ORANGA TAMARIKI
Ministry for Children

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

The correct path in clearing, to understand and make right

Tari o Te Tumu Tauwhiro
Office of the Chief Social Worker

A review of the practice in relation to Malachi Subecz and his whānau

29 November 2022

Te Kāwanatanga o Aotearoa

He whakamihi | Acknowledgments

Homai te atua, tau mai te tapū

Ka hau miri ake a hine-tū-ahu-oana

Ki ā te ika a Tūmatauenga

Orooro te tārai

Ka puta te wairua

Ka tū tekoteko

Ka tū te pounamu

Potini ara ake

Haumī e hui e

Tāiki e

Our deity draws in as sacredness arrives

Our entities softly caress and mould a life form

Vibrating with potential

The spirit enters

It gains an identity

A treasured living being

Learned pathways for the future

Bound together as one

This report is written about Malachi Rain Subecz (Malachi), a little boy whose life ended not long after his fifth birthday. Five months prior to his death, Oranga Tamariki had received a Report of Concern about Malachi, completed an initial assessment, and determined that it did not have a role at that time. Malachi's mother had made a guardianship decision for Malachi to be cared for by her friend, and Malachi remained in her friend's care until he was admitted with critical injuries to Starship Hospital on 1 November 2021.

We acknowledge the tragic loss of Malachi and the devastating impact his loss has caused to his whānau.

We are grateful to the whānau of Malachi, who have generously shared their stories to help us understand what happened and what we need to do differently.

Over the period 2009 to 2019, 78 tamariki have been killed as a result of child abuse and neglect in Aotearoa (New Zealand).[1] Oranga Tamariki is the statutory care and protection and youth justice agency responsible for promoting the wellbeing of tamariki (children) and their whānau, hapū and iwi to prevent them from suffering harm.

Our vision is for Aotearoa to value the oranga (wellbeing) of tamariki above all else.

[1] Family Violence Death Review Committee, Seventh Report: A duty to care. Pūrongo tuawhitu: Me manaaki te tangata. 7 June 2022. Health Quality & Safety Commission New Zealand, p16.

Kupu whakatahi | Foreword

Peter Whitcombe - Te Tumu Tauwhiro - The Chief Social Worker

I firstly mihi to Malachi, his mother, father, stepfather and whānau, who loved him dearly. I have observed the grace and bravery in their telling of what has happened. Their desire was for Oranga Tamariki to listen, explore and respond to the concerns they had. Their challenge is for this not to happen again.

It is with our heads bowed that we have undertaken this Review. We have strived to do the right thing, to be true in how we reflect back what we have heard, and to be bold in what we think is right.

The Oranga Tamariki staff we have spoken with have been open, their reality laid bare in the pursuit of responses that must be better. Other agencies and individuals have been generous in their time and sharing of experiences and expertise with us.

Child protection social work is innately complex and challenging. It is up to leaders to be relentlessly committed in supporting an environment for staff where both excellence and care is fostered. Trusting relationships are at the heart of good practice. Relationships that strengthen tamariki and children, whānau and families, communities and each other.

There is work to do. This report lays a challenge to be taken up - by social workers, service leaders, the wider Oranga Tamariki supporting functions, other agencies, communities, and government. All of us play a role in the safety and wellbeing of children. Taking accountability for what has happened will also mean committing and acting on the change required.

I wish to acknowledge the Review Team. Jane Caffery, Dr Nikki Evans, Joanne Dawson, Sarah Parker, Ashley Seaford, and Julia Breuer, who have brought everything that they are into this work. I have received support and wisdom from Shayne Walker, the Reference Group, and colleagues from Te Tira Hāpai and Quality Practice and Experiences Group. In particular I would like to acknowledge the support of Lorraine Hoult, Michelle Turrall and Aroha King to whom I am deeply thankful.

It is now our responsibility to take this work forward.

Shayne Walker - on behalf of the External Reference Group

Hā ki roto	*Breathe in*
Hā ki waho	*Breathe out*
Kia tau te mauri e kōkiri nei	*Settle the emotions that stir inside of me*
I ngā piki, me ngā heke	*Through the ups and downs*
Ko te rangimārie tāku e rapu nei	*It is peace that I seek*
Tīhei Mauri Ora	*Sneeze, the breath of life*

The death of Malachi reaches deep inside the hearts and minds of all of those involved in this Practice Review process. The circumstances around Malachi's death evoke anger and pain. I say this karakia so that we may 'settle' and learn from the experiences of Malachi and his whānau.

Hopefully, there is opportunity for healing and forgiveness. The whānau did everything they could to care for Malachi. Where knowledge is gathered, wisdom should follow. This Review is an honest account of 'what happened' and what Oranga Tamariki is doing about it, both for Malachi and his whānau, and for children and tamariki of Aotearoa New Zealand. The detailed findings and implementation of the subsequent recommendations is the true measure of the depth of the apology to Malachi and his whānau.

The Reference Group and I have endeavoured to ensure that this Review was conducted in a manner that was tika (correct and honest), pono (behaviours of integrity) and aroha (motivated by love). Our hope is that this review provides a whakawātea (clear pathway) for all those involved in this process.

We are indebted to the 'on the ground reviewers' for upholding the mana of all of those who contributed their voices to this review. Our deep regret is that Malachi did not receive this level of care when he was alive.

Lastly, to all of those who provided the detail required to weave the fabric of this report together, your voices will have an impact on practice with whānau Māori and all children and families we work with.

Ngā ihirangi | Contents

This report is presented in three sections.

1. Understanding what happened

The first section introduces Malachi and his whānau. It provides an overview of his early life and the events leading up to the change in Malachi's care arrangements. It then then examines the first Report of Concern made to Oranga Tamariki in June 2021, the second Report of Concern made in November 2021, and the practice that occurred up until Malachi's death 12 days later.

This section highlights the aroha that Malachi's mother and his whānau had for him, the concerns regarding his care, and their focus on protecting him.

2. Setting the scene

The second section is presented in four parts. The first explains the background to this Practice Review, the guiding principles, and methodology. The second part briefly explores how Oranga Tamariki practices and responds when Reports of Concern are made. Next, the Oranga Tamariki operating environment and challenges within Te Āhuru Mōwai site which responded to the Report of Concern, are examined. This section concludes with descriptions of what Malachi's whānau expected from Oranga Tamariki.

3. What should have occurred, what was found and what must change

The final section outlines what the Review Team found in the course of this review and consequent recommendations to address these findings. The Review identifies four areas which contributed to Oranga Tamariki failing to provide Malachi and his whānau with the right response. The first centres around the areas of practice decision-making that fell short of what was required to deliver a quality service to Malachi and his whānau, including the decision not to progress the initial assessment to a core assessment. The second is the site environment, support, and leadership which impacted on the ability of social workers to deliver best practice. The third is the practice guidance, professional development, and inter-agency processes which require strengthening to support social workers to consistently recognise and respond to the complex needs of tamariki and whānau. The fourth area is the wider community and system which did not communicate or respond in a connected way using a locally led, partnered approach to the initial Report of Concern.

The Review then makes specific recommendations based on what was found to enable Oranga Tamariki to address the gaps that were identified.

Section One

He aha te take me tōna māramatanga

Understanding what happened

Te māramatanga o Malachi me tōna ao | Understanding Malachi and his world

Introduction

The purpose of this Practice Review was to develop a holistic understanding about what happened to Malachi and his whānau, and how Oranga Tamariki responded. The Review makes findings of fact and recommendations for change. These are to be shared with wider government agencies and support agencies to inform internal and external system learnings. From these learnings Oranga Tamariki will strengthen the way it responds to tamariki and whānau when there are concerns for safety or wellbeing.

This Review finds that Oranga Tamariki did not meet their obligations to Malachi or his whānau. 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. The Review Team's first recommendation is that Malachi's whānau be offered an apology.[2]

To help us build an understanding of what happened to Malachi and his whānau, we have spoken with Malachi's whānau, talked with Oranga Tamariki staff, examined relevant documentation, and interviewed staff from other agencies who were involved.

Malachi, like all tamariki in Aotearoa, has rights under the United Nations Convention on the Rights of the Child (UNCROC). These include the right to life, survival, and development,[3] to be safe from all forms of abuse and violence[4], and to be cared for by their family and whānau[5] as far as possible. Under te Tiriti o Waitangi, tamariki and whānau Māori have special rights as tangata whenua, as do children with disabilities under the United Nations Convention on the Rights of Persons with Disabilities.

This report opens with the story of Malachi, in the context of his whakapapa, and whānau. This section explores the period from Malachi's birth in 2016 until Malachi's mother was held in custody in 2021.

Oranga Tamariki did not have contact with Malachi. The understanding of Malachi and his world that the Review Team have developed is based on the narratives of his whānau.

[2] The recommendations are set out on pages 69 – 74.
[3] Article 6.
[4] Article 19.
[5] Article 9.

Malachi and his whānau

Malachi Rain Subecz was born on 28 September 2016 in Tokoroa. At the time of his birth, he lived with his mother at the paternal grandmother's home, along with some of his paternal aunts and uncles. Malachi was named by his paternal grandmother.

> *[She] suggested the name Malachi. I looked up the name Malachi and it is biblical, although I am not religious, but I wanted a meaningful name and Malachi means messenger sent from God. [She] suggested it - I looked into the meaning, it was my decision in the end.*
>
> *[For his second name] I liked the name Reign, spelt like R-e-i-g-n. But that spelling was too common, and [she] said, why don't you spell it like R-a-i-n like the weather. I thought it is very different than how people usually spell it as reign, and I liked the name* (Malachi's mother).

Malachi's surname, Subecz, was his late maternal grandmother's name. Malachi's mother identifies as NZ European (Irish, German, and Hungarian) and his paternal whānau is of whakapapa Māori with tribal connections to Ngāi Tahu, Te Arawa, Ngāpuhi and one other iwi still in rangahau (an inquiry undertaken by Māori) by the paternal whānau.

Reflecting on her relationship with her son, Malachi's mother felt that Malachi had saved her life – her pregnancy with him being the reason she started to focus on her own wellbeing. He was her world, and Malachi referred to her as 'mummy'.

s9(2)(a) OIA

When Malachi was approximately three months old, his mother moved to Tāmaki Makaurau (Auckland) with her new partner and Malachi. In 2018, Malachi's mother eventually married this man, and he became Malachi's stepfather. Malachi referred to him as 'Dadda.' Even when this relationship subsequently ended, Malachi and his stepfather remained in touch with video calls and celebrated significant events together. Malachi's stepfather is described as a gentle man, and devoted husband and father who adored both Malachi and his mother. He has been described as rocking Malachi to sleep in his arms, even as a four-year-old. Malachi's stepfather was a very important person in Malachi's life and if Malachi couldn't be with his mother, he would choose to be with his stepfather.

> *Even though we were apart, he was still very much a part of Malachi's life … [they were] close as, close as* (Malachi's mother).

> *The breakup was a surprise. I said let's keep the ties for Malachi. He is my son. Even in the year when we broke up, we were not that type of parents that didn't talk. We called every two days, and video called with Malachi. We even video called in Wellington to celebrate our birthdays [when they were away]* (Malachi's stepfather).

Malachi was also very close to his stepfather's mother, who lived with them for a time, and would also visit and call frequently.

Malachi and his mother spent time in Te Whanganui-a-Tara (Wellington), Tāmaki Makaurau, and Tauranga moving to stay with whānau members and for employment opportunities. There was constant communication with whānau when Malachi and his mother were in Tauranga – and she would travel between cities on the bus, with Malachi.

> *The bus drivers described him as such a good little boy* (Maternal aunt).

Malachi was very close to his maternal whānau and spent time staying with extended whānau members and celebrating birthdays and other special occasions. His mother's sister was also very close to Malachi and enjoyed looking after him.

> *Even when we were around, she would change him and feed him* (Malachi's stepfather).

Malachi was particularly close to the husband of his mother's sister, who has been referred to by many as Malachi's ultimate favourite person. Many people refer to this man as "Pop", but to Malachi, he was "Poppy."

> *The little ones in the whānau are all really close to Pop and he's been described as the "baby whisperer"* (Maternal whānau).

Malachi loved playing with dinosaurs and his favourite movies were, 'The Land Before Time' and 'The Good Dinosaur.' Malachi was close to his cousins, particularly the five cousins that all celebrated their birthdays within a six-week period of his.

Malachi's life in Tauranga

In 2017, Malachi and his mother moved to Tauranga. While living there Malachi's mother introduced Malachi to Michaela Barriball (Michaela), a friend who she had met through work. Malachi's mother has stated that Malachi and Michaela had a good relationship and would see each other most days when they lived in Tauranga.

After separating from Malachi's stepfather, Malachi and his mother moved to Wellington, where they lived with one of his maternal aunts for a year. On returning to Tauranga, Malachi and his mother moved in with Michaela's mother. Michaela and her sister were living elsewhere.

During this time Malachi's mother became involved in offending, s9(2)(a) OIA . The offending of Malachi's mother was picked up by the authorities. When Malachi's mother became aware that she would be facing criminal charges, she was advised that she would need to think about who would care for Malachi in the likely event that she was sent to prison.

Malachi's mother was in discussions with members of her family about the care arrangements for Malachi up until she appeared in court. Malachi's maternal whānau said that his mother told different people different information about which of them would care for Malachi while she was in prison. Whānau talked about each person knowing something different because they were given different information by Malachi's mother. Malachi's mother told members of Malachi's maternal whānau that he was going to be staying with his maternal cousin, but his mother had not spoken to the cousin about this possibility.

Malachi's pāpā was aware that Malachi's mother had kept him away from his paternal family his whole life. Malachi's pāpā reports that he had tried to locate Malachi and his mother at different times, without success. It was his belief that Malachi's mother didn't want to share Malachi with him or the paternal grandmother, even when she knew she was going to be sentenced to prison.

Malachi's mother discussed her fear of losing Malachi with the Review Team. While Malachi's mother knew that his stepfather would have taken him "in a heartbeat," and cared for him very well, she was worried that if he cared for Malachi while she was in prison, he would be able to keep Malachi when she was released.

According to his maternal whānau, there were a number of people who would have cared for Malachi. Malachi's aunts had conversations with his mother about the option of her oldest sister being Malachi's primary caregiver while she was in prison. Again, Malachi's mother was worried Malachi wouldn't be returned to her when she was released and thought he would end up staying permanently with her sister.

Despite telling members of her whānau that Malachi was going to go to his maternal cousin, Malachi's mother decided that her friend Michaela would be the best person to care for Malachi. Part of her reasoning was that Michaela lived closer to the prison in Auckland so Malachi wouldn't need to travel so far (from Te Whanganui-a-Tara) to come and visit her.

> *At the time, I believed I did the right thing for Malachi…I did the best I could (*Malachi's mother).

Malachi's mother and Michaela arranged to file an application in the Family Court appointing Michaela as an additional guardian of Malachi and placing Malachi in Michaela's legal custody. On 18 June 2021, Malachi's mother and Michaela prepared these applications, and they were filed by consent with the Family Court on 30 June 2021. Malachi was appointed a Lawyer for Child to represent him in the Family Court process.

On 21 June 2021, Malachi's mother pled guilty to the criminal charges and was sent to prison in Auckland to await sentencing.

Malachi's mother did not tell her whānau that she was going to plead guilty and likely go to prison on this day. She did not say anything to Malachi's stepfather either, even though he had spent time with her and Malachi the day before she went to court.

> *One day before she went to prison, we [Malachi, his mother and stepfather] went on a date. I showed them my new house, we did a drive by. I told her, I'm close by you, whenever you need me, I am here. [Looking back now] something was up [that day] … He was crying. I didn't know why … she didn't tell me she was going to prison* (Malachi's stepfather).

Malachi's mother went through the prison admission process with Ara Poutama Aotearoa (Department of Corrections) staff. Malachi's mother does not recall being asked if she had a child during the admission process, but recalls telling staff soon after that she wanted to organise to have her son and friend as approved contacts, saying to staff:

> *My mate is looking after him* (Malachi's mother).

On 21 June 2021, Malachi left the court with Michaela. Malachi went to stay with Michaela as his mother and Michaela had planned. This was by agreement and there were no legal orders in place to support this arrangement.

The Review Team do not know how Malachi was feeling when he left the court that day, but acknowledge that being separated from his mother, his whānau, his home and surroundings would have been significant.

Upon hearing that Malachi's mother had been remanded in custody and that Malachi was staying with Michaela, Malachi's maternal cousin said that she contacted Ara Poutama Aotearoa, sharing her "major concerns about the child and where he was placed." The person Malachi's maternal cousin spoke with said that they would get Malachi's mother to call her back when she arrived.

On 23 June 2021, Malachi's mother returned this call after she arrived at prison. During that telephone conversation, Malachi's maternal cousin asked if she could pick Malachi up from Michaela's care. Malachi's maternal cousin reported that Malachi's mother refused.

Malachi's maternal cousin told his mother that she had major concerns for Malachi and was worried that Malachi might be intentionally hurt. Malachi's mother shared her belief that Michaela and her family would not harm Malachi because they are her friends. Malachi's maternal cousin disagreed, saying:

> *They are not your friends. They are the reason you are in here* (Malachi's maternal cousin).

When Malachi's maternal cousin spoke with his mother, she explained to her that all she needed to do was give permission through the lawyers for Malachi to be with his maternal cousin, not Michaela. Malachi's mother said that she would sort issues like this when she got out of prison. In reply, Malachi's maternal cousin told her she had spoken to Oranga Tamariki, and she would be filing applications for custody of Malachi in court.

First Report of Concern made by Malachi's whānau

On 22 June 2021, Malachi's maternal cousin visited an Oranga Tamariki site in the lower North Island. She met with the Duty Social Worker and made a Report of Concern for Malachi. She provided the name of Malachi's mother, but his father was listed as unknown.

According to CYRAS[6] (the Oranga Tamariki case management system) records, Malachi's maternal cousin shared the following concerns for Malachi:

- [Malachi's mother] has been remanded in custody until 5 August 2021. s9(2)(a) OIA and will be facing a hefty jail sentence as a result.
- [Malachi's mother] has pled guilty to the charges she is facing. [Malachi's mother] is known to be easily influenced and there are concerns she has been manipulated into this situation.
- Malachi is believed to be in the care of a Michaela Barriball of Tauranga.

s9(2)(a) OIA

- The people who have the current care of Malachi are unknown to family and they are concerned for Malachi's wellbeing.
- There are at least three different people who have been asked to care for Malachi.
- Malachi has missed a specialist appointment at Wellington Hospital as he has had a recent eye surgery, he has a speech delay and possible Asperger's as he is quite "flappy". Malachi has never been away from his mother before and witnessed her being taken away at court.

[6] CYRAS is an acronym which stands for Care and Protection, Youth Justice, Residential, Adoptions Services.

– Malachi has also moved between Porirua and Tauranga countless times in the past year whilst in the care of his mother.

The Social Worker recorded the Report of Concern on CYRAS and transferred it to Te Āhuru Mōwai (Tauranga West) site who service the region where Malachi was believed to be staying with Michaela.

In addition to the concerns recorded on CYRAS, the Review Team was told by Malachi's maternal cousin that she recalled providing other information, including:

- Her concern that Michaela was living with her sister, and her belief that at the time s9(2)(a) OIA .
- That all Malachi's family were in Wellington, apart from his stepfather who was in Tauranga. She explained who the stepfather was to Malachi, and their relationship.
- That she did not know who Malachi's birth father is, so was unable to give that information to the social workers who recorded the Report of Concern.

