ORANGA TAMARIKI
Ministry for Children

New Zealand Government

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

March 2022

Contents

Background

This is the second 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 s78 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 first report outlining the findings of this work in August 2021, covering the period 1 September 2020 to 31 December 2020. This report can be read here.

This report provides details on the results of case-file analysis covering the review period 1 January 2021 to 31 August 2021.

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.

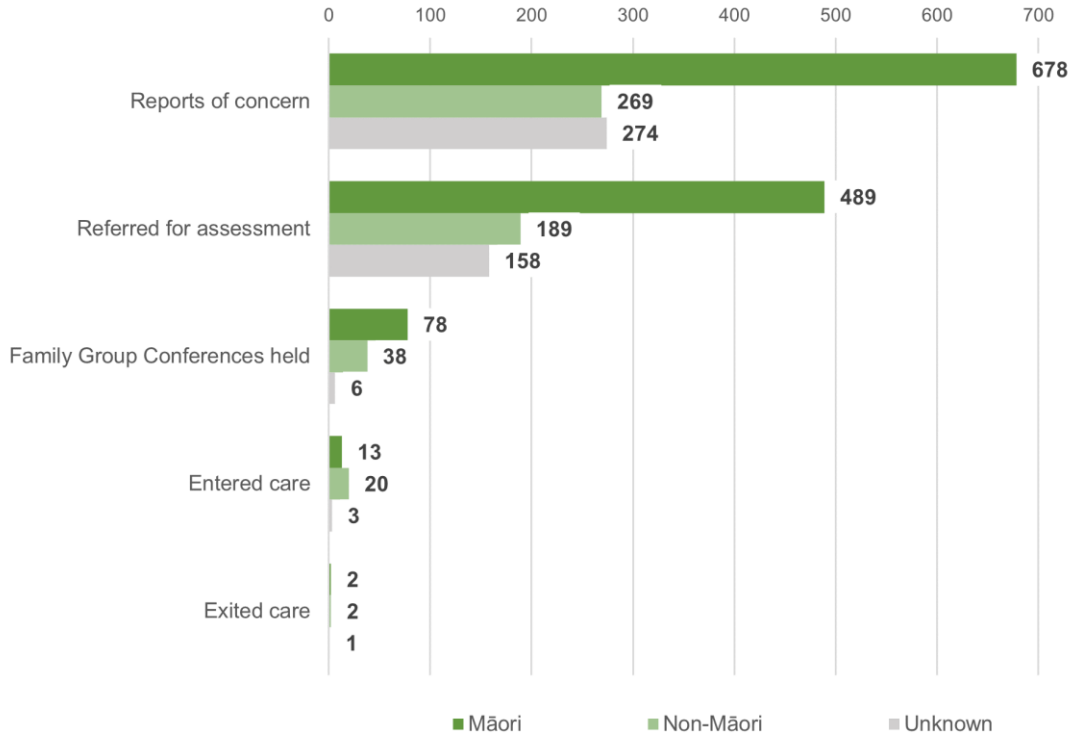
There are several different warrants and legal orders under the Oranga Tamariki Act 1989 (the Act) which can be used to place pēpi into the custody of Oranga Tamariki. The focus of the Ombudsman's report and this case-file review is s78 care entries.

Section 78 of the Act 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 January 2021 to 31 August 2021)



It shows that over these eight months:

- safety concerns about 1,221 unborn and new-born pēpi were reported to Oranga Tamariki and 836 pēpi were referred for assessment
- for 122 new-born and unborn pēpi, care and protection concerns resulted in Oranga Tamariki convening a family group conference with whānau
- for 36 pēpi, safety concerns resulted in their being placed into the custody of Oranga Tamariki. Twenty one of these 36 custody orders were section 78 applications and are the subject of these review findings[3].

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, and whether they were issued on a with or without notice basis.

