

He Take Kōhukihuki



**Pūrongo e Tūhura ana i ngā kaupapahere,
tikanga me ngā hātepe mō te tango i ngā pēpi
hou a Oranga Tamariki**

Here-turi-kōkā 2020

Peter Boshier

Tari o te Kaitiaki Mana Tangata

 **Ombudsman**

Tuia kia ōrite · Fairness for all

A Matter of Urgency



Investigation Report into policies, practices and procedures for the removal of newborn pēpi by Oranga Tamariki, Ministry for Children

August 2020

Peter Boshier

Chief Ombudsman

Tari o te Kaitiaki Mana Tangata

 **Ombudsman**

Tuia kia ōrite · Fairness for all

KUPU KŌRERO MAI I TE AMOKAPUA

Message from the Chief Ombudsman

TUIA KIA ŌRITE

Fairness for all

He aha te mea nui ō te ao nei?

He tangata, He tangata, He tangata.

Hoianō ma te poipoi me te tiaki tōtika o ā tātou pēpi.

Ka ora tonu ai tāua te tangata.

What is the greatest thing in this world?

It is people, it is people, it is people

However, it is the proper care and nurturing of our babies
that will sustain the existence of people.

Na te whakaaro ake ki tēnei whakataukī kua āta hōparatia me te tutukitanga o te rīpoata ā te Amokapua, mo ngā mahi me ngā mana whakahaere a te Kāwanatanga. I āta tirohia ngā mahi ā te Manatū Oranga Tamariki ki te tango pēpi whānau hou, kia mōhiohia he aha ngā āwangawanga e pa ana ki ngā take ā pūnaha.

With this whakataukī in mind, the Chief Ombudsman has investigated and reported on the actions and power exercised by government. The systems and practices of the Ministry for Children were examined to identify if there were systemic issues with the removal of newborn babies.

 **Ombudsman**

Tuia kia ōrite · Fairness for all

E whakaata ana te tauira i ngā ringaringa manaaki me te poipoi.

Ko te koru o waho te taha wairua me te āhuatanga tūturu o ā tātau pēpi.

Ko te koru o waenganui te hononga i waenga i ā tātau pēpi, ō rātau whānau me te hapori whānui.

The pattern represents caring and nurturing hands.

The outer koru are the spiritual and natural being of our pēpi.

The inner koru are the connection between our pēpi, their whānau and the wider community.



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Foreword

Whakapuakitanga

In April 2017, Oranga Tamariki—Ministry for Children was launched and was tasked with transforming Aotearoa’s care, protection and youth justice service by 2022. This was a response to a review in 2015 which identified that the existing system did not meet the needs of tamariki and rangatahi in Aotearoa. A raft of legislative and policy changes were introduced to support a new operating model that placed tamariki and their needs for a stable, loving whānau at its centre.

In May 2019, approximately halfway through the Ministry’s five-year transformation programme, Newsroom published a story about an attempt by the Ministry to remove a newborn pēpi from their young mother. The video documentary that later accompanied the original written article gave rise to public dismay and a questioning of the Ministry’s policies and practices.

The Government expressed confidence in the actions of the Ministry, yet media reports of further examples continued. The public reaction indicated there was growing distrust of the Ministry.

My role as Aotearoa’s Ombudsman, Kaitiaki Mana Tangata, is to investigate and report on the actions and power exercised by the government. I decided to examine whether there were systemic issues with the Ministry’s practices for the removal of newborn pēpi under section 78 interim custody orders, bearing in mind the purpose of an Ombudsman as articulated in 1970 by Chief Justice Milvain:¹

...[they] can bring the lamp of scrutiny to otherwise dark places, even over the resistance of those who would draw the blinds. If [their] scrutiny and observations are well-founded, corrective measures can be taken in due democratic process, if not, no harm can be done in looking at that which is good.

The Oranga Tamariki Act 1989, born out of the findings of *Te Pūao-te-Ata-Tū*,² generally reflects the expectations of protection, partnership and participation arising from te Tiriti o Waitangi as well as obligations under international law. The Act includes a number of options that permit the Ministry to act quickly to remove pēpi who are at immediate risk of serious harm. There is a hierarchy of relevant responses, from a place of safety warrant (which is applied for without notice and lasts a maximum of five days) to final custody orders made after a family group conference (FGC) has been held. A section 78 order sits between the two. It is an interim custody order and it is intended to be temporary. In sum, section 78 interim custody applications are meant to be reserved for urgent cases where other options to ensure safety of pēpi have already been considered by the Ministry.

1 *Re Alberta Ombudsman Act* (1970), 10 DLRDLR (3d) 47 (Alta SC) at 61.

2 The Ministerial Advisory Committee on a Māori Perspective *Te Pūao-te-Ata-Tū* (Department of Social Welfare, September 1988).





Removing a newborn pēpi from their parents is an extraordinary use of the government’s power, and as a matter of fairness and law those parents must have the opportunity to respond and have input in all but the most exceptional circumstances. Accordingly, the expected norm is that the Ministry’s section 78 applications should be made with notice, meaning parents and whānau are informed and can respond.

What I found is the Ministry routinely applied for without notice interim custody of unborn and newborn pēpi. All of the 74 custody cases I examined, from 2017 to 2019 across nine of the Ministry’s sites, involved without notice applications. The Ministry’s own review of section 78 cases identified that the majority of the parents and whānau were not given notice before the Ministry removed their newborn pēpi. This has also been confirmed by data supplied by the Ministry of Justice which showed that over 94 percent of **all** section 78 orders for 2017/18 and 2018/19 were granted on the basis of without notice applications.

My investigation found that the Ministry was usually aware of the pregnancy and reported concerns for a significant period before the birth of pēpi. In 77 percent of the cases I examined, the Ministry had 60 working days or more to assess and explore options, and to develop plans to ensure the safety of pēpi. However, the Ministry did not consistently utilise the available tools and mechanisms, such as hui ā-whānau and FGCs, to engage early with parents and whānau.

The Ministry also did not use that window of opportunity to plan early with professionals and external parties. In most of the cases, the Ministry did not meet the formal timeframe for completing its assessments. I also found variable use of the key checks and balances, such as referrals to Care and Protection Resource Panels, use of the Child and Family Consult, professionals meetings, completion of the Ministry’s assessment tool (Tuituia) and professional supervision.

The outcome is that in many cases decisions were being made late and without expert advice or independent scrutiny, and, most concerningly, without whānau involvement.

I found that urgency was created through the Ministry’s inaction and lack of capacity to follow processes in a timely and effective way. As a consequence, parents were disadvantaged—first, by not having an opportunity to respond to the allegations or challenge the information relied upon by the Ministry **before** their pēpi were removed, and second, by having to challenge orders **after** they were made, and when the parents were vulnerable because they were either heavily pregnant or had just given birth.

I found that the rights of disabled parents were not visible in either policy or practice. All the cases I reviewed required a disability rights-based response from the Ministry but this did not occur. That is a significant breach of the Disability Convention.

In terms of the Ministry’s practices relating to the physical removal of newborn pēpi, my investigation also found there was late or limited planning and engagement with parents and whānau and other external professionals. I also found limited support was offered to mothers who wished to breastfeed.

My investigation found that the Ministry was usually aware of the pregnancy and reported concerns for a significant period before the birth of pēpi.





Finally, I am not satisfied that, when the removal was executed by the Ministry, it provided parents and whānau with the opportunity for ngākau maharatanga me te ngākau aroha; a period of 'quality time' that reflects consideration, empathy, sympathy and love. In addition, the Ministry did not ensure that the parents and whānau had their support people present. Nor did it provide them with clear information on next steps. There was no support offered to parents and whānau to deal with the trauma and grief of child removal, or to help their healing.

In presenting this report to Parliament, it is my intention to ensure that there can be greater public trust and confidence in the Ministry. While I have identified systemic issues with the Ministry's practices connected to the removal of newborn pēpi, I have also found some evidence of good practice. For example, the Ministry has a number of tools and mechanisms, such as the Practice Standards, that broadly reflect the objects and principles of the Act and, once fully operationalised, will support best practice. I found some sites where leadership was well connected and embedded within the community; there was effective engagement and participation in these decisions by Māori, particularly where specialist Māori positions were valued and embraced by staff. The Ministry must build on these successes to achieve true transformation by 2022.

To this end, I have made a number of recommendations for the Ministry to take action to address the issues I have found. These include improvements to guidance and practices; the use of all tools available in a timely way; establishing effective reporting frameworks and quality assurance; and prioritising engagement with whānau, hapū, and iwi; and enhanced cultural competency of staff.

I am grateful to the staff of the Ministry and members of the communities who were interviewed. They have enabled me to understand the policies, procedures and practices that are operating, the impact these have on those involved, how that impact is being perceived, and what is required to ensure fairness for all.

Peter Boshier
Chief Ombudsman
August 2020



Acknowledgments

He Mihi

First, and most importantly, I acknowledge the pēpi, parents, and whānau whose information formed the basis of my findings and recommendations. I also acknowledge mana whenua of the regions of Aotearoa visited during my investigation.

I would like to thank Oranga Tamariki—the Ministry for Children for its assistance and cooperation throughout this investigation. In particular, I am grateful to the Ministry’s front line staff who spoke frankly and passionately about their work during interviews.

My thanks also to the other individuals and organisations that provided information and comment for my investigation including:

- Four members of Pūhara Mana Tangata (my Māori Advisory Panel)
- Principal Family Court Judge
- District Health Boards
- People First New Zealand Inc Ngā Tāngata Tuatahi
- IHC New Zealand
- Disability Commissioner (Human Rights Commission)
- Iwi social service providers and organisations
- National Māori Women’s Welfare League
- Nga Maia Māori Midwives Aotearoa
- New Zealand College of Midwives
- New Zealand Police
- VOYCE Whakarongo Mai
- Public Service Association
- Social Workers Registration Board
- Michelle Carter (Lactation expert)





A note about terminology

I acknowledge the importance of language and terminology for this investigation, particularly for Māori and the disability community. I understand that there are varying preferences and views on the meaning, accuracy and effects of particular terms.

The legislation relevant to my investigation refers to 'children, young persons, and their families, whānau, hapū, iwi, and family groups'. Recognising te reo Māori as an official language of Aotearoa, I have chosen in the context of this investigation to use:

- pēpi when referring to baby or babies;
- whānau when referring to family or families;
- te tamaiti when referring to a child;
- tamariki when referring to children; and
- rangatahi when referring to young person.

I have also relied on the Ministry's online glossary of te reo Māori terms and acknowledge that these are not iwi specific. I acknowledge that some iwi use different terminology and spellings for kupu.

In the context of disability, the terms 'learning disability', 'learning impairment' or 'intellectual disability' are commonly used. I acknowledge that parts of the disability community prefer the term 'learning disability'. People with intellectual disabilities are a diverse group but they may have challenges understanding new or complex information, learning new skills or tasks, and living independently.

In Te Ao Māori, 'tangata whaikaha hinengaro' may be used to refer to a person with an intellectual or learning disability.

See [Appendix 1](#) a glossary of the terms used in this report.³

3 Refer to page 201 of this report.



Executive Summary
He Whakarāpopototanga





Executive summary

He Whakarāpopototanga

My investigation

The role of Oranga Tamariki—the Ministry for Children (the Ministry) is to promote the wellbeing of tamariki, rangatahi and their whānau. Under the Oranga Tamariki Act 1989 (the Act) the Ministry has the power to take custody of, and remove, tamariki and rangatahi from their whānau when they are at risk of harm. This includes newborn pēpi.⁴

Under section 78 of the Act, the Ministry is able to apply for, and be granted, interim custody of tamariki in cases where other options to ensure their safety are not available. Further, in urgent cases it is able to do so without providing the parents and whānau of newborn pēpi the opportunity to be heard or respond before interim custody orders are granted. This should be in the context where other legal avenues, such as place of safety warrants and truncated notice periods, are not available. Given that without notice applications are a departure from the fundamental natural justice requirements enshrined in law, it is critical that there is independent oversight of the Ministry's policies, procedures and practices connected to the removal of newborn pēpi in such circumstances.

My role as an Officer of Parliament is to provide such independent oversight. By conducting investigations into the administrative conduct of public sector agencies, such as the Ministry, I promote government accountability and transparency. This in turn enables Parliament and the public of Aotearoa to have high levels of trust and confidence in government.

I have examined whether there are any systemic issues connected to the Ministry's policies, procedures, and practices relating to the removal of newborn pēpi under without notice interim custody orders.

In doing so, I acknowledge that the Ministry operates within a wider system. The work undertaken by other agencies will, at times, impact the Ministry's ability to meet its core purpose of ensuring *'all tamariki are living with loving whānau and in communities where oranga tamariki can be realised'*.

The timeframe for my investigation is from 1 July 2017 to 30 June 2019. This covers the Ministry's actions and decisions during the first two years of its five-year programme of transforming Aotearoa's care and protection operating model.

As part of my investigation, I arranged for visits to nine out of 50 of the Ministry's care and protection sites and undertook interviews with the relevant staff there. I also arranged for interviews with key third parties who play a role in the removal

My investigation covers the Ministry's actions and decisions during the first two years of its five-year programme of transforming Aotearoa's care and protection operating model.

⁴ For the purposes of this investigation, newborn pēpi are defined as those aged 0–30 days old.



of newborn pēpi at a site level. This included staff from the associated District Health Boards (DHBs), the New Zealand Police, and, where possible, relevant social service providers.

Interviews were also undertaken with staff from the Ministry’s National Office, and with other stakeholders and interested parties. This included Family Court judges, iwi social service providers and organisations, representatives from the disability community, National Māori Women’s Welfare League, Nga Maia Māori Midwives Aotearoa, the New Zealand College of Midwives, the Public Service Association and the Social Workers Registration Board.

I analysed the Ministry’s case files for 74 newborn (and unborn) pēpi in respect of whom the Ministry applied for interim custody under section 78 during the period between 1 July 2017 and 30 June 2019. These were all the section 78 files in the relevant period from the nine care and protection sites visited for my investigation. In all 74 files, the Ministry applied for without notice interim custody. I am not aware of any cases from these nine sites where, over the relevant period, a section 78 interim custody order for pēpi was applied for with notice. These 74 cases represent between 20 and 25 percent of all section 78 cases involving newborn pēpi during the relevant timeframe. In the 74 cases I examined, 56 pēpi (75 percent) were physically removed.

Between 1 July 2017 and 31 June 2019, the Ministry received reports of concern relating to over 4000 pēpi. In this period, across all sites, the Ministry removed approximately 300 newborn pēpi from their parents under section 78.⁵ The Ministry was unable to identify the exact number of newborn pēpi removed without the parents and whānau being notified of the decision to seek interim custody. However, its own review in 2019 of half of these cases identified that the majority of the parents and whānau were not given notice before the Ministry removed their newborn pēpi. Further, data supplied by the Ministry of Justice has shown that over 94 percent of **all** section 78 orders for 2017/18 and 2018/19 were granted on the basis of without notice applications by the Ministry.

Over 94 percent of all section 78 orders for 2017/18 and 2018/19 were granted on the basis of without notice applications by the Ministry.

My findings

The Ministry’s policies and procedures

I examined the Ministry’s operating policies and procedures as they relate to the decision to apply without notice for interim custody of, and remove, newborn pēpi.

Legal framework

In order to understand the Ministry’s policies and procedures, I first considered the relevant legal framework—in particular, the Oranga Tamariki Act 1989. The wording of the legislation generally reflects the obligations arising from te Tiriti

⁵ The Ministry has noted that the *'the available evidence shows that the majority of unborn/newborn pēpi brought to its attention do not enter care and those that do may enter under different orders'*.





o Waitangi and international law. The Act has been in a state of transition, with many amendments coming into force after I commenced my investigation. However, the obligations and expectations on the Ministry have been in place for a considerable period. In particular, I identified the following principles enshrined in law that should inform the Ministry's policies, procedures, and practices relating to the removal of newborn pēpi under section 78.

- Pēpi have the right, as far as is possible, to know and to be cared for by their parents, whānau, hapū, and iwi.
- Any intervention in family life should be the minimum necessary to ensure pēpi's safety and protection.
- Where pēpi are at risk, the parents and whānau should be provided assistance to support them in discharging their responsibilities to their pēpi, and they have a right to fully participate in the decision making processes.
- The use of without notice section 78 applications for interim custody should be reserved for urgent cases where all other options to ensure the safety of pēpi have been considered, and the delay caused by making an on notice application would create a risk to the safety of pēpi.

The Ministry's policies and procedures

In general, the content of the Ministry's overarching Practice Standards adequately reflect the objects and principles of the Act. However, the rights of disabled parents are a significant omission from the Practice Standards.

The Ministry has a wealth of other operating policies and guidance available on its publicly available online Practice Centre, most of which is consistent with the objects and principles of the Act and the obligations under international law. I appreciate that the Ministry is in the process of updating and reviewing the content of the Practice Centre (as it is required to do to meet its transformation programme). However, as it currently stands, I found its Practice Centre is difficult to navigate and the links back to the overarching Practice Standards are not readily apparent.

For the period I considered, I identified a number of gaps in the Ministry's operating policies and guidance.

Critically, I found the Ministry did not have any specific operating guidance on the use of without notice section 78 applications. It had some general guidance on the use of emergency powers (of which interim custody under section 78 is one) but this did not address the use of without notice applications. The available guidance did not sufficiently articulate clear criteria for how staff are meant to identify and assess the viability of other options to secure the safety of tamariki. Further, I found the Ministry's staff training material for 2017 was very brief and included inaccurate advice about the use of without notice applications.

The rights of disabled parents are a significant omission from the Practice Standards.

Critically, I found the Ministry did not have any specific operating guidance on the use of without notice section 78 applications.



While the training material for 2018 remedied this, it did not emphasise the need for the Ministry to consider all other options before applying for interim custody under section 78.

The lack of appropriate guidance on this issue is a serious failing in the context of the Ministry's routine reliance on such applications as a way to establish safety for pēpi.

The Ministry had one policy document, *Strengthening our response to unborn babies*, that provided specific guidance for unborn or newborn pēpi. I found this to be generally adequate, with the following exceptions.

- There was no reference to trauma-informed social work practice vis-à-vis assessing the parents' own childhood histories of abuse or neglect.
- It did not explicitly require specialist assessments for parents with alcohol or drug misuse, mental health needs or intellectual disabilities.
- It did not reflect the legal obligation on the Ministry to ensure that, where pēpi are at risk, the parents and whānau are provided assistance to support them in discharging their responsibilities to their pēpi.

I found there was very limited guidance in respect of disabled parents. It was not apparent from the available material that the Ministry appreciated alcohol or drug misuse and other mental health needs require a disability rights-based response. In terms of the specific guidance for parents with intellectual disability, I am concerned that the Ministry may have been operating in an outdated medical (deficits-based) model of disability. In addition, the guidance did not sufficiently emphasise that IQ should not be used as a sole measure of parenting capacity. Nor did it explicitly refer to the obligation under international law that no tamariki should be separated from their parents based on a disability of one or both of the parents.

With the exception of breastfeeding, I found the Ministry did not have any guidance and policy specifically developed for the process of removing tamariki once section 78 interim custody orders are granted. None of the memoranda of understanding between the Ministry and the District Health Boards referred to this process. Nor was it apparent from the material made available to me that the Ministry had agreements in place, during the period of my investigation, about the required or expected practice with other third parties who may be involved in, or impacted by, the removal process. This situation is highly unsatisfactory, given the potential long-term impacts of a removal.

Finally, the available guidance on breastfeeding could be improved by including an explicit acknowledgment of the rights to breastfeeding as provided for under the United Nations Convention on the Rights of the Child (UNCROC), and the recommendations of the World Health Organization and the Ministry of the Health about exclusive breastfeeding.

I found the Ministry did not have any guidance and policy specifically developed for the process of removing tamariki



The Ministry’s practices

I considered the Ministry’s decision-making practices in two distinct but related phases: the time before an application is made to the Family Court for a without notice section 78 interim custody order; and the removal of pēpi, if that occurred, once the section 78 order was granted.

First phase—applications for without notice interim custody

In general, I found the Ministry has sufficient tools and processes to enable the objects and principles of the Act to be achieved. For example, the Ministry was able to utilise hui ā-whānau, family group conferences (FGC), Māori specialist roles, Child and Family Consults, professionals meetings, Tuituia reporting (the Ministry’s assessment tool), and Care and Protection Resource Panels (CPRP).⁶ However, my investigation found that the Ministry did not consistently apply the available tools and processes in practice, and was instead resorting to removing these pēpi without notice.

In terms of engagement with parents and whānau, during the period covered by my investigation, the Ministry piloted new ways to engage, which were shown to be much more effective for Māori. Māori have a long history of problem solving in a way that allows things to be tika and pono—concepts understood and seen as beneficial by the Ministry’s staff in how they engage successfully with Māori. Hui ā-whānau and FGCs are extensions of this and, if they were utilised in the way intended, could have made a major impact on the outcomes for pēpi and whānau. Therefore, I consider it concerning that in over half of the 74 cases I reviewed, hui āwhānau or FGCs did not occur prior to the birth of pēpi. I was also disappointed to find that, for the timeframe of my investigation, there appeared to be a lack of an agreed national strategy within the Ministry to promote and encourage Māori to take more of a lead in decisions affecting them.

I did find that the involvement of kairāanga was transformative. However, there were only 33 kairāanga engaged by the Ministry (as at April/May 2019) and the support given to them was not consistent across regions visited by my investigation. One of the barriers identified to using kairāanga was the lack of ‘site readiness’. However, it is unclear how a site could be ‘ready’ until the Māori specialist positions were effectively embedded to provide leadership in this space. I found that the slow progress to change was self-perpetuating and appeared to reflect, and potentially inflame, a fundamental distrust of a different way of operating.

It also appeared to me that trauma-informed practice was not entrenched within the Ministry. I was unable to find any evidence that the Ministry’s staff saw the parents’ childhood histories, as well as experiences of being in care themselves and the Ministry’s prior removal of their children, as traumatic events for parents that required a different response.

The Ministry has sufficient tools and processes to enable the objects and principles of the Act to be achieved.

⁶ Refer to the glossary in [Appendix 1](#) at page 201 of this report for an explanation of these terms.





I found disabled parents were a group that was poorly served by the Ministry. All the cases I reviewed involved a parent with a disability, ranging from intellectual disability to alcohol or drug misuse and other mental health needs. However, the Ministry did not demonstrate any understanding of their rights in this regard. Over 20 percent of the cases involved a parent with an intellectual disability, but less than 17 percent of those cases had up-to-date specialist assessments relating to this. This reflects a general failure by the Ministry to operate within a human rights framework and to recognise the social model of disability for parents who may have disability-related needs.

When the Ministry has concerns about the wellbeing of an unborn pēpi, it is crucial that the Ministry takes advantage of the time before the pēpi is born to assess the situation and plan. This should start as early as possible and involve whānau, as well as other professionals and organisations supporting the parents and whānau. However, my investigation found that the Ministry did not take advantage of the unique opportunity to act early and with whānau and external parties before pēpi were born.

I found that in 77 percent of the cases I reviewed, the Ministry was aware of the pregnancy, and the reported concerns, 60 working days or more before the birth of pēpi. Yet, it took over 50 working days in nearly half of the cases to complete a Child and Family Assessment. This was well outside the maximum expected timeframe of 36 working days.

High caseloads and limited numbers of kairāanga appeared to be contributing factors to the delays in these cases. These were exacerbated by mixed caseloads, where the focus was understandably on the immediate safety of other tamariki identified to be at risk, rather than the long-term wellbeing of an unborn pēpi and their whānau. When combined with workload pressures, this appeared to result in cases involving unborn pēpi not being prioritised until the birth was imminent. Many of those interviewed described kairāanga as transformative, and said they made a difference in terms of finding and engaging with whānau early. Unfortunately, except in a few sites, they were either not available or struggling with acceptance or workload.

I found the outcome in many of these cases was that decisions for pēpi were being made late and without expert advice or whānau involvement. I also found that urgency and the need for without notice applications were created through the Ministry's lack of capacity to follow its own processes in a timely and effective way. As a consequence, the parents were disadvantaged—first, by not having an opportunity to respond to the allegations or challenge the information relied upon by the Ministry **before** their pēpi were removed, and second, by having to challenge orders **after** they were made, and when the parents were vulnerable because they were either heavily pregnant or had just given birth.

My investigation, and the Ministry's own reviews, identified much variability in the application and quality of key checks and balances. In particular, 20 percent of the cases I reviewed had no record of the matter being referred to a Care and Protection Resource Panel, despite this being a statutory obligation. In a third of the cases I reviewed, there was no evidence on the files of the Ministry

It is crucial that the Ministry takes advantage of the time before the pēpi is born to assess the situation and plan.

In 77 percent of the cases I reviewed, the Ministry was aware of the pregnancy, and the reported concerns, 60 working days or more before the birth of pēpi.

Decisions for pēpi were being made late and without expert advice or whānau involvement.





undertaking a Child and Family Consult, which was required in all cases where a removal was being considered. In 77 percent of the cases I reviewed, there was no evidence of consultation with the Ministry’s solicitors. Professionals meetings did not occur in 64 percent of cases I reviewed, and in half of the cases, the Tuituia report was not completed within the expected timeframe of 36 working days. Significantly, in 7 percent of cases, there was no Tuituia report completed at all. Further, in 46 percent of cases, there was no evidence of professional supervision. Where there were records of professional supervision, 90 percent of these were focused on tasks, actions and next steps, rather than the required critical and reflective practice.

Overall, the failure to undertake the Ministry’s own key checks and balances that have been built into the system severely compromised the quality, robustness, and transparency of the Ministry’s decision making. This is particularly concerning because of the wide-reaching and coercive nature of the Ministry’s powers, and the overwhelming impact the use of these powers can have on individuals and their whānau.

The Ministry must act in a way that is lawful, fair and reasonable, transparent, and open. Crucially, the Ministry must be guided by the legislative presumption that tamariki are entitled to know and be cared for by their parents. Additionally, the parents’ rights to know the allegations against them, and to have an opportunity to respond, are at the heart of Aotearoa’s legal system, and are of central importance in the context of the coercive powers of the Ministry.

In practice, I found that without notice applications seemed to be the default position in cases involving unborn or newborn pēpi. Although I accept that the applications were made because the Ministry had serious concerns for pēpi, it is essential that all Ministry staff understand the law, plan carefully, and apply it consistently. I note the Ministry has accepted that without notice applications needed more oversight, following the Hastings Practice Review.

The Ministry must ensure that the fundamental safeguards in the Act are understood and complied with. This is especially critical in the context of the subsequent child provisions, where custody of a previous child has been removed. These provisions have been interpreted as reversing the onus of proof, so parents have to prove that they are not a risk to their tamariki. I consider this to be highly problematic for parents who struggle to advocate for themselves. In my view, the issue was made worse because of the Ministry’s failure to understand and follow the statutory requirements in applicable cases, resulting in the Court not having the oversight expected in these cases, and parents not having access to independent advice and representation.

The failure to undertake the Ministry’s own key checks and balances [...] severely compromised the quality, robustness, and transparency of the Ministry’s decision making.

Without notice applications seemed to be the default position in cases involving unborn or newborn pēpi.





Second phase—removal of newborn pēpi

I found minimal evidence that parents and whānau had been involved by the Ministry in planning the removal process. Late and limited pre-birth planning, communication and information sharing with DHBs and midwives, and variable information provided in safety/birth plans are also key issues that I identified.

I observed that where there have been good planning and improvements in practice, these flowed from the efforts of individual staff. The Ministry had no set guidance or established agreements with its health partners to identify the expected or required practice for social workers specifically in the area of newborn removals.

I am concerned about the consequences of poor planning on parents, whānau, and on hospitals. For parents and whānau, it was likely to cause uncertainty, fear, and anxiety. In the hospital setting, interviewees were concerned that the Ministry’s late planning resulted in uncertain, rushed decision making, which compromised practice and increased escalation.

I also found insufficient support was offered to breastfeeding mothers. In around half of the cases where the mother planned to breastfeed, initial contact with pēpi was just once or twice a week. I found the Ministry’s guidance in this regard was not followed, and I was not assured that the Ministry was therefore prioritising and taking sufficient steps to support exclusive breastfeeding where that was appropriate and desired by the mother. I also found the Ministry’s practices were inconsistent with the United Nations Convention on the Rights of the Child and the recommendations of the World Health Organization and Ministry of Health around exclusive breastfeeding for the first six months of pēpi’s life.

When a removal decision was executed, I found parents and whānau were not provided with the opportunity for ngākau maharatanga me te ngākau aroha; a period of ‘quality time’ that reflects consideration, empathy, sympathy and love. In addition, the Ministry did not ensure that the parents and whānau had their support people present. Nor did it provide them with clear information on next steps. There was no record of support being offered to parents and whānau to deal with the trauma and grief of child removal, or to help their healing. There was little evidence that trauma-informed practice had occurred consistently.

I am concerned about the consequences of poor planning on parents, whānau, and on hospitals.

There was no record of support being offered to parents and whānau to deal with the trauma and grief of child removal.





My opinion

In my opinion, the content of the Ministry's overall operating policies and guidance, effective during the period covered by my investigation, were generally adequate and reflective of the objects and principles of the Act. However, I identified some gaps in the Ministry's policies and guidance.

In particular, my opinion is it was unreasonable that:

- there was no comprehensive guidance on the use of without notice section 78 applications, and the available guidance on emergency powers did not articulate clear criteria for how staff were meant to identify and assess the viability of other options to secure the safety of pēpi;
- the subsequent children provisions, and the Ministry's corresponding guidance, have placed the responsibility on parents for gathering evidence to demonstrate that the risk of harm has been satisfactorily removed;
- there was limited specific guidance for unborn and newborn pēpi, and the available guidance did not:
 - include reference to trauma-informed social work practice vis-à-vis assessing the parents' own childhood histories of abuse and/or neglect, as well as experiences of being in care themselves, and the Ministry's prior removal of their children as traumatic events for parents that required a different response; or
 - reflect the legal obligation on the Ministry to ensure that, where pēpi are at risk, parents and whānau are provided assistance to support them in discharging their responsibilities to pēpi;
- the rights of disabled parents were not reflected in the Ministry's overarching Practice Standards;
- there was an overall lack of guidance in respect of disabled parents, and the available guidance:
 - did not identify that alcohol or drug misuse and other mental health needs of parents require a disability rights-based response;
 - in relation to parents with intellectual disability:
 - › appeared to be based on an outdated medical (deficits-based) model of disability;
 - › did not emphasise that IQ should not be used as a sole measure of parenting capacity;
 - › did not specify the obligation under international law that no pēpi is separated from their parents based on a disability of one or both of the parents;



- with the exception of breastfeeding, the Ministry did not have any guidance and policy specifically developed for the process of removing pēpi once section 78 interim custody orders are granted;
- the available guidance on breastfeeding did not include explicit acknowledgements of:
 - the rights to breastfeeding as provided for under the United Nations Convention on the Rights of the Child; and
 - the recommendations of the World Health Organization and the Ministry of Health on exclusive breastfeeding for the first six months of pēpi’s life.

It is also my opinion that, during the period covered by my investigation, the Ministry’s decision making practices connected with the removal of newborn pēpi under section 78 of the Act were unreasonable. The evidence I have considered did not demonstrate that the Ministry consistently met the objects and principles of the Act and the obligations under international law. In particular, I do not consider that the Ministry had adequately ensured:

- without notice applications for interim custody were reserved for urgent cases where all other options to ensure the safety of pēpi had been considered;
- a pēpi’s right, as far as is possible, to know and to be cared for by their parents and whānau;
- no pēpi was separated from their parents based on a disability of one or both of the parents;
- the primary role in caring for and protecting pēpi was with their whānau, hapū, iwi, and family group;
- the parents and whānau were provided assistance to support them in discharging their responsibilities to their pēpi;
- (where possible) whānau, hapū, and iwi were able to participate in decision making and regard was given to their views;
- (where possible) the relationship between pēpi and their whānau, hapū, and iwi was maintained and strengthened;
- endeavours were made to obtain the support of pēpi’s parents;
- (where possible) decisions affecting pēpi were made and implemented within a timeframe appropriate to their age and development;
- the primary role in caring for and protecting pēpi was with their whānau, hapū, iwi, and family group;
- whānau, hapū, and iwi were supported, assisted, and protected as much as possible, and any intervention in family life was minimised;
- pēpi and their mothers were supported in their rights to breastfeeding; and
- parents and whānau were given assistance when their relationship with pēpi was disrupted.