Further contact by Malachi's whānau with Oranga Tamariki about his care and safety

On 23 June 2021, the following information was recorded on CYRAS as a case note after a call from Malachi's maternal cousin. She advised the Social Worker that she had been to see a lawyer about filing a 'without notice' application for Malachi in the Family Court.[7] Malachi's maternal cousin shared that the maternal whānau remained very concerned about Malachi and did not know where he was. Malachi's maternal cousin said she would call the Social Worker back should the without notice application be granted, to advise of Malachi's whereabouts.

Contact from Malachi's stepfather

It is not recorded on CYRAS; however, the Review Team now know Malachi's stepfather telephoned the Contact Centre on 23 June 2021, with the assistance of a friend.

He was transferred to Te Āhuru Mōwai site. Malachi's stepfather identified himself as Malachi's father, not his biological father, but said he had been in Malachi's life since he was a baby. His worries for Malachi were that his mother had gone to prison, and he didn't know where Malachi was or who was caring for him. Malachi's stepfather expressed concerns about where Malachi might be staying and that he may not be in a good environment. He advised that Malachi had a heart murmur.

[7] A without notice application is an application filed in the Family Court without informing the other parties involved and goes directly to a Judge for consideration.

Malachi's stepfather was informed that Oranga Tamariki had already received concerns about Malachi, and Oranga Tamariki would call him back once it was known where he was. Malachi's stepfather then attempted to call Malachi's mother at prison but was unable to speak to her as they were no longer in a relationship. Malachi's stepfather did not hear back from Oranga Tamariki.

Further contact from Malachi's maternal cousin

On 28 June 2021, Malachi's maternal cousin contacted the Duty Social Worker at Te Āhuru Mōwai site. She advised that her lawyer had stated she would be unlikely to be successful in a without notice application for Malachi as she lived in the lower North Island and Malachi was living in Tauranga. In their conversation with Malachi's maternal cousin, the Social Worker recorded the following information on CYRAS:

- [Malachi's maternal cousin] is speaking to a lawyer around without notice application for orders but they have advised they do not think she will get it due to her being located in [lower North Island] and Malachi having to relocate there.
- [Malachi's mother] is [Malachi's maternal cousin's aunt] making Malachi her cousin.
- [Malachi's cousin] is very worried that Malachi is being used as or could be used as a blackmail tool. s9(2)(a) OIA .
- The family believes Malachi has some sort of developmental delay.
- [Malachi's maternal cousin] had a photo of Malachi sent to her recently and she thought it looked like there was bruising around his eye. I [The Social Worker] have advised her that she can email this to the [Contact Centre] to ask them to attach it to the Report of Concern.

The Review Team were subsequently told, that after raising her concerns about Malachi's wellbeing with Oranga Tamariki, Malachi's maternal cousin felt that she needed to provide evidence to support her concerns. She therefore asked Michaela to send a photo of Malachi so that she could see how his eyes were after his recent eye surgery. Michaela sent Malachi's maternal cousin a photo of Malachi. Malachi's maternal cousin felt that she could see possible bruising in the photos and other whānau members agreed with her. This is the photo referred to in CYRAS, above.

On 28 June 2021, Malachi's maternal cousin emailed the photo of Malachi to the Contact Centre as instructed. Her email read as follows:

> *Hi i* (sic) *have been asked to send this photo through that i* (sic) *recived* (sic) *of Malachi Subecz*
> *D.O.B 28/09/2016*
>
> *I have been in contact and raised my concerns already and was asked to send this through.*

> *Possible brusing* (sic) *around eye?*
> *Could be nothing but best to pass it on to you guys.*

The Contact Centre Social Worker (Acting Supervisor) forwarded the photo of Malachi via email to Te Āhuru Mōwai site email address for the attention of the two Social Workers who had taken calls from Malachi's maternal cousin. In the email, the photograph was noted as additional information for the Report of Concern which had been made on 22 June 2021. The photo was then put on a waitlist to be entered into CYRAS by Contact Centre customer service specialists.

Social workers from Te Āhuru Mōwai site viewed the photograph after it was emailed to the site and were of the view that there were no actual indicators of harm for Malachi at that point. The viewing and analysis of the photo was not recorded in CYRAS.

> *I remember looking at the photo and trying to find a bruise on it… and not* (Te Āhuru Mōwai Social Worker).

Contact from Malachi's mother

On 29 June 2021, Malachi's mother phoned the Contact Centre from prison. According to her, a Corrections Officer told her someone from Oranga Tamariki had called her and she was returning the call. Oranga Tamariki has no record of phoning her.

The Review Team are now aware that prior to this phone call from Malachi's mother to the Contact Centre, Malachi's maternal cousin had informed his mother that she had already contacted Oranga Tamariki with concerns about Malachi's wellbeing.

The Review Team understand from Malachi's mother that she spoke to the Social Worker at Te Āhuru Mōwai site and explained her reasons for leaving Malachi in the care of Michaela.

> *It was just the basic questions like how long I have known her for. I don't think I was asked too much. They asked if I thought she was stable and if I have been to her place before. If she had any kids? I said no but she helped raised her sister's kids* (Malachi's mother).

The following information was recorded as a case note in CYRAS:

- [Malachi's mother] called from Auckland Women's Regional Correctional Facility
- She doesn't understand why her family is judging Michaela. She said Michaela does not do drugs and is not gang affiliated. She said Michaela is in a s9(2)(a) OIA home. She

would not have placed Malachi with Michaela if he didn't want to be there and she didn't think it was safe.

- When I [the Social Worker] explained the concerns around Malachi being used as blackmail she said they s9(2)(a) OIA would never do that.
- She wanted to call and be open and honest because she has nothing to hide.
- [Malachi's mother] would like someone to come to visit her at the prison.
- She is currently going through family court to support Michaela getting guardianship and parenting orders [for Malachi].

Malachi's mother asked the Social Worker to contact Ara Poutama Aotearoa (Department of Corrections) to request that Malachi's maternal cousin and Malachi be added to her phone list of people she could speak with while she was in prison.

Malachi's paternal whānau were not aware of Oranga Tamariki involvement.

Oranga Tamariki undertook an initial assessment[8]

On 29 June 2021, the Report of Concern for Malachi was given to a Social Worker at Te Āhuru Mōwai site to complete the initial assessment. The Social Worker allocated had previously taken a call from Malachi's maternal cousin in the role of Duty Social Worker on 28 June 2021.

The Social Worker had recently started in the role at Oranga Tamariki and was on a 'supported practice step'. This meant for the first six months the Social Worker had a lower caseload and had higher levels of support and supervision. Initial assessments should be undertaken by experienced social workers, but due to a high volume of cases waiting for allocation, the intake role was being shared across the site based on whomever had capacity, with support and guidance.

The Social Worker was not aware that the Report of Concern had been entered into CYRAS by another Oranga Tamariki site rather than the Contact Centre. The Social Worker assumed that Malachi's maternal cousin had contacted the Contact Centre directly. The Social Worker from the Lower North Island site did not record that the notifier had come into the site office to report the concerns.

The Social Worker had already spoken to Malachi's maternal cousin and to Malachi's mother. The Social Worker checked CYRAS for any Oranga Tamariki history with Malachi.

[8] An initial assessment is the process of a social worker gathering sufficient information to understand the needs of te tamaiti and inform the decision about whether te tamaiti requires further statutory assessment or an alternative response. Section 17 of the Oranga Tamariki Act 1989 gives the social worker discretion to determine whether it is necessary or desirable to investigate the concerns reported under section 15. This is not the same as investigating the concerns and there are different parameters for the enquiries the social worker can make with others during the initial phase of assessment.

In the course of the initial assessment, the Social Worker identified the following needs for Malachi and recorded this as a case note in CYRAS:

- Malachi needs to know and be cared for by safe family. Malachi's mother is currently remanded in custody facing charges relating to s9(2)(a) OIA . Malachi needs family who will care for him long-term in this instance.
- Malachi needs a relationship with his mother. Malachi has been with his mother and had time to build a bond and attachment over the first four years of his life, he needs someone to help him sustain this relationship and attachment while she is unable to be his primary caregiver. Malachi's current care arrangements do not allow for this due to the non-association order between s9(2)(a) OIA .
- Malachi needs to be safe from being used as a blackmail tool between his mother and OIA s9(2)(a) OIA .

There is nothing recorded to show whether the Social Worker considered the photograph of Malachi as part of the initial assessment. The photograph had not yet been saved onto CYRAS by the Contact Centre and there was no case note referring to the fact that the photograph had been received.

The Social Worker determined that while Malachi had unmet needs, there were no care and protection concerns[9] for him.

> *There was nothing to say that Malachi's mother couldn't make decision for her son. The Social Worker considered that [Malachi's mother] had made a guardianship decision about where her child should live. The absence of history about her [Malachi's mother] ability to care for her son informed the Social Worker that [the mother] had made decisions for her son that had not previously raised any concern* [Practice Analysis].

At this time, it was not normal practice for Te Āhuru Mōwai site to make referrals to agencies for needs identified as part of an initial assessment. The Social Worker was of the view that the involvement of the Family Court meant that if there were any safety issues identified for Malachi, these could be referred back to Oranga Tamariki.

> *The fact the family had engaged the Family Court was an indicator of safety for Malachi as outlined in the [Intake] Decision Response Tool. That if concerns should arise in the Family Court process, the Family Court can refer to Oranga Tamariki* [Practice Analysis].

[9] Care and protection concerns are defined by s14 & s14AA Oranga Tamariki Act 1989 Oranga Tamariki Act 1989 No 24 (as at 01 September 2022), Public Act 14 Definition of child or young person in need of care or protection – New Zealand Legislation.

The Social Worker completed a Pathway Rationale[10] that recommended no further action be taken by Oranga Tamariki and sent this to their Supervisor for approval.

On 30 June 2021, a different Supervisor confirmed and signed off the Pathway Rationale. It was common practice at this site for the Supervisors to consult together before approving the Pathway Rationale. The Supervisors were not aware of the photograph. It was not recorded on CYRAS or in the Pathway Rationale.

The Social Worker phoned Malachi's maternal cousin to advise of the outcome of her Report of Concern. This phone call was not recorded as a case note on CYRAS.

Further actions of Oranga Tamariki

On 6 July 2021, a customer support specialist from the Contact Centre, who had been hired temporarily to address a backlog, entered the photograph of Malachi onto CYRAS. The photograph was added as a case note entitled 'additional information' after the case had been closed.

On 9 July 2021, the Social Worker who completed the initial assessment for Malachi followed up the request from Malachi's mother and emailed Ara Poutama Aotearoa to request that Malachi's mother be able to speak to Malachi's maternal cousin and Malachi by phone.

Events for Malachi following the initial assessment

The following information is what the Review Team now know from conversations with whānau, and other agencies involved with Malachi and his whānau during this time.

Members of the maternal whānau agreed that Malachi's maternal cousin would be the one to apply for custody of Malachi in the Family Court. They believed that Malachi's maternal cousin would be the most likely to be successful. On 19 July 2021, Malachi's maternal cousin was declined leave to apply for custody of Malachi.[11] This was later granted on 13 September 2021.

On 19 July 2021, Michaela took Malachi to his specialist eye appointment at Wellington Regional Hospital. Malachi's maternal cousin arranged to meet with Michaela and Malachi while they were in Te Whanganui-a-Tara. Malachi's maternal cousin bought some new clothes for Malachi so that she could check for bruises or any signs of harm when she got him to try them on. She did not see any bruising on him that day. Malachi's maternal cousin was trying hard to "get the evidence" she believed Oranga Tamariki needed to act on her concerns for Malachi.

[10] A Pathway Rationale is a written analysis of the information the social worker has captured as part of the Initial Assessment and records the recommended outcome of the Report of Concern.
[11] Leave to apply is seeking permission from the court to file an application.

When Malachi's maternal cousin hugged Malachi goodbye, he didn't want to let go – holding onto her like "a koala to a tree." When Malachi's maternal cousin put Malachi in the car, she whispered to him, "Don't worry, you'll be back here soon."

Malachi's maternal cousin has told the Review Team that she contacted many services and organisations trying to raise awareness of possible harm to Malachi.

On 22 July 2021, Ara Poutama Aotearoa records show the Probation Officer for Malachi's mother contacted the Social Worker who had completed the initial assessment for Malachi. The Probation Officer was concerned about the safety and wellbeing of Malachi and contacted Oranga Tamariki. When the Probation Officer spoke to the Social Worker, they advised that the concerns had already been assessed by Oranga Tamariki and no further action was required. This conversation was not recorded as a case note and the Social Worker has no recollection of the phone call.

On 25 July 2021, Malachi's maternal cousin made a complaint to Oranga Tamariki via the website. She made the complaint after learning that an investigation would not occur into her Report of Concern for Malachi. Malachi's maternal cousin and whānau had major concerns about where and who he was staying with. Malachi's maternal cousin was concerned that after one phone call from Malachi's mother, who was remanded in custody and had not seen Malachi since her court date, no one was looking into the concerns she had raised.

By this time, Malachi's maternal cousin knew her Family Court application for leave to apply for custody of Malachi had been unsuccessful.

On 30 July 2021, the Supervisor from Te Āhuru Mōwai site, who had supported closure of the Report of Concern, was asked by the Manager to respond to Malachi's maternal cousin about her complaint. The Supervisor advised Malachi's maternal cousin the reasons why the case had been closed and confirmed this to her in an email on the same day.

The reasons were:

- There were no specific concerns regarding Malachi's care or protection.
- Malachi's mother had confirmed that she had placed Malachi with Michaela as he knew her, and he wanted to be there.
- Michaela was geographically closer to where Malachi's mother was imprisoned, and this would make visits easier.
- The Social Worker had contacted Ara Poutama Aotearoa and advocated for Malachi's mother to be able to contact Malachi's maternal cousin and Malachi.
- There was no role for Oranga Tamariki.
- Malachi's maternal cousin was able to make another Report of Concern for Malachi if she had further concerns for his safety.
- The Family Court applications of Malachi's maternal cousin were still being considered.

s9(2)(ba) OIA,s11(b) Family Court Act (FCA) 1980

On 2 August 2021, Malachi and Michaela met with the Lawyer for Child. This is the lawyer that had been appointed for Malachi in the Family Court proceedings.

> …*they presented well. She* [Michaela] *would talk sometimes, interpret for him* [Malachi]*, because some of the things he said were hard to understand* (Lawyer for Child).

s9(2)(a) OIA

Between 19 July 2021 and 2 November 2021, Malachi's mother used her prison phone card, paid for by wages she earned in prison, to make 160 calls to Michaela so she could speak to Malachi. Forty-four of these phone calls were answered, and Malachi spoke to his mother on about 25 occasions.

On 16 August 2021, Malachi and his mother were approved by Ara Poutama Aotearoa to have face-to-face visits. On 17 August 2021, New Zealand was moved to COVID-19 Alert Level 4. This meant that Malachi could not travel to prison for visits with his mother as arranged. Audio Visual Link (AVL) visits were set up as an alternative.

The Review Team have been advised that Michaela received financial assistance from the Ministry of Social Development s9(2)(a) OIA so Malachi and Michaela showered and ate their meals in her father's house.[13]

On 13 September 2021, Michaela was granted interim guardianship of Malachi in the Tauranga Family Court. This meant that she could make guardianship decisions for Malachi such as educational or health decisions. s9(2)(ba) OIA

[12] Under the Care of Children Act 2004. A Family Court Registrar requests Oranga Tamariki to provide brief, written advice on the nature and extent of any involvement Oranga Tamariki has had with the parties to an application for a guardianship order or parenting order.

[13] s9(2)(ba) OIA

s9(2)(ba) OIA [redacted]

On 24 September 2021, Michaela took Malachi to a visit at the local Primary School where he was due to start on 18 October 2021.

On 27 September 2021, Michaela dropped Malachi at his day-care. Malachi had a different hairstyle with his hair over his forehead and injuries to his face including a black eye.[14] When the day-care staff asked Michaela what had happened, she said that Malachi had fallen off his bike and fallen over the weekend.[15] The day-care staff asked Malachi if he had fallen off his bike and he said no. While staff attended to his injuries, Malachi told them that Michaela would be angry with him.[16] The day-care staff took photographs of Malachi's injuries but did not notify the Ministry of Education, the Police or make a Report of Concern to Oranga Tamariki.

s9(2)(a) OIA [redacted]

s9(2)(a) OIA [redacted], Michaela took Malachi to a function with her whānau s9(2)(a) OIA [redacted] Some of Michaela's whānau members noticed a healing burn on Malachi's forehead and were worried that he was being harmed by Michaela. When they asked Michaela what had happened, she told them that he had burnt himself in the shower and she had taken him to see a doctor.[18]

On 28 October 2021, Michaela and her father took Malachi to the local medical centre asking for a letter confirming that Malachi did not have autism. This was to support Michaela's application in the Family Court for custody of Malachi. The Review Team have been told that Malachi was seen by a health professional on this day.

[14] s9(2)(ba) OIA [redacted]
[15] Ibid p5.
[16] Ibid p5-6.
[17] Ibid p6.
[18] Ibid p9.

The Family Court hearing to decide on Malachi's care arrangements was due to take place on 1 November 2021. Prior to that hearing, Michaela advised that she was required to undergo COVID testing and therefore could not attend. Malachi's maternal cousin offered to drop off a laptop to Michaela so the court hearing could go ahead, but Michaela declined the offer. The hearing was adjourned.

On 1 November 2021, at about 8:30am, an ambulance was called to the home of Michaela's father. Malachi was unconscious and having seizures. Malachi's medical presentation was consistent with having suffered a traumatic brain injury. While treating him, ambulance staff noticed Malachi had burns on his abdomen. Malachi was taken to Tauranga Hospital and then airlifted to Starship Children's Hospital. At approximately 1pm he underwent emergency surgery, had a tube inserted to help him breathe, and was placed into an induced coma.[19]

It is now known that Malachi experienced sustained abuse from Michaela.

Second Report of Concern and the last days of Malachi's life

On 1 November 2021, a hospital staff member made a Report of Concern about Malachi to Oranga Tamariki. The Report of Concern said that Malachi had been admitted to Starship Hospital and there were indications that he had suffered non-accidental injuries.[20] The Report of Concern was accepted by Te Āhuru Mōwai site and a social worker allocated the next day. The Social Worker was different to the one who had completed the initial assessment.

Te Āhuru Mōwai social workers requested to travel to Tāmaki Makaurau to be present with Malachi and his whānau at the hospital. This request was declined by the Site Manager due to COVID-19 travel restrictions and the need for them to be in the office for other work commitments. Social workers were advised that the work could be carried out remotely.

On 2 November 2021, the Social Worker made an information request to the Ministry of Social Development to try and ascertain details about Malachi's pāpā. No information was available because Malachi's pāpā was not listed on his birth certificate.

Several attempts were made by the Oranga Tamariki social workers to understand Malachi's whakapapa. Malachi's mother would not provide any information to the Social Worker about Malachi's pāpā.

> *She didn't want to talk about him [paternal father]. I asked a few times; I asked [maternal whānau member] as well – he has nothing to do with him, we are not talking about what his name is* (Social Worker).

[19] s9(2)(ba) OIA

[20] A non-accidental injury results when a person does something that physically harms or injures a child and the explanation given is not consistent with the presenting injuries.

> *We asked her [Malachi's mother] … where does Subecz come from; are you Māori/Pakeha? I asked specifically if he* [Malachi] *was Māori – so I respected that* (Social Worker).