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

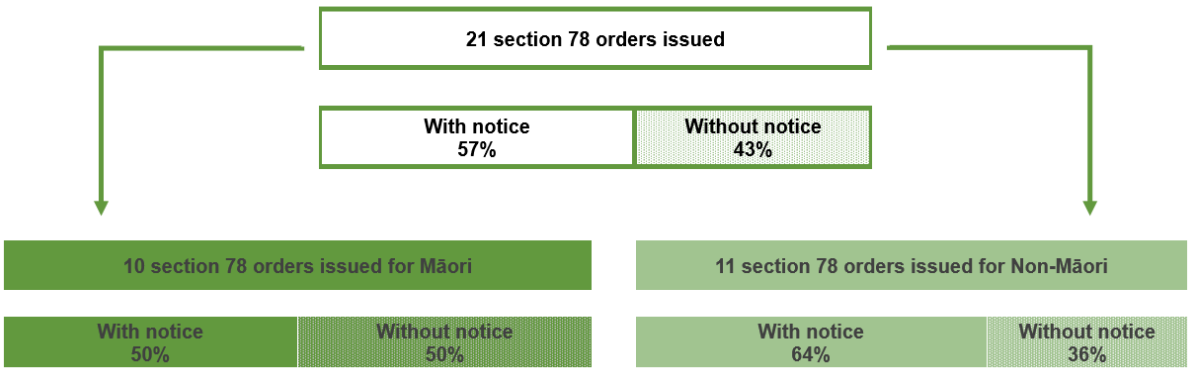
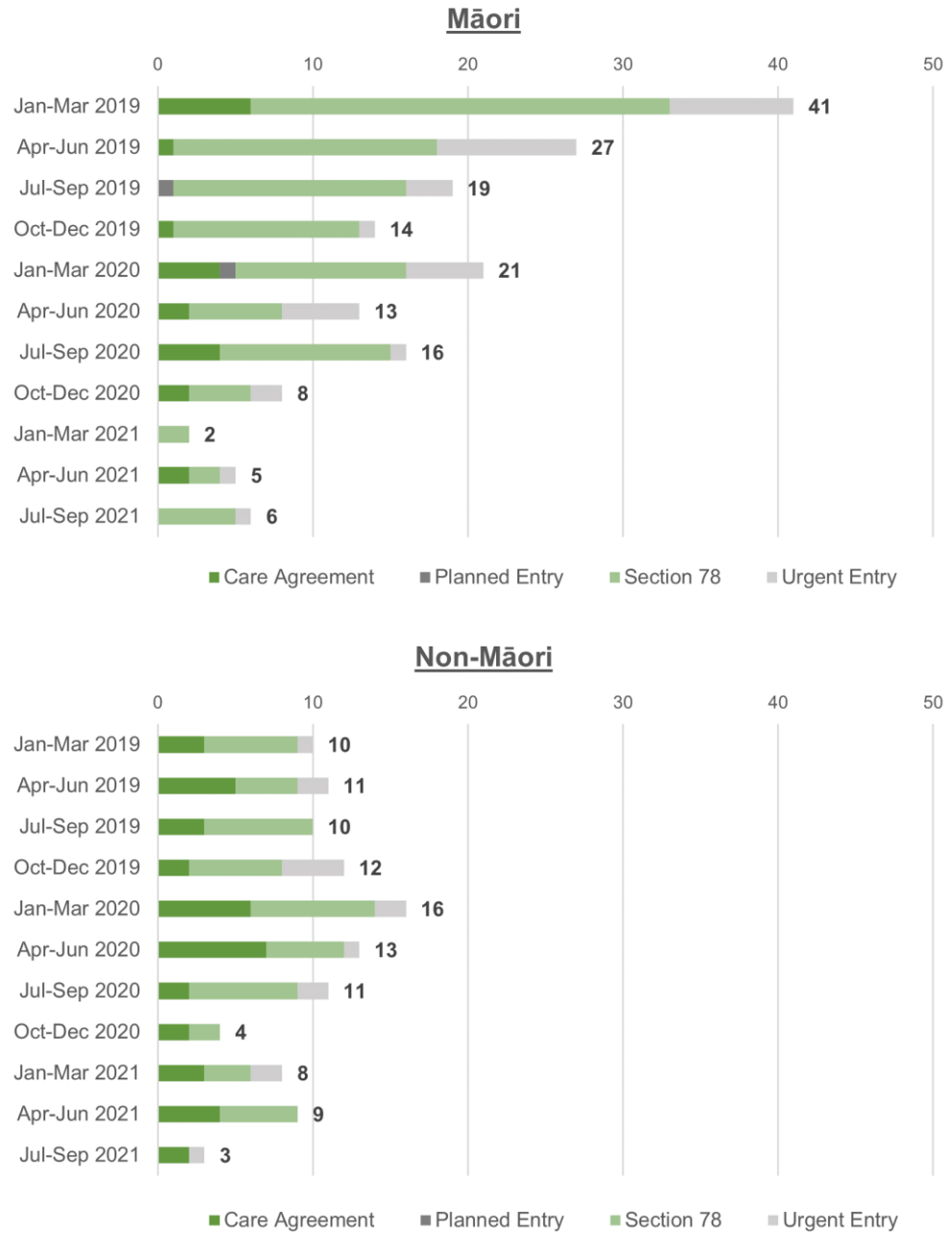


Figure 3 provides information on changing patterns of care entry for pēpi over the last three years, specifically the total number of care entries for pēpi by type of custody order, for both Māori and non-Māori. This includes s78 orders, temporary custody entries that are agreed between parents and Oranga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

[3] The remaining pēpi entered custody under either a s39, s139 or s140 of the Oranga Tamariki Act 1989.

Figure 3: Entries to care for unborn to 30-day old pēpi, for Māori and non-Māori pēpi and entry type (1 January 2019 to 30 September 2021)



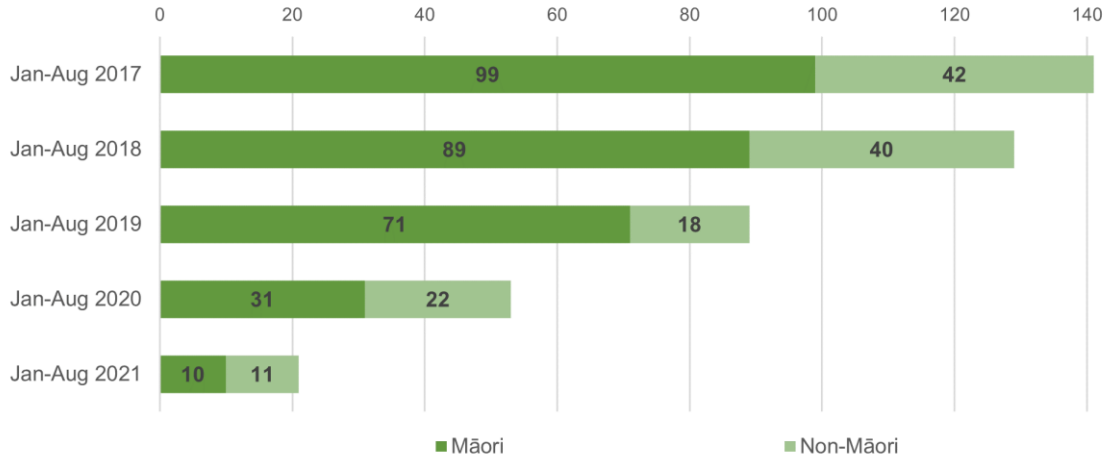
The figure shows that:

- the total number of custody orders issued for pēpi has reduced significantly
- the reduction in care entries is apparent across all custody orders
- reductions in custody orders are most pronounced for pēpi Māori.

