ORANGA TAMARIKI
Ministry for Children

New Zealand Government

# Safety of Children in Care

Annual Report July 2019 to June 2020

# Acknowledgements

## Authors

Safety of Children in Care Unit
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## Acknowledgements

This report reflects the work undertaken across Oranga Tamariki to keep children in care safe and free from harm. We would like to acknowledge the children and young people whose voices remain strong in this space and who provide a constant reminder to us all of the importance of honest and challenging conversation to provide the best for them. We also wish to acknowledge the work of individual practitioners in supporting children to raise concerns and in addressing them once raised.

## Disclaimer

We seek to tell the children's stories in a way that reflects what is known without disrespecting their right to privacy.

## Publication status

Due for publication

# Contents

# Introduction

When children come into care Oranga Tamariki is responsible for providing them with stable and secure placements and ensuring they are safe. Children come into care for a wide range of reasons, including neglect, abuse, family violence, and household drug and alcohol abuse.

The evidence tells us that children who have suffered abuse and neglect are at greater risk of experiencing further harm.

The Safety of Children in Care Unit was established in 2018 to enable us to better understand and prevent harm to children in care.

The Unit and its regular reporting is one aspect of a demonstrated commitment to openness and continuous improvement to ensure the safety of all tamariki.

All of the children and young people reported on in this report have had their allegations of harm investigated and followed up, and their plans reviewed to strengthen care arrangements and provide for their safety.

The insights provided by the data in this report have enabled us to put in place a number of changes to better support tamariki, rangatahi, whānau and caregivers.

# Guide to the Annual Report

This report provides detailed information relating to:

- the overall number of individual children who have experienced harm
- the number of individual children who have had more than one finding of harm in the past 12 months
- the number of individual children who have experienced each type of harm
- the number of findings of each type of harm experienced
- where the child was living when the harm occurred
- whether the harm occurred inside or outside the placement
- who is alleged to have caused the harm
- the number of people who are alleged to have caused more than one finding of harm in the period
- the key characteristics of the people who are alleged to have caused the harm.

Harm is defined as an action or inaction that meets the definition of the four abuse types: neglect, emotional abuse, physical abuse and sexual abuse (as described in the report).

The level of detail in this report is based on a desire to be open and transparent while protecting the privacy of those affected by the harm.

We have not provided detail of circumstances that relate to less than five children or adults – this is in line with accepted ethical standards adopted in comparable studies and prevents the risk of identification or self-identification.

We have provided descriptive scenarios to illustrate clusters of harmful behaviour. These are composite summaries made up of the predominant factors present in a number of situations and do not describe one circumstance for one individual child.

**There are several ways the data is collated:**

- When we report the overall number of individual children with a finding of harm, we count children only once even if they have more than one finding of harm.
- When we report the number of individual children within each type of harm, we are counting children once within each type of harm but the sum of all the types will be greater than the overall number of individual children as some children have experienced more than one type of harm.
- When the number of findings of harm is reported, this number reflects all findings and therefore a child may be counted more than once in the following circumstances:
    - if they experience more than one incident of harm (this describes a distinct and separate harmful event taking place in a different time period as we recognise that often what is described as a harmful event reflects repeated behaviours and not a one-off event), and/or
    - the finding relates to more than one person who caused the harm, and/or
    - an incident relates to more than one abuse type.
- When we report on the person alleged to have caused the harm, individuals are counted for every finding recorded against them. This may reflect findings for more than one child or for different types of harm.

Please note that due to the numbers being small in many of the categories reported it is difficult to draw conclusions from any emerging patterns at this stage.

# Additional Information

**Terminology**
The terms *child* or *children* are used within this report to refer to all children and young people under the age of 18, irrespective of what age group they are in. When we use the term *young person* or *young people* in this report, we are specifically referring to individuals who are aged 14 years and above. *Children in care* are defined as being subject to a custodial order or legal agreement under the Oranga Tamariki Act 1989 in the care or custody of the Chief Executive of Oranga Tamariki.

The language we use reflects standard definitions and terminology to describe the four abuse types: neglect, emotional abuse, physical abuse and sexual abuse (as described within the report).

The numbers reported are based on the date the findings are made, not the date of the harm experienced by the children.

**Examining harm in different placement types**
For this review, all placement arrangements are considered including those where children return or remain at home and those where they live more independently.

We have grouped smaller placement types together under non-family placement (see 'Placement type classifications' for detail). We acknowledge this describes a range of situations, but it enables us to aggregate information to prevent identification or self-identification by the individuals involved.

**Placement type classifications**
A **family placement** is an out-of-home placement where a child has been brought into the custody of the Chief Executive and supported to live with a member of their family as their caregiver (who has been assessed and approved).

A **non-family placement** is an out-of-home placement where a child has been brought into the custody of the Chief Executive and supported to live within the following arrangements:

- with unrelated caregivers who have been assessed and approved as caregivers
- in family home and other group home settings such as therapeutic homes
- in independent living situations.

These placements include care by caregivers and staff members managed by Oranga Tamariki, by NGO providers and by iwi Support Services.

**Return/remain home placement** describes arrangements where children are in the legal custody of the Chief Executive but return to or remain in the care of their immediate family (usually parents). These placements are most commonly used where we are attempting to support the reunification of a family, while still maintaining legal custody.

**Residential placement** describes an out-of-home placement that provides a secure living environment for children who are in the custody of the Chief Executive (includes care and protection and youth justice).

In some circumstances, children were harmed away from their current placement (for example, children harmed by parents during a contact visit, or children harmed while absconding). Wherever possible we have contextualised the incidents and provided narrative to enable better understanding of the circumstances.

The harm experienced by children in care is caused by a range of people.

**Classification of people alleged to have caused the harm**
**Family caregiver** describes a person who provides care for a child and has a family connection or other significant connection to the child.

**Non-family caregiver** describes a person who provides care for a child, does not have a pre-existing connection to the child and is not related to the child.

**Parent (as caregiver)** refers to the person who has been in the parenting role for the child before entering care and continued providing care or had the child returned to their care.

**Staff (Oranga Tamariki & CFSS[1])** describes a person employed directly by Oranga Tamariki or through contractual arrangements with NGO and iwi providers to provide care in a number of settings.

**Children in placement** refers to all children living in the same household/environment as the child in care (this could describe other children in care or a caregiver's own children).

**Other children** describes all children who do not live in the same household as the child in care and could describe related children or unrelated children.

**Parent (not as caregiver)** describes the biological or de facto parent of a child who is not currently providing care for the child.

**Adult family member** refers to all family members aged 18 and overwho are not defined as parents or caregivers and are not currently providing care for the child.

**Non-related adult** describes any person aged 18 and over who does not fall into any of the other categories. This could include a babysitter or unrelated household member or a stranger to the child.

[1] CFSS refers to Child Family Support Services provided by NGO and iwi Social Services.

# Ensuring Safety and Wellbeing of Children in Care

**How we respond to allegations of harm for children in care**

Allegations of harm for children in care can be raised in a number of different ways from a range of people, including the child themselves. In each instance, a formal report of concern is completed, and this ensures a consistent and structured process is followed in the social work response. On every occasion, social workers engage with the child and complete an assessment to understand what has happened to them. This assessment will involve those providing care for the child to ensure that the child's immediate needs are met and to manage any ongoing risks that might be present. Social workers are required to formulate an assessment plan for investigating the incident and where appropriate this will involve the Police.

Social workers arrange and provide support to children to ensure they feel safe and secure and to address any impact of the harm they have experienced. Once the assessment has been completed, a social worker determines whether the harm meets one of the four abuse types and records this in the child's records along with the details of the person who allegedly caused the harm. This information forms the basis of a finding of harm and the Safety of Children in Care Unit reviews all of these findings and examines the underpinning social work practice. In cases where harm results in serious injury or death additional practice analyses and review processes take place across the organisation.

**How children are supported**

In the cases assessed for this report, social work assessments have taken account of the child's needs and, in all cases where the assessment of ongoing risk has determined it necessary, children have been moved to alternative placements. Where placement arrangements have continued, an assessment of the support needs for the people providing care was undertaken and, in some cases, additional supports have been put in place. Some children have received counselling support to address the impact of the harm they have experienced. For other children, this will be considered at a later point to reflect their immediate need for care arrangements to be stabilised before more focused support. Some family members have also been provided with additional supports to ensure they can help their child address the impact of harm and to address their own support needs.

**Outcomes for the person alleged to have caused the harm**

There are a range of possible outcomes for the person alleged to have caused the harm. Some have faced criminal charges and have been prosecuted – these decisions are managed by the Police. When harm has been caused by caregivers, a reassessment of their circumstances and the appropriateness of care arrangements is completed. In some circumstances, the additional caregiver approval process is undertaken again. These assessments consider whether additional supports can strengthen care arrangements to ensure safe and stable placements can continue.

Where harm has been caused by staff an assessment of any ongoing risks is made and the appropriate actions taken. It should be noted that the timeframes for reporting this information do not allow for a review of the longer-term outcomes.

# Overview

## Context

As at 30 June 2020 there were 5945 children and young people in care and protection custody and 96 young people in youth justice custody of the Chief Executive of Oranga Tamariki.

The Safety of Children in Care Unit within Oranga Tamariki was established in 2018 to ensure a greater understanding of harm and the circumstances in which it happens. This enables us to understand how to prevent harm to children in care. The Unit provides a dedicated response which is focused on understanding the elements that provide for the safety of children in care and can promote best practice in this area while also providing comprehensive public information.

The Unit is responsible for reviewing and reporting on non-accidental harm caused to children in care. The Unit reviews the findings of harm in line with the definitions used throughout the organisation by practitioners to describe actions or inactions that cause harm and form the basis for a finding of harm for a child. Definitions are provided throughout the report.

Real-time review of findings enables a thorough analysis of casework practice and regular feedback to practitioners to ensure robust management of any continuing safety issues on an individual basis. This work enables the lessons from emerging trends and patterns to inform continuous practice improvement across Oranga Tamariki. This understanding enables us to focus our efforts on improving our practice and supports and services for children and young people in care, their whānau and caregivers.

Since 2019 we have reported publicly on the safety of children in care and in December 2019 the first annual report was published. This first annual report detailed the findings of harm for children in care using the new measurement approach for the period 1 July 2018 to 30 June 2019.

In March 2020 a biannual report was published, and this annual report takes account of that and reports on the findings for the second biannual period in 2020. Analysis of the data is provided over the whole year, with additional emerging patterns identified across the two years to date.

## What we know about the findings of harm

In the 12-month period July 2019 to June 2020, 411 children in care had 690 findings of harm (this represents 5.4% of all children in care at any time during the 12 months).

The majority of children had one finding of harm in the period.

The majority (90%) of children and young people with findings of harm experienced one incident of harm in the period, though some had more than one finding related to that one incident.

