ORANGA TAMARIKI
Ministry for Children

New Zealand Government

Third report on section 78 custody orders for unborn and new-born pēpi

April 2023

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Background

This is the third report responding to recommendations by the Chief Ombudsman relating to the auditing and public reporting of information regarding section 78 custody orders for unborn and new-born pēpi.

He Take Kōhukihuki, A Matter of Urgency[1] was released by the Chief Ombudsman in August 2020. It set out the findings and recommendations from his review of Oranga Tamariki policies and procedures relating to the placement of unborn and new-born pēpi into Oranga Tamariki custody (between 1 July 2017 and 30 June 2019).

The report had a number of recommendations, including that Oranga Tamariki:

- establish timeframes and reporting frameworks, quality assurance and monitoring to demonstrate ongoing compliance with all statutory requirements related to without notice removals of new-born pēpi (recommendation 1.e)
- report publicly against the monitoring framework (outlined above) every six months (recommendation 1.f)
- regularly audit case files to ensure compliance with policy and practice guidance (recommendation 2.o) (case file analysis).

Using the recommendations of *He Take Kōhukihuki* and the Hawke's Bay Practice Review,[2] Oranga Tamariki developed a structured set of questions to investigate:

- compliance with policy and guidance
- the broader practice around section 78 applications, to provide a more comprehensive understanding of practice and early intervention with pēpi, and support identification of strengths and improvements needed.

Oranga Tamariki published its second report outlining the findings of this work in April 2022, covering the period 1 January 2021 to 31 August 2021. That report can be read here.

This third report provides details on the results of case-file analysis covering the 12-month review period 1 September 2021 to 31 August 2022.

1 Chief Ombudsman (2020) He Take Kōhukihuki | A Matter of Urgency | Ombudsman New Zealand
2 Oranga Tamariki (2019) *Professional Practice Group Practice Review into the Hastings Case* Hawkes-Bay-Practice-Review.pdf (orangatamariki.govt.nz)

Setting the scene

This section provides summary data on Oranga Tamariki engagement with whānau with unborn or new-born pēpi.

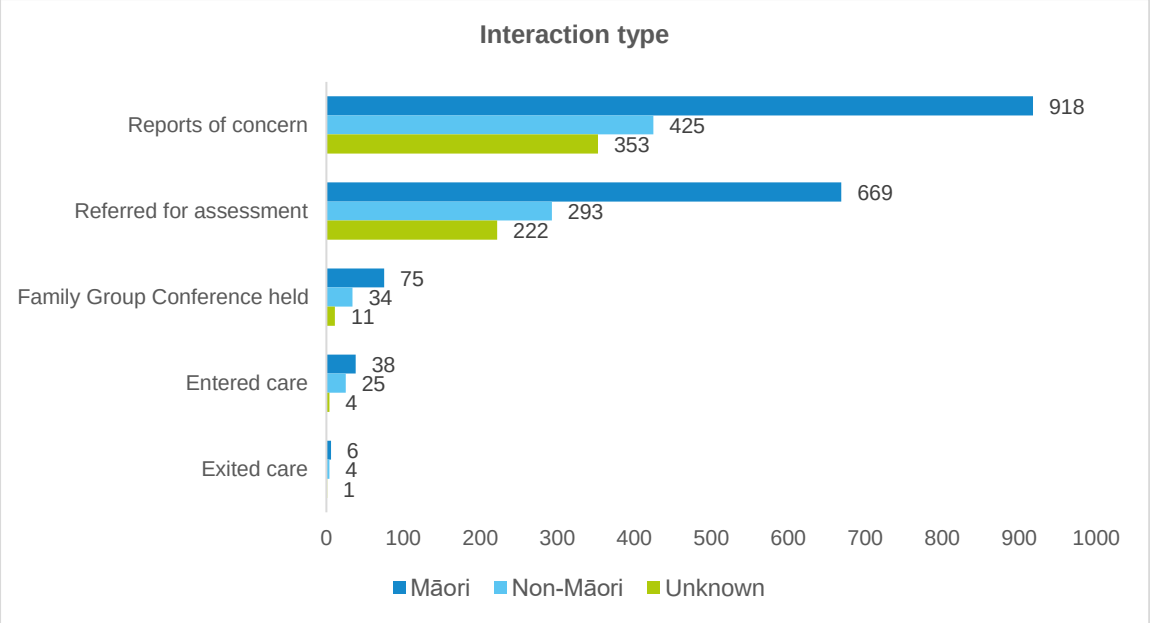
There are several different warrants, care agreements and legal orders under the Oranga Tamariki Act 1989 (the Act) which can be used to place pēpi into the custody of Oranga Tamariki.[3] The focus of the Ombudsman's report and this case-file review is section 78 custody orders.

Section 78 of the Act (s78) allows for the Court to place a tamaiti in the interim care of Oranga Tamariki when there are immediate concerns for their safety and wellbeing. These custody orders can be applied for in two ways:

- with notice, where the application is served on the parent(s) before it is granted by the Court, and
- without notice, where parent(s) are not informed of the application before it is granted by the Court.

Oranga Tamariki engagement with whānau in relation to safety concerns for pēpi spans the initial receipt of a report of concern, subsequent engagement with whānau in those cases that warrant further assessment, support through an agreed family group conference plan and, for a small number of cases, application to the Family Court for a custody order. Figure 1 below provides data on the total number of unborn or new-born pēpi up to 30 days old with whom Oranga Tamariki was engaged over the period covered by this review.

Figure 1: Number of unborn to 30-day old pēpi, by interaction type with Oranga Tamariki (1 September 2021 to 31 August 2022)



3 Legal statuses for custody, guardianship, or placement | Practice Centre | Oranga Tamariki

It shows that over these twelve months:

- safety concerns about 1,696 unborn and new-born pēpi were reported to Oranga Tamariki and 1,184 pēpi were referred for assessment
- for 120 unborn and new-born pēpi, care and protection concerns resulted in Oranga Tamariki convening a family group conference with whānau
- for 67 pēpi, safety concerns resulted in their being placed into the custody of Oranga Tamariki. Forty-one of these 67 custody orders were s78 applications and are the subject of these review findings. The remaining pēpi entered custody under a s39 place of safety warrant, or a s139 or s140 temporary care agreement
- pēpi Māori were overrepresented at all stages of interaction with Oranga Tamariki, representing 54% of the pēpi for whom an initial report of concern was received, 57% of pēpi referred for assessment, 63% of pēpi for whom there was a family group conference, and 57% of the pēpi placed into the custody of Oranga Tamariki. Reducing this over-representation and supporting tamariki Māori to be safely cared for within their whānau, hapū and iwi remains an area of significant and priority focus for Oranga Tamariki.

Figure 2 below shows the total number of s78 custody orders issued for unborn and new-born pēpi over the review period, for both Māori and non-Māori pēpi, and whether they were issued on a 'with' or 'without notice' basis.

Where a s78 order was granted for pēpi Māori, it was more likely that this would be granted on a 'without notice' basis (62.5%) than for non-Māori pēpi (41.2%), reflecting the broader disproportionality for pēpi Māori noted above.

Figure 2: Section 78 interim custody orders issued for unborn to 30-day old pēpi by filing method (1 September 2021 to 31 August 2022)

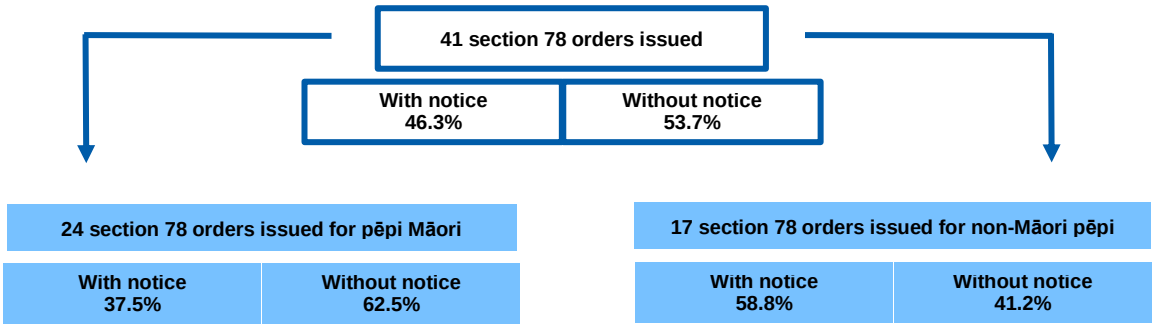
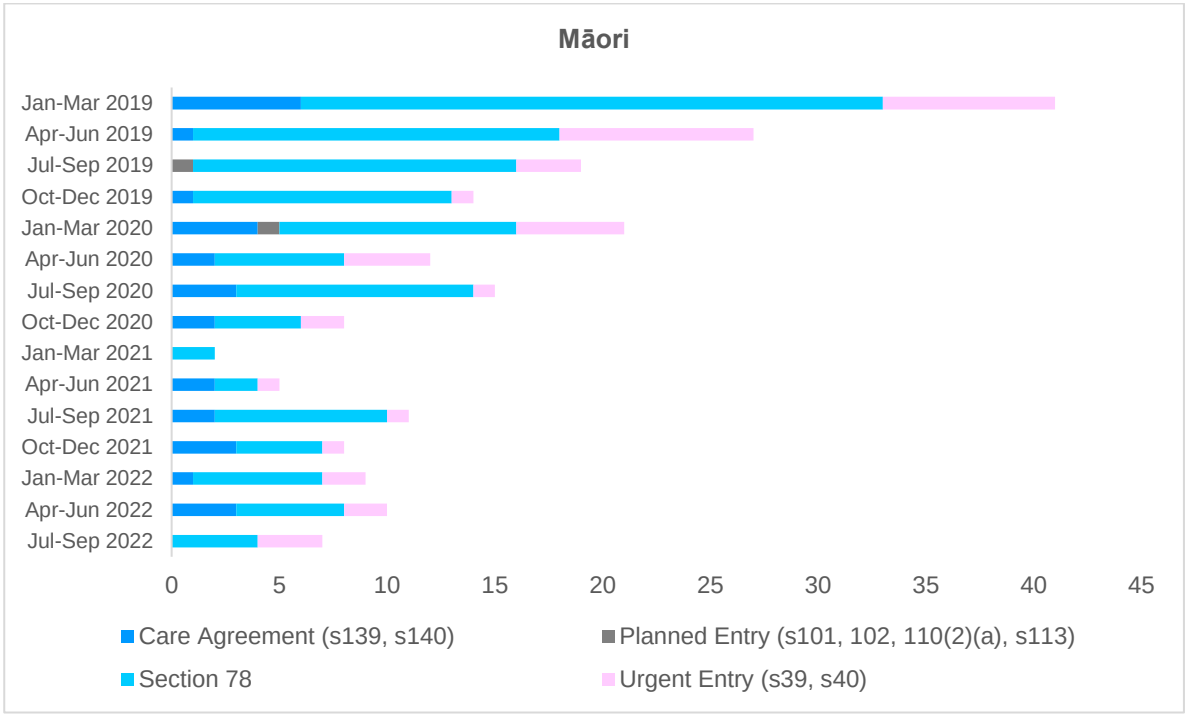