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

Figure 4 below shows that the number of situations in which a s78 custody order was sought in order to achieve safety has continued to reduce since 2017 (note Figure 4 looks at the January-August time period, which is the time period covered by this review). While pēpi Māori continue to be overrepresented in s78 orders this is steadily declining, with the percentage of s78 orders for pēpi Māori dropping from 70% in 2017 to 48% in 2021 (note, pēpi Māori comprised 27.5% of all births in 2019.[4])

Figure 4: Total number of s78s for unborn and new-born pēpi, January – August 2017 – 2021



[4] Ministry of Health Report on Maternity web tool (shinyapps.io)

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 January and 31 August 2021 (21 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 focussed on those areas of practice that are required to be clearly documented.

As legislative, policy and practice requirements continue to evolve, particularly in those areas where the Ombudsman identified gaps (mainly disabilities, supporting breastfeeding and recording requirements relating to the circumstances in which any pēpi are removed), we will adjust review questions to ensure they remain aligned with practice expectations.

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 21 s78 orders for unborn and new-born pēpi were granted over the review period 1 January 2021 to 31 August 2021 and were included in this review.

Twelve s78 orders (57%) were *with notice* and nine (43%) were *without notice*.

Of the 21 cases reviewed, 11 pēpi were New Zealand European/Other (52%), nine were Māori (43%) and one was Māori and Pacific (5%).

In twelve (57%) of the 21 reviewed cases, Oranga Tamariki prior involvement with the siblings of pēpi was extensive (other tamariki of parents were previously or currently in care), in four cases (19%) it was significant (multiple non-care interventions), in one case (5%) it was moderate (multiple assessments during the assessment phase, but no interventions), and in two cases (9%) it was limited

(reports of concern received, single or no assessment). In a further case, there was no Oranga Tamariki prior involvement, but pēpi had older siblings in the care of whānau. In the remaining case, pēpi was the parents' first child.

In ten of the 21 cases (48%), the mother of pēpi was currently or had previously been in the care of Oranga Tamariki. In one of the 21 cases (5%), the father of pēpi was currently or had previously been in the care of Oranga Tamariki.

In all cases reviewed, the mother of pēpi was pregnant at the time the report of concern was made. The report of concern was received more than 200 days before the birth of pēpi in seven cases (33%), between 100 to 200 days before birth in nine cases (43%), between 50 and 100 days before birth in two cases (10%), and less than 50 days from birth in three cases (14%).

No pēpi were identified on CYRAS as within the provisions of s18B of the Act (the 'subsequent children' provisions).

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 children within the family. The most common risks identified in the applications for a s78 order were the presence of family harm in 11 cases (52%), followed by parental substance abuse in ten cases (48%) and mother's mental health in seven cases (33%). No cases were identified in which historical concerns were the sole basis for the s78 application.

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 first round of case-file analysis:

- Over the period of this review there continued to be a decrease in section 78 orders, and while pēpi Māori continue to be disproportionately represented the gap is decreasing.
- Overall, there continues to be a sustained decrease in the use of without notice applications for pēpi since the Ombudsman's review.
- Engagement with whānau through the use of hui-ā-whānau and family meetings prior to a section 78 application continues to strengthen.
- Whilst the timeliness of consultation could be strengthened, the review found a positive increase in the use of Care and Protection Resource Panels by social workers during the initial assessment stage.
- In many cases reviewers found evidence that support services were provided with a focus on preventing removal of pēpi from parents' care.
- The use of whānau searching, to provide every opportunity for pēpi to be cared for within their whānau, hapū and iwi, remains high.
- In the majority of cases reviewed, initial plans for care arrangements were to support the parent(s) and/or whānau to care for pēpi and there was an increase in the number of pēpi who remained with parent(s) and/or whānau during the review period.

The review also identified areas of practice that require further focus. These include:

- Whilst in all cases a safety and risk screen was completed to identify whether further assessment or immediate action to secure the safety of pēpi was required, both timeliness and engagement with parents and whānau during this initial assessment stage remain key areas for improvement.
- Although opportunities for earlier whānau-led decision-making through the use of Family Group Conferences have strengthened since the last review, opportunities remain to further strengthen the use of Family Group Conferences including consultation with Care and Protection Resource Panels prior to a Family Group Conference.
- Professional supervision for kaimahi remains a key area for improvement.

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 our custody
- our findings in relation to core policy and practice requirements, and any evidence on if and how practice has changed
- a summary of further actions underway to continue to strengthen practice.

Initial assessment

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

What is required?

Once a report of concern has been received by Oranga Tamariki, social workers are required to complete an initial safety and risk screen. This identifies whether the safety and wellbeing concerns are such that they require further assessment or investigation to determine if immediate action is required.

The timeframe this screen must be completed within (the 'criticality response timeframe') is determined when the report of concern is first made. During the period under review in this report, options were <24 hours, <48 hours, <7 days, <10 days, or <20 working days[5].

The safety and risk screen is completed once a social worker has engaged with the 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 what efforts were made to complete the screen within timeframes, should be recorded thorough an exception case note in the case

[5] The critical response timeframes have changed since this review period and future response timeframes will not include <7 days and <20 days.

management system, CYRAS. There are a number of reasons for such an exception, including because the whānau can't be located or is reluctant to engage in the assessment process, or the Police are already investigating the situation and engagement may put the tamaiti at risk.

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

In all 21 cases, reviewers found evidence of a safety and risk screen in CYRAS.

In 11 out of 21 cases (52%), the screen was completed following engagement with parents or whānau. In four of these cases (19%), engagement was also within timeframes, or an exception case note was recorded.

In 14 out of 21 cases (67%), the screen was completed within the timeframe, or an exception case note recorded. Ten of these cases were completed before parental or whānau engagement had occurred. In one of these cases, reviewers found evidence that the social worker had attempted unsuccessfully to engage parents prior to completing the screen. These findings are consistent with the findings in the previous review period.