Recommendations

Pursuant to section 22(3) of the Ombudsmen Act 1975 I recommend the following:

1. The Ministry:
 - a ensures its current policies, training material and practices make explicit that without notice interim custody applications are reserved for exceptional urgent cases where all other options to ensure the safety of pēpi are unavailable;
 - b develops comprehensive guidance with clear criteria to enable its staff to assess the viability of other options to ensure the safety of pēpi in urgent cases;
 - c exercises best endeavours, in all but the most exceptional of cases, to use a place of safety warrant or truncated notice period when the Ministry learns of a pregnancy at a late stage and determines pēpi to be at imminent risk;
 - d takes immediate measures in terms of reports of pēpi at risk to ensure that all statutory requirements are met, and in particular:
 - i commences an investigation as soon as practicable (section 17(1)(a) of the Act);
 - ii consults a Care and Protection Resource Panel in all cases and as soon as practicable after an investigation has commenced (section 17(1)(b) of the Act), and at subsequent stages where required (sections 21(1)(a) and 31(1)(e) of the Act);
 - iii convenes a family group conference (section 18(1) of the Act);
 - e establishes timeframes, reporting frameworks, quality assurance and monitoring to demonstrate appropriate ongoing compliance with all statutory requirements as these relate to without notice removals of newborn pēpi; and
 - f reports publicly against the framework for monitoring detailed in recommendation 1(e) every six months.
2. Additionally, the Ministry:
 - a reviews its processes to ensure that all cases involving unborn or newborn pēpi are given the necessary priority;
 - b reviews its policies and practices to ensure whānau engagement is prioritised in all cases involving unborn or newborn pēpi, including family group conferences and hui ā-whānau where appropriate;



- c develops, in partnership with iwi and other Māori groups, a national strategy for:
 - i effective engagement with whānau, hapū, and iwi, including provision for localised relationship-based implementation with centralised support; and
 - ii enhanced cultural competency of staff;
- d develops memoranda of understanding with the Ministry of Health, the DHBs, midwifery representatives, and other relevant parties to ensure appropriate information sharing, clear and defined roles, and effective early planning for at-risk pēpi;
- e works with the relevant providers to ensure that all social workers are trained in, and engage, trauma-informed practice that is underpinned by te ao Māori, and consults with the Social Workers Registration Board to assist with the achievement of this;
- f develops specific guidance for cases involving unborn and newborn pēpi that:
 - i requires trauma-informed social work practice when parents have experienced childhood abuse and/or neglect, been themselves in care or had tamariki previously removed by the Ministry;
 - ii reflects the obligations on the Ministry to ensure that where pēpi are at risk, parents and whānau should be provided assistance to support them in discharging their responsibilities to pēpi;
- g develops clear guidance, with supporting tools, for social workers to ensure all legislative and procedural safeguards are engaged with respect to subsequent tamariki, pending the outcome of the Ministry's review of the subsequent children provisions;
- h amends its policies and practices relating to the subsequent children provisions to make clear that social workers are responsible for actively seeking out up to date information and conducting a full assessment of the parents' current circumstances;
- i works with relevant agencies to assist parents who have had previous tamariki removed with access to independent advocacy during the Ministry's assessment and intervention phases;
- j amends its overarching Practice Standards, as well as its policies, procedures, and practices to recognise the rights of disabled parents and ensure full compliance with the United Nations Convention on the Rights of Persons with Disabilities;
- k ensures all its policies, procedures, and practices are consistent with the social model of disability and a rights based framework by:



- i providing reasonable accommodation;⁷
 - ii explicitly recognising that drug and/or alcohol misuse and mental health needs require a disability rights-based response;
 - iii ensuring disabled parents have access to specialist advocacy during the assessment and intervention phases;
- l in implementing recommendations 2(j) and (k) above, closely consults with and actively involves disabled people, their whānau and organisations that represent disabled people, as well as other relevant agencies within the system;
- m ensures all parents have information about their legal rights, including information about accessing legal aid, in an accessible format;
- n develops specific policies and procedures for the process of removing newborn pēpi, once section 78 interim custody orders are granted, that:
- i ensure, to the fullest extent possible, planning, communication and information sharing with parents, whānau, DHBs and midwives;
 - ii ensure, to the fullest extent possible, the removal of pēpi takes place in a manner that reflects ngākau maharatanga me te ngākau aroha, a period of quality time that encompasses consideration, empathy, sympathy and love; minimises trauma; and provides parents and whānau with support and clear information on next steps;
 - iii explicitly recognise the right of pēpi to be breastfed consistent with the United Nations Convention on the Rights of the Child, as well as guidance from the World Health Organization and the Ministry of Health;
 - iv reflect best practice to support breastfeeding;
 - v ensure appropriate therapeutic and other support is available to all parents who have had pēpi removed from their care; and
- o regularly audits case files to ensure compliance with policy and practice guidance.
3. The Ministry reports back to me on its achievement of recommendations 1 and 2 on a quarterly basis for the next year, with the first report by **4 November 2020**.

My office is available to assist the Ministry with the implementation of these recommendations.

⁷ Refer to page 239 of this report for an explanation of reasonable accommodation.



Introduction
Kōrero whakataki





Introduction

Kōrero whakataki

Oranga Tamariki—the Ministry for Children (the Ministry) was launched in April 2017.⁸ It was tasked with transforming Aotearoa’s care and protection service by 2022. While the transformation programme was expected to take five years to complete, the vision of the new Ministry was clear from the outset:⁹

The new Ministry puts children and young people’s safety and wellbeing first. It will work with families and whānau to ensure children and young people get access to the care and support they need, and will ensure they have a say in decisions that affect them.

The Ministry’s core roles include:¹⁰

- *‘responding to and supporting children and young people, and their families, when they are at risk due to abuse, neglect, self-harm, or behavioural issues’;*
- *‘providing care and protection to children and young people who are in need of it’;*
- *‘delivering family-led decision-making to address care and protection concerns...’; and*
- *‘purchasing services for vulnerable children’.*

I acknowledge that the Ministry operates within a wider system. The work undertaken by other agencies will, at times, impact the Ministry’s ability to meet its core purpose of ensuring *‘all tamariki are living with loving whānau and in communities where oranga tamariki can be realised’.*

The Ministry derives its functions from a number of legislative instruments.¹¹ For the purposes of my investigation, the key statutory provisions are set out in the Oranga Tamariki Act 1989 (the Act).¹² The current purpose of the Act is *‘to promote the well-being of children, young persons, and their families, whānau, hapū, iwi and family groups’.*¹³

I acknowledge that the Ministry operates within a wider system.

8 Its initial name, the Ministry for Vulnerable Children, attracted criticism. This was subsequently changed in October 2017.

9 Anne Tolley “New Ministry for Vulnerable Children, Oranga Tamariki launched” (press release, 1 April 2017).

10 Oranga Tamariki—Ministry for Children *Briefing to the Incoming Minister* (October 2017) at 3.

11 This includes the Children’s Act 2014, the Children’s Commissioner Act 2003, the Adoption Act 1955, the Adoption (Intercountry) Act 1997 and the Adult Adoption Information Act 1985.

12 As part of the five-year transformation programme, a raft of amendments were made to the former Children, Young Persons, and their Families Act 1989. The majority of the amendments took effect on 1 July 2019 with a small number coming into force in April and July 2017, including a change to the title of the Act.

13 Section 4(1) of the Act, as amended in July 2019. Similar wording was set out in s 4 of the Act that was effective in July 2017.



The Act authorises the Ministry to apply to the Family Court for custody of tamariki or rangatahi who are in need of care or protection.¹⁴ When granted a custody order by the Family Court, the Ministry is able to remove tamariki or rangatahi from their parents and place them with people who the Ministry considers appropriate. This includes newborn pēpi. Alternatively, the Ministry may choose to place tamariki with their parents while the Ministry has a custody order.

Given that the removal of tamariki from their parents and whānau is significant intervention by the State,^{15 16} the legislation places a number of obligations on the Ministry.¹⁷ This includes assisting parents, whānau, hapū, iwi, and family groups in discharging their responsibilities and facilitating their participation, where possible, in the decision-making processes.

Section 78 of the Act allows the Ministry to apply for (and be granted) interim custody of tamariki in urgent cases pending determination of the substantive care and protection proceedings. It is important to note that section 78 orders are a temporary measure taken before any final decisions are made.

Significantly, applications under section 78 of the Act can be made on a without notice basis in certain limited situations.¹⁸ In these cases, it means the parents and whānau are not provided the opportunity to be heard or to respond before interim custody orders are granted by the Court. In light of the far-reaching implications of this power, I have focused my investigation on the Ministry's decision making as it relates to without notice applications under section 78.

Between 1 July 2017 and 31 June 2019, the Ministry received reports of concern relating to over 4000 pēpi. In this period, across all sites, the Ministry removed approximately 300 newborn pēpi from their parents under section 78.¹⁹ The Ministry was unable to identify the exact number of newborn pēpi removed without the parents and whānau being notified of the decision to seek interim custody. However, its own review of a sample of these cases identified that the majority of the parents and whānau were not given notice before the Ministry removed their newborn pēpi.^{20 21} Further, data supplied by the Ministry of Justice has shown that over 94 percent of **all** section 78 orders for 2017/18 and 2018/19 were granted on the basis of without notice applications.²²

14 Sections 14, 67, 78, 101, and 102 of the Act effective in July 2017. See ss 14, 68, 78, 83, 101, and 102 of the Act as amended in July 2019.

15 Affidavit affirmed by Grant Robert Bennett dated 5 July 2019 (Wai 2915, 2020) at [55].

16 Kenneth Burns, Tarja Poso and Marit Skivenes *Child Welfare Removals by the State: A cross-country analysis of decision-making systems* Oxford University Press 2017.

17 See, for example, ss 4, 5, 6, 7 and 13 of the Act effective in July 2017. See ss 4, 4A, 5, 7, 7AA and 13 of the Act as amended in July 2019.

18 Rule 220(2) of the Family Court Rules 2002.

19 The Ministry has noted that the 'the available evidence shows that the majority of unborn/newborn pēpi brought to its attention do not enter care and those that do may enter under different orders'.

20 Oranga Tamariki – Ministry for Children *s78 Casefile Analysis* (November 2019).

21 Oranga Tamariki – Ministry for Children *Section 78 Practice Insights for Operational Groups* (PowerPoint presentation, November 2019).

22 Exhibit VJC-2.2 of affidavit affirmed by Valmai Joy Copeland dated 20 March 2020 (Wai 2915, 2020) at [10]. This did not specify whether the s 78 orders were for newborn pēpi.

The removal of tamariki from their parents and whānau is significant intervention by the State.



The Ministry has acknowledged that removing tamariki from their parents and whānau *'is in and of itself inherently traumatic'*.²³

A recent international literature review noted the following about the psychological impact of removal at birth on mothers:²⁴

...the impact of removal at birth is acutely traumatic, and has a far-reaching impact ... The literature reveals both the immediate intensity of loss and grief, which heightens women's vulnerability, but also the enduring nature of this loss ... the impact of deep-felt grief, guilt and shame ... led to their further social isolation and a reliance on problematic coping strategies such as substance misuse ... Women described a removal at birth as deeply distressing and de-humanising. Women's loss compounded existing problems, including emotional disconnection from others and misuse of substances.

There are long-lasting negative consequences for tamariki brain development when separated from their parents.

Similar observations were made about the impact on fathers and it was suggested that *'the traumatic impact of state intervention is not confined to the birth parents but likely reverberates throughout the kin network'*.²⁵

Most importantly, the impact of a removal must also be understood in terms of pēpi themselves. Numerous studies show that there are long-lasting negative consequences for tamariki brain development when separated from their parents.²⁶ Of particular significance for newborn pēpi is the increased risk of developing separation and attachment disorders, as well as other health issues.²⁷

There are no doubt situations where the best interests and safety of a newborn require intervention by the State, and occasions where the immediacy of the danger to pēpi is such that notice to the parents is not viable. The Act recognises and provides for this. However, it is crucial that the Ministry, as a responsible state agency, acts fairly and reasonably—particularly where the parents and whānau are not provided an opportunity to be heard, or even informed, before their pēpi is removed. This is in accordance with its statutory obligation to promote both the wellbeing of newborn pēpi and that of their whānau, hapū, and iwi when intervening in such cases.

23 Oranga Tamariki—Ministry for Children *Practice Review: Professional Practice Group, Practice Review into the Hastings Case* (5 November 2019) at 41. Referred to as the Hastings Practice Review in this report.

24 Claire Mason, Laura Robertson and Karen Broadhurst *Pre-birth assessment and infant removal at birth, experiences and challenges: A literature review* (Nuffield Family Justice Observatory, December 2019) at 12–13.

25 At 13–14.

26 Shanta Trivedi "The Harm of Child Removal" (2019) 43 NYURevL & SocChange 523 at 528–531.

27 Allan Shore and Jennifer McIntosh "Family Law and the Neuroscience of Attachment, Part I" (2011) 49(3) Family Court Review 501 at 504–507.





My Investigation
Taku tūhuratanga





My investigation

Taku tūhuratanga

My role as Chief Ombudsman, Kaitiaki Mana Tangata, is to help give effect to a number of key democratic and human rights measures aimed at safeguarding the rights of individuals and promoting government accountability and transparency. I provide independent oversight of administrative conduct by the public sector to enable Parliament and the public of Aotearoa to have high levels of trust and confidence in government. My overarching goal is to ensure that people in Aotearoa are treated fairly.

One of the means I use to achieve this goal is conducting self-initiated systemic investigations. These investigations examine issues of significant public interest where an impartial examination of the actions of an agency is needed, particularly where there may be deteriorating public trust and confidence in the agency. The actions relating to the Ministry's removal of newborn pēpi clearly constituted a matter where a systemic investigation was needed.

Purpose and scope

The purpose of this investigation is to examine the Ministry's policies, procedures, and practices that relate to the removal of newborn pēpi. There are two specific areas of focus to my investigation:

- the Ministry's decision making around applications to the Family Court for section 78 interim custody orders (without notice) for newborn (and unborn) pēpi; and
- the Ministry's removal of newborn pēpi, after section 78 interim custody orders (without notice) have been granted by the Family Court.

Newborn pēpi are defined as those aged 0–30 days old. The legislative provision referred to is section 78 of the Oranga Tamariki Act 1989 (the Act).

The scope of my investigation is limited to the period between 1 July 2017 and 30 June 2019. This timeframe starts when the Ministry became operational and began its five-year transformation programme, which is expected to be completed by 2022.





Summary of the investigation methodology

A detailed description of my investigation methodology is set out in [Appendix 2](#).²⁸ A summary is set out below.

Following preliminary discussions between my staff and officials from the Ministry at the end of May 2019, I formally notified its Chief Executive of my investigation on 6 June 2019.²⁹ I publicly announced my investigation on 19 June 2019 when appearing before Parliament’s Governance and Administration Committee.³⁰ On 18 July 2019, I subsequently issued an updated Terms of Reference for my investigation.³¹

In order to establish whether there were any systemic issues with the Ministry’s practices connected to the without notice removal of newborn pēpi, it was critical for me to understand:

- what the Ministry’s policies and practices were at the time;
- how these were being applied by the Ministry’s frontline staff; and
- the impact this was having.

Accordingly, I arranged for visits to nine out of 50 of the Ministry’s care and protection sites³² and undertook interviews with the relevant staff there.

Interviews were also undertaken with staff from the Ministry’s National Office, and with other stakeholders and interested parties. This included Family Court judges, and representatives from the disability community, National Māori Women’s Welfare League (MWWL), Nga Maia Māori Midwives Aotearoa, the New Zealand College of Midwives, the Public Service Association (PSA), and the Social Workers Registration Board (SWRB).

I also arranged for interviews with key third parties who play a role in the removal of newborn pēpi at a site level. This included staff from the associated District Health Boards (DHBs), the New Zealand Police and relevant iwi social service providers and organisations.

I also obtained and reviewed other written documentation from the Ministry, including its policies and guidance, training material, memoranda of understanding, and evaluations of various pilot projects. I reviewed the relevant legislation and international conventions.

28 Refer to page 206 of this report.

29 This step is required by section 18(1) of the Ombudsmen Act 1975. This investigation has been conducted pursuant to ss 13(1) and 13(3) of that Act.

30 Office of the Ombudsman “Chief Ombudsman to conduct wide-ranging investigation into the removal of newborn babies” (press release, 19 June 2019).

31 An initial Terms of Reference dated 6 June 2019 was provided to the Ministry when it was notified of the investigation. The updated terms of reference refined the purpose and scope of the investigation. This is available at <www.ombudsman.parliament.nz/resources/oranga-tamariki-newborn-removal-investigation-terms-reference>.

32 The number of the Ministry’s care and protection sites has fluctuated, with some sites merging and others splitting. At 1 July 2017, the Ministry had 49 care and protection sites in 11 regions. According to the Ministry’s 2017/18 Annual Report, there were 63 sites in 11 regions; Oranga Tamariki—Ministry for Children *Annual Report 2017/18* (October 2018) at 44.



In addition, I analysed the Ministry's case files for 74 newborn (and unborn) pēpi in respect of whom the Ministry applied for interim custody under section 78 during the period between 1 July 2017 and 30 June 2019.³³ These were all the section 78 files in the relevant period from the nine care and protection sites visited for my investigation. In all 74 files, the Ministry applied for without notice interim custody. I am not aware of any cases from these nine sites where, over the relevant period, a section 78 interim custody order for pēpi was applied for with notice. These 74 cases represent between 20 and 25 percent of all section 78 cases involving newborn pēpi during the relevant timeframe. In the 74 cases I examined, 56 pēpi (75 percent) were physically removed.

On 16 July 2020, before finalising my report, I provided the Ministry with an opportunity to be heard and to comment on my provisional findings and recommendations. I also invited comment from relevant third parties. This included:

- Four members of Pūhara Mana Tangata (my Maori Advisory Panel);
- Principal Family Court Judge;
- District Health Boards;
- People First New Zealand Inc Ngā Tāngata Tuatahi;
- IHC New Zealand;
- Disability Commissioner (Human Rights Commission);
- Health and Disability Commissioner;
- New Zealand Police;
- National Māori Women's Welfare League;
- Nga Maia Māori Midwives Aotearoa;
- New Zealand College of Midwives;
- Public Service Association;
- Social Workers Registration Board;
- Ministry of Health; and
- Chief Archivist.

I carefully considered the responses from all of the parties and, where necessary, I have amended my report to reflect their feedback.

³³ The files selected and provided by the Ministry were extracted from its case management system: Care and Protection, Youth Justice, Residential and Adoption Services (CYRAS). These files did not constitute the entirety of the Ministry's involvement with a particular pēpi or their whānau. Instead, the files were limited to the period from when the report of concern (that led to the Ministry's s 78 application) was received by the Ministry to a period following the removal of pēpi.



In reaching my opinion and recommendations, I have also relied upon:

- the qualitative evidence gathered from the interviews conducted for my investigation; and
- the quantitative evidence gathered from:
 - my review and analysis of 74 case files from the nine sites visited where the Ministry had applied for interim custody of a newborn (and unborn) pēpi under section 78 between 1 July 2017 and 30 June 2019;
 - the Ministry's *s78 Casefile Analysis* completed in November 2019, in which it examined 153 of the 309 cases where pēpi were placed in its custody under section 78 orders between 1 July 2017 and 30 June 2019;³⁴ and
 - the Ministry's review and analysis of 62 cases where pēpi under 30 days old were placed in its custody between 1 July 2017 and 30 June 2018.³⁵

I assessed the evidence of the Ministry's practices against the relevant legal framework and the expectations of best practice, primarily sourced from the Ministry's online Practice Centre³⁶ and its findings in the Hastings Practice Review.³⁷

I also considered the publicly available written and oral evidence presented to the Royal Commission of Inquiry into Abuse in Care,³⁸ as well as the publicly available evidence presented to the Waitangi Tribunal in respect of its urgent inquiry into the Ministry.³⁹

34 Above n 20.

35 Oranga Tamariki—Ministry for Children *Babies and children entering Oranga Tamariki care* (June 2019).

36 Oranga Tamariki—Ministry for Children Practice Centre is available at <practice.orangatamariki.govt.nz/>.

37 Hastings Practice Review, above n 23.

38 This is available at <www.abuseincare.org.nz/public-hearings/about/contextual-hearing/>.

39 Waitangi Tribunal *The Oranga Tamariki Urgent Inquiry* (Wai 2915, 2020).



I took account of the other related inquiries undertaken by the Office of the Children’s Commissioner and Whānau Ora. I also considered previous reviews undertaken of the Ministry and its predecessors, including *Te Pūao-te-Ata-Tū*⁴⁰ and the reports by Ken Mason in 1992,⁴¹ Michael Brown in 2000,⁴² and the Modernising Child, Youth and Family Expert Panel in 2015.^{43 44}

The Ministry has reported that since July 2019 it has made changes relating to its use of without notice applications for section 78 interim custody orders and the removal of newborn pēpi. Whilst these are outside the timeframe of my investigation, it is important that I acknowledge them. They are set out in [Appendix 3](#).⁴⁵

Structure of this report

My report is divided into four parts:

- **Part One** is a profile of the parties who are at the heart of my investigation. These are pēpi, their parents and whānau, and the Ministry.
- **Part Two** examines the Ministry’s operating policies and procedures that relate to the removal of newborn pēpi. In order to assess the Ministry’s policies and procedures, I first set out the relevant legal framework—specifically, the Oranga Tamariki Act 1989 and the obligations arising from te Tiriti o Waitangi and international law. Next, I move on to consider the relevant policies and procedures themselves.
- **Part Three** takes a detailed look at the Ministry’s decision making practices in two distinct but related phases. The first is before an application is made to the Family Court for a (without notice) section 78 interim custody order, and the second is removal of pēpi once the section 78 order is granted. For each of these phases, I identify the key elements that, in my opinion, would constitute a fair and reasonable decision making process and assess the evidence of the Ministry’s practices against those elements.
- **Part Four** contains my conclusions, consolidated findings, and recommendations.

40 The Ministerial Advisory Committee on a Māori Perspective *Te Pūao-te-Ata-Tū* (Department of Social Welfare, September 1988).

41 Kenneth Mason *Review of the Children, Young Persons and their Families Act 1989* (Department of Social Welfare, February 1992).

42 Michael JA Brown *Care and Protection is about adult behaviour: The Ministerial Review of the Department of Child, Youth and Family Services, Report to the Minister of Social Services and Employment Hon Steve Maharey* (December 2000).

43 Ministry of Social Development Modernising Child, Youth and Family Expert Panel: *Interim Report* (31 July 2015).

44 Ministry of Social Development *Expert Panel Final Report: Investing in New Zealand’s Children and their Families* (April 2016).

45 Refer to page 218 of this report.





Part One: A profile of the parties
Wāhanga Tuatahi:
He kōrero mō
ngā rōpū





Part One: A profile of the parties

Wāhanga Tuatahi: He kōrero mō ngā rōpū

In order to contextualise the decision making by the Ministry and its removal of newborn pēpi from their parents and whānau, it is important to understand who the central parties are.

The pēpi, parents, and whānau

The Ministry has accepted that tamariki Māori are disproportionately represented within the care system.⁴⁶

Of the 74 case files I reviewed, 45 involved whānau Māori (60 percent).⁴⁷ Māori make up around 16.5 percent of the population of Aotearoa,⁴⁸ with approximately 26 percent of tamariki under 15 years identifying as Māori.⁴⁹

The Ministry's *s78 Casefile Analysis* completed in November 2019, and the information in the 74 case files I examined, shows that the basis of the Ministry's section 78 (without notice) applications included its concerns about a range of intertwined factors, including family violence, drug and alcohol misuse, transience, mental health needs, and disability-related needs. [Figure 1](#) below shows the prevalence of these multiple adverse issues as reported in the case files.⁵⁰

Of the 74 case files I reviewed, 45 involved whānau Māori (60 percent).

46 Affidavit of Grant Robert Bennett, above n 15, at [6].

47 This was based on the information recorded in the case files about the ethnicity of pēpi and their parents. This data was broken down into two categories: Māori and non-Māori. The former includes the cases where the information suggested that the ethnicity of pēpi and/or their parents was both Māori and another ethnicity. The latter category includes all cases where the ethnicity was unclear.

48 Statistics New Zealand "New Zealand's population reflects growing diversity" (press release 23 September 2019) retrieved from <www.stats.govt.nz/news/new-zealands-population-reflects-growing-diversity>.

49 Statistics New Zealand "How is our Māori population changing" (press release 17 November 2015) retrieved from <archive.stats.govt.nz/browse_for_stats/people_and_communities/maori/maori-population-article-2015.aspx#gsc.tab=0>.

50 Refer also to [Table 3](#) at page 221 of this report.



Critical factors facing parents as reported by the Ministry

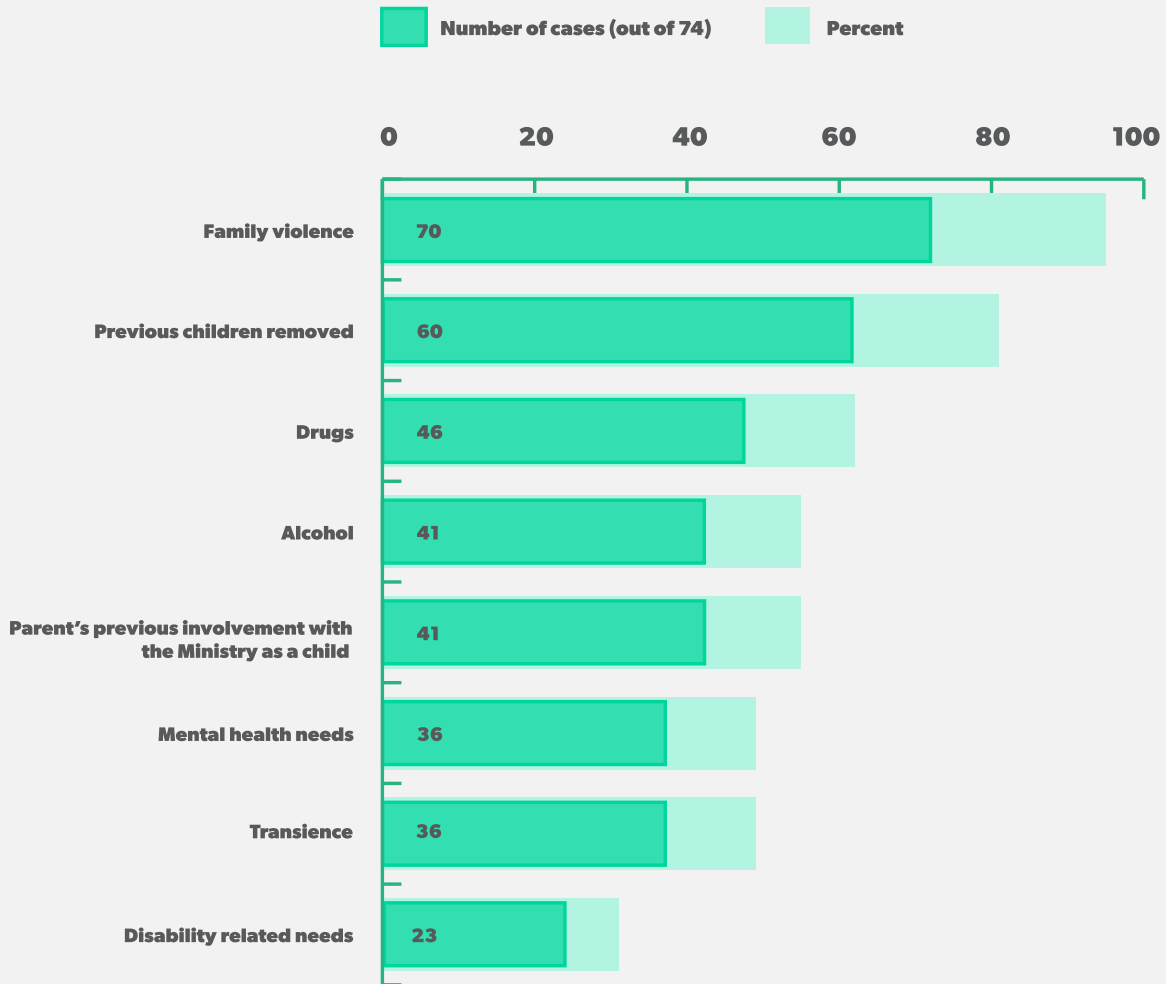


Figure 1: Critical factors facing parents as reported by the Ministry in the 74 case files reviewed.

It is significant to note that:

- family (or intimate partner) violence is recorded as a concern by the Ministry in nearly all of the case files I examined; and
- in 81 percent of the cases, the parents were involved with the Ministry in relation to previous tamariki.



The Ministry's *s78 Casefile Analysis* also showed that it had previous involvement with the parents in 97 percent—that is, nearly all—of its section 78 cases.⁵¹ This analysis also showed that partner violence or within family violence underpinned around half of the section 78 applications, as did maternal alcohol or drug use.⁵² The mother's 'intellectual disability or impaired learning/cognition' was a factor identified in 17 percent of the 153 cases sampled by the Ministry (estimated at 20 percent of the total population of 309 cases).⁵³

The high number of case files recording these factors reflect that parents are living with multiple, complex issues which research shows commonly co-occur and compound. For example, the impact of having a child removed has been linked to the exacerbation of housing instability, interpersonal violence, excessive alcohol and drug taking, mental health needs, the entering of negative intimate relationships, and also repeat pregnancy.⁵⁴

Evidence presented to the Royal Commission of Inquiry into Abuse in Care by Dr Charlene Rapsey outlined the significant trauma, stigma, loss of identity, guilt and marginalisation experienced by mothers who have their pēpi removed. She noted:⁵⁵

Internationally, quantitative evidence finds that compared with mothers in the general population, mothers whose children were taken into care had higher rates of mental disorder, housing instability, and poverty prior to having their children removed.

In 2012, the Families Commission completed two reports to address the question 'what could be done with ... families to prevent additional children coming into these families and being put at risk'.^{56 57} One of the reports, a literature review by Dr Fiona Cram that focused on whānau Māori, discussed risk factors in the following terms:⁵⁸

51 *s78 Casefile Analysis*, above n 20, at 7.

52 At 8.

53 At 9.

54 Karen Broadhurst and others *Vulnerable Birth Mothers and Recurrent Care Proceedings: Final Main Report* (Centre for Child and Family Justice, Lancaster University, October 2017) at 17–24, 79–87 and 102.

55 Evidence of Dr Charlene Rapsey to the Royal Commission of Inquiry into Abuse in Care, Contextual Hearing Transcript (6 November 2019) at 823.

56 Anne Kerslake Hendricks and Katie Stevens *Safety of subsequent children: International literature review* (Families Commission, January 2012) at 6 and 14.

57 Fiona Cram "Safety of Subsequent Children. Māori children and whānau. A review of selected literature" (Families Commission, January 2012) at 6 and 11.

58 At 25.

Parents are living with multiple, complex issues which research shows commonly co-occur and compound.



...risk factors are not separate things that may or may not culminate in child maltreatment; rather, they are intertwined and associated factors that often fall into place along a chain of causality. For example, parenting skills are undermined by substance abuse and mental health problems. Substance abuse has been linked to experiences of childhood sexual abuse that have, in turn, been linked to social welfare policies that were not responsive to indigenous cultural practices and often resulted in the loss of children from indigenous families and communities.

In her evidence to the Royal Commission of Inquiry into Abuse in Care, Dr Alison Green specifically discussed the unaddressed long-term vulnerability of some Māori families to child removal and ‘antecedents to child removal’.⁵⁹ She said that legislation, policy and practice across the social, economic, and political spheres have reduced some Māori families to an extreme vulnerability to child removal. She referred to whānau who have not had assets and resources, not known where they were from, and not been grounded in tikanga and te reo Māori. Referring to racism, the subjugation of tikanga and te reo Māori, poverty, educational failure, lack of housing, gangs and addiction, Dr Green said that:⁶⁰

...those antecedents to the removal of our children urgently need addressing because unless those are addressed, the burden of poverty, the burden of marginalisation, of violence, of abuse, will continue to fall on our families.

The Ministry

The Ministry’s role is to promote the wellbeing of tamariki, rangatahi and their whānau. It focuses on tamariki and rangatahi who are at risk of harm and works to ‘restore their mana, their sense of self, their important connections and relationships, their right to heal and recover, and reach their potential’.⁶¹

History

The Ministry has its own complex past. To appreciate the challenges it faces now and in the future, it is useful to understand its genesis.

The February 2020 report *Ko Te Wā Whakawhiti: Time for Change* provides a comprehensive history of the Crown’s policies and practices in relation to child welfare.⁶²

59 Evidence of Dr Alison Green to the Royal Commission of Inquiry into Abuse in Care, Contextual Hearing Transcript (29 October 2019) at 196, 207 and 209.

60 At 209.

61 Oranga Tamariki—Ministry for Children *Annual Report 2017/18* (October 2018) at 13; *Annual Report 2018/19* (October 2019) at 10.

62 Hector Kaiwai and others *It’s Time for Change: A Māori Inquiry into Oranga Tamariki* (Whānau Ora Commissioning Agency, February 2020) at 22–39.



To understand the Ministry's history, I have also referred to *Te Pūao-te-Ata-Tū*, the seminal report produced in 1988 about the Ministry's predecessor, the former Department of Social Welfare. This report led to the development of the current legislative framework. In particular, the report noted (emphasis added):⁶³

*...although in general it is staffed by highly dedicated, committed people working under great pressure it is seen as being a **highly centralised bureaucracy insensitive to the needs of many of its clients**. The Department ... is not capable of meeting its goal without major changes in its policy, planning and service delivery.*

...

*the **institutional racism reflected in this Department** ... [in] a number of problem areas—policy formation, service delivery, communication, racial imbalances in the staffing, appointment, promotion and training practices.*

...

*At the heart of the issue is **a profound misunderstanding or ignorance of the place of the child in Māori society** and its relationship with whānau, hapu, iwi structures.*

The Children, Young Persons and Their Families Act that came into force in 1989 sought to correct that '*profound misunderstanding*'. It recognised the views of whānau, hapū, and iwi as fundamental to determining what was best for children, with family group conferences (FGCs) as the key tool to enable whānau-led solutions.

This was ground-breaking legislation and Aotearoa was lauded internationally for its approach. However, in the intervening 30 years, Aotearoa's care and protection service has been the subject of numerous reviews and restructures.⁶⁴ These reviews have generally been crisis driven, frequently as a response to the tragic, and often high-profile, cases of fatal harm to tamariki, as well as the staggering rates of violence and abuse in our communities.⁶⁵

63 *Te Pūao-te-Ata-Tū*, above n 40, at 7.