Figure 3 provides information on changing patterns of care entry for pēpi over the last three years, specifically the total number of care entries for pēpi by type of custody order, for both Māori and non-Māori pēpi. This includes s78 orders, temporary care agreements that are agreed between parents and Oranga Tamariki (s139 and s140) and urgent place of safety warrants (s39).

Figure 3: Entries to care for unborn to 30-day old pēpi, by quarter and by entry type, for Māori and non-Māori pēpi (1 January 2019 to 30 September 2022)



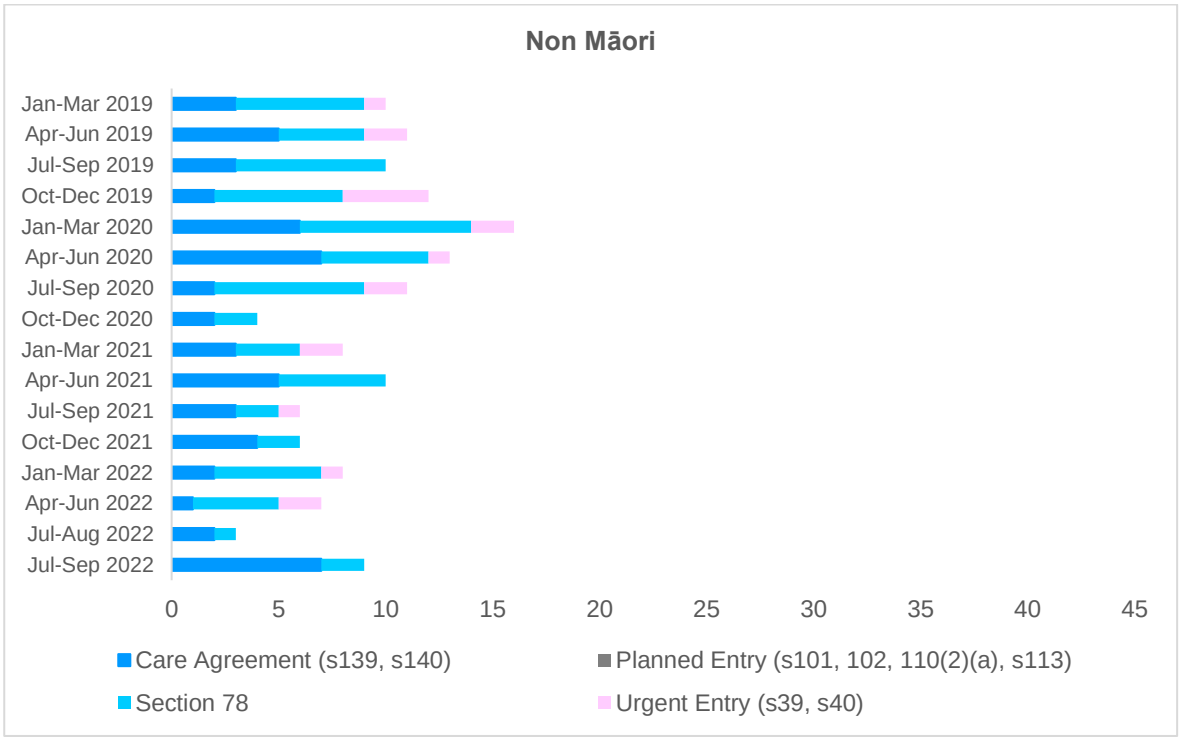
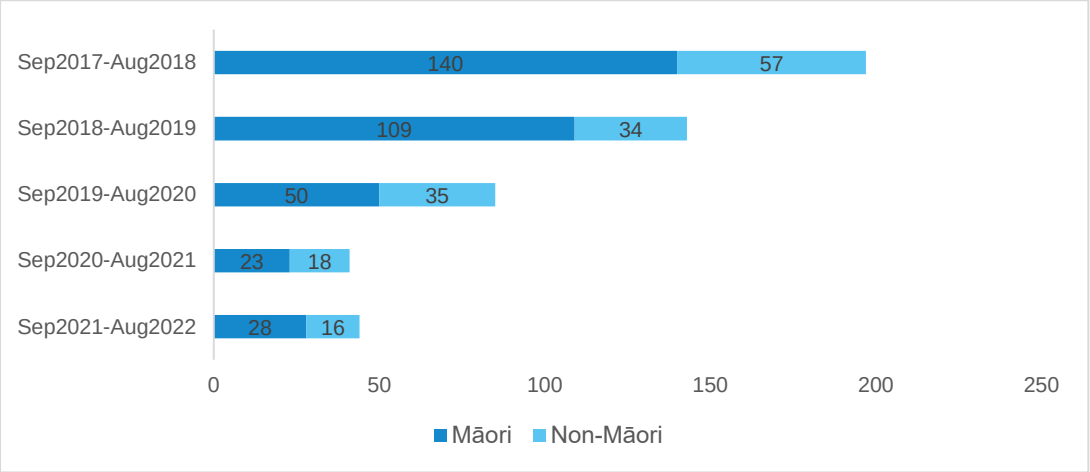


Figure 4 shows the total number of s78 orders for the twelve-month period of our review (1 September 2021 – 31 August 2022), compared with the same twelve-month period each year back to 2017-2018.

Figure 4: Total number of s78s[4] for unborn and new-born pēpi, Sep-August 2017-2022



Figures 3 and 4 show that:

- the total number of custody orders for pēpi has now broadly stabilised after a period of decline
- although the reductions in custody orders have been most pronounced for pēpi Māori, they continue to be overrepresented as a proportion of the total number of pēpi entering care.

This reduction in care orders for pēpi is in line with, but more pronounced than, reductions in care entries across all age groups since 2017. Further information on this can be found here Entries into Care.

We note that, for some pēpi, the use of s78 custody orders remains a necessary intervention in order to secure their safety where other intervention options have been exhausted, and for this reason we anticipate that we will likely see a continued stabilisation of volumes rather than a further decline.

[4] This is the total number of s78 orders granted, not the total number of pēpi. Some pēpi may have had two s78 orders within the time period, hence the total number of s78 orders for September 2021 to August 2022 is higher than the number of pēpi in the review period.

Case-file analysis

Overview

The population of interest is all unborn pēpi and pēpi up to 30 days old placed in Oranga Tamariki custody under s78 'with' and 'without notice' orders between 1 September 2021 and 31 August 2022 (41 cases in total).

The review period for each case was from the initial report of concern until four weeks after pēpi entered custody.

The initial case-file analysis was a desk-based exercise focused solely on information recorded in the record for the pēpi in the main Oranga Tamariki case management system, CYRAS. Questions focused on those areas of practice that are required to be clearly documented.

At the end of the initial case-file analysis, further investigation was undertaken to gather additional information about casework in those cases where key pieces of information were missing from the record for pēpi on CYRAS.

The case-file analysis reviewed two key phases of work:

1. Practice prior to the decision to apply for custody of pēpi, focusing on:
    - the early work with whānau to seek solutions and provide supports prior to the decision to apply for custody of pēpi
    - the decision-making process to apply for custody of pēpi and identifying whānau caregivers.
2. Practice following pēpi being placed in Oranga Tamariki custody, focusing on:
    - the process of removing pēpi, where removal was required
    - the work occurring immediately following pēpi being placed in custody.

Profile of the section 78 cases

A total of 41 s78 orders for unborn and new-born pēpi were granted over the review period 1 September 2021 to 31 August 2022 and were included in this review.

Nineteen s78 orders (46%) were 'with notice' and 22 (54%) were made on a 'without notice' basis.