Subsequent follow-up with sites in relation to these cases found that in one case engagement with the mother did occur, however wasn't clearly recorded. In the remaining cases, the screens were completed without parent or whānau engagement as it was believed that enough information was known to decide that further assessment was required.

Reviewers observed that completing the screen within timeframe was often being prioritised before engaging whānau and that delays in engagement with whānau were often caused by the length of time it can take to allocate a social worker after a report of concern has been received. It is also clear that working with whānau in these circumstances is a complex area of practice. Successful engagement requires sustained effort which takes into account the context for whānau, their circumstances, any previous experiences of state intervention in their lives and the difficulties in addressing the complex concerns that are raised.

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 made, and sites have been reminded that an exception can be sought if more time is required.

In our last report we noted Oranga Tamariki has introduced new policy requirements around assessment designed to ensure the most appropriate response times to individual circumstances, including a strengthened focus on early engagement with whānau. This review indicates further work is needed to reinforce those policy expectations and support quality practice at these early points of assessment.

A Practice Note to all kaimahi will be issued by the Chief Social Worker to support their understanding of the purpose and function of the safety and risk screen. This will be reinforced in upcoming engagements with all frontline Practice Leaders, and Senior Advisors at the regional level. These engagements will also provide the opportunity to identify insights around whether further changes are needed to the tool itself, and/or the associated policy requirements, in order to strengthen engagement with whānau from the earliest opportunity.

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 hui ā-whānau or a family meeting as part of this next phase of work, to ensure whānau strengths are understood and can be drawn on to create safety for pēpi.

Where a social worker believes, after having completed a core assessment, that pēpi needs care or protection,[6] they are required to make a referral to a care and protection coordinator for a family group conference.[7]

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. Safety planning[8] is used by social workers to create a network of protection around pēpi and their whānau and is required prior to holding a family group conference.

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 means a family group conference will be held before the s78 application wherever possible.

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

A hui ā-whānau or family meeting was held prior to the application for a s78 order in 20 of the 21 cases reviewed (95%). Nine of those hui ā-whānau or family meetings (43%) were held prior to the social worker forming a belief that the pēpi was in need of care and protection in the child and family assessment phase (assessment phase). Holding a hui ā-whānau or family meeting prior to the social worker forming a belief that pēpi is in need of care and protection supports open engagement and whānau participating in this decision.

In one case reviewed (5%), reviewers found no evidence of a hui ā-whānau or family meeting having been held. Further investigation found that the site considered that the significant known safety concerns for pēpi warranted an early decision to refer to a family group conference to create safety for pēpi. The family group conference was held prior to the s78 application.

Of the 10 cases of pēpi Māori reviewed, nine (90%) had a hui ā-whānau or family meeting; four of these (44%) were held prior to making a decision in the assessment phase.

On the basis of these results, engagement with whānau through the use of hui ā-whānau or family meetings prior to making a s78 custody order continues to

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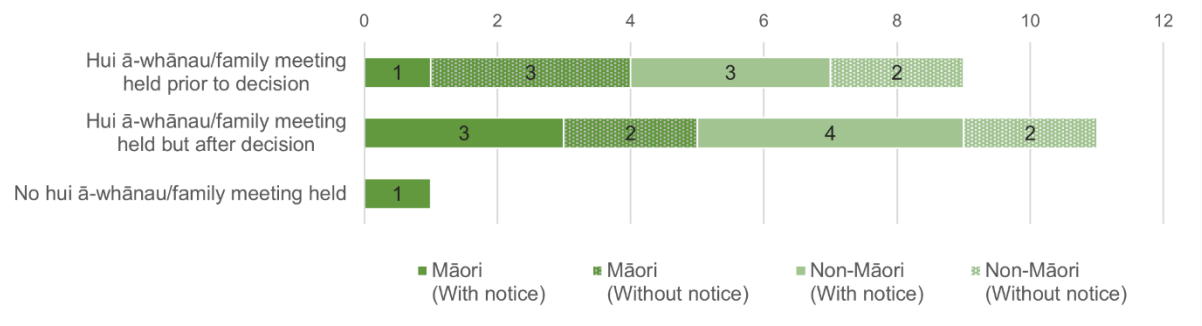
6 As defined by s 14(1) of the Oranga Tamariki Act 1989.
7 Under s 18(1) of the Oranga Tamariki Act 1989.
8 Oranga Tamariki Practice Centre - Safety planning https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/building-safety-around-children-and-young-people/

strengthen. Specifically, over the period covered in this review, a hui ā-whānau or family meeting was held in 95% of cases prior to the s78 application, compared with 82% in the previous review period and less than 25% of cases over the 1 July 2017 to June 2019 period in the Ombudsman's review.

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



A family group conference was held prior to the application for a s78 order in nine cases (43%), and after the application in five cases (24%). In seven cases (33%), there was no record of a family group conference being held within the review period.[9]

These findings indicate that opportunities for earlier whānau-led decision-making through the use of family group conferences have strengthened since the last review, which found a family group conference was held prior to the s78 application in 24% of cases and held after the application in 41% of cases. The percentage of family group conferences being held overall remains consistent with the previous review.

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

[9] The review period covered the time from when the report of concern was made up until four weeks after pēpi entered custody.

Of the 12 cases in which a family group conference was not held prior to the application for the s78 order, 11 cases (92%) recorded rationale for delays including:

- risks to pēpi in delaying the s78 order
- difficulties in contacting or engaging with parents or whānau
- delays related to parent(s)' health or disability, obtaining assessments, or COVID-19 lockdowns, and
- pēpi being delivered early.

COVID-19 has had some impact on the ability to hold family group conferences during this period, including restricting when family group conferences could be safely held through the different alert levels and how many whānau could attend in person. This has placed an unusual level of pressure on sites' capacity to complete family group conferences.

In one case, reviewers could not identify a rationale for the delay. Further investigation into this case found that unsuccessful attempts to engage with parents combined with a high demand for family group conferences had led to this delay.