64 A representation of these structural changes is set out in [Appendix 3](#) at page 218 of this report.

65 Emily Devaney "Are We There Yet? The Journey to Oranga Tamariki the Ministry for Vulnerable Children: An Analysis of the Law Reform Process" (LLB (Hons) paper, Victoria University of Wellington, 2017) at 13–15.



Recurring themes from the various reviews include the overrepresentation of Māori in state care, the absence of involvement of whānau in the decision-making processes, the lack of coordination between the various government agencies and support services, and the poor quality of social work practice.⁶⁶ More recently, in 2015, these issues were also noted:⁶⁷

- *concern that CYF was not responding adequately to the increases in demand, and was becoming 'reactive' and 'incident-focused' rather than undertaking more preventative work with families, combined with a lack of on-going support to children once they were in care;*
- *scant management reporting and financial capability, including the organisation's inability to provide a clear picture of workload and resourcing;*
- *uncertainty about where CYF sits within the 'continuum' of services purchased by government, including how it works with more preventative, community based non-government organisations and the wider social sector;*
- *consistent concerns about social work capability and professionalism;*
- *the need for a better understanding of the place of children in Māori society and the roles of iwi, hapū and whānau in providing support and guidance for their children;*
- *continual tension between protecting the child and supporting the family/whānau, and more recently a concern about the loss of the 'voice of the child' in the system; and*
- *also more recently, a concern about the lack of an evidence base for child protection methods, including the limited use of supporting analytical tools and a lack of systematic evaluation of the effectiveness of many interventions.*

66 See, for example, Kenneth Mason *Review of the Children, Young Persons and their Families Act 1989* (Department of Social Welfare, February 1992); Department of Social Welfare *Te Punga o Matahorua: our bicultural strategy for the nineties* (Wellington, 1994); Michael JA Brown *Care and Protection is about adult behaviour: the Ministerial Review of the Department of Child, Youth and Family Services, Report to the Minister of Social Services and Employment Hon Steve Maharey* (December 2000); Office of the Commissioner for Children *Final report on the investigation into the death of Riri-o-te-Rangi (James) Whakaruru, born 13 June 1994, died 04 April 1999* (Wellington, 2000); Ministry of Social Development, Child, Youth and Family, and the Treasury *Report of the Department of Child, Youth and Family Services First Principles Baseline Review* (Wellington, 2003); Office of the Commissioner for Children *Report on the investigation into the deaths of Saliel Jalessa Aplin, Olympia Masia Aplin* (2003); Mel Smith *Report to Hon Paula Bennett, Minister for Social Development and Employment: Following An Inquiry into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to the Welfare, Safety and Protection of Children in New Zealand* (31 March 2011); Office of the Minister for Social Development *The White Paper for Vulnerable Children* (October 2012); and Office of the Chief Social Worker *Workload and Casework Review: Qualitative Review of Social Worker Caseload, Casework and Workload Management* (Wellington, May 2014).

67 *Modernising Child, Youth and Family Expert Panel: Interim Report*, above n 43, at 23.



In 2015, a report by the Modernising Child, Youth and Family Expert Panel (the Expert Panel) observed:⁶⁸

...the current system is fragmented, lacks accountability, and is not well-established around a common purpose. Children in care not only experience unacceptable levels of re-abuse and re-victimisation, they also have poor long-term outcomes in health, education, employment and in living crime-free lives. Importantly, the system as a whole is ineffective in preventing further harm, as shown by high rates of children and young people coming back into the system.

There is a need to address the over-representation of Māori children in the system. Māori children and young people are twice as likely to be notified to CYF compared to the total population. Potential causes of this over-representation include higher levels of deprivation in Māori families, conscious and unconscious bias in the system, and a lack of strong, culturally appropriate models.

To address these challenges, the Expert Panel recommended the creation of ‘a new department with a single point of accountability for ensuring a coherent and complete response for vulnerable children and families’.⁶⁹

In response, the former Minister of Social Development, Hon Anne Tolley, announced that Cabinet had agreed to a ‘radical overhaul’ of the existing system.⁷⁰ The Ministry was launched in April 2017, and was tasked with transforming Aotearoa’s care and protection service by 2022.

Transformation

In September 2017, the new Ministry published its *Strategic Intentions 2017–2022*. This explained its vision, purpose, and values in the following terms:⁷¹

Our vision is that New Zealand values the well-being of tamariki above all else.

Our purpose is to ensure that all tamariki are living with loving whānau and in communities where oranga tamariki can be realised.

...

Our six core values are (the Oranga Tamariki Way):

- *We put tamariki first—We will challenge when things aren’t right for the child or young person.*
- *We respect the mana of people—We listen, we don’t assume, and we create solutions with others.*

68 Expert Panel Final Report, above n 44, at 7.

69 At 14.

70 Anne Tolley “Radical changes to child protection and care” (press release, 7 April 2016).

71 Oranga Tamariki—Ministry for Children *Strategic Intentions 2017–2022* (22 September 2017) at 10.



- *We believe aroha is vital—It keeps us focused on what is right.*
- *We value whakapapa—Tamariki are part of a whānau and a community.*
- *We are tika and pono—We do what we say we'll do.*
- *We recognise that oranga is a journey—We understand the long-term impact of our actions today.*

The Ministry's October 2017 *Briefing to the Incoming Minister* noted the following 'opportunities and challenges' for its transformation journey (emphasis added):⁷²

*Stabilising our current operations is important for the Ministry's performance and service quality. The Ministry has inherited some longstanding issues with current services. In order to provide credible leadership for the wider system, **the Ministry needs to become an exemplar of good practice.** We are reprioritising funding and leadership expertise to assist sites with significant performance challenges.*

Over the next year, we are focusing on making improvements in the following priority areas, each of which poses opportunities and challenges for the Ministry:

- *We are **leading a consistent and high-quality approach to social work practice** that is **child-centred, trauma-informed and effective for Māori** as well as other cultures.*
- *We are **working with partners across New Zealand, including iwi** and non-government organisations (NGOs), in new ways to build stronger services for our children and young people.*

The Ministry's Annual Report for 2018/2019 described the transformation in the following terms (emphasis added):⁷³

*We **inherited a system recognised as fundamentally failing the children of New Zealand**, with a long way to go to put it right. Indeed, while five years was set aside to transform the organisation, for whānau and wider society this shift is generational—but we could **start making a difference immediately.***

After our formation on 1 April 2017, our first full year as a Ministry focused on strengthening a somewhat fragile base. Listening to what children and caregivers told us was most urgent, we prioritised three core areas; Quality Practice, Stronger Partnerships, and Loving Homes.

72 Oranga Tamariki—Ministry for Children *Briefing to the Incoming Minister* (October 2017) at 17.

73 Oranga Tamariki—Ministry for Children *Annual Report 2018/19* (October 2019) at 7–9.



The 2017–18 year was about fixing many of those most urgent shortcomings of the system as it was under Child, Youth and Family; including ... **ensuring more tamariki Māori in care were placed with whānau, and strengthening social work practice.**

...

More importantly, these shifts—the **first green shoots of change** we achieved—were the ways in which we showed our intent and commitment to doing things differently, and to **move towards the much larger mindset change** which the system needed.

...

In our second full year as a new Ministry in 2018–19, our focus began to move beyond fixing and improving the system that already existed, and toward building the transformed system promised over the coming years.

The path towards that new system was set out in the amendments to the Oranga Tamariki Act (formerly Children, Young Persons, and Their Families Act), most of which would take effect on 1 July 2019. Accordingly, **a key focus for the 2018–19 year was getting in place the building blocks to deliver on these changes** for the year to come. This included:

...

- **improving outcomes and reducing disparities for Māori**, through meeting the requirements of section 7AA;⁷⁴
- preparing our front line for the new legislation and ways of working it requires, with **81 new pieces of practice policy and guidance**; and
- working closely with our partners to increase the capacity and reach of preventative support across care and youth justice.

The Ministry went on to acknowledge (emphasis added):

We know that **no child can be properly cared for in isolation, without having regard to mana tamaiti, whakapapa and whanaungatanga**. As we move from focusing not just on keeping kids safe, but also recovery and whole-of-life wellbeing, being child-centric alone isn't enough—we **take a broader view with the child at the**

74 This section came into force in July 2019, and the Ministry is now under a duty 'to recognise and provide a practical commitment to the principles of the Treaty of Waitangi (te Tiriti o Waitangi)'.⁷⁴



centre, but in the context of their whānau. To do this, we need to work with children using our newly-developed Mana Tamaiti objectives to guide us. These principles apply to all children and we'll continue to embed these objectives throughout our policies, practices and services over the coming years as we mature as an organisation.

My investigation covers the Ministry's actions and decisions during the first two years of this transformation journey.

Staff

It is important that I acknowledge the Ministry's frontline staff who were interviewed as part of my investigation. It is clear that they are passionate about their work. Many are working under significant pressures with limited resources. They have experienced multiple restructures, changing legislative requirements and new work environments. This has required them to keep abreast of new frameworks for their social work practice and training, on top of day-to-day workloads.

Care and protection cases are challenging, complex, and require significant time and skill. Frontline staff conveyed the intense pressure and personal sense of responsibility they feel to ensure the safety of pēpi. The country's highly publicised case history of harm to tamariki, and public criticism of the perceived failures by the Ministry, inevitably has had a significant influence on the practices of its frontline staff. These staff also shared the impact they have felt of recent intense media scrutiny with the filming of pēpi being removed at birth and the protests that followed the Hastings case, including outside their site offices throughout the country.

It is clear that [staff] are passionate about their work. Many are working under significant pressures with limited resources.



**Part Two: The Ministry's policies
and procedures**

**Wāhanga Tuarua:
Ngā kaupapahere
me ngā hātepe a
Oranga Tamariki**





Part Two: The Ministry’s policies and procedures

Wāhanga Tuarua: Ngā kaupapahere me ngā hātepe a Oranga Tamariki

This part of my report examines the Ministry’s operating policies and procedures as they relate to the decision to apply without notice for interim custody of, and remove, newborn pēpi.

In order to understand the Ministry’s policies and procedures, I first set out the relevant legal framework—in particular, the Oranga Tamariki Act 1989 (the Act). Next, I move on to assess the relevant policies and procedures themselves.

Legal framework

I have considered the Act in terms of the obligations arising from te Tiriti o Waitangi and international law.

It is proper that I first acknowledge te Tiriti o Waitangi, as it is part of Aotearoa’s unique constitutional framework and provides the basis for the relationship between the Crown and Māori. In the context of statutory social work, the Ministry must ensure that it is working in a manner that demonstrably applies and respects the Crown’s commitments enshrined in te Tiriti o Waitangi. The generally understood expectations of protection, partnership, and participation appear to be reflected in the wording of the Act.

However, to be clear, I have not specifically considered whether the Ministry’s policies, procedures and practices are consistent with the Crown’s obligations and commitments expected from te Tiriti o Waitangi. This is a matter currently before the Waitangi Tribunal, which is the appropriate forum to make a decision in this regard.

The relevant obligations under international law to which Aotearoa has subscribed are as follows.

- The family is the fundamental unit group of society and entitled to protection.⁷⁵

75 *Universal Declaration of Human Rights* GA Res 217A (1948), art 16(3); *International Covenant on Civil and Political Rights* 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), art 23(1); and *International Covenant on Economic, Social and Cultural Rights* 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976) art 10(1).





- Parents and families, particularly disabled parents, must be provided assistance in the performance of their child-rearing responsibilities.⁷⁶
- A child has the right to know and be cared for by their parents.⁷⁷
- Parents have the primary responsibility for the upbringing and development of the child.⁷⁸
- Disabled people have the right to found a family and decide freely on the number and spacing of their children.⁷⁹
- The best interests of a child must be a primary consideration in all decisions affecting that child.⁸⁰
- A child should not be separated from their parents against their will, unless a competent authority determines that this is necessary for the best interests of the child.⁸¹ All interested parties should be given the opportunity to participate in the relevant proceedings.⁸²
- No child should be separated from their parents based on a disability of either the child or one or both of the parents.⁸³
- The removal of a child should be a measure of last resort and should, where possible, be temporary and for the shortest duration possible, taking account of the best interests of the child.⁸⁴
- A child and their parents should be supported in the advantages of breastfeeding.⁸⁵

A detailed analysis of the foregoing is set out in [Appendix 6](#).⁸⁶

76 United Nations Convention on the Rights of the Child (UNCROC) 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990) art 18(2); and United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008) art 23(2).

77 UNCROC, arts 7 and 16.

78 UNCROC, art 18(1).

79 UNCRPD, art 23(1).

80 UNCROC, art 3(1).

81 UNCROC, art 9(1); and UNCRPD, art 23(4).

82 UNCROC, art 9(2).

83 UNCRPD, arts 3, 4(1), 5 and 23(4).

84 *United Nations Guidelines for the Alternative Care of Children* GA Res 64/142 (2010) at II.B.14.

85 UNCROC, art 24(2)(e).

86 Refer to page 231 of this report.



Oranga Tamariki Act 1989

As noted earlier, there are a number of amendments to this Act that came into force on 1 July 2019, which I have noted where applicable. However, for the purposes of my investigation I have referred to and relied on the statutory provisions that were in force for the period I considered: 1 July 2017 to 30 June 2019.

Objects

Since the introduction of the Act in 1989, its object has been to (emphasis added):⁸⁷

...promote the well-being of children, young persons, and their families and family groups by—

- (a) **establishing and promoting, and assisting in the establishment and promotion, of services and facilities within the community** that will advance the well-being of children, young persons, and their families and family groups and that are—
 - (i) **appropriate** having regard to the needs, values, and beliefs of particular cultural and ethnic groups; and
 - (ii) **accessible** to and understood by children and young persons and their families and family groups; and
 - (iii) provided by persons and organisations sensitive to the cultural perspectives and aspirations of different racial groups in the community:
- (b) **assisting parents, families, whanau, hapu, iwi, and family groups to discharge their responsibilities to prevent their children and young persons suffering harm, ill-treatment, abuse, neglect, or deprivation:**
- (c) **assisting children and young persons and their parents, family, whanau, hapu, iwi, and family group where the relationship between a child or young person and his or her parents, family, whanau, hapu, iwi, or family group is disrupted:**
- (d) **assisting children and young persons in order to prevent them from suffering harm, ill-treatment, abuse, neglect, and deprivation:**
- (e) **providing for the protection of children and young persons from harm, ill-treatment, abuse, neglect, and deprivation:**

...

⁸⁷ Section 4 of the Act at July 2017. This was amended in July 2019 to include reference to whānau, hapū and iwi—see s 4(1) of the Act as amended.



- (g) **encouraging and promoting co-operation between organisations** engaged in providing services for the benefit of children and young persons and their families and family groups.

Principles

Section 6 of the Act stated that the welfare and interests of te tamaiti shall be the first and paramount consideration, having regard to the principles set out in sections 5 and 13.⁸⁸ These principles have largely been in place since 1989, when the Act was first introduced.

In summary, the principles provide that:

- whānau, hapū, iwi, and family groups should participate in decision making wherever possible, and regard must be had to their views wherever possible;⁸⁹
- the relationship between te tamaiti and their whānau, hapū, iwi, and family groups should be maintained and strengthened wherever possible;⁹⁰
- endeavours should be made to obtain the support of te tamaiti's parents;⁹¹
- decisions affecting te tamaiti should, wherever possible, be made and implemented within a timeframe appropriate to their age and development;⁹²
- in determining the welfare and best interests of te tamaiti, decision makers must be guided by the principle that te tamaiti must be protected from harm and have their rights upheld;⁹³
- the primary role in caring for and protecting te tamaiti lies with their whānau, hapū, iwi, and family group;⁹⁴ and
- whānau, hapū, iwi, and family groups should be supported, assisted, and protected as much as possible, and any intervention in family life should be minimised.⁹⁵

88 Section 6 of the Act at July 2017, since repealed. See s 4A at July 2019.

89 Section 5(a) of the Act at July 2017, since amended. See s 5(1)(c)(v) at July 2019.

90 Section 5(b) of the Act at July 2017, since amended. See s 5(1)(c)(iv) at July 2019.

91 Section 5(e)(i) of the Act at July 2017, since amended. See s 5(1)(c)(vi) at July 2019.

92 Section 5(f) of the Act at July 2017, since amended. See s 5(1)(b)(v) at July 2019.

93 Section 13(2) of the Act at July 2017, since amended. See s 13(2)(a)-(k) at July 2019.

94 Section 13(2)(b) of the Act at July 2017, since amended. See s 5(1)(c)(i) at July 2019.

95 Section 13(2)(b) of the Act at July 2017, since amended. See ss 13(2)(b) and 13(2)(e)-(i) of the Act at July 2019.



Duties on the Ministry

The Act as enacted in 1989 specified a number of duties on the Ministry and its Chief Executive.⁹⁶ These duties have remained in force since, and are set out in section 7 of the Act (emphasis added):⁹⁷

- (1) *It is the duty of the chief executive to **take such positive and prompt action** and steps as will in the chief executive's opinion best ensure—*
- (a) *that the **objects of this Act are attained**; and*
 - (b) *that those objects are attained in a manner that is **consistent with the principles set out in sections 5 and 6.***

There are further specific obligations set out in section 7(2) of the Act (emphasis added):

- (2) *In carrying out the duty imposed by subsection (1), the chief executive must—*
- ...
- (b) *promote—*
 - (i) *the **establishment of services** (including social work services, family support services, and community-based services designed to advance the welfare of children and young persons in the community or the home); and*
 - (ii) *the **adoption of policies** (including the **provision of financial support to parents, families, and family groups**)—*

*that are designed to **provide assistance to children and young persons** who lack adequate parental care, or require protection from harm, or need accommodation or social or recreational activities:*

- ...
- (c) *ensure, wherever possible, that **all policies adopted** by the department, and all services provided by the department,—*
 - (i) *recognise the **social, economic, and cultural values** of all cultural and ethnic groups; and*

96 Sections 30H and 30I of the State Sector Act 1988, which deal with consequential changes to references to departments and chief executives following reorganisation.

97 Section 7 of the Act at July 2017, since amended. See s 7 of the Act at July 2019, which contains similar wording.



- (ii) **have particular regard for the values, culture, and beliefs of the Maori people; and**
- (iia) *have regard to the **views of children and young persons**, including the views received by the services referred to in subsection (2)(bb):*
- (iii) **support the role of families, whanau, hapu, iwi, and family groups; and**
- (iv) **avoid the alienation of children and young persons from their family, whanau, hapu, iwi, and family group:**

Again, for the most part, these specific duties on the Ministry have been in place since 1989.

I note that the Act was amended to include specific duties *‘to recognise and provide a practical commitment to the principles of the Treaty of Waitangi (te Tiriti o Waitangi)’*.⁹⁸ This section came into force in July 2019—notably, after the period that I investigated. However, as a public sector agency acting on behalf of the Crown, the Ministry has always been obliged to act consistently with te Tiriti o Waitangi, and I have proceeded on that basis.

The statutory care and protection process

Section 17 of the Act sets out steps in the process that the Ministry must undertake *‘as soon as practicable’* upon receiving a report of concern that raises care and protection issues. In particular, the Ministry must:

- after receiving a report that te tamaiti has been or is likely to be harmed, ill-treated, abused, neglected or deprived (section 15), determine whether an investigation is necessary or desirable;
- if so, commence an investigation to the extent that is necessary or desirable;
- after an investigation has commenced, consult a Care and Protection Resource Panel (CPRP) as soon as practicable; and
- if, after investigation, there is a reasonable basis to believe te tamaiti is in need of care or protection, notify the Ministry’s care and protection coordinator.

Section 14 of the Act defines a *‘child or young person in need of care or protection’*.⁹⁹

98 Section 7AA of the Act as amended in July 2019.

99 Section 14(1) of the Act at July 2017, since amended. This is set out in full at [Appendix 7](#) at page 241 of this report. See also section 14(1) of the Act at July 2019.



The Act provides that the Ministry’s care and protection coordinator must then consult with the CPRP, make reasonable endeavours to consult with the parents and whānau, and convene a family group conference (FGC).¹⁰⁰ Section 28 of the Act provides that the purpose of the FGC is to consider whether te tamaiti is in need of care or protection and to formulate plans to ensure the safety of te tamaiti. If no agreement can be reached by the FGC, then the Ministry may take any action it considers appropriate.¹⁰¹ For the timeframe I considered, this included the Ministry seeking a declaration that te tamaiti is in need of care or protection,¹⁰² and applying for custody and/or guardianship.¹⁰³

The details of the Ministry’s care and protection process, and its various phases, are set out in a diagram at [Appendix 8](#).¹⁰⁴

Subsequent children provisions

In July 2016, sections 18A to 18D of the Act came into force. These sections are referred to collectively as the ‘subsequent children provisions’. The provisions are complex and are set out in full in [Appendix 9](#).¹⁰⁵ To assist, I have set out a simplified explanation of the process in a diagram at [Appendix 10](#).¹⁰⁶

In essence, the subsequent children provisions prescribe the process where a parent has a subsequent child and meets the criteria in section 18B—namely, after having a previous child permanently removed or where the parent has been convicted of particular offences. In those cases, the Ministry must assess whether the parent is unlikely to ‘inflict’ or ‘allow’ the same harm on the subsequent child.¹⁰⁷

Two aspects are critical. First, the Ministry must identify whether the parent meets the criteria under section 18B. Not all cases where a parent has lost the care of a child will meet the strict criteria. There must have been a finding or agreement that there is no reasonable prospect of the child returning into the parent’s care. The mere fact that a child has left the parent’s care and seems unlikely to return is not sufficient without a specific finding by the Court or an agreement.

100 Sections 18 and 21 of the Act at July 2017, since amended. See sections 18 and 21 of the Act at July 2019.

101 Section 31(2) of the Act at July 2017.

102 See section 67 of the Act at 1 July 2017, since repealed. As part of the legislative reform introduced in 2019, the Ministry is no longer required to seek a separate declaration from the Family Court that te tamaiti is in need of care or protection. Instead, the Court is able to make a care or protection order, under s 68 of the Act at July 2019. This order is defined under s 2 of the Act and includes interim custody orders under s 78. The Ministry has explained that the intent of this legislative change ‘was to reduce the complexity of, and delays in, care and protection proceedings’.

103 Sections 78, 101, 102 and 110 of the Act at July 2017, since amended. See ss 78, 101, 102, and 110 of the Act at July 2019.

104 Refer to page 244 of this report.

105 Refer to page 246 of this report.

106 Refer to page 251 of this report.

107 Section 18A(3) of the Act.



Second, the Ministry must carry out an assessment as to whether the parent is unlikely to inflict or allow the same kind of harm that led to them having the previous child removed. This assessment is a specific requirement in the Act, and the parent must be told they are being assessed under section 18A. The Ministry must then apply to the Court. As is shown in the diagram at [Appendix 10](#),¹⁰⁸ what happens in court will generally depend on the outcome of the Ministry's assessment. If the same concerns remain, the parent's subsequent child may meet the definition of being in need of care or protection under section 14(1) (ba) of the Act.¹⁰⁹

Emergency powers

The Act contemplates the possibility that there may be situations where there is a need to take some form of emergency action to ensure the safety of tamariki. Sections 39 and 40 authorise the Ministry to seek a warrant to remove tamariki for a period of five days.¹¹⁰ Similarly, section 78 enables the Ministry to seek interim custody of tamariki pending final decisions.

78 Custody of child or young person pending determination of proceedings

- (1) *In any proceedings in a court under Part 2 in relation to a child or young person, the court may, on the application of any party to the proceedings, or a barrister or solicitor representing the child or young person, or of its own motion, make an order relating to the custody of the child or young person pending the determination of the proceedings.*
- (2) *Without limiting the generality of subsection (1), the court may make an order under that subsection in relation to a child or young person in the following cases:*
 - (a) *where the child or young person has been placed in the custody of the chief executive pursuant to section 39 or section 40 or section 42 and is brought before the court pursuant to section 45:*
 - (b) *where the court is satisfied that the child or young person is in need of care or protection for the period of the order:*
 - ...
 - (d) *where the court has made a declaration under section 67 and has adjourned the proceedings pending their disposition:*
 - (e) *where an application for a variation or discharge of any*

108 Refer to page 251 of this report.

109 This has since been amended—see section 14(1)(c) of the Act at July 2019.

110 Section 45 of the Act. Similar powers are also available to the New Zealand Police under ss 39, 42 and 48 of the Act.



order (or the variation or discharge of any condition of any order) is made to the court under section 125, at any time before such application is finally disposed of:

- (f) where a report is furnished to the court pursuant to section 135, at any time before the court has completed its consideration of the report and accompanying revised plan under section 137.
- (3) An order under subsection (1) may be made on such terms and conditions as the court thinks fit.

Section 78 interim custody

It is important to emphasise that an interim custody order is only intended to be in force for a fixed period of time or until another event. It is temporary in nature.

The law permits an application to be made without notice in limited circumstances. The relevant part of Rule 220(2) of the Family Court Rules 2002 provides (emphasis added):

- (2) An application need not be made on notice if ... the court is satisfied that—
 - (a) **the delay that would be caused** by making the application on notice **would or might entail**,—
 - (i) in proceedings under the Oranga Tamariki Act 1989, **serious injury or undue hardship, or risk to the personal safety of the child or young person** who is the subject of the proceedings, or any person with whom that child or young person is residing, or both.

Case law

In 1995, the Family Court clarified that ‘the expression “child” in the 1989 Act includes at the least the unborn child which has achieved a state of development where it could survive independently of the mother’.¹¹¹ There have been a number of other cases since where the nuances of the Court’s jurisdiction over an unborn pēpi have been considered and debated.¹¹² I do not intend to explore this beyond noting that it is accepted that the Ministry’s powers under the Act have been interpreted to extend to unborn pēpi.¹¹³

111 *Re Baby P (An Unborn Child)* [1995] NZFLR 577 (HC) at 583.

112 See, for example, *Re an Unborn Child* [2003] 1 NZLR 115 (HC) at [66].

113 *L v Chief Executive of Oranga Tamariki—Ministry for Vulnerable Children* [2018] NZHC 1420 at [27]–[39].



In terms of applying for interim custody, the Court of Appeal has emphasised the need for the Ministry to consider all other options before applying under section 78 of the Act.¹¹⁴ The High Court has also commented on without notice applications in the following terms (emphasis added):¹¹⁵

*...an application for a custody order without notice **should only be made in special or exceptional circumstances given its inherent departure from the fundamental requirements of natural justice and the underlying right to be heard.** The power to make such an order must be used with great caution and only in circumstances in which it is really necessary to act immediately. The statutory principles favour the parents' involvement in decisions relating to their child and an order made without satisfaction of the jurisdictional threshold amounts to a serious procedural impropriety, providing a ground for judicial review.*

Summary

To summarise, there are some fundamental principles enshrined in law that should inform the Ministry's decisions relating to the removal of newborn pēpi under section 78.

- Pēpi have the right, as far as is possible, to know and to be cared for by their parents, whānau, hapū and iwi.
- Any intervention in family life should be the minimum necessary to ensure pēpi's safety and protection.
- Where pēpi are at risk, the parents and whānau should be provided assistance to support them in discharging their responsibilities to their pēpi, and they have a right to fully participate in the decision-making processes.
- The use of without notice applications for interim custody should be reserved for urgent cases where all other options to ensure the safety of pēpi have been considered, and the delay caused by making an on notice application would create a risk to the safety of pēpi.

I acknowledge the Act has been in a state of transition, with many amendments coming into force after I commenced my investigation. However, the obligations and expectations on the Ministry—and, in particular, the fundamental principles noted above—have been in place for a considerable period. I am satisfied that the Act generally provides a reasonable legal framework to achieve these principles. As such, I expected to see them demonstrably incorporated in the Ministry's policies, procedures, and practices relating to the application for section 78 interim custody orders and the removal of newborn pēpi over the period that I considered.

I acknowledge the Act has been in a state of transition, with many amendments coming into force after I commenced my investigation.

114 *DE v Chief Executive of the Ministry of Social Development* [2007] NZCA 453 at [43]–[49], [81]–[84] and [98].

115 *CLM v The Chief Executive of the Ministry of Social Development* CIV-2009-404-7117 at [31].





Policies and procedures

Having set out the relevant legal framework, I now move on to assess the Ministry's operating policies and procedures as they relate to the decision to apply without notice for interim custody of, and remove, newborn pēpi. As identified earlier, the Ministry is under a duty to 'promote ... the adoption of policies ... that are designed to provide assistance to children'.¹¹⁶

Explanation from the Ministry

In its communication with my office in August 2019, the Ministry explained (emphasis added):

*We introduced Practice Standards in November 2017. These describe the core elements of social work practice which underpin all social work undertaken by Oranga Tamariki staff with tamariki, whānau and families and partner agencies and emphasise the critical practice skills of **engagement, working with others, assessment planning and reviewing, working with tamariki Māori and families, record keeping and using professional supervision**. They provide a standard and underlying guidance that staff must adhere to across all of our social work, are informed by a best practice evidence base and inform much of our learning and development content.*

...

A number of pieces of guidance are more general but shape the social work that we do including, but not limited to, our work with unborn or newborn babies. They provide the underlying evidence and knowledge base for the way we work with tamariki and families and inform our needs and risk assessment and decision making.

Significantly, the Ministry advised that:

*We **did not have specific guidance around the processes in which tamariki enter our care during the period of the review**. This process relies on practitioners utilising their professional decision making while being guided by our **assessment and decision making policy, which includes use of supervision, consults tools, and practice and assessment frameworks**. There is a link to ... Memorandums of Understanding ... in particular DHB specific protocols about bringing tamariki into care from health settings.*

116 Section 7(2)(b)(ii) of the Act.



In terms of its procedures, the Ministry advised my office as follows:

*When someone contacts us about concerns for any child, our National Contact Centre (NCC) assesses this information and **makes a decision about whether or not an investigation is necessary or desirable**. This decision is later confirmed or changed when the NCC refers the concern to the local site. At this point Oranga Tamariki can provide advice, link the child and family to other supports or begin an investigation or assessment into the concern. If Oranga Tamariki consider that **there is a need to assess the concerns further to determine if the child is in need of care and protection, we undertake an assessment** (referred to as an investigation in section 17 of the Oranga Tamariki Act 1989).*

...

***After completing an assessment or investigation into a report of concern, social workers have a range of choices**—to take no further action, to refer to other services including Strengthening Families or to work with the family informally under an agreed plan (known as a Family/whānau agreement). Where an assessment or investigation of any child or young person, including an unborn or newborn baby, has been completed and **the social worker determines that the child is in need of care or protection they must notify a care and protection co-ordinator, who must in turn convene a Family Group Conference** under section 20 of the Oranga Tamariki Act 1989.*

The Ministry went on to provide me with electronic copies of its operational policy, guidance and training content, amounting to over 350 individual documents. Most of this material was sourced from the Ministry's Practice Centre.

The Practice Centre

This is a publicly accessible online resource to assist the Ministry's staff with the 'must-dos, how-tos and guidance in their work with tamariki and their families/whānau' and in particular:¹¹⁷

The Practice Centre has:

- *our practice standards and guidance, as well as the practice framework knowledge and evidence base*
- *our practice policies, which set out what we must do when we're working with tamariki and their families/whānau*
- *guidance to help practitioners follow the policies.*

117 This is available at <practice.orangatamariki.govt.nz/>.



My understanding of the Ministry's care and protection process is set out in a diagram at [Appendix 8](#).¹¹⁸

Below, I provide an overview of the Ministry's operating policies and guidance, including an explanation of the Practice Framework, a brief summary of the Practice Standards, and the elements of effective practice. In general, I am satisfied that the overarching Practice Standards adequately reflect the objects and principles of the Act and most of the obligations under international law.

The Ministry's Practice Framework

In November 2017, the Ministry launched its new Practice Framework. This consists of:¹¹⁹

- Practice Standards—the '*must [dos]*' for all its staff;
- Practice Guidance—guidance on '*how-to*' achieve the Practice Standards; and
- knowledge base—the '*theory, evidence, child's voice and core elements of practice*'.

The Ministry also has other frameworks that '*complement and strengthen*' its Practice Framework.

- *Te Toka Tumoana*, which is the Ministry's '*indigenous and bicultural principled framework*'¹²⁰
- *Va'aifetū*, which is the Ministry's '*cultural-practice tool that informs practice design, review and workforce support to best serve the needs of Pacific children and their families*'¹²¹

Te Toka Tumoana

This framework was developed and implemented between 2013 and 2016. It identified eight principles designed to assist the Ministry's staff '*in their engagement with mokopuna and whānau Maori, but can also be used cross culturally to support quality social work practice*'.¹²² In particular, the eight principles are tikanga, te reo Māori, whakamanawa, wairuatanga, kaitiakitanga, whakapapa, manaakitanga, and rangatiratanga.

118 Refer to page 244 of this report.

119 This is available at <practice.orangatamariki.govt.nz/practice-standards/about-our-practice-framework/>

120 The current version of this guidance is available at <practice.orangatamariki.govt.nz/practice-standards/working-with-maori-te-toka-tumoana/>.

121 This current version of this guidance is available at <practice.orangatamariki.govt.nz/practice-standards/working-with-pacific-peoples-vaaifetu/>.

122 I have referred here to the Ministry's guidance that was applicable at July 2017. This has since been updated and is available at <practice.orangatamariki.govt.nz/practice-standards/working-with-maori-te-toka-tumoana/>.



Practice Standards

In brief, the eight Practice Standards are as follows.¹²³

- *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’.*
- *See and engage whānau, wider family, 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’.*
- *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’.*
- *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’.*
- *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 impact of this on their long term wellbeing’.*
- *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’.*
- *Keep accurate records—‘I will document my key actions and decisions for each tamaiti I am working with, in order to ensure significant decisions are clearly evidenced and transparent’.*
- *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’.*

The Ministry’s Practice Centre guides its staff through a series of criteria and questions for each Practice Standard under the following headings:

I will know I have achieved this standard when...