This reflects that some children had findings for more than one type of harm but it mainly reflects that the harm was caused by more than one person.

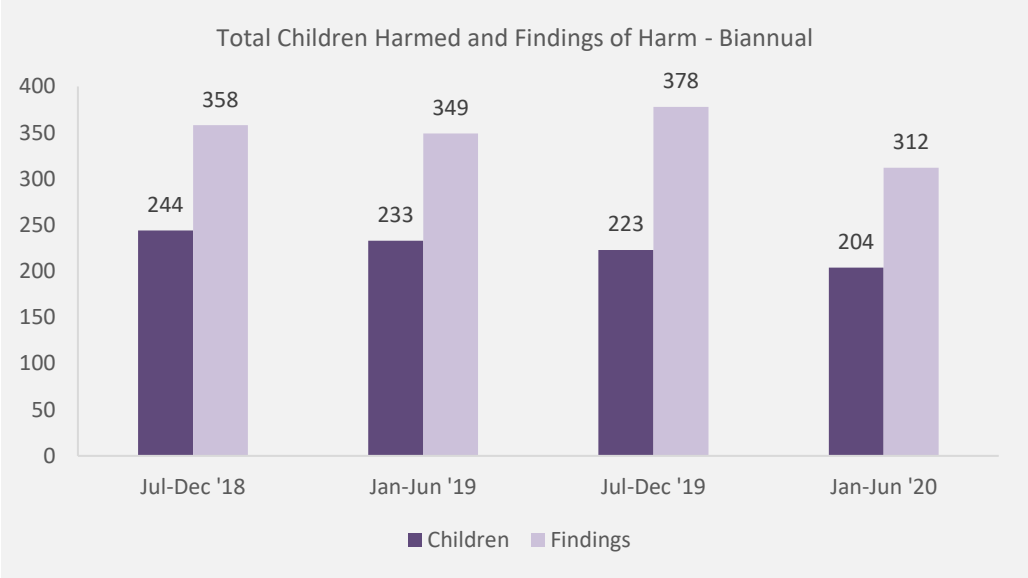
A small proportion (10%) of children experienced more than one incident of harm.

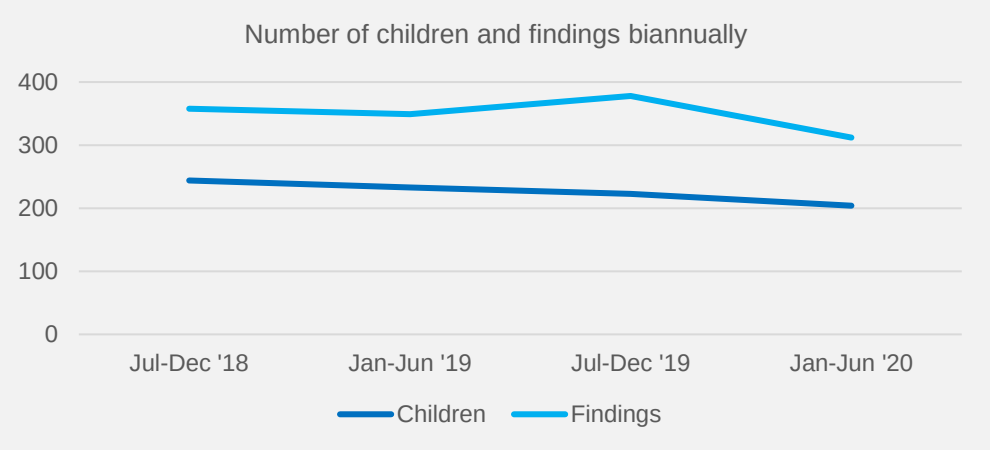
There has been a drop in both the number of children and the number of findings in the most recent period.[2] There has been a 9% drop in the number of children with findings from the period July to December 2019 to the period January to June 2020, and there has been a 21% drop in the number of findings overall.

There has been an 11% drop in the number of children with findings in this last year when compared with first year reporting however a 10% increase in the findings to child ratio in this last year.

[2] We need to advise caution in examining this given that this period encompasses March, April and May 2020, all of which were significantly impacted by the COVID-19 lockdown, in particular with the numbers of notifications coming through. Therefore, we may see a peak of numbers in the next period as delayed notifications emerge.

**Total children harmed and findings of harm – biannual numbers**

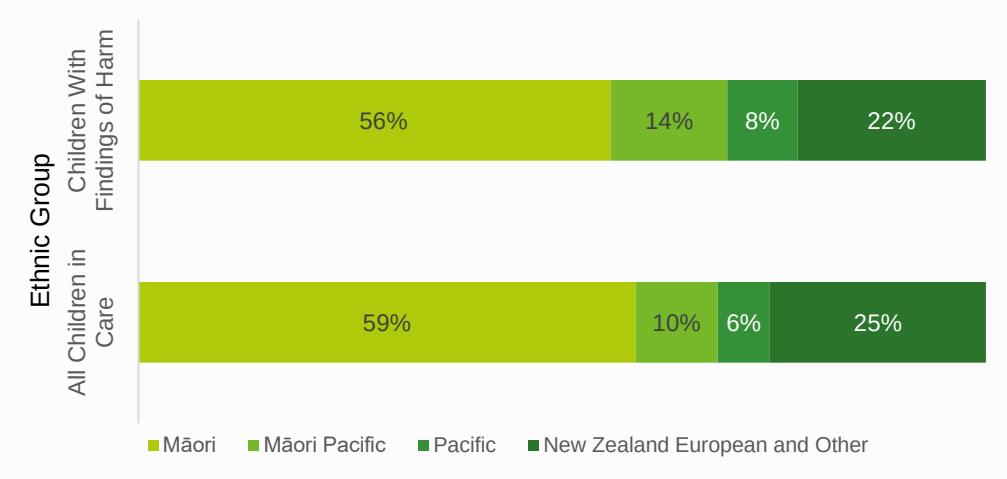


## What we know about the children

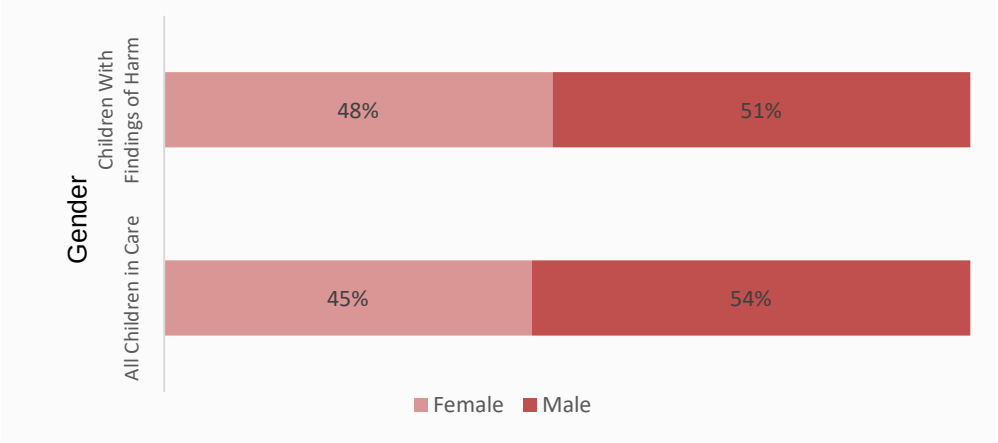
In the period 1 July 2019 to 30 June 2020, 411 children had 690 findings of harm recorded for them.

### Ethnicity of children harmed




- It is notable that the proportion of tamariki Māori and Māori Pacific in care with findings of harm in this period (70%) reflects the overall numbers of tamariki Māori and Māori Pacific in care in the period (69%). In previous reporting periods tamariki Māori were overrepresented within the findings of harm group.
- 14% of the children with findings of harm were Māori Pacific. This is proportionately greater than the number of tamariki Māori Pacific in care (10%).
- 8% of children with findings of harm were Pacific. This is also slightly proportionately greater than the overall numbers of Pacific children in care (6%).
- 22% of children with findings were classified as New Zealand European and Other while the overall care rate is 25%.

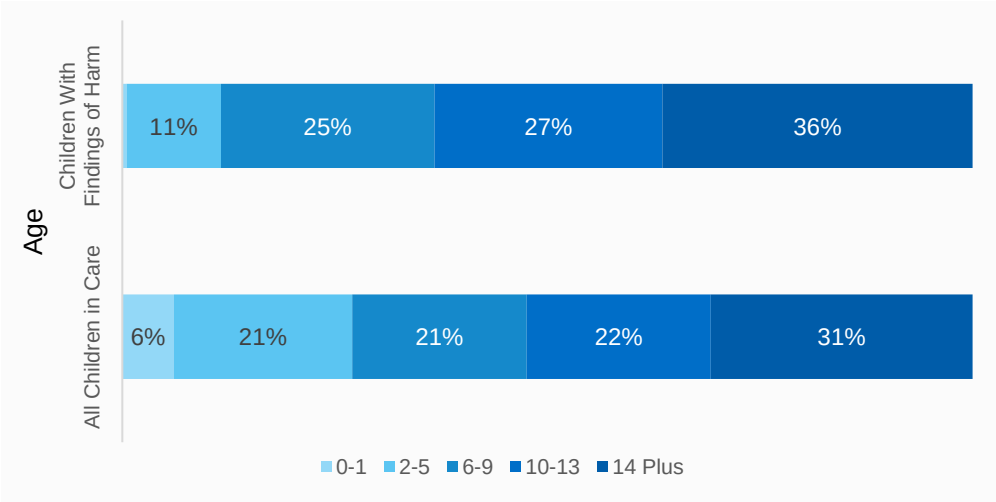
### Gender of children harmed




- 51% of children with findings of harm in this period were boys. This is proportionately lower than the number of boys in care in the period (54%).