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. Work is currently underway to update family group conference guidance on the Practice Centre to better align with the new practice framework and support practitioners to strengthen whānau-led decision making and experiences.

Notwithstanding COVID impacts on family group conferences over this period, work is also underway to look at the wider capacity of the family group conference co-ordinator workforce, to better understand the patterns of demand across the country and how to best support timely family group conferences for tamariki and whānau.

Oranga Tamariki has established and grown the number of Kairaranga ā-whānau across the country.[10] Kairaranga ā-whānau play an important role in supporting early engagement with whānau Māori, facilitating hui ā-whānau and enabling more whānau participation in our decision-making process.

Mechanisms to support whānau care

In this section, we investigate how Oranga Tamariki worked with 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 family or whānau, hapū and iwi networks.

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

'Safety planning' is used by social workers to support whānau to create a network of protection around te tamaiti.[11] Effective safety planning can prevent the need for tamariki 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. Māori NGOs often bring different and valuable perspectives, 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 where, based on a comprehensive assessment, the safety of te tamaiti can only be maintained by moving them to a safer care environment. Where 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 family or 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 safety plan and can be used to support family or 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,[12] working with specialists such as kairaranga ā-whānau[13] to complete whakapapa searching[14] and making substantial use of whānau hui 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.[15]

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

The previous review found that while 100% of cases reviewed had safety plans, these were largely developed close to the birth of pēpi and not during the early stages of engaging with parent(s) and whānau. In this review period, reviewers shifted their focus to look at whether safety planning had occurred early in the assessment phase.

In 10 of the 21 cases reviewed (48%), a safety plan was recorded for pēpi in the assessment phase. Parent(s) and/or whānau were involved in safety planning in nine of the 10 cases and professionals were involved in planning in seven of the 10 cases. A safety plan was developed for five of the 10 cases of pēpi Māori, and all five of these involved parent(s) and/or whānau.

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11 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/

12 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/

13 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/

14 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/

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

Of the 11 cases where 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 five cases. In another three 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 one case there was no evidence of safety being built early, however a safety plan was created for the birth. In the remaining two cases, a safety plan hadn't been built early on and the intent was for this to be developed at the family group conference; however, in one of these cases, the conference was delayed and didn't take place within the review period and in the other case, there was a non-agreement at the conference. Further investigation with sites into these two cases showed that actions had been undertaken ahead of the family group conference to build safety and identify whānau carers for pēpi. These findings indicate that safety is being built early on for pēpi however recording of safety plans could be strengthened.

In eight of the ten pēpi Māori cases reviewed (80%), there was evidence that cultural supports were provided to whānau. Further investigation with sites into the remaining two cases found that a kairaranga ā-whānau was involved in intake discussions in one case, and in the remaining case it was not confirmed that pēpi was Māori until after birth and a DNA test had occurred. Of the eight cases in which there was evidence of cultural support, six involved a kairaranga ā-whānau, four involved a marae or iwi-based social service, two a Kaupapa Māori service and one another cultural support. The previous review period found that cultural supports were provided in 69% of cases of pēpi Māori.

There was evidence of whānau searching in the assessment phase in 20 of the 21 cases reviewed (95%). The most frequently evidenced whānau searching involved discussions with whānau to explore identification and narratives of whānau, followed by genograms and chronologies, and involving the kairaranga ā-whānau to assist in searching. The previous review period found evidence of whānau searching in 100% of cases.

Whānau searching was evidenced in nine of the 10 cases of pēpi Māori reviewed (90%). In seven of those 10 cases, a kairaranga ā-whānau or another cultural advisor supported whānau searching.

In the one case where there was no evidence of whānau searching in the assessment phase, whānau searching had occurred previously for the older siblings of pēpi who were already in the care of Oranga Tamariki.

In this review period, reviewers asked an additional question to look at what support services were provided to parent(s) and/or whānau with a focus on preventing removal of pēpi from their care. In 15 out of 21 cases (71%), 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 offered was a residential parenting program in seven cases, followed by community-based social worker support in six cases, iwi or Kaupapa Māori social service in five cases, housing support in five cases, alcohol and/or drug treatment in four cases, family violence interventions in four cases and a range of other bespoke solutions in six cases (including disability support and extra support from health care providers).[16]

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

In five of the six cases in which supports were not provided, supports were either offered and not taken up, whānau provided the care required, or it had already been decided at family group conference that the parents would not retain the care of pēpi. Further investigation with the site into the remaining case revealed that social workers had attempted to engage with the mother directly and through other professionals to discuss concerns and provide supports unsuccessfully.

In 18 of the 21 cases reviewed (86%), initial plans for care arrangements were to support the parent(s) and/or whānau to care for pēpi. In the remaining three cases (14%), an early decision was made that pēpi would not be cared for by parent(s) and/or whānau. In one of these three cases, an early decision was made with whānau that pēpi would be cared for by non-whānau caregivers already caring for the older siblings of pēpi. In the other two cases, reviewers did not find evidence of plans for pēpi to be cared for by parent(s) and/or whānau prior to the s78 application. Further investigation with sites into these two cases found that in one case, the mother refused to engage and acknowledge concerns which prevented them from developing a safety plan to support pēpi remaining in her care and in the remaining case, the initial plans were for mum to care for pēpi with support from professionals.

At the time the s78 order was made, 13 out of 21 pēpi (62%) remained in the care of parent(s) and/or whānau. This compares with 53% in the previous review period.

In eight cases (two of whom were pēpi Māori), pēpi was initially placed with non-kin caregivers. In six of these cases, this was done with the agreement of whānau; in two cases, this was an Oranga Tamariki-led decision. In both of these cases, the agreed safety plan for pēpi had broken down and there were no whānau placements available.