Quality practice means I also...

Why do we have this standard?

How will we know we have made a difference?

123 Detailed information about the Practice Standards can be found at <practice.orangatamariki.govt.nz/practice-standards/>.



Knowledge and evidence base—elements of effective practice

The Ministry has also identified a further eight ‘elements of effective practice’ that are its ‘core beliefs, behaviours and approaches’.¹²⁴

- *Mana tamaiti—We actively support and uphold the mana of te tamaiti.*
- *Working effectively with Māori—We focus on practice that enhances the mana and long term outcomes of Māori.*
- *Culturally informed practice—We respond to the cultural diversity of tamariki, whānau and caregivers.*
- *Collaboration and partnerships—We work in partnerships with others to meet the needs of tamariki.*
- *Oranga whānau—We support whānau and caregivers to care effectively for their tamariki.*
- *Kaimahi ora—We focus on supporting our own and others’ wellbeing.*
- *Prevention and wellbeing—We identify and address the needs of tamariki early to support them to thrive.*
- *Trauma-informed practice—We understand and respond to trauma to prevent further harm and to promote wellbeing.*

For each of these eight elements, the Practice Centre identifies the overall ‘focus’ and what ‘quality practice includes’. It also poses questions to assist its staff with ‘reflecting on practice’, and a number of external resources are identified.

Relevant guidance

It is clear that the Ministry has an extensive amount of operating policy and guidance. However, most of the material I was provided was of general application, rather than being specifically focused on unborn or newborn pēpi and/or the use of without notice section 78 applications. That said, given its broad applicability, I have referenced some of this material in the next part of my report, which specifically addresses the Ministry’s practices.

Below, I have identified and commented on the guidance that is critical to the scope of my investigation. These are in relation to:

- the use of without notice section 78 applications;
- subsequent children;
- unborn and newborn pēpi;
- the needs of disabled parents; and
- breastfeeding.

124 Further details about the Ministry’s Practice Framework knowledge and evidence bases can be found at <practice.orangatamariki.govt.nz/practice-standards/practice-framework-knowledge-and-evidence-base/>.



I should note that (with the exception of breastfeeding) the Ministry does not have any guidance and policy specifically developed for the process of removing tamariki once section 78 interim custody orders are granted. None of the memoranda of understanding between the Ministry and the District Health Boards (DHBs) referred to this process. Nor is it apparent from the material made available to me that the Ministry had agreements in place, during the period of my investigation, about the required or expected practice with other third parties who may be involved in, or impacted by, the removal process. This is situation is concerning given the wide-reaching and coercive nature of the Ministry’s powers, and the overwhelming impact the use of these powers can create.

There is one additional preliminary matter I wish to address, and this relates to the Ministry’s Practice Centre.

The Practice Centre

I have found navigating the Ministry’s Practice Centre to be an onerous exercise. There is a wealth of information and resources available. However, it has been hard to identify all of the relevant information efficiently. The structure and layout of the Practice Centre could be more intuitive and user friendly. The Practice Centre frequently crossreferences multiple other documents and policies, making it difficult to get a clear sense of how all the material fits together cohesively under the Practice Standards.

I am aware that the Ministry is in the process of updating and reviewing the content of the Practice Centre (as it is required to do to meet its transformation programme). However, the Ministry has provided me with a large amount of decommissioned material that is no longer available on its Practice Centre. While it is entirely appropriate for the Ministry to continuously update its guidance, its previous operating policies should continue to be accessible, albeit with a clear indication of when it was effective and when it ceased to be so.

As a publicly accessible resource, the Practice Centre should enable parents and whānau engaging with the Ministry to understand and anticipate its practices, as well as to challenge those practices when they are inconsistent with the Ministry’s own guidance. This, ultimately, leads to enhanced trust and confidence in the Ministry.

At present, I am concerned that the complexity of the Practice Centre, and the fact that previous policies and guidance are no longer available, may be limiting the ability of parents and whānau to understand and navigate the Ministry’s practices and to hold the Ministry accountable for its actions.

I now move to comment on the specific guidance that I have identified as critical to my investigation.

I have found navigating the Ministry’s Practice Centre to be an onerous exercise.





Use of without notice section 78 applications

In its correspondence with my office, the Ministry identified seven policy guidance documents relating to the court processes that were effective for the timeframe I investigated.

- ‘Custody, guardianship and wardship’, dated 10 July 2014
- ‘Use of support orders’, dated 24 February 2017
- ‘A beginner’s guide to Court terms’, undated but effective 1 July 2017
- ‘Court plans—Policy’, dated 1 April 2017
- ‘Planning and reviewing’, dated 24 February 2017
- ‘Returning children and young people safely home’, dated 21 June 2017

I have examined this material and note that it did not contain any specific guidance for the Ministry’s staff on the use of without notice section 78 applications.

However, I have identified one document, ‘Pathways to care: Emergency Action’, dated 1 July 2016, which provided guidance on the use of emergency powers. The relevant parts of that guidance are set out below (emphasis added):¹²⁵

*Removing a mokopuna from their parents/caregivers is a significant and traumatic event, **undertaken only when the mokopuna cannot remain safe in the care of their parents/caregivers.** It is best carried out in a manner that minimises trauma to the mokopuna and ensures an agreed plan for meeting the wellbeing needs of the mokopuna. There are times however when **because of immediate safety concerns the mokopuna is removed quickly without their parents’ consent.** This document sets out the provisions available when a mokopuna needs to enter into care in an emergency situation.*

Emergency actions

*Emergency action is only used **to secure the safety and wellbeing of a mokopuna when all other intervention options have been considered.** Decisions to carry out emergency actions are made **through robust practice consultation with the supervisor and practice leader, using the child and family consult.** These are **matters of professional judgment, however if there are more complex legal issues it may be useful to talk to Legal Services.***

Once the decision is made that emergency action is required, the Children, Young Persons, and Their Families Act 1989 (CYP&F Act) outlines powers to act for both the social worker and the Police. Most commonly used emergency actions are:

¹²⁵ The current guidance ‘Pathways to care: Emergency Actions’ is dated 26 November 2019 and is available at <practice.orangatamariki.govt.nz/previous-practice-centre/policy/seeking-solutions-with-families/resources/pathways-to-care-emergency-actions/>.



- s39 (place of safety warrant)
- s42 (search without warrant)
- s48 (unaccompanied children and young people)
- s78 (custody of child or young person pending determination of proceedings).

...

Once the decision is made to apply for a particular court order, an affidavit or statement of facts is required.

Steps to consider when carrying out emergency actions

- **Consult with others and plan how you will approach carrying out the emergency action.** Are there potential safety concerns to be aware of? Will the Police or other person in authority (eg Kaumatua) be able to support the situation to occur safely? **Who might be able to support the family/whānau after the mokopuna has left the home?**
- It may be a **really challenging time in your relationship with the family/whānau—keep contact with them respectful; keep them as informed as possible whilst maintaining the safety of the mokopuna; keep them engaged so they can remain well connected to their mokopuna.**
- This will be a very traumatic time for the mokopuna. Take steps to make the process as nurturing as possible for the mokopuna, such as obtaining clothing and items that are familiar to them. Try and work with the family/whānau to make this happen. Afterwards, spend time with the mokopuna to help them understand what has happened and why; answer any questions or worries they have; [let] them know what contact they will have with their family/whānau.
- Seek support for yourself prior to, during, and following an emergency action being taken (if needed you can access the Employee Assistance Programme). Separating a mokopuna from their parent/caregiver is one of the most stressful situations that social workers will deal with; it can affect people in different and various ways.



This guidance does state the staff are required to:

- consider all other intervention options first; and
- undertake a consultation with their supervisor and practice leader; and
- use the Child and Family Consult tool.¹²⁶

However, I am concerned with the suggestion that consultation with the Ministry's Legal Services was optional. This does not accord with the expectation expressed by the Ministry's Chief Legal Advisor, at interview for this investigation, that the Ministry's solicitors would routinely attend case consults where the Ministry was considering an application for a without notice interim custody order.

Further, this guidance is too brief to assist staff with properly determining when to use the emergency powers of the Act, such as section 78. The Ministry has not sufficiently articulated clear criteria for how staff are meant to identify and assess the viability of other options to secure the safety of tamariki. I appreciate that the use of professional judgment is necessary in such cases. However, in my view, the Ministry, in the interest of fairness and consistent decision making, ought to provide greater clarity for its staff about when it may be appropriate to seek interim custody.

Significantly, the guidance does not specifically address the use of without notice applications. In this regard, I note that I have considered the material from the Ministry's training programme (Practice Curriculum) that was in place for 2017. This material stated (emphasis added):¹²⁷

Interim orders allow us to keep a child safe while we go through the formal and time consuming process of applying for final orders. This involves applying for a s67 declaration and holding a FGC. (Applications can be made 'ex parte'—'without notice' if giving notice to those involved would hamper our investigation or put children at risk.)

In my view, this advice was highly deficient and did not accurately reflect the legal requirements. To be clear, the law does not permit without notice applications where providing notice would 'hamper' the Ministry's investigation.

I understand that in 2018 the Ministry's training programme was revised and the new content explained (emphasis added):¹²⁸

*In urgent situations it is possible to apply without notice. A without notice application is an application made to the Court where the parent is not given notice of the application. **This is an exception to the rule that parties should always be aware of applications made, and have an opportunity to put their version of what has happened***

126 A brief description of this term can be found in the glossary in [Appendix 1](#) at page 201 of this report. Further details about this tool are set out under the heading 'Child and Family Consult' at page 130 of this report.

127 Child, Youth and Family *Social Workers and the Law—Workbook* (December 2016) at 32.

128 Oranga Tamariki—Ministry for Children *Care and Protection Law Workbook* (April 2017) at 47–48.

The Ministry has not sufficiently articulated clear criteria for how staff are meant to identify and assess the viability of other options to secure the safety of tamariki.





to the court before it makes a decision. Because a without notice application is a departure from the Court requirement that notice be given, **it should be used with extreme caution in only the most urgent or delicate situations.** Judges are reluctant to deal with without notice applications. Because parents are not aware that an application is being made, this could result in trauma and subsequently prevent an amicable solution.

It may also violate the parent's right to be told. **A preferable approach in an urgent situation may be to seek leave for an abridgement of time.** What this means is that the time is reduced for the parents or other parties to respond to the application, ie to file evidence in court that they disagree with the application. It is possible to reduce this time down to only a few hours, but usually this is reduced to 24 or 48 hours. The court can hear the application more quickly than applications made on notice.

Without notice applications deprive the other side of the opportunity to be heard and to present their side of the story before decisions are made about the child. The Court requires the person applying to the court, normally the Social Worker, to set out all the relevant information including those facts not in favour of the Ministry's case.

Without notice applications are authorised by Rule 220(2)(a)(i) Family Courts Rules 2002 which must be complied with.

In support of a without notice application under the CYP & F Act, the Social Worker (or applicant) should file an affidavit or supporting information to explain that the matter is urgent and that the delay caused by proceeding on notice would or might entail serious injury or undue hardship; or might entail risk to the personal safety of the child or someone the child is living with (Rule 220 (2) (a) (i); i.e. there must be evidence that if the parents or caregivers knew of the application, this would affect the personal safety of the child or someone else they lived with, or it may cause serious injury or undue hardship.

This training advice is an improvement on the earlier content, which was highly deficient in respect of the legal test for without notice applications. However, this 2018 training content did not specifically address the use of without notice applications in the context of seeking interim custody under section 78.

The overall lack of specific guidance on the use of section 78 without notice applications is particularly concerning in the context of the Ministry's routine reliance on such applications. As identified earlier, over 94 percent of the section 78 orders for 2017/18 and 2018/19 were granted on the basis of without notice applications by the Ministry.¹²⁹

129 Exhibit VJC-2.2 of affidavit affirmed by Valmai Joy Copeland dated 20 March 2020 (Wai 2915, 2020) at [10].



I am aware that the Ministry has recently also updated its Practice Centre to reflect the recommendations it made following its Hastings Practice Review.¹³⁰ The guidance now includes an escalation process for without notice applications with the relevant site manager, practice leader and regional litigation manager.

Some of these improvements may serve to strengthen the Ministry's decision making. However, I note that, based on interviews with frontline staff, it appears that consultation with supervisors and practice leaders (and at some sites with the site manager) was already occurring during the period covered by my investigation.

Subsequent children

Based on the material supplied, I identified five specific pieces of guidance that relate to the subsequent children provisions as effective during the period covered by my investigation.¹³¹

- 'Subsequent children—Te Toka Tumoana', dated 1 July 2016
- 'Assessing safety and wellbeing when parents and caregivers have lost the care of other mokopuna', dated 1 July 2016
- 'Subsequent children: s18A assessment by social worker', dated 1 July 2016
- 'Subsequent children s18B criteria', dated 1 July 2016'
- 'Subsequent Children: a step by step guide'

While the material referring to *Te Toka Tumoana* framework clearly identifies the importance of the Ministry working with a 'Māori cultural analysis lens', it is difficult to see how this material provided practical guidance to the Ministry's frontline staff in the context of considering sections 18A to 18D of the Act. This is in contrast with the other guidance relating to the subsequent children provisions that were effective during the timeframe of my investigation.

In terms of that other guidance, I observe that the Ministry began by noting (emphasis added):¹³²

*Evidence shows that past behaviour is often a good predictor of future behaviour. Unless significant change has occurred, **there is significant risk of harm to mokopuna who are parented by someone who has had a child or young person previously removed due to abuse or neglect, or has been convicted of the murder, manslaughter or infanticide of a previous child or young person.***

130 The current guidance dated 7 August 2019 is available at <practice.orangatamariki.govt.nz/policy/without-notice-application-for-interim-custody-of-a-tamaiti-or-rangatahi/>.

131 The Ministry has updated its guidance and this is available at <practice.orangatamariki.govt.nz/our-work/assessment-and-planning/assessments/child-and-family-assessment-or-investigation/subsequent-children/>.

132 Oranga Tamariki—Ministry for Children *Assessing safety and wellbeing when parents and caregivers have lost the care of other mokopuna* (1 July 2016); and *Subsequent children: s18A assessment by social worker* (1 July 2016).



Elsewhere it was noted (emphasis added):¹³³

The subsequent child sections (s18A–s18D) of the Children, Young Persons and Their Families Act 1989 (CYP&F Act) provide for greater oversight from the Family Court to help ensure children’s safety and wellbeing when parents have had previous children permanently removed due to abuse or neglect, or have been convicted of causing the death of a child they cared for.

*In these situations, **it is assumed any subsequent child these parents are caring for is in need of care or protection.** In your care and protection assessment, completed through working closely with the parents, you need to decide whether the subsequent child is or isn’t safe with their parent. You then need to report this to the court.*

I am concerned the foregoing advice from the Ministry may encourage a fixed or predetermined view of certain parents and the supposed risk they present to their tamariki. This is simply unfair. Further, as I explain later in my report, across **all** the files I reviewed, the parents’ history of previous removals was often relied upon by the Ministry when seeking without notice interim custody under section 78.

I also note the Ministry’s guidance in 2016 stated (emphasis added):¹³⁴

*...the parent must demonstrate that they are unlikely to inflict, or allow to be inflicted, the kind of harm that was previously inflicted on the previous mokopuna. **The responsibility to show that the risk of harm is satisfactorily removed rests with the parent(s).***

It is unclear to me that the statute expressly requires the parents to show the risk of harm has been ‘satisfactorily removed’.

The Ministry’s step-by-step guide published in April 2017 (emphasis added) noted:¹³⁵

*A key difference is that the responsibility sits with the parent(s) to demonstrate that they are unlikely to inflict (or allow to be inflicted) the kind of harm as was inflicted previously. In practice, the social worker will be looking at **how the parent gathers information and evidence of change, and their engagement in the assessment process.***

The Ministry’s guidance seems to suggest that it is the parent’s responsibility to gather evidence. However, it is the Ministry’s responsibility under section 18A(2) to assess whether the parent is unlikely to inflict or allow harm to a subsequent child and to apply to the Court. Therefore, the suggestion that the social worker is only responsible for analysing the evidence provided by the parents is, in my view, incorrect.

133 Oranga Tamariki—Ministry for Children *Subsequent children: s18A assessment by social worker* (1 July 2016).

134 Oranga Tamariki—Ministry for Children *Assessing safety and wellbeing when parents and caregivers have lost the care of other mokopuna* (1 July 2016).

135 Oranga Tamariki—Ministry for Children *Subsequent Children: a step by step guide* (1 April 2017) at 3.



In this regard, while the guidance entitled *'Subsequent children: s18A assessment by social worker'* dated 1 July 2016, lists a number of questions to guide the assessment process, there does not appear to be any emphasis placed on the Ministry being responsible for facilitating advocacy and providing support to assist the parents. The guidance seems to be predicated on the view that, in the absence of the Ministry's assistance, the parents should have been able to turn their lives around. In my view, this is an unreasonable expectation.

Given the backgrounds and circumstances common to parents and whānau involved with the Ministry, it is highly unfair to expect them to be able to navigate the complex subsequent children provisions and gather the necessary evidence, especially without appropriate independent advocacy and specialist support. My investigation found that these parents and whānau did not get the assistance they required.

As noted earlier, in 2012 the Families Commission commissioned two reports—one a general review and the other addressing the *'needs of whānau Māori who have had previous children removed'*.¹³⁶ Both reports note the lack of literature focusing on whānau who have had previous tamariki removed, with most looking at effective interventions with complex or vulnerable whānau, or a particular problem such as substance abuse. The general report concludes:¹³⁷

Support for families after a child has been removed should ensure the original reasons for child removal (including any adult issues) are addressed. Long-term, sustainable change is required, but more evidence is needed about the most effective supports to enable such change. What has been effective in supporting families who have had their first child removed, but who did not go on to have a second or subsequent child/ren removed? What made a difference to ensure the safety and wellbeing of these subsequent children within the same family? A retrospective study of families who have had subsequent children removed, and those who have not, may be worth considering.

The second report by Dr Fiona Cram, which focused on the needs of Māori whānau, referred to the *'intertwined and associated factors that often fall into place along a chain of causality'*.¹³⁸ She went on to address whether there are programmes and services that *'specifically address the parenting needs of parents who have had a child(ren) removed, to increase opportunities for whānau ora should they become caregivers again'*.¹³⁹ Dr Cram observed (emphasis added):¹⁴⁰

136 Above n 56 and 57.

137 Above n 56, at 84.

138 Above n 57, at 25.

139 At 38.

140 At 40.



*The literature is virtually silent on what needs to happen with parents who have had a child(ren) removed. This silence creates the impression that **once a child is removed the focus of child welfare services is then solely on the child and the parent(s) are somehow forgotten**, as if this instance of child removal makes **no allowance for them becoming primary caregivers for a child(ren) in the future** or continuing their relationship with their child.*

The view above was also expressed by third parties, such as the DHBs and social service providers, who were interviewed as part of my investigation. Significantly, Dr Cram's report concluded:¹⁴¹

- *children are often removed from whānau because the whānau is experiencing complex issues*
- *the support that whānau need in order to prevent additional children being removed, following the removal of one or more children, is similar to the support that whānau experiencing complex issues need*
- *whānau need additional support when they have had a child removed because of:*
 - *the configuration of issues that has led to that removal*
 - *the grief that a whānau experiences following a removal.*

Any solution that does not acknowledge and respond to the complex problems whānau experience will likely fail to meet the needs of whānau. In addition it may be that, as well as recognising the common issues that these whānau have, solutions need to be tailored to the particular situation of any one whānau and their support structures.

I acknowledge that there may be unique risks to subsequent children of some parents. However, in my view, a fair and balanced decision-making process requires a case-by-case assessment by the Ministry based on the nature of the risk posed to subsequent children as it manifests at the time.

Further, several of the senior staff from the Ministry repeated the view that they inherited a 'broken system' and that the Ministry needed to make significant change as part of its transformation.¹⁴² Implicit in this acknowledgment is that, in the past, the Ministry's decision making did not meet the needs of tamariki, their parents and whānau. This raises the question whether in these circumstances it is reasonable to rely on those earlier decisions (to permanently remove previous tamariki) as the basis for removing subsequent tamariki without thorough assessment. To do so could compound prejudice to an already fractured and traumatised whānau.

141 Above n 57, at 41–42.

142 See also Oranga Tamariki—Ministry for Children *Annual Report 2018/19* (October 2019) at 7.



This is especially critical for Māori, who are more likely than others to be reported to the Ministry and to have their tamariki in care.¹⁴³ I am deeply concerned that the Ministry’s application of the subsequent children provisions may have unfairly disadvantaged Māori parents. In the absence of sufficient steps taken at a systemic level to reduce disparities and to address multiple historical injustices that have led many into the state care system in the first place, some Māori parents may find it difficult to be in a position to show the kind of improvement expected by the Ministry.

I am deeply concerned that the Ministry’s application of the subsequent children provisions may have unfairly disadvantaged Māori parents.

In sum, my opinion is that the way the subsequent children provisions are currently addressed is at odds with:

- the objects and principles of the Act, and at international law, to promote the wellbeing of tamariki and their whānau;
- the legal obligations on the Ministry, where tamariki are at risk, to assist parents and whānau (including financially) in discharging their child-rearing responsibilities;
- the principles of *Te Toka Tumoana*, such as whakamanawa, rangatiratanga, whakapapa and manaakitanga, identified by the Ministry as being ‘particularly relevant in the processes, planning and practice with subsequent children’;¹⁴⁴ and
- the requirement on the Ministry to facilitate the participation of parents and whānau in the decision-making processes where possible.

I understand, at the time of preparing this report, that the Ministry was in the process of reviewing the subsequent children provisions ‘to make sure there are no unintended consequences ... [and] to ensure that there is a path back for those parents who have turned their lives around’.¹⁴⁵ I consider it important that my findings feed into this review, as well as prompting a consideration of legislative amendment to aid clarity of interpretation and to ensure that the system operates fairly towards subsequent tamariki and their whānau.

143 I refer here to statistical data published by the Ministry that can be accessed at <www.orangatamariki.govt.nz/about-us/reports-and-releases/statistics-about-how-we-work-with-children/>. This shows that (for the period I investigated) about 50 percent of the reports of concern received by the Ministry were in relation to Māori pēpi, tamariki or rangatahi. In terms of entries into care, that figure is approximately 64 percent. Again, it is worth noting that Māori represent approximately 16.5 percent of Aotearoa’s population.

144 Oranga Tamariki—Ministry for Children *Subsequent children—Te Toka Tumoana* (1 July 2016).

145 Tracey Martin “Release of Oranga Tamariki Practice Review” (press release, 7 November 2019).





Unborn and newborn pēpi

In terms of unborn and newborn pēpi, the Ministry specifically identified and provided me with copies of four documents from its Practice Centre that were effective for the period I considered.

- ‘Vulnerable infants—practice triggers’, undated but effective at 1 July 2017
- ‘Safe sleep’, undated but effective at 1 July 2017
- ‘Growing a healthy baby’, undated but effective at 1 July 2017
- ‘Strengthening our response to unborn babies’, dated 21 January 2015¹⁴⁶

Having considered this material, the latter is the most relevant for my investigation.

This explained the importance of the Ministry’s response to unborn and newborn pēpi (emphasis added):

*When we are made aware of **concerns before birth** we have a **unique opportunity to work with families/whānau and other professionals to assess parenting capacity**, assess needs and implement a plan that will build a set of ‘eyes’ around the newborn infant and provide **a multi-agency approach to safety**.*

*We know that **newborn babies are extremely vulnerable**. It is important that we look to the future and **consider how the family/whānau will be supported** to ensure not just immediate safety after birth but also the brightest future for their child.*

The guidance identified the following as key to the Ministry’s work with unborn and newborn pēpi:

- early engagement and assessment, which includes support for antenatal health, engagement with fathers, identifying wider whānau strengths, assessment of parenting capacity and willingness to change and ability to maintain changes, and use of the Child and Family Consult to inform robust decision making;
- assessment of the parents’ own childhood history of abuse or neglect;
- early collaboration with other professionals; and
- early family group conference and planning.

For the most part, this guidance seems to be in accordance with the objects and principles of the Act and the obligations under international law that I have identified above. However, there are two issues I have identified.

146 This guidance was last updated on 19 December 2019, but the key expectations remain largely the same. The current guidance is available at <practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/strengthening-our-response-to-unborn-and-newborn-babies/>.



First, there is no reference to trauma-informed social work practice in this guidance vis-à-vis the parents' own childhood histories of abuse or neglect. I consider this a significant omission, as the Ministry has emphasised elsewhere the importance of trauma-informed practice:¹⁴⁷

Being 'trauma-informed' means understanding and recognising how trauma is experienced by te tamaiti, their whānau and caregivers in the following areas:

- *Historically through colonisation in Aotearoa.*
- *Across families and generations.*
- *Within systems we are part of.*
- *Directly to individuals.*

...Trauma-informed practice means:

- *understanding and recognising the impacts of all forms of trauma*
- *working closely together in responding effectively*
- *preventing further trauma and providing the resources needed for healing.*

The second issue I have identified relates to the references in the guidance to parents with 'learning or intellectual limitations' and 'alcohol and drug abuse issues, unmanaged mental health issues and anti-social behavioural issues'. Again, this is relevant to the needs of disabled parents, which I address in the next section. For now, I note that the Ministry's guidance states (emphasis added):¹⁴⁸

- *parents with learning difficulties or intellectual limitations require careful assessment that **may need to involve a specialist** who understands the impact of disability on parenting. Your **assessment needs to consider not only a capacity to parent safely but also if it will be practical to maintain any required supports long-term and if the supports are able to evolve as the child's needs change.***
- *parents with alcohol and drug abuse issues, unmanaged mental health issues and anti-social behavioural issues **may require a separate assessment** specific to these issues to inform the social worker's assessment of their capacity to care. Research has shown that pregnancy may be a window of opportunity to intervene for substance abuse problems ... and may be the first time that a woman has sought medical care ... Pregnant women as a group*

147 This is part of the Ministry's Practice framework knowledge and evidence base. This is available at <practice.orangatamariki.govt.nz/practice-standards/practice-framework-knowledge-and-evidence-base/trauma-informed-practice/>.

148 This guidance was last updated on 19 December 2019, but the key expectations remain largely the same. The current guidance is available at <practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/strengthening-our-response-to-unborn-and-newborn-babies/>.



are invested in the health of their babies and can no longer deny that their alcohol or drug abuse is hurting anyone but themselves. Women in recovery have reported that they wanted help during pregnancy but didn't know how to ask ... Keep in mind that mothers can often abstain from alcohol and drug abuse while pregnant because of the effect on the baby but return to substance abuse post pregnancy because they think the baby will no longer be affected.

- *parents with unmanaged mental health issues and anti-social behavioural issues **may require a separate assessment specific** to these issues in order to ensure that the social worker's assessment of parenting capacity is thorough and considers all the risk factors, strengths and support needs of the situation.*

Given the complexity of the issues facing these parents, it is surprising that specialist assessments are not mandatory in such cases. It is not clear to me that the Ministry is in a position to determine whether pēpi meet the statutory definition of being in need of care or protection in the absence of such specialist assessments. I am also concerned that the wording of this guidance as noted does not reflect the legal obligation on the Ministry to ensure that, where pēpi are at risk, the parents (and whānau) should be provided assistance to support them in discharging their responsibilities to their pēpi.

Needs of disabled parents

As noted in my analysis of the relevant international obligations in [Appendix 6](#),¹⁴⁹ there is no universally accepted definition of disability. However, an approach consistent with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is to take a non-exhaustive view of disability. Such a view of disability is also consistent with the New Zealand Disability Strategy, which was co-designed with disabled people. Where the State identifies that an impairment may affect a person's ability to parent, it comes under an obligation to provide reasonable accommodation.¹⁵⁰ Further and most importantly, for my investigation, UNCRPD specifically:

- requires that disabled parents be provided assistance with their child-rearing responsibility;¹⁵¹ and
- prohibits the separation of tamariki from their parents on the basis of a disability of one or more parent.¹⁵²

What I have found is that the Ministry has very limited guidance on the needs of disabled parents. There is a large amount of material in respect of disabled tamariki and rangatahi. However, it is not apparent that the Ministry has considered the needs of disabled parents in the same way. I also note that, while

The Ministry has very limited guidance on the needs of disabled parents.

149 Refer to page 231 of this report.
 150 UNCRPD, art 5(3).
 151 UNCRPD, art 23(2).
 152 UNCRPD, art 23(4).





there were a number of training documents that referred to the needs of disabled tamariki and rangatahi, there was no reference to UNCRPD in that material. Significantly, the Ministry’s Practice Standards do not specifically refer to the needs of disabled parents.

As identified above, the Ministry’s guidance on the subsequent children provisions and unborn/newborn pēpi refers at various points to parents with ‘learning or intellectual limitations’, ‘alcohol and drug abuse issues, unmanaged mental health issues and anti-social behavioural issues’ and ‘mental health, intellectual functions ... personal resilience, physical health [and] substance abuse’.¹⁵³ However, there is no acknowledgement in that guidance that engagement with these parents must be undertaken in a manner consistent with the obligations under UNCRPD. In particular, it is not apparent that the Ministry has appreciated alcohol or drug misuse and other mental health needs require a disability rights–based response. This is a major failing on its part that needs to be rectified.

Intellectual disability

The Ministry does have some guidance in its Practice Centre relating to parents with intellectual disabilities (often referred to as learning disabilities).¹⁵⁴ This guidance says:

Parental intellectual impairment is an important factor that social workers need to consider when assessing parenting ability and putting in place suitable parenting support to ensure children and young people are able to reach their full potential. Intellectually disabled parents may need specific supports to enable them to [fulfil] their parental role, and some of this support may require linking the disabled parents with family, whānau and/or disability organisations. This is complex work but when completed well, can have hugely beneficial outcomes for all parties.

The guidance suggests disability services are ‘better able to provide support to intellectually disabled parents than [the Ministry]’. In summary, the guidance recommends that:

- the Ministry’s work has a better chance of success if the parent has access to support and advocacy services from a disability support service, and it addresses the power imbalance between whānau and a statutory agency;
- the Ministry is better able to monitor tamariki’s safety and wellbeing than disability support services;

153 This guidance was last updated on 19 December 2019, but the key expectations remain largely the same. The current guidance is available at <practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/strengthening-our-response-to-unborn-and-newborn-babies/>.

154 This guidance was last updated on 22 September 2013 and is available at <practice.orangatamariki.govt.nz/previous-practice-centre/knowledge-base-practice-frameworks/disability/parental-intellectual-disability/>.

Alcohol or drug misuse and other mental health needs require a disability rights–based response.



- it is the Ministry’s role to assess parenting capacity. However, it is a specialised area and the Ministry’s staff will need the expertise of experienced professionals;
- the Ministry’s role is to take a collaborative approach with the disability sector; and
- co-working and reflective supervision is essential.

The guidance refers to a Parent Assessment Manual held at Regional Offices. However, none of the Ministry’s staff interviewed for my investigation referred to this document, and it was not mentioned in any of the case files I examined. In any case, the guidance states that *‘it is not a psychometric or validated assessment tool, and should not be used for Family Court matters’*.

Specific reference is made to circumstances where tamariki of a disabled parent come into care:

Where disabled parents lose custody of their children, they need planned and resourced on-going support to maintain contact with them. Parental vulnerability makes it somewhat inevitable that contact with their children will be lost unless this issue is explicitly addressed.

The guidance sets out key questions the Ministry’s staff should use when *‘balancing the needs of parents and children’* to determine the interests of the child. These include questions about the *‘type and severity of the parental disability’*, what supports are in place, what other family members are available, and accessibility of disability and advocacy services.

Some of the guidance material suggests to me that the Ministry may still be operating in a medical (deficits-based) model of disability, rather than a social (strengths-based) model. A brief explanation of these models is set out below.

In addition, there is nothing in this guidance to remind staff of the obligation under international law that no tamariki should be separated from their parents based on a disability of one or both of the parents.

Similar concerns about the Ministry’s guidance were identified by representatives of the disability community who were interviewed for my investigation. I also understand that the Ministry’s guidance was not developed in consultation with the disability sector, as required by UNCRPD.¹⁵⁵

The Ministry’s guidance was not developed in consultation with the disability sector, as required by UNCRPD.

155 UNCRPD, arts 4(1)(c) and 4(3).



Medical based model

A medical based model views disability as a problem of the person, directly caused by disease, trauma, or other health condition, which therefore requires sustained medical care provided in the form of individual treatment by professionals. Within its framework, professionals follow a process of identifying the impairment and its limitations (using the medical model), and taking the necessary action to improve the position of the person with a disability. The management of the disability is aimed at a 'cure', or the individual's adjustment and behavioural change that would lead to an effective cure.

Social based model

The social model sees disability as a socially created phenomenon. In this model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. The management of the problem requires social action and is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life.

Views of the disability community

As noted above, in the course of my investigation, interviews were undertaken with representatives of the disability community, specifically: Cindy Johns, the National Manager of People First New Zealand Incorporated Ngā Tāngata Tuatahi; Paula Tesoriero MNZM, Disability Rights Commissioner at the Human Rights Commission; and Trish Grant, Director of Advocacy at IHC.