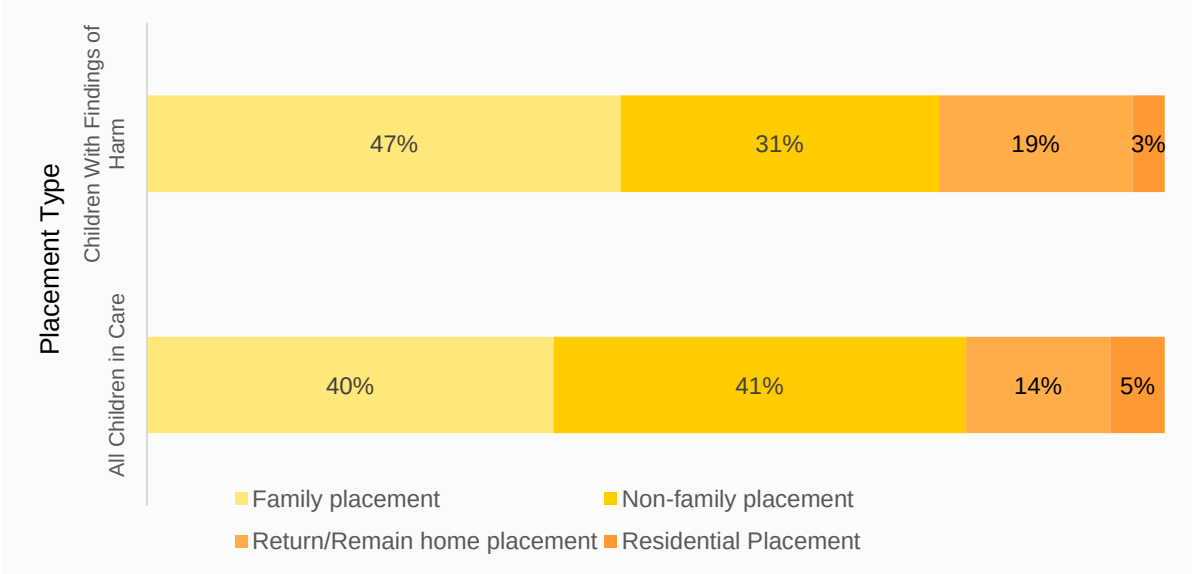
- There is a slightly different gender split in this period when compared to previous reporting periods, when girls had more findings than boys.
- Despite the lower numbers of girls, they remain overrepresented in the children in care with findings numbers compared with the wider children in care numbers.

## Age of children harmed




- Older children and young people were overrepresented within the children with findings of harm while the youngest age group of children are underrepresented.
- 36% of the children with findings of harm were aged 14 years plus. This is proportionately greater than this age group in the wider care numbers overall (31%) and is a higher proportional rate than in previous reporting periods.
- 27% were aged 10 to 13 years old. This is proportionately greater than the number in this age group in care (21%) but reflects previous reporting.
- 25% of children with findings of harm were aged 6 to 9 years old, proportionately greater than the number in this age group overall (21%).
- 11% were aged between 2 and 5 years old while 21% of the wider care population are in this age group.
- The numbers of children with findings aged under 1 year old is unreportable as numbers are too small. There was a reduction in the number of children with findings in this age group compared to previous reporting periods.

**Placement type of children harmed**




This is a breakdown of the overall proportion of time spent by all children in care within each placement type, compared to the proportion of children in care with findings of harm in each placement type (note that placement type does not always indicate where the harm took place or the person who caused the harm[3] ).

- 47% of children with findings of harm in this period were in family placements. This is proportionately greater than the number of children in care in this type of placement (40%). This reflects an increase in the proportional rate of harm in the placement type compared with year one reporting (42%).

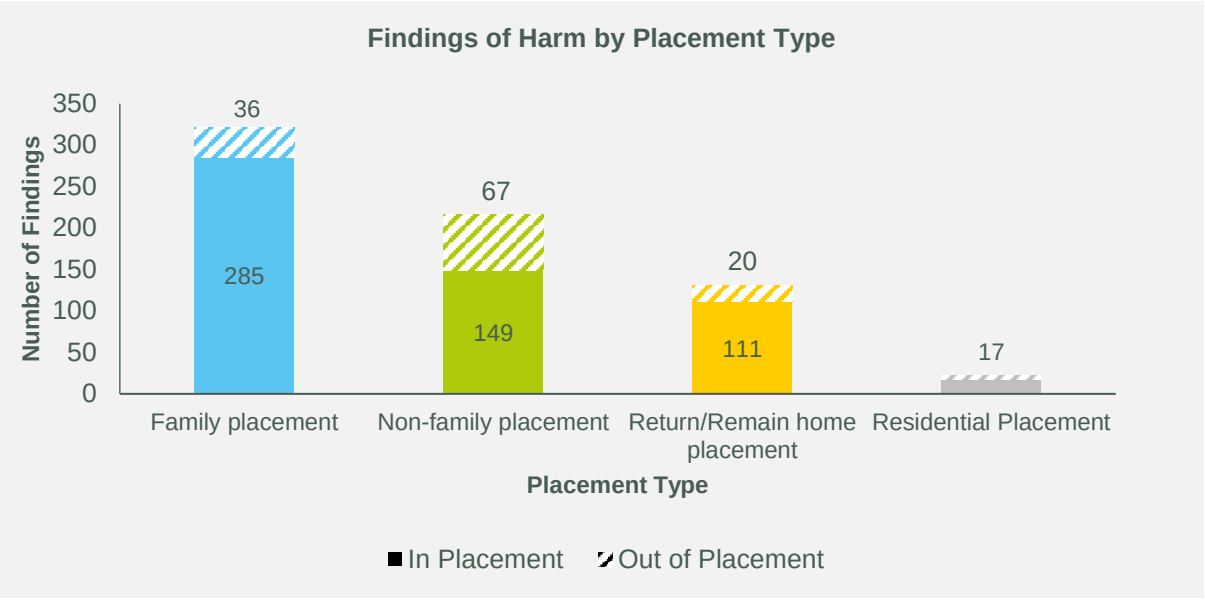
- 19% of children with findings of harm were in return/remain home placements. This is proportionately greater than the number of children in care in this type of placement (14%), which is the same as in previous reporting periods. This reflects a decrease in the proportional representation of this placement type within the findings of harm when compared with the first-year annual data (24% in year one).

- 31% of children with findings of harm were in a non-family placement, compared to 41% of children in care overall. This is comparable to previous reporting periods.

- 3% of children with findings of harm were in residences. This is proportionately lower than the overall number of children in care in residences (5%) and is a slight decrease in comparison to previous reporting periods.

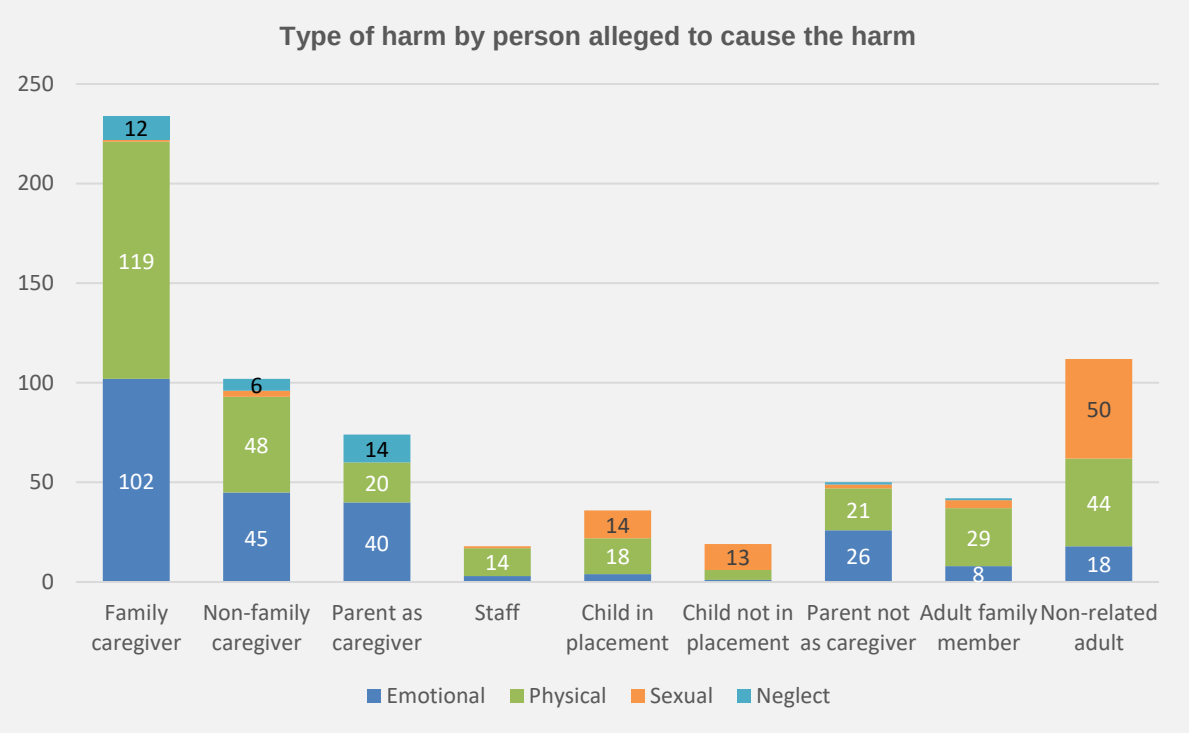
[3] Detail on where harm occurred and by whom is presented in the types of harm sections in the report.

## What we know about where harm occurs and by whom




Overall, most harm (81%) occurred within placements. However, in non-family care a significant proportion of harm occurred outside of the placement.

## What we know about the different types of harm caused by different types of people



## What the data tells us about the experiences of children in the care of Oranga Tamariki

As at 30 June 2020 there were 6041 children and young people in the custody of the Chief Executive of Oranga Tamariki. Of these 5945 were in care and protection custody and 96 were in youth justice custody.

Most children in care from July 2019 to June 2020 were safe and had the support they needed to ensure they could thrive and flourish in loving homes.

However, during this time 411 children in care (representing approximately 5.4% of all children in care in the period) had experienced an incident of harm for which they have had a recorded finding. The number of recorded findings in the period was 690.

Most children in care have entered care due to experiencing a form of abuse or maltreatment and we know this can mean they are at greater risk of further harm from others. Research which examines the outcomes for children in care in other countries highlights that children who have experienced harm are more vulnerable to further harm. Children who have experienced physical violence, child sexual abuse and maltreatment from a parent or caregiver have a higher chance of being polyvictims (to be at risk of multiple incidents of different kinds of harm) (Finkelhor et al 2009b)[4].

This understanding underpins all our practice in care. Understanding the needs of children who have experienced trauma and have additional vulnerabilities is a critical component in preparation and planning for safe and loving care arrangements.

### When did harm occur?

The majority of findings (91%) related to incidents that had occurred in the previous 12 months, with approximately 54% of these findings related to incidents occurring in the previous 3 months. Only 9% of findings related to incidents that had occurred prior to 12 months before the concern was raised and are categorised as more historical incidents.

### What type of harm is occurring?

Findings related to neglect were the lowest number of all harm types and the numbers of findings of neglect have halved in the last year (78 to 34). Notifications concerning neglect of children in the wider population (ie. children not subject to custodial or care arrangements) have also been at a lower level in this last year.

Findings related to physical harm were the highest number of all harm types and were at a comparable rate to the previous year of reporting.

Findings of sexual harm were at a rate comparable to previous reporting.

Numbers of findings per child for emotional harm have increased in the last year (208 findings of emotional harm for 153 children in year one reporting compared to 248 findings of emotional harm for 156 children in this last year). In the main this reflects that more than one person caused the harm in any individual incident. Emotional harm can sometimes be the only type of harm experienced by a child but is also the most prevalent type of secondary harm caused to children.