At the time of writing this report, 13 pēpi were in parent(s) and/or whānau care (62%) (seven of whom are pēpi Māori), one pēpi remained with non-kin caregivers with their older siblings (5%), and seven pēpi were placed with non-kin caregivers (33%).

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 are designed to ensure that wherever possible all 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 who do need to be removed from their parents' care and providing support to those parents to enable tamariki to be returned to their care.

Guidance in strengthening our response to unborn and new-born pēpi has been updated. It strongly emphasises a rights-based approach to whānau, hapū, iwi and family groups being supported to care for pēpi so that any intervention is the minimum necessary to ensure safety and protection of pēpi. The mother's vulnerability and parents' own potential trauma histories are emphasised for consideration in our assessment and support needs offered.

Guidance has also been updated on the Practice Centre when urgent action is needed to secure the safety of pēpi, tamariki and rangatahi. The guidance supports kaimahi to ensure that alternatives to entry to care are explored fully and all possible means of supporting the pēpi, tamaiti or rangatahi to live safely with their parents or whānau are explored.

Supporting parents with disabilities

In this section, we investigate support and advocacy for parents with disabilities 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.

The Ombudsman's report identified Oranga Tamariki had a lack of adequate practice guidance and policy to support parents with disabilities and needed to work in partnership with the disability sector to take a disability rights lens to develop new guidance.

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

In this review period, reviewers expanded the definition of disability to a psycho-social definition that includes addiction or mental health impairment. This was in response to recommendations made by the Ombudsman and subsequent changes to Oranga Tamariki guidance on strengthening their response to working with unborn and newborn pēpi where the parent(s) have a disability. Using this psycho-social definition, the mother of pēpi had a known disability in 13 of the 21 cases reviewed (62%), and the father of pēpi had a known disability in seven of the 21 cases reviewed (33%). Of the 20 cases in which a known parental disability (mother and/or father) was identified, there was evidence that action was taken to address those needs or that existing supports were in place in 16 cases (80%), though in two of these cases the parent declined support.

Focusing on the smaller subset of parents who were eligible for Ministry of Health disability-related services (physical, intellectual, or sensory disability), the report of concern or assessment identified parenting needs associated with the cognitive functioning of the mother of pēpi in five of the 21 cases (24%) and with the cognitive functioning of the father of pēpi in three cases (14%). No reviewed cases identified physical or sensory disability needs.

In six of the eight parents where the report of concern or assessment identified parenting needs associated with their cognitive functioning, there was evidence that action was taken to address those needs or that existing supports were in place. In three of these cases, advocacy support was also sought. The previous review identified that advocacy support was put in place to support all mothers for whom a parenting need associated with cognitive functioning was identified, however there was no evidence regarding engaging those mothers with disability supports to support their parenting need. Further monitoring is required before drawing any firm conclusions regarding practice change in this area.

In all cases in which there were parenting needs associated with the cognitive functioning of the mother and/or father of pēpi, there were additional care and protection concerns and cognitive disability was not the sole reason for the s78 application. The additional care and protection concerns included family violence, substance abuse, neglect, sexual harm, transience, and unsafe living environments.

Further strengthening practice

As part of work to embed its new Practice Framework, Oranga Tamariki has engaged with disabled people's organisations, VOYCE Whakarongo Mai and its own practice Expert Advisory Group about ensuring disability-aware, inclusive, and rights-based practice is undertaken. This work is continuing.

New guidance on Oranga Tamariki response to unborn and new-born pēpi came into effect in August 2021 and includes content on:

- the rights of disabled parents and pēpi to an ordinary family life and to create and maintain families
- the need for assessments and plans to consider the parents' strengths and how these can be developed in their parenting role, and how their disability needs are being met or could be met
- the need to work with disability, mental health, and addiction services to share appropriate information and develop joint plans that address the safety needs of both pēpi and the parents
- when parents are not engaged with specialist services, and Oranga Tamariki believe that a referral is required, the need to talk to the lead maternity carer and agree next steps with the consent of the parents.

Future review work will consider practice against these new guidelines.

Work is underway on the Practice Centre to bring together rights-based disability guidance and information into one space to support and enable easier access for kaimahi.

In February 2022, Oranga Tamariki leadership approved the development of a disability strategy and the establishment of a cross-sector disability advisory group to inform the strategy and work plan. Wider work across government to transform the health and disability sector is also key to improving access to support for parents with disabilities.

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 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 as well as 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 co-ordinators are also required to consult with their site's CPRP when they have received 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 the 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

[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/

without notice custody order, Oranga Tamariki policy was amended to require that all s78 without notice applications be approved by the Site Manager, and the decision be endorsed by the site's Practice Leader and the Regional Litigation Manager, before they can be filed.

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

The Child and Family Consult

In this review period, the focus was extended to not only look at whether a child and family consult occurred in the assessment and/or intervention phases of work to support decision-making and next steps, but also whether one was held to support decision-making around the s78 application itself.

In 19 of the 21 cases reviewed (90%), there was evidence that a child and family consult had been used in the assessment and/or intervention phases to support decision-making and next steps. This compares with 88% of cases in the previous review and only 30% of cases reviewed by the Ombudsman covering the 1 July 2017 – 30 June 2019 period. This indicates that progress previously made to strengthen practice in this area has been maintained.

In 13 of the cases reviewed (62%), a child and family consult was used to support the decision to apply for the s78 order. Whilst in eight cases (38%) there was no evidence of a consult to support the decision itself, in most of these cases a previous consult had occurred.

Care and Protection Resource Panels

In 17 of the 21 cases reviewed (81%), reviewers found evidence that the site's CPRP had been consulted during the assessment phase (eight of these cases were for pēpi Māori). In eight of the 17 cases in which consultation occurred, it occurred in a timely manner.