This matter was not explored further with her at this time.

s9(2)(a) OIA

. Malachi had one-on-one nursing care provided 24 hours a day.

On 1 November 2021, Ara Poutama Aotearoa granted Malachi's mother compassionate leave from prison, and she was with Malachi at the hospital.

Malachi's maternal uncle has reported to the Review Team that he called the Contact Centre on the morning of 2 November 2021 to enquire about the Oranga Tamariki complaints process. He reports that he was told that there is no complaints process. Oranga Tamariki has no record of this phone call.

In the evening of 2 November 2021, Malachi's maternal uncle called the Contact Centre and raised his concerns about the closure of the first Report of Concern and Malachi's subsequent injuries. In this call Malachi's maternal uncle also asked the Oranga Tamariki complaints process. His concerns were recorded as a case note and he was advised how to make a complaint.

On 2 November 2021, the Social Workers contacted numerous whānau, Health and Education professionals, Police, and Lawyers keeping them updated about the situation for Malachi. This included having to break the news of Malachi's hospitalisation as some were not aware of what had happened. A multi-agency professionals meeting occurred involving Health professionals, Police and Oranga Tamariki. These professionals created a multi-agency safety plan[21] for Malachi. The Multi Agency Safety Plan considered safety issues for Malachi, how his safety needs would be addressed and the plan moving forward.

On 3 November 2021, Malachi's maternal uncle contacted the Minister for Children's Office to express his concerns for Malachi and request that Michaela not be permitted to make guardianship decisions for Malachi.

s11(b) FCA 1980

[21] A multi-agency safety plan is a written plan developed with multiple agencies which identifies the safety issues for te tamaiti and how these safety issues will be addressed.
[22] Section 31 Care of Children Act 2004.

s11(b) FCA 1980

[23]

On 4 November 2021, Te Āhuru Mōwai Practice Leader phoned Malachi's maternal uncle to respond to the call he made to the Contact Centre on the evening of 2 November 2021 and followed up with an email. During this conversation, the Practice Leader [24] reported that they asked the whānau member who Malachi's father was. The Practice Leader noted that the whānau member said that they knew but were not prepared to give that information to Oranga Tamariki.

On 5 November 2021, Malachi's mother asked that her sister, her sister's husband, and Malachi's stepfather come to the hospital to support her and to be present at Malachi's bedside. Arrangements were made accordingly.

On the same day, Malachi's maternal cousin contacted Oranga Tamariki requesting that she be present at Malachi's bedside. The Supervisor said that it would not be possible for Malachi's maternal cousin to be there in line with the wishes of Malachi's mother.

During this time, Malachi's maternal aunt phoned his paternal aunt and informed her that Malachi had been harmed and was in hospital. Malachi's paternal aunt then informed his paternal grandmother. Then she called Malachi's paternal great-grandmother.

> *She heard about it on the news. Her friends and her were watching it. She was saying, that poor whānau. I said, nana, sit down. I said, nana, that's your mokopuna. That's your oldest mokopuna* (Malachi's paternal aunt).

Malachi's grandmother told his pāpā that Malachi was in hospital. Malachi's pāpā contacted Starship Hospital and requested to visit Malachi. According to him, he was told there was no one by that name in the hospital.

> *As soon as I found out, I rang the hospital. I said I was the father. They said we don't have that name here and they blocked me out … I wanted to go and sit with him* (Malachi's pāpā).

Malachi's pāpā and paternal whānau received their information about what had happened to Malachi from watching the news.

On 8 November 2021, Starship staff provided a medical update to Malachi's maternal whānau and Oranga Tamariki. They advised that Malachi would not survive without the support of the

[23] The Review Team noted there was high regard for the work that the Social Workers undertook at that time. OIA s9(2)(a) OIA

[24] A senior role based in site offices, the Practice Leader provides practice advice, support, supervision, coaching and quality assurance.

ventilator. A hui (meeting) was planned for the following day to discuss removing the ventilator. Malachi's mother requested that her sister, her sister's husband, and Malachi's stepfather be present for this meeting.

On 9 November 2021, a hui was held with Malachi's mother and her whānau supports, Ara Poutama Aotearoa, Starship staff, and Oranga Tamariki. The medical team advised that Malachi's breathing tube needed to be removed as there was no other option for his recovery unless he could breathe on his own. Malachi's mother provided her consent for Malachi's breathing tube to be removed the following day.

As Malachi's paternal whānau had not been involved up until this point, they were not included in the decision to remove Malachi's breathing tube, or the timing of its removal.

> *Where was [Malachi's pāpā's] decision when they switched off his life support? What if he wanted to wait so he could say goodbye? Also, what if he wanted to say no, and hope for a miracle?* (Paternal aunt).

Malachi's paternal aunt was the only member of the paternal whānau to have the opportunity to say goodbye to Malachi. She did this on a phone that Malachi's maternal aunt held up to his ear. Malachi's paternal aunt said that the maternal whānau knew that Malachi was Māori, and that she asked for them to find someone at hospital who could do a karakia for him, "because that's our way." She does not think that happened.

On 10 November 2021, Malachi's breathing tube was removed. Malachi's mother, stepfather, and maternal aunt remained with him until he passed away two days later, on 12 November 2021, in the arms of his maternal uncle Poppy.

Section Two

Whakarite i te kaupapa

Setting the scene

Te tirohanga whānui o ngā mahi arotake | Overview of the Practice Review approach

Introduction

This section covers the reasons for undertaking this review, and the purpose, scope, and methodology that has been used.

Reasons for the review

On 22 June 2021, Oranga Tamariki received a Report of Concern for Malachi. Maternal whānau members were worried about Malachi as his mother had been imprisoned and she had left him in the care of a friend. An initial assessment was completed. An initial assessment is undertaken to gather information to determine what is the best response for a child and whether there is a role for Oranga Tamariki to complete a further assessment or investigation to understand the safety needs for the child. A decision was made that there was no role for Oranga Tamariki due to Malachi's mother being clear she wanted Malachi to live with Michaela. The case was closed with no further action taken by Oranga Tamariki.

On 1 November 2021, Malachi was admitted to hospital after sustaining severe, non-accidental injuries to his head and body. He was also suffering from acute malnutrition. Another Report of Concern was made to Oranga Tamariki s11(b) FCA 1980 .

On 10 November 2021, Malachi's breathing tube was removed. Tragically Malachi passed away two days later on 12 November 2021. The cause of Malachi's death was determined to be blunt force head injury.[25]

On 22 December 2021, Michaela Barriball was charged with the murder of Malachi as well as other charges related to harming Malachi. Michaela subsequently pled guilty to the charge of murder, one charge of injuring with intent to injure, and two charges of ill-treatment of a child.[26] Michaela was remanded in custody to await sentencing.

On 30 June 2022, Michaela was sentenced to life imprisonment with a minimum period of imprisonment of 17 years.[27]

Following the death of Malachi, a Practice Analysis[28] report was drafted, however, when reviewed in May 2022, there remained gaps in information regarding the quality of practice and decision making and Te Tumu Tauwhiro (the Chief Social Worker) was not able to provide

[25] s9(2)(ba) OIA
[26] *R v Barriball* [2022] NZHC 1555 para 1.
[27] Ibid para 106.
[28] A Practice Analysis gathers a chronology of Oranga Tamariki involvement, reviews the quality of practice undertaken and develops a response plan.

assurance regarding the quality of practice. It was therefore decided that a review be commissioned that explored all aspects of what happened for Malachi, his whānau, and whether the Oranga Tamariki response was appropriate.

In May 2022, Te Tumu Whakarae mō ngā Tamariki (the Secretary for Children) commissioned Te Tumu Tauwhiro to lead a review into the circumstances, practices and actions of Oranga Tamariki in relation to Malachi and his whānau and make findings and recommendations as appropriate.

In May 2022, Chief Executives decided to commission a system-wide review. Dame Karen Poutasi was appointed to lead this in June 2022. The system-wide review will explore the roles of all government agencies that had contact with Malachi and his whānau, and what may be learnt as a system in how to best respond to tamariki who may be at risk of harm.[29] This Review will inform the system-wide review. To support this, observations and insights for partner agencies have been included in this report.

Scope

The scope of the review covers the period from June 2021 when Malachi's mother was imprisoned, until he passed away on 12 November 2021. Any history of prior involvement of Malachi, his whānau and the other parties with Oranga Tamariki has been considered only to the extent that it is necessary to understand what happened during the above period of time.

The purpose of the practice review report is to:

– consider and advise whether the decisions made by Oranga Tamariki were appropriate;
– provide advice and recommendations on whether the current assessment procedures, policy and guidance of Oranga Tamariki needs to be modified;
– understand the wider system conditions present at the time and to what extent these impacted on decision making and the practice approach;
– apply any reflections and insights into the processes within Oranga Tamariki and the wider system;
– uphold the mana and oranga of all review participants.

In order to determine the appropriateness of the Oranga Tamariki response to Malachi and his whānau, we have reviewed the social work practice, decision-making and assessment of needs and risk. The purpose of this review is to identify if there were any gaps, challenges or

[29] Other government agencies involved in the systems review are: Ara Poutama Aotearoa (Department of Corrections), NZ Police, Te Whatu Ora (Ministry of Health), Ministry of Education and the Ministry of Social Development.

opportunities which can be further explored to improve our practice and the way we respond to tamariki and whānau.

Specifically, we have reviewed:

- the quality (depth and breadth) of the initial assessment;
- engagement with whānau, hapū and iwi;
- engagement with relevant professionals as required;
- the application of current practice policy and tools;
- practice policy, tools, and legal advice relating to the intake and initial assessment approach;
- supervision and leadership;
- site culture and contextual challenges, including but not limited to workflow trends, recruitment and learning and development.

To inform the review we have examined relevant evidence and documentation available to us and interviewed Malachi's whānau. A list of the documents we have relied upon and the people we have spoken to is attached as Appendix Two.

Out of scope for this review is any external complaints processes associated with these events.

Methodology

Oversight of the review

This review has been led by Te Tumu Tauwhiro (the Chief Social Worker) of Oranga Tamariki and facilitated by senior staff from his office. The Review Team has been supported by staff from Oranga Tamariki Quality Practice and Experiences, including Te Tira Hāpai (the Māori Practice Advice Team), Legal Services, Communications and Human Resources.

The review process has been overseen by Independent Advisor Mr Shayne Walker (Mr Walker). Mr Walker (ONZM, Ngāi Tahu, Kāti Māmoe, Waitaha, Ngāti Kahungunu) is a senior lecturer, Department of Sociology, Gender and Social Work, University of Otago. The role of the Independent Advisor is to advise and assist Te Tumu Tauwhiro in all aspects of the review.

The review has been undertaken under the oversight of an external Reference Group. The purpose of the external Reference Group is to act in an advisory capacity to Te Tumu Tauwhiro and the Independent Advisor. The external Reference Group has been chosen for their ability to bring a child-centred and whānau-focussed view to the work of the review.

The external Reference Group comprises:

- Chief Executive, Social Services Providers Aotearoa;

– Senior Specialist Advisor, Family Violence Death Review Committee, Health Quality & Safety Commission;
– Senior Advisor, Iwi and Māori Engagement – requested by paternal whānau.

The role of the external Reference Group is to:

– provide advice and support in engaging with whānau, particularly in relation to the non-accidental death of a tamaiti;
– impart Te Ao Māori ways of knowing, being and doing;
– provide advice on the different perspectives of those involved in these events;
– test, challenge and provide advice to Te Tumu Tauwhiro and Independent Advisor around the issues arising from the review;
– provide advice on appropriate approaches to resolution and healing for Malachi and his whānau;
– be guided by whānau for approaches towards resolution and healing for the loss of Malachi;
– provide advice on stakeholder engagement and in particular the approach to dissemination of findings to review participants.

The Office of the Children's Commissioner has also participated in the review process to bring a child's rights perspective and knowledge of Te Tiriti o Waitangi (the Treaty of Waitangi) to the review. Representatives from the Office of the Children's Commissioner have ensured that the review process, analysis and findings are robust, adhere to the principles agreed at the outset, and inform improved practice.

Guiding Principles

In carrying out this review, we committed to upholding the principles of Te Tiriti o Waitangi; the organisational values of Oranga Tamariki; the legislative responsibilities of the Oranga Tamariki Act 1989; and Te Ao Māori knowledge, principles and practices.

Te Tiriti o Waitangi

Te Tiriti o Waitangi (Te Tiriti) lays the foundation of the relationship between Māori and Tauiwi. Te Tiriti guides the reciprocal responsibilities we have to each other as bicultural partners to ensure positive and equitable outcomes for Māori communities, hapū and iwi.

Section 7AA of the Oranga Tamariki Act imposes a duty on Oranga Tamariki to recognise and provide a practical commitment to the principles. This section requires Oranga Tamariki to ensure that any policies or practices which impact on the wellbeing of tamariki, have the

objective of reducing disparities for tamariki Māori. The services provided by Oranga Tamariki must also have regard to mana tamaiti, the whakapapa of tamariki Māori, and the whanaungatanga responsibilities of whānau, hapū, and iwi.[30]

United Nations Convention on the Rights of the Child

Aotearoa is a state party to the UNCROC. This means there is a duty and responsibility to ensure that the human rights of all tamariki are upheld and respected. When it comes to child safety, Article 19 of UNCROC makes clear that all children have the right to be free from all forms of physical or mental violence, injury, abuse (including sexual abuse), neglect and maltreatment, while in the care of their family or anyone else caring for them.

Oranga Tamariki Act 1989

The Oranga Tamariki Act 1989 is the principal legislation guiding the work of statutory Social Workers in their role promoting the well-being of tamariki and their whānau, families, hapū, iwi and family groups.[31]

The key principles of the Oranga Tamariki Act, relevant to this review, are:

- the wellbeing and best interests of children are paramount[32]
- children must be provided with support and encouragement to express their views and these views must be taken into account[33]
- children should participate in decisions which affect them[34]
- the rights of children must be respected and upheld[35]
- children need safe, stable and loving homes[36]
- the wellbeing and mana tamariki of children will be protected through the recognition of their whakapapa and the whanaungatanga responsibilities of their whānau[37]
- children should be seen holistically[38]
- the place of a child, within their whānau, should be recognised and respected.[39]

[30] Section 7AA(2)(b) Oranga Tamariki Act 1989.
[31] Section 4.
[32] Section 4A.
[33] Section 5(1)(a).
[34] Section 5(1)(a).
[35] Section 5(1)(b)(i).
[36] Section 5(1)(b)(iii).
[37] Section 5(1)(b)(iv).
[38] Section 5(1)(b)(vi).
[39] Section 5(1)(c).

Oranga Tamariki values

In undertaking this review, the Review Team have strived to always act in accordance with the Oranga Tamariki values:

- We put tamariki first
- We believe aroha is vital
- We respect the mana of the people
- We are tika and pono
- We value whakapapa
- We recognise that oranga is a journey

Te Ao Māori knowledge, principles and practices

While engaging with others the Review Team has been guided by Te Ao Māori principles and tikanga.

We have honoured the importance of engaging with others kanohi ki te kanohi (face-to-face), especially when establishing first contact. We have worked to foster whanaungatanga, establishing meaningful connections with others, in pursuit of respectful relationships. We have displayed manaakitanga in the way we have treated others and ensured that our engagement has been mana-enhancing[40]. Finally, we have acted in accordance with the principle of whakapono (integrity and honesty) in the course of this review to uphold the mana of Malachi, his whānau and all those who have participated in this review.

We have also adhered to the principles of Te Toka Tūmoana. Te Toka Tūmoana is the Oranga Tamariki indigenous and bicultural principled framework which guides us in our engagement with whānau Māori.[41] Some examples of these principles in action have been through the use of karakia, waiata, koha atu, koha mai, and utilising an āta approach[42] through āta titiro, āta whakarongo and āta whakaako.

Oranga Tamariki has a Practice Framework that provides a body of knowledge and way of working that underpins practice guidance for all practitioners. This framework supports a focus on ensuring safety and oranga needs for children are met within in the context of their

[40] Mana-enhancing practice was promoted as an approach which combines techniques for engagement that enhances rather than strips Māori people's experiences from their cultural realities or contexts (Ruwhiu, 1999, p. 53). The founding premise of mana-enhancing practice reinforces the holistic relational aspects of this paradigm not only to people as in many western paradigms, but to spiritual and environmental factors. This requires a belief and deep understanding of mana described as the 'cultural adhesive' which binds the three dimensions of human, spirit and nature that all cultural worldviews are built upon (Ruwhiu, 1999, p. 448).

[41] The principles of Te Toka Tūmoana are: Tikanga, Te Reo Māori, Whakamanawa, Wairuatanga, Kaitiakitanga, Whakapapa, Manaakitanga, and Rangatiratanga.

[42] Pohatu, T. W. (2013). Āta: Growing respectful relationships. Ata: Journal of Psychotherapy Aotearoa New Zealand, 17(1), 13-26. DOI: 10.9791/ajpanz.2013.02 © New Zealand Association of Psychotherapists Inc. 14 Ata:Journal of Psychotherapy Aotearoa New Zealand Āta: Growing Respectful Relationships provide for more human existence for those who are marginalised, oppressed and exploited" (Smith, 1997, p. 32).

whānau (family), hapū and iwi, whilst not compromising on standards of safety. It is centred on relational, inclusive and restorative ways of working. Embedded in the framework is a set of eight core Practice Standards,[43] which have helped to guide and frame this review.

Oranga Tamariki future direction

Oranga Tamariki has been on a journey of evolution since 2015 when the Expert Advisory Panel was created to review Aotearoa's care and protection and youth justice systems. This led to the creation of Oranga Tamariki in 2017.

In January 2021, the Oranga Tamariki Ministerial Advisory Board (the Board) was appointed. The task of the Board was to provide advice regarding the relationship between Oranga Tamariki and families, whānau, and Māori; professional social work practices; and the organisational culture. The Board released their report, 'Hipokingia ki te Kahu Aroha Hipokingia ki te Katoa' (Te Kahu Aroha) in September 2021.

Oranga Tamariki responded to the recommendations in Te Kahu Aroha with the Future Direction Plan. This document sets out five programmes of work that Oranga Tamariki is focussed on and has helped to inform and strengthen some of the Review Team's recommendations.

The Oranga Tamariki Action Plan (OTAP) was released in 2022. It is a collective commitment by children's agencies to prevent harm and promote the wellbeing of tamariki in Aotearoa.[44]

[43] Practice standards | Practice Centre | Oranga Tamariki

[44] The other agencies involved OTAP are: Te Whatu Ora (Ministry of Health), Ministry of Education, Ministry of Social Development, Ministry of Housing and Urban Development, Ministry of Justice, Ara Poutama Aotearoa, Police.

Te māramatanga o Oranga Tamariki | Understanding Oranga Tamariki

Introduction

This section is presented in three parts. The first briefly explores how Oranga Tamariki manages it's work. Next, the operating environment of Te Āhuru Mōwai site during the early part of 2021 is examined. The final section describes the response that Malachi and his whānau should have received from Oranga Tamariki.

Oranga Tamariki

If there are concerns about the needs and/or wellbeing of tamariki these are usually reported in one of two ways to Oranga Tamariki. Notifiers can call the Contact Centre and/or visit an Oranga Tamariki site to discuss their concerns. The majority of Reports of Concern come through the Contact Centre.[45]

From 1 July 2020 to 30 June 2021 Oranga Tamariki received 77,953 Reports of Concern.[46]

When a Report of Concern is received, the Contact Centre does the following:

- gathers information from the caller
- checks any history for te tamaiti and their whānau
- assesses the level of need/risk to te tamaiti
- makes a suggestion for a response timeframe
- forwards the information to the nearest Oranga Tamariki site to where te tamaiti is living.