Of the 41 cases reviewed, 15 pēpi were New Zealand European/Other (37%), 24 were pēpi Māori (59%) and two were Pacific pēpi (5%).

Previous involvement with Oranga Tamariki

In 15 of the 41 cases (37%), the mother of pēpi was previously, or currently at the time of our review, in the care of Oranga Tamariki. In a further case, a parent of pēpi was also being supported by Oranga Tamariki (but was not in Oranga Tamariki custody). In four of the 41 cases (10%), the father of pēpi was previously, or currently at the time of our review, in the care of Oranga Tamariki.

In 21 (51%) of the 41 reviewed cases, Oranga Tamariki prior involvement with the siblings of pēpi was extensive (other tamariki of the parents were previously or currently in care, and/or a parent met the requirements of s18B of the Oranga Tamariki Act 1989[5]); in two cases (5%), it was significant (multiple non-care interventions); in two cases (5%), it was moderate (multiple assessments during the assessment phase, but no interventions); and, in one case (2%), it was limited (reports of concern received, single or no assessment). In two cases (5%), there was no Oranga Tamariki prior involvement with siblings.

In the remaining 13 cases (32%), pēpi was the parents' first tamaiti. In six of these cases, one of the parents was either previously, or currently at the time of our review, in Oranga Tamariki care, and in a further case a parent of pēpi was being supported by Oranga Tamariki (but was not in Oranga Tamariki custody).

Timing of report of concern

The report of concern was received more than 200 days before the birth of pēpi in eight cases (20%), between 100 to 200 days before birth in 22 cases (54%), between 50 and 100 days of birth in one case (2%), less than 50 days from birth in seven cases (17%), and after the birth of pēpi in three cases (7%). Of note, there was a higher proportion of reports of concern received either close to or after the birth of pēpi in this reporting period (24%) than our previous reporting period (14%), which had some impact on the ability of kaimahi to effectively engage whānau in planning and decision-making (this is described further in the 'Findings' section below). The review found a relationship between when the report of concern was received and whether the s78 order was made on a 'with' or 'without notice' basis, with 80% of the reports of concern received less than 50 days prior to birth resulting in a 'without notice' order.

Presenting concerns

The cases reviewed were all complex and high risk. Most often, the initial concerns raised reflected the same issues that had led to safety planning and interventions to address care and protection needs for the older tamariki within the whānau. The most common risks identified in the applications for a s78 order reviewed were parental substance misuse in 25 cases (61%), the presence of family harm in 24 cases (59%), and concerns about the mother's mental health in 17 cases (41%). Thirty-one of the 41 cases reviewed (76%) identified three or more risk factors impacting parenting in the application for the s78 order.

Reviewers noted an increase in the frequency and severity of concerns about mothers' mental health in this review period, with a significant proportion of those with identified mental health concerns receiving treatment under the Mental Health (Compulsory Assessment and Treatment) Act 1992 throughout the period reviewed.

As Oranga Tamariki practice continues to prioritise early engagement with whānau, hapū and iwi and to find alternative solutions to securing the safety and oranga of pēpi without the need for a custody order, those cases that do result in a s78 custody order are increasingly likely to include a proportionately higher number of late

[5] During the period of this review, a person met the s18B criteria if they had been convicted under the Crimes Act 1961 of murder, manslaughter, or infanticide of a child or had a child permanently removed from their care. Section 18B was partially repealed in December 2022 and future review work will reflect these changes https://practice.orangatamariki.govt.nz/policy/subsequent-child/#section-18b-criteria

presentations during pregnancy and higher and multiple risk factors. Meaningful engagement with whānau to build safety and provide supports in these circumstances takes sustained effort and time, and the success of this may, in a number of cases, be impacted by the length of time social workers have available to engage with whānau prior to the birth of pēpi.

Summary of insights

The review identified the following areas in which improvements had been maintained, or practice continued to strengthen, since the report by the Chief Ombudsman and our monitoring of practice first began:

- The total volume of s78 orders being made for pēpi annually continues to show signs of having stabilised after a period of steady decline.
- Early engagement with whānau as part of the 'safety and risk screen' process when concerns are first reported to Oranga Tamariki has strengthened.
- In most cases, whānau were engaged in a process to discuss the concerns and create safety for pēpi prior to the s78 application.
- Consultation with other professionals to inform the assessment for pēpi remains high.
- There was an increase in the number of cases where a safety plan was developed early to build safety for pēpi.
- In many cases, reviewers found evidence that support services were provided with a focus on preventing removal of pēpi from the care of their parent(s) and/or whānau.
- The use of whānau searching, to provide every opportunity for pēpi to be cared for within their whānau, hapū or iwi, remains high.
- In the majority of cases, initial plans for care arrangements were to support the parent(s) and/or whānau to care for pēpi, and there continues to be an increase in the number of pēpi remaining in the care of their parent(s) and/or whānau following the s78 order.

The review identified the following areas of practice that continue to require a focus:

- While the overall number of applications being made on a 'without notice' basis remains considerably lower than the Ombudsman's review (which covered the period 1 July 2017 to June 2019), the proportion of applications made on a 'without notice' basis has shown some increase over this review period. However, this is in the context of an increase in the number of reports of concern made close to, or after, the birth of pēpi, which had some impact on the time available to kaimahi to effectively engage whānau to build safety for pēpi prior to the s78 application (with 80% of reports of concern made within 50 days of the birth of pēpi resulting in a 'without notice' s78 order).
- There was a decrease in the use of Care and Protection Resource Panels by social workers and FGC Coordinators during this reporting period.
- Although, in the majority of cases, whānau were engaged to discuss the concerns and create safety for pēpi prior to the s78 application, the use of formal whānau engagement processes, such as hui ā-whānau or family meetings and family group conferences, decreased in this reporting period.

However, as noted above, this is in the context of an increase in the number of presentations late in pregnancy and a high level of risk and complexity in the cases reviewed.

- Although, in most cases, support services were in place to address parental disability needs, there is an opportunity to strengthen how assessments and plans evidence those needs and specify how they will be met.
- Ensuring social work practice is underpinned by regular, quality supervision that is effectively evidenced in case recording remains an area for improvement, and has been identified as a key practice priority for Oranga Tamariki in 2023.

Practice with pēpi who did not enter care

During this reporting period, additional review work was carried out to look at practice with a sample of 70 unborn and new-born pēpi for whom care and protection concerns were identified but who *did not* enter care under a s78 order. This work was undertaken to support our understanding of the extent to which the decrease in s78 orders for pēpi in recent years reflects quality practice and decision-making in addressing concerns about the safety of these pēpi. The review found that, overall, the practice gains identified with respect to s78 practice were also broadly replicated in practice with pēpi for whom orders were not sought. These included:

- good evidence of early whānau engagement and whānau searching
- completion of safety and risk screens in most cases, with similar opportunities as seen in our routine monitoring work to strengthen the timeliness of these and engagement with whānau at this specific stage of practice
- high levels of engagement with other professionals to inform assessments and plans
- in most cases, evidence that support services were provided to parent(s) and/or whānau with the intention of building safety
- opportunities to strengthen supervision practice (consistent with the findings of our wider monitoring activity).

For those pēpi for whom a family group conference was held and who did not enter care,[6] reviewers found that the practice of early engagement and decision-making with whānau was addressing safety for the pēpi within their whānau in most cases. Only two pēpi in the cohort of 70 pēpi reviewed had subsequently entered care at the time of our review.

[6] Within six months of the family group conference being held.

Findings

This section of the report sets out:

- core policy and practice requirements for Oranga Tamariki practitioners, from receipt of the first report of concern for pēpi through to the initial weeks after pēpi was placed in Oranga Tamariki custody
- our findings in relation to core policy and practice requirements, and any evidence on if and how practice has changed
- a summary of actions underway to continue to strengthen practice.

Responding to initial concerns

In this section, we investigate whether initial concerns about the safety of pēpi were responded to in a timely way.

What is required?

Once a report of concern has been received by Oranga Tamariki and an initial assessment of those concerns has determined that further action in the form of a core social work assessment is required, social workers are required to complete an initial safety and risk screen. This is the first step in the completion of the core assessment, and identifies whether the safety and wellbeing concerns are such that immediate action is required while further assessment is undertaken.

The timeframe this screen must be completed within (the 'criticality response timeframe') is determined when the report of concern is received and a decision that it requires assessment is made. During the period under review in this report, options were <24 hours, <48 hours and <10 days.

The safety and risk screen is completed once a social worker has engaged with te tamaiti, their whānau and professionals/others who know them. This helps to ensure that engagement builds from a basis of openness and trust, and information on the current circumstances for the whānau.

If it is not possible to complete the initial safety and risk screen within timeframes, the reason for this, as well as the efforts made to complete the screen within timeframes, should be recorded via an exception case note in the case management system CYRAS. There are a number of reasons for such an exception, including because the whānau can't be located or are reluctant to engage in the assessment process, or the Police are already investigating the situation and engagement may put te tamaiti at risk.

What happened over the review period and how has practice changed?

In all 41 cases, reviewers found evidence of a safety and risk screen in CYRAS.

In 25 out of 41 cases (61%), the screen was completed following engagement with parents or whānau. In half of these cases where engagement occurred, engagement was also within timeframes, or an exception case note was recorded. This represents an improvement on our last review period, in which we found 52% of screens had been completed following engagement with parents or whānau.