### Who is experiencing harm?

Slightly more boys than girls experienced harm. This is a different gender split than in the previous reporting period when more girls experienced harm. Generally, older children (aged over 10 years) were harmed more frequently than younger children.

The proportion of tamariki Māori with findings of harm while in care is comparable in this period to the number of tamariki Māori in care or custody overall. The proportional rate of tamariki Māori with findings of harm has decreased in this recent reporting period compared to the previous year's reporting, dropping from 81% to 70% (tamariki Māori and Māori Pacific).

[4] Finkelhor et al 2009b cited in UCLAN The Abuse of Children in Care in Scotland – A Research Review.

The children who experienced harm lived in a range of care placements, and incidents occurred both in and out of their placement. The different types of harm all occurred more frequently in placement with the exception of sexual harm which most frequently occurred out of placement.

More harm occurred within family placement types than in any other placement – 47% of children with findings were living in family placements, which is proportionately greater than the number of children overall in care living in this placement type (40%). This reflects an increase in the representation of this placement type compared to last year.

Children living in a return/remain home placement were the highest risk group, with 19% of children with findings in this placement type and 14% of all children in care in this placement type. This reflects a decrease in the rates of harm from 24% in year one reporting to 19% in this last year.

**Who is causing harm?**

Children experienced harm from a range of people, although some types of harm were caused by particular categories of people more often.

Physical harm most often in the form of harsh or inappropriate discipline measures was mostly caused by family caregivers. This is comparable to previous reporting.

Sexual harm was more often caused by non-related adults, some of whom had existing relationships with children and young people and some of whom didn't. A significant number of sexual harm incidents were also caused by other children or young people both in and out of placement and again the emerging patterns of sexual harm mirrored previous reporting.

# Findings

## Neglect

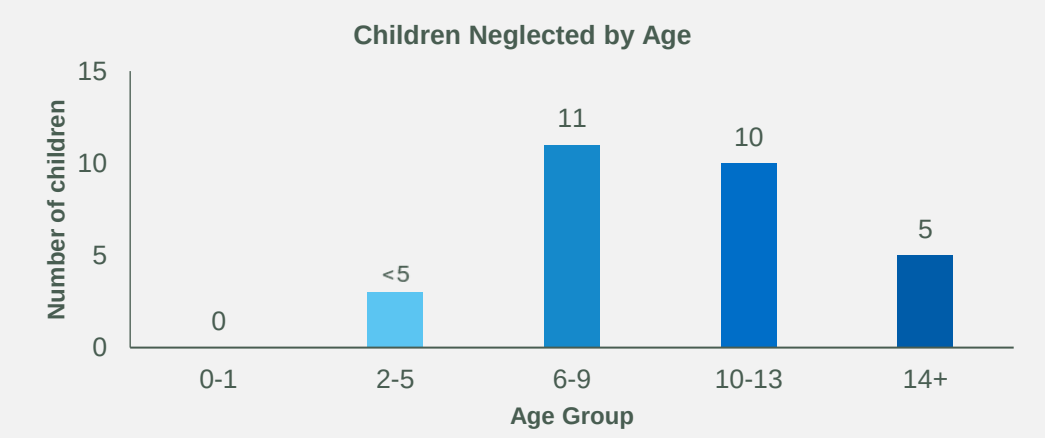
**29 children had 34 findings of neglect.**

**This represents 0.4% of the total number of children in care at any time during the 12-month period.**

Definition: Neglect is defined as the failure to provide children with their basic needs – physical (inadequate food or clothing), emotional (lack of emotion or attention), supervisory (leaving a child home alone), medical (health care needs not met), or educational (failure to enrol or chronic non-attendance at school). Neglect can be a one-off incident or may represent a sustained pattern of failure to act. (Oranga Tamariki Practice Centre website 2019)

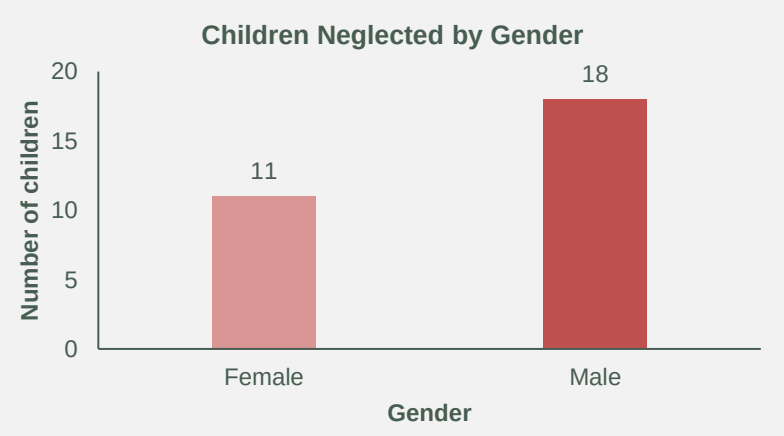
***What we know about the children***

### Children neglected by age




Approximately half of the children (48%) were aged under 10 years old.

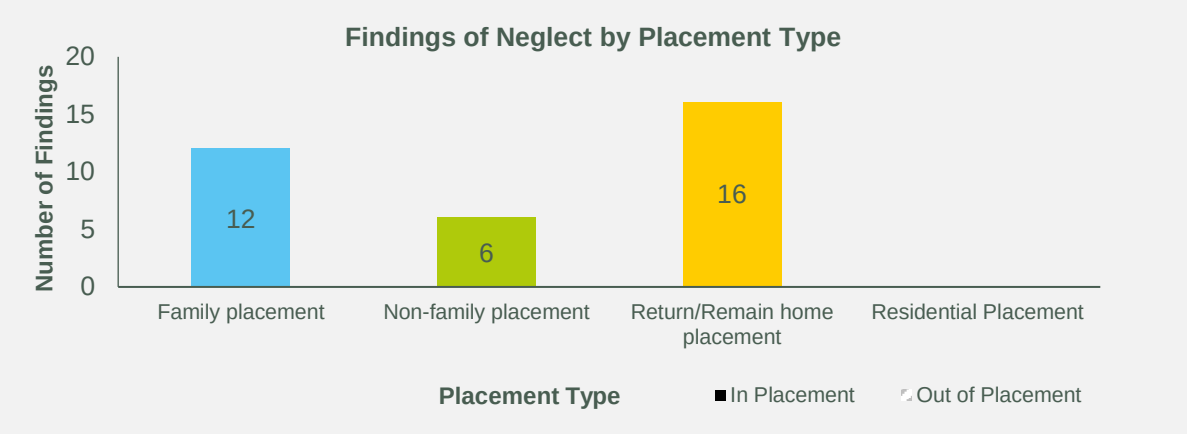
### Children neglected by gender




Slightly more boys than girls were neglected in this period.

***What we know about the findings of harm***[5]

**Findings of neglect by placement type**




All neglect occurred within the placement.

12 children living in family placements had 12 findings of neglect and this was caused by the family caregiver.

6 children living in non-family placements had 6 findings of neglect, all of which were caused by the non-family caregiver.

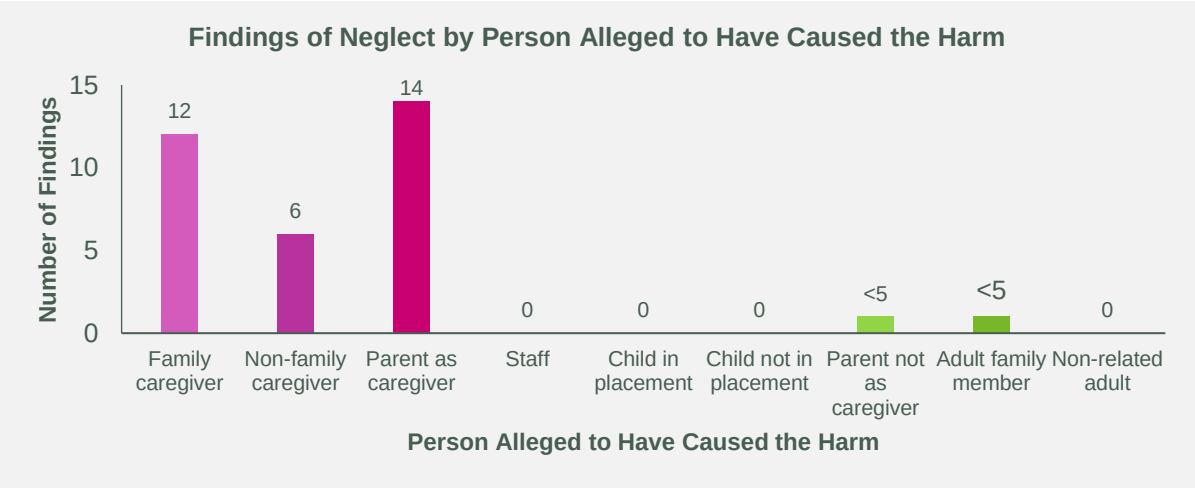
11 children living in return home placements had 16 findings of neglect. The majority (14 findings) was caused by parents as caregivers.

Neglect by parents and family caregivers involved children regularly not going to school or regularly not being engaged in routine activities that provide for their basic needs.

In these cases there were times when children had continued exposure to drug and alcohol use in the home by parents, family and others, and on occasion it reflected that older siblings were responsible for caring for younger siblings to the detriment of their own needs.

Neglect in non-family placements reflected the absence of protective behaviours by adults in the caring role to keep children safe from physical harm caused by others.

**Findings of neglect by person alleged to have caused the harm**




[5] There were 34 findings of neglect in this period due to the fact that the children were harmed by more than one person.

# Emotional Harm

**156 children had 248 findings of emotional harm.**

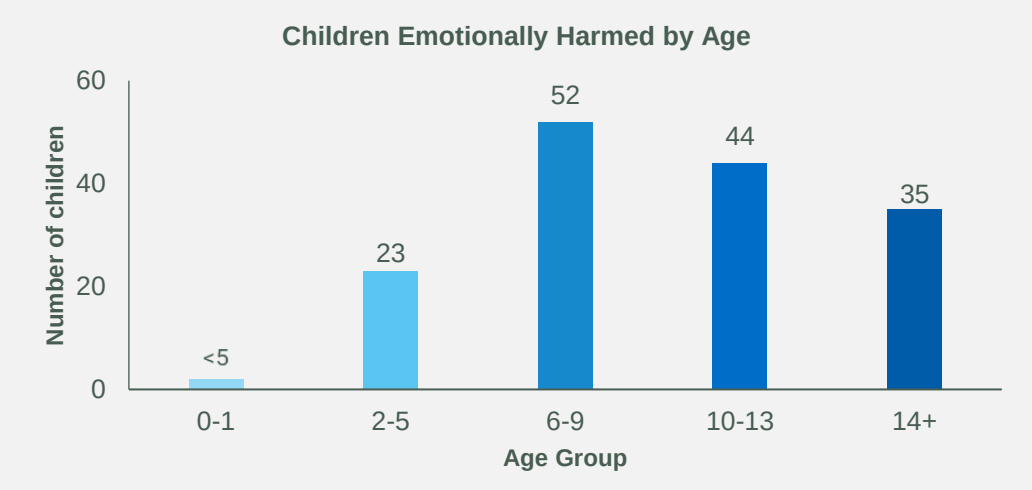
**This represents 2% of the total number of children in care at any time during the 12-month period.**

Definition: Emotional abuse is defined as a situation where the psychological, social, intellectual and emotional functioning or development of children has been damaged by their treatment.

