ORANGA TAMARIKI
Ministry for Children

New Zealand Government

Ko te huarahi pono, ka wātea, kia whakamarama, kia whakatika

The correct path in clearing, to understand and make right

Oranga Tamariki Leadership Team – Te Riu

Responding to the Chief Social Worker Practice Review
A review of the practice in relation to Malachi Subecz and his whānau

November 2022

Contents

Foreword

Tēnā koutou katoa ngā kaipānui o ta mātau whakautu ki te rīpoata a te Tumu Tauwhiro. Tēnā anō koutou i runga ake i ngā tini āhuatanga katoa o te wā.

Otira, e tika ki a mihia te hunga mate me te kī anō, waihohia rātau te hunga mate ki a rātau whanga mai i te ao wairua. Ka hoki mai ki a tātau te hunga ora, no reira tēnā koutou, tēnā koutou, tēnā tātau katoa.

To all the people who will consider our response to the Chief Social Worker's report, you are acknowledged. I also acknowledge you all and the many challenges that we face. In the end, it is appropriate that we must always acknowledge they who have passed and in the same way say let them remain and await us, in the world of spirits.

To those of us who remain in the world of the living, I acknowledge you all, I acknowledge you all, I acknowledge us all.

Words are inadequate to acknowledge the grief and loss experienced by Malachi's extended family, whānau and the hapū and iwi to which he belongs. Malachi was part of a whānau who loved him deeply and did all that we would ask any whānau to do, to ensure he was safe and well cared for and to raise the alarm when they were worried about his safety and wellbeing. Yet tragically, Malachi has become another child who has died at the hands of someone who was caring for him, where clear opportunities to prevent this from occurring were missed.

The significance of Malachi's whakapapa connections to the iwi of Ngāi Tahu, Nga Puhi and Te Arawa is not lost on us. Neither are the renewed calls from Māori communities that Oranga Tamariki continues to fall short in addressing the factors that result in tamariki Māori experiencing greater rates of harm than their peers.

Oranga Tamariki is part of a wider system that includes the community and our government partners. Alongside the Chief Social Worker's review, we also welcome the broader findings of the Systems Review *Ensuring strong and effective safety nets to prevent abuse of children* completed by Dame Karen Poutasi. We will take every opportunity to act collectively with our partners to drive our shared responsibility to protect all tamariki and support their whānau.

It is clear, through the work by the Chief Social Worker, that when concerns were reported to Oranga Tamariki these should have been acted on. Had they been, Malachi would have been seen and the safety of the care he was receiving from Michaela Barriball would have been assessed. This did not happen, and this represents a significant failure by Oranga Tamariki to Malachi and those who loved him.

Malachi passed away a year ago, we acknowledge it has taken us too long to fully understand our involvement in Malachi's short life. Since this review was commissioned, it was necessary and appropriate for the Chief Social Worker to take

the time needed to engage fully with Malachi's whānau and to build a detailed understanding of what occurred. Nevertheless, Malachi, his whānau and the public were entitled to expect that Oranga Tamariki would have acted more quickly and comprehensively to review our response to Malachi at the time we became aware of his passing. We should have initiated the Chief Social Worker's review much sooner.

Malachi's whānau shared their story in the hope that it would be a catalyst for change for 'other Malachi's who are out there in the world'. Ultimately, as a leadership team we are responsible for preventing mistakes such as those which happened in our involvement with Malachi. We take this responsibility seriously and commit to the actions set out in this response.

What the review found and what we will do

The Chief Social Worker found that there were significant failures in the Oranga Tamariki response to Malachi and his whānau. We agree that:

Members of Malachi's whānau made repeated, sincere, and considered efforts to raise their concerns about the care, safety, and wellbeing of Malachi. The Oranga Tamariki response to these concerns was inadequate.

We agree that:

- Concerns reported to Oranga Tamariki about Malachi should have resulted in a decision to undertake a comprehensive assessment of his care
- The supporting environment for social work staff within the Te Āhuru Mōwai site contributed directly to the quality of practice decision making
- Strengthened professional development, supervision, practice guidance, and interagency approaches are necessary to support social workers to consistently recognise and respond to the complex needs of tamariki and whānau
- Malachi and his whānau would have benefited from a more collaborative system of response to their Reports of Concern from Oranga Tamariki, their community and other agencies, which had a clear focus on preventing harm.