In 29 out of 41 cases (71%), the screen was completed following engagement with professionals.

In 22 out of 41 cases (54%), the screen was completed within the timeframe, or an exception case note was recorded. In nine of these cases (41%), the screen was completed before engagement with parents or whānau had occurred. In the previous review period, reviewers found that 67% of screens were completed within timeframe which suggests that the increase in engagement during this process may have had some impact on timeliness. Hence, while social workers may be taking more time to complete the screen, they are more likely to be drawing from their engagement with whānau and other professionals to inform the screen and determine next steps.

Where engagement did not occur, subsequent follow-up with sites found that, in a number of cases, an unborn pēpi was referred early in pregnancy and an appropriate decision was made to wait until the second trimester before engaging parents and/or whānau. In the remaining cases, the screens were completed prior to engagement with parents or whānau as it was believed that enough information was known from the report of concern or from engaging with professionals working with the whānau to decide that further assessment was required.

Further strengthening practice

Individual follow-up has occurred with each site involved in the review about the need to engage parents and/or whānau prior to the screen being completed and the decision about further assessment being made, and sites have been reminded that exceptions can be sought if more time is required.

A Practice Note was issued by the Chief Social Worker in May 2022 to support kaimahi understanding of the purpose and function of the safety and risk screen and the use of exceptions when further time is required to complete the screen.

Work is currently underway to review the safety and risk screen to ensure alignment with the new Oranga Tamariki practice approach and Practice Framework, including a strengthened focus on early engagement with whānau.

Mechanisms to support whānau-led decision-making

In this section, we consider the use of hui ā-whānau and family meetings, and family group conferences.

What is required?

Where the initial safety and risk screen identifies there are safety and wellbeing concerns that need to be more fully understood, social workers are required to undertake a further assessment or investigation, depending on the nature of the concerns.

Practice guidance underlines the importance of early whānau engagement through a hui ā-whānau or a family meeting as part of this next phase of work, to ensure whānau strengths and needs are understood and can be drawn on to create safety for pēpi.

When a social worker believes, after having completed a core assessment, that pēpi needs care or protection,[7] they are required by legislation to make a referral to a care and protection coordinator for a family group conference.[8]

A family group conference is a formal meeting where Oranga Tamariki, whānau and other professionals providing support work together to develop a plan to ensure pēpi is safe and well cared for.

Applications for custody can be made prior to a family group conference if safety for pēpi cannot be secured in the interim, however best practice is for a family group conference to be held before the s78 application wherever possible.

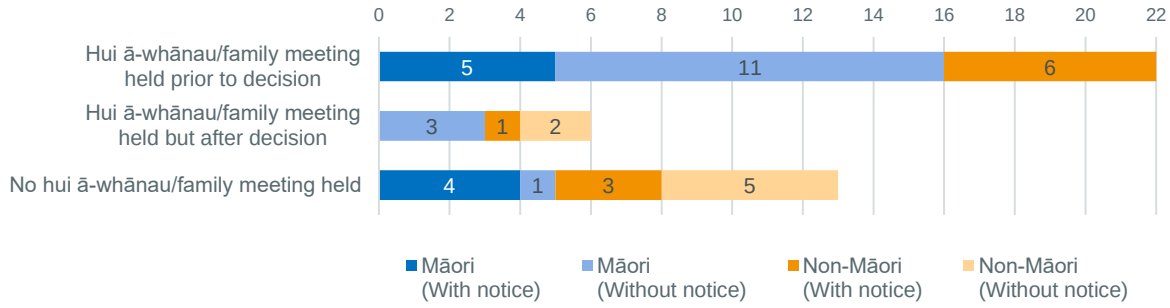
What happened over the review period and how has practice changed?

In 34 of the 41 cases reviewed (83%), whānau were engaged in a formal process to discuss the concerns and create safety for pēpi prior to the s78 application. In 23 of these 34 cases, whānau engagement occurred through a hui ā-whānau or family meeting, in six cases engagement occurred through a family group conference, and in the remaining five cases engagement occurred through both a hui ā-whānau or family meeting *and* a family group conference.

A hui ā-whānau or family meeting was held prior to the application for a s78 order in 28 of the 41 cases reviewed (68%). Of the 24 cases of pēpi Māori reviewed, 19 (79%) had a hui ā-whānau or family meeting prior to the s78 application.

This compared with 95% of cases in our previous review period, although remains significantly higher than the Ombudsman's review (covering the period 1 July 2017 to June 2019) which found that a hui ā-whānau or family meeting was held prior to the s78 order in less than 25% of cases. However, as noted above, this is in the context of an increase in the number of presentations late in pregnancy (or after the birth of pēpi) and a high level of risk and complexity in the cases reviewed which may have had some impact on the ability of kaimahi to effectively engage whānau in planning and decision-making in some cases.

Figure 5: Hui ā-whānau or family meeting held prior to a decision being made in the assessment phase



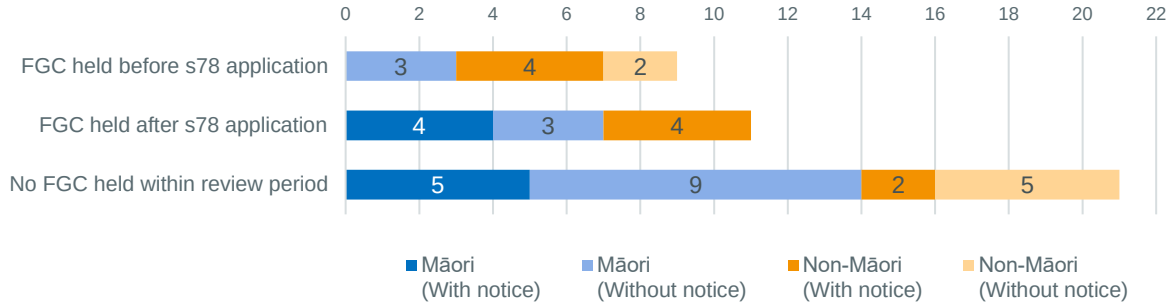
A family group conference was held prior to the application for a s78 order in nine cases (22%), and after the application in 11 cases (27%). This compares with findings of 43% and 24% respectively in our previous review period. In 21 cases

7 As defined by s14(1) of the Act.
8 Under s18(1) of the Act.

(51%), there was no record of a family group conference being held within the review period (from report of concern up until four weeks after pēpi entered custody) – however, it is noted that most of the cases reviewed had evidence of a family group conference held outside of this time period.

The length of time between the report of concern being made and the birth of pēpi, and whether the s78 application was made on a 'without notice' basis, both have an impact on whether a family group conference is able to be held prior to the s78 application. As previously noted, in this review period, there was a higher number of reports of concern received less than 50 days from the birth of pēpi, and a higher proportion of 'without notice' applications, which likely impacted on these findings.

Figure 6: Family group conference held prior to the application for the s78 order



Of the seven cases where there was no evidence of formal whānau engagement (via either a hui ā-whānau, family meeting or family group conference), a rapid application for orders was required to secure the safety of pēpi in three cases. In a further three cases, whānau had been engaged prior to the birth of pēpi to inform planning, but not through a formal hui ā-whānau/family meeting or family group conference process. In the remaining case, it was unclear why engagement had not occurred prior to the decision to apply for a s78 application, but reviewers identified that there had been a significant prior event involving a sibling of pēpi that likely contributed to practice decision-making in this case.

Further investigation into these cases identified that, in most cases, there were multiple factors impacting on the ability to undertake formal engagement processes prior to the s78 order. Significant mental health concerns, addictions and fractured whānau relationships were predominant and reviewers observed that social workers were often trying to balance the needs and rights of pēpi, mum and whānau.

Further strengthening practice

The introduction of a new Practice Framework in 2021 supports relational and rights-based practice and aims to strengthen whānau-led decision-making and realising the oranga of pēpi in the context of their whānau and whakapapa. Within the new Practice Framework, three new practice models (for Māori, Pacific and tauiwi whānau) and a new assessment approach are currently being trialled in selected sites, with the intent of these being introduced nationally in the next 12-24 months.

In January 2023, family group conference guidance was updated on the Oranga Tamariki Practice Centre to better align with the new Practice Framework and support practitioners to strengthen whānau-led decision-making and experiences.

Over this review period, Oranga Tamariki continued to establish and grow the number of kairaranga ā-whānau across the country.[9] Kairaranga ā-whānau play an important role in supporting early engagement with whānau Māori, facilitating hui ā-whānau and enabling more whānau participation in decision-making processes. Further monitoring of the use of hui ā-whānau and kairaranga ā-whānau to support early whānau-led decision-making is required to ensure that these processes are embedded and practice is aligned to the new Practice Framework.

Mechanisms to support whānau care

In this section, we investigate how Oranga Tamariki worked with parents and whānau to enable parents to retain care of their pēpi or to support whānau to care for pēpi where the parents were not a safe care option.

What is required?

When social workers identify issues that could impact on the safe care of a tamaiti, their first priority is to determine how te tamaiti can be kept safe within the care of their parents and within the wider network of protection provided by extended whānau, hapū and iwi networks.

'Safety planning' is used by social workers to support whānau to create a network of protection around te tamaiti.[10] Effective safety planning can prevent the need for a tamaiti to come into care, even when it is recognised that safety concerns exist, because it provides a means to build a safe environment for te tamaiti.