This often results from repeat exposure to negative experiences, particularly in a context of insecurity. Witnessing intimate partner violence may constitute emotional harm if the functioning, safety or care of the children has been adversely affected or put at risk. (Oranga Tamariki Practice Centre website 2019)

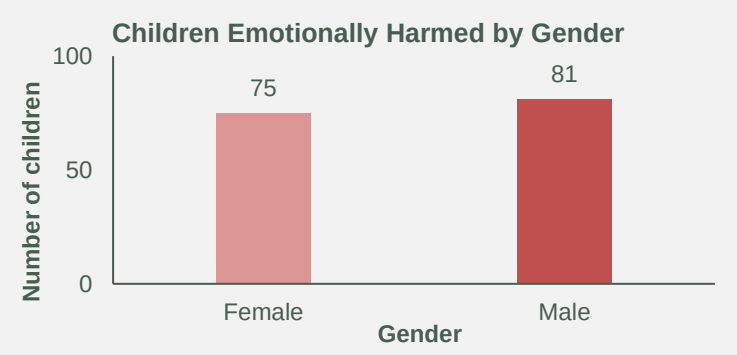
***What we know about the children***

**Children emotionally harmed by age**




The children experiencing emotional harm were varied in age but there was a slightly higher prevalence (a third) in the 6 to 9 age range.

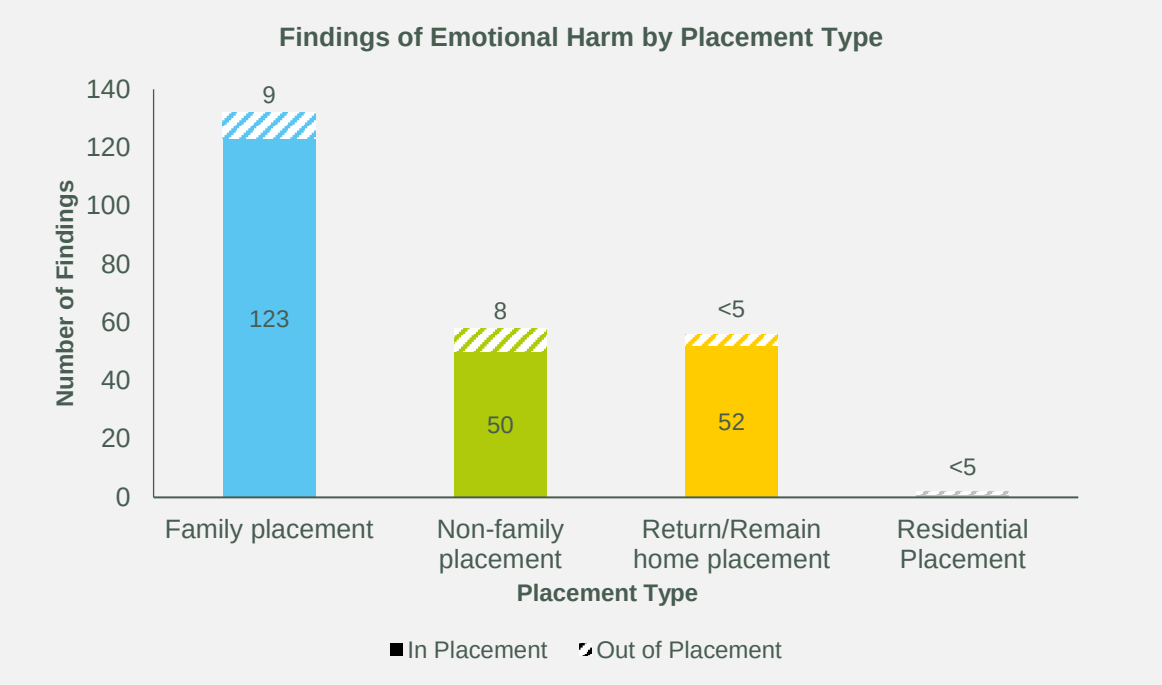
**Children emotionally harmed by gender**




Slightly more boys than girls were emotionally harmed in this period.

***What we know about the findings of harm***

**Findings of emotional harm by placement type**



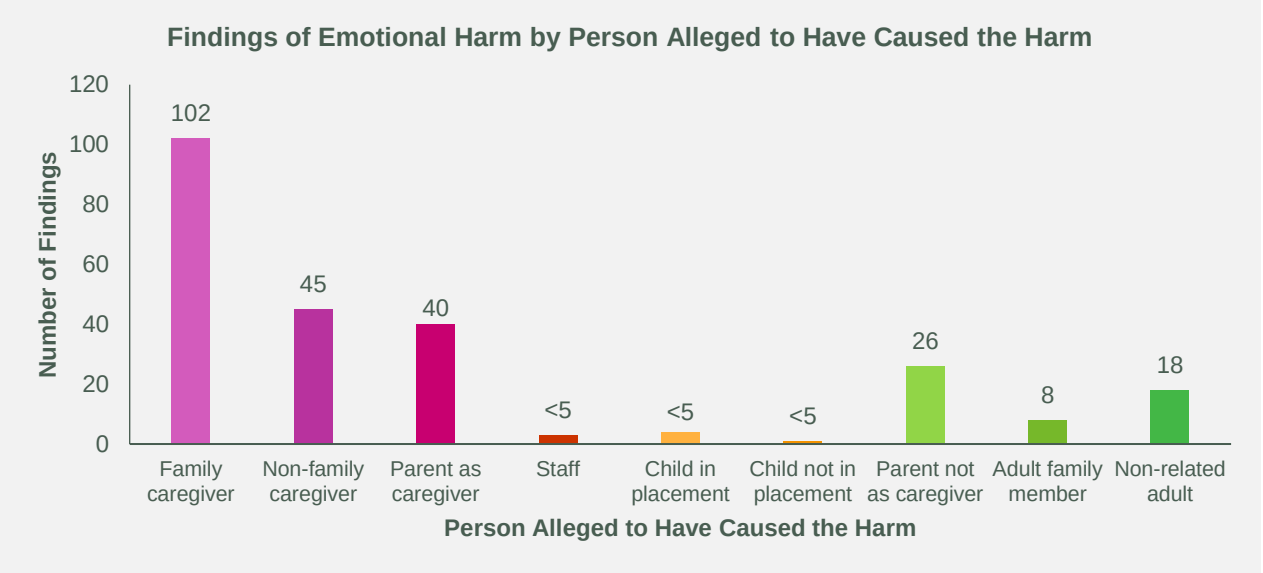

The majority of emotional harm occurred within the placement for all placement types except in residences where the emotional harm occurred while away from placement.

81 children living in family placements had 132 findings of emotional harm. The majority of this was caused by the family caregiver (102/132) The high rate of findings to child ratio reflects that in the main children were harmed by more than one person in the same incident (50/78).

42 children living in non-family placements had 58 findings of emotional harm. The majority of this was caused by the non-family caregivers (45/58).

31 children living in return home placements had 56 findings of emotional harm. Most of this was caused by parents as caregivers (40/56).

**Findings of emotional harm by person alleged to have caused the harm**




Emotional harm caused by family caregivers was related to adult stress within the household or inappropriate responses to child behaviours or punitive forms of discipline. For children this presented as being scared of the caregiver due to their anger and often involved repeated name calling and being told they were unwanted or threatened with harm. In some circumstances this involved being locked out of the home.

Parents who were not providing care for their children but having contact with them were responsible for a proportion (10%) of the emotional harm caused. For some children, emotional harm was caused by the partners of their parents. The emotional harm was often due to children being exposed to violence between their parent and their family caregiver or their parent and partner either during contact or within the placement setting.

The majority of emotional harm caused by non-family caregivers related to inappropriate responses to children's behaviour. For children, distress was caused by seeing their siblings or others in the placement setting being hurt by the caregiver and for some children the distress was due to feeling scared about being hurt as well. It was noted that emotional harm findings in this period involved high numbers of large sibling groups.

For almost all of the children within return/remain home placements, the harm caused related to being exposed to family violence within the home often involving the current or ex-partner of the parent. In half of the incidents drug or alcohol use was a factor. Some of these children were made to feel responsible for the adult behaviours or were threatened with harm for trying to intervene.

Emotional harm caused by non-related adults largely involved older young people and described intimate partner violence from adults who the young people were in relationships with. Emotional harm was often caused alongside violent behaviour.

# Physical Harm

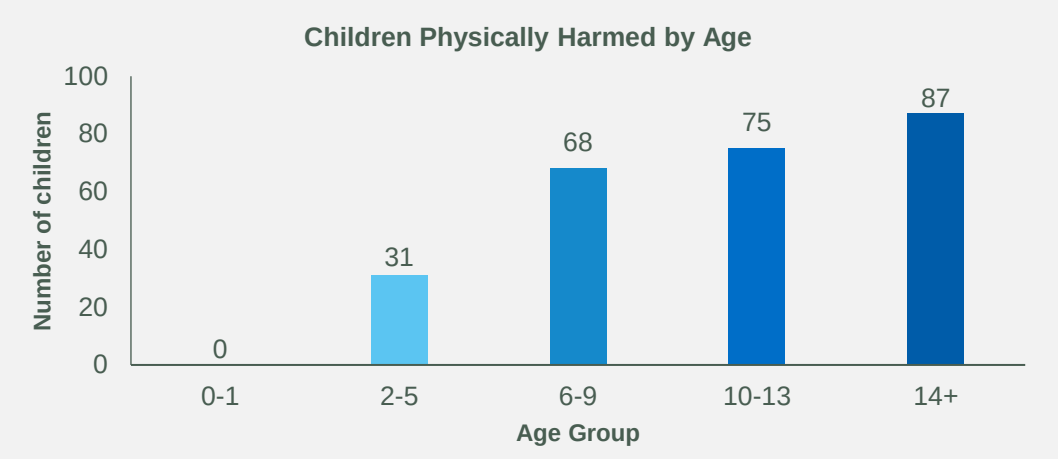
**261 children had 320 findings of physical harm.**