For some sites across Aotearoa, the Contact Centre completes an initial assessment and then transfers the information electronically via CYRAS to the closest Oranga Tamariki site where te tamaiti and whānau are living. This Report of Concern is referred to the site's intake queue (on CYRAS) for a further assessment or investigation to occur.

For other sites, the Report of Concern information is recorded by the Contact Centre and assessed by the site. This is facilitated by electronically transferring the Report of Concern to the closest Oranga Tamariki site to where te tamaiti and whānau are living.

[45] The Contact Centre is open 24/7 and is based in Auckland.
[46] Annual Report 2020/21 (orangatamariki.govt.nz)

Supervisors are responsible for overseeing the Reports of Concern received at the site, yet to be allocated, to ensure that tamariki and whānau with urgent needs receive a priority response.

If an initial assessment has determined further action is required, tamariki must be seen by a Social Worker and the safety and risk screen completed by Oranga Tamariki within specified timeframes. The recommended response timeframes are either critical (24 hours), very urgent (48 hours), or urgent (ten days).

The Report of Concern is then allocated to a Social Worker to assess.

Intake and early assessment practice

In 2019, Oranga Tamariki introduced the Intake and Early Assessment practice model. This was a new way to understand and respond to concerns reported to Oranga Tamariki. Analysis of data[47] found that Social Workers were spending extended periods of time investigating and assessing concerns, only to conclude that there was no role required for Oranga Tamariki.

The previous way of working was putting tamariki and whānau through statutory assessment and investigation processes that, for over half of the Reports of Concern accepted, led to no further action or interventions at the end of that process.

The intent of the Intake and Early Assessment model is to apply more in-depth analysis at the point of the initial assessment to enhance the right service response to tamariki and whānau, so they get the right support much earlier. This reduces 'churn', whereby tamariki are getting re-notified to Oranga Tamariki, because there is an earlier, more consistent and accurate response to harm, needs and vulnerabilities.

The Intake and Early Assessment model is one assessment with three distinct phases:

– Initial assessment
– Core assessment
– Full assessment

Initial assessment

Initial assessment is the phase of the Oranga Tamariki Intake and Early Assessment model that was applied to understanding what occurred before Malachi was harmed.

[47] From 1 July 2017 to 30 June 2018 Oranga Tamariki received 106,217 reports of concern about tamariki. 46,571 of those were investigated under a child and family assessment. 4,341 (or 13%) were referred to Family Group Conference following the finding of care and protection concerns.

At initial assessment, the purpose is to gather sufficient information to understand the needs and vulnerabilities of te tamaiti, including wellbeing concerns and the harm (or likelihood of harm) to ensure te tamaiti and whānau receives an appropriate response.

During initial assessment, Social Workers are required to:

– consider the concerns that have been reported
– explore the reported concerns through a conversation with the notifier
– develop a chronology to understand Oranga Tamariki history with tamariki and their whānau in order to identify key events that have impacted on te tamaiti and their whānau and highlights cumulative patterns and responses to previous Reports of Concern.

In some circumstances, it may be appropriate for social workers to speak with professionals or other agencies during initial assessment about the concerns raised by the notifier. This could include iwi, schools, early childhood educators, health professionals, and community agencies. Social workers are also encouraged to seek advice from Kairaranga ā-whānau (specialist Māori role) or other specialist cultural advisors as appropriate.

At this early stage of assessment, social workers do not engage with te tamaiti or whānau that the Report of Concern is about (with the exception where the notifier was either te tamaiti or whānau). This is because this would be investigating the concern when it has not yet been determined whether an investigation is necessary.[48]

Practice guidance, which was based on the legislation before it was amended in 2019, drew a clear distinction between assessing the Report of Concern and the power of a social worker to investigate, but only after first determining that an investigation was necessary or desirable.

> ***Section 17 Investigation of report of ill-treatment or neglect of child or young person***
>
> *(1) If the chief executive or a constable receives a report under section 15 relating to a child or young person, they must –*
>
> *(a) as soon as practicable after receiving the report, if it appears that an investigation is necessary or desirable, commence an investigation…*

The practice guidance shaped how social workers practice in this part of the assessment process.

On completion of the initial assessment, there are several options:

- No further action

[48] According to section 17(1)(a) Oranga Tamariki Act, a social worker **must** commence an investigation of a Report of Concern **if** it appears that an investigation is necessary or desirable.

- Refer to service
- Continue involvement and move to a core assessment phase.

A Pathway Rationale is completed, and the outcome of the initial assessment is approved by a Supervisor.

As this new model was embedded, Oranga Tamariki sites operationalised it in ways that were appropriate for their site size and wider community environment. An important change in the approach was to allocate staff resourcing at the front end of the work and to ensure experienced and capable social workers were undertaking the initial assessment practice. [49]

The outcome of the first Report of Concern made by Malachi's maternal cousin was 'no further action'.

Te Āhuru Mōwai site

Te Āhuru Mōwai is one of two Oranga Tamariki sites in the Tauranga region.[50]

The population in Tauranga has increased rapidly over the past 10 years and from 2013 – 2018 had the fifth highest population growth rate in Aotearoa.[51] This rapid growth has meant that services for tamariki and whānau have struggled to keep up with the demands of the growing community. Oranga Tamariki staff and community partners talked about long waitlists for services and issues accessing community support before concerns escalate.

From 1 July 2020 to 30 June 2021, Te Āhuru Mōwai received 1,500 Reports of Concern. From this total, social work staff at Te Āhuru Mōwai assessed that 791 (53%) of these Reports of Concern required further exploration by Oranga Tamariki through an assessment under section 17 of the Oranga Tamariki Act. The national average for this is 52%.

During interviews, some site social work staff painted a picture of a site under pressure from a high workload and some office culture challenges (during the early part of 2021):

> *The volume of work is unbearable; our Supervisor has protected us.*
>
> *We have been, for the past few years, in a state of uncertainty – lack of trust in the site leadership team…*
>
> *Afterhours is hell – you pray that the phone is not going to call. We are in a horrible cycle of dealing with crisis during the day.*

[49] Intake and Early Assessment 'Get Ready' Leaders pack dated 12 June 2019. "The Intake phase includes deeper assessment – and will require skilled social workers to complete this assessment." p1. "Workforce: having experienced, capable social workers undertaking initial and core assessment activities." p8.
[50] Ngā Parirau (Tauranga East) is the other site in Tauranga.
[51] Tauranga City Statistical Information Report 2022, Tauranga City Statistics (tauranga.govt.nz)

> *It is a cumulation of events and things that have happened … I don't know how many times I have to tell [site] management that it is not ok… you never know what you are going to get. I don't feel they are supportive of me or us.*

Other Social Work staff were more positive with one noting:

> *My Supervisor is one of the best I have ever had; she has my back – and given me lots of opportunities to learn.*

In terms of professional development opportunities:

> *It is limited – the organisation needs to do better with this but there is no budget.*[52]

In terms of the site's relationship with external partners and the community, staff members observed:

> *Individually people build their networks, there is a negative view of our site/our organisation.*

> *In terms of the community, it's not good [site reputation]. If it was good in the community then we wouldn't be having the same vacancies.*

Between the period August 2020 to November 2021 nine SOSHI reports[53] were raised by Te Āhuru Mōwai staff members. The SOSHI system ensures all security, health and safety incidents are recorded, reviewed, investigated, and responded to in a timely manner to ensure the safety and security of all Oranga Tamariki staff. The SOSHI reports raised by Te Āhuru Mōwai site staff related to the impact of high workload, a high number of unallocated cases, lack of capacity on site, burnout and stress, and concern about the flow-on impact on social work practice.

> *06 April 2021 – Expressing concern about social workers' caseloads.*

> *14 June 2021 – Workload is impacting safe practice…. increasingly worried about the health and safety and quality of social work we are providing the community.*

These SOSHI reports are visible for the site leadership and inform Health and Safety Committee planning.

In terms of addressing these issues, relationship difficulties between senior staff members in site management and regional management positions meant that efforts to resolve these

[52] From 1 July 2021 professional development budgets were removed from all business units and centralised to fund an intensive cultural competency national programme called Te Hāpai ō.
[53] SOSHI is an acronym for Security, Occupational Safety and Health Incident. These nine SOSHI were lodged by six different staff members.

issues were not fully successful. With this relationship not functioning as well as it should, the site issues were not able to be addressed or escalated as they should have been.

> *Been ongoing for years, RM [Regional Manager] employed a professional … it feels like every year there have been more attempts to address issues. It may provide short term change – but ultimately it reverts back* (Staff member).

The Review Team were informed of the following attempts to resolve the issues being raised.

In late 2020, an external provider was employed to support the development of the leadership culture at Te Āhuru Mōwai in response to two years of concerning Kōrero Mai staff survey[54] results. This entailed five sessions with the site leadership team and the Site Manager. Additional supports were contracted through another provider whose role was to develop a Culture Charter for Te Āhuru Mōwai site.

In June 2021, the Senior Human Resources Advisor (Advisor) met with Te Āhuru Mōwai site to better understand the office environment. This was to help inform the development of a plan to enhance site culture. At the hui, staff members raised concerns about site leadership not being unified, a punitive atmosphere, and an inability to speak out due to fear. Some site leaders were said to be caring and supportive. Some staff members reported that if things didn't improve at the site they may consider leaving. A few weeks later a forum was held for the site at a local Marae to continue these discussions. The Advisor reported that things were starting to improve.

The Report of Concern for Malachi arrived at Te Āhuru Mōwai site in late June 2021.

[54] Kōrero Mai is an annual staff survey that gives staff members a voice and an opportunity to provide feedback to the leaders of Oranga Tamariki.

He aha te kawatautanga o te whānau mai i a Oranga Tamariki | What whānau expected from Oranga Tamariki

Introduction

This section outlines the voices of Malachi's whānau as told to the Review Team, and what they expected Oranga Tamariki to do to keep Malachi safe. The quotes below provide a snapshot of their views to help the Review Team understand their hopes and expectations of the social work response, and what Oranga Tamariki needs to do differently in the future.

Malachi's mother

Malachi's mother would have wanted Oranga Tamariki to speak to Malachi's stepfather as he was a significant person in Malachi's life.

> *Probably, I would have asked them to talk to [Malachi's stepfather] as he would have a completely different opinion to me. In his victim impact statement, he said that he tried to visit Malachi a few times and Michaela never let him meet Malachi and always said that he was at kindy.*
>
> *If they had've talked to [Malachi's stepfather]. He would have said 'I [Malachi's stepfather] would have taken Malachi at a drop off a hat.'*

Malachi's mother thought that Oranga Tamariki had visited Malachi when he was staying with Michaela.

> *I thought they [Oranga Tamariki] had visited where he was. I thought they'd been around.*

Malachi's mother has been very clear to the Review Team that at the time she thought leaving Malachi in the care of Michaela was the best decision for him.

> *I believed I was doing the right thing.*

Malachi's maternal whānau

Malachi's maternal cousin was intentional and thoughtful in approaching Oranga Tamariki with her concerns for Malachi and persistent when Oranga Tamariki did not respond in the way she anticipated. The maternal whānau expected Oranga Tamariki to have gathered information from a range of sources, and to visit and speak with Malachi.

> *Oranga Tamariki should have gone and seen Malachi.*

Oranga Tamariki should have done welfare checks. They should have seen marks on Malachi. … social workers should have visited.

They should have checked with the kindy and talked to the people who cared for him and those who were living on the property. Social workers should have sighted him. They trusted what Malachi's mother said without being aware of the influence of others. Oranga Tamariki should have talked to other family members and done character references for Malachi's mother and Michaela's family.

Oranga Tamariki should have talked to the Police – Malachi went to the family s9(2)(a) OIA *with no checks. Oranga Tamariki should have checked that.*

For the photo to be taken seriously. Trust family when they say he looks different - we know him best.

There were no criminal checks on Michaela, and she didn't have kids – how did anyone know she could look after Malachi?

We expected you to 'sight the child.'

Malachi's stepfather

Malachi's stepfather was concerned that Oranga Tamariki did not take the time to know or understand Malachi and expressed worries about other tamariki that might be in the same situation.

He is not an object.

There are heaps of Malachi's still struggling out there in the world.

Malachi's pāpā

Malachi's pāpā expected Oranga Tamariki to check whether Michaela was a safe person to care for Malachi, and also to be identified and included in all decisions made for his son.

Do police checks on people who care for children.

I expected to be contacted and considered in the solutions – at all points.

Malachi's paternal whānau

Malachi's paternal whānau felt that there was a role for Oranga Tamariki in keeping tamariki within their whānau.

> *Keep the families involved. Keep the outsiders out.*
>
> *Even if the families don't get along – get the mum's family together and get the dad's family together and they can hopefully get a plan together.*
>
> *Our children don't need to go to someone they don't know – it screws them up badly.*

Paternal whānau members were concerned that Oranga Tamariki never visited Malachi when he was staying with Michaela or spoke to other agencies about him.

> *Why don't they do that, do unannounced visits?*
>
> *Why didn't they ring the kindy?*

Malachi's paternal whānau expressed concern for other tamariki like Malachi who had been killed by people responsible for caring for them.

> *What about all the babies before Malachi? He's not the only one.*

Section Three

Te takahitanga, te kitenga, te hurihanga

What should have occurred, what was found and what must change

Te takahitanga, te kitenga, te hurihanga | What should have occurred, what was found, and what must change

Introduction

This section describes the practice we would have expected to see in relation to Malachi and his whānau based on existing Oranga Tamarki practice standards, policy and guidance, what we found actually occurred and what factors contributed to that response.

It then outlines a series of recommendations for Oranga Tamariki and the wider children's system, based on these findings.

What should have occurred, and what was found

The Review Team identified four over-arching areas in which Oranga Tamariki fell short of what was required to deliver a quality service to Malachi and his whānau.

1. 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

Correct practice was not followed when it was decided to take no further action in regard to the first Report of Concern made by Malachi's whānau. When further concerns were subsequently reported, the decision to take no further action was not revisited. Moving to undertake a core assessment would have resulted in Malachi being seen, his safety having been established, and the complexities surrounding his care arrangements thoroughly explored with his whānau. Consultation with Police about the possibility of physical abuse would also have occurred.

2. 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 in regard to Malachi

Social work staff at Te Āhuru Mōwai site were clear at the time of their involvement with Malachi and his whānau, that workload and resourcing issues were having a direct impact on their practice. Whilst these pressures are not unique to this site, a broader range of known process, culture, leadership, and stakeholder relationship issues were also present, had not been addressed and likely contributed directly to decisions made in regard to Malachi.

3. 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 Review Team identified some gaps within existing practice guidance, professional development, and processes for working with partner agencies in regard to responding to Reports of Concern. It is likely these contributed to limited engagement with others (including Malachi and his whānau) during the initial assessment, a failure to recognise underlying factors which may have impacted on Malachi's care and a lack of consultation with other professionals, particularly around the possibility of physical abuse.

4. 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 current operating model for responding to Reports of Concern can result in isolated decision making. It is also vulnerable to being used as a means of managing workload rather than offering a pathway to ensure tamariki and whānau are linked to the support needed at the earliest opportunity to address needs and prevent harm. A lack of partnered decision making, resourcing, wider community and cross-government collaboration and information sharing, are also recognised features of the current approach. New ways of working collaboratively with iwi, Māori, community, and partner agencies are beginning to emerge. Had such approaches been available, they would have no doubt strengthened the response Malachi and his whānau received.

1. Practice decision making

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Correct practice was not followed when it was decided to take no further action in regard to the first Report of Concern made by Malachi's whānau. When further concerns were subsequently reported, the decision to take no further action was not revisited. Moving to undertake a core assessment would have resulted in Malachi being seen, his safety having been established, and the complexities surrounding his care arrangements thoroughly explored with his whānau. Consultation with Police about the possibility of physical abuse would also have occurred.

Receiving, recording, and referring the first Report of Concern

1.1) **The first Report of Concern provided a clear and professional outline of the concerns that Malachi's maternal cousin had reported in regard to his safety and wellbeing.**

What we would expect to occur

Anyone can report a concern to Oranga Tamariki about te tamaiti and these concerns can be received at a site or through the Contact Centre. Every effort should be made to gather as much information as possible from the person making the Report of Concern, including wider context about te tamaiti and their whānau. This is also an opportunity to make sure that the person reporting the concerns knows what will happen with their information and what to expect next. The information that is shared must be carefully recorded as a new Report of Concern in order for an initial assessment of the concerns to be commenced.

What occurred for Malachi and his whānau

The Social Worker who met with Malachi's maternal cousin appropriately recorded the concerns about Malachi's care within CYRAS and transferred the Report of Concern to Te Āhuru Mōwai site. This record included concerns about Malachi's mother being remanded in custody, whether Malachi was safe and well in his current care arrangement, the potential for Malachi's mother to be manipulated with respect to these arrangements and whether needs related to his health and potential disability were being addressed. Whilst Malachi's maternal cousin recalls sharing some additional information that was not recorded in the Report of Concern, the information that was included was sufficient for the purposes of initiating the initial assessment.

Undertaking the initial assessment as to whether further action was required

1.2) **Allocation of the initial assessment for Malachi to a new social worker who was completing their Supported Practice Step should not have occurred**

What we would expect to occur

The first step when a Report of Concern is received is for an initial assessment to be undertaken in order to determine the type of response that is required in relation to the reported concerns. This assessment should be completed by an experienced practitioner with appropriate supervision support and oversight.

What occurred for Malachi and his whānau

Malachi's case was allocated to the Social Worker who was rostered as the Duty Social Worker[55] on the day that Malachi's maternal cousin called. This Social Worker did not normally complete initial assessment work. The Social Worker had been on a student placement with Oranga Tamariki and employed permanently since February 2021. The Social Worker was in the process of completing their Supported Practice Step.[56] This is not consistent with the instruction given to sites to only have capable and experienced social workers completing initial assessment work. The Social Worker's relative lack of experience was likely to have contributed to the level of quality of the initial assessment. Significant supervision support, coaching, and close monitoring would have been needed for an inexperienced social worker completing an initial assessment.

1.3) **Considerations such as the potential for manipulation and blackmail in the relationship between Malachi's mother and Michaela, required deeper exploration as part of the initial assessment.**

1.4) **The initial assessment did not consider Malachi's needs in terms of potential disability, or how this may have contributed to the concerns of maternal whānau regarding his placement with Michaela.**

1.5) **Not seeking information from other agencies impacted on the ability of Oranga Tamariki to assess Malachi's safety and wellbeing.**

What we would expect to occur

Generally, the initial assessment is based on information already known to Oranga Tamariki, the knowledge of the person who has reported the concerns, and in some cases by talking to other professionals working with the family. Current practice guidance specifies that it may be appropriate in some circumstances to speak to other agencies about the notifier's concerns, but that this is not required in order to make a response decision.[57]

[55] A Duty Social Worker is the social worker rostered on for the day to take queries or undertake tasks that are not allocated to an individual social worker. Part of this role includes speaking with people who come into the site or phone the site with worries about a child.
[56] The Supported Practice Step was introduced into Oranga Tamariki in 2019 to better support university, polytechnic and wānanga graduates into their first statutory social work position. Social workers on the Supported Practice Step are provided with additional support and learning for the first six months in their role and have restrictions on the number of tamariki they work with to allow time for learning, supervision and reflection.
[57] Initial assessment phase | Practice Centre | Oranga Tamariki

An initial assessment should include the development of a chronology[58] which identifies key events and previous concerns known to Oranga Tamariki that may have impacted on te tamaiti and their whānau.