Ms Grant has advised me:

Due to limited contemporary understanding within Oranga Tamariki about intellectual disability and parenting, we suggest there is a tendency for Oranga Tamariki to make assumptions about:

- *The risk of harm to a child when their parent has an intellectual disability. For example, that parents will not be able to learn how to keep their child safe from unintended injury or to feed and care for them well, due to their disability.*
- *The on-going wellbeing of the child as they grow up with a parent with intellectual disability. Concerns can include questions as to what happens as the child gets older, such as when a child's cognitive ability exceeds their parent's.*

There are several issues that we request you consider as part of your investigation to ensure appropriate balancing of the human rights involved including, for example, the child's rights to be safe and to know and be cared for by their parents, with State support, and the parent's right to family and equal rights under the law. We believe a more nuanced, human rights-based approach to the complex issues involved in care and protection cases involving parental disabilities might lead to better outcomes for all, as well as helping New Zealand to meet its international obligations.



Ms Grant also commented on the Ministry's guidance relating to parents with intellectual disability (emphasis added):

...we note with concern that the Oranga Tamariki practice centre guidance on parental intellectual disability says that collaboration between child protection and disability support agencies is difficult for a number of reasons. These include a 'value clash between the "best interests of the child" and the "parental advocacy" approach of disability support agencies who are informed by the social model of disability' ... **This presentation of the parent's and child's rights as being in opposition with each other is unhelpful. We believe the best interests of the child must be a primary consideration and that part of considering their best interests is respecting their rights to identity and family.** IHC favours a constructive approach that looks at what needs to happen, in each case, to protect and advance the rights of all involved.

The issues we have identified as potentially having some bearing on your investigation include the following:

1. Whether children of parents with intellectual disability are made vulnerable to uplift by the State due to a lack of understanding about intellectual disability, bias and structural discrimination within the health, child protection and Family Court systems, such as:
 - Assumptions that parents with intellectual disability do not have, and cannot develop, the skills required to parent children safely and well.
 - Inflexibility in the disability and parenting support systems and funding streams making it difficult to develop wraparound packages to support parenting, especially in cases where no family or other support is readily available to parents.
 - Limited access to family support services for parents with intellectual disability or reasonable accommodations within universal parenting supports.
 - Overestimation and generalisation as to the nature of the risk to the child by Oranga Tamariki, coupled with a lack of understanding as to how appropriate disability supports can mitigate that risk. (Our experience is that there tends to be a lack of specificity as to the nature of the risk posed to the child, with a focus on life outcomes rather than risks of abuse and neglect, which can make planning to mitigate risk difficult.)



- *On-going influence of profiling and risk assessment tools because, as a population group, people with intellectual disability are over-represented in statistics often associated with (but not determinative of) poor outcomes for children such as involvement in the Oranga Tamariki system themselves as children, having a low income or living in benefit dependent households, low level of educational achievement.*
2. *Whether the processes and practices involved in uplifting children make appropriate accommodations for a parent's intellectual disability and ensure their equal access to justice, in accordance with Article 13 of the United Nations Convention on the Rights of Persons with Disabilities.*
 3. *What scope there is, when children are taken into State care, to maintain the parent/child relationship and protect the child's rights to identity, whakapapa and whanaungatanga.*

Similar views were expressed by the others interviewed.

In addition, Ms Tesoriero talked about the importance of access to legal advice, advocacy, and funding for support services. She noted that while, clearly, safety is paramount, that can be achieved while upholding the other basic human rights involved. In terms of the Ministry's guidance, Ms Tesoriero suggested that it needed to begin with an unequivocal statement that IQ should never be used as a sole measure of parenting capacity; at present this is not sufficiently emphasised. I agree with Ms Tesoriero in this regard.

At interview, Ms Johns also made the point that disabled people have a right to parent and that the nondisabled community needed to do better to support them. She added that having a disability does not automatically mean there is a limited capacity to parent, and that in all cases there must be an assessment by a relevant specialist working from a strengths-based model.

These suggestions are consistent with requirements in other jurisdictions. For example, Scotland has *Good Practice Guidelines for Supporting Parents with a Learning Disability*.¹⁵⁶ These guidelines include a right to access independent advocacy at the earliest opportunity and a right to accessible information. They also set out good practice for assessment of parents, including meeting support needs before the assessment, carrying out the assessment at home, and involving significant adults in the parent's life. Relevant specialist input should always be sought whenever it is thought that a parent has an intellectual disability.

IQ should never be used as a sole measure of parenting capacity.

156 The Scottish Government *Supported Parenting: Refreshed Scottish Good Practice Guidelines for Supporting Parents with a Learning Disability* (Scottish Consortium for Learning Disability, 2015).



Breastfeeding

Expectations around support to maintain breastfeeding is the only area in relation to the Ministry's removal process where the Practice Centre contains specific guidelines regarding newborn pēpi. This is noted in a section entitled 'Maintaining breastfeeding' under the main guidance for 'Maintaining family/whānau relationships'. The guidance states (emphasis added):¹⁵⁷

*If a mokopuna is breastfeeding, **all efforts should be made to ensure this can continue.** Be aware of the emotional and psychological side of breastfeeding for both mother and her mokopuna, and treat this issue with respect and sensitivity.*

*The first option should be to **support the mother and mokopuna to meet regularly throughout the day for feeding.** If additional feeding is required, the mother (if she wishes) should be **supported with the practical necessities required to express breast milk and arrangements made to provide this to the mokopuna.***

*Any **considerations about feeding should be discussed with the mother** and anyone else who has guardianship, and their consent should be obtained. Please note that in some situations the chief executive may also be a guardian. This includes the consideration of rare methods of feeding such as supply from a breast milk bank or breastfeeding by another person, including a caregiver.*

*Other aspects to consider include **mothers who have infections or illnesses that can be passed through breast milk, including HIV or mothers with drug and alcohol addictions. Consultation with relevant medical professionals is advised in these situations.***

The feeding routine should be carefully noted in the 'All about me' care information that is provided to the caregiver and the roles and responsibilities of all involved made clear once this has been negotiated.

This guidance generally reflects the importance of breastfeeding to the wellbeing of pēpi.

However, it is important to recognise that Article 24 of the United Nations Convention on the Rights of the Child (UNCROC) guarantees a child the right to the enjoyment of the highest attainable standard of health and in particular, it requires States Parties 'to ensure ... that parents and children ... are supported in ... the advantages of breastfeeding'.¹⁵⁸ It is generally considered that UNCROC 'supports the proposition that children have rights in relation to breastfeeding' and consequently:¹⁵⁹

157 This guidance was last updated on 24 February 2017 and is available at <practice.orangatamariki.govt.nz/previous-practice-centre/policy/caring-for-children-and-young-people/key-information/maintaining-family-whanau-relationships/>.

158 UNCROC, art 24(2)(e).

159 Karleen D Gribble and Morgan Gallagher "Rights of Children in Relation to Breastfeeding in Child Protection Cases" (2014) 44 British Journal of Social Work 434 at 434.



...child protection workers and authorities have a responsibility to ensure that their interventions support and do not undermine mothers in breastfeeding their children.

The importance of breastfeeding is also endorsed in the guidance from the World Health Organization and United Nations Children’s Fund. They recommend that ‘infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health’.¹⁶⁰ The Ministry of Health also recommends exclusive breastfeeding for pēpi for the first six months of life.¹⁶¹

I consulted with a lactation expert for my investigation.¹⁶² Commenting on the health benefits for pēpi, the lactation expert confirmed that in the first six months, exclusive breastfeeding, with no other food or drink, is recommended ‘to protect the baby from any food or waterborne pathogens, while breastmilk supplies several components to improve the infant’s ability to fight infection’. The lactation expert also noted ‘a longer duration of breastfeeding has been associated with reducing the risk of childhood chronic illness and obesity, and improving cognitive outcomes’.

Further, it has been observed that (emphasis added):¹⁶³

...in relation to a child’s right to breastmilk, this is an area where parental rights and children’s rights align with each other. Thus, the England and Wales High Court (Administrative Court), in examining a case from a human rights perspective, determined that authorities must take the wishes of mothers in relation to breastfeeding into consideration in their decisions about care arrangements and contact in child protection cases. Their decision states that:

If the state, in the guise of a local authority, seeks to intervene so drastically in a family’s life—and at a time when, ex hypothesi, its case against the parents has not yet even been established—then the very least the state can do is to make generous arrangements for contact. And those arrangements must be driven by the needs of the family, not stunted by lack of resources. Typically, if this is what the parents want, one will be looking to contact most days of the week and for lengthy periods. And local authorities must be sensitive to the wishes of a mother who wants to breast-feed and must make suitable arrangements to enable her to do so—and
when I say breast-feed I mean just that, I do not mean merely bottle-feeding expressed breastmilk. Nothing less will meet the imperative demands of the Convention. Contact two or three times a week for a couple of hours a time is simply

160 World Health Organization and UNICEF *Global Strategy for Infant and Young Child Feeding* (Geneva: WHO, 2003) at 7–9.
 161 Ministry of Health *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper* (4th ed, Wellington, May 2008, partially revised December 2012) at 7 and 14–21.
 162 Michelle Carter, Internationally Board-Certified Lactation Consultant *Report to the Ombudsman: Evidence Based Lactation Best Practice—Oranga Tamariki Removal of Newborns* (16 April 2020).
 163 Gribble and Gallagher, above n 159, at 439.



not enough if parents reasonably want more (Re M. (Care Proceedings: Judicial Review, 2003)).

Where child protection authorities intervene in such a way as to result in the cessation of breastfeeding, **such actions could be considered as tantamount to preempting a decision of permanent alternate care for the child.**

While the Ministry has guidance for its staff on breastfeeding, in my view this material does not explicitly acknowledge the rights to breastfeeding as provided for under UNCROC, or the recommendations of the World Health Organization and the Ministry of Health on exclusive breastfeeding for the first six months of pēpi's life.

The lactation expert I consulted for my investigation also made the following comments about the Ministry's guidance:

My expert view is that while the section does say all efforts should be made so that breastfeeding can continue and that regular contact through the day for the mother and baby to breastfeed should be supported, there is nothing specific to keep social workers to this aim if they themselves do not have the knowledge of how to support breastfeeding.

I would recommend a more detailed plan for social workers to follow...

I would recommend a [child's] right to breastfeed [is] acknowledged as part of Oranga Tamariki's policy.

The expert lactation advice also suggested that where a pēpi is going to be removed, the Ministry should adopt the following procedures to support and sustain breastfeeding where this is the wish of the mother:

- a. *Open consultation with the mother and family / whānau including culturally appropriate support*
- b. *Collaboration between multidisciplinary health and social workers*
- c. *Adoption of a formal plan, agreed with all parties and led by one individual*
- d. *In the initial postnatal period mother and baby will stay together for 5 days in Maternity allowing unlimited skin to skin cuddles and time to establish breastfeeding*
- e. *Where possible, arrange for a minimum of one daily contact [session] for a minimum of three hours in an environment conducive to breastfeeding and mother/child bonding*
- f. *If supervision is required during the contact session it should be by someone agreeable to all parties*



- g. *Provision of a hospital grade breast pump and milk storage bags*
- h. *Education to Social workers and Caregivers about breastfeeding would support this policy*

I agree with the suggestions from the lactation expert and consider that the Ministry should amend its policy and guidance accordingly.

Summary

In general, I am satisfied that the content of the Ministry's overarching Practice Standards adequately reflect the objects and principles of the Act and most of the obligations under international law. However, I consider that the rights of disabled parents are a significant omission from the Practice Standards.

The Ministry has a wealth of other operating policies and guidance available in its Practice Centre, most of which are consistent with the objects and principles of the Act and the obligations under international law. I appreciate that the Ministry is in the process of updating and reviewing the content of the Practice Centre (as it is required to do to meet its transformation programme). However, as it currently stands, I found its Practice Centre is difficult to navigate, and the links back to the overarching Practice Standards are not readily apparent.

For the time period I considered, I identified a number of gaps in the Ministry's operating policies and guidance.

Critically, the Ministry did not have any specific operating guidance on the use of without notice section 78 applications. It had some general guidance on the use of emergency powers (of which a section 78 application is one), but this did not directly address the use of without notice applications. The available guidance did not sufficiently articulate clear criteria for how staff are meant to identify and assess the viability of other options to secure the safety of tamariki. Further, the training content for 2017 on the use of without notice applications included inaccurate advice. While the training material for 2018 remedied this, it did not emphasise the need for the Ministry to consider all other options before applying for interim custody under section 78. The lack of appropriate guidance on this issue is an extremely serious failing in the context of the Ministry's routine reliance on such applications as a way to establish safety for pēpi.

My investigation has also found that there is little specific guidance for unborn or newborn pēpi and disabled parents.

The Ministry has one policy document '*Strengthening our response to unborn babies*' that provided specific guidance for unborn or newborn pēpi. I found this to be generally adequate, with the following exceptions.

- There is no reference to trauma-informed social work practice vis-à-vis assessing the parents' own childhood histories of abuse or neglect.
- It does not explicitly require specialist assessments for parents with alcohol or drug misuse, mental health needs or intellectual disabilities.



- It does not reflect the legal obligation on the Ministry to ensure that where pēpi are at risk, the parents and whānau are provided assistance to support them in discharging their responsibilities to their pēpi.

I found there was very limited guidance in respect of disabled parents. It was not apparent from the available material that the Ministry appreciated alcohol or drug misuse and other mental health needs require a disability rights-based response. In terms of the specific guidance for parents with intellectual disability, I am concerned that the Ministry may have been operating in an outdated medical (deficits-based) model of disability. In addition, the guidance did not sufficiently emphasise that IQ should not be used as a sole measure of parenting capacity. Nor did it explicitly refer to the obligation under international law that no tamariki should be separated from their parents based on a disability of one or both of the parents.

The Ministry does not have any guidance and policy specifically developed for the removal process itself, except in relation to breastfeeding. This situation is highly unsatisfactory, given the potential long-term impacts of a removal.

The available guidance on breastfeeding could be improved by including an explicit acknowledgment of the rights to breastfeeding as provided for under UNCROC, and the recommendations of the World Health Organization and the Ministry of Health on exclusive breastfeeding for the first six months of pēpi's life.

The Ministry may have been operating in an outdated medical (deficits-based) model of disability.



Part Three: The Ministry's practices
Wāhanga Tuatoru:
Ngā Tikanga a
Oranga Tamariki





Part Three: The Ministry's practices

Wāhanga Tuatoru: Ngā Tikanga a Oranga Tamariki

This part of my report examines the Ministry's decision making practices in two distinct but related phases: before an application is made to the Family Court for a without notice section 78 interim custody order; and the removal of pēpi, if that occurred, once the section 78 order is granted.

For each of these phases, I first identify the key elements that I consider would constitute a fair, transparent, and reasonable decision making process drawn from the obligations under international law, the Oranga Tamariki Act 1989 (the Act), and the Ministry's own expectations of best practice.

I then address each of these key elements by describing:

- the expectations of what should happen as required by the Ministry's guidance, as well as by those who were interviewed for my investigation;
- what is typically happening based on the evidence before me, which includes:
 - the quantitative evidence gathered from:
 - › my review and analysis of the 74 case files from the nine sites I visited where the Ministry had applied for interim custody (without notice) of newborn (and unborn) pēpi under section 78 between 1 July 2017 and 30 June 2019;
 - › the Ministry's *s78 Casefile Analysis* completed in November 2019, where it examined 153 of the 309 cases where pēpi were placed in its custody under section 78 orders between 1 July 2017 and 30 June 2019;¹⁶⁴
 - › the Ministry's review and analysis of 62 cases where pēpi under 30 days were placed in its custody between 1 July 2017 and 30 June 2018;¹⁶⁵ and
 - the qualitative evidence gathered from the interviews conducted for my investigation;
- the factors I identified as contributing to the Ministry's typical practice during the period of my review; and
- the consequences, perceptions, and impact of the Ministry's typical practice.

164 *s78 Casefile Analysis*, above n 20.

165 *Babies and children entering Oranga Tamariki care*, above n 35.



**Part Three: First phase—applications
for without notice interim custody**

**Wāhanga Tuatoru:
Wāhanga tuatahi
– ngā tono mō te
whakatau tiaki
tamariki wā poto
kore pānui**





Part Three: First phase—applications for without notice interim custody

Wāhanga Tuatoru: Wāhanga tuatahi – ngā tono mō te whakatau tiaki tamariki wā poto kore pānui

Based on my understanding of the legal framework, and the Ministry's expectations of best practice, applications for without notice interim custody under section 78 are meant to be reserved for urgent cases where all other options to ensure the immediate safety of pēpi have been exhausted or are not available. Therefore, it is my expectation that the Ministry's decision making practices, before applying for without notice interim custody of newborn pēpi, should reflect the following key elements:

- engagement with whānau, hapū, iwi, and family groups to ensure (where possible) they are able to participate in the decision making process and their views are taken into account;
- early planning;
- checks and balances in the decision making process; and
- understanding of, and compliance with, the law.

I have addressed each of these key elements in turn below.

Engage with whānau, hapū, and iwi

The first key element I have considered is engagement with whānau, hapū, and iwi, as it is clear that such engagement is required by the legal framework, as well as the Ministry's policies and procedures. To reiterate, the principles of the Act provide that:

- whānau, hapū, and iwi should participate in decision making wherever possible, and regard must be had to their views wherever possible;¹⁶⁶
- the primary role in caring for and protecting pēpi lies with their whānau, hapū and iwi;¹⁶⁷ and
- pēpi's whānau, hapū, and iwi should be supported, assisted, and protected as much as possible, and any intervention in family life should be the minimum necessary to ensure pēpi's safety and protection.¹⁶⁸

166 Section 5(a) of the Act at 1 July 2017, since amended. See s 5(1)(c)(v) at 1 July 2019.

167 Section 13(2)(b) of the Act at 1 July 2017, since amended. See s 5(1)(c)(i) at 1 July 2019.

168 Section 13(2)(b) of the Act at 1 July 2017, since amended. See ss 13(2)(b) and 13(2)(e)-(i) at 1 July 2019.



Further, one of the objects of the Act is to assist whānau, hapū and iwi to prevent harm to their tamariki,¹⁶⁹ and the Ministry is the government agency tasked with facilitating that assistance.

What should happen

In the context of care and protection concerns for newborn pēpi, it is critical that the Ministry works effectively with parents, whānau, hapū and iwi. This will enable the Ministry to:

- identify any need for support, as well as identifying sources of that support and facilitating that assistance for pēpi, their parents, whānau, hapū, and iwi; and
- work towards maintaining and strengthening pēpi’s relationship with their parents, whānau, hapū, and iwi.

Doing everything possible to engage with parents, whānau, hapū, and iwi **before** pēpi is born increases the chance of placement with whānau. It is widely accepted that placement outside whānau is likely to lead to alienation and the loss of relationships with parents, whānau, hapū, and iwi. The result is continued trauma and damage to whānau and whakapapa. That result is contrary to the objects and principles of the Act and the obligations arising under international law.

Research has shown that a newborn pēpi needs to form secure and healthy attachments with their natural parents to have better long-term outcomes.¹⁷⁰ These long-term implications are especially relevant because the Ministry has permanency goals for all children;¹⁷¹ for pēpi, the aim is to find a ‘home for life’ within six months of coming into care. The rationale for this is that children need stable and continuous care, and this should be achieved in a timeframe appropriate for the child’s age and development.

In the context of the Act, ‘home for life’ may be with the parents, with whānau, or with someone else, including a caregiver approved by the Ministry.

In recognition of the need to engage effectively with Māori, some sites have kairāanga, a specialist Māori role.

It is critical that the Ministry works effectively with parents, whānau, hapū and iwi.

Some sites have kairāanga, a specialist Māori role.

169 Section 4(b) of the Act at July 2017, since amended. See section 4(1)(c)(i) at 1 July 2019.

170 Shore and McIntosh, above n 27.

171 The Ministry’s guidance (effective at June 2018) about this can be accessed at <practice.orangatamariki.govt.nz/previous-practice-centre/policy/noho-ake-oranga/>.



Kairāranga

A kairāranga is described on the Ministry Practice centre as ‘a person who is a weaver of family connections’.¹⁷² The role has different names throughout the country (including kairāranga-a-whānau or kairangahau) reflecting tikanga of mana whenua. Some kairāranga are employed by the Ministry and others are contracted from iwi/Māori providers.

This position had been established at some of the Ministry’s sites, as a site-specific initiative, for over ten years. In 2017, as part of the Ministry’s transformation programme, it called for expressions of interest from all its sites to establish nationally funded kairāranga positions based at individual sites.¹⁷³ At the time, there were ten sites that were ‘already working in whānau searching, whakapapa research and hui ā-whānau’.¹⁷⁴ These ten sites were selected for the pilot of the kairāranga role.

Over time, additional kairāranga were appointed in a number of other sites and at May/April 2019, there were 33 kairāranga roles.¹⁷⁵ This had increased to 41 roles by February 2020.¹⁷⁶ In late 2018 and early 2019, the Ministry appointed the Family Centre Social Policy Research Unit to conduct an external evaluation of the kairāranga pilot in three ‘exemplar’ sites. The evaluation report *Enhancing Tamariki and Whānau participation in decision making: External Evaluation Report* was completed in February 2019.

The other key tools the Ministry uses to engage are hui ā-whānau and family group conferences (FGCs)—the latter being a statutory process. A hui ā-whānau is a meeting ‘to support and enhance the rights, participation and decision-making of tamariki and their whānau, hapū, iwi and support network as early as possible’.¹⁷⁷ It is a meeting led by whānau, where the participants discuss events and concerns. The Ministry’s policies and guidance set out an expectation that its staff will use these tools to provide whānau and families with the opportunity to participate fully in assessment, planning, and decision making. However, engaging with whānau is not a mechanical or ‘tick-box’ exercise. It must be done in a meaningful way to give effect to the objects and principles of the Act.

Senior staff from the Ministry who were interviewed explained that frontline staff receive training on how to empower whānau to lead decision making; having hui ā-whānau prior to FGCs; and how to use the system and recognise their unique role in facilitating whānau decision making, as opposed to organisational decision making.

Engaging with whānau is not a mechanical or ‘tick-box’ exercise.

172 A description of this position can be found on the Ministry’s Practice Centre <practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairaranga-a-whanau/>.

173 Catherine Love and others *Enhancing Tamariki and Whānau participation in decision making: External Evaluation Report* (Family Centre Social Policy Research Unit, Oranga Tamariki – Ministry for Children) February 2019 at 16.

174 Internal Ministry document dated 29 May 2019 sent to the Ministry’s Regional Managers discussing Māori Specialist Roles.

175 Above n 174.

176 Affidavit affirmed by Grant Robert Bennett, above n 15, at [8].

177 Further details are available at <practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/hui-a-whanau/>.



Since many of the parents who have pēpi removed have had previous children removed or have been in state care themselves,¹⁷⁸ best practice also requires the Ministry to act in a trauma-informed manner to ensure good quality engagement. The Ministry has explained trauma-informed engagement as follows (emphasis added):¹⁷⁹

*Within the child protection system, **removing tamariki from whānau care even when this is required to ensure safety, is in and of itself inherently traumatic.** Whilst for whānau Māori, this is overlaid by the historical trauma of colonisation and the intergenerational impacts of exposure to the statutory child protection system, their culture also offers a unique context in which healing can occur. Social workers need to be aware of **indicators of trauma such as whānau experiencing powerlessness, having no voice, or self-esteem (trampling of mana) and having no protective boundaries (violation of tapu).***

*When social workers are able to **demonstrate understanding and empathy** towards parents and whānau based on an awareness of their own trauma, they are more likely to be able to see concerns within context and **support the development of appropriate strategies to respond in ways that promote resilience and wellbeing.** Social workers can also support whānau they are working with to address trauma by **noticing resilience factors and setting goals** to build upon these. This might mean actively acknowledging small changes made by whānau members over time and building upon these in shared planning for tamariki.*

I have examined the Ministry's engagement with disabled parents, as this requires special consideration, given that the United Nations Convention on the Rights of Persons with Disabilities (UNCPRD) specifically requires that '[i]n no case shall a child be separated from parents on the basis of a disability of . . . one or both of the parents'.¹⁸⁰

What is typically happening

I will now address what I found to be typically happening with respect to the requirement to engage. I have also focused on areas of particular concern that arose during the course of my investigation. These are in respect of trauma-informed engagement, as well as engagement with Māori and disabled parents.

I am pleased to find that the Ministry's staff were all aware of the Practice Standards and, in particular, the need to engage with parents and whānau. Frontline staff spoke enthusiastically about using hui ā-whānau as a way to maintain the mana of whānau and to work through complex and longstanding issues. Staff described being tika and pono in their interactions with parents,

Staff described being tika and pono in their interactions with parents.

178 Of the cases I examined, 92 percent involved parents who had been in care, or had previous tamariki removed, or both. The Ministry's *s78 Casefile Analysis* provided a higher figure of 97 percent.

179 Hasting Practice Review, above n 23, at 41–42.

180 UNCPRD, art 23(4).





ensuring parents understood the concerns and what they needed to do to address them. The importance of transparency was frequently mentioned by frontline staff.

I note that the Ministry's publicly available analysis *Babies and children entering Oranga Tamariki care* noted (emphasis added):¹⁸¹

*An analysis of a random sample of 62 of the 242 cases in which a baby under 30 days was placed (either pre-birth or after birth) by the Family Court in Oranga Tamariki custody between 1 July 2017 and 30 June 2018 showed that in most of these cases, **we had worked with the parents and whānau over a number of months to develop a plan that would enable the baby to remain safely at home.***

It is not clear from this analysis whether the work done with parents and whānau was before or after pēpi were in the Ministry's custody. However, the Ministry's *s78 Casefile Analysis* over the same two-year period covered by my investigation provides a clearer picture of the efforts to engage. I have set out in [Appendix 11](#) extracts of the relevant tables from the Ministry's analysis.¹⁸²

The low level of engagement with whānau using the required processes of hui ā-whānau and FGCs as shown in the Ministry's analysis, is also consistent with my review of the 74 case files from the nine sites I visited. In particular, I found there were hui ā-whānau and/or FGC **before** pēpi was born in only half of cases involving Māori, as set out in [Table 4](#) in [Appendix 4](#).¹⁸³

Despite these being the tools the Ministry should use under its operating guidance, no hui ā-whānau were held prior to pēpi's birth in 58 of 74 cases, and no FGC occurred prior to pēpi's birth in 51 of 74 cases, shown in [Figure 2](#) and [Figure 3](#) below.

181 Above n 35, at 3.

182 Refer to [Figure 20](#) at page 253 of this report; and *s78 Casefile Analysis*, above n 18, at 10.

183 Refer to [Table 4](#) at page 221 of this report.

Family group conferences

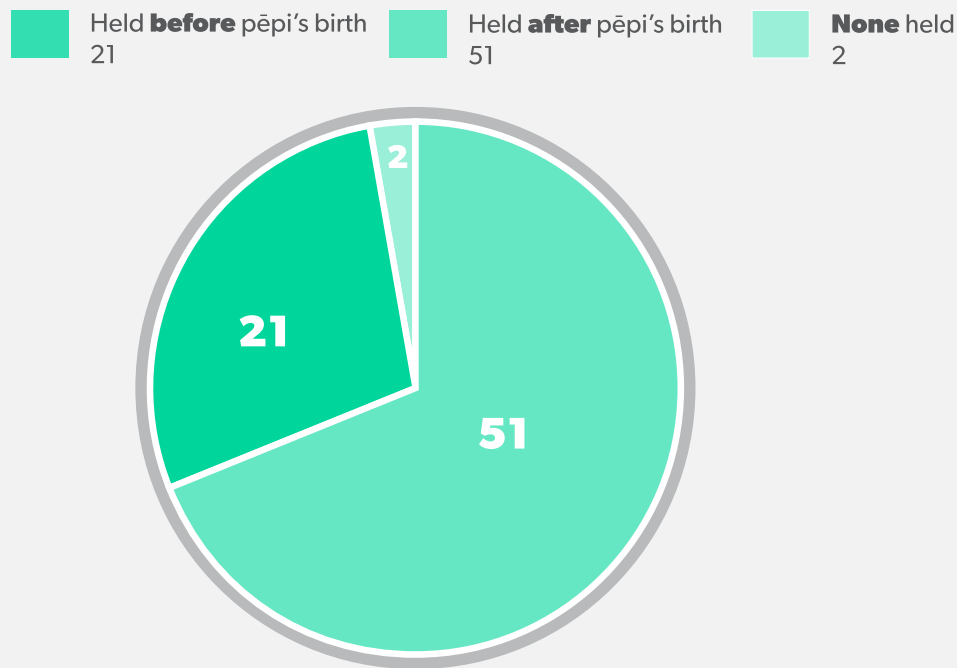


Figure 2: FGC in the 74 case files reviewed

Hui ā-whānau

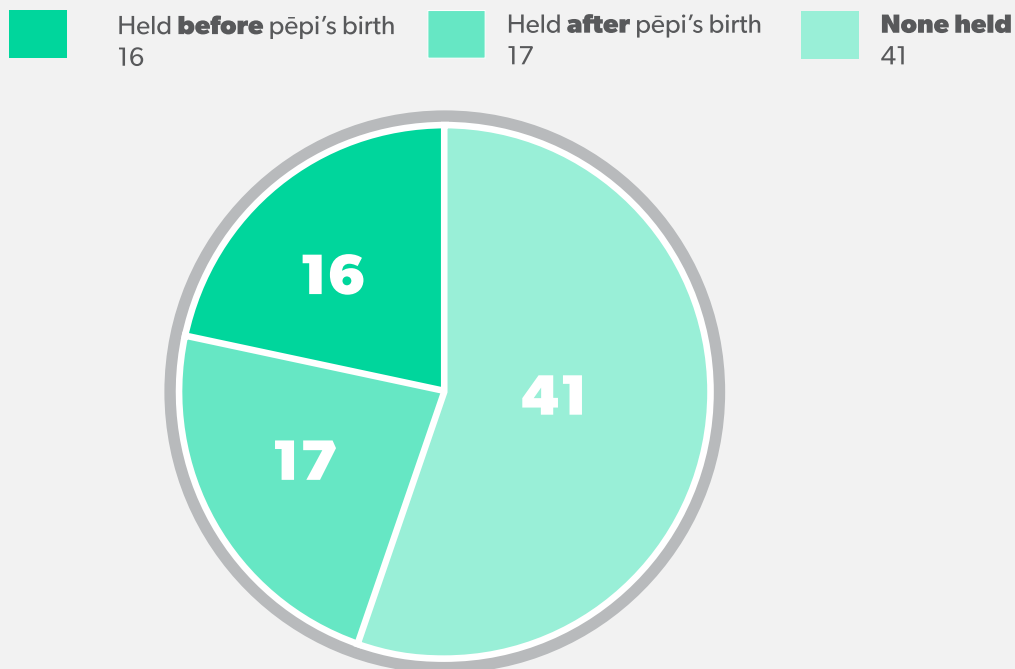


Figure 3: Hui ā-whānau in the 74 case files reviewed



Cases with both family group conference and hui ā-whānau

■ Held **before** pēpi's birth 5
 ■ Held **after** pēpi's birth 17

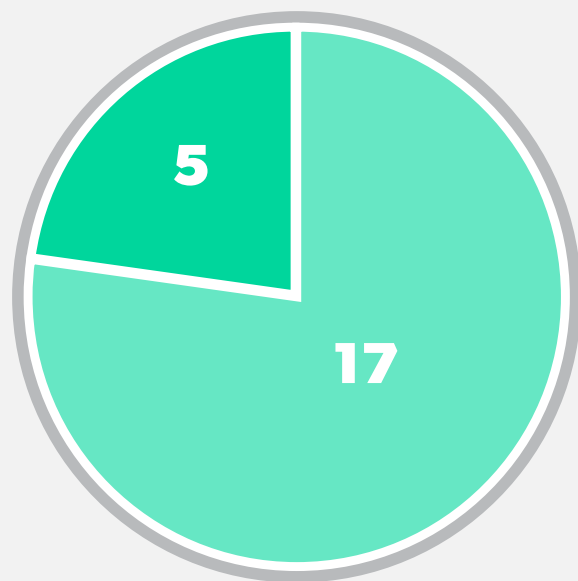


Figure 4: Both FGC and hui ā-whānau in the 74 case files reviewed

As I will explore below, this lack of engagement was despite the Ministry knowing of the pregnancy for a significant length of time before the pēpi was born. In 77 percent of the cases I examined, the Ministry knew of the pregnancy for over 60 working days before the birth.

In 77 percent of the cases I examined, the Ministry knew of the pregnancy for over 60 working days before the birth.

Trauma-informed engagement

As noted above, the Ministry has identified that engagement with parents who have had previous children removed must be undertaken in a manner that is consistent with a trauma-informed approach. In particular, frontline staff are expected to:¹⁸⁴

...seek support for parents whose wellbeing and parental capacity may be impacted by their own history and provide support to enable them to experience parenting skills, styles and sources of knowledge which are different to the parenting they experienced themselves as children.