**This represents 3.4% of the total number of children in care at any time during the 12-month period.**

Definition: Physical abuse describes a situation where children have sustained an injury or were at serious risk of sustaining an injury. Injuries may be deliberately inflicted or the unintentional result of behaviour (such as shaking an infant). Physical abuse may result from a single incident or combine with other circumstances to justify a physical harm finding. (Oranga Tamariki Practice centre website 2019)

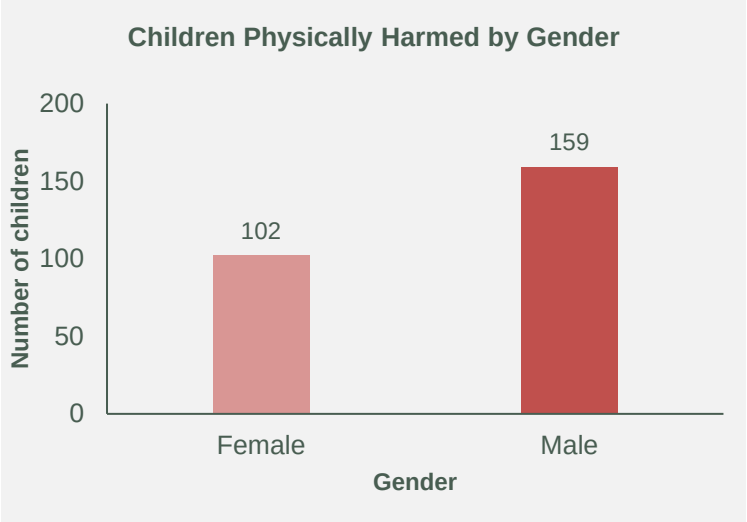
***What we know about the children***

**Children physically harmed by age**




62% of the children were aged over 10 years old, with a third aged over 14.

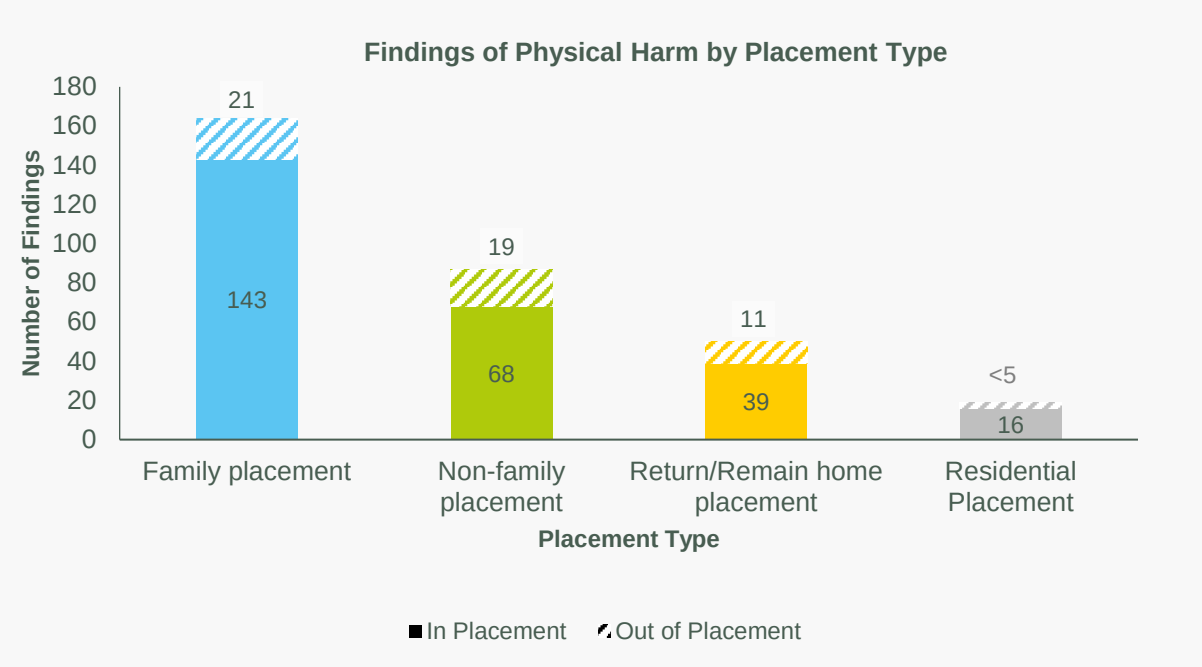
**Children physically harmed by gender**




More boys than girls were physically harmed (60% of all findings were for boys).

***What we know about the findings of harm***

**Findings of physical harm by placement type**




The majority of physical harm (266/320) occurred within the placement setting.

**Family placements**

127 children[6] had 164 findings of physical harm. The majority of the physical harm (143/164) occurred within the placement. The majority was caused by the caregiver (119/164). The higher ratio of findings to child in this placement type was due to more than one person causing harm in the same incident.

**Non-family placements**

79 children in non-family placements had 87 findings of physical harm. The majority of the physical harm (65/87) occurred within the placement and was mainly caused by caregivers (48/87).

**Return/remain home placements**

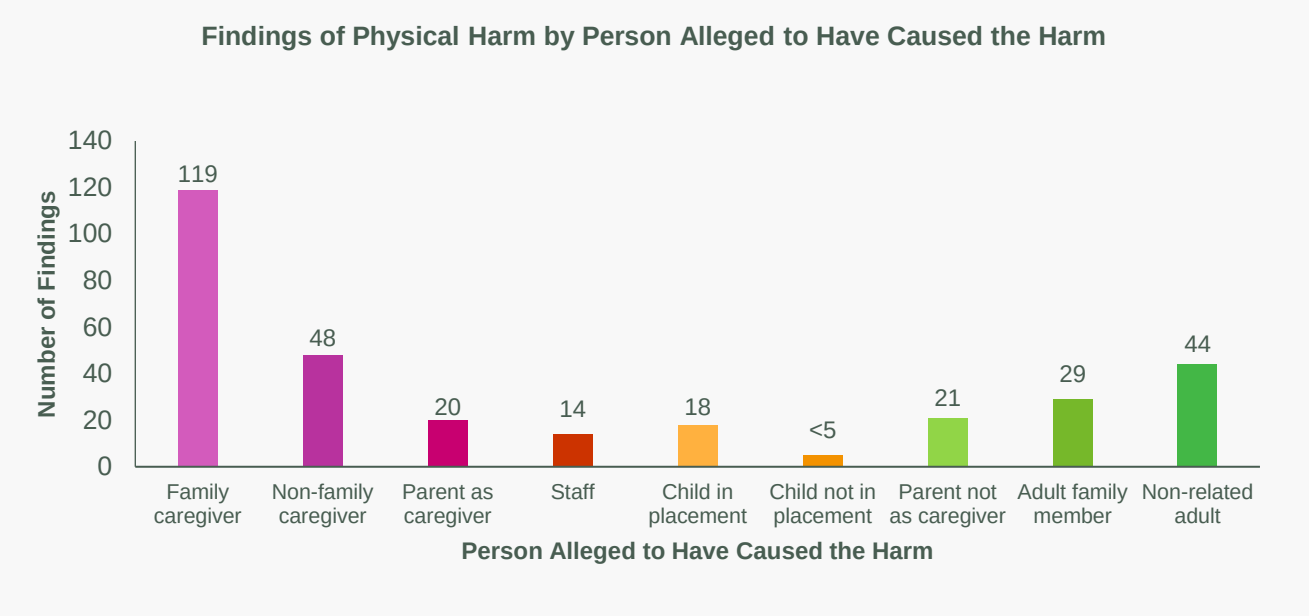
41 children in return/remain home placements had 50 findings of physical harm. More than three-quarters of the findings of physical harm occurred within the placement. A significant proportion of the physical harm was caused by non-related adults (often these being stepparents or current/ex-partner of parent). Approximately a third of the findings were caused by parents as caregivers.

**Residential placements**

17 children had findings of physical harm. The majority of findings occurred within the placement, with half of these caused by staff.

[6] The number of children in each placement type with findings of physical harm is greater than the total number of children experiencing physical harm overall due to the fact that children can live in a number of different placements in the year.

## Findings of physical harm by person alleged to have caused the harm




Almost two-thirds (201/320) of physical harm findings were caused by caregivers, parents as caregivers or staff. The majority of these incidents related to inappropriate discipline of children or inappropriate responses or reactions to behaviour, or in response to children challenging the poor behaviour of the adult. All involved physical injury or harm.

Some of the harm was of a serious nature and some children sustained bruising and welts as a result. Some of the children talked of being scared of the caregiver.

Physical harm findings caused by non-related adults in the main described intimate partner violence towards teen girls from current partners. Most of these young women were living independently at the time the harm occurred but remained subject to legal custody status.

In residences, the findings of physical harm caused by staff were related to behaviour management and often occurred during restraint procedures. Harm caused by other young people in the placement resulted from arguments that escalated to incidents of physical harm.

In the year to June 2020 there was less prevalence of alcohol or drug use as a causal factor or as part of the incident summary involving physical harm when compared to the previous year to June 2019.

The higher number of findings per child in this category of harm reflects in most cases that a number of children were harmed by more than one adult in the same incident and most often this reflects both caregivers or both parents.

# Sexual Harm

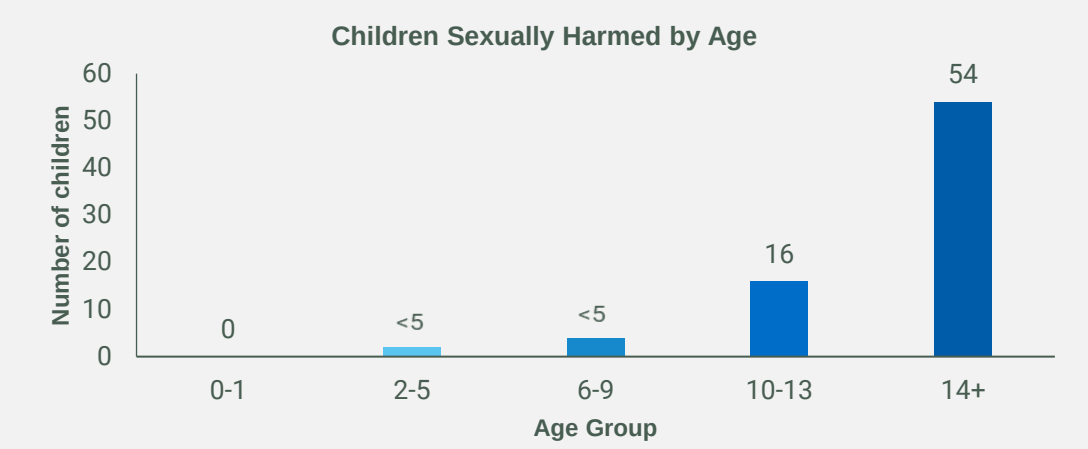
**76 children had 88 findings of sexual harm.**