Practitioners outside of Oranga Tamariki can assist in helping whānau to create safety for te tamaiti. They are often better positioned to engage and build meaningful relationships with whānau who access these services by choice.

Iwi and Māori partners and NGOs can bring a different perspective that is grounded in a restorative approach and underpinned by a Māori-principled worldview. They may also make use of cultural practices that are familiar and safe for whānau Māori. As a result, whānau may be more likely to be open about their aspirations, challenges and successes with these practitioners. When these insights are available, Oranga Tamariki social workers can gain a richer view of how whānau are progressing, and it can often help inform consideration of if and how the safe care of tamariki can be achieved.

There are occasions when, based on a comprehensive assessment, the safety of te tamaiti can only be maintained by moving them to a safer care environment. When it is determined that custody orders are required, social workers must ensure that they are taking every opportunity to enable te tamaiti to be cared for within their whānau, hapū or iwi. They must also have regard to the principles within the Act which emphasise stability and sibling relationships. Custody orders can form part of the

9 practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairaranga-a-whanau/

10 Oranga Tamariki Practice Centre - Safety planning https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/building-safety-around-children-and-young-people/

safety plan and can be used to support whānau, hapū or iwi to create safety and stability for pēpi while further assessment and support is undertaken with parents.

In practice, social workers achieve this by undertaking whānau searching,[11] working with specialists such as kairaranga ā-whānau[12] to complete whakapapa searching,[13] and making substantial use of hui ā-whānau and family meetings as a mechanism for sharing concerns and developing plans which keep tamariki safe. It also means holding family group conferences at the earliest opportunity, to facilitate plans to support whānau to care for tamariki and meet their needs.[14] Building meaningful relationships with whānau to support them to participate in planning and decision-making takes sustained effort and time. The extent of prior whānau experience with Oranga Tamariki and the length of time the report of concern is received prior to birth both impact on social workers' ability to meaningfully engage whānau in building safety and providing supports.

What happened over the review period and how has practice changed?

In 27 of the 41 cases reviewed (66%), a safety plan was recorded for pēpi in the assessment phase. Parent(s) and/or whānau were involved in safety planning in 21 of the 27 cases, and professionals were involved in planning in 19 of the 27 cases. A safety plan was developed in 16 of the 24 cases of pēpi Māori (67%), and all but one of these safety plans involved parent(s) and/or whānau.

These findings suggest an improvement in early safety planning when compared with our previous reporting period, which found safety plans were recorded in the assessment phase in 48% of the cases reviewed.

Of the 14 cases in which no safety plan was recorded in the assessment phase, reviewers found evidence that social workers were building safety with parent(s) and/or whānau in three cases. In another seven cases, there was evidence that social workers had attempted unsuccessfully to engage with parent(s) and/or whānau to try to build safety early. In three cases, a safety plan hadn't been built early on but had been developed prior to the birth of pēpi. In the remaining case, the mother of pēpi made an early decision to place pēpi for adoption.

In 15 of the 24 pēpi Māori cases reviewed (63%), there was evidence that cultural supports were provided to whānau. In the previous review period, reviewers found cultural supports were provided in 80% of cases of pēpi Māori reviewed. Further investigation with sites into the nine cases in which such supports were not evident in CYRAS found that, in three cases, a kairaranga ā-whānau was involved in providing support but this had not been recorded on CYRAS; in two cases, support was sought to engage whānau from a staff member of the same iwi; in one case, iwi were involved to offer support however the mother of pēpi disengaged; and, in a

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11 Oranga Tamariki Practice Centre - whānau searching https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/whanau-searching/

12 Oranga Tamariki Practice Centre – kairaranga a-whānau https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairaranga-a-whanau/

13 Oranga Tamariki Practice Centre - Whakapapa research https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/whakapapa-research/

14 Oranga Tamariki Practice Centre – FGC Standards https://practice.orangatamariki.govt.nz/policy/family-group-conferencing-practice-standards/

further case, the whānau was well known to Oranga Tamariki through involvement with older siblings and there was a whānau-led plan to care for pēpi in place.

Of the 15 cases in which there was evidence of cultural support, ten involved a kairaranga ā-whānau, six involved a marae or iwi-based social service, six a Kaupapa Māori service and three another form of cultural support.[15]

These findings indicate that cultural support is being provided in most cases, although the recording of this support could be strengthened. Discussions with sites identified some particular challenges around the documentation of support provided by kairaranga ā-whānau, including where the kairaranga ā-whānau role was located and their access to and training on CYRAS, as well as concerns about the cultural appropriateness of recording whānau stories and whakapapa. Further work is required to understand and embed the way cultural support is documented and evidenced in case recording.

There was evidence of whānau searching in the assessment phase in 36 of the 41 cases reviewed (88%). The most frequently evidenced whānau searching involved discussions with whānau to explore identification and narratives of whānau to inform searching, followed by engagement with other whānau identified by parents, recording of iwi affiliations, engagement of kairaranga ā-whānau to assist in searching, and recording of chronologies. In the previous review period, reviewers found evidence of whānau searching in 95% of cases.

Whānau searching was evidenced in 22 of the 24 cases of pēpi Māori reviewed (92%). In 11 of those 22 cases (50%), a kairaranga ā-whānau or another cultural advisor supported whānau searching.

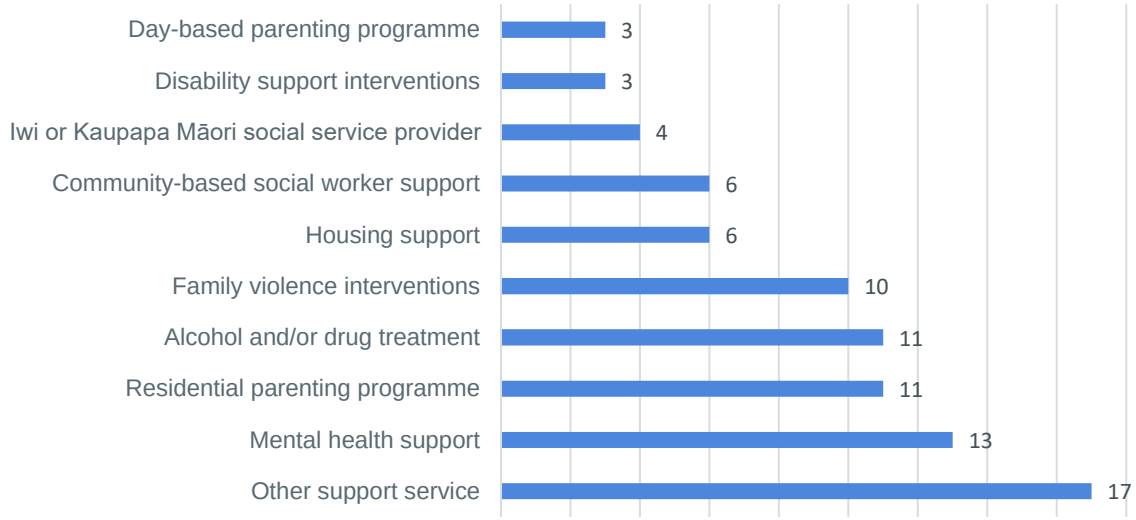
In the five cases in which there was no evidence of whānau searching in the assessment phase, whānau searching had either occurred in the intervention phase or previously for the older siblings of pēpi who were already in the care of Oranga Tamariki.

In 27 out of 41 cases (66%), reviewers found evidence that support services were provided to parent(s) and/or whānau with a focus on preventing removal from parent(s)' care. The most frequent support provided was mental health support in 13 cases, followed by alcohol and/or drug treatment in 11 cases, a residential parenting programme in 11 cases, a family violence intervention in 10 cases, community-based social work support in six cases, housing support in six cases, involvement with an iwi or Kaupapa Māori service provider in four cases, disability support services in three cases, and day-based parenting in three cases. There were a range of other types of support service provided in 17 cases.[16] In the previous review period, reviewers found support services were provided in 71% of cases.

[15] These figures total more than 15 as some parents and/or whānau were engaged with several cultural supports.

[16] These figures total more than 27 as some parents and/or whānau were engaged with several support services.

Figure 7: Support services provided with a focus on preventing removal from parent(s)' care



In 13 of the 14 cases in which supports were not provided, supports were either offered and not taken up or there was an early decision that the parents would not retain the care of pēpi. Further investigation with the site into the remaining case revealed that a combination of a short time period between the report of concern being received and the birth of pēpi and a significant previous event for the older sibling of pēpi influenced decision-making in regard to support services being offered prior to the s78 application.

In 33 of the 41 cases reviewed (80%), initial plans for care arrangements were to support the parent(s) and/or whānau to care for pēpi. Of the remaining eight cases, in three cases, an early decision was made that pēpi would not be cared for by parent(s) and/or whānau; in one case, the initial plan was for pēpi to be adopted; and, in the remaining four cases, the initial care arrangements were to be agreed at the family group conference. In the previous review period, reviewers found there were initial plans to support parents and/or whānau to care for pēpi in 86% of cases.

At the time the s78 order was made, 28 out of 40 pēpi (70%) remained in the care of parent(s) and/or whānau. This compares with 62% and 53% in our previous two reporting periods. One of the 41 pēpi reviewed was sadly stillborn.