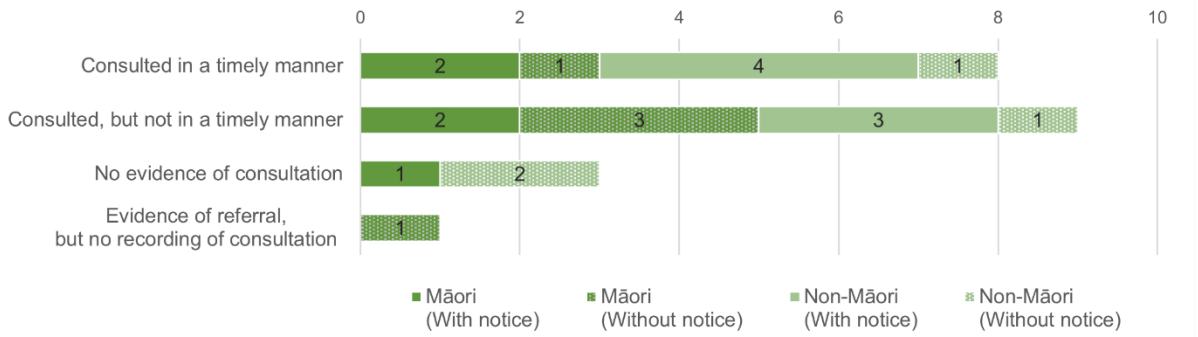
In three of the 21 cases (14%), there was no evidence of consultation; in one case (5%), there was evidence of referral to the CPRP but no recording of the consultation. Further investigation with sites into the cases where there was no evidence of consultation found that in two cases consultation had occurred and there was an administrative error in recording, in one case the site's CPRP was unable to reach a quorum due to COVID impacts and in the remaining case, no evidence was found.

Whilst the timeliness of consultation could be strengthened, these findings show a positive increase in the use of CPRP by social workers since the previous review period and the Ombudsman's review (which found social workers had consulted the CPRP in 59% and 30% of cases respectively).

Of the 14 cases in which a family group conference was held within the review period, reviewers found evidence of CPRP consultation by the Care and Protection FGC Co-ordinator prior to the family group conference in six cases (43%) and no evidence of consultation in the remaining eight cases (57%). Further investigation with sites into these cases identified an acknowledgement of some challenges in this area, including difficulties forming a CPRP quorum and adherence to / awareness of processes around referrals to the CPRP. These findings are consistent with the previous review period and indicate further work is required to better understand and

explore how this mechanism could be fully utilised to support robust decision-making.

Figure 7: Consultation with Care and Protection Resource Panel by social worker



Supervision

In this review period, reviewers expanded the focus to look at supervision in both the assessment and intervention phases. Of the 21 cases reviewed, there was evidence of supervision between the social worker and the supervisor in the assessment phase in ten cases (48%). The previous review period found evidence of supervision occurring in the assessment phase in 24% of cases, indicating practice in this area has improved.

Reviewers found evidence of supervision in the intervention phase in 13 cases (62%). Reviewers found no evidence of supervision in either the assessment or intervention phase in five cases (24%). We were not able to review whether social workers were receiving professional supervision over this period, as this form of supervision is not recorded in CYRAS.

Working in partnership

In 19 of the 21 cases reviewed (90%), other professionals were consulted to inform the assessment phase. This compares with a finding of 100% in the previous review period.

Further investigation into the two cases where reviewers did not find evidence of consultation found that in one case most of the assessment work was undertaken in the intervention phase where consultation with professionals occurred and in the remaining case the mother had refused professional involvement. Most consultation occurred with midwives or maternity professionals, followed by Police and parenting or family support service professionals. Of the 10 cases of pēpi Māori, iwi social services or marae-based services were consulted in the assessment phase in three cases (30%). As reported above, professionals were involved in seven of the 10 safety plans created.

In regard to the extent to which whānau had the opportunity to be heard in the Family Court, 12 of the 21 s78 applications (57%) were made on a *with notice* basis and nine (43%) were made *without notice*. Five of the 12 *with notice* applications (42%) and five of the nine *without notice* applications (56%) were for pēpi Māori.

The previous review period found 35% of s78 applications were made *without notice*. However, overall, there continues to be a significant downwards practice shift in the

use of *without notice* s78 applications for pēpi – over the period reviewed by the Ombudsman, almost all s78 orders were sought on a *without notice* basis.

Oversight of without notice custody applications

In eight of the nine cases of *without notice* s78 applications (89%), the required approval had been granted by the Site Manager and endorsed by the Practice Leader and Regional Litigation Manager. In the remaining case, approval had been granted by the Site Manager and endorsed by the Practice Leader but not by the Regional Litigation Manager. Further investigation found this s78 order was never executed and was discharged in court. Remedial action has been undertaken with the site to ensure that the approval process is fully understood.

Further strengthening practice

Supervision is a key focus area for Oranga Tamariki. The Oranga Tamariki Future Direction Plan released in September 2021 commits to working with the Social Workers Registration Board to introduce micro-credentialing for supervision and other specialist areas, to recognise the skills and knowledge that are required by supervisors and other specialist roles. This is aimed at enhancing the capability of practitioners to in turn enhance the mana of tamariki and whānau they work with.

An initiative to enhance the capability of supervisors and strengthen supervision practice was to shift the focus of the Supervisor Development programme in Oranga Tamariki to ensure supervisors are receiving training in bicultural supervision. Working in partnership with Te Wānanga o Aotearoa, Oranga Tamariki piloted the Kaitiakitanga Bicultural Supervision Post Graduate Diploma. The pilot programme was successfully completed in 2021. Review of the programme is currently in progress.

As part of its Practice Programme, Oranga Tamariki is developing a new tangata whenua and bicultural model of supervision for all kaimahi (informed by a supervision survey undertaken by Oranga Tamariki practitioners in 2021). The model will be trialled with selected sites in 2022 to identify the ways in which it can support improvement in supervisory practices, for both supervisors and supervisees.