**This represents 1% of the total number of children in care at any time during the 12 month period.**

Definition: Sexual abuse is defined as any action where an adult or a more powerful person (which could include other children) uses children for a sexual purpose. Sexual abuse doesn't always involve bodily contact. Exposure to inappropriate sexual situations or to sexually explicit material can be sexually abusive, whether touching is involved or not. Children may engage in consensual sexualised behaviour involving other children as part of normal experimentation; this is not considered sexual abuse. (Oranga Tamariki Practice Centre website 2019)

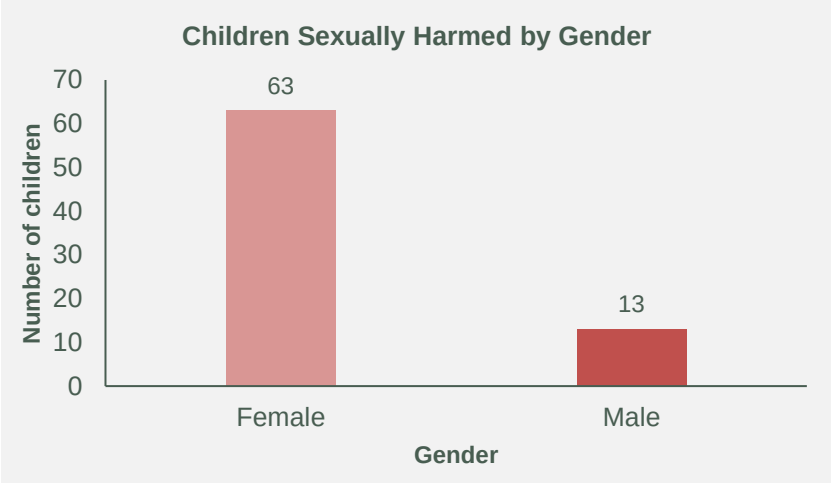
## *What we know about the children*

### Children sexually harmed by age




More than two-thirds of the children were aged 14 years and above (71%).

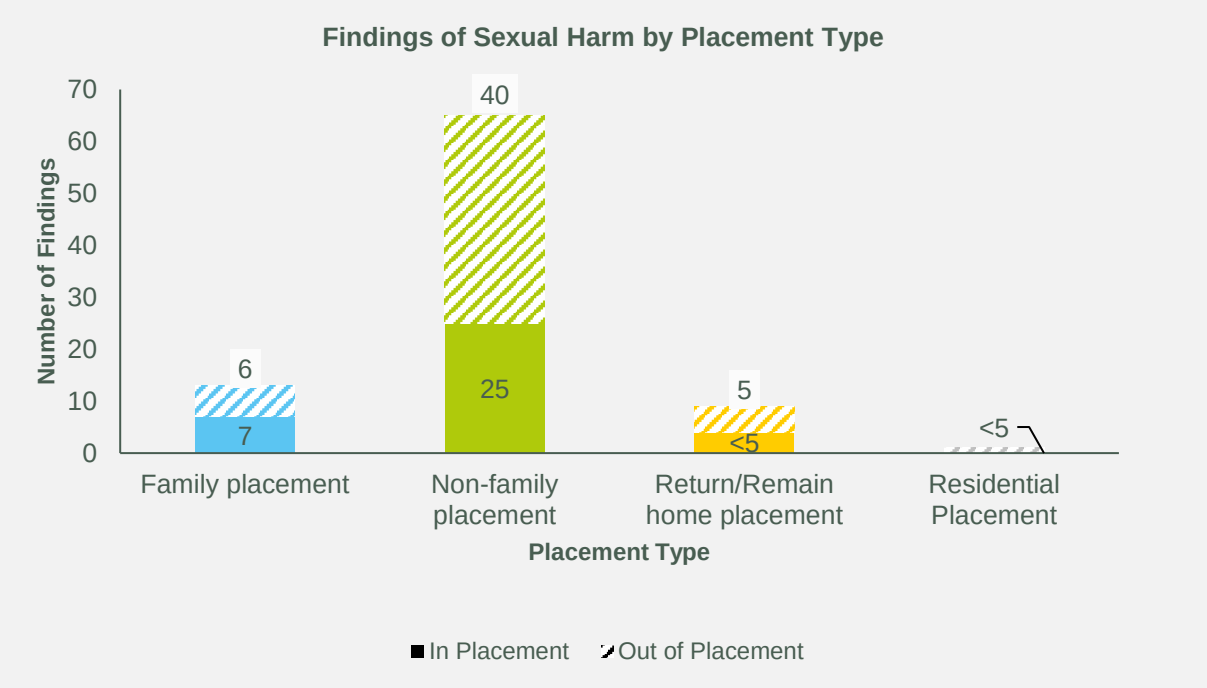
### Children sexually harmed by gender




The majority of sexual harm was caused to girls.

***What we know about the findings of harm***[7]

**Findings of sexual harm by placement type**




The majority of sexual harm (59%) took place outside of the placement and more children who experienced sexual harm were living in non-family placements than any other placement type.

Most sexual harm in non-family placements that occurred in placement was caused by other children or young people in placement and not by caregivers.

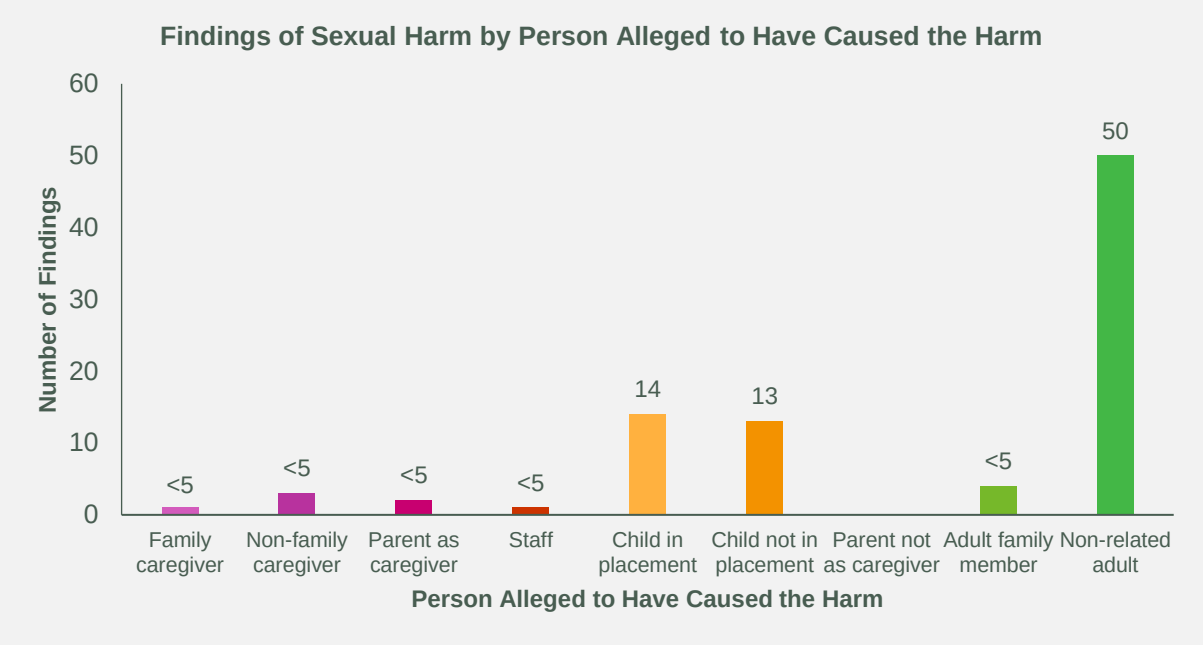
Most sexual harm in family placements and in return/remain home which occurred in placement was caused by adult family members and not by caregivers or parents.

Overall, most of the sexual harm to children was caused by non-related adults mostly outside of the placement setting.

Most non-related adults were unknown to the young person and many of the incidents of sexual harm occurred while the young person was missing from their placement. Some non-related adults had an established relationship with the child or young person before the harm occurred or had made a connection with the child or young person.

[7] There were 88 findings of sexual harm in this period due to the fact that the children were harmed by more than one person and some children experienced more than one distinct sexual harm incident.

## Findings of sexual harm by person alleged to have caused the harm




Non-related adults represented the highest number of alleged perpetrators in sexual harm and caused a significant number of physical harm incidents to older young people.

Some of the non-related adults who caused harm were known to the child or young person through existing relationships (for example, family friends, partners of family members, family of caregivers).

Some of the non-related adults had recently established a connection with the child or young person and grooming of the child had taken place.

Some of the sexual abuse took place after the young people had been specifically targeted by the person who was alleged to have caused the abuse.

For some young people they were sexually abused by non-related adults who were complete strangers. This was more prevalent than in the previous year's reporting. In some instances, the alleged abuser groomed the vulnerable child or young person and used bribes to entice them such as offering money, alcohol, cigarettes and/or drugs.

For a small number of incidents social media was used either in how contact between the child/young person and the alleged abuser was made (Facebook, Tinder) or where the sexual abuse was recorded and then shared with others without the child or young person's knowledge.

Some children and young people were sexually abused after they had been given alcohol or drugs by the alleged abuser, increasing their vulnerability. In some incidents, serious sexual harm was caused, as well as children and young people sustaining physical injuries.

# Insights

## Strengthening responses to children in care

***In this second year of reporting the patterns and emerging trends were comparable with previous insights and the prevalence of harm by family caregivers and parents highlights a number of core issues.***

**Family caregivers**

The most prevalent theme when looking at the range and types of abuse experienced by children in family care (particularly physical and emotional abuse) is that these experiences were very similar to what originally led to children coming into care in the first place.

Understanding and assessing the intergenerational experience of abuse and trauma across a family enables us to make informed decisions about risk and strengths. We can respond by identifying and putting in place a level of support that not only helps prevent further risk of harm to a child but also builds and strengthens the capacity of the family over time.

There is a need to strengthen support to caregivers to enable greater levels of understanding of the needs and experiences of children and the ongoing capacity of family members to meet these needs. Robust discussion which explores how family dynamics can account for change in needs and the changing expectations within family relationships is essential and at times not evident in practice.

Establishing within Oranga Tamariki a dedicated Caregiver Recruitment and Support Team has meant that every caregiver now has an allocated social worker who can help to identify support needs and ensure that caregiver support plans meet those needs. There is a higher number of social workers providing support to caregivers which enables supports to be mobilised in a timely and responsive manner which can prevent stressed situations from escalating to harmful reactions.

Caregiver social workers identify learning needs for all caregivers and provide caregiver training which reflects the nature of need, i.e. caring for children who have experienced trauma or caring for children with foetal alcohol syndrome.