A range of practice prompts within the Intake Decision Response Tool[59]and practice guidance encourages broad consideration of: whānau dynamics; strengths and risk factors during the initial assessment (including but not limited to the nature and suitability of the care arrangements of te tamaiti); factors impacting the whānau such as disability, substance abuse and criminal activity; and the extent of existing connections to whakapapa, hapū, iwi and extended family support.

What occurred for Malachi and his whānau

While there were no previous Reports of Concern for Malachi, a search on CYRAS was completed and a chronology was completed for Malachi's mother. A check on CYRAS should also have been undertaken for Michaela and this did not occur.

The complexity of the situation with Malachi's mother, her criminal charges, and the potential dynamics in her relationship s9(2)(a) OIA , and with Michaela, were not recognised or given adequate consideration during the initial assessment.

s9(2)(a) OIA

The Social Worker did not seek more information to better understand this dynamic. OIA s9(2)(a) OIA

As part of the Report of Concern for Malachi, his maternal cousin also raised a question around whether Malachi might have autism. The initial assessment summary did identify possible autism as a need for Malachi, however, this was not discussed with Malachi's mother. It does not appear that consideration was given as to whether Michaela would be able to meet Malachi's needs, or to what supports or help might be required to meet his needs. Greater input from the Supervisor may have been needed to support the Social Worker's understanding and analysis of Malachi's needs in the context of a potential disability.

[58] Using chronologies to support decision-making in the initial assessment phase | Practice Centre | Oranga Tamariki

[59] Intake decision response tool | Practice Centre | Oranga Tamariki

The Social Worker who completed the initial assessment for Malachi did not contact any outside agencies for information about Malachi and his whānau. Relevant outside agencies included the s9(2)(a) OIA where Malachi's mother had told Oranga Tamariki that Malachi and Michaela were living; the Police who held information about the relationship between Malachi's mother and s9(2)(a) OIA Malachi's day-care; or any health professionals to understand the concerns that maternal whānau held about Malachi having suspected autism.

Contact with these professionals would have deepened the Social Worker's knowledge of Malachi's needs and may have provided some understanding as to the existence and suitability of any support already in place. Determining which agencies to engage with as part of the initial assessment was at the discretion of the Social Worker. However, this determination requires experience, and greater input from the Supervisor may have been needed to help determine who else to contact.

Consideration of additional information following the first Report of Concern

1.6) **Three pieces of key 'additional information' provided to the site were not properly recorded, communicated and therefore not considered in decision making. This had a serious impact and culminated in a misinformed decision to not fully assess the concerns for Malachi or understand more about his safety and wellbeing.**

1.7) **The Social Worker did not follow Practice Centre Guidance on the input and recording of additional information (the photograph) to support a Report of Concern.**

What we would expect to occur

The Practice Centre guidance is clear where 'new' information identifies concerns that are different from the previous reported concerns or are the same as previous concerns but have occurred at a different time, this information must be considered using the Intake Decision Response Tool.[60] In other words, consideration must be given to whether this information warrants a new Report of Concern, rather than just adding the information into the response to an existing or previous Report of Concern.

In addition, Oranga Tamariki has a policy about case recording.[61] Social workers have a professional and legal requirement to maintain full and accurate records, so that information is visible, retrievable, and available for consideration. This policy applies for all tamariki and whānau Oranga Tamariki works with across all stages of its work.

Accurate case recording is not simply a mechanism to record information and analysis. It has a purpose in ensuring information can be used, both in the present and the future, so that

[60] Recording decision responses | Practice Centre | Oranga Tamariki
[61] Case recording | Practice Centre | Oranga Tamariki

decisions regarding safety and wellbeing are well informed. Poor recording can impact analysis and understanding, contributing to inaction, or the wrong actions being taken.

What occurred for Malachi and his whānau

As well as the initial concerns reported by Malachi's maternal cousin, additional attempts to share information with Oranga Tamariki about Malachi occurred during the course of the initial assessment and shortly after the Report of Concern had been closed.

Firstly, Malachi's stepfather telephoned with concerns for Malachi, at the time that the initial assessment was being undertaken. This phone call was not recorded or communicated to the Social Worker responsible for the initial assessment for Malachi, and therefore was not able to be considered within the initial assessment.

Secondly, Malachi's maternal cousin provided a photo of suspected bruising at the time the initial assessment was being undertaken. While this was emailed to the site by the Contact Centre when it was received, and was subsequently viewed by the Social Worker, it was not entered as a new Report of Concern and was only recorded in CYRAS on 6 July 2021.

There were two missed opportunities in recording the photograph as a new Report of Concern (through both the Contact Centre and the Social Worker).

There is no evidence that this information was taken into account as part of the initial assessment rationale that the Social Worker provided to the Supervisor. There is no indication that the Social Worker recognised that these pieces of information might indicate new concerns for Malachi or an escalation from those that had originally been reported. The impact was compounded when the Supervisor reached the decision to approve the outcome of no further action based on incomplete information. Noting the inexperience of the Social Worker, it would have been appropriate for the Supervisor to review all case notes and discuss the initial assessment with the Social Worker.

Finally, a phone call from the Probation Officer (allocated to Malachi's mother) was made a few weeks following the first Report of Concern being made. In this call the Probation Officer expressed worries about the care of Malachi. This call was not treated as a new Report of Concern, recorded on CYRAS, or communicated to the Supervisor. The information provided by the Probation Officer was an opportunity to reconsider the earlier outcome of the initial assessment, based both on new information, and due to another party being concerned.

The failure to record and act on these additional sources of information about Malachi represent missed opportunities to build a deeper understanding of Malachi, his whānau, and their situation.

Response to potential physical abuse

1.8) **The photograph of Malachi with potential bruising, provided to Oranga Tamariki, should have been considered as a possible indicator of physical abuse. This**

photograph required further consultation and assessment, through referral to Police under the Child Protection Protocol.

What we would expect to occur

Oranga Tamariki social workers are not medically trained to assess potential bruising. The Child Protection Protocol: Joint Operating Procedures (CPP) [62] provides step by step guidance to support practitioners and provides clarity in how to respond to potential abuse.

> *We must follow the CPP when we are responding to complaints (Police) or reports of concern (Oranga Tamariki) that allege actions or behaviour that may constitute a criminal offence, and where there is a role for each party. These actions or behaviour fall into three categories:*
>
> – *Physical abuse*
> – *Sexual abuse*
> – *Neglect*

Social workers are not required to be certain that abuse or neglect has occurred in order to consult with Police as part of the CPP. Consultation can occur at any time it is considered that the reported concerns *may* constitute possible abuse or neglect in line with agreed definitions within the CPP.

If it is agreed that the concerns meet the requirements of the CPP, a joint investigation plan will be agreed. Tasks for Oranga Tamariki will generally relate to talking to te tamaiti, establishing their safety and wellbeing and developing plans with their whānau to ensure they are being cared for safely. The role of Police is to assist in the establishment of the safety of te tamaiti and to investigate potential criminal offending. Assessment by a health professional may also occur during the course of such an investigation.

If it is agreed that the concerns do not meet the requirements for joint investigation, Oranga Tamariki can still undertake an assessment of the safety, care and wellbeing needs of te tamaiti in the usual way in response to a Report of Concern if that is the outcome of the initial assessment.

What occurred for Malachi and his whānau

Malachi's maternal cousin sent Oranga Tamariki a photograph with what she thought might be suspected bruising around Malachi's eye. The Contact Centre sent the photograph to the site on the same day via email marking it as 'additional information' to support the Report of Concern. The Contact Centre emailed the photograph of Malachi because it was reported to be possible bruising, and this would ensure it was immediately available to the site to consider how best to respond.

[62] Child Protection Protocol (CPP) | Practice Centre | Oranga Tamariki

We now know that some site staff viewed this photograph (although nothing was recorded) and determined that in their view, there was no bruise showing in the photograph.[63] The Social Worker did not discuss the photograph with Malachi's maternal cousin. This was a missed opportunity to gather important contextual information about why this photograph worried Malachi's maternal cousin who knew Malachi well and how he normally presented. This would have helped inform a new Report of Concern.

The potential bruising identified by Malachi's maternal cousin was sufficient to initiate a consultation with Police as it was an indication that physical abuse *may* have occurred. However, Oranga Tamariki did not consult with Police to determine if the concerns about suspected bruising in the photograph met the criteria for an investigation under the CPP.

Had a consultation occurred, this would either have resulted in an agreement with Police to jointly investigate the concerns if it was agreed that they met the criteria in the CPP, or Oranga Tamariki could have taken further steps to assess the situation through a Core Assessment.

Outcome of the initial assessment and decision to take no further action

1.9) **While needs for Malachi were identified, no assistance to access supports through a referral to community services occurred.**

1.10) **The first Report of Concern should have been advanced into a comprehensive core assessment. Consequently, a visit to Malachi should have occurred to understand his needs, strengths, and vulnerabilities, ensuring he was safe and cared for.**

What we would expect to occur

The focus of an initial assessment is to understand the needs, risks, and vulnerabilities of te tamaiti and to make a decision about an appropriate response. This response could be to take no further action, to make a referral to another service who is best placed to meet the needs of te tamaiti and their whānau, or to undertake further assessment or a joint investigation with Police.

Social workers should be guided by the Intake Decision Response Tool to determine the appropriate pathway for the concerns to be addressed. According to the Practice Centre it is only appropriate to take no further action in response to a Report of Concern when, following an initial assessment, it is determined there is no substance to the report, the concerns do not indicate harm to the child, or the concerns are being responded to by others. If the criteria for taking no further action, within the Intake Decision Response Tool, are not met, one of the other responses should be taken.

[63] The Review Team subsequently consulted Dr Patrick Kelly (Dr Kelly)[63], Paediatrician from Starship Hospital. He was shown the photograph of Malachi and was of the view that evidence of bruising was "non-specific", and that Malachi would have required a health assessment for an examination to occur.

All information gathered during the initial assessment must be recorded and carefully considered in order to determine the appropriate response. A 'pathway rationale' is then completed by the Social Worker which sets out the information gathered, who else has provided information, what needs te tamaiti and their whānau may have and the appropriate response. This rationale must be approved by a Supervisor who must independently consider whether the pathway chosen appropriately responds to the Report of Concern and information gathered during the initial assessment before approving the decision.

What happened for Malachi and his whānau

The Social Worker completed the initial assessment and recorded a pathway rationale with no further action as the outcome. This decision was subsequently approved by Supervisors, although as noted, they approved the decision based on incomplete information. It appears clear from the initial assessment rationale that there were unmet needs and concerns that, based on the information known to Oranga Tamariki, were not being addressed by other agencies. On this basis, the decision to take no further action in response to the initial assessment was not appropriate.

As part of the initial assessment, the Social Worker identified needs for Malachi, but these were not resolved or addressed through a referral to a service, or by exploring with Michaela what support she might need to care for Malachi.

When considering whether a referral to services is an appropriate response following an initial assessment, the practice guidance states:

> *This is a voluntary pathway appropriate where support from another agency, iwi or cultural social service is likely to achieve positive outcomes. We choose this pathway when the needs can be addressed, or the impact on te tamaiti minimised, with the support of other professionals or services…*[64]

At the time of approving and closing the initial assessment, there was an opportunity for the Supervisors to provide direction to the Social Worker to explore ways for the needs identified for Malachi to be met, which did not occur. It should be noted that Te Āhuru Mōwai site did not have a practice of making referrals to community services following initial assessment closures. The Review Team was informed that this was influenced by lack of capacity to follow up with whānau to obtain consent for a referral to service, and a perceived lack of capacity of community agencies to respond.

Consideration could have been given to making a referral for services, based on the nature of concerns and the further information received during the course of the initial assessment. However, the appropriate response would have been for Oranga Tamariki to undertake a core assessment (or a joint investigation with Police if there was agreement that the concerns met the CPP).

[64] Considerations when developing a decision response | Practice Centre | Oranga Tamariki

Had such an assessment occurred, in a developmentally appropriate way, Malachi could have been spoken with in the context of the home he was staying in. This would have given some insights into how he was feeling through the process of being placed with Michaela, how he felt about his mother not being with him, and whether he felt safe. His voice could have been heard. The capacity for Michaela to provide safe care would have also been explored.

Through the assessment, further engagement would have also occurred with Malachi's mother and whānau members, as well as his pre-school, and other professionals. Additionally, it would have been an opportunity for Oranga Tamariki to establish the need for Malachi to have an assessment of his health needs with the consent of his mother.

Through these actions, Oranga Tamariki could have developed a deeper understanding of Malachi within the context of his whakapapa and supported Malachi's mother and extended whānau to consider collective decisions regarding Malachi's care through a family meeting or hui-a-whānau.

It is important to note that such an assessment may still not have identified the factors that subsequently led to Michaela inflicting the critical injuries which caused Malachi's death.

Guardianship rights, the Oranga Tamariki Act and the Family Court

1.11) **In determining whether or not further action by Oranga Tamariki was required, the wellbeing and best interests of Malachi were not appropriately considered and balanced alongside the guardianship rights of Malachi's mother.**

1.12) **Oranga Tamariki incorrectly assumed that the Family Court would resolve the care issues for Malachi and did not undertake its responsibilities with the Oranga Tamariki Act.**

What we would expect to occur

It is appropriate that social workers recognise that as guardians, parents have the right to make day-to-day care decisions for their tamariki. However, tamariki also have rights, within the context of their whānau, to be safe, loved, and free from harm and abuse. The Oranga Tamariki Act requires that the wellbeing, and best interests of te tamaiti are the first and paramount consideration in all decisions taken under the Act (including in response to Reports of Concern).[65] This means that when there are competing rights, it is the right of te tamaiti (in particular the right to safe and nurturing care) which must be given greater weight.

It is not unusual for Oranga Tamariki to be working with whānau to address care and protection concerns whilst applications are before the Family Court about the day-to-day care of tamariki. It is important that social workers understand that it is not the function of the Family Court under the provisions of the Care of Children Act to address care and protection concerns and that this remains the responsibility of Oranga Tamariki.

[65] Section 4A Oranga Tamariki Act 1989.

What occurred for Malachi and his whānau

When considering the Report of Concern for Malachi, considerable emphasis was placed on the right of Malachi's mother to make decisions about his care as his parent and legal guardian.

The needs of Malachi were identified by the Social Worker as:

- *Malachi needs to know and be cared for by safe family.*
- *Malachi needs family who will care for him long-term in this instance.*
- *Malachi needs a relationship with his mother.*
- *Malachi needs to be safe from being used as a blackmail tool.*

While the initial assessment did consider the rights of Malachi, the decision to close the case did not preference these rights as none of them had been assured at the time of closure.

In addition, the decision to take no further action following the initial assessment appears to assume that the concerns of Malachi's maternal cousin would be addressed through the Family Court process under the Care of Children Act 2004. Malachi's maternal cousin spoke of her intention to apply for custody of Malachi through the Family Court, although she had received advice that she was unlikely to be successful. The Social Worker's apparent over-reliance on this application as the means to ensure Malachi's safety, demonstrates a lack of clarity in the core role of Oranga Tamariki and the role, functions and responsibilities of the Family Court.

The Intake Decision Response Tool[66] should have been utilised to consider more broadly the information that was received, including the tensions between guardianship decision making and the identified needs for Malachi. It is the role of reflective supervision alongside the Supervisor's support and knowledge that assists the Social Worker in examining and exploring these tensions.

Engagement with whānau

1.13) **Oranga Tamariki did not realise its obligations to more fully engage with whānau.**

1.14) **During Oranga Tamariki involvement, Malachi was not understood within the context of his whakapapa. This contributed to paternal whānau not having their voice and wishes heard.**

What we would expect to occur

[66] https://practice.orangatamariki.govt.nz/core-practice/practice-tools/intake-decision-response-tool/overview-of-the-intake-decision-response-tool/

Existing practice guidance does not support engagement with tamariki and whānau during the course of an initial assessment. This is because the purpose of the initial assessment is to determine whether an assessment ought to occur in order to fully engage with te tamaiti and their whānau. Changes to this guidance will be needed as a result of this review.

Practice guidance supports social workers in seeking as much information as possible that will support their understanding of the needs of te tamaiti and their whānau from the person reporting the concerns and any other information that can be gathered during the initial assessment. Supervision discussions support the Social Worker's understanding and application of practice guidance.

The Intake Decision Response Tool encourages a particular focus on exploring whānau or family connectedness to whakapapa, hapū, iwi or extended family support.

What occurred for Malachi and his whānau

Not engaging more fully with Malachi's mother and whānau meant there was missed potential for whānau to have their perspectives heard and understood regarding Malachi's safety and oranga.

There were two influencing factors that contributed to this. Firstly, the previously noted Practice Centre guidance which directs that social workers should not speak with tamariki or whānau during the initial assessment.[67] Secondly, some members of the maternal whānau did not want to share the identity of Malachi's father.

Despite this, it is the role of Oranga Tamariki to advocate for Malachi's right to know who he is and where he comes from. There were a number of occasions where there were opportunities to more fully engage with whānau and to identify the whānau and whakapapa connections of significance to Malachi.

During the initial assessment:

- Malachi's maternal cousin contacted Oranga Tamariki multiple times to convey her concerns and when Oranga Tamariki did not do what she expected, she made a complaint about this.
- Malachi's stepfather phoned Oranga Tamariki to share his worries for Malachi, however, his phone call was not recorded as a case note and no one phoned him back.
- When the Social Worker spoke with Malachi's mother there was an opportunity to explore more deeply who else was important in Malachi's life.

After Malachi was injured:

[67] Initial assessment phase | Practice Centre | Oranga Tamariki

- In November 2021 (at the time that Malachi had been critically injured), there were not sufficient attempts made to explore and understand who Malachi's father was, or his whakapapa. This meant Oranga Tamariki lost any opportunity to engage with his paternal whānau, his hapū and iwi.

The Review Team would have expected the Supervisor through supervision to ensure that this information was identified for Malachi and his whānau.

1.15) **Malachi and his whānau did not receive an adequate response from the Oranga Tamariki complaints system specifically:**

a) There was not appropriate independence in the review of the complaint.
b) Malachi's maternal cousin was not made aware of how to appeal the outcome of her complaint, limiting her avenues for advocacy.
c) Malachi's maternal uncle was given unclear and incorrect information about the complaints pathway.

What we would expect to occur

The current Oranga Tamariki complaint process enables a complaint to be reviewed at either a site, regional or national level, depending on the nature of the concerns. The intention is to support early resolution of concerns. However, this must be balanced with ensuring that complaints are reviewed in a manner which is fair, robust, and independent.

Where a complaint is unable to be resolved, information should be made available to the person making the complaint about pathways for further review or resolution. Information about the complaints process should be accessible and staff should feel confident in supporting individuals to understand and access the complaints process.

The need for a strengthened complaint system, which is trusted and responsive to tamariki and whānau, has been recognised as part of the Future Direction Plan.[68]

What occurred for Malachi and his whānau

On 25 July 2021 a complaint was made by Malachi's maternal cousin after the Report of Concern she made about Malachi was closed with no further action. The complaint was referred to Te Āhuru Mōwai site for resolution by the Complaints Team and the complaint was not upheld.