184 Hasting Practice Review, above n 23 at 42.



In my analysis of the 74 cases I reviewed, as shown in [Figure 5](#) and [Figure 6](#), most parents had previous involvement with the Ministry as a child themselves, or because of involvement with their previous children, or both.¹⁸⁵

Parental involvement with the Ministry (Māori)

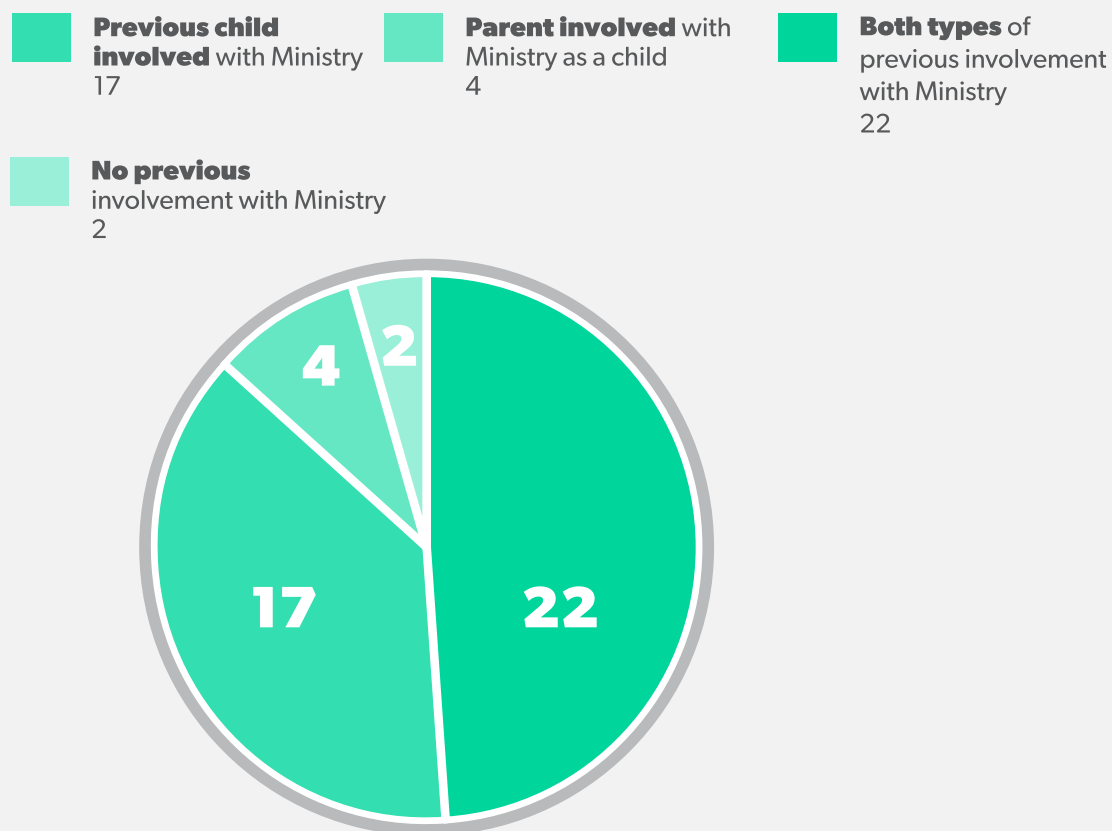


Figure 5: Parental involvement with the Ministry (Māori)

185 Refer to [Table 5](#) at page 222 of this report.

Parental involvement with the Ministry (Non-Māori)

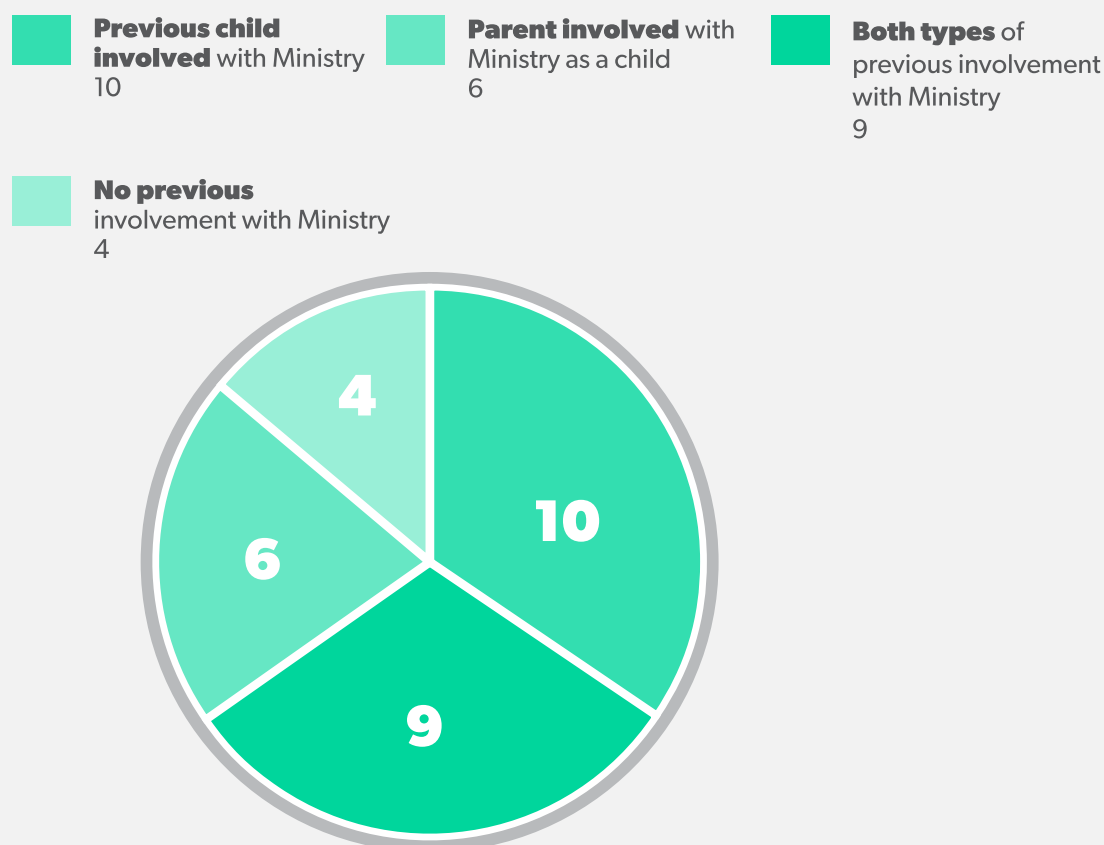


Figure 6: Parental involvement with the Ministry (Non-Māori)

As noted earlier, the Ministry's *s78 Casefile Analysis* also found a high percentage of parents had previous involvement with the Ministry. In around 97 percent of cases, the Ministry had been involved with one of the parents. The Ministry also identified that the nature of its involvement was the 'parents' own history and a history of previous children' in over half of the cases sampled.¹⁸⁶

The case files I reviewed often summarised the history of parents who had been in the care of the Ministry. This included descriptions of neglect and abuse by their whānau. For some parents, there was also a history of multiple placements and, in some cases, recorded alleged abuse while in the care of the Ministry or its predecessor. Some parents had mental health needs because of events as a child or young person. In short, there was no doubt the majority of the parents had experienced significant trauma themselves.

The majority of the parents had experienced significant trauma themselves.

¹⁸⁶ *s78 Casefile Analysis*, above n 20, at 7.



The parents' history often formed part of the basis for the Ministry's concerns and its application for interim custody. In the Ministry's *s78 Casefile Analysis*, historical concerns or events were identified as a factor underpinning the decision to seek a custody order in between 47 and 58 percent of cases.¹⁸⁷

In the case files reviewed for this investigation, parental history was usually seen solely as a risk to pēpi and not as a factor that would warrant a trauma-informed approach. There was rarely acknowledgement of the role the Ministry had in the trauma parents had experienced. Nor were any steps taken by the Ministry to address that trauma. Some interviewees from the Ministry and the District Health Boards (DHBs) said that the Ministry was not the appropriate agency to ensure parents were supported through the trauma. The Ministry's staff frequently stressed that their client was the pēpi, and the Ministry's focus was on the safety of pēpi, rather than on addressing the needs of parents and whānau who have been impacted by trauma.

The failure to understand and address trauma may explain the data in the Ministry's *s78 Casefile Analysis* about the support services that were provided with a focus on preventing the removal of pēpi. I have set out an extract of the Ministry's analysis of this issue at [Appendix 11](#).¹⁸⁸

That analysis shows that the Ministry:

- was able to positively identify the type of support services it had provided (with a focus on preventing the removal) in only 38 percent of the sampled cases;
- was unable to determine if any support services were provided in 31 percent of the sampled cases; and
- found that in 24 percent of the sampled cases there appeared to have been 'limited engagement' with the mother.

I am especially concerned that despite partner violence or within-family violence being prevalent in the cases,¹⁸⁹ the Ministry's own analysis showed that family violence intervention services were provided in **only** 2 to 3 percent of cases. This is highly unsatisfactory.

Based on the Ministry's own analysis, it was plainly not meeting its statutory objective of 'assisting parents, families and whānau to discharge their responsibilities' to pēpi.¹⁹⁰

The Ministry's own analysis showed that family violence intervention services were provided in only 2 to 3 percent of cases.

187 At 8.

188 Refer to [Figure 21](#) at page 254 of this report; and *s78 Casefile Analysis*, above n 20, at 11–12.

189 Refer to comments under the heading 'The pēpi, parents, and whānau' at page 39 of this report.

190 As required by section 4(b) of the Act at in July 2017; since amended. See sections 4(1)(c)(i) and 4(d) of the Act at July 2019.



Engagement with Māori

As noted above, I am satisfied that the Ministry has adequate policies and guidance to promote appropriate engagement with Māori. However, as shown in [Figure 2](#) and [Figure 3](#) above and in the Ministry's *s78 Casefile Analysis*, in practice, hui ā-whānau and FGCs were not being consistently used to engage with whānau, hapū, and iwi before pēpi were born.

Interview with the Ministry's senior staff member

Putting tamariki first is about putting them first within the context of their whānau, their whakapapa . . . really upholding their mana, whichever culture they're from, and we've kind of, somewhere along the line, lost that as being the priority.

In the sites my investigators visited, I found the use of hui ā-whānau and FGCs occurred more frequently where the sites have partnered with local iwi or Māori agencies.

This is confirmed in the Ministry's *s78 Casefile Analysis*. I have set extracts of the relevant tables from the Ministry's analysis at [Appendix 11](#).¹⁹¹

Although it appears there were high rates of engagement using hui ā-whānau and FGCs in partnered sites, it is clear that the Ministry's practices in terms of engaging with Māori were variable.

Not all sites have partnerships with Māori or use kairāanga or other specialist Māori roles.

Only two of the nine sites visited by my investigators had partnerships with local iwi or Māori agencies. These two sites had well-established processes for searching for whānau and arranging hui ā-whānau. However, four of the other sites visited also had kairāanga or staff in specialist Māori roles (for example, to run FGCs). One site visited had a Whānau Ora navigator.

From interviews with the Ministry's staff and third parties, it seems that the sites with partnerships have a strategic and operational commitment to place tamariki with whānau—in one case, specifically with their iwi. They used local relationships and the expertise of their specialist Māori staff to find the best way to engage with a whānau, using their knowledge of the whānau and of tikanga. At those sites, it is apparent that the focus on whānau opened up opportunities to engage using hui ā-whānau. Underlying the partnered sites' approach was an implicit understanding that whānau are key to caring for pēpi, and particularly for pēpi Māori.

Outside of the sites with partnerships with local iwi or Māori organisations, I observed less capacity and competency to engage with whānau.

Outside of the sites with partnerships with local iwi or Māori organisations, I observed less capacity and competency to engage with whānau.

191 Refer to [Figure 22](#) and [Figure 23](#) at page 255 of this report; and *s78 Casefile Analysis*, above n 20, at 13–14.





Interview with iwi social service provider

In regard to the Treaty, we're a partner so why aren't they [the Ministry] working with us? Why are they working away from us? We have as much right as what they have to know what's going on, as working out in the community. And being open to us about what their issue is so that we can sit around and discuss – well actually, we know that family. We know who to talk to, we can talk to the grandparents or the great-grand parents because we grew up with them.

Even those sites with kairāanga were limited in terms of their capacity, because of their high workloads. Kairāanga were also reliant on referrals from the Ministry's frontline staff, and it was reported that these referrals were not always made, or were not made in a timely way.

During interviews, kairāanga identified other barriers to good engagement with Māori, including grievances held by whānau against the Ministry for past failures, and a lack of trust. One kairāanga talked about the need to use hui to address grievances the whānau may have with the Ministry. For example, I was advised of one case where whānau had not known their mokopuna (moko) was already in the Ministry's care. The kairāanga identified that *'there was a lot of... mending'* that needed to take place, and the first step they took was to meet with whānau and apologise.

Another kairāanga described the importance of the whānau being able to trust the Ministry's staff member. They explained that the key to that was honesty and transparency; both whānau and the Ministry need to be clear about the concerns. The kairāanga described having multiple complaints from whānau that they did everything required, but the Ministry would later shift the goalposts—thus creating uncertainty and losing the trust of whānau.

In sites with no kairāanga, social workers relied on their own resources to find and then engage with whānau. In one site, the social worker described using *Te Whare Tapa Whā* as a Māori model of practice to engage with Māori.¹⁹² She used it to give the whānau confidence.

Interview with Ministry staff member

Māori talk a lot, so Māori need to be able to release... their hara, their anger, the issue of being here first and foremost, and so one hui doesn't fit. You've got to have that first hui, that initial hui, gather whoever is willing to come, and then the next hui you get to start getting the key people.

In some of the other sites with no kairāanga, I found that if the Ministry's frontline staff had personal links to whānau, they used these to effectively engage with parents and whānau. However, they were in the minority. Most staff primarily engaged with the mother, and sometimes the father. If immediate whānau were

192 Mason Durie "A Māori perspective of health" (1985) *Social Science and Medicine* 20(5) at 483–486.



known, the staff member might speak with them. However, as is clear from the low number of hui ā-whānau and FGCs before birth, this engagement did not utilise the prescribed processes.

Many of the Ministry’s staff described asking the mother about other whānau, but said that the mothers were often reluctant to involve them. In this regard, one site reported that there were networks available to assist the Ministry’s staff to connect with wider whānau when they were not the same ethnicity as the social worker. However, this was not reported at other sites. Instead, staff said they would commonly ask colleagues of the same ethnicity as the parents for help.

Significantly, there was no apparent capacity and competency to engage with hapū and iwi within most of the Ministry’s sites that were visited by my investigators. Nor was there any evidence on the case files of attempts to do so at those sites.

At the Ministry’s National Office level, there is one Māori manager working with particular iwi identified as a priority. While tamariki in care whakapapa to 88 iwi, this manager decided to start with the nine iwi with the highest numbers of tamariki in care. There is another senior Māori manager who works at a strategic level with Māori stakeholders. Although this manager appeared to have a strategy for working with iwi, it was unclear from interviews with the Ministry’s staff at its National Office that there is an agreed national strategy to improve engagement with hapū and iwi at a site level.

Engagement with disabled parents

One area where there was no significant difference between sites was in relation to engagement with disabled parents.

As noted earlier, there is limited guidance material in the Practice Centre relating to disabled parents.¹⁹³ In terms of the Ministry’s practices, what I have found is that the limited available guidance was not generally followed: specialist assessments were not routinely obtained, and disability support or reasonable accommodation was not made available. In my view, this is a significant breach of the obligations under the United Nations Convention on the Rights of People with Disabilities (UNCRPD).¹⁹⁴

My review of 74 case files showed high numbers of disabled parents. Where alcohol or drug misuse and other mental health needs are included, **all** of the 74 cases involve one or more parent potentially having a disability. However, it is not evident from the cases files that the Ministry in fact recognised alcohol or drug misuse and other mental health needs required a disability rights—based response. This is a significant oversight.

Staff said they would commonly ask colleagues of the same ethnicity as the parents for help.

193 Refer to comments under the heading ‘Needs of disabled parents’ at page 77 of this report.

194 UNCRPD, arts 2, 5(2) and 21.



Excluding alcohol or drug misuse and other mental health needs, 19 of 74 cases (approximately a quarter) referred to an impairment, with 18 of these cases indicating a parent with an intellectual disability. What this means is that it was critical that the Ministry understood and accommodated their specific needs in order to respond appropriately to those disabled parents.

The cases involving parents with intellectual disabilities were particularly concerning. These parents were not necessarily assessed as meeting the definition of *'intellectual disability'* for the purpose of receiving funded support. Nevertheless, some parents were described by the Ministry in its case file records as *'low functioning'*, or as having *'cognitive issues'*.

As with the overall percentages, Māori were disproportionately represented in this group, with 58 percent identified as Māori. It is important to recognise here that when key indicators of marginalisation—such as ethnicity, gender and disability—intersect, the result can be an even greater cumulative disadvantage.

I also found that there was an inconsistent approach to obtaining relevant specialist assessments. Up-to-date specialist assessments were obtained in only three of the 18 cases involving a parent with an intellectual disability prior to the Ministry applying for without notice interim custody under section 78. There was no reference made to a specialist assessment in six of the case files I examined. In eight of the cases, the Ministry relied on previous or historical specialist assessments for its decision making.

The number of parents accessing disability services, advocacy and assistance was also low, with parents only accessing them in three of the 18 cases. It should be noted that parents may choose not to engage with disability services for a variety of reasons, including parents not considering themselves to have a disability.

In some cases, the Court may consider that a person needs a litigation guardian to conduct proceedings on their behalf.¹⁹⁵ In two of the cases I reviewed, a litigation guardian was appointed to assist a disabled parent after the section 78 order was made. In one case, no litigation guardian was available, so a lawyer was appointed to assist them. In another two cases, it is unclear from the material in the case files whether a litigation guardian was appointed, but there was reference to one.

Not all of the parents in the 19 cases, identified by the Ministry as having an impairment, required a litigation guardian. However, all those identified as having an impairment should have been assessed by the Ministry to find out what their particular needs were and how best to support them. That did not happen consistently across the files I examined. Nor did the Ministry partner with agencies that could support the parents.¹⁹⁶

The cases involving parents with intellectual disabilities were particularly concerning.

There was an inconsistent approach to obtaining relevant specialist assessments

195 For an explanation of the term 'litigation guardian' refer to the glossary in [Appendix 1](#) at page 201 of this report.

196 Assessments in the period leading up to the birth of pēpi appear to have occurred in one region only.





Further, I consider it was unreasonable of the Ministry to have relied on outdated assessments in almost half of the cases. In addition to their lack of currency, reliance on any earlier assessment takes a static or fixed view of a disabled person’s needs.

Material is not available in formats suitable for a person with an intellectual disability

The Ministry has material available on its website and brochures about its processes. However, this material is not available in formats suitable for a person with an intellectual disability.¹⁹⁷ My investigation also found that, even where the Ministry was aware of the challenges some parents had in understanding or retaining information provided to them, there was no evidence that it took steps to assess how best to present information to ensure parents did, in fact, understand. In my view, this amounts to a ‘denial of reasonable accommodation’ that meets the definition of ‘discrimination on the basis of disability’ under UNCRPD.¹⁹⁸

Contributing factors

While there is some evidence of whānau-centred social work practice, this was not observed across all the sites visited or the case files reviewed. In my view, there are a number of reasons why the Ministry has struggled to engage effectively with whānau, hapū, iwi, family, and family groups as expected by the purpose and principles of the Act. I have also identified certain barriers within the Ministry to ensuring effective partnership and engagement. I have addressed each of these matters in turn below.

The child protection model

It seems to me that the main reason that the Ministry has not prioritised consistent engagement with whānau is due to an ingrained belief amongst its staff that the ‘buck stops with them’, and the Ministry is solely responsible for the safety of tamariki. Many frontline staff interviewed for my investigation feel this acutely. This is understandable, because there has been significant publicity about the failure of the Ministry and its predecessors to protect tamariki from harm inflicted by their whānau. Often the blame for such cases is seen as the responsibility of individual staff members or as a result of the practices of one site.

Although the Ministry’s staff talked about the importance of involving whānau, I found the common perception of the Ministry’s role being ‘child-focused’ or ‘child-centred’ in its actions and decisions overrode this. At times, frontline staff contrasted the focus of their practice to the focus of other people or organisations:

197 For example, People First has an Easy Read translation service. Their website explains Easy Read as follows: *Easy Read is a way of presenting information for people with a learning disability that is easier for people with a learning disability to understand.*

198 UNCRPD, arts 2, 5(2) and 21.





Interview with Ministry staff member

Midwifery focus is a woman focus, and ours is a child focus but in the context of whānau ... so ... it's coming from two different places really.

I have considered the 2019 evaluation report of the kairāanga pilot,¹⁹⁹ and note this referred to three models of child and family welfare.²⁰⁰ The first model, 'child protection' is 'characterised by a reliance on state and judicial intervention in families to protect children from harm in their own homes'.²⁰¹ The second is 'family service', where childcare and family support are the 'shared responsibility of families, communities, and the state'.²⁰² The third model is 'community care'. The report stated this model's central concept is 'to locate responsibility and authority for child care within the extended family, rather than with parents or the state'.²⁰³

The 2019 kairāanga evaluation report noted that Aotearoa's system of child and family welfare and wellbeing is grounded in the first model of child protection. The third model, the report stated, is the one that is consistent with traditional Māori models of childcare, welfare, and wellbeing, as well as being relevant to obligations under te Tiriti o Waitangi. Both systems prioritise safety, but the difference is where responsibility for safety lies. In the child protection model, it sits with the State; with the community care model, it sits within the extended family.

Over the years, attempts have been made to bring aspects of the third model into law and practice, through the principles of the Act and a focus on FGCs and frameworks such as *Te Toka Tumoana*. However, the first model and the third model cannot be easily aligned. This, combined with the ingrained belief of frontline staff, has meant that the child protection model remains pervasive.

The government and the Ministry have acknowledged the need to do things differently, and the five-year transformation programme, including the introduction of new legislation, is intended to achieve that. This was reflected in interviews with senior staff at the Ministry's National Office who acknowledged the failings of the past, and it is also noted in the Ministry's evidence to the Waitangi Tribunal.²⁰⁴

I am aware that the Ministry has a Māori-specific 'end goal'— that the Ministry:²⁰⁵

199 Love and others, above n 173.

200 At 21, referring to Gary Cameron and Nancy Freymond (eds) *Towards positive systems of child and family welfare: International comparisons of child protection, family service, and community caring systems* (University of Toronto Press, Toronto, 2006).

201 Love and others, above n 173, at 21.

202 At 22.

203 At 22.

204 *The Oranga Tamariki Urgent Inquiry* above n 39. See, for example, the affidavit affirmed by Hoani Jeremy Lambert dated 25 March 2020 at [21] where it is stated, 'Since [1 April 2017] Oranga Tamariki has been implementing changes to improve the system previously recognised as fundamentally failing the children of New Zealand'.

205 Affidavit affirmed by Hoani Jeremy Lambert dated 25 March 2020 (Wai 2915, 2020) at [33].



...ensure tamariki Māori thrive under the protection of whānau, hapū and iwi.

To achieve this, the Ministry has developed five mana tamaiti objectives.²⁰⁶

These reflect the object and principles of the Act, as well as obligations under te Tiriti o Waitangi and the United Nations Convention on the Rights of the Child (UNCROC). They are also reminiscent of the strategies Child, Youth and Family described to Judge Michael Brown in his 2000 review of CYF:²⁰⁷

We are implementing a range of strategies to give effect to Government's Closing the Gaps strategy. These include:

- *Maximising kin-based care as the best opportunity to ensure the safety and well-being of Maori children.*
- *Promoting by-Maori-for-Maori service strategies.*
- *Supporting provider development for iwi and Maori providers.*
- *Promoting opportunities for Maori influence in decision-making about outcomes for their own children and young people, and about the service responses required to enhance Maori wellbeing.*

As Judge Brown said:²⁰⁸

It is surprising that these strategies are stated as only just being implemented when they are embedded in the principles of the 1989 Act.

I note that the new Outcomes Framework and the Māori-specific 'end goal' is also similar to the new direction CYF announced in 2001 in response to Judge Brown's report.²⁰⁹

All Māori children will be safe and have opportunities to flourish in their communities.

In 2012, Child Youth and Family reported to the Minister that:²¹⁰

Māori groups in particular report that much more could be done to engage whānau and hapū in the family group conference process. There was a strongly articulate[d] view that whakapapa search needs to be strengthened and practice needs to reflect much more strongly Māori values and traditions. Importantly the criticism coming from

206 Details about the five mana tamaiti objectives are available at <www.orangatamariki.govt.nz/about-us/how-we-work/outcomes-framework/>.

207 *Care and Protection is about adult behaviour*, above n 42, at 79.

208 At 79.

209 Child, Youth and Family *Te Pounamu: manaaki tamariki, manaaki whānau* (Department of Child, Youth and Family Services, December 2001) at 4.

210 Ministry of Social Development REP/12/6/562—*Final Recommendations on Improving Family Group Conferences to Achieve Better Outcomes for New Zealand's Most Vulnerable Children* (Child, Youth and Family, 13 September 2012) at [11].





consultation with Māori was that FGC practice appears to support the aspirations of the social workers primarily and practice needs to reflect a spirit of partnership between the state and families rather than a more adversarial approach which is being described by some Iwi groups and Maori leaders.

In summary, the Ministry has been expected to involve whānau and to improve outcomes for tamariki Māori since 1989. Some are not persuaded that the changes will shift the dominant child protection focus:²¹¹

...while a 'vener' of Māori process has been incorporated into main stream social work practi[c]e and legislative requirements—effective power, including the power of perception, has remained with Social Workers and staff operating within a self-contained, individualistic 'Child Protection' framework.

If the Ministry's transformation programme is to be successful, addressing the barriers of the child protection model will be fundamental.

Green shoots of good practice

Based on the two-year period covered by my investigation, I did find there to be some 'green shoots' of good practice.²¹² In particular, my investigation identified encouraging examples of bicultural, whānau-centred social work practice in two sites my staff visited: Blenheim and Christchurch East.²¹³

There are three concomitant features of these sites that I consider were critical to their relative success at engaging with whānau, hapū and iwi:

- Leadership:
 - Wāhine Māori provide leadership at both sites and they are well connected to their community and have established a team of people with clear mandates and objectives.
- Accountability:
 - Both sites have processes that create accountability to their Māori community through formal partnerships and reporting.
- Specialist Māori roles:
 - These positions are valued and embedded across work streams in the sites.

²¹¹ Love and others, above n 173, at 23.

²¹² The phrase 'green shoots' was used by a senior manager from the Ministry's National Office. It also appears in the Ministry's Annual Report for 2018/19.

²¹³ There are other sites my staff visited where kairāanga were employed. However, although access to kairāanga is an improvement and has been transformative in individual cases, this does not appear to have achieved transformation at a systemic level or achieved the level of engagement with whānau imagined in *Te Pūao-te-Ata-Tū* and described in the objects and principles of the Act.

The Ministry has been expected to involve whānau and to improve outcomes for tamariki Māori since 1989.

My investigation identified encouraging examples of bicultural, whānau-centred social work practice



Both sites have low levels of pēpi coming into care, and those that do are placed with whānau. Neither sites would claim to have ‘solved the problem’. However, at the Blenheim site there is a robust and ongoing relationship with local Māori organisations that continue to challenge the site to do better.

Green shoots of good practice – Blenheim site – a summary

Blenheim has had kairāanga services operating for over a decade. Under the leadership of a manager who both understands and believes in kaupapa Māori approaches, kairāanga and kaimahi at this site expressed security in their ability to perform their roles in a culturally appropriate manner.

This was a description of the Blenheim site in the Ministry’s 2019 evaluation of its specialist Māori positions.²¹⁴

My investigators visited this site and interviewed a number of the Ministry’s staff and members of the Iwi Advisory Committee at that site.²¹⁵ Site data shows that for the two-year period of 1 July 2017 to 30 June 2019 all pēpi subject to section 78 orders were placed with parents or whānau.

Kaye MacDonald was the former site manager at Blenheim and is the Regional Manager for the top of the South Island. She is highly respected by the staff and in the local community. Ms MacDonald has whakapapa links to the local iwi, and the iwi has strongly influenced her career. She has a strong leadership team at the Blenheim site who share a vision for the site. It is a vision that places whānau at the centre of decision making.

Ms MacDonald and the site are accountable to an advisory committee made up of representatives from the Māori Women’s Welfare League and the local iwi. Committee members described a partnership with the Ministry that arose in 2018 because of concern about mokopuna Māori coming into care. They said partnership with the site was possible because Ms MacDonald and other women at the site are ‘part of us’.

The Ministry’s staff and members of the Committee agreed that they are on a path to changing the way the site works with the community, parents, whānau, hapū, iwi and family groups. They did not claim to have solved all the problems they perceived. However, they were optimistic that through the strong leadership at the site and accountability to the community, they would continue to see improvements.

A third factor creating positive change was the expanded use of specialist Māori positions. These are not necessarily held by social workers: instead they are filled by people with other skills and connections to the community. This did challenge the usual ways of working, and there was some resistance initially. The need for the positions is identified by the Ministry in partnership with the Committee as they work together to identify issues and possible solutions. There are currently five specialist positions at the site with input into cases from the initial assessment

214 Love and others, above n 173, at 103.

215 Referred to as an Advisory Board in the 2019 kairāanga pilot evaluation report.



through to placement where it is required, as well one which guides the site in its responsiveness to Māori generally.

While social workers at the site are valued for their social work skills, the people in the specialist Māori positions are valued for their ability to bring *Te Toka Tumoana* to life and embed them in site practice as the principles in that framework are those they live: tikanga, te reo Māori, whakamanawa, wairuatanga, kaitiakitanga, whakapapa, manaakitanga and rangatiratanga.

I note that the Māori Women’s Welfare League (MWWL) is a key partner with the Blenheim site. It is a national organisation but advised that it was unable to reach an agreement with the Ministry about the nature and extent of its involvement at a national level. The MWWL believed that was because of the Ministry’s focus on strategic agreements with iwi.²¹⁶

I have also heard from other Māori who wish to partner with sites to achieve better outcomes for whānau. In particular, Kahui Arahi is a regional Māori navigation group established in Tāmaki Makaurau in August 2018 to inform and guide, and to assure cultural integrity with respect to how the Ministry upholds the rights and interests of Māori and responds to the needs and aspirations of whānau, hapū, iwi, and Māori communities. This group of kaumātua described the responsibility they felt as mana whenua. They have the wisdom of an intergenerational approach and are committed to a solution with whakapapa in the centre. At this stage, the relationship with Kahui Arahi has not resulted in immediate change across all sites in Tāmaki Makaurau. However, Kahui Arahi was confident that they are helping to anchor the Ministry’s regional managers, and then it will be for the individual site managers to permeate change.

Barriers to effective partnership

Although there are examples of the Ministry working in better ways with whānau and a desire by iwi and Māori agencies to do more, these rely on the Ministry being able to partner effectively. I am concerned that at a systemic level there are barriers to this that have continued despite the attempts described above.

The ongoing barriers to effective partnership and improved engagement are, in my view, exemplified by fact that the kairāanga initiative has not been rolled out across the country. Although it was favourably evaluated, I understand that not all sites have kairāanga. During interviews with the Ministry’s staff, there was some confusion about whether the position would be rolled out across the country; some sites were expecting this, but it had not transpired. One site reported that it had not been approved for a kairāanga. Some interviewees, including those at the Ministry’s National Office, identified that sites needed to be ‘site ready’ before kairāanga could be successfully introduced.

I note that ‘site readiness’ was described in the 2019 kairāanga evaluation as one of the challenges in implementation (emphasis added):²¹⁷

216 The Ministry has since advised that it has agreed to enter into a strategic partnership with MWWL.

217 Love and others, above n 173, at 92.



Kairāranga and kaimahi described difficulties feeling accepted and valued in their sites, when other Oranga Tamariki staff were unsure or dismissive of the value of their work and held differing understandings of the objectives, standing and skill sets of kairāranga.

The report also noted the following implementation challenges:²¹⁸

- *Site Readiness*
 - *Leadership*
 - *Resourcing*
 - *Staff understanding of and support for Kairāranga role*
- *Kairāranga involvement in decision making processes*
- *Opportunities for Early Intervention*
- *Hostile Whānau/Whānau Distrust of Oranga Tamariki*
- *Cultural Differences in Practice Styles and Ethics*
 - *Variable wider understandings of kaupapa Māori tikanga and mahi*
 - *Variable terms to describe kairāranga/kaimahi roles*
- *Data Collection Systems and Reporting Protocols*
- *Non-permanent positions limit opportunities and pathways*

Site readiness was also described by the Ministry in an internal document as:²¹⁹

Site readiness factors/conditions for supporting effective practice for working with Maori inclusive of Specialist Maori roles include:

- *Working relationship—An effective working relationship is in place with mana whenua and other iwi and Māori organisations that enables the Kairaranga-a-Whānau and other staff (as appropriate) to work together to achieve safety and wellbeing for tamariki and their whānau*
- *Regional and site leadership—Leadership understands and supports the role of the Kairaranga-a-Whānau by; including the Kairaranga-a-Whānau in the site leadership team, actively promoting the value of Kairaranga-a-Whānau to all staff, and adapting site systems and processes to integrate the Kairaranga-a-Whānau work efficiently and effectively.*

218 At 92.

219 Internal Ministry document dated 29 May 2019 sent to the Ministry's Regional Managers discussing Māori Specialist Roles.



- *Role Clarity—The role and function of the Kairaranga-a-Whānau is understood and supported by all staff and there is clarity about when, where and how the Kairaranga-a-Whānau becomes engaged in the site system.*

In any event, there does not appear to be an agreed national strategy to employ more kairāranga, and even senior Māori managers at the Ministry did not agree on whether it should be a role within the Ministry or if it should sit with iwi.

Moreover, the concept of ‘site readiness’ appears to have been a self-fulfilling impediment to engaging kairāranga—the absence of a working relationship with mana whenua being a reason not to engage a kairāranga is illogical, given that part of the role of the kairāranga was to help build that very working relationship. I note none of the Ministry’s senior staff at its National Office identified a specific strategy to address sites that were considered as not being ‘site ready’.

Challenges related to ‘site readiness’ do not appear to be isolated to the kairāranga role. There have been other pilots to trial new ways of working to improve outcomes for Māori. The evaluations of those pilots have identified some common themes.