In twelve cases (three of which were for pēpi Māori), pēpi was initially placed with non-kin caregivers. In ten of these cases, this was done with the agreement of whānau; in the remaining two cases, the decision was led by Oranga Tamariki. In one of these two cases, a whānau caregiver was unable to be identified in time; in the other case, the agreed safety plan for pēpi had broken down and there were no whānau placements available.

At the time of review, 29 pēpi were in the care of parent(s) and/or whānau (73%) (22 of whom were pēpi Māori (92%)), one pēpi remained with non-kin caregivers with their older siblings (3%), and ten pēpi were placed with non-kin caregivers (26%).

These findings indicate that the number of pēpi remaining in the care of parent(s) and/or whānau continues to strengthen.

Further strengthening practice

The fundamental shift in practice Oranga Tamariki is making (through the introduction of a new Practice Framework, and associated practice models and assessment approach), is designed to ensure that, wherever possible, whānau are enabled to create their own solutions for ensuring the oranga of their tamariki. This includes ensuring whānau have the support they need to care for tamariki.

A programme of work, 'Enabling Communities', is currently underway to partner with Māori and communities to support them to develop solutions for their tamariki, rangatahi and whānau. The programme will be led by Māori and communities, with Oranga Tamariki playing an enabling and coordinating role. Prototypes for how Oranga Tamariki can partner and share decision making are being trialled in selected regions across the country, and the successes and learnings that come out of these prototypes will be used to fine-tune the approach to extending this work across the rest of Aotearoa and to determine a new way of partnering with Māori and communities.

Oranga Tamariki is committed to improving the cultural capability of its staff. Te Hāpai Ō has been developed and launched, which is a whole-of-organisation approach to building the Māori cultural capability of all kaimahi. Te Hāpai Ō includes five key workstreams that ensure our approach to enhancing cultural capability is comprehensive and cohesive:

- Tū Māia training programme: Development and delivery of a training programme focused on growing the cultural capability of all staff at Oranga Tamariki
- Te Hāpai Ō Resources: Development of a suite of cultural capability resources available to all staff on our learning management system, MyLearn
- Māori Cultural Capability Baseline: Establishment of a cultural capability baseline to measure the cultural capability of Oranga Tamariki
- Evaluation Framework: Creation of an evaluation framework to monitor the effectiveness of Te Hāpai Ō and inform its ongoing development
- Te Reo Māori Strategy: Development of a Te Reo Māori strategy for Oranga Tamariki.

As noted earlier, the kairaranga ā-whānau role continues to be embedded and established across sites. Further monitoring of the use of kairaranga ā-whānau to support early whānau decision-making is required, including the extent to which this critical cultural support is being evidenced and the most appropriate mechanism for capturing such support in case recording.

Supporting parents with disabilities and health related needs

In this section, we investigate support and advocacy for parents with disabilities and health related needs where there were concerns for the safety of pēpi.

What is required?

The United Nations Convention on the Rights of Persons with Disabilities is clear that no tamaiti should be separated from parents based on a disability of one or both

parents. Parents with a disability should also be provided with advocacy support as well as support to discharge their parental responsibilities.

Oranga Tamariki guidance outlines that assessments and plans need to consider the parents' strengths and how their disability or health related needs are being met or could be met. Where parents have a disability or health related need, guidance advises the need to work closely with those parents, and with disability, mental health or addiction services, to share information and develop joint plans. Where parents are not engaged with specialist services, we should work with their consent to make referrals where required.

What happened over the review period and how has practice changed?

Disability

Of the 41 cases reviewed, the mother of pēpi had an identified disability in 10 cases (24%), all of which were cognitive. In four cases (10%), the father of pēpi had an identified disability, three of which were cognitive and one a neurodevelopment disorder.

Of the 14 parents for whom a known parental disability (mother or father) was identified, there was evidence that action was taken to address those needs or that existing supports were in place in nine cases (64%). This compares with 75% in the previous review period. In two of the five cases in which there was no evidence of actions taken or supports put in place, evidence suggested that the social worker had attempted but been unable to engage the parent.

Health-related needs

Of the 41 cases reviewed, the mother of pēpi had an identified health need in 29 cases (71%). Eighteen of these related to mental health needs and 11 related to substance addiction needs. In seven cases (17%), the father of pēpi had an identified health need; four of these were substance addiction needs and three were mental health needs.

Of the 36 parents with an identified health need (mother or father), there was evidence that action was taken to address those needs in 26 cases (72%), although, in nine of these 26 cases, the social worker had taken action to put in place supports but these were declined by the parent.

For this reporting period, reviewers also sought to additionally understand whether the assessment and plans for the pēpi described how the parental disability or health-related needs were being or could be met, and found that evidencing these needs in assessment and planning work was a particular area for practice improvement (evident for around half of mothers, and no fathers). Where the parental need related to disability in particular, reviewers noted that this was often less well described in assessments and plans.

Reviewers observed that the presence of significant mental health needs for mothers of pēpi was high, noting that, of the 18 cases where a mental health need was recorded, ten included the mother being treated under the Mental Health (Compulsory Assessment and Treatment) Act 1982. Reviewers noted that this added to both the complexity and the level of resourcing required to support the mother to have an opportunity to safely care for their pēpi, and to participate in planning and decision-making.

Further strengthening practice

Oranga Tamariki has developed a Disability Evidence Plan and guidance for working with Disabled People. Rights-based disability guidance and information has been brought together into one space on the Practice Centre to support easier access for kaimahi. This includes assessment of needs relating to any disability, working with disabled tamariki and their whānau, and working with disability and learning supports and ACC. In March 2023, learning was delivered to frontline kaimahi on rights-based practice and the social model of disability.

The Disability Evidence Plan supports our Disability Strategy and work programme. It will continue to be adapted as the strategy is further developed and as we learn through data, research, and evaluation activities and wider engagement. Oranga Tamariki has established a Disability Advisory Group made up of six experts from a range of backgrounds who will work closely with the Chief Advisor Disability to provide advice and feedback to senior leaders at Oranga Tamariki. The Disability Advisory Group will provide advice on the Disability Strategy, which will help make positive changes to our services for disabled people. To inform the strategy, we are working in partnership with organisations supporting people with disabilities to hold workshops and interviews with disabled people who have lived experience of care and protection and/or youth justice services.

Wider work across government to transform the health and disability sector is also key to improving access to support for parents with disabilities and health-related needs.

Mechanisms to ensure appropriate decision-making by Oranga Tamariki practitioners

In this section, we investigate the nature of the consultation and decision-making between practitioners within Oranga Tamariki, professionals from other agencies, and other partners.

Social workers are required to exercise their individual professional judgement, obligations and ethics in the context of a legislative and organisational framework designed to help ensure the appropriate exercise of Oranga Tamariki powers and duties through the promotion of collaborative and consultative decision-making.

The Child and Family Consult

The Child and Family Consult process supports social workers to identify and consider indicators of danger and harm alongside indicators of safety and strengths. It supports decision-making at any point in the social work assessment, planning, intervention and review process. The consult must be used during the assessment or investigation phase or when removal from home is considered, to inform the analysis and next steps.

Supervision

Effective supervision is a critical part of ensuring good outcomes for tamariki and whānau. It is also integral to ensuring safe social work practice and helping practitioners to reflect on practice and decision-making, and to develop skills.

Supervision has a range of functions and can occur in a range of ways. One of the functions of supervision is case-specific discussions. These can occur during a structured professional supervision session or during more informal supervision, such as real-time case consultation with a Supervisor, Practice Leader or peer.

Oranga Tamariki policy stipulates how often an individual practitioner must receive *professional supervision*. There are no specific requirements around the frequency of informal supervision that is directly case-related, and this typically happens on a day-to-day basis, depending on the circumstances of the case or the needs of the staff involved. Supervision that involves case-related decisions needs to be recorded on CYRAS.

Care and Protection Resource Panels

Care and Protection Resource Panels (CPRP) are statutory bodies under the Oranga Tamariki Act 1989. Legislation provides for the establishment of CPRP to provide external advice and guidance to social workers undertaking their responsibilities under the Act. When CPRP effectively represent local communities (particularly local iwi/Māori) and the broader child wellbeing sector, they can provide a useful professional challenge to social workers' thinking, and open alternative strategies and solutions to address tamariki safety.

Social workers are required to consult with their site's CPRP as soon as possible after having commenced an investigation.[17] FGC Coordinators are also required to consult with their site's CPRP when they receive a referral for a family group conference and when there is a non-agreement at a family group conference.

Working in partnership

Social workers need to build effective and collaborative relationships with other professionals and recognise the unique contribution that they make to maintaining the safety of tamariki. By sharing information with them, seeking their professional judgement in assessment and decision-making, and working with them to involve whānau in decision-making processes, the quality of social work assessments and plans is strengthened.

Oversight of without notice custody applications

In instances where fast and decisive action is required to ensure the immediate safety of a tamaiti, social workers may seek an interim custody order on a 'without notice' basis. This involves the Family Court making an interim custody decision without representation from parent(s) or guardians and prior to the appointment of counsel for te tamaiti.

There is a high bar for applying for orders on this basis because of the principles in legislation that prioritise whānau, hapū, iwi and family group participation in decision-making. Following the Hawke's Bay Practice Review, which involved the use of a 'without notice' custody order, Oranga Tamariki policy was amended to require that, before they can be filed, all s78 'without notice' applications be approved by the Site Manager, and the decision endorsed by the site's Practice Leader and the Regional Litigation Manager.