For some family caregivers who had had intergenerational experiences of abuse and trauma and of child protection services, this was not always explored in depth before children were placed in their care. Exploring the family's experience of parenting and being parented may have highlighted the use of physical measures or discipline as an inappropriate behaviour management strategy, and specific supports could have been considered to mitigate the risk of further harm to the child.

In some situations, there was limited assessment of the caregiver's skill and ability to meet the specific needs of a child. The assessment appeared to be more of a general nature with less testing of the depth of relationship between the caregiver and child, or a testing of the understanding the caregiver had of the child's needs. In some instances, strengthened practice in assessment was required to account for adults who were clearly either residing in the home or going to have a role in caring for the child.

A strengthened Prepare to Care Training programme is being implemented across the country and is designed to be delivered in a flexible caregiver focused manner. This strengthened preparatory training will enable greater levels of assessment.

It is also important that the child's views or thoughts about the care arrangement being considered for them are understood. There is a need to learn from children about the relationship they have with the family member who is providing care of them, to understand the strength of the relationship and how this might contribute to their safety within the placement.

Often actual support needs of caregivers were assessed separate to their caregiver assessment. This sometimes meant that supports were not in place at the start of a child's placement and at times were subject to availability. While extended family members were often identified during the caregiver

assessment as being supports, the detail as to what practical support would look like was not always clear. In some situations, there appeared to be an overreliance on others to provide the necessary supports to sustain safety in placements.

A renewed focus within caregiver support teams on ensuring provisional arrangements are reviewed and strengthened as soon as possible will ensure that any changes in circumstances are taken account of in plans.

**Protecting and restoring family relationships**

There were some excellent examples of practice which were shaped by the presence of the new role of the Kairaranga ā-whānau and the positive impact this made when working with family to be part of decision-making for children and to identify family who wanted to provide ongoing care for children.

There were also some good examples of how hui ā-whānau was used to bring family together to discuss concerns present in a placement, to discuss support needs and to enable whānau to then plan what support could be provided and by who to increase safety for te tamaiti and support for the whānau caregiver.

There were also some examples of social workers supporting family-led processes in response to allegations of abuse of children in care. While our role with children and families does end at some point, children will continue to have ongoing relationships and connections with family members who have provided care. There remains an obligation for Oranga Tamariki to ensure these relationships are repaired and made safe as much as possible given our commitment to ensuring improved lifelong outcomes for children and families we work with.

While there is a need to develop these practice expectations to become the norm, it is encouraging to see the efforts being made to support and develop improved practice with tamariki and whānau Māori by providing clear messages about our obligations and responsibilities in relation to mana te tamaiti, whanaungatanga and whakapapa, by developing and making available strong practice policy and guidance, and by establishing strategic partnerships with iwi and kaupapa Māori organisations across the country.

**Working with parents and addressing safety issues in return home arrangements**

Physical harm by parents in return home arrangements tended to be of a higher level of seriousness and was often seen to reflect the adult's own propensity for violence, rather than being in the context of trying to correct a child's behaviour by using physical discipline. Family violence within these homes was a continuing and regular feature. Vulnerable infants (those aged under 5 years) are being physically hurt when the parents are assaulting each other, usually when under the influence of drugs or alcohol.

It is acknowledged that returning children home is a particularly vulnerable time and therefore a time when the levels of support need to increase, not decrease. Many of the examples where harm was caused in the last year were unplanned return home placements, such as an older child returning themselves home, or placements breaking down and no other placement being able to be identified – in these instances suitable preparation and support is often mobilised after the immediate placement home.

The majority of cases reviewed, following an allegation of harm, required a greater level of assessment to understand the nature of parent's ability, willingness or confidence to recommence caring for the child and to do so safely and to take account of the circumstances that led to children returning home and the circumstances for the day-to-day care of children.

There was a need for more robust safety planning with family, with supports in place to progress change in adult behaviours in the household or in overseeing the ongoing safety and wellbeing of children and ensuring sustained change. Often the support for the return home placement dropped off or was not established at the time of return home, and the parent did not receive sufficient financial, practical or educative assistance to support the social work plan for the child.

Some return home placements come with a level of innate risk, and careful planning and support is required to ensure the success of a return home placement over time. More carefully considered assessment of the key areas of risk and harm for each individual parent is required so that these risks can be fully understood, and steps taken to mitigate them. Equally, the strengths and protective

factors need to be understood so that they can be enhanced to increase the safety and success of the placement. There are some specific indicators of risk that have been identified as a result of the safety of children in care data and these can inform where a strengthened response is required to mitigate possible future harm to a child who has returned home. In particular, parents who are still using harmful substances such as drugs and alcohol, or who are still in relationships that have been characterised by family harm, are likely to further harm their child. There is some risk with parents who do not wish to engage with a social work plan once a child has returned to their care. Plans will reflect the network of safety that is built up with people in the child's life but how they are working to keep children safe and well needs to be understood by the social worker. This understanding requires ongoing engagement between social workers and children and parents and at times will need to overcome parents' reluctance to engage. This could be because they are still engaging in behaviours that they know would be viewed as a risk to their child, or because of their own previous experiences with the child protection system.

Return/remain home placements have been identified as a higher area of proportional risk and this knowledge allows us to focus attention on strengthened safety planning in placements with higher rates of harm. We are implementing strengthened transition periods in return home placements and prioritising the use of Child and Family Consults to robustly test decision-making and ensure that supports are in place to sustain safety and wellbeing for children.

***Physical and sexual harm by non-related adults in this last year has also mirrored previous emerging patterns***

**Responding to allegations of sexual harm**

Several older children and young people had needs that required intensive wraparound services. Some of these children and young people had placement arrangements that were temporary and often with very limited ongoing family supports available to them, and some required specialist one-to-one care. Some children and young people were missing from their placement when the abuse occurred, which increased their vulnerability. Some of the intensive supports needed to address the risks and vulnerabilities of older children and young people are difficult to provide with any efficacy when placement arrangements are unstable

It was evident from the responses to allegations of sexual harm and physical harm that children and young people find it difficult to engage in the formal evidential process. The expectations placed on children and young people often do not take account of the specific needs of children and there is little understanding of the dynamics of disclosure. This includes the impact of trauma and cumulative harm on a child or young person's ability to disclose and the risks children and young people associate with disclosing abuse. This lack of understanding in the system can lead to sexual harm being minimised and to a lack of consistency in follow-up. We have observed some excellent practice in addressing these issues; practice that takes account of children's needs to revisit decisions, allows for numerous appointments and enables engagement in formal processes through patient and child centred approaches. Through sharing some of these best practice examples we can enable improvement on a more consistent basis

For young people who are routinely in high-risk environments and who struggle to engage in the formal services on offer to manage risk or to address impacts of harm, the view by professionals can become fatalistic in nature. At times it appears that professionals from all the agencies can adopt a view that 'the child's own risk-taking behaviour' led to the sexual harm that happened. This can in turn result in children and young people being redefined as not vulnerable and in some an acceptance that further abuse is inevitable and responses become transactional. Several children and young people said they didn't want to do an evidential interview as part of criminal proceedings due to a previous negative experience of the process or because of genuine fear that the alleged abuser would retaliate. These insights have informed service design developments in the Joint Venture on Sexual Violence.

While the majority of children and young people already had therapeutic support in place or were referred to supports, there has been little analysis of how successful the supports have been in helping children and young people recover, how quickly referrals were picked up or the availability and quality of services in the area. This is an area of work that is being strengthened in the coming period to examine what works best and how young people resistant to supports can be encouraged to engage.

The analysis undertaken provides us with an opportunity to unpick the complexities and contextual settings of harm and the practice in responding to it. This helps us identify where preventive measures might be most needed and to provide a greater level of safety planning for children in certain circumstances. For example, feedback provided to the joint venture on sexual violence provided insights on geographical areas that are seeing most sexual harm to children in care and was also able to provide information on the types of people causing harm and the context in which harm occurs. This information enables focused delivery of services and encourages investment in services to be targeted and tailored to meet most need.

**Continuous improvement in responding to allegations of harm for children in care**

Regular feedback provided to sites and practice briefings provides opportunities to challenge skewed thinking and to ensure that in every instance children and young people's needs have paramountcy. Social workers acknowledge the need to advocate for children and young people within the formal system and this needs to remain a core objective when offering supports in this complex area of work.

The level of assurance undertaken within the organisation and the nature of reporting requirements in this area of our work means we have a better understanding of the areas of most need and as a result have set some immediate areas for focus and will set further areas as part of continuous improvement activities.

Reporting in the last year to the Independent Children's Monitor (with specific reference to regulation 69 – Responding to allegations of abuse or neglect for children in care) has acknowledged the need for improvements in consistency of practice.

Regular data and reporting on rates of harm allows us to respond as an organisation to the emerging patterns and trends we are seeing, to identify where preventive measures and practice improvements might be most needed and to provide a greater level of safety planning for children in certain circumstances. Information enables focused delivery of services and encourages investment in services to be targeted and tailored.

The detailed review of practice related to regulation 69 has enabled thorough understanding of those areas we are doing better in and those that require practice improvement:

- Consistently across the year, we demonstrated that we prioritise immediate actions needed to ensure the safety of tamariki where allegations of harm were raised.
- Annual data demonstrates high levels of compliance in ensuring children's plans were reviewed and progress was made on this area of our work through the year.
- We are more consistently meeting the requirement to put supports in place to address harm.
- The recording of practice is generally inconsistent, and specific requirements of regulation 69 are not evidenced routinely in records. For example, we are inconsistent in demonstrating that we are communicating assessment outcomes to children but practice that reflects increased levels of support for children would suggest that children are made aware of decisions but that social workers are not routinely or habitually recording this.
- In terms of timeliness, delay in finalising outcomes and in closing down phase records that relate to allegations of harm often relate to best practice intent and are not indicative of poor outcomes for tamariki – for example, delaying evidential interview processes to enable participation of tamariki, extending feedback periods to enable caregivers to engage, prioritising the health, social and emotional needs of tamariki over the needs of assessment and investigation work. Again, there is a need for a renewed focus on recording practice and the criticality of this in evidencing best practice and in enabling tamariki to understand how we responded and why.

- We have implemented a series of practice briefings to update site staff and ensure practice expectations are clearly communicated to all. The briefings also provide a series of resources and tools to promote consistent decision-making and recording to ensure a greater level of compliance with regulation 69. Additional focused coaching and

mentoring to staff is provided where needed.

- There is strengthened information and reporting available to operational leaders to enable them to oversee and drive continuous improvement in practice at a local level with a particular focus on consistency of decision-making, communicating outcomes, accuracy of recording and timeliness.
- We have further strengthened our internal assurance system to provide increasing insight into our practice with tamariki in care to take account of earlier decision-making processes and to enable understanding of how we address the impact of harm and what works well to prevent risk of harm.