Monitor to review the implementation of those recommendations in one year's time from publication of the report (in December 2023), so that change in the system can be monitored.

In December 2022, the Minister for Children announced that the Government accepted six of the recommendations in full, a further three in principle and the Government would seek further advice before committing to the remaining five recommendations (appendix one). In correspondence between the Executive Director and the Chief Executive of the Ministry of Social Development, the Monitor signalled its intent to undertake Recommendation 14 as a review under Section 26 of the Oversight of the Oranga Tamariki Act 2022 (the Act) once the Act commences in May 2023.

Reflecting its independence, the monitor has chosen to review and report on the implementation of all recommendations – whether they have been accepted, rejected or are still under consideration in December 2023. The scope of this monitoring will also include

<sup>1</sup> Ministry of Corrections, Ministry of Education, Ministry of Health, Ministry of Social Development, New Zealand Police and Oranga Tamariki.

any actions the six agencies committed to (individually or collectively) in response to any of the recommendations (appendix two). This will include analysis of the Child Protection Protocol between Oranga Tamariki and the New Zealand Police and the stated intention for the Ministry of Health to join in a tripartite protocol.

This document outlines Aroturuki Tamariki's planned review of the progress those agencies have made in implementing the recommendations.

Formation Act 1981 As stipulated in the Act, the final review report will be presented to the House of Representatives and published.

#### Key objectives

#### To understand:

- what actions agencies have committed to in response to the recommendations, outcomes they expect to achieve and how will they measure the impact.
- what progress those agencies have made in implementing their committed actions.
- how those committed actions contribute to addressing the critical gaps in the Children's Sector identified by Dame Poutasi.
- how those agencies are addressing recommendations with consideration of Te Tiriti o Waitangi front of mind.
- how agencies are working differently with parents who have been incarcerated, including hearing from parents and tamariki and their whānau about their experiences

#### Questions

- 1. What actions have been defined and committed to and what progress has been made?
- 2. What policy and practice guidelines underpin those responses?
- 3. How effective are those actions and the barriers and enablers that impact on their implementation of the recommendations?
- 4. How have agencies reflected their obligations under te Tiriti o Waitangi in their responses?
- 5. Are there further initiatives underway that are supporting additional safety nets that were not identified in the report or agency responses?

#### Approach

The methodology will mirror that of the Monitor's current mixed-method approach. This includes analyses of quantitative self-monitoring and other data relevant to the six agencies' progress in implementing Dame Poutasi's recommendations, along with qualitative analysis of interview data collected from professionals from these agencies. Interviews will be conducted with government agencies and providers directly and indirectly identified as possible sources of information as well as parents who entered prison in the year between publication of the Poutasi Report and December 2023. Secondary research and other literature relevant to Dame Poutasi's report will be considered in this review as context, and a point of reference in examining the response of government.

#### Data requirements

- Agency administrative data relevant to the recommendations. This may include comparison data prior to actions being implemented.
- Access to interview parents, whānau and professionals, including National Office kaimahi, from the six agencies and other relevant government and non-government agencies/organisations.

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## **Appendix 1: Dame Karen Poutasi's full recommendations**

On 22 November 2022, Cabinet noted that, of the 14 recommendations made by Dame Karen:

**Five recommendations** are operational in nature or otherwise within the authority of Chief Executives to support and progress, with two of these already being implemented:

	<u> </u>
#	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 locally
	relevant teams can help assess, respond to the risk to a child and provide
	support.
4	Medical records held in different parts of the health sector should be
4	linked to enable health professionals to view a complete picture of a
	child's medical history.
Е	The health sector should be added as a partner to the Child Protection
5	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.
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
13	Deguler public awareness compaigns should be undertaken as the nublic
	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.'
	Acteurous society fieeds to fiear the message don't look away.

Three recommendations would require Ministerial and Cabinet approval and subsequent legislative amendments;

#	Recommendation
10	There should be active monitoring of the 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.
11	The agencies that make up the formal Government's children's system should be specifically defined in legislation
12	These agencies should have a specific <b>responsibility included in their founding legislation</b> to make clear that they share responsibility for checking the safety of children.

**Five recommendations** should be the subject of further consideration because of the significant consequences that could arise from implementation and would also require legislative change if introduced;

#	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
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.
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.

8 Professionals and services who work with children should be mandated to report suspected abuse to Oranga Tamariki. I recommend this 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. The introduction of mandatory reporting should be supported by a 9 package approach that includes: a. 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. b. **Defining mandatory reporters**, all of whom should receive regular training. c. 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 11.

The final recommendation (14) is that the Independent Children's Monitor review Dame Karen's recommendations in one year's time.

certificates conditional on training and refreshers.

responsibilities and the detection of child abuse, with practising

# Appendix 2: Summary of each of the six agency recommendations

In identifying the needs of a dependent child when charging and prosecuting sole parents through the court system

#### Oranga Tamariki

- Should be engaged in vetting a carer when a sole parent of a child is arrested and/or taken into custody.
- 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.
  - Note that all Oranga Tamariki actions must be taken in accordance with its duties under s 7AA of the Oranga Tamariki Act 1989, and under Te Tiriti o Waitangi (and its principles).

#### Police

• 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.

In the process for assessing the risk of harm to a child, which is too narrow and one dimensional

#### Ministry of Health

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

#### All agencies

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 locally relevant teams can help assess, respond to the risk to a child and provide support.

### In agencies and their services not proactively sharing information, despite enabling provisions

#### Oranga Tamariki

 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.

#### Ministry of Social Development

Should notify Oranga Tamariki when a caregiver who is not a formal 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 sole parent is in prison.

#### In a lack of reporting of risk of abuse by some professionals and services

Ministry of Education and the Education Review Office (ERO)

 There should be active monitoring of the 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.

#### All agencies

- Professionals and services who work with children should be mandated to report suspected abuse to Oranga Tamariki. I recommend this 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.
- The introduction of mandatory reporting should be supported by a package approach that includes
  - o 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 like the New South Wales 'Risk of Significant Harm' definition.
  - o Defining mandatory reporters, all of whom should receive regular training.
  - o 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.

In allowing a child to be invisible. The system's settings enabled Malachi to be unseen at key moments when he needed to be visible

#### All agencies:

- The agencies that make up the formal Government's children's system should be specifically defined in the legislation.
- These agencies should have specific responsibility included in their founding legislation to make clear that they share responsibility for checking the safety of children.
- Regular public awareness campaigns should be undertaken so the public is attuned to
  the signs and red flag that can signal abuse and are confident in knowing how to
  repost this so children can be helped. Aotearoa needs to hear the message 'don't look
  away.'

Note all agencies have responsibilities to design and deliver their services and actions in accordance with Te Tiriti o Waitangi, and my recommendations must be addressed with consideration of Te Tiriti in front of mind.