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17 Oranga Tamariki Practice Centre – CPRP https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/working-with-the-care-and-protection-resource-panel/

What happened over the review period and how has practice changed?

The Child and Family Consult

In 32 of the 41 cases reviewed (78%), a child and family consult was used to support the decision to apply for the s78 order (17 of these were for pēpi Māori.) In nine cases (22%), there was no evidence of a consult to support the decision itself; however, further investigation with sites found that, in four of these cases, a consult had occurred but had not been recorded and, in a further case, there was evidence that a previous consult had occurred. In the previous review period, reviewers found that a child and family consult was held to support the decision to apply for the s78 order in 62% of cases.

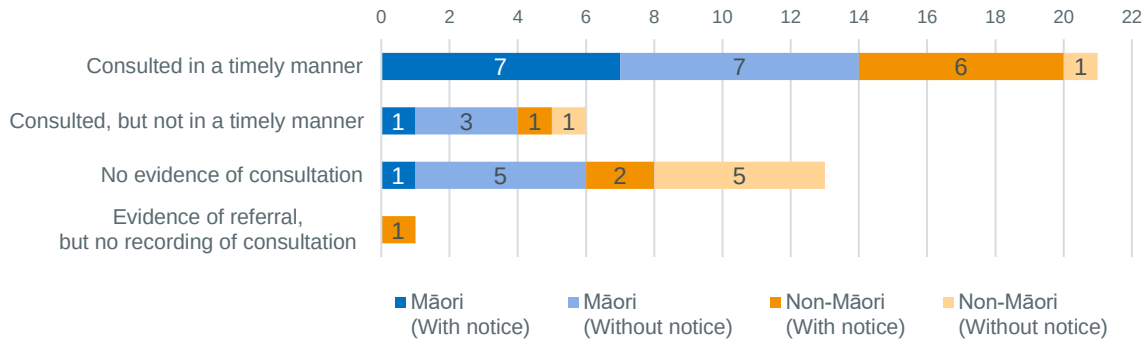
These findings show that practice in using the child and family consult tool to support key decisions has strengthened since the last review period.

Care and Protection Resource Panels

In 27 of the 41 cases reviewed (66%), reviewers found evidence that the site's CPRP had been consulted during the assessment phase. Consultation with the CPRP was more likely to occur for pēpi Māori, with reviewers finding evidence of consultation in 71% of cases. In 21 of the 27 cases in which consultation occurred, it occurred in a timely manner. In the previous review period, reviewers found evidence of consultation with the CPRP during the assessment phase in 80% of cases.

In 14 of the 41 cases (34%), there was no evidence of consultation; in one of these cases, there was evidence of a referral to the CPRP but no recording of the consultation.

Figure 8: Consultation with Care and Protection Resource Panel by social worker



Of the 20 cases in which a family group conference was held within the review period, reviewers found evidence that the FGC Coordinator consulted the CPRP prior to the family group conference in six cases (30%) and no evidence of consultation in the remaining 14 cases (70%). In the previous review period, reviewers found evidence of consultation by the FGC Coordinator in 43% of cases.

Further investigation with sites into the cases in which consultation was not evidenced identified a number of ongoing challenges in this area, including difficulties forming and maintaining effective representation of local communities on the panel and in forming a CPRP quorum which were further impacted by COVID-19, and awareness of/adherence to both referral processes and the role and function of the CPRP.

Supervision

In our engagement with sites, in nearly all cases, kaimahi reported supervision had occurred to inform their case work and decision-making. However, this was evidenced in CYRAS in only 22 of the 41 cases reviewed (54%). This compares with a finding of 76% in our previous review period.

Of the 41 cases reviewed, there was evidence on CYRAS of supervision between the social worker and the supervisor in the assessment phase in 14 cases (34%) and in the intervention phase in 15 cases (37%).

While these findings represent a decrease on our previous reporting period, discussions with kaimahi indicate that this is largely a recording issue. Further work is required to strengthen recording practice to ensure that any supervision that involves case-related decisions is documented in CYRAS.

Working in partnership

In 40 of 41 cases reviewed (98%), other professionals were consulted to inform the assessment. This compares with a finding of 90% in the previous review period, indicating that the practice of consulting with other professionals to inform the assessment for pēpi remains high.

Most consultation occurred with midwives or maternity professionals, followed by mental health professionals, Police, parenting and family support service professionals and family violence professionals. Of the 24 cases of pēpi Māori, iwi social services, marae-based services or Kaupapa Māori services were consulted in the assessment phase in five cases. Reviewers were unable to determine from recording how many of the broader kaimahi supporting parent(s) and whānau (for example, maternity professionals) were also kaimahi Māori.

Regarding the extent to which whānau had the opportunity to be heard in the Family Court, 19 of the 41 s78 applications (46%) were made on a ‘with notice’ basis and 22 (54%) were made ‘without notice’ during the period of our review.

Annual data for the 2022 year[18] showed a small overall increase in the proportion of s78 orders for pēpi being made on a ‘without notice’ basis when compared with 2021 – 60% of s78 orders for pēpi were made on a ‘without notice’ basis in 2022, compared with 53% in 2021. However, the proportion of ‘without notice’ orders remains considerably lower than that reported by the Chief Ombudsman in his August 2020 review. As noted earlier, reviewers observed a relationship between the timing of the report of concern and whether the order was made on a ‘without notice’ basis, with 80% of the cases in which the report of concern was received less than 50 days prior to birth resulting in a ‘without notice’ s78 order.

[18] 1 January – 31 December 2022.

Oversight of without notice custody applications

Of the 22 cases in which a 'without notice' s78 order was granted, 21 were applied for by Oranga Tamariki.[19] In 19 of these 21 cases (90%), the required approval had been granted by the Site Manager, endorsed by the Practice Leader and Regional Litigation Manager, and uploaded to CYRAS. Further investigation into the two cases without approval recorded identified that the correct approvals had been granted prior to the s78 application, but the approval forms had not yet been uploaded to CYRAS at the time of our review. This has since been completed.

Further strengthening practice

Follow-up has occurred with Practice Leaders and Family Group Conference Team Leaders around the statutory requirement for consultation with the CPRP during the assessment and prior to a family group conference. Practice Centre guidance on strengthening our response to unborn and new-born pēpi has recently been updated to reinforce the requirement to consult with the CPRP. Reviewers will continue to follow up with individual sites where this practice expectation has not been met.

The current CPRP guidance is being updated to better align with the Oranga Tamariki practice direction and wider legislative context. This work is being informed by the CPRP Annual Reports provided by regions across the country.

The need to strengthen consultation between kaimahi and the CPRP panel was also identified in previous reporting periods, and remains an identified area for improvement. An increased focus on this area of practice is required to ensure the intent of the CPRP (for representatives from the local community to provide meaningful advice and guidance to kaimahi) can be fully realised.

Ensuring social work practice is underpinned by regular, quality supervision has been identified as a key practice priority for Oranga Tamariki in 2023. There are several initiatives currently underway to enhance supervision practice and experience, and a working group has been established to develop an Enhancing Supervision Strategy which will support the expansion and acceleration of a comprehensive supervision offer across the organisation.

Of the initiatives currently underway, a new Tangata Whenua and Bicultural Supervision model has been developed under the Practice Programme, and is currently being trialled with selected sites. Initial feedback from the trial sites has been positive and plans are underway for the model to be rolled out nationally in late 2023.

A new mirimiri a-korero consultation tool is also currently being trialled in selected sites – it has been developed to support sense-making and planning with respect to practice and decision-making, and has a strong focus on understanding the views, experiences and aspirations of tamariki and whānau about oranga.

[19] Section 78 of the Act allows others who are party to the court proceedings to make an application for an interim custody order.

Support for parents and whānau through the removal process, where removal is required

In this section, we review joint planning with others to support the removal process, and support for parents and whānau through the removal.

What is required?

In some instances where a s78 order has been granted, the parents retain the day-to-day care of pēpi, or they support their whānau or other carers having the day-to-day care of pēpi until longer-term solutions are found.

In other circumstances, executing the order requires pēpi to be physically removed from parents. This requires a planned approach that clearly identifies risks and ensures that all professionals involved understand their role. Practitioners must effectively prepare and support parents and whānau to minimise the impact of trauma on them – for example, by having time with pēpi and whānau before pēpi is removed.

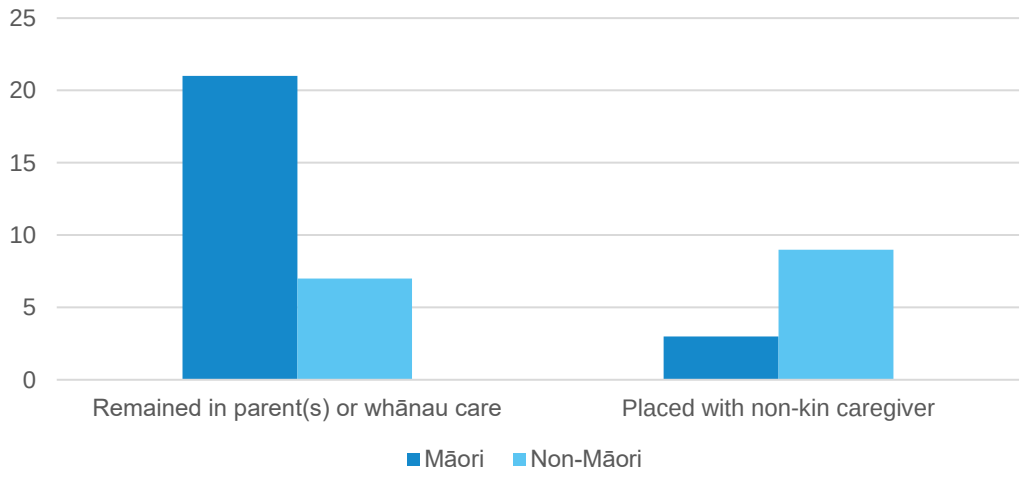
What happened over the review period and how has practice changed?

