ORANGA TAMARIKI
Ministry for Children

30 August 2021

[redacted]

Tēnā koe [redacted],

Thank you for your email of 2 August 2021 to Oranga Tamariki—Ministry for Children (Oranga Tamariki), requesting the following information under the Official Information Act 1982 (the Act):

- *In the last 15 years how many children have died in state care, broken down by year and region.*
- *How many died by suicide, broken down by year and region.*
- *How many died of natural causes, broken down by year and region.*
- *How many died in accidents, broken down by year and region.*
- *How many died due to child abuse, homicide or manslaughter.*
- *How many of the deaths resulted in investigations.*
- *How many children passed through state care in the last 15 years.*

We have centrally collated data concerning deaths of tamariki in care as part of our work supporting Coronial functions since our establishment on 1 April 2017. We are unable to provide consistent data for deaths of tamariki in our care prior to establishment. Accordingly, we are refusing the part of your request for information before this time under section 18(f) of the Act, as the information is not centrally recorded and cannot be made available without substantial collation or research.

We have answered each of your questions in turn below, for data since 1 April 2017 only.

Oranga Tamariki strives to ensure that no tamaiti is harmed or injured while in care and that all tamariki are in safe, secure homes where they can thrive. The death of any tamaiti is a tragedy and, where a tamaiti in care dies, we are dedicated to understanding what lessons can be learned to prevent it happening again.

Should a tamaiti in the care of Oranga Tamariki die, we investigate the circumstances fully, however, we do not determine the cause of a death. The Coroner determines the manner of death, e.g. suicide, homicide or accident. Under the Coroners Act 2006, New Zealand Police are responsible for making referrals to the Coroner upon receiving any report about a death.

Following the death of tamariki in Oranga Tamariki care, a Practice Analysis process is undertaken. Through this process, opportunities for social work practice learning and changes to systems are identified and can be implemented at site and national level. Oranga Tamariki also provides relevant information and support as requested by Coroners to assist their inquiries.

Please note that “in care” is a legal status, and covers a range of circumstances, from being in care at one of our residences, to being in the care of caregivers, a provider, or whānau, or even returned home to parents. However, “in care” does not include tamariki who we are involved with in a support role, or Family Group Conference plan, or doing an initial assessment. Having a social worker assigned to them does not necessarily mean a tamaiti is “in care”.

For more information on our processes when tamariki or rangatahi in care dies, please follow the below link.

https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/caring-for-children-and-young-people/resources/when-a-child-or-young-person-dies/

- *In the last 15 years how many children have died in state care, broken down by year and region.*

Since 1 April 2017, a total of 27 tamariki have died in state care.

- *How many died by suicide, broken down by year and region.*

Oranga Tamariki has a Towards Wellbeing suicide prevention programme, that supports and gives advice to social workers who work with tamariki and rangatahi who are having thoughts about suicide or have tried to kill themselves.

Towards Wellbeing supports social workers by:

- helping to assess and understand suicide risk based on known risk factors
- helping to develop a responsive suicide risk management plan focusing on increasing current safety and protective factors, as well as reducing long-term risks

- providing ongoing support and advice on the review of risk and protective factors for te tamaiti
- sharing knowledge about mental health and suicide, including how to access resources
- liaising with mental health services when needed
- providing advice when planning to end our involvement with te tamaiti or rangatahi (case closure)
- providing one-off consultations on managing suicide risk when te tamaiti or rangatahi is not on the Towards Wellbeing programme.

When we identify te tamariki or rangatahi has a suicide risk, we place a suicide alert on our case management system - CYRAS. This ensures Towards Wellbeing access to CYRAS, including:

- the Substances and Choices Scales, Kessler and Suicide (SKS) screens and suicide person characteristics to help identify which tamariki or rangatahi may be at risk
- case notes for te tamaiti on the programme to check for changes in risk levels or progress.

Towards Wellbeing also supports our practice by:

- engaging with sites, regions, and National Office when practice issues are identified.
- visiting sites to enhance use of Towards Wellbeing (by arrangement and subject to available resources)
- delivering training to new social workers as part of the Oranga Tamariki Practice Curriculum training
- delivering practice clinics when needed to build knowledge, confidence, and practice depth in identifying and managing suicide risk.
- reporting to the Suicide Prevention Steering Committee to identify and understand trends, practices, and performance against the contracted services.