The review of this complaint was allocated by the Manager to the Supervisor who had overseen and supported the approval to close the initial assessment for Malachi. The Supervisor talked through the complaint with Malachi' maternal cousin, and emailed her in

[68] 1.4 OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)

follow up, explaining and confirming the rationale for not further assessing the concerns she had raised.

This should not have occurred. Had the complaint been reviewed independently of those directly involved, it may have identified that there were concerns in the way the Report of Concern had been responded to.

On 2 November 2021, Malachi's maternal uncle phoned the Contact Centre to enquire about the Oranga Tamariki complaints process. He reported to the Review Team that during the call he was told there was no complaints process. While Oranga Tamariki does not have a record of this call, the Review Team believe it is likely to have occurred. Later that evening he again phoned the Contact Centre to raise his concerns and received an appropriate response.

The complaints process should have afforded members of Malachi's whānau a further opportunity to ensure that Oranga Tamariki had heard and were acting on their concerns. The response received to their complaints meant that this did not occur.

Application of the Oranga Tamariki Practice Standards

1.16) **The Oranga Tamariki Practice Standards were not consistently and fully applied to all aspects of the response to Malachi and his whānau.**

What we would expect to occur

Oranga Tamariki has a set of eight Practice Standards.[69] These are a description of the core expectations of social work practice, in the context of legislated responsibilities to tamariki and whānau. They are embedded within the Oranga Tamariki Practice Framework.

These Practice Standards apply throughout all aspects of Oranga Tamariki social work practice and must be met within the context of the policy and guidance settings relevant to the social work action being taken or decision being made. The Practice Standards help social workers and Supervisors remain centred on the core aspects of practice and have a strong focus on engaging with te tamaiti and whānau, accurately recording information and ensuring safety. They also emphasise the importance of professional supervision in ensuring safe and accountable social work practice.

What occurred for Malachi and his whānau

Based on the expected practice within current policy and guidance in regard to social work involvement with Malachi and his whānau, it is apparent that the Practice Standards were not consistently applied. The following table sets out each Practice Standard and a high-level indication of the extent to which the Practice Standard was met based on the findings of this Review.

[69] Practice standards | Practice Centre | Oranga Tamariki

Analysis of the practice that occurred for Malachi and his whānau, against the Oranga Tamariki Practice Standards	
Ensure safety and wellbeing	
I will take action every time I am worried about harm to te tamaiti, in order to protect them from harm and the long term impact on their wellbeing.	*While an initial assessment was undertaken, a core assessment should have occurred to ensure Malachi's safety and wellbeing.*
See and engage tamariki	
I will see and engage with each tamaiti I am working with, in order to understand their needs, build their trust and ensure they have a say in decisions.	*Malachi was not seen or spoken with during the initial assessment, which was consistent with existing practice guidance. However, this would have occurred within a core assessment had it been undertaken.*
See and engage whānau, wider family and caregivers and when appropriate victims of offending by tamariki	
I will see and engage with family, whānau, caregivers and victims, in order to understand their needs and ensure they have a say in decisions about te tamaiti.	*While the Social Worker did speak with Malachi's mother and maternal cousin, there was opportunity to engage more broadly with whānau to understand their views, which would have occurred within the core assessment.*
Work closely in partnership with others	
I will engage and collaborate with key people working with each tamaiti, in order to ensure their full range of needs are identified and addressed in a coordinated way.	*While the Social Worker did engage with Malachi's mother and act in accordance with her views, information and support was not sought from partner agencies that would have enhanced the initial assessment.*
Keep accurate records	
I will document my key actions and decisions for each tamaiti I am working with, in order to	*While some information was recorded appropriately, other information was not*

ensure significant decisions are clearly evidenced and transparent.	*recorded, contributing to an initial assessment outcome that was not fully informed.*
 **Use professional supervision**	
I will use professional supervision to critically reflect on my practice, in order to ensure my decision-making is robust and to build the quality of my professional practice.	*While professional supervision was evidenced, it was observed that this focussed heavily on the support of staff, potentially at the expense of critical reflection and guidance.*
 **Create, implement and review a written assessment and plan**	
I will create a written assessment and plan with each tamaiti and review them when required, in order to identify and address their full range of needs.	*The assessment did identify Malachi's needs that required support; however, it did not include key information or establish a pathway to ensure these needs were met.*
 **Whakamana te tamaiti: Practice empowering tamariki Māori**	
I will apply the principles of Mana Tamaiti, Whakapapa and Whanaungatanga to my practice, in order to ensure I'm responsive to tamariki and whānau Māori.	*Malachi was not identified as Māori, and knowledge of his whakapapa was not sought. This impacted the ability of his whānau, hapū and iwi to exercise their whanaungatanga obligations.*

2. Site environment, support and leadership

> *We all turn up every day to do our best. Staff need to be backed, to be supported by everyone – Oranga Tamariki leadership, the community – to make changes…* (Te Āhuru Mōwai social worker).

The supporting environment for social work staff within Te Āhuru Mōwai site at the time contributed directly to the quality of practice decision making in regard to Malachi.

Staff at Te Āhuru Mōwai site were clear that at the time of their involvement with Malachi, workload and resourcing issues were having a direct impact on their practice. Whilst these pressures are not unique to this site, a broader range of known process, culture, leadership, and stakeholder relationship issues were also present, had not been addressed and likely contributed directly to decisions made in regard to Malachi.

Oranga Tamariki has a responsibility to ensure that quality practice is enabled and supported.

The shift in practice which Oranga Tamariki is making is based on relational practice and the aspiration for all tamariki to be safe, loved, and nurtured within the context of their whakapapa. This approach relies on social workers having the time to effectively build and maintain trusted relationships, identify and respond to needs, and to access support which is tangible, holistic, and enduring, for tamariki and whānau.

As registered professionals, social workers have a set of accountabilities, standards, and ethics that they must adhere to. Their employers need to be mindful of creating the environment and systemic conditions that support social workers to exercise these professional requirements.

The Review Team observed that social work staff at Te Āhuru Mōwai site were not consistently supported and did not have the necessary resources and conditions in order to consistently deliver quality social work practice.

The following findings describe the environment that contributed to the quality of practice at Te Āhuru Mōwai site.

Leadership approach

2.1) **Te Āhuru Mōwai site leadership did not have effective processes in place to manage workload and allocation. In particular they should not have allowed social workers with insufficient experience to undertake initial assessment work.**

2.2) **Relationships between the region and Te Āhuru Mōwai site leadership impacted on the level of tangible support provided to site staff.**

Workload pressures were visible and of concern to staff at Te Āhuru Mōwai site.

Although the Review Team did not speak to all staff at Te Āhuru Mōwai site, some staff members reported not feeling supported by site leadership. The Review Team observed that some staff members felt overwhelmed and unsupported, and this led to team members becoming protective of each other in the provision of support and guidance. This prevented the development of a whole of site culture of openness, challenge, learning and growth that is essential in promoting consistent service responses to tamariki and whānau.

Site staff felt that site leadership did not foster collaborative relationships internally and externally, were not effectively allocating and managing work and were not providing the level of support needed by social work staff when it was clear that the site was under stress.

The approach taken by site leadership to manage these issues tended to reinforce transactional rather than relational practice responses. Where there is strong leadership, even in the context of high service demand, opportunities can be created to better understand the needs of tamariki, to find pathways to access supports for their whānau and to promote kaimahi ora (wellbeing of staff).

Longstanding tensions between site and regional leadership had been unable to be resolved and contributed to a lack of openness, trust and confidence. This in turn impacted the ability to progress collective solutions in order to effectively address the site's challenges and support needs. Site and regional leaders carry significant responsibilities in regard to their staff and communities. How these are exercised contributes directly to the service tamariki and whānau receive. Leaders need to be well supported to carry out these functions and responsibilities.

Community partnerships and collaboration

2.3) **Poor relationships between Te Āhuru Mōwai site and some community organisations, and a perceived lack of community capacity to support whānau, contributed to an environment where referrals were not made to meet Malachi's needs.**

Actively fostering relationships and building capacity across the community is also a core leadership responsibility. However, it is also essential that social workers are intentional and proactive in building their own community networks.

A cohesive and enabled network of iwi, Māori, and other community agencies, that have partnered and open relationships with Oranga Tamariki, is a cornerstone for ensuring that there are appropriate and supportive responses to address safety and support needs when working with tamariki and whānau.

Te Āhuru Mōwai staff observed that relationships between the site and community were not strong and there was less engagement with community agencies than there had been in the past.

> *We used to have visits to site from communities/agencies but not since the administration person has left.*

In terms of the community, it's [site reputation] not good.

It was the view of many Te Āhuru Mōwai social work staff that at the time concerns were raised for Malachi's safety, community services were at capacity. This knowledge acted as a disincentive for social work staff to commit the time required to gain whānau consent and make referrals when there was not confidence that the services that were needed by whānau would be able to be provided by agencies in a timely way.

It is not clear that there were active strategies in place within the site to understand the extent of these gaps, or that would have encouraged collaborative, solution focussed ways of working with the community.

Workload and work management

2.4) **High workloads at Te Āhuru Mōwai site contributed to the lack of quality practice.**

Te Āhuru Mōwai social work staff were under pressure from high workloads and were expressing concerns that this was impacting on the quality of practice.

At the time the Report of Concern for Malachi was received, Te Āhuru Mōwai site was experiencing long-standing workload pressures and did not have a robust system of workload allocation in place to manage this. An example of this pressure and lack of process, was the allocation of Malachi's initial assessment to a new social worker. There were other differences in the approach to the allocation and management of new work by this site, as compared to other sites who were also experiencing high demand for services.

Health and Safety reports were being made within the site highlighting these concerns, and the Review Team observed that these pressures were escalated and known across the region.

Te Āhuru Mōwai site was resourced to have 17 full time social workers, and the site had one vacancy at that time. While allocated social work caseload sizes were equivalent with other sites, it was observed that Te Āhuru Mōwai had large numbers of tamariki who were not allocated to a social worker. In addition, the site was averaging Reports of Concern about 120 tamariki each month, a high flow of referrals, and at times long waitlists for tamariki to have an initial assessment.

When workload pressures are high, a greater tolerance for risk may occur and reasons may be found to close an open case rather than exploring the best response to what may be occurring within or needed by the whānau. At such times decision making can default to a triage model based on managing the highest risk in order to mitigate workload pressures. The premise for the work of Oranga Tamariki must always be based on responding to the safety and wellbeing needs for tamariki and whānau. Effective leadership strategies are needed to ensure this focus is not compromised by high workload and demand.

Whilst there were unique features that compounded the workload issues within Te Āhuru Mōwai site, high demand, workload, and case complexity is a known feature that is impacting

on the social work workforce within Oranga Tamariki and more broadly across the sector. Oranga Tamariki has work underway as part of the Future Direction Plan to continue to address this.[70]

3. 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 Review Team found some gaps within existing professional development, practice guidance and processes for working with partner agencies in regard to responding to Reports of Concern. It is likely these contributed to limited engagement with others (including Malachi and his whānau) during the initial assessment, a failure to recognise underlying factors which may have impacted on Malachi's care and a lack of consultation with other professionals, particularly with regard to the possibility of physical abuse.

Professional Development

3.1) **Practice knowledge and expertise of Oranga Tamariki staff requires continued focus and investment.**

A range of areas of professional development which require support and strengthening were observed during the Review and are outlined below. These include ensuring clarity about the role and responsibilities of Oranga Tamariki, recognising and responding to complex and dynamic risk factors, understanding key areas of practice policy and guidance, and the provision of critical reflection and challenge within professional supervision.

Particular investment is needed in ensuring that new social workers (particularly new to the profession, but also the organisation) receive effective induction and training when they first begin and throughout their first year of practice. Similarly additional support and development is needed for Supervisors to ensure they have the skills, knowledge, and supports needed to support their staff to meet core practice requirements.

[70] 2.3 OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)

Areas for additional Professional Development focus
Understanding core legal responsibilities to ensure safety from harm and that the rights of tamariki are enacted within the context of their whānau. (Finding 1.1 and 1.11)
Enacting the CPP process and what to do if there is evidence of potential harm, including the management of physical evidence of potential harm such as photographs. (Finding 1.7 and 1.8)
Complete accurate case recording that captures the story of tamariki and their whānau and records critical decisions and information. (Finding 1.6)
Understanding dangerous dynamics and complex considerations in child protection practice. (Finding 1.3 and 1.5)
Recognising and responding to disability needs in tamariki and whānau. (Finding 1.4 and 1.9)
Utilising and providing quality supervision effectively. (Finding 3.1)
Embedding Te Ao Māori knowledge and practices, in particular understanding tamariki in the context of their whakapapa.[71] (Finding 1.13 and 1.14)

Practice Guidance

3.2) **The current Practice Centre guidance relating to engagement with tamariki, whānau and others when undertaking an initial assessment is misaligned with wider principles in the Oranga Tamariki Act.**

The current Practice Centre guidance directs that tamariki and whānau should not be engaged with during the course of an initial assessment. This guidance restricted the Social Worker from engaging with Malachi and his whānau to the extent required to support a fuller understanding of their concerns about Malachi's care.

This guidance draws from an understanding of the legal framework for assessment and investigation prior to substantive changes made to the Oranga Tamariki Act in 2019. The

[71] Significant work in lifting cultural competency is progressing through the new Practice Approach and Te Hāpai ō.

rationale for not engaging with tamariki and whānau is because at this point the purpose of the initial assessment is to determine whether an investigation is necessary or desirable.

Precluding engagement with tamariki and whānau regarding any decision made under the Oranga Tamariki Act (including during an initial assessment) is not consistent with the Chief Executive's responsibilities and principles within sections 4A, 5, 7AA, 11 and 13 of the Oranga Tamariki Act.[72]

This practice guidance requires updating urgently to better reflect the 2019 Oranga Tamariki Act legislative changes so that where appropriate tamariki and whānau can be contacted during the initial assessment, whilst ensuring the focus of the assessment at this point remains on determining how best to respond to the reported concerns.

Child Protection Protocol

3.3) **Greater access and clearer pathways are required for social workers to seek appropriate advice from a health professional, in regard to physical indicators and symptoms of abuse and neglect.**

The Social Worker who received the photograph of Malachi with suspected bruising told the Review Team that in their view there was no bruise showing. Consideration was not given to testing this view through consultation with either Police or a Health Professional with appropriate expertise in physical evidence of potential abuse.

When to seek appropriate professional advice for areas which sit outside a social worker's expertise should be made clear to social workers. During this review, Dr Patrick Kelly (Dr Kelly)[73] was consulted, and was of the view that Oranga Tamariki staff should routinely have access to health professionals experienced in identifying suspected non-accidental injuries and should not be making these decisions in isolation. Dr Kelly recognised that there is currently no straightforward channel for a social worker to get rapid access to expert health assessments.

Whilst there is nothing preventing social workers from attempting to seek a health opinion as part of their assessment, there is also no confirmed means by which such advice around potential indicators of abuse can be routinely and reliably sought. Te Whatu Ora (Health New

[72] This includes the wellbeing and best interests of tamariki being the first and paramount consideration (s4A); the need to encourage and assist tamariki to participate in and express their views about any proceeding, process or decision affecting them (s5(1); the family, whānau, hapū, iwi and family group of a tamaiti should participate in decisions wherever possible (s5(1)(c)(v); policies, practices, and services should have regard to mana tamaiti (tamariki) and the whakapapa of Māori children and the whanaungatanga responsibilities of their whānau, hapū, and iwi (s7AA); the need to encourage and assist tamariki to participate in any proceeding or process, express their views, and take their views into account (s11); providing early support and services to tamariki should occur on a consensual basis and in collaboration with those involved wherever possible (s13(2)(b)(iii).

[73] Paediatrician, Te Puaruruhau (Child Protection, Shaken Baby Prevention and Family Violence Intervention) and Puawaitahi. Honorary Associate Professor, Department of Paediatrics: Child and Youth Health, Faculty of Medical & Health Sciences, University of Auckland.

Zealand) is not a formal partner within the CPP. If they were, such access to health expertise may be more easily achieved.

Oranga Tamariki sites are required to hold annual, joint training sessions with Police to ensure all staff are aware of the requirements of the CPP and to discuss any issues. Te Ahuru Mōwai held their annual joint training sessions on 27 July 2021 and 30 August 2022. There would be value in involving health professionals as part of this training.

4.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 Reports of Concern from Oranga Tamariki, their community and other agencies, focussed on preventing harm.

The current operating model for responding to Reports of Concern can result in isolated decision making. It is also vulnerable to being used as a means of managing workload rather than offering a pathway to ensure tamariki and whānau are linked to the support required to address needs and prevent harm, at the earliest opportunity. A lack of partnered decision-making, resourcing, wider community and cross-government collaboration and information sharing are also recognised features of the current approach. New ways of working collaboratively with iwi, Māori, community, and partner agencies are beginning to emerge. Had such approaches been available, they would have no doubt strengthened the response Malachi and his whānau received.

4.1) **A consistent system for localised, cross-agency, information sharing that also prioritises responding to identified needs when there are safety and wellbeing concerns, was not a feature of the assessment approach at Te Āhuru Mōwai.**

A lack of joined up information, a narrow lens on risk as opposed to oranga, and a lack of connection with iwi and the wider community, contributed to decision making occurring in isolation. This did not serve Malachi or his whānau well and impacted on the ability of Oranga Tamariki to understand the situation for Malachi and accurately assess his safety and wellbeing.

Throughout the Review, it was observed that both social worker time and community agency capacity were under pressure. The intent expressed in multiple previous reviews for the transfer of decision making, resources and services to enable iwi and Māori-led solutions has not yet been realised.

Establishment of community enabled partnered practice is required, where Oranga Tamariki, Māori, Te Whatu Ora (Health New Zealand), Ministry of Education, Police, and community

agencies come together to support information sharing and decision making. Access to supports for tamariki and whānau should be facilitated as a priority in this process.

There are a number of positive examples of such partnered practice working that are effective and require embedding in a consistent way. Connected and communicating workers who understand how to respond together, is critical in ensuring safety and wellbeing.

Continuity of relationship

4.2) **Requiring whānau to speak to multiple people within the organisation during different stages of their involvement with Oranga Tamariki is not conducive to building relationships and understanding.**

The operating model for assessing and responding to Reports of Concern remains transactional, has multiple interface points between the Contact Centre and sites, and at times can result in whānau and agencies having to engage with multiple people about their concerns.

Malachi's maternal cousin shared her worries for Malachi with the Social Worker at a lower North Island site but was then required to repeat her worries to a number of social workers. When Malachi's stepfather phoned Oranga Tamariki, he was directed to a different site in Tauranga and his concerns were not recorded as a case note or provided to the Social Worker completing the initial assessment.

The Review Team also observed that since 2019, Oranga Tamariki sites have arranged social work teams around different phases or functions of work undertaken with whānau. A whānau may work with one social worker during an assessment phase, a different social worker if a Family Group Conference is to be held and a different social worker again if a child is taken into care. This has meant that tamariki and whānau can have multiple changes in social worker during their involvement with Oranga Tamariki. The need to constantly build new relationships is not conducive to building trust and is inconsistent with the shift towards relational and restorative social work practice.

The Review Team also observed that more recently the Contact Centre has increased its role in completing initial assessment work when a Report of Concern is received. While intended as a way to provide an independent perspective and to support local sites to manage their workload, having this work completed remotely does not easily enable local ownership, local knowledge, and whānau and community decision-making to occur.

Ngā tūtohunga | Recommendations

> *We want this review to be for all tamariki, because there are other children out there just like Malachi, who need to be* heard. (Malachi's uncle)

Apology to whānau

Oranga Tamariki did not meet their obligations to Malachi or his whānau.