Twenty eight out of 40 pēpi[20] (70%) remained in the care of parent(s) and/or whānau following the s78 order being made – this was notably higher for the pēpi Māori reviewed, with 88% of these pēpi remaining in the care of parent(s) and/or whānau. In the previous review period, reviewers found 62% of pēpi remained with parent(s) and/or whānau following the s78 order. These findings indicate that the proportion of pēpi remaining in the care of parent(s) and/or whānau continues to strengthen.

In eight of the 28 cases, the decision to apply for a s78 order while pēpi remained in the care of parent(s) and/or whānau was based on concerns held by Oranga Tamariki; in 19 cases, the decision was based on shared concerns held by both whānau and Oranga Tamariki; and, in the remaining case, the decision was based on concerns held by whānau. In the majority of cases in which pēpi was placed with parent(s) and/or whānau, the rationale for the s78 order was to provide security for the placement of pēpi due to concerns that parent(s) may not adhere to the safety plan in place for pēpi.

[20] This figure refers to 40 pēpi as one pēpi was sadly stillborn.

Figure 9: Care arrangements for pēpi following the s78 order



Of the 12 cases (30%) in which pēpi did not remain with parent(s) and/or whānau following the s78 order, pēpi was removed from their care following the s78 order in eight cases. In four of those eight cases, pēpi was already in the custody of Oranga Tamariki prior to the s78 order being granted. In one case, pēpi entered care under a s139 voluntary agreement[21] before the s78 application was made. In a further three cases, pēpi entered care under a s39 place of safety warrant[22] before the s78 order was made.

Of the eight cases in which pēpi was removed from the care of parent(s) and/or whānau following the s78 order, reviewers found evidence of a plan established in advance for that process in seven cases. In the remaining case, there was no evidence of a plan on CYRAS. In this case, due to significant health concerns for mum, Health led the planning. In all eight cases, pēpi was removed from the care of their parent(s) in hospital.

Of the seven cases in which a plan was established in advance, the plan was made by Oranga Tamariki with whānau and other professionals in four cases, and with professionals only in three cases.

In six of the eight cases (75%), reviewers found evidence on CYRAS that parent(s) had been provided with dedicated time with pēpi and whānau before pēpi was removed from their care. In one case, it was unclear from recording whether special time was provided (we note that significant concerns about the mother's mental health would likely have made it difficult for this to occur safely). In the remaining case, reviewers found evidence that parents had spent a day and night in hospital with pēpi following the birth, but not following the s78 order being served due to safety concerns.

21 Section 139 of the Act allows any parent or guardian who is temporarily unable or unwilling to care for their tamaiti to place te tamaiti in the care of the Chief Executive of Oranga Tamariki, or an iwi social service or cultural social service, or a director of a child and family support service, for a period not exceeding 28 days.

22 Section 39 of the Act allows Police and Oranga Tamariki, in executing a search warrant for a tamaiti, to remove or detain te tamaiti and place them in the custody of the Chief Executive when all other intervention options to secure safety have been exhausted.

Findings indicate that practice in this area has remained largely consistent with the previous review period, in which it was found that 71% of parents were provided with dedicated time with pēpi and whānau before pēpi was removed from their care.

In 11 of the 12 cases (92%) in which pēpi did not remain with their parent(s) or whānau,[23] reviewers found evidence that support(s) were offered to parent(s) and whānau or that supports were already in place. In the remaining case where evidence was not found of supports being offered to parent(s) and whānau to help them to deal with the separation from pēpi, reviewers noted that there was a history of trying to put in place supports for the parents unsuccessfully. These findings indicate practice continues to strengthen in this area, with reviewers in the previous review period finding evidence of supports offered in 88% of cases.

Further strengthening practice

Follow-up has occurred with individual sites on the requirement to ensure that parent(s) and whānau have opportunities for special time with their pēpi following the s78 order and that this is recorded on CYRAS.

In March 2022, a new schedule was signed under the Memorandum of Understanding between Oranga Tamariki, Police and Health, setting out our agreement to engage with iwi Māori to develop localised procedures and plans to support parent(s) and whānau when decisions have been made that pēpi needs to be removed from their care. Work continues around the country to support Health, Police and Oranga Tamariki to develop these local level agreements alongside their iwi/Māori partners.

Support for parents and whānau after the s78 order was made

What is required?

Practice guidance on breastfeeding speaks to the concept of ūkaipō. Ūkaipō refers to the nurturing of a person, not just the physical nurturing but also the spiritual and emotional nurturing. As well as providing physical nourishment, breastfeeding connects pēpi and their mother spiritually and emotionally. Social workers need to ensure breastfeeding and access to breast milk, and the physical connection of pēpi to their parents and whānau, are supported.

All efforts should be made to ensure breastfeeding can happen if this is the mother's wish and is safe for pēpi. Only in exceptional circumstances, where the immediate safety or health of pēpi would be compromised through breastfeeding, will breastfeeding not be supported and encouraged when a pēpi enters care. When a mother is unable to feed her pēpi because she is physically unable to breastfeed, or it is unsafe to do so, every effort should be made to enable skin-to-skin contact, bonding and attachment to occur.

Supports for parents and whānau, including to maintain and strengthen connections with their pēpi, are important considerations and should be identified throughout assessment, discussed as part of planning, and formalised within the family group conference plan or Family Court plan.

[23] This includes the four pēpi who initially entered care under a s139 agreement or a s39 warrant.

What happened over the review period and how has practice changed?

Of the 32 cases in which pēpi was cared for by their whānau or a non-kin caregiver and did not stay in the care of their mother, there was evidence in 19 cases (59%) that the mother's wishes in regard to breastfeeding pēpi were discussed. Of these 19 cases, the mother of pēpi expressed that they did not want to breastfeed in eight cases, and that they did want to breastfeed in 11 cases. The previous review period found evidence in 50% of cases that the mother's wishes in regard to breastfeeding were discussed.

In a further two cases, there was evidence that health professionals had advised it was unsafe for breastfeeding to occur. In one case, although there was no evidence of a discussion taking place, reviewers found evidence that the mother was breastfeeding pēpi and being supported to do so. In another case, reviewers found evidence that the mother did not want to engage to have this discussion. In the remaining nine cases, reviewers found no evidence of a discussion about breastfeeding.

Of the eleven cases in which there was evidence that we had discussions with the mother of pēpi and she wished to breastfeed, supports were put in place to enable this to occur in six cases. Of the remaining five cases, in one case, supports were not put in place due to concerns that the breast milk was not safe. In the other four cases, it was unclear from recording whether supports were put in place. In the previous review, reviewers identified that, in four out of six cases where the mother of pēpi wished to breastfeed, supports were in place to enable her to do this.

Reviewers noted an inconsistent approach to recording of information about the mother's intention to breastfeed and of clear plans to enable this to occur. There continue to be opportunities to strengthen both recording and practice in this area.

In 36 of 40 cases (90%), there was evidence of either breastfeeding or opportunities for skin-to-skin contact, bonding and attachment to occur between mother and pēpi. Of the four cases in which there was no evidence that breastfeeding or skin-to-skin contact occurred, in the first case, the mother's mental health prevented this from occurring safely and, in the second, the health of pēpi prevented this from occurring safely. In the third case, pēpi was already in care under a s139 voluntary care agreement when the s78 was granted and the mother of pēpi was unable to be located. In the fourth case, pēpi was removed from mother's care under a s39 warrant, and breastfeeding and opportunities for skin-to-skin contact were unable to happen in a safe way. In the previous review period, reviewers found evidence of breastfeeding or opportunities for skin-to-skin contact in all cases.

Further strengthening practice

Individual follow-up has occurred with sites around the rights of mothers and their pēpi to breastfeed and the need to ensure that there are opportunities for skin-to-skin contact, bonding and attachment to occur. In future review work, we will continue to monitor practice alignment with breastfeeding guidance and follow up with individual sites when this has not occurred.

Next steps

Insights from the case-file analysis will be used to continuously inform and strengthen practice in this area. This includes engaging directly with practitioners and sites where there are practice issues or examples of excellent practice identified through the review, and sharing insights with operational leaders.

Case-file analysis for all unborn and new-born pēpi entering Oranga Tamariki custody under a s78 order is an ongoing process and occurs on a routine basis as part of our core quality assurance activity. This enables fast feedback loops back to sites and ensures any gaps and/or learning opportunities are promptly identified and addressed to support ongoing improvements in practice for pēpi and their whānau.

In 2023, monitoring of s78 practice will be expanded to include a focus on the quality of entry to care practice and decision-making for tamariki *of all* age groups, where care and protection concerns have been identified. The review will consider practice where tamariki and rangatahi entered care under a s78 order, and will also look at practice for a sample of tamariki and rangatahi for whom a family group conference was held but custody orders were not sought.