In 2018, an evaluation was undertaken of the Mokopuna Ora pilot in Waikato.²²⁰ The strengths and concerns that were identified in that report were similar to those noted in the evaluation of the kairāranga pilot. These included the importance of leadership and vision at the site, and the lack of clarity about roles.²²¹ The report also noted (emphasis added):²²²

*...the overall **lack of cultural understanding, willingness to engage and unconscious bias** among Social Workers and site Managers was a barrier to the effective implementation of Mokopuna Ora.*

Another example was an iwi-led care and protection FGC initiative between Rangitāne o Wairarapa and the Ministry that commenced in July 2017.²²³ The Summary Evaluation Report of this initiative in 2019 identified the importance of relationships between the Ministry and iwi and the community. Further, the report identified tino rangatiratanga and local ministry site champions as critical to the success of the initiative (emphasis added):²²⁴

*...a key tenet of the iwi-led agreement to coordinate FCGs was that Rangitāne would design their own processes and practices. This was fully endorsed by the local site as there was a **clear intention that the iwi-led process and practice should not duplicate the mistakes made by Oranga Tamariki.***

220 Chelsea Grootveld and Timoti Brown *Qualitative Process Evaluation of Mokopuna Ora* (AKO Consultants Limited, June 2018). This report is an evaluation of the Waikato-Tainui Mokopuna Ora partnership with the Ministry. It involved a one-year pilot in 2017/2018 where the Ministry’s social workers referred whānau to iwi-based Support Advisors.

221 At 8.

222 At 12.

223 Michael Roguski *Iwi-led Care and Protection Family Group Conference Evaluation Summary Report* (March 2019).

224 At iii.



...

tino rangatiratanga was synonymously discussed as something that needed to be guarded, a continual process of protecting iwi independence and ensuring tino rangatiratanga was **not eroded by unintentional behaviours and/or policy dictates arising out of Oranga Tamariki** ... the success of the initiative needs to be appreciated in light of a small number of local Oranga Tamariki staff who were acutely aware of the difficulties facing Māori providers and engaged in a rigorous process of 'protecting' Rangitāne from influences that could detract from their practice. Within this context, **the critical importance of champions, based in the local Oranga Tamariki site**, were identified as a critically important.

Another initiative is the appointment of iwi FGC coordinators under an agreement between the Ministry and Te Runanganui o Ngāti Porou. While this initiative focused on youth justice FGC processes, the Summary Evaluation report of the pilot noted (emphasis added):²²⁵

*The opportunity to evolve and grow a truly iwi-led approach was compromised by delays in setting up the project; **lack of communication, engagement and socialization** of the intent of the project with key local stakeholders (including Oranga Tamariki ...); and limited resourcing and flexibility to redesign the FGC process in line with Ngāti Porou values and principles.*

The report also identified a number of learnings which include (emphasis added):²²⁶

- *Ensure collaborations with iwi are premised on **shared principles, values and outcomes and enacted by all parties to the agreement at all levels of the organisation***
- *Enact **sharing of power and control** in relation to sharing data, training, resources and funding to enable joint collaborations to be effective*
- *Identify and mobilise **champions** to socialize iwi-led models **amongst a range of stakeholders***
- *Ensure **leadership supports the integrity of an iwi-led approach** including enabling innovative, flexible and transformative solutions*
- *Allow **sufficient time** for iwi Coordinators to conduct whakapapa searching and hui ā-whānau*

225 Kataraina Pipi, Cain Kerehoma, Roxanne Smith *Summary Report: Formative evaluation of the iwi-led family group conference pilot* (Oranga Tamariki—Ministry for Children, November 2018) at [1.2].

226 At [1.5].



It is clear from the evaluations of various pilots involving specialist Māori roles that endorsement and clear support by the Ministry’s leadership and socialisation with its staff are critical factors.²²⁷

There is significant expertise within the Māori community to support the Act’s expectations that the Ministry engages with whānau, hapū, and iwi. It is not apparent that the Ministry is taking full advantage of this and accessing that expertise in a partnership model at a systemic level, despite the clear effectiveness of the approach demonstrated at a small number of sites through various pilots or initiatives.

There is significant expertise within the Māori community to support the Act’s expectations that the Ministry engages with whānau, hapū, and iwi

Visibility of disabled parents

The factors noted above regarding the child protection model and barriers to effective partnership are in many ways analogous to the Ministry’s engagement with disabled parents. However, I have identified some additional contributing factors.

It is significant that the Ministry’s frontline staff who were interviewed were unaware of the obligations under UNCRC in respect of disabled parents. This is unsurprising, given that none of the training content that the Ministry provided to me referred specifically to this Convention. While there were a number of training documents that referred to disabled children, I did not identify any training content that referred to the rights of disabled parents. I refer also to my earlier comments on the adequacy of the Ministry’s policies and guidance for disabled parents.²²⁸

I acknowledge that the Ministry has staff appointed in the role of Regional Child Disability Advisors, but, again, their focus is on disabled children, rather than disabled parents. While the Ministry’s frontline staff were aware of the Advisors, the Advisors were not consulted in any of the section 78 case files reviewed.

In totality, there does not appear to be any recognition of the rights of disabled parents across the Ministry, or indeed any visibility of those disabled parents. This appears to have contributed to the Ministry’s failure to properly identify and respond to the needs of disabled parents in the context of applying for without notice interim custody orders under section 78.

Impact

The Ministry’s failure to engage effectively and consistently with whānau, hapū, and iwi results in continued trauma and damage to whānau and whakapapa. It may also explain why many continue to be suspicious of, and distrust, the Ministry.

Based on the information I considered, the Ministry did not consistently provide parents of at-risk tamariki with support and referrals to appropriate advocacy services, and did not generally see that as a role it should take, despite

227 Oranga Tamariki—Ministry for Children *Specialist Māori Roles (SMR)—Synthesis of Recent Evidence and Insights* (September 2019) at 22–23.

228 See comments under the heading ‘Needs of disabled parents’ at page 77 of this report.





its statutory obligations to assist whānau. While the Ministry’s frontline staff encouraged parents to address their issues and sometimes made referrals, the parents were, in practice, responsible for engaging and proving to the Ministry that they were not a risk.

However, many of these parents have been systemically disadvantaged because of their ethnicity, disability, trauma from previous experience, or a combination of these factors. The support and services they require to address the Ministry’s concerns—such as residential treatment and parenting programmes—are not always available or, if available, are not always accessible to them in practice. As I have noted under the relevant legal framework, the Ministry is under a duty to promote the establishment of services that are designed to provide assistance to tamariki and their whānau.²²⁹

The disadvantages to these whānau have been amplified by the requirements of the subsequent children provisions in the Act and the Ministry’s guidance on the issue. At interview, the Ministry’s frontline staff talked about the need for parents to show they have changed. I have already explained my concerns about the interpretation of these statutory provisions and the Ministry’s guidance on the matter.²³⁰ For now, it suffices to note the difficulty that the Ministry’s expectations pose for parents who do not have significant support, advocacy and connection with whānau and whakapapa. I have found this to be the case for many of the parents whose pēpi were removed.

I want to acknowledge that the Ministry is operating within a wider system, and there are many aspects that it cannot control or influence alone. However, in the context of this investigation, it is notable that many of whānau were also disadvantaged by low education, poor health outcomes and/or involvement in the criminal justice system.

Early planning

The second key element to ensuring a fair, transparent and reasonable decision making process is planning early. Acting consistently with the principles of the Act (and particularly those requiring engagement with whānau, hapū, and iwi) requires time and expertise so that relationships, understanding and trust can be established. The Ministry has recently acknowledged the importance of planning early in the context of its involvement with newborn pēpi (emphasis added).²³¹

*Whānau and social workers need to be able to come together to share information **at the earliest opportunity** and to take a shared approach to building a plan to achieve safety for te tamaiti.*

...

Many of these parents have been systemically disadvantaged

Importance of planning early in the context of its involvement with newborn pēpi

229 Sections 4(a)-(c) and 7(2)(b)(i) of the Act at July 2017, since amended.

230 See comments under the heading ‘Subsequent children’ at page 70 of this report.

231 Hastings Practice Review, above n 23, at 8 and 31.





When social workers are made aware of concerns before birth they have **a unique opportunity to work with families/whānau and other professionals in advance of the birth to assess parenting capacity, identify and address needs and implement a plan that supports safety.** When social workers are able to begin an assessment early in the pregnancy they are able to explore opportunities to support and enable good ante natal care as well as beginning to engage and work with both parents. This is particularly important for first time parents whose parenting capacity is untested.

These expectations are also reflected in the Ministry's policies, and were confirmed in interviews of the Ministry's staff and third parties.

What should happen

In terms of early planning, there are two relevant timeframes identified in the Ministry's guidance:

- the initial timeframe for completing a Safety and Risk Screen; and
- the timeframe for completing a Child and Family Assessment.

The purpose of the Safety and Risk Screen is to establish the immediate safety of te tamaiti, and should include meeting with the whānau. The timeframe for a Safety and Risk Screen will depend on an assessment of the urgency of the situation when the report of concern is first received, ranging between 24 hours for 'critical' and 20 working days for 'low urgency' cases.²³²

The guidance about timeframes set out in the Practice Centre does not specifically refer to unborn pēpi. It requires staff to consider whether:

- there has been prior Ministry involvement;
- whānau have a history of engaging with services; and
- whānau have the capacity to respond appropriately to tamariki in order to keep them safe.

The purpose of the Child and Family Assessment is to determine whether te tamaiti is in need of care or protection. The timeframe for completing a Child and Family Assessment for tamariki under five years of age is 36 working days.²³³ This assessment process includes a number of steps.²³⁴

- Planning

232 Oranga Tamariki—Ministry for Children *Intake Decision Response Tool* (March 2017) available at <practice.orangatamariki.govt.nz/assets/resources/Templates/intake-decision-response-tool.pdf>.

233 For tamariki over five years of age, the Ministry's timeframe was 43 working days.

234 Oranga Tamariki—Ministry for Children *Assessment and decision making—policy* (1 April 2017); *Assessing Kaitiaki Mokopuna* (15 November 2013); *Undertaking a care and protection assessment* (28 October 2016); *What did we find? Recording findings in child and family assessments and investigations* (1 April 2017); *Child and family assessment or investigation* (1 April 2019); and *Conducting an assessment* (1 April 2019). The current guidance is available at <practice.orangatamariki.govt.nz/our-work/assessment-and-planning/assessments/child-and-family-assessment-or-investigation/>.



- Researching whānau and whakapapa
- Gathering information from a wide range of sources
- Recording analysis in the Tuituia recording tool²³⁵

The Ministry's guidance specifies that the Child and Family Assessment must include direct contact with the parents, significant whānau and other professionals working with them. In addition, the guidance indicates that hui ā-whānau is most effective when initiated as early as possible. If a site has access to kairāanga, the Ministry's current guidance encourages their early involvement to ensure 'tamariki Māori have their right to whānau, hapū and iwi Māori connection met'.²³⁶

The Ministry's guidance on unborn pēpi specifically identifies early planning as critical (emphasis original):²³⁷

Having a family group conference or family/whānau hui prior to birth allows an opportunity to work with the parents and wider family/whānau to identify clear expectations of what is needed in order to ensure that the new baby will be safely cared for.

There is no barrier to holding a family group conference before a baby is born, however a referral for FGC or application for court orders should wait until after 20 weeks when there is less chance of something going wrong in the pregnancy. Assessment and safety planning can occur prior to this.

*Taking a pro-active approach to early planning, **well before the baby is born**, provides the opportunity to:*

- *mobilise support and/or care systems within the wider family/whānau and community so that they are well established by the time baby is born*
- *give parent[s] the opportunity to demonstrate change proven over time before baby is born*
- *support the family/whānau to make stable care arrangements and support early attachment in circumstances where the assessment has shown it is not safe for the baby to remain in [the] parents' care*

235 This is the Ministry's core assessment tool and includes the Tuituia Framework, recording tool and report. For an explanation of this term, refer to the glossary in [Appendix 1](#) at page 201 of this report. Refer also to the comments about the Tuituia Framework under the heading 'Checks and balances' at page 129.

236 This guidance is available at <practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairaranga-a-whanau/>.

237 This is the wording of the Ministry's guidance 'Strengthening our response to unborn babies' (21 January 2015) and effective for the period covered by my investigation. This guidance was last updated on 19 December 2019 but remains largely the same—though the reference to whānau hui was amended to hui ā-whānau. The current guidance is available at <practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/strengthening-our-response-to-unborn-and-newborn-babies/>.



- *have a clear plan to minimise multiple placements for the infant*
- *establish a clear pathway to a 'home for life' for babies who will not be able to remain in their parents' care*
- *when the decision is made for a baby to remain or return home, the plan will have clear goals, be focused on the changes that the parents need to make in order to demonstrate safety, and specific timeframes and contingencies that can be implemented immediately if the main goal is not achievable*
- *utilise the five eyes on under fives as a means of establishing a monitoring and support system around the new born baby*
- *support the parents so that they are prepared to meet the basic needs of the baby when it is born such as adequate housing, access to medical care and safe baby sleeping arrangements*
- *work with health and other providers about exactly what will occur when the baby is born to ensure safety. This can then lead on to further planning when baby is ready to leave hospital.*

During interviews, the Ministry's frontline staff reported they were unlikely to engage with whānau before a woman was 12 weeks pregnant because of the risk of miscarriage. However, once a woman had passed that stage, staff from both the Ministry and the DHBs agreed that it was best to start working as soon as possible with the whānau and the agencies involved with them.

Representatives from the College of Midwives and Nga Maia (Māori Midwives Aotearoa) also emphasised the important role the midwife has in supporting the mother and whānau through the pregnancy. If there are concerns for the wellbeing of pēpi, the College of Midwives said the midwife can walk beside the woman and her whānau, and they should be involved with the Ministry at an early stage.

Interviewees reported that, in some parts of the country, there is limited access to services such as residential parenting courses, disability services and alcohol and drug services. Given the complexity of some of parents' needs, it is important for the Ministry to identify those needs early so that it can put in place appropriate assistance to support their parenting.

It is especially critical that social workers work with specialist experts when they identify potential needs resulting from an intellectual disability or experience of mental distress. In practice, this means taking time to work with whānau and specialists, and potentially engaging in different ways to ensure parents understand the concerns and can be involved in planning next steps.

There was also agreement by those interviewed that hui ā-whānau and FGCs should be held before pēpi was born wherever possible. Care and protection coordinators, who are responsible for the FGCs being held, were particularly keen to hold FGCs as early as possible.



Kairāanga who were interviewed indicated that they needed to be involved early in Child and Family Consults and hui ā-whānau.²³⁸ As stated previously, the role of kairāanga varied from site to site. However, all those interviewed emphasised the need to be brought in early to enable them to undertake their role effectively.

Kairāanga and care and protection coordinators also frequently described the care needed to identify and bring whānau together. They noted this was not always easy, as parents were often disconnected from whānau, and some were resistant to involving wider whānau. Kairāanga said it was important to have time to spend researching whānau and to bring in people who might be able to support the family. Kairāanga also described the negative way whānau perceived the Ministry, and that time was required to build relationships and trust.

In an evaluation of the use of kairāanga, the following comments were made about their early involvement:²³⁹

There was a consensus amongst kairāanga and kaimahi that early involvement—from initial notification and assessment—was where their involvement should begin. Some sites had successfully implemented front-end processes where kaimahi were involved in initial assessments.

...

Early involvement of kaimahi/kairāanga will bring positive outcomes for tamariki/whānau because they ensure active participation of tamariki/whānau from the beginning.

What is typically happening

I accept that if the Ministry only becomes aware of the pregnancy at the time of the birth, or if the birth occurs unexpectedly early, the Ministry might need to take steps quickly to assure immediate safety of these pēpi before they have an opportunity to fully engage and plan with the whānau and professionals involved.

However, this was the situation in only five of the 74 cases I reviewed.²⁴⁰ While I found some instances where the Ministry worked hard to take advantage of the window of opportunity during the pregnancy, on a systemic level the picture was very different.

While neither pregnancies nor social work are mathematical exercises, in a practical sense my assessment of whether the Ministry is planning early has focused on whether it is meeting its own timeframes, and how early in the

238 This is a tool used by the Ministry during its care and protection assessment. For an explanation of this term, refer to the glossary in [Appendix 1](#) at page 201 of this report. Refer also to the comments about the Child and Family Consult under the heading 'Checks and balances' at page 129.

239 Love and others, above n 173, at 84.

240 Four of the cases were not known to the Ministry at all until the birth was imminent or had occurred; in the remaining case, another site had been aware of the pregnancy but had been unable to contact the mother.

process the Ministry engaged with whānau. I have also looked at how early social workers were involving kairāanga, since this is identified in the Ministry's guidance as critical.

Formal timeframes

As noted above, the timeframes the Ministry works to are working days. A pregnancy of 36 weeks is approximately 180 working days. As previously stated, the Ministry generally does not become actively involved with a pregnant woman before she is 12 weeks, or around 60 working days, pregnant.

I accept that the Ministry can only respond and plan early if it knows about a pregnancy early. As shown in [Figure 7](#), in 6 cases (around 8 percent) the Ministry was only made aware of the pregnancy within 20 working days of the birth. In 57 of the 74 cases (77 percent) of the cases I reviewed, the Ministry had over 60 working days to engage and develop plans with the parents and whānau.²⁴¹ In 18 out of the 74 cases (24 percent), there was more than 120 working days to do so.²⁴²

Working days between the Ministry becoming aware of pregnancy and birth

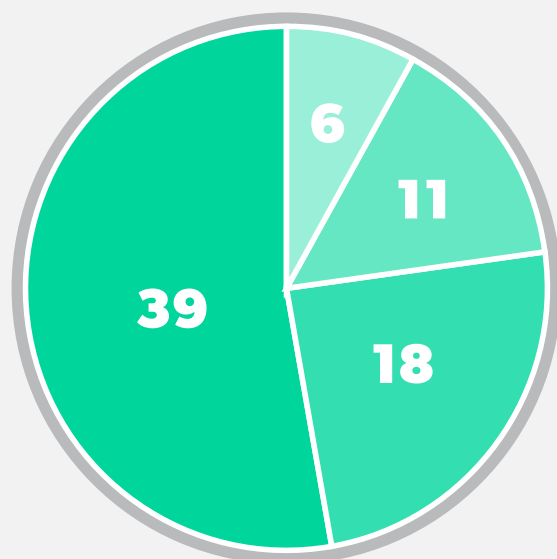
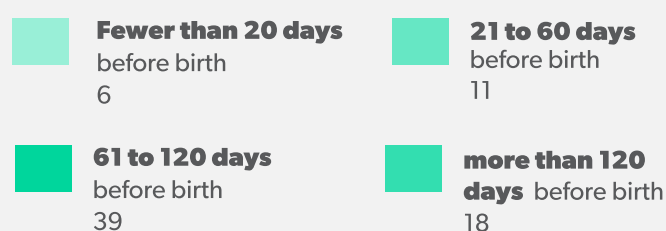


Figure 7: Working days between the Ministry becoming aware of the pregnancy and birth

241 This includes 39 cases that had between 61 to 120 working days as well as 18 cases that had more than 120 working days.

242 Refer to [Table 6](#) at page [222](#) of this report.

As noted above, the Ministry sets various timeframes for completing the Safety and Risk Screen—from 24 hours to 20 days, depending on the urgency of the case. Table 7 in Appendix 4 shows that 45 of 74 cases (61 percent) were assessed (either initially or following review) to be ‘low urgency’, requiring a Safety and Risk Screen within 20 working days.²⁴³

As shown in Figure 8, I found that the Ministry met the timeframes for completing the Safety and Risk Screen in 58 of 74 cases (78 percent). Additionally, in 35 cases, the Safety and Risk Screen was completed in less than a working week.

Safety and Risk Screen timeframes

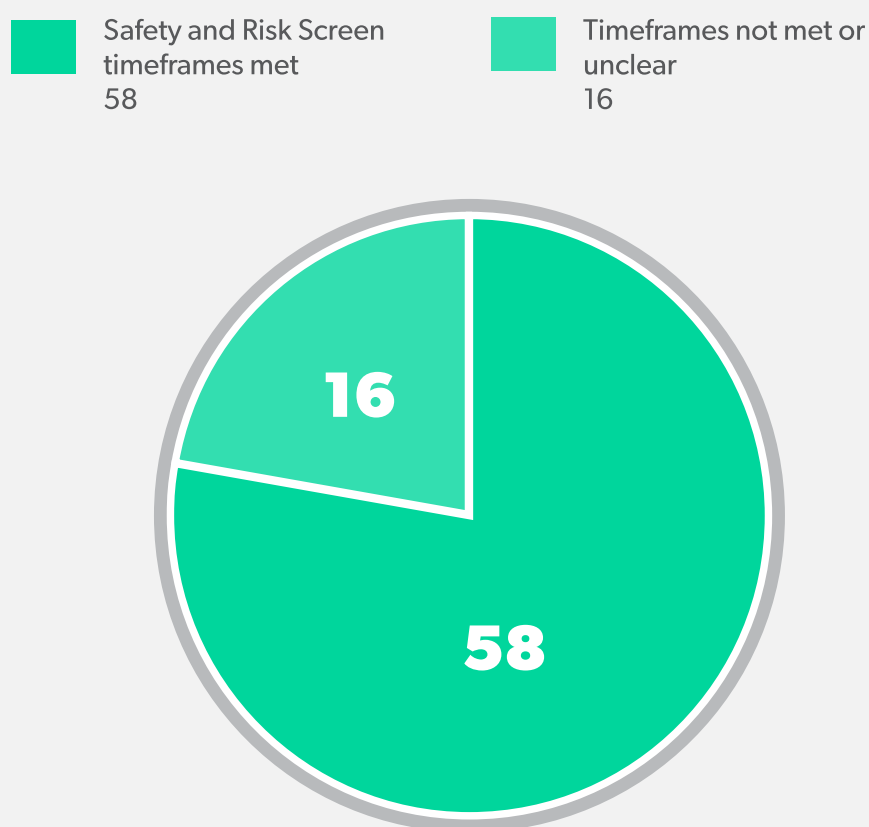


Figure 8: Safety and Risk Screen timeframes

The second timeframe is for the Child and Family Assessment, which is 36 working days. Finding a precise date for the end of the assessment was not straightforward. The Ministry’s case management system recognises an ‘*investigation phase*’, and records a start date and an end date. I understand the ‘*investigation phase*’ is another term for the ‘*assessment phase*’. This should end near the time the Tuituia report is completed.

243 Refer to Table 7 at page 222 of this report.

However, that was not always the case in the files I reviewed. In some instances, the Tuituia report was not completed at all, or was completed during an earlier or later phase. Therefore, I have provided analysis of the timeframes for the investigation phase in [Figure 9](#), as well as the time taken from starting the investigation phase to completing the first Tuituia report (where one was completed) in [Figure 10](#).^{244 245}

Working days taken to complete Child and Family Assessment from investigation phase

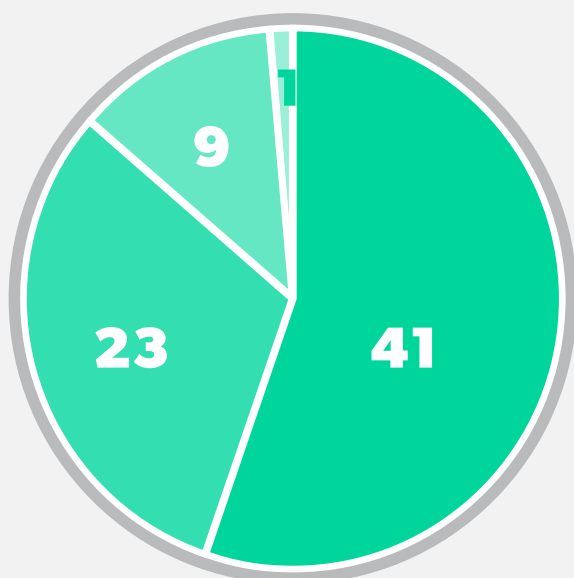


Figure 9: Working days taken to complete Child and Family Assessment from investigation phase

On this measure, in around two-thirds of the 74 cases I reviewed, the Ministry did not meet its own timeframes for completion of the assessment, with 55 percent (41 cases) taking longer than 50 working days to complete the assessment phase.

244 Refer also to [Table 8](#) and [Table 9](#) at page 223 of this report.

245 The Ministry's guidance indicates that the Tuituia record should be updated as new information is received and circumstances change.

Working days taken to complete Child and Family Assessment from investigation phase to Tuituia completion

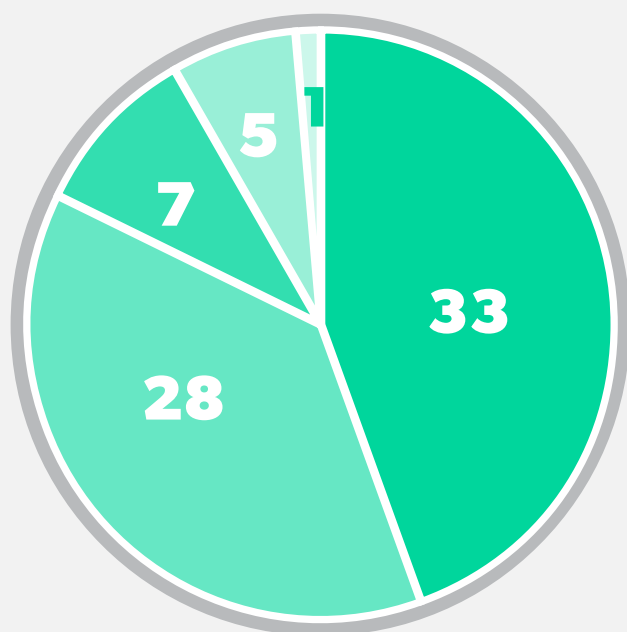
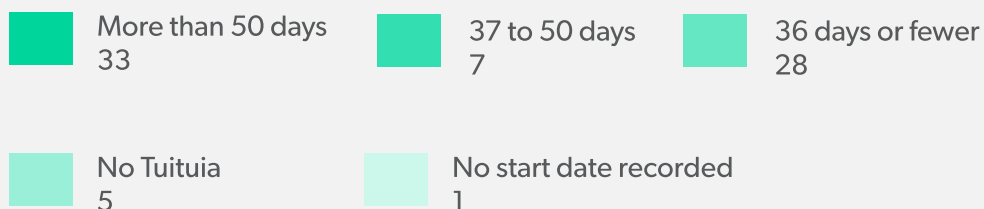


Figure 10: Working days to complete Child and Family Assessment from investigation phase to Tuituia completion

Even measured this way, the Ministry did not meet its own timeframes in around half of all cases.

In a further 5 cases (7 percent), it was not possible to tell whether the assessment timeframe was met, either because of the lack of a start date or due to failure to complete the Tuituia report. In one of those cases, it was not possible to complete a Tuituia report before pēpi was born, because the report of concern was only made on the day of the birth. However, in the other four cases, the Ministry was aware of the pregnancy between 31 and 81 working days before the birth.

As with the previous measure, there is still a high percentage (45 percent) of assessments taking more than 50 days to complete.

Engagement with whānau

Hui ā-whānau and FGCs are designed to assist whānau to understand concerns, receive information, and make decisions. Again, best practice suggests that both should occur before pēpi is born.



As noted previously, [Figure 3](#) shows that there was no record of hui ā-whānau in 41 of the 74 cases I examined.²⁴⁶ Where hui ā-whānau were held, they were more likely to occur after birth for Māori pēpi than for non-Māori.²⁴⁷ In 51 of the 74 cases, FGCs were held after birth, which was not in accordance with best practice.

Despite the Ministry being aware in 77 percent of cases of the pregnancies more than 60 working days before the birth, there was a low number of cases where hui ā-whānau (16 cases, or 21 percent) and FGCs (21 cases, or 28 percent) were held before pēpi was born. This finding is consistent with the Ministry's *s78 Casefile Analysis*. That review showed:²⁴⁸

- FGCs were held prior to entry to care in only 15 percent of cases; and
- hui ā-whānau were used in 20 percent of cases in sites which had partnered with iwi/Māori, but were used in only 13 to 15 percent of cases in other sites.

The Ministry's analysis also identified that partnered sites used other methods to share the concerns with whānau and family in all but 3 percent of cases. This contrasts with nonpartnered sites where, in 25 percent of cases, there was no evidence of sharing concerns with whānau through any means.

In summary, in the majority of cases, the Ministry did not engage with whānau and family in hui ā-whānau and FGCs early enough in the pregnancy and in accordance with its internal timeframes and expected practice.

Involvement of kairāranga

As stated earlier, kairāranga or similar roles were available in six of the Ministry's sites visited.

The level and timing of involvement of kairāranga were different depending on which site they worked at. In the sites where the role was well established, kairāranga spoke positively about sitting within the social work team and identifying cases where they could assist at an early stage. Due to the small number of section 78 cases at these sites, it is difficult for me to draw any conclusions from them.

In sites where the kairāranga role was not as well established, there was little evidence on case files that they were involved early. My investigation found that, for those sites, kairāranga said they were less likely to be involved early, either because of workload or because social workers were reluctant to involve them, despite the Ministry's guidance.

Accordingly, although there was evidence of some early involvement of kairāranga, I do not consider this practice was well established at a systemic level across sites for the period of my investigation.

246 Refer to page 96 of this report for [Figure 3](#).

247 Refer to [Table 4](#) at page 221 of this report.

248 Refer to [Figure 22](#) and [Figure 23](#) at page 255 of this report; and *s78 Casefile Analysis*, above n 20, at 13–14.



Across the case files reviewed and the sites visited, it is clear that the Ministry was not utilising the opportunities it had to assess and plan early with whānau.

Contributing factors

I have identified two main factors, discussed in detail below, that appear to have contributed to the Ministry's failure to plan early.

- High workloads and competing priorities
- A focus on immediate safety

Other factors have also had an impact, and these are discussed in detail elsewhere in my report. These are:

- the child protection model;²⁴⁹
- the establishing, resourcing and support for the kairāanga role;²⁵⁰ and
- a poor understanding of the law, particularly in relation to the requirements of the subsequent child provisions.²⁵¹

High workloads and competing priorities

Social workers who were interviewed spoke about high workloads. However, many also said they felt comparatively better resourced and supported in the newly formed Ministry.

Interview with Ministry staff member

We're two social workers short and the cases that we have are quite complex, so it would be good for people to have lower caseloads ... we have an unallocated caseload ... We're always trying to say 'what can we close, what can we close' ... people have too much work.

Interview with Ministry staff member

It was a really tough environment back then, much tougher than it is now. We're so much better resourced now than we were.

249 Refer to comments under the heading 'The child protection model' at page 105 of this report.

250 Refer to comments under the heading 'Barriers to effective partnership' at page 110 of this report.

251 Refer to comments under the heading 'Understand and comply with law' at page 152 of this report.



Some interviewees from the Ministry's sites my staff visited advised that 20 tamariki should be the maximum caseload, except for new social workers, who should have fewer.²⁵² It is my understanding that caseloads refer to the number of individual tamariki allocated to a social worker as the key worker.

As part of embedding the Ministry's new Practice Standards, each of its care and protection sites undertook a Practice Check in 2018. This revealed caseloads as follows for the sites that completed the review.

Site	Caseload range
Blenheim	9 – 50
Central Otago	14 – 29
Manawatu	14 – 55
Mangere	17 – 92
Nelson	14 – 38
Otago urban	14 – 55
Otara	18 – 61
Pukekohe	18 – 74
Rotorua	8 – 40
South Canterbury	0 – 35
Taranaki	22 – 50
Taupo	15 – 54
Tautahere	1 – 55
Te Kaipara	5 – 50
Teaotahi Whangarei South	16 – 40
Tokoroa	11 – 78
Whanganui	14 – 48
Christchurch East	16 – 35
Kaikohe	20 – 65
Southland	11 – 49

In their Practice Checks, many sites referred to staffing pressure. For example, it was reported.²⁵³

Over the last year, the site has carried a number of vacancies and has also been impacted by sick leave, adding to workload pressures on staff.

...

Kaimahi at [site] are caring and committed to supporting each other in a whānau-orientated way, however, at times they feel overwhelmed with the pressures of work and their high case loads.

252 At interview, the Public Service Association (PSA) referred to the 2015 collective agreement, which set 20 as a high number for a caseload. The PSA also referred to its casework and workload survey of its members in 2018. The results of that survey included a reported average number of children on a social worker's caseload was 33, with a quarter of care and protection social workers having responsibility for 42 or more children. The PSA noted this was only children where the social worker was allocated as the key worker, not those where they were co-working cases.

253 These quotes are examples from the various Practice Checks completed in 2018.



During the period of this investigation, some sites were operating a model where teams worked across all phases of a case. For example, a social worker may have been responsible for assessments as well as managing placements of tamariki. In this model, frontline staff may have also been responsible for a variety of tasks, including attending FGCs to review plans and writing plans for Court. In these circumstances, the staff member was likely to be balancing the competing priorities of the urgent and immediate care and protection needs of other tamariki with the future needs of an unborn pēpi.

I understand that the Ministry has since changed its operating model so teams are responsible for specific phases. Now, one team will carry out the Child and Family Assessment, handing over to another team once the section 78 is granted to manage the placement. I appreciate that this new system is still bedding in, and it is hoped that it will assist with balancing of priorities and improving timeliness.

High workload was also raised as an issue for kairāanga in many of the sites visited. This was not always the case in the sites visited where kairāanga were well established and working as part of a team. However, where there was only one kairāanga operating in the absence of any other specialist Māori roles, there was often more need for the expertise kairāanga had to offer than they had time.