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.

Recommendation That Oranga Tamariki accept full responsibility for the failings identified in this report and apologise to the whānau of Malachi.

That Oranga Tamariki works with whānau members to determine an appropriate process of apology and gives consideration to further restorative actions which will uphold the mana and oranga of Malachi's whānau, with the hope of restoration and healing.

1. Practice decision making - Recommendations

Every tamaiti and whānau is entitled to a practice response that upholds their safety, oranga, and mana. Oranga Tamariki must take action to ensure core practice expectations are being consistently met.

Urgent action is required to set clear expectations that only sufficiently experienced staff should be undertaking initial assessments and to emphasise the critical importance of the accurate recording of information.

In addition, a renewed focus on the eight Oranga Tamariki Practice Standards is needed within the organisation to ensure that all staff are working to the same core expectations in their practice with tamariki and whānau. Leaders across the organisation must take steps to ensure that these Practice Standards are clearly understood and are being enacted in practice.

To achieve these recommendations, Oranga Tamariki must have leadership and enabling functions that are committed to promoting the time, tools, resources, professional development – the system supports – that enable quality front line practice. These include

tangible ways to support the wellbeing of social work staff as they manage the complexities of their work alongside tamariki, whānau and communities.

Recommendation That **as a matter of urgency** Oranga Tamariki resets the expectation that only experienced and capable social workers should complete initial assessments and takes steps to ensure this is occurring consistently.

Recommendation That **as a matter of urgency** Oranga Tamariki reiterates to all staff the requirements of the case recording policy and the need to record and action the voices of whānau and any other people who make contact. This should be done by immediately issuing a Practice Note from the Chief Social Worker.

Recommendation That Oranga Tamariki establish and embed an accountability and reporting mechanism based on the core aspects of statutory social work – the eight Practice Standards. This framework will be used to measure and monitor the application of the Practice Standards, giving social workers, Supervisors and managers greater visibility about the extent to which the Practice Standards are being met.

Recommendation That Oranga Tamariki provides clarity to social workers about their responsibilities to meet the Practice Standards and implements responses when they are not met. These responses must balance the provision of development support and personal accountability and ensure that poor practice is not accepted.

2. Site environment, support and leadership - Recommendations

All sites should offer a safe environment where social work staff have access to the support they need in order to consistently undertake safe, accountable, quality practice.

Oranga Tamariki must take urgent steps to address the issues identified at Te Āhuru Mōwai site.

Recommendation **That as a matter of urgency** Oranga Tamariki works with Te Āhuru Mōwai site and the Bay of Plenty regional team to create a support plan to address the specific issues which have been identified in terms of leadership, site culture, professional development and engagement with community partners.

Recommendation That Te Āhuru Mōwai site undertakes work in partnership with iwi, Māori, community and other government services in the re-design of a local approach to Reports of Concern which responds when worries are raised about the safety and wellbeing of tamariki.

3. Practice guidance, professional development and interagency processes - Recommendations

Practice knowledge, supervision and leadership capability requires increased and sustained focus and investment.

Recommendation That Oranga Tamariki ensures social workers have the opportunity to engage in professional development, training, coaching and mentoring relevant to their level of experience in order to respond confidently and capably in the areas of practice identified within the findings of this review.[74]

Recommendation That Oranga Tamariki progress the action within the Future Direction Plan to develop and implement a post-graduate professional practice course for statutory social workers.[75]

Recommendation That Oranga Tamariki ensures Supervisors have access to ongoing training, development, regular internal support, and external supervision. That Oranga Tamariki accelerates work currently underway to lift the capability and quality of supervision practice.[76]

Recommendation That Oranga Tamariki ensures all site and regionally based managers have access to appropriate training and professional development to carry out their role. This includes the provision and resourcing of professional development plans, leadership training, coaching and regular external supervision.

Workload and Work Management

Reasonably sized and well managed caseloads are needed in order for Oranga Tamariki social workers to undertake quality practice and ensure the safety and wellbeing of tamariki.

Recommendation That Oranga Tamariki develops a caseload sizing approach, which accounts for complexity and establishes a baseline for an acceptable workload in order for individual practitioners to undertake professional, reflective, and responsive practice. This approach must be able to be

[74] Finding 3.1 Professional Development.
[75] Te Kahu Aroha and 4.8 OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)
[76] 4.3 OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)

applied in relation to an individual practitioner and across teams and sites as a whole.

Recommendation That Oranga Tamariki progress the action within the Future Direction Plan to establish a national visibility model for caseload/workload management, that enables regular reporting and identifies gaps in capacity where additional workforce investment and wider resources may be required.[77]

Practice Guidance and Policy

Current practice guidance prevents engagement with tamariki and whānau during initial assessments and this is fundamentally misaligned with the principles of the Oranga Tamariki Act 1989.

In addition, practice guidance that is clearer on the importance of engagement with other professionals and agencies for the purposes of safety and wellbeing is needed.

Recommendation That **as a matter of urgency** Oranga Tamariki, involving the Office of the Chief Social Worker, completes a review of the legal position and policy underpinning initial assessment practice.[78]

Child Protection Protocol

Greater clarity and access for social workers needing specific health expertise is required and this could be achieved through a clear role for health professionals within the Child Protection Protocol.

Recommendation That Oranga Tamariki and Police work with Te Whatu Ora (Health New Zealand) to consider their inclusion as a party to the Child Protection Protocol, and to ensure that the CPP provides for greater clarity, support and expertise from health when assessing potential signs and indicators of abuse and neglect.

Complaints Processes

The Oranga Tamariki Complaints System requires improvement in order to be trusted by and responsive to tamariki and whānau.

Recommendation That work underway as part of the Future Direction Plan[79] to develop a fit for tamariki and whānau complaint process takes into account the

[77] 2.3 OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)
[78] Urgent review of the legal position on sections 15 and 17 following the 2019 Oranga Tamariki Act amendments is underway.
[79] 1.4 OT-Future-Direction-Action-Plan.pdf (orangatamariki.govt.nz)

experiences and insights of Malachi's whānau, with particular regard to the need for greater independence and accessibility.

4. The wider community and system: a need for local and connected responses - Recommendations

The underpinning operating model that responds to concerns for tamariki requires strengthening in providing support for identified needs and understanding potential harm.

Partnered decision-making underpinned by Te Tiriti o Waitangi, appropriate resourcing, wider community and cross-government collaboration and information sharing, are components that support a system that can be more successful in understanding and responding holistically to reported potential harm.

In order to achieve this, and to realise the recommendation within Te Kahu Aroha that communities take the lead in preventing harm to tamariki, with Oranga Tamariki support and collaboration, a fundamental re-design of the intake and assessment approach is required. Collective approaches involving Oranga Tamariki, iwi, Māori and community agencies and government partners working together should provide the basis of a response that is more protective and supports the strengthening of whānau structures.

The Review Team observed that there are other communities that are already successfully practising in this way. The insights from this Review should serve as an accelerator in more broadly achieving practice that is truly preventative, responsive, and fully reflective of the principles of the Oranga Tamariki Act.

This will require a significant shift from the current risk triage and workload management approach to one where the best response is chosen based on an understanding of the oranga of tamariki in the context of their whakapapa.

Collaborative decision making

Recommendation

That work is accelerated as part of the Future Direction plan to fundamentally shift how Oranga Tamariki assesses and responds to Reports of Concern with our partner agencies to ensure collaborative decision-making and support.

That this work should build on partnered approaches and processes already being used in some parts of the country.

That careful consideration is given during design of this approach in order to understand and make provision for the resourcing requirements to enable this model to work effectively.

That the following principles and elements should be considered in the development of this approach:

- Tamariki are understood in the context of their whānau and whakapapa.
- The expertise of iwi, local marae, Kaupapa Māori services and Kairaranga a-whānau, are recognised in understanding and strengthening cultural connection and identity for tamariki and whānau Māori.
- Engagement with tamariki and whānau should occur at the earliest opportunity, based on a prevention response, to address unmet needs which impact on their oranga.
- Joined up approaches with other agencies, are grounded in shared commitments, responsibilities, and clear accountabilities for tamariki.
- Support options must be available and able to be readily activated, whether through whānau, natural networks within communities, or through more formal support agencies.
- Ensuring continuity of the relationship with a social worker, which (when required) is not disrupted. This will require allocating a social worker at the point where a Report of Concern is received.
- Information sharing between professionals and agencies for the purpose of safety and wellbeing is utilised, and that this occurs as part of an established process agreed to between the children's agencies.
- An analysis of the required resources will be needed to enable the implementation of the future model and must be a feature of the design approach.

Recommendation

We propose consideration of a review of the effectiveness of the Children's Act 2014. The purpose of this would be to clarify the responsibilities of children's agencies in supporting timely information-sharing and prioritisation of services for tamariki who come to the attention of Oranga Tamariki, with an emphasis on a collaborative approach to responding to Reports of Concern.

Te tākupu whakamutunga | Final Comment – Tumu Tauwhiro | Chief Social Worker

It is with enormous sadness that this review has been required and undertaken. It is my expectation that the service Malachi and his whānau received, is not repeated, that their story is understood and learned from, and that collectively these recommendations are taken forward with heart and enduring commitment.

This report reinforces and strengthens the focus and urgency required in pressing on in the intent of Te Kahu Aroha and the Future Direction Plan:

- For Oranga Tamariki to be a highly trusted statutory care and protection and youth justice agency, and

- An enabler and coordinator for Māori and communities, to empower them to put in place the support, the solutions and the services that they know will work for their people.

It will be with hope, with action, and with the spirit of kotahitanga that this is achieved.

Tihei Mauri Ora

Kuputaka | Glossary of terms

Ara Poutama Aotearoa – the Department of Corrections.

Āta – thoughtful deliberation before action.

Aotearoa – literal translation is Land of the Long White Cloud, used interchangeably with New Zealand.

Aroha – loving, caring, compassionate, sympathetic.

Contact Centre – the Contact Centre is one point of contact for people to connect to services within Oranga Tamariki. The Contact Centre provides a centralised 24/7 service to people with concerns about the safety and wellbeing of tamariki.

COVID-19 Alert System – alert levels determined by the New Zealand government which specify the public health and social measures to be taken in the fight against COVID-19.

CYRAS (Care and Protection, Youth Justice, Residential and Adoption Services) - the computer case recording system of Oranga Tamariki.

Hapū – subtribes, nations of Aotearoa.

Iwi –collective of hapū, tribe(s).

Kaimahi ora – refers to the whole of person wellbeing. Quality supervision has a central focus on maintaining kaimahi ora and is therefore a critical mechanism in achieving workplace health and safety.

Kairaranga ā-whānau – a role within Oranga Tamariki to ensure tamariki Māori have their right to whānau, hapū and iwi Māori connections met.

Kaitiakitanga – guardianship.

Kanohi ki te kanohi – face-to-face.

Karakia – invocation, incantation, prayer.

Koha atu, koha mai – to give and to receive.

Mahi – to work, do, perform, make accomplish, practice.

Mana – one's power, honour, prestige, authority, self-esteem, influence, humility and voice, customary authority

Mana Tamaiti – a child's power, honour, prestige, authority, self-esteem, influence, humility and voice.

Manaakitanga – caring for and giving service to enhance the potential of others, give due customary respect and hospitality.

Oranga – the wellbeing Oranga Tamariki want to help the children we work with to have. Te Puna Oranga is the Oranga Tamariki model for oranga for all tamariki, children, rangatahi, young people whānau and families.

Pāpā – father, uncle, dad.

Pono – true.

Practice Leader – A senior role based in site offices, the Practice Leader provides practice advice, support, supervision, coaching and quality assurance.

Rangahau – is an inquiry undertaken by Māori, for Māori, as Māori; in pursuit of conveying a Māori empirical perspective of the world.

Rangatahi – young person.

Report of Concern – anyone who is worried about a child or young person can make a Report of Concern to Oranga Tamariki or the Police. This happens usually when they believe a child or young person has been or is likely to be harmed, ill-treated, abused, neglected, or deprived. Or they have serious concerns about the child or young person's wellbeing.

Supervisor – a social work role based in a site office, who manages a team of social workers providing oversight, supervision and support in the delivery of social work practice with tamariki, rangatahi and whānau.

Tamaiti – child.

Tamariki – children.

Tari o Te Tumu Tauwhiro –Office of the Chief Social Worker

Tauiwi – foreigner, European, non-Māori.

Te – used when referring to a particular or individual thing.

Te Ao Māori – Māori world view the Māori world, dimension.

Te Tiriti o Waitangi – the Treaty of Waitangi.

Te Toka Tūmoana – the Oranga Tamariki indigenous, bicultural, principled, wellbeing practice framework.

Te Tumu Whakarae mō ngā Tamariki – Secretary for Children.

Te Tumu Tauwhiro – Chief Social Worker, Oranga Tamariki.

Tika – correct.

Tikanga – correct processes and protocols, right ways of doing things.

Titiro – to look, observe or examine.

Waiata – song, chant, psalm.

Wairuatanga – using Māori values, beliefs, theories, ideologies, paradigms, frameworks, perspectives, and worldview to inform, validate and legitimate Māori cultural wellbeing processes and practices.

Whakaako – to teach, instruct, or educate.

Whakamanawa – encourage.

Whakapapa – blood lines and genealogical ties to a common ancestor.

Whakapono - belief, faith.

Whakarongo – to listen or hear.

Whakataukī – proverb, significant saying, formulaic saying.

Whānau – family covering both whakapapa whānau (bloodlines often referred to as whānau whanui) and kaupapa whānau (those based on interests – sports, religious bodies, teams, work environments etc where whānau orientated values traditions and beliefs are commonly fostered).

Whanaungatanga – purposeful relationships, blood lines and meaningful, relational associations.

Without notice – an application that is filed in the Family Court without informing the other parties involved and goes directly to a Judge for consideration.

Te tirohanga mai i ngā tira amarara mō ngā tūranga, haepapa me te tautāwhi | Addendum – Insights into the roles, responsibilities and support from other agencies

This addendum provides areas for the Systems Review being undertaken by Dame Karen Poutasi to review and consider.

Oranga Tamariki cannot be isolated in achieving the vision where all children are safe, loved and nurtured by whānau and supported by communities. It is through collaborative partnerships and connected ways of working that tamariki, rangatahi and whānau will be best served and supported.

The following areas were specific observations of the Review Team.

Support for caregivers of tamariki not in State Care[80]

The Review Team observed that for Malachi and Michaela, while there was access to financial support at times, there is not a national system in Aotearoa that safeguards and supports tamariki whose responsible parent or usual caregiver is incarcerated, and new care arrangements are required. A high proportion of these parents have experienced trauma and harm in their own childhoods, may be estranged from their whānau, and not closely linked into a community of support. This can create a high degree of vulnerability for these tamariki and rangatahi that our current systems do not, as a matter of course, proactively address.

There is no system or legal requirement to meet with or complete safety checks for caregivers who care for tamariki when their parents are incarcerated. The caregivers may not be well known to te tamaiti, may not have played a significant and enduring role in their lives, or know what is available to assist them in supporting the needs of te tamaiti.

Recognising and responding to harm

There were further opportunities for concerns for Malachi to be raised and acted on. There may be an opportunity to strengthen policies and practice in recognising and responding to signs of potential harm across the children's workforce.

s9(2)(ba)OIA, s11(b)FCA

s9(2)(ba) OIA, s11(b) FCA 1980

[80] This refers to non-financial resources and supports.

s9(2)(ba) OIA, s11(b) FCA 1980

New Zealand Police

s9(2)(a) OIA

s9(2)(a) OIA

Appendix one – Terms of Reference

Terms of Reference: Chief Social Worker Independent Practice Review - Malachi Subecz 2021.

Oranga Tamariki acknowledges the tragic passing of Malachi, and we give our condolences to his mother, father, and whānau.

Background

Malachi was a precious 5-year-old boy of Māori, Irish, and New Zealand European descent who was admitted to Hospital on 1 November 2021 after sustaining significant non accidental head injuries and bruising. Tragically he passed away on 12 November 2021, after his breathing tube was removed. His mother was understood to have been his primary carer throughout his life until sometime mid 2021 when she placed him in the care of a friend who was later charged with his death.

Oranga Tamariki had received a Report of Concern from a family member about Malachi in June 2021 and this was closed with no further action.

In May 2022 Te Tumu Whakarae mō ngā Tamariki (Secretary for Children) commissioned the Tumu Tauwhiro (Chief Social Worker) to lead a review into the circumstances, practises and actions of Oranga Tamariki in relation to Malachi, and make findings and recommendations as appropriate.

It is right for Malachi's whānau to have the circumstances surrounding this tragedy explored, and the review will start from a place of making no assumptions. It is intended that the experience of the review for Malachi's family will be culturally responsive, relational, restorative and compassionate.

Purpose

1. The purpose of the review is to engage with the principles of Te Tiriti o Waitangi, the legislated responsibilities of the Oranga Tamariki Act, 1989, Oranga Tamariki values and a range of Te Ao Māori knowledges, principles and practices to understand holistically what happened and how we responded.

We will:

- Consider and advise on whether the decisions made were appropriate
- Provide advice and recommendations on whether our current assessment procedures, our policy and guidance needs to be modified
- Understand the wider system conditions present at the time and to what extent these impacted on decision making and the practice approach taken

- Apply any reflections and insights into the system and processes within Oranga Tamariki
- Uphold the mana and oranga of all review participants

2. The review report will be shared with wider government agencies and support services that had touchpoints with Malachi to inform internal and external system learnings and consider whether any actions may be taken to strengthen our collective care and responsiveness into the future for all children who may be being harmed.
3. The output of the review will be a report that makes findings of fact and recommendations for change. The report will be provided to the Chief Executive of Oranga Tamariki, legal guardian(s) and key whānau members as discussed and agreed to by the Reference Group.

Roles of Chief Social Worker, Independent Advisor, External Reference Group and Office of the Children's Commissioner

4. The review will be led by the Oranga Tamariki Chief Social Worker with support from Shayne Walker, Senior Lecturer in Social Work, Social and Community Work Programme, University of Otago Social Work Department (the Independent Advisor)
5. The role of the Independent Advisor will be to advise and assist the Chief Social Worker in all aspects of the review. The Independent Advisor may provide additional comment or recommendations to the Chief Executive after having the opportunity to consider the Chief Social Workers recommendations.
6. The Chief Social Worker and Independent Advisor will be supported by members of the Chief Social Worker's Office and Quality Practice and Experiences practice team members.
7. In addition to the internal support, an external reference group will be established to act in an advisory capacity to the Chief Social Worker and Independent Advisor. Accountability for the review remains the responsibility of the Chief Social Worker on behalf of Oranga Tamariki.
8. The reference group brings a child-centred and whānau-focussed view. It comprises:
   - A representative of Social Service Providers Aotearoa (Chief Executive, Dr Claire Achmad)
   - A representative from the Family Violence Death Review Committee (Health Quality & Safety Commission, Senior Specialist Advisor, Pauline Gulliver)
   - Senior Advisor, Iwi and Māori Engagement – requested by paternal whānau.
9. The role of Reference Group will be to:

- Provide advice and support in engaging with whānau, particularly in relation to the non-accidental death of a tamaiti
- Impart Te Ao Māori ways of knowing, being and doing
- Provide advice on the different perspectives of those involved in these events
- To test, challenge and provide advice to the Chief Social Worker and Independent Advisor around the issues arising from the review
- Provide advice on appropriate approaches to resolution and healing for Malachi and his whānau; Be guided by whānau for approaches towards resolution and healing for the loss of Malachi
- Provide advice on stakeholder engagement and in particular the approach to dissemination of findings to review participants

10. As an independent monitor, the Office of the Children's Commissioner will not be included in the Reference Group. However, the Office of the Children's Commissioner will participate so as to bring a child rights lens and knowledge of Te Tiriti o Waitangi to the mahi.
11. The Office of the Children's Commissioner representatives will seek to provide assurance to the Children's Commissioner that the review process, analysis and findings are robust, follow the principles agreed at the outset, and inform improved practice.
12. The Reference Group will be consulted with prior to the Terms of Reference being finalised, will provide support as required throughout the review and provide reflection and support as part of the report finalisation.

