

Response: Independent Children's Monitor

Response from Oranga Tamariki–Ministry for Children to the second report of the Independent Children's Monitor – Agency compliance with Regulations 69 and 85 of the Oranga Tamariki (National Care Standards and Related Matters) Regulations for June 2020.

Response to the second report of the Independent Children's Monitor

Oranga Tamariki–Ministry for Children ('Oranga Tamariki') welcomes the second report of the Independent Children's Monitor ('the Monitor').

Ensuring the safety and wellbeing of tamariki and rangatahi in care remains an absolute priority for Oranga Tamariki and is an area of significant focus and investment. As we noted in our response to the Monitor's first report, fully achieving the aspiration of the care standards will take time and forms part of our multi-year transformation journey.

The Monitor's second report provides a further assessment of how Oranga Tamariki and approved organisations are performing against regulation 69 and 85, focusing on the three-month period from 1 October to 31 December 2019. We accept all the Monitor's findings.

We were particularly pleased to note the Monitor's finding of full compliance with regulation 69, 85 and 86 from a policy and procedure perspective, high levels of compliance in ensuring children's plans were reviewed and improvements in reviewing caregiver plans and providing supports.

We note the specific areas for further improvement identified by the Monitor including timeliness of assessments and investigations following allegations for children and young people in care, communicating the outcomes of investigations and assessments to children and young people, and the consistent recording of key information in the records for children and young people.

In response to these findings, the Safety of Children in Care Unit ('the Unit') has carried out additional analysis of the cases where timeframes were not met to further understand the barriers to completing assessment and investigation within current policy timeframes. We note that in all cases an investigation or assessment was completed by the social worker and that practitioners clearly prioritised immediate actions needed to ensure the safety of tamariki where allegations of harm were raised. The Unit particularly noted the high levels of complexity in some of these cases which required specialist input from a range of professionals, careful engagement with those impacted and implicated in the allegation, and at times lengthy evidential and assessment requirements.

We are taking the following actions to continue to improve our practice:

- We have increased oversight of allegations against caregivers including a particular focus on the timeliness for caregiver investigations.
- We are providing coaching and support to specific sites identified through our internal quality assurance processes as additional practice support.
- There is strengthened information and reporting available to operational leaders to enable them to oversee and drive continuous improvement in practice at a local level with a particular focus on communicating outcomes, accuracy of recording and timeliness.
- We have commenced the development of additional resources for frontline supervisors to support them to oversee and assure the quality of individual investigations and assessments for tamariki.
- There is increased engagement with frontline leaders of practice to support them in their role in leading and championing practice quality within individual sites.
- We have commenced development of specific guidance for frontline practitioners on communicating outcomes of investigations and assessments to tamariki.

We note that the retrospective nature of Monitoring means that the impact of the actions taken in response to this report will not be realised within the timeframe of the Monitor's next report (November 2020) which will focus on the period January – June 2020.

In response to the Monitor's first report and our own internal assurances processes we have already undertaken a number of actions:

- We have implemented strengthened practice guidance for our front-line practitioners to use when responding to allegations for children in care.
- We held workshops with our NGO partners to ensure consistent understanding of regulation 69 requirements and the respective roles of Oranga Tamariki and its partners.
- We have further strengthened our internal assurance system to provide increasing insight into our practice with tamariki in care. As noted by the Monitor, we have implemented three new assurance processes to provide a complete view of regulation 69:
 - routinely reviewing a random sample of tamariki in care to ensure that where allegations are raised these are formally recorded;
 - reviewing a sample of reports of concern where a decision was made that no further action was required to assess the appropriateness of this decision;
 - and following up on a sample of cases reviewed by the Safety of Children in Care Unit 9 to 12 months following a finding of harm to establish whether the longer-term actions needed to address the impact of harm experienced by tamariki were implemented.

The impact of these actions will contribute to continuous improvement and a positive outcome for tamariki that will be evident in future reporting cycles.

In addition to the Monitor's analysis and comments, a key focus for Oranga Tamariki is fulfilling our practical commitments to the Treaty of Waitangi set out in the Section 7AA ('s7AA') provisions. The Monitor's report provides an opportunity for us to consider our obligations and practice in relation to s7AA, and how we are improving the outcomes for tamariki Māori. Section 7AA also requires that all practices have the objective of reducing disparities. We take these responsibilities seriously and through the work of the Unit we are working to further understand the experience of tamariki Māori in care.

The Safety of Children in Care unit review provides opportunities to understand:

- how the needs of tamariki Māori, and their whānau needs, were considered and responded to, and
- how they, and their whānau, were engaged with by Oranga Tamariki when allegations of abuse were assessed.

We examine practice for tamariki Māori in relation to mana tamaiti, whakapapa and whanaungatanga (as set out under section 7AA and embodied in the mana tamaiti objectives). This includes examining whether tamariki and whānau Māori have been enabled and supported to maintain their important relationships with each other while the child is in, or has been, in care or whether practice has supported the child to be connected to their culture (under mana tamaiti objective 4). The Unit will also comment on the involvement of Kairaranga-a-whānau and use of hui-a-whānau. These mechanisms provide opportunities to better involve tamariki Māori and their whānau in decisions made about the tamariki.

In-Confidence

The Unit's work enables practice development conversations with sites. This gives us the opportunity to provide practice feedback about social work engagement with tamariki and whānau Māori to inform areas of practice development. Regional feedback is also provided via our engagement with Practice Leader groups and Regional Leadership teams.

We welcome the ongoing work with the Monitor on s7AA and we look forward to further work with the Monitor to support improvements in outcomes for tamariki and whānau Māori.