We have taken immediate steps, in response and have:

- Engaged with Malachi's whānau and extended whānau and apologised for our failings. We acknowledge apology and redress is an ongoing process and there will be further engagement with all whānau.
- Addressed the decisions and actions taken by Oranga Tamariki staff in response to reported concerns
- Directed that only social workers with more than 12 months experience, as a registered and practicing social worker, have the sole responsibility for completing initial assessments. This will be regularly monitored across all sites and any concerns immediately addressed.
- Deployed additional senior leaders and practitioners to Te Āhuru Mōwai site to support and strengthen decision making and practice on that site
- Reached an in-principle agreement with NZ Police the Ministry of Health and Te Whatu Ora – Health New Zealand to include a clear role for health in the Child Protection Protocol
- With Police, completed a recent review and strengthened the Child Protection Protocol, in particular the need for early consultation to determine whether reported concerns meet the threshold for joint investigation.
- Confirmed that all sites have completed the annual Child Protection Protocol joint training with Police.

Addressing the harm that has been caused

Our first responsibility is to Malachi and his whānau. We join our Chief Executive in offering our unreserved apology to them, and Malachi's hapū and iwi, for our failure to fully understand and act on their concerns which were repeatedly shared with Oranga Tamariki and others.

The Chief Executive has begun a process of engagement with whānau members, and members of Malachi's hapū and iwi, thanking them for telling their story and expressing our regret for failing to act on the concerns reported about Malachi and failing them

The apologies are the beginning of our accountability to Malachi, his whānau and iwi. They are the beginning of a process of redress which we hope in time will offer some small measure of healing and restoration.

Practice decision making

Concerns reported to Oranga Tamariki about Malachi should have resulted in a decision to undertake a comprehensive assessment of the care he was receiving

The Chief Social Worker has identified critical failures in our core practice, as described in the eight Oranga Tamariki Practice standards[1], which resulted in no action being taken to assess the safety of the care of Malachi despite concerns being raised about his safety and wellbeing. It is vital that the public can be confident in the systems and processes which are in place to respond to reports of concern, that they are operating as intended, and resulting in decisions which keep children safe and support their whānau.

In response we have:

1.1. Addressed the decisions and actions of Oranga Tamariki staff with regards to Malachi, with a particular focus on management and leadership accountability, recognising that the social worker who undertook the initial assessment should not have been put in a position of responsibility beyond their experience.

1.2. Provided all senior managers with a letter of expectation from the Chief Executive that requires them to:

- Ensure that only social workers with more than 12 months experience, as a registered and practicing social worker, have the sole responsibility for completing initial assessments
- Reinforce that the practice standards are the core requirements and minimum expectations for practice, and that it is their responsibility to ensure that:
  - All staff understand this
  - The standards are well understood by their staff
  - They regularly review practice to understand the extent to which standards are being met
  - Regular feedback is provided to staff about their practice, and action is taken, including additional support, development, and oversight, where it is identified that the standards are not being met
  - They are actively managing and addressing systemic issues that may prevent social workers from being able to meet the standards

[1] Practice standards | Practice Centre | Oranga Tamariki

- They immediately escalate any concerns which may be impacting on the quality of our response to tamariki and whānau when these are unable to be resolved locally

1.3. Reminded all staff of the channels to raise any concerns they have that are impacting on their ability to perform their role. This includes raising any concerns directly with their line manager in the first instance, and/or confidentially via the Oranga Tamariki Speak Up channel if appropriate.

1.4. Issued a practice note from the Chief Social Worker reminding all social workers, supervisors, and practice staff that the practice standards are the minimum expectations, with a particular focus on case recording requirements

1.5. Established regular social work forums for all social work staff to engage directly with the Chief Social Worker and other senior social work leaders on issues which may be impacting their ability to meet core practice expectations.

Within the next six months we will:

1.6. Finalise the assessment of all recent reports of concern at the Te Āhuru Mōwai site in the last three months where the initial assessment did not result in further action; take any remedial actions required

1.7. Review our practice in response to reports of concern across the country and act on any findings and recommendations to strengthen practice

1.8. Ensure all social workers employed by Oranga Tamariki for less than 12 months have completed the current practice induction and are being actively supported to only undertake duties consistent with their level of experience

1.9. Progress developing an accountability and reporting mechanism that will give social workers, supervisors, and managers greater visibility about the extent to which practice standards are being met across their practice

1.10. Ensure Practice leaders review a sample of cases with their staff, using the Quality Practice Tool[2] and report on the extent to which there is evidence that the expected standards are being met

1.11. Review and update performance development and performance review tools and processes for social work practitioners and managers to ensure the practice standards are well embedded, enabling the provision of development support and appropriate responses when they are not met.

[2] A tool to provide insights into quality of practice using a structured set of questions.