Scope

The focus of the review is to explore the practice, decision making, and assessment of risk within Oranga Tamariki critically consider these in relation to Malachi Subecz to examine the gaps, challenges, and opportunities across the organisation to decrease the potential for such a tragedy occurring again.

13. The scope of the review should examine all relevant evidence and documentation, and interview relevant parties. A list of documents accessed will be provided as an appendix to the final report.
14. Documents and information will be provided to the Chief Social Worker, Independent Advisor, Reference Group and the OCC during the course of the review.
15. Other evidence and documents may be requested as required.
16. The scope will include:
    - the quality (depth and breadth) of the initial assessment
    - engagement with whānau, hapū and iwi
    - engagement with relevant professionals as required

- the application of current practice policy and tools
- review of practice policy, tools, and agency legal guidance relating to the intake and initial assessment approach
- Supervision and leadership
- Site culture and contextual challenges, including but not limited to workflow trends, recruitment and learning and development

17. The internal and systems approach will inform any recommendations for change in the practice and enabling structures within Oranga Tamariki, as well as provide insights into the roles, responsibilities and support from other agencies.
18. The period covered by the review will be from June 2021, when Malachi's mother was remanded in custody through to 12 November 2021 when Malachi's breathing tube was removed, and he passed away from his injuries. The review is limited to the period outlined above.
19. The following is out of scope of the review:
    - formal complaints processes associated with these events, including the review of the complaint to the Ombudsman (any recommendations of that Opinion will be addressed via business-as-usual channels)
    - matters that are subject to proceedings before the Court (although the process and quality of assessment and planning informing court action may be relevant to the review)

Whānau, Hapū and Iwi Engagement

The Review Team will seek to uphold the mana and oranga of whānau, hapū and iwi by engaging in whakawhanaungatanga (building respectful relationships) with whānau, through whakapapa (genealogy) connections to Malachi, listening to understand their view of events, hearing their concerns, and providing space for feedback into how the review will be conducted, and how they would like ongoing engagement in the review process.

Stakeholder Engagement

We will seek to uphold the mana and oranga of all review participants.

20. A stakeholder engagement plan will be developed as part of the review.
21. The approach to engagement will include:
    - Initial phone and then written contact by the Chief Social Worker's Review Team, explaining purpose and approach, co-existence of other processes and role(s)

- Kanohi ki te kanohi (face-to-face) engagement to be undertaken by Chief Social Worker's Review Team with parties involved (Note: pending COVID restrictions, other engagement methods will be utilised)
- A process to provide feedback to participants on findings

Methodology

The methodology draws from Te Tiriti o Waitangi, the legislated responsibilities of the Oranga Tamariki Act, 1989, Oranga Tamariki values and a range of Te Ao Māori knowledges, principles and practices.

22. Direct interviews will be used to build an understanding of what has occurred. Our approach to the analysis of practice will be guided by the Review Group (as identified in this Terms of Reference) and will be informed by our legislative framework, our practice approach and practice standards.
23. Final outputs from the review will be confirmed through the detailed design phase but will include a summary report of key findings, areas of learning and any further proposed resolution actions.
24. Decisions around any public release of general findings will be made by Te Tumu Whakarae mō ngā Tamariki (The Secretary for Children) in consultation with Te Tumu Tauwhiro (The Chief Social Worker), with Malachi's mother, whānau, hapū, iwi, and stakeholders involved in this review.
25. The timeframes of review will be balanced by a culturally responsive, relational, restorative, compassionate approach to engaging with this whānau and those staff involved. While we will seek to complete the review as soon as possible we acknowledge that this work will need to progress at a pace appropriate to the needs of the whānau, Oranga Tamariki site and regional staff, agency partners and the community.
26. The review will include the following phases (note that the timeframes below are indicative only and that depending on whānau readiness, need and preference these may need to be adjusted to ensure their mana and oranga is upheld throughout the process).
    - Phase One late May to mid-June 2022: Detailed design, gathering information, preparation and initial engagement;
        - review and clarification of practice analysis provided by the site(s) involved
        - collation and review of information recorded in Oranga Tamariki case management system.
        - development of a working timeline of case events.
        - design approach to ensure whānau voice is central through review process.
        - initial engagement with whānau, site and regional staff and other key participants and scheduling of interviews.
    - Phase Two mid-June to late July 2022: Engagement with participants

- Face-to-face discussion with key representatives of:
  - Mother
  - Maternal Whānau
  - Malachi's biological father's Whānau
  - Other Whānau
  - Contact Centre
  - Site and Regional Staff
  - Any other community or professional representatives as identified

- Phase Three late July to mid-August 2022: Analysis and writing
  - review and analysis of information gathering
  - draft findings report prepared

- Phase Four late August - September Feedback and forward-planning
  - feedback of findings to participants and other key stakeholders as appropriate. NOTE: The draft and final reports will be shared with Malachi's mother, and then his father, before any other of Malachi's whānau, other participants or stakeholders.
  - finalise report
  - identification of further resolution/ restorative actions

Appendix two – Āta sessions, wānanga, and hui held

Date	Whānau	Oranga Tamariki	Notes
23 June 2022	Maternal whānau	Nikki Evans, Jane Caffery, Site Supervisor	
01 July 2022	Maternal whānau	Nikki Evans, Jane Caffery, Site Supervisor	
14 July 2022	Maternal whānau	Nikki Evans, Jane Caffery, Site Social Worker, Site Supervisor	
22 July 2022	Maternal whānau	Nikki Evans, Jane Caffery	
25 July 2022	Maternal whānau	Nikki Evans, Jane Caffery, Shivani Sharma (Scribe)	
27 July 2022	Maternal whānau	Nikki Evans, Jane Caffery	Meeting cancelled whānau member unwell
29 July 2022	Maternal whānau	Nikki Evans, Jane Caffery, Shivani Sharma (Scribe)	
8 August 2022	Maternal whānau	Nikki Evans, Jane Caffery	
11 August 2022	Maternal whānau	Nikki Evans, Jane Caffery, Kiri Alexander (scribe)	
19 August 2022	Paternal whānau	Nikki Evans, Jane Caffery	Meeting cancelled whānau member unwell
09 September 2022	Paternal whānau	Nikki Evans, Jane Caffery	
14 September 2022	Paternal whānau	Michelle Turrall, Jane Caffery, Nikki Evans	
21 September 2022	Paternal whānau	Nikki Evans, Michelle Turrall, Aroha King, with Jane Caffery	Microsoft Teams
23 September 2022	Maternal whānau	Nikki Evans	
3 October 2022	Maternal whānau	Nikki Evans, Jane Caffery	
4 October 2022	Maternal whānau	Peter Whitcombe	Introduction/report discussion Telephone call
6 October 2022	Maternal whānau	Nikki Evans, Jane Caffery	
7 October 2022	Paternal whānau	Nikki Evans, Jane Caffery	

10 October 2022	Maternal whānau	Nikki Evans, Jane Caffery	
11 October 2022	Maternal whānau	Peter Whitcombe, Nikki Evans, Jane Caffery	
11 October 2022	Maternal whānau	Nikki Evans, Kiri Alexander	
12 October 2022	Maternal whānau	Jane Caffery	
13 October 2022	Maternal whānau	Jane Caffery	Microsoft Teams
18 October 2022	Paternal whānau	Nikki Evans	
19 October 2022	Maternal whānau	Peter Whitcombe, Jane Caffery, Michelle Turrall, Nikki Evans	

Date	Role/Site	Oranga Tamariki	Notes
16 June 2022	Site staff Te Āhuru Mōwai	Peter Whitcombe, Nikki Evans, Sarah Parker, Joanne Dawson	Discussing Terms of Reference with the site
20 June 2022	Social Worker Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
21 June 2022	Staff members Contact Centre	Joanne Dawson, Sarah Parker	Discussing Terms of Refence with relevant Contact Centre staff
27 June 2022	Social Worker Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	Discussing Terms of Refence with the social worker
14 July 2022	Senior Social Worker Contact Centre	Joanne Dawson, Sarah Parker	
14 July 2022	Social Worker and Supervisor Contact Centre	Joanne Dawson, Sarah Parker	
14 July 2022	Social Worker and Supervisor Contact Centre	Joanne Dawson, Sarah Parker	
14 July 2022	Practice Leader	Joanne Dawson, Sarah Parker	

	Contact Centre		
19 July 2022	Social Worker Lower North Island	Joanne Dawson, Sarah Parker	
21 July 2022	National Practice Advisor	Joanne Dawson, Sarah Parker	
22 July 2022	Senior Advisor Business Operations	Joanne Dawson, Sarah Parker	
25 July 2022	Manager Quality Systems and Analysis	Joanne Dawson, Sarah Parker	
25 July 2022	Executive Manager Bay of Plenty	Joanne Dawson, Sarah Parker	Discussing Terms of Refence with the social worker
27 July 2022	Social Worker Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
27 July 2022	Social Worker Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
27 July 2022	Supervisor Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
27 July 2022	Senior Advisor Bay of Plenty	Joanne Dawson, Sarah Parker	
28 July 2022	Practice Leader Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
28 July 2022	Lawyer Bay of Plenty	Joanne Dawson, Sarah Parker	
28 July 2022	Supervisor Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
28 July 2022	Manager Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	

09 August 2022	Supervisor Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
10 August 2022	Supervisor Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
10 August 2022	Executive Manager Bay of Plenty	Joanne Dawson, Sarah Parker	
10 August 2022	Regional Māori Practice Coach Bay of Plenty	Joanne Dawson, Sarah Parker	
15 August 2022	Regional Manager Bay of Plenty	Joanne Dawson, Sarah Parker	
24 August 2022	Senior Practitioner Family Harm Team	Joanne Dawson, Sarah Parker	
29 August 2022	Senior Advisor Feedback and Complaints	Joanne Dawson, Sarah Parker	
29 August 2022	Regional Māori Practice Coach Bay of Plenty	Joanne Dawson, Sarah Parker	
30 August 2022	Team Leader Intake and Enabling Feedback and Complaints	Joanne Dawson, Sarah Parker	
09 September 2022	Manager Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
12 September 2022	Human Resources Bay of Plenty	Joanne Dawson	
14 September 2022	Social Work Staff Ngā Parirau site	Joanne Dawson, Sarah Parker	

03 October 2022	Manager Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
05 October 2022	Regional Manager Bay of Plenty	Joanne Dawson, Sarah Parker	
05 October 2022	Manager Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
05 October 2022	Supervisor Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
05 October 2022	Social workers x 2, Supervisors x 2, PSA staff x 2, NUPE staff x 2 Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
05 October 2022	Lawyer Bay of Plenty	Joanne Dawson, Sarah Parker	
07 October 2022	Supervisor Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
10 October 2022	Social work staff, Supervisors x2, Manager Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	
11 October 2022	Staff members Lower North Island	Joanne Dawson, Sarah Parker	Fact checking, feedback
11 October 2022	Supervisor Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	Fact checking
12 October 2022	Manager Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	Fact checking
12 October 2022	Supervisor Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	Fact checking

12 October 2022	Staff Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	Fact checking
12 October 2022	Practice Leader Te Āhuru Mōwai	Joanne Dawson, Sarah Parker	Fact checking
12 October 2022	Regional Manager Bay of Plenty	Joanne Dawson, Sarah Parker	Fact checking
12 October 2022	Site staff Te Āhuru Mōwai site	Joanne Dawson, Sarah Parker	Fact checking
18 October 2022	Regional Māori Practice Coach Bay of Plenty Kairaranga-a-whānau and support staff Te Āhuru Mōwai	Joanne Dawson	Feedback
18 October 2022	Senior Advisor Operations National Practice Advisor	Joanne Dawson	Feedback
18 October 2022	Manager Feedback and Complaints General Manager Quality Practice and Experiences	Joanne Dawson, Sarah Parker	Consultation, fact checking
19 October 2022	Social Workers x 2, Supervisor, Practice Leader, Manager Contact Centre	Joanne Dawson, Sarah Parker	Feedback

Date	Role	Organisation	Notes
09 August 2022	Manager	Ministry of Education	
10 August 2022	Manager	Abbey's Place Childcare	
11 August 2022	Staff members	s9(2)(a) OIA	
11 August 2022	Lawyer for Child		
11 August 2022	Senior Detective Sergeant	New Zealand Police	
15 August 2022	Lawyer for Child		
24 August 2022	Paediatrician	Starship Hospital	
2 September 2022	Staff member	Pirirakau Hauora	
19 September 2022	Contractor	Private	
3 October 2022	Social Worker	Starship Hospital	
6 October 2022	Staff members	s9(2)(a) OIA	Fact checking, feedback
6 October 2022	Lawyer for Child		Fact checking, feedback
6 October 2022	Managers x 2	Ministry of Education	Fact checking, feedback
20 October 2022	Paediatrician	Starship Hospital	Feedback

Date	Independent Advisor Reference Group	Oranga Tamariki/External	Notes
25 May 2022	Shayne Walker	Peter Whitcombe	Planning
9 June 2022	Shayne Walker	Peter Whitcombe, Sarah Parker, Jane Caffery, Nikki Evans, Joanne Dawson	Planning
5 July 2022	Shayne Walker, Pauline Gulliver, Dr Claire Achmad, Office of the Children's Commissioner	Peter Whitcombe, Sarah Parker, Jane Caffery, Nikki Evans	Hui

22 July 2022	Pauline Gulliver	Peter Whitcombe, Sarah Parker, Jane Caffery, Nikki Evans, Joanne Dawson	Hui
17 August 2022	Pauline Gulliver, Dr Claire Achmad, Shayne Walker	Te Tira Hāpai Māori Practice Team, Lorraine Hoult, Peter Whitcombe, Joanne Dawson, Sarah Parker, Jane Caffery, Nikki Evans, Ashley Seaford	Review workshop
15 September 2022	Office of the Children's Commissioner, Pauline Gulliver, Shayne Walker	Peter Whitcombe (1 hour) Ashley Seaford, Julia Breuer, Nikki Evans, Te Tira Hāpai Māori Practice Team Lorraine Hoult, Joanne Dawson, Sarah Parker, Michelle Turrall	Hui
5 October 2022	Office of the Children's Commissioner, Pauline Gulliver, Dr Claire Achmad, Shayne Walker	Peter Whitcombe, Ashley Seaford, Michelle Turrall, Joanne Dawson, Jane Caffery, Nikki Evans, Sarah Parker, Lorraine Hoult	Hui

Date	Organisation	Oranga Tamariki	Notes
30 August 2022	Review Secretariat	Peter Whitcombe, Jane Caffery, Joanne Dawson, Charlotte Beaglehole	Briefing on draft preliminary findings
8 September 2022	Review Secretariat	Ashley Seaford, Joanne Dawson	Further questions from Dame Karen Briefing
28 September 2022	Office of the Ombudsman	Peter Whitcombe, Jane Caffery, Joanne Dawson, Charlotte Beaglehole	
10 October 2022	Review Secretariat	Peter Whitcombe, Joanne Dawson, Nikki Evans	

Date	Kaupapa	Oranga Tamariki/External	Notes
9 August 2022	Whakapapa Wānanga Steering Group	Peter Whitcombe, Shayne Walker, Michelle Turrall, Aroha King, Nikki Evans, Jane Caffery	
18 August 2022	Whakapapa Wānanga Steering Group	Peter Whitcombe, Shayne Walker, Michelle Turrall, Aroha King, Nikki Evans, Jane Caffery	
12 September 2022	Whakapapa Wānanga Steering Group	Peter Whitcombe, Shayne Walker, Michelle Turrall, Aroha King, Nikki Evans, Jane Caffery	

Appendix three – Autoethnography

Autoethnography calls for an enquiry into 'the intersection of self and others, self and culture' (Ellingson & Ellis, 2008, p.4). It can also be used as an analytical tool to explore the self within wider social contexts or the position of cultural locatedness, historical trauma and colonisation, as a way of reaching out for shared understandings and new learnings. "It may be that we feel the connection between ourselves and others most readily in the wake of pain, fear, and loss, but we also construct our positive meanings in relationship with others' (Ellingson & Ellis, 2008, p.14).

Te Hāngaitanga | Approach

An understanding of autoethnography in this context was demonstrated through Te Ao Māori praxis.

Āta: Growing Respectful Relationships, Taina Whakaatere Pohatu

The principles of Āta provide a cultural base for reflective deliberation ensuring the spiritual, emotional, and intellectual levels of the social work process are valued and respected. The humanistic and multi-dimensional nature of Āta provides social workers with a values-based philosophy that is part of the wider context of Mātauranga Māori. Āta offers social workers an option of how to enter, engage in, and exit relationships in the relational world. Effective social workers build meaningful relationships with tamaiti, rangatahi, and whānau through their being. The Āta philosophy opens a door for social work professionals to internalise their beliefs and principles and integrate them into intentional, relational, and restorative social work praxis.

Applied Āta principles were selectively and interchangably used to build respectful relationships with whānau throughout the practice review engagement by staff members from Te Tari ō Te Tumu Tauwhiro (Office of The Chief Social Worker). Commonly used constituents of Āta were:

- **Āta titiro** - watching and engaging with whānau through sincerity, integrity, and reflexivity was important.
- **Āta whakarongo** - listening with reflective deliberation. Extending patience and tolerance, giving space to listen and communicate to the heart, mind and soul of the whānau, context and environment was imperative.
- **Āta-kōrero** - communicating and speaking with whānau by applying clarity to ensure a quality of presentation (kia mārama ki te kaupapa), to speak with conviction (kia pūmau ki te kaupapa), and to be focussed (kia hāngai ki te kaupapa).

- **Āta-tuhi** - communicating and writing with deliberation. The need to be constantly reflective; to know for what reason, writing is being undertaken. The significance of consistently monitoring and measuring quality of the 'whānau voice' was implicit.

- **Āta-noho -** giving quality time to be with whānau and their concerns, stories and solutions. It was important to give this time with an open and respectful mind, heart and soul. This signals the level of integrity required in our relationship.

- **Āta-whakaako** - to deliberately instil knowledge and understanding. There are clear reasons why knowledge is shared; it is given in the required manner to and from whānau, at the appropriate time and place.

- **Āta-haere** - to be intentional and deliberate and to approach reflectively, moving with respect and integrity. It signals the act of moving with an awareness of relationships, their significance, and requirements.

Tikanga Māori Values

All tikanga Māori are firmly embedded in mātauranga Māori, which might be seen as Māori philosophy as well as Māori knowledge (Mead, 2003, p.7).

- **Whakawhanaungatanga** - engaging in deliberate relationships was at the centre of our engagement with whānau, and is at the heart of culturally responsive social work praxis. Whanaungatanga embraces whakapapa and focuses upon relationships...many tikanga prescribe ways of restoring a balance in relationships and includes non-kin persons who become 'like kin' through shared experiences and care.