Interview with kairāanga

It [the kairāanga-a-whānau role] needs to be full-time, it needs to be a full-time role and it needs to be flexible in terms of how you work because ... probably the best way you can engage with Māori whānau is outside of 9 to 5 ... the whānau can see that you're actually committed ... to go the extra mile to engage with them.

I have previously commented on the successes of two sites my staff visited in embedding the kairāanga role within their processes and the transformative effect that can have. The Practice Centre has appropriate policies and guidance that promote the involvement of kairāanga at an early stage. Despite this, kairāanga were neither established nor accepted in all sites, undermining their ability to be the natural starting point in all cases with whānau.

A focus on safety in the present, rather than wellbeing

Connected with the competing priorities is the focus on immediate safety. It was apparent that frontline staff felt an at times overwhelming burden of responsibility for the safety of tamariki in their caseload. Understandably, tamariki at immediate risk of harm to their physical safety would be the top priority for staff. Given competing priorities, this has resulted in a default deprioritising of unborn pēpi. The low priority these pēpi were accorded is confirmed by the response timeframes I observed in the 74 cases I reviewed—the vast majority being identified as 'low urgency'.



Impact

The failure to plan early results in limited time for the Ministry to engage with parents and whānau to identify solutions that support the safety and wellbeing of pēpi.

In 77 percent of the cases I examined, the Ministry had over 60 working days to engage and develop plans with the parents and whānau before the birth of pēpi. However, many whānau were not involved early enough to participate in the decision making and identify solutions. This is in part because of the delays in completing assessments. In all measurements, as indicated in the figures above, Māori were worse off, as they were less likely to have assessments completed on time and have hui ā-whānau and FGCs before the birth of pēpi. As a result, whānau were deprived of having the opportunity, and the information, to contribute to making good decisions about their pēpi. This is contrary to the objectives and principles of the Act and the obligations under international law.

In some cases, it may have been unavoidable that when pēpi were born, they could not stay in the care of their parents. In other cases, parents may have only been able to care for pēpi with support in the home. In either case, the failure to plan early means there was limited opportunity to identify and assess caregivers or supportive people within the whānau, hapū, iwi, and family group who may have been able to care for pēpi.

Given the complexity of some of the parents' needs, the lack of early planning also means that their needs were not being identified by the Ministry to ensure appropriate supports were in place.

Moreover, my investigation has found that the role of kairāanga was not systematically being utilised and supported in accordance with the Ministry's expected practice. Where kairāanga are not brought in early to find whānau and whakapapa, this negatively affects the rights of pēpi and parents. In the long term, it is likely that this will lead to further alienation and disconnection.

The failure to consistently adhere to expected screening and assessment timeframes raises serious questions about the 'urgent' basis for which the Ministry has **routinely** sought without notice interim custody orders in respect of newborn pēpi. The lack of early planning means that the Ministry was less able to identify other suitable options, apart from interim custody. I will discuss the use of interim custody orders under section 78 in detail later. However, I note it is meant to be a measure of last resort where all other options are excluded. Given the impact of the failure to plan early, I am concerned about the overall reasonableness of the Ministry's decision making.

I consider the failure of the Ministry to consistently plan early for the safety and wellbeing of pēpi to be an enormous missed opportunity. Where the Ministry is notified of an unborn pēpi at risk, there is a unique window that is unavailable in other cases. This window enables Ministry to intervene to assist parents, engage whānau, and work proactively in advance of the birth. That this opportunity had not been appropriately engaged is, in my view, a serious failing of the Ministry.

In all measurements, ...Māori were worse off.

The role of kairāanga was not systematically being utilised and supported

I consider the failure of the Ministry to consistently plan early for the safety and wellbeing of pēpi to be an enormous missed opportunity.





Checks and balances

The third key element to ensuring a fair, transparent and reasonable decision making process is having robust checks and balances. In the context of removing newborn pēpi, this is essential. The nature of the powers and duties of statutory social workers, including the fact that engagement with whānau is typically non-voluntary, requires strong mechanisms to ensure accountable practice that meets regulatory, professional and organisational standards.²⁵⁴

What should happen

As set out in the Practice Centre and confirmed in the Hastings Practice Review, the Ministry expects that assessment and decision making will involve the following key mechanisms and processes that are *'designed to promote safe statutory practice and to ensure a culture of accountability, reflection, challenge and transparency'*:²⁵⁵

- Consultation with a Care and Protection Resource Panel (a legislative requirement)
- Child and Family Consults
- Legal consultation
- Partnering with external professionals, iwi, and organisations
- Tuituia Assessment Framework²⁵⁶
- Professional supervision

The effective use of each of these mechanisms across the Ministry's assessment process offers different opportunities for internal and external scrutiny. It enables the Ministry to identify potential bias, subjectivity, 'blind spots', and gaps before final decisions and recommendations are made.

Care and Protection Resource Panel

The Ministry is legally required to consult with a Care and Protection Resource Panel (CPRP) in relation to an investigation as soon as practicable after an investigation has commenced.²⁵⁷ In addition, it must consult with a CPRP before convening any FGC.²⁵⁸ Where no agreement is reached at an FGC, the Ministry must consult with a CPRP again.²⁵⁹

254 Hasting Practice Review, above n 23, at 17.

255 At 11.

256 Also referred to as the Tuituia assessment or recording tool.

257 Section 17(1)(b) of the Act. See also the glossary in Appendix 1 at page 201 of this report for an explanation of CPRP.

258 Section 21 of the Act.

259 Section 31(1)(e) of the Act.



CPRP functions include providing advice to the Ministry’s staff on the exercise of their functions, powers and duties,²⁶⁰ and promoting the coordination of services by the community to tamariki in need of care or protection and their families and family groups.²⁶¹

The Practice Centre includes information to support the Ministry’s staff in understanding the purpose and requirements of attending the CPRP, as well as the type of information they could take to the CPRP to help it provide the right advice (for example, Child and Family Consult, Safety and Risk Screen).²⁶² Because of the CPRP’s broad community focus and expertise in specialist areas, it can assist in working with whānau and inform assessment and decision making.

The Ministry has reiterated the importance of the CPRP in the following terms:²⁶³

When these panels effectively represent local communities (particularly local iwi/Māori) and the broader child wellbeing sector, they can provide a useful professional challenge to social workers’ thinking and open up alternative strategies and solutions to address tamariki safety.

Child and Family Consult

The Ministry’s guidance requires the use of the Child and Family Consult during the care and protection assessment to inform the analysis and next steps (emphasis added).²⁶⁴

*The Child and Family Consult process supports robust, open and transparent decision making, brings a range of experience and expertise to complex issues and can be an effective mechanism to **involve other professionals and agencies directly in decision making— all of which are important mitigators to the isolated use of statutory powers.***

According to the Practice Centre, the Child and Family Consult is a tool intended to help structure thinking about what is happening in the whānau, taking into account issues such as dangers, strengths, complicating factors, and areas of ambiguity. The consult process seeks to balance out a focus on risk with the strengths of the whānau.²⁶⁵

The aim of the approach is to increase safety for the child or young person by utilising the strengths and resources that the family/whānau has, to address the areas of danger or harm.

260 Section 429(a) of the Act.

261 Section 429(c) of the Act.

262 This information is available at <practice.orangatamariki.govt.nz/practice-standards/work-closely-in-partnership-with-others/care-and-protection-resource-panel/>.

263 Hastings Practice Review, above n 23, at 53.

264 Above n 23, at 11.

265 Oranga Tamariki—Ministry for Children *Child/young person and family consult guidelines* (22 September 2013). This guidance was updated on 1 April 2019 and is available at <practice.orangatamariki.govt.nz/our-work/practice-tools/other-practice-and-assessment-tools/childyoung-person-and-family-consult/>.



The Ministry’s guidance is clear that the Child and Family Consult must be used when removal from home is considered. However, the consult should be considered for use throughout the process of assessment, planning, intervention, and review, to assist analysis and decision making.

Further, the Child and Family Consult may be used in a variety of ways. For example, the use of a group consult process provides additional practice strengths and possibilities including robust, open, and transparent decision making, a range of expertise and experience, and it builds professional capacity.²⁶⁶ Additionally, regardless of the method, the Ministry guidance is clear that a written record of the consult must be transferred into the Ministry’s case management system, CYRAS.

Legal consultation

The Ministry has a team of solicitors at its National Office, and regionally across Aotearoa connected to each of its sites. As well as providing legal advice to social workers, they also represent the Ministry in court proceedings. When the Ministry considers that court action is necessary to secure the safety of a child, and when considering urgent court action, the Practice Centre stipulates the importance of frontline staff consulting with the Ministry’s solicitors about the particular order to apply for.

During the interview with the Ministry’s Chief Legal Advisor, she expressed an expectation that the Ministry’s solicitors would routinely attend any case consult that led to a decision to apply for a without notice interim custody order, and that there would be a clear record of the legal advice provided. The Practice Centre also identifies that the social worker must consult with a solicitor in cases involving the subsequent children provisions of the Act (sections 18A to 18D).

Legal consultation is designed to ensure that proposed court applications are warranted, appropriate procedures have been followed, and other alternatives have been sufficiently explored. It is also intended to ensure that the Ministry acts in accordance with the legislation and challenges proposed actions by frontline staff that are inconsistent with the law.

Partnering with external professionals, iwi, and Māori organisations is pivotal to the quality of the Ministry’s assessment and decision making

Partnering with external professionals, iwi and organisations

The Practice Centre identifies that the assessment process must include consultation with professionals working with te tamaiti and whānau, hapū, and iwi. This is in accordance with the obligations under te Tiriti o Waitangi, as noted by the Ministry.²⁶⁷

Statutory practitioners are required to work in partnership with Māori in ways that support their participation and protection as indigenous people in matters that concern them.

266 This information is available at <practice.orangatamariki.govt.nz/our-work/practice-tools/other-practice-and-assessment-tools/childyoung-person-and-family-consult/>.

267 Hastings Practice Review, above n 23, at 18.





Working in partnership with professionals, iwi, and external organisations is an expectation of the Ministry's Practice Standards 'Work closely in partnership with others' and 'Whakamana te tamaiti'.²⁶⁸

It is also a minimum expectation of the Social Workers Registration Board's (SWRB) Core Competence Standards and, in particular, the standard 'Competence to promote empowerment of people and communities to enable positive change'. This identifies that a competent social worker 'effectively collaborates and engages with others and works in partnership with clients to gain access to resources'.²⁶⁹

Further, the Ministry has identified that:²⁷⁰

When working with whānau Māori, social workers should particularly seek to work closely with professionals within iwi and from other Māori organisations who can support and strengthen culturally safe ways of engaging with whānau.

Partnering with external professionals, iwi, and Māori organisations is pivotal to the quality of the Ministry's assessment and decision making, as it ensures that there is a holistic understanding of needs, and that key people are involved in significant decisions for pēpi. The connections and relationships external organisations have established with whānau mean that their involvement is highly relevant to ensuring the safety and wellbeing of pēpi (emphasis added).²⁷¹

*Practitioners outside of Oranga Tamariki can assist in the effective practice of whakamana te tamaiti. They are often **better positioned to engage and build meaningful relationships with whānau who access these services by choice.** Māori NGOs often bring different and valuable perspectives, grounded in a restorative approach and underpinned by a Māori-principled worldview. **They may also make use of cultural practices that are familiar and safe for whānau Māori. As a result, whānau may be more likely to be open about their aspirations, challenges and successes with these practitioners.** When these insights are available, Oranga Tamariki social workers can gain a richer view of how whānau are progressing and it can [often] help inform consideration of if and how the safe care of tamariki can be realised.*

268 Refer to comments under the heading 'Practice Standards' at page 63 of this report. Further information is available at <practice.orangatamariki.govt.nz/practice-standards/>.

269 The Social Workers Registration Board Core Competence Standards are available at <swrb.govt.nz/social-workers/competence/core-competence-standards/>.

270 Hastings Practice Review, above n 23, at 44.

271 Hastings Practice Review, above n 23, at 39.



Tuituia Framework

The Tuituia Framework (and its associated tools and reports) is the Ministry's core mechanism for staff undertaking a Child and Family Assessment.²⁷² It brings together all key information to analyse the needs, strengths and risks for pēpi and their parents, across three central domains.

- Mokopuna ora: holistic wellbeing
- Kaitiaki mokopuna: the parent's or caregiver's capacity to nurture
- Te ao hurihuri: whānau, social, cultural and environmental influences

The Ministry's social workers are responsible for completing the Tuituia assessment report in consultation with other professionals. This Tuituia report evidences the Ministry's assessment and decision making process and is the written record of an assessment at a given point in time. It should provide the reasons leading to the outcome of the Child and Family Assessment and the recommendations made.

The Ministry's guidance requires that a Tuituia report should always be completed before an intervention, including a referral to FGC or court proceedings. In the case of the FGC, it is necessary to assist the care and protection coordinator to understand the issues and the views of those involved, as well as giving a clear explanation of the social worker's concerns. In relation to court proceedings, the framework prompts the Ministry's staff to evaluate the evidence and satisfy themselves that an application for interim custody is justified.

As well as informing the intervention, the Tuituia assessment is then used to inform placement decisions, ongoing work with te tamaiti, their whānau, caregivers, and other agencies.

I have not assessed the efficacy of the Tuituia Framework (or its associated tools and report) in detail as part of this investigation. However, I am aware that the Ministry is reviewing whether it is fit for purpose, as indicated in its correspondence with my Office in August 2019:

We will be undertaking a review of the Tuituia Assessment Framework. The purpose of the review is to determine whether the Framework remains fit for purpose in the context of our new legislative framework and in particular the Section 7AA of the Oranga Tamariki Act 1989 and the new wellbeing provisions. We will also be considering whether it supports rigorous, inclusive and effective decision making across all elements of our operating model. This is in the early stages of scoping.

Professional supervision

Supervision is a requirement for registration as a social worker. The SWRB identifies professional supervision as an essential element to ensuring competent social work practice and quality service provision. The SWRB also

272 Information about this framework is available at practice.orangatamariki.govt.nz/our-work/practice-tools/the-tuituia-framework-and-tools/the-tuituia-framework-and-domains/.



identifies that supervision promotes safe and accountable practice and *'inclusive practice underpinned by te Tiriti o Waitangi, responsiveness to Māori, and sound ethical principles'*.²⁷³

Professional supervision is also one of the Ministry's Practice Standards. The Ministry expects its staff will use supervision to:²⁷⁴

- critically reflect on their practice to ensure that their decision-making is robust;
- advise and guide;
- challenge and support practice;
- create space for critical reflection; and
- support safe cultural engagement and practice with Māori, and with Pacific and other diverse cultures in Aotearoa.

The expectations of the frequency of supervision are one hour per week for social workers with less than 12 months of experience in the Ministry, and one hour per fortnight for social workers with more than 12 months of experience. For the renewal of a practising certificate, the SWRB expects that a social worker will access regular and appropriate supervision at least monthly.

The Ministry's guidance requires that for each supervision session, supervision records are to be created and retained that capture discussion and agreed action, and provide evidence of attendance. The Ministry has recently commented on professional supervision in the following terms (footnote omitted):²⁷⁵

Professional supervision plays a critical role in safe social work practice as it promotes professional competence, accountable and safe practice, continuing professional development, critical reflection, and practitioner wellbeing. Practitioners are required to exercise their professional judgement in complex circumstances and sometimes amidst apparently competing or contradictory objectives and opinions.

The Ministry's guidance specifically identifies that cultural supervision supports its staff to be more effective in working with Māori and tamariki and whānau from diverse backgrounds. It is intended to ensure that practices are culturally responsive.²⁷⁶

273 The Social Workers Registration Board's policy "Supervision expectations for registered social workers" sets out principles of supervision and the SWRB's expectations of registered social workers in respect of supervision. The policy is available at <[swrb.govt.nz/about-us/policies/](https://www.swrb.govt.nz/about-us/policies/)>.

274 Oranga Tamariki—Ministry for Children *Professional Supervision—Policy* (effective 1 July 2017); *Use professional supervision* (8 November 2017); *Use professional supervision—guidance* (8 November 2017); *Cultural supervision* (28 November 2018); *Professional supervision* (1 April 2019); and *Professional supervision practice standards* (1 April 2019). The Ministry's current guidance (22 June 2020) is available at <practice.orangatamariki.govt.nz/policy/professional-supervision/>.

275 Hastings Practice Review, above n 23, at 52.

276 Oranga Tamariki—Ministry for Children *Cultural supervision* (28 November 2018). The current guidance is available at <practice.orangatamariki.govt.nz/practice-standards/use-professional-supervision/cultural-supervision/>.

What is typically happening?

My investigation has found gaps and variability in the Ministry's adherence to important checks and balances on its assessment and decision making. [Figure 11 below](#) provides a high-level summary of the extent to which the section 78 case files I reviewed demonstrated the use of the processes discussed above.²⁷⁷

Overview of compliance with required key mechanisms

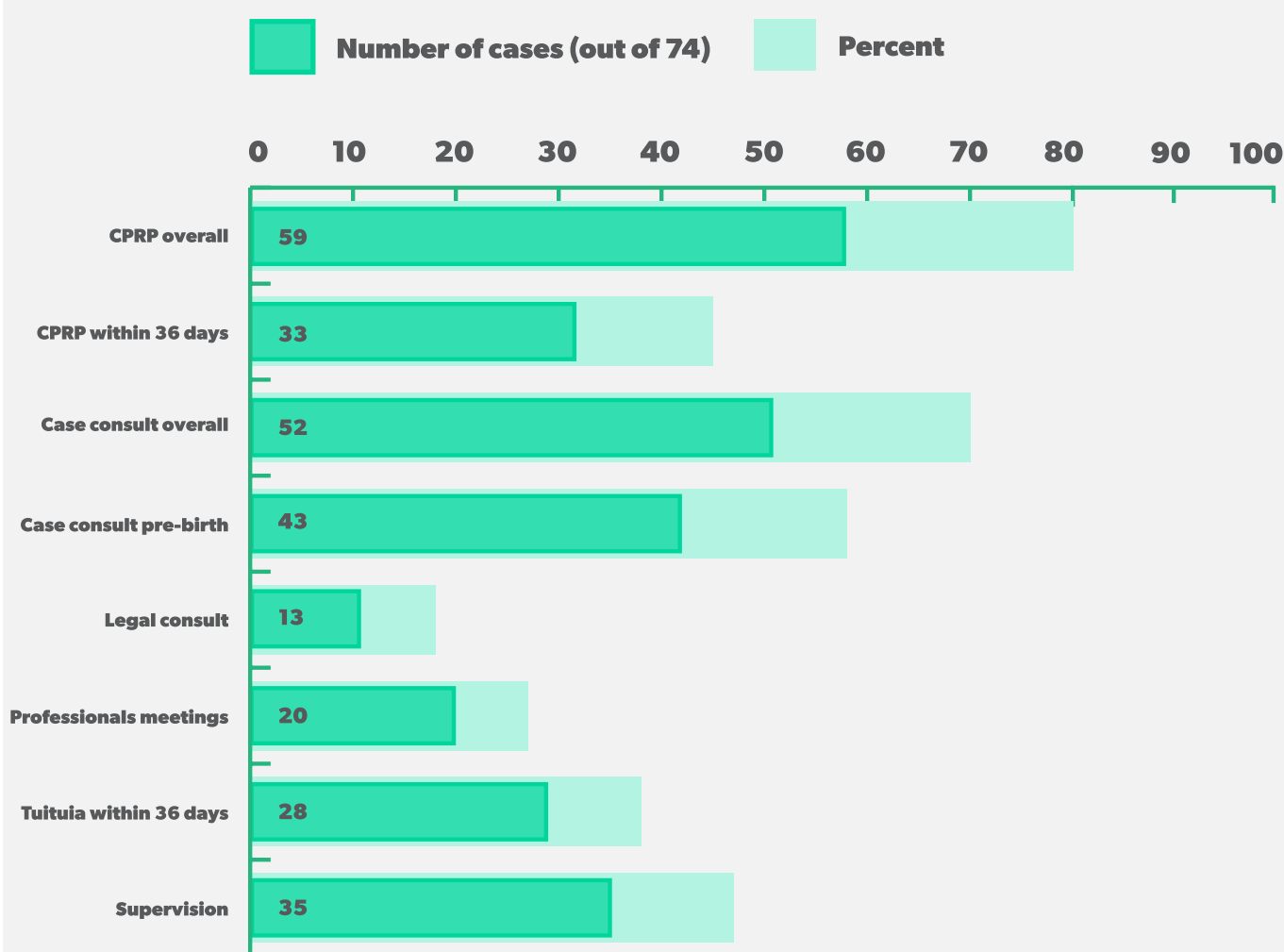


Figure 11: Overview of compliance with required key mechanisms



²⁷⁷ Refer also to [Table 10](#) at page 224 of this report.



Care and Protection Resource Panel

As shown in [Figure 12](#) of the 74 cases assessed, 80 percent (59 cases) were reviewed by a CPRP. Twenty percent (15) of cases had no record of the case being considered by a CPRP even though it is a legislative requirement.²⁷⁸

Evidence of CPRP consults

 CPRP consult held 59	 No evidence of CPRP consult 15
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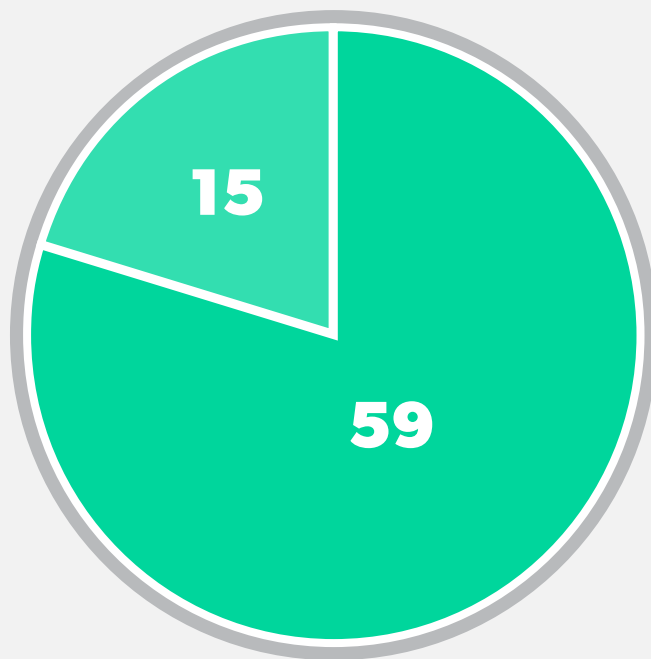


Figure 12: Evidence of CPRP consults

These findings are similar to those in the Ministry’s *s78 Casefile Analysis*. That review found that 76 percent of sampled cases went to a CPRP.²⁷⁹ However, the Ministry did not examine whether it was presenting cases to CPRPs ‘as soon as practicable’ in accordance with legislative requirements.

The Ministry’s guidance is unclear as to how it interpreted the ‘as soon as practicable’ requirement prior to the shift to its new intake model in 2019–2020.²⁸⁰ This question was put the Ministry and it has advised that (emphasis added):

278 Refer also to [Table 11](#) at page 224 of this report.

279 *s78 Casefile Analysis*, above n 20 at 12.

280 The timeframe for CPRP meetings is also unclear. Interview feedback appeared to indicate that CPRPs met fortnightly or every 10 working days. However, the Ministry’s policy states that CPRPs must meet on ‘a regular basis’.





The timeframe set out by the decision response tool refers to the timeframe for sighting tamariki and establishing their immediate safety once we have determined the level of urgency (critical, very urgent, urgent, low urgency). **We also consult the Care and Protection Panel in line with the same timeframe.** The 36 or 43 working day timeframe is the timeframe we previously used for completing a Child and Family Assessment or investigation, following the usual process set out in the policy and related guidance.

As such, I would not expect ‘as soon as practicable’ to mean that it would take weeks for cases to be presented to a CPRP. At the very least, I would expect cases to be before a CPRP within the 36 working days required for the completion of a Child and Family Assessment or investigation. According to the Ministry’s advice above, consultation with a CPRP should occur within the timeframe set by the Safety and Risk Screen.

As identified earlier, the majority of the 74 cases I reviewed were accorded low urgency, thus requiring a response and consultation with a CPRP within 20 working days. Based on the information before me, I am not satisfied that the Ministry consistently met its legal requirement to have cases before the CPRP ‘as soon as practicable’ after an investigation has commenced, and, where it did, there were issues with the quality of CPRPs.

As [Figure 13](#) shows, only 15 cases (20 percent) were considered by a CPRP within 20 working days and only 33 cases (45 percent) were considered by a CPRP within 36 working days.²⁸¹

281 Refer also to [Table 12](#) at page 224 of this report.



Timeframes of CPRP consults

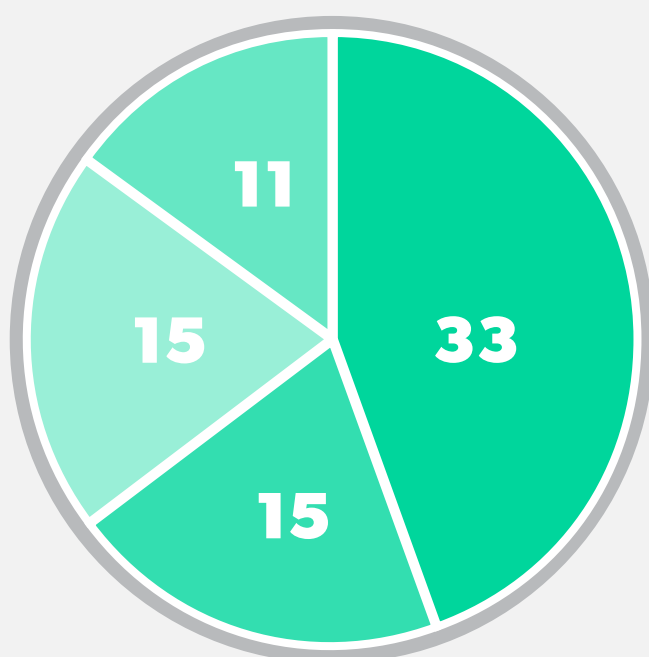
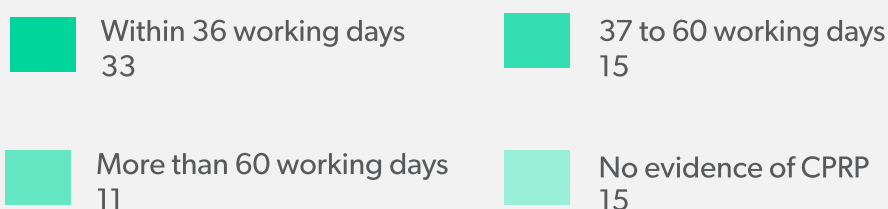


Figure 13: Timeframes for CPRP consults

It is apparent that the delay in cases going to a CPRP is not just because of the time it takes for cases to be referred. There are also delays occurring in the period following the referral and the case being put before the CPRP.

Interview feedback from CPRP members and the Ministry's staff confirmed and gave insights into the data. Commonly, concerns highlighted were that:

- there were unacceptable delays in cases being presented to the CPRP (for example, three months, or not until the end of an investigation);
- at a site level, cases were being brought to the CPRP by some but not all of the Ministry's staff;
- the Ministry's staff were appearing before the CPRP ill-prepared;
- limited or incomplete information was being provided to the CPRP; and
- CPRPs were commonly cancelled due to a lack of quorum.



Child and Family Consult

As shown in [Figure 14](#), there was variable use of the Child and Family Consult.²⁸²

This is despite the Ministry’s policy that a family consult is required in every case during the assessment phase, as well as the consistent recognition of its value and importance, in site interviews with the Ministry’s staff. Indeed, the Child and Family Consult, used in a group consult process, was one of the mechanisms most discussed at interviews. Frontline staff clearly recognised it as an important tool in the section 78 decision making process. However, this was not borne out in evidence on the case files I reviewed.

Evidence of Child and Family Consults

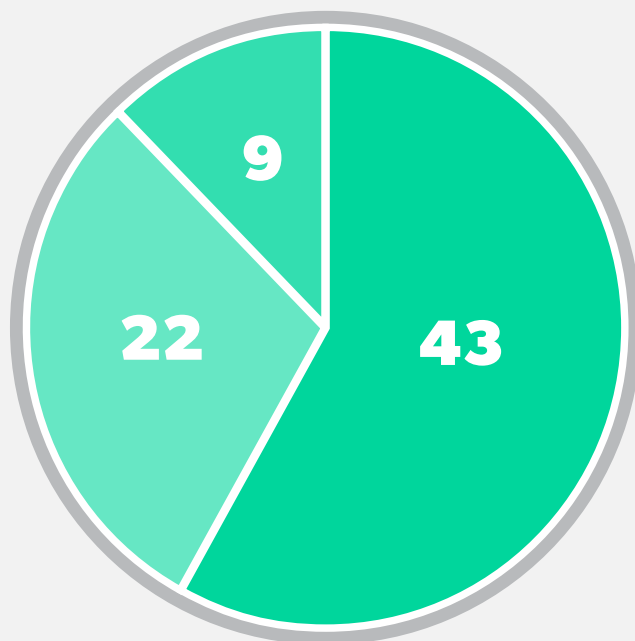
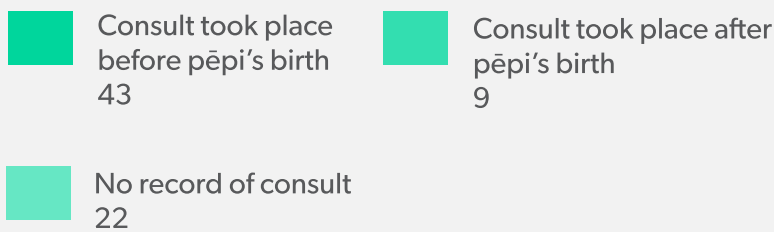


Figure 14: Evidence of Child and Family Consults

I am concerned that there is no evidence of a Child and Family Consult in 30 percent of the cases I examined.²⁸³

282 Refer also to [Table 13](#) at page 225 of this report.

283 Of these cases, only one was a situation where there was little time between the report of concern and birth of the baby.



The Ministry has also identified that these consults were not consistently being used to inform its decision making. Its *s78 Casefile Analysis* found that they were only used in 69 percent of the 153 sampled cases.²⁸⁴

In a separate review conducted in 2019 of section 78 cases relating to **all age groups** entering care, the Ministry reported the group consult process occurred in 60 percent of cases, even though the expected practice is that this tool is used in all cases when removal is considered.²⁸⁵ The Ministry identified that this process is less likely to be used with Māori tamariki (though that is not evident from the case files reviewed for my investigation), in spite of the specific statutory obligations on the Ministry to engage whānau, hapū, and iwi.

The Ministry's analysis also found that group consults were not well recorded.²⁸⁶ This may or may not affect an understanding of whether case consults are occurring. Nevertheless, the Practice Centre sets out the expectation that a written record of the consult will be transferred into CYRAS. This is particularly important when decisions from the consult lead to without notice interim custody orders for, and the potential removal of, newborn pēpi from their parents. The Practice Standards also make clear the importance of ensuring significant decisions are clearly evidenced and transparent, in accordance with the requirements of the Public Records Act 2005.

Of the nine sites visited as part of my investigation, the evidence of the case files showed that case consults were not standard practice in three of the selected sites.

Interview with Ministry staff member

We have a fantastic tool called the 'Child and Family Consult Tool'. When it was introduced, some years ago now, we used it frequently. We probably, unfortunately, don't use it as much as we should now. I think that is just because of the time it takes ... We sometimes use it. But, you are supposed to use it before you close every assessment. You are supposed to use it to make a decision. But, we just have too much work. It would take a good hour or so to have a consult. At least one hour, sometimes 1.5 hours. So, it is the time it takes.

Site level interviews with the Ministry's staff confirmed limited use of the consult tool in two of these sites, and potential insufficient and ill-explained record keeping at another site. One practice leader suggested that, if there is no evidence of consults on case files, the documentation process had '*been overlooked*', rather than the practice itself.

Site interviews also suggested that the case consults could regularly include external professionals to add external and other professional insights and robustness to the process. That is encouraged by the guidance in the Practice Centre. However, the 74 case files I reviewed showed little evidence of the Ministry routinely engaging with external professionals in the Child and Family Consult process.

284 *s78 Casefile Analysis*, above n 20, at 12.

285 Oranga Tamariki—Ministry for Children *Practice and decision making around the entry of tamariki into care under section 78 orders* (19 September 2019) at [19]. This review considered 185 cases of tamariki across all age groups entering the Ministry's care under section 78 orders.

286 Above n 285, at [19].





In my opinion, it is deeply concerning that such a critical tool was not being utilised routinely and effectively by the Ministry, particularly when the consequences can be grave for those involved. Poor documenting of the process is also unacceptable, given the significant decisions that result from that process. As stated by an interviewee from the Ministry's National Office, the record contributes to telling the child's story and the exercise of the Ministry's powers over their life, which can have an enduring effect. It is also an expectation of the Public Records Act 2005 and the SWRB.²⁸⁷

Poor documenting of the process is also unacceptable given the significant decisions that result.

Foreword

Executive Summary

Introduction

My investigation

Part One

Part Two

Part Three

Part Four

Appendices

287 The SWRB core competency 'Competence to practice within legal and ethical boundaries of the social work profession' is one of ten core competence standards reflecting minimum standards of practice for the social work profession and includes the requirement to keep clear and accurate records. The core competencies are available at <swrb.govt.nz/social-workers/competence/core-competence-standards/>.





Legal consultation

At interview, the Ministry’s staff confirmed that legal consultation is a Ministry requirement in the decision to apply for a section 78