Site environment, support, and leadership

The supporting environment for social work staff within the Te Āhuru Mōwai site contributed directly to the quality of practice decision making regarding Malachi

The Chief Social Worker has reached clear conclusions that factors within the site and region such as workload, management practices, leadership, culture, and stakeholder relationships directly impacted on the quality of practice in our response to Malachi and that social workers considered these to be having a broader impact on their ability to meet their core practice expectations. Leaders across the organisation have a responsibility to recognise and act when such factors may be impacting on practice.

In response we have:

2.1. Deployed senior social workers, a manager, practice leader and national practice advisor to the Te Āhuru Mōwai site to strengthen site leadership and support practice decision making

Within the next six months we will:

2.2. Complete work already underway to analyse critical workforce, practice, and work management measures across all sites to identify whether there are other sites with indicators of practice and management concern warranting further examination and intervention.

2.3. Implement a comprehensive plan for the Bay of Plenty region that addresses the broader workload, leadership, development, stakeholder, practice, and culture issues identified in the review

2.4. As part of the Future Direction Plan work to develop an operating model, identify early opportunities to free up social work capacity through consideration of paraprofessional roles, reallocation of tasks, centralised approaches to non-core social work and removing no longer required policy expectations.

Practice guidance, professional development, and interagency processes

Strengthened professional development, supervision, practice guidance, and interagency approaches are necessary to support social workers to consistently recognise and respond to the complex needs of tamariki and whānau

The Chief Social Worker's Review found that some practice guidance had not kept pace with changes to legislation in 2019 and that an urgent revision of some aspects was needed. A focus on the appropriate professional development, interagency processes and supervision was also needed to support the complex nature of child protection decision making. Responding appropriately to complaints from whānau and taking action to understand the quality of our practice were also features of the review.

In response we have:

3.1. With Police, completed a recent review and strengthened the Child Protection Protocol[3] in particular, the need for early consultation to determine whether reported concerns meet the threshold for joint investigation

3.2. Confirmed that all sites have completed the annual Child Protection Protocol joint training with Police

3.3. Reached in principle agreement with the Police Commissioner, Ministry of Health, and Te Whatu Ora - Health New Zealand to include a clear role for health in the Child Protection Protocol to assist in identifying and determining evidence of child abuse and neglect

3.4. Commenced a review of existing complaints processes and policies with a view to determining which complaints require a site, regional or national response.

Within the next six months we will:

3.5. Review existing policy and guidance to ensure there is clear direction about the recording and assessment of photographs and other 'additional information' received following an initial report of concern

3.6. Review the quality of investigations undertaken subject to the Child Protection Protocol, and act on findings and recommendations to strengthen practice, including sharing any learnings with Police

[3] child-protection-protocol-joint-operating-procedures-dec2021.pdf (orangatamariki.govt.nz)

3.7. Commence a range of supervision initiatives that will significantly enhance the quality of supervision social workers receive and the capacity of supervisors to provide quality supervision

3.8. In early 2023 launch the new Puawai (required practice induction for all Social Workers) and Leaders in Practice professional development programme, and develop additional learning resources for all practice staff, ensuring that the critical learning needs identified in the review are embedded within the core curriculum

3.9. Review and improve the graduate pathway for prospective and new social workers that includes the current supported practice step programme[4]

3.10. Refresh information about our complaints process on our website, in our offices and in a form which can be given to whānau to make it easier for them to understand their right to complain and what to expect when they do

3.11. Undertake a training session with all managers on the current Oranga Tamariki complaints process aimed at improving the way complaints are recognised and responded to

3.12. Review and update how we respond to serious events to ensure we move quickly to understand, review, and assess the quality and appropriateness of our practice.

[4] Supporting new graduates into their first statutory social work role where they are identified as emerging practitioners and have additional support for at least six months.

The wider community and system: a need for local and connected responses

Malachi and his whānau would have benefited from a more collaborative system of response to their Reports of Concern from Oranga Tamariki, their community and other agencies, which had a clear focus on preventing harm

The Chief Social Worker's reinforces the need for a fundamental reimagining of how we respond to reports of concern, with a particular emphasis on greater engagement with whānau, collaborative decision making with partners and the provision of early support to meet whānau need and prevent harm to tamariki. This approach is underway in some areas and work will continue to be taken forward as part of the Future Direction Plan, however, some more immediate steps can be taken.

We recognise the important of ensuring we are progressing work to respond to the Systems Review '*Ensuring strong and effective safety nets to prevent abuse of children'.*

We will proactively engage with all agencies regarding the recommendations in that review and progress, with agencies, a review of the Children's Act to give effect to the Chief Social Worker's recommendation.

In response we have:

4.1. Made immediate changes to guidance[5] regarding the degree to which engagement with tamariki, whānau and others can occur as part of the initial assessment in line with 2019 legislation changes.