Oranga Tamariki is continuing work alongside key stakeholders to update guidance regarding Care and Protection Resource Panels to align with the Oranga Tamariki practice direction and wider legislative context.

Individual follow-up has occurred with sites around the statutory requirement for Co-ordinators to consult the CPRP prior to a family group conference, and is also occurring with the relevant FGC Team Leaders. Findings from the review will also be shared with the FGC Team Leader network to ensure the purpose and importance of consultation with the CPRP is well understood. This will provide an opportunity to understand any barriers to practice in this area and explore how this mechanism could be more fully utilised to support robust decision-making.

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?

Thirteen out of 21 pēpi (62%) remained in the care of parent(s) and/or whānau following the s78 order being made (80% of these were pēpi Māori). In five of the 13 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 the other eight cases, the decision was based on shared concerns held by both whānau and Oranga Tamariki. In the majority of cases where 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) would not adhere to the safety plan in place for pēpi.

In the eight cases (38%) 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 seven cases. In one case, pēpi entered care under a s139 agreement before the s78 application was made. The previous review period found that 41% of pēpi were removed from the care of parent(s) and/or whānau.

Of the seven 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 six cases. In the remaining case, there was no evidence of a plan on CYRAS. In this case, a residential placement for the mother and pēpi was being sought even after birth. When a placement was unable to be located, the decision was made for pēpi to be placed with caregivers.

Of the six cases in which a plan was established in advance, the plan had been made by Oranga Tamariki with whānau and other professionals in four cases, and with professionals only in the remaining two.

In five of the seven cases (71%), 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, although the mother of pēpi was caring for pēpi in hospital prior to the separation. In the remaining case, reviewers found no evidence on CYRAS that special time had been provided to parent(s) and whānau. Further investigation

into this case revealed that social workers were unable to safely facilitate pēpi coming into care and Police were involved.

Findings indicate that practice in this area has remained largely consistent with the previous review period.

In seven of the eight cases (88%)[18] in which pēpi were separated from their parent(s) and whānau, reviewers found evidence that support(s) were offered to parent(s) and whānau or that supports were already in place. In the remaining case, no evidence was found that supports were offered to parent(s) and whānau to help them to deal with the separation from pēpi. Reviewers noted that pēpi was returned to their mother's care five days after the removal. These findings indicate a significant practice improvement in this area, with the previous review period finding evidence of supports offered in only 13% of cases.

Further strengthening practice

New guidance was developed in August 2021 that underlines the importance of ensuring parent(s) and whānau have special time with their pēpi where pēpi is going to be removed from their care and the importance of recording these events in the record for the pēpi. We are also reviewing our recording policy to ensure it is clear that the circumstances surrounding the removal of pēpi are case noted on CYRAS. Future review work will consider practice against this new guidance.

Oranga Tamariki has a memorandum of understanding (MOU) between Police and District Health Boards. A new schedule has been developed under this MOU called *Schedule 5 Ensuring the safety and wellbeing of unborn and newborn pēpi in health settings.* This schedule requires Oranga Tamariki as te Tiriti partners 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. This schedule was completed in March 2022 and work is underway to support health, Police and Oranga Tamariki to begin 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 for the period of review recommended that any considerations about feeding need to be discussed with the mother and anyone else who has guardianship. All efforts should be made to ensure breastfeeding can happen if this is the mother's wish and is safe for pēpi.

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 FGC plan or Family Court plan.

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

During this review period, reviewers changed their focus slightly to look at whether there was evidence that discussions had taken place with the mother of pēpi about her wishes in regard to breastfeeding.

[18] This includes the one pēpi whom initially entered care under a s139 agreement.

Of the 16 cases where pēpi did not stay in the care of their mother, there was evidence in eight cases (50%) that the mother's wishes in regard to breastfeeding pēpi were discussed. Of these eight cases, five mothers expressed they did not wish to breastfeed, and three mothers expressed they did wish to breastfeed.

In a further three cases, although there was no evidence of a discussion taking place, reviewers found evidence that pēpi was being breastfed by the mother. In another case, reviewers found evidence that a discussion about breastfeeding was held with whānau, but not with mother. In the remaining four cases, reviewers found no evidence of a discussion. These findings indicate that recording around mothers' wishes and plans to breastfeed is inconsistent.

Of the six cases in which pēpi was being breastfed, in four cases (67%) reviewers found evidence that supports were provided to enable this to occur. In one case, supports were not put in place due to concerns that the breast milk was not safe due to substance abuse. In the remaining case, it is unclear from recording if supports were put in place. The previous review identified that, in all 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 information about the mother's intention to breastfeed. Given the small numbers and inconsistent nature of recording in this area, further monitoring is required before drawing firm conclusions about practice shifts.

Reviewers expanded questions in this review period to explore opportunities for pēpi to bond where the mother did not wish or was unable to breastfeed. In all cases where the mother of pēpi did not wish or was unable to breastfeed, reviewers found evidence that there were opportunities provided for skin-to-skin contact, bonding and attachment to occur.

Further strengthening practice

Breastfeeding guidance was updated in May 2021. The guidance is rights-based and emphasises the importance of the concept of ūkaipō which refers to the physical, spiritual and emotional nurturing of pēpi. Further investigation to better understand practice alignment with the new guidance will be included in the next case-file review of s78 custody orders for unborn and new-born pēpi.

The Minister for Children has announced the Future Direction Plan which outlines the Minister's priorities and how Oranga Tamariki need to better engage with communities and whānau. A core part of this is identifying whānau-centred support for parents who are not in a position to provide long-term care for their children. As we move through the Future Direction Plan, we will continue to find new and innovative ways to do this.

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 identified through the review and sharing insights with operational leadership.

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

The next public report will cover practice over the 12-month period between 1 September 2021 and 31 August 2022, and will be published in early 2023.