Oranga Tamariki is not responsible for determining cause of death or manner of death such as natural causes, homicide, or suicide. The manner and cause of death is determined by the attending doctor or by the Coroner as part of their inquiries.

Please see the below table for the number of tamariki and rangatahi whose cause of death is suicide whilst in the care of custody of the Chief Executive from 1 April 2017 to 4 May 2021.

Table One: Deaths in care by suicide, broken down by region and year

Calendar Year	Regions	Number of suicides
2017	East Coast	**1**
2018	Lower South	**1**
2019	Taranaki/Manawatu, Bay of Plenty	**2**
2020	n/a	**0**
2021	Central Auckland	**1**
Total		**5**

Table Two: Deaths in care by natural causes, broken down by region and year

Calendar Year	Regions	Number of deaths
2017	Tamaki Makaurau, Lower South, East Coast, and Te Tai Tokerau	4
2018	Canterbury, Te Tai Tokerau, and Taranaki/Manawatu	3
2019	Waikato, Bay of Plenty, Taranaki/Manawatu, Canterbury, and Tamaki Makaurau	5
2020	n/a	0
2021	South Auckland, Central Auckland, and Taranaki/Manawatu	3
Total		**15**

- *How many died in accidents, broken down by year and region.*

Table Three: Deaths in care by accidents, broken down by region and year

Calendar Year	Regions	Number of deaths
2017	Taranaki/Manawatu, Bay of Plenty	2
2018	n/a	0
2019	Canterbury, Tamaki Makaurau	2
2020	n/a	0
2021	Te Tai Tokerau	1
Total		**5**

- *How many died due to child abuse, homicide or manslaughter.*

Table Four: Deaths in care by child abuse, homicide or manslaughter, broken down by region and year

Calendar Year	Regions	Number of deaths
2017	n/a	0
2018	Tamaki Makaurau	1
2019	n/a	0
2020	Taranaki/Manawatu	1
2021	n/a	0
Total		**2**

- *How many of the deaths resulted in investigations.*

Table Five: Deaths in care resulting in investigations, broken down by region and year

Calendar Year	Regions	Number of deaths
2017	n/a	0
2018	Tamaki Makaurau	1
2019	n/a	0
2020	Taranaki/Manawatu	1
2021	Te Tai Tokerau	1
Total		**3**

We have interpreted “investigation” as an investigation by the New Zealand Police, which are only necessary if the cause of death is considered suspicious. The other deaths that did not require further Police investigation may have been obviously accidental deaths or natural causes.

- *How many children passed through state care in the last 15 years.*

We have provided this information as at 30 June each year.

Please also note we are unable to provide accurate data prior to 2008 due to errors in some of the earlier data recording. Accordingly your request for 2006-2007 data is refused under section 18(f) of the Act, as the information requested cannot be made available without substantial collation or research.

Table Six: Children in Custody of the Chief Executive as at 30 June 2006-2021

Financial year	Number of children in custody of the Chief Executive as at 30 June	Definition*
F2008	6,136	Including Warrants
F2009	5,689	Including Warrants
F2010	5,446	Including Warrants
F2011	5,020	Including Warrants
F2012	4,979	Including Warrants
F2013	4,960	Including Warrants
F2014	5,188	Including Warrants
F2015	5,026	Including Warrants
F2016	5,312	Including Warrants
F2017	5,708	Including Warrants
F2018	6,365	Including Warrants
F2019	6,429	Excluding Warrants
F2020	5,945	Excluding Warrants
F2021	5,239**	Excluding Warrants

* Warrants refer to those under Legal status sections 48, 42, 39, 40 or 45 of the Oranga Tamariki Act 1989. It was decided to exclude these in the definition of "Custody" from 30 June 2019, as these were of a short term nature.

**F2021 data is provided as at 30 April 2021.

Oranga Tamariki intends to make the information contained in this letter available to the wider public shortly. We will do this by publishing this letter on our website. Your personal details will be deleted and we will not publish any information that would identify you as the person who requested the information.

If you wish to discuss this response with us, please feel free to contact OIA_Requests@ot.govt.nz.

If you are not satisfied with this response, you have the right to ask an Ombudsman to review this decision. Information about this is available at www.ombudsman.parliament.nz or by contacting them on 0800 802 602.

Nāku noa, nā

Steve Groom
General Manager Public, Ministerial and Executive Services