Within the next six months we will:

4.2. Review the existing Decision Response Tools[6], that guide how we respond to Reports of Concern, associated practice guidance and policy to ensure they are consistent with legislation and best practice expectations. Including clearer guidance about our response to tamariki who are incarcerated, and how concerns are reported about their safety, wellbeing, and care.

4.3. Engage with partner agencies regarding the Chief Social Worker's recommendation to consider a review of the effectiveness of the Children's Act 2014 in clarifying the responsibilities of children's agencies. Such engagement would occur alongside the consideration of recommendations arising from the Systems Review.

[5] Initial assessment phase | Practice Centre | Oranga Tamariki
[6] Overview of the intake decision response tool | Practice Centre | Oranga Tamariki

Alignment to our Future Direction

The review confirms the Direction set by Te Kahu Aroha and our Future Direction Plan

Preventing what occurred for Malachi and his whānau, aligns to the core recommendations at the heart of the Ministerial Advisory Board's report *Hipokingia ki te Kahu Aroha Hipokingia ki te katoa.* These were:

- To lead prevention of harm to tamariki and their whānau, collective Māori and community responsibility and authority must be strengthened and restored
- To work collaboratively with Māori, community organisations and other government agencies, the purpose of Oranga Tamariki must be clarified.

In 2021, Oranga Tamariki developed a Future Direction Plan in response to these recommendations which includes actions and the need for:

- fundamental changes in how we respond to reports of concern and how we share decision making with partners
- clear processes to ensure that tamariki and whānau are heard and their concerns acted on, including when they make a complaint
- increased support for the social work workforce, particularly those who are new to the profession and to Oranga Tamariki.

Fundamental changes in responding to reports of concern

How we respond when concerns first emerge about a child is a fundamental decision that has a lifelong impact on their safety and the wellbeing of their whānau. The Chief Social Worker Practice Review reinforces the need for a complete reimagining of how these decisions are made and by who, including accelerating the role of partners in shared decision making and clarifying the role of Oranga Tamariki within both the National Contact Centre and in our sites.

Through the Future Direction Plan we are:

- Developing an operating model that drives locally led, centrally enabled ways of working and ensure the operating model allows the agency to invest more resources and staff into early support
- Making a greater investment in partners with a particular focus on early support and invite and resource communities to work alongside Oranga Tamariki in the care and protection system
- Fundamentally shifting how we assess and respond to reports of concern with our partner agencies to ensure collaborative decision-making and support at the

earliest possible point and to ensure the safety and wellbeing of tamariki and whānau based on best practice.

Hearing and acting on Tamariki and Whānau concerns

Ensuring the voices of tamariki and whanau continue to be at centre of our practice and decision making. and there are trusted channels available to whānau to hold us to account.

Through the Future Direction Plan we are:

- Placing the voices of tamariki and rangatahi at the centre of decision-making at all levels and support tamariki and whānau to participate in and be central to decision-making
- Strengthening the feedback and complaints system to ensure that tamariki, rangatahi and their whānau have their voices heard and have confidence in the process.

Workforce Development and capacity, particularly for new social workers

A well supported, professional workforce is needed to ensure tamariki and whānau get the skilled and effective support they deserve. We must also ensure new social workers receive the support they need to ensure they are prepared for this complex work.

Through the Future Direction Plan we are:

- Developing a workforce strategy that will support high quality social work and invest in the capability of leaders (especially frontline leaders) to ensure shifts to practice and culture take place
- Working with the Social Workers Registration Board on supervision and other specialist areas, which recognises the skills and knowledge that are required by supervisors and other specialist roles
- Developing a three-month post-degree professional practice course, partnering with tertiary providers
- Developing a model to inform allocation and resourcing decisions at a regional and national level
- Investing in the capability of leaders (especially frontline leaders) to ensure shifts to practice and culture take place.

Holding ourselves to account

We expect to be held to account for the actions we take in response

It is important we demonstrate accountability to Malachi and his whānau, the hapū and iwi to which he belongs, to the public and to our key monitoring partners. We will do this by:

- Regularly engaging with Malachi's whānau and the iwi to which he belonged, to the extent they wish, on what we have done in response to the lessons we have learned from Malachi's short life
- Inviting regular assurance and feedback from the Oranga Tamariki Ministerial Advisory Board, alongside their oversight of our implementation of the Future Direction Plan and their quarterly assurance reporting to the Minister for Children
- Providing regular reports to the Ombudsman and Office of the Children's Commissioner on progress against the actions we are taking
- Publishing regular updates on the Oranga Tamariki website against the actions we have committed to and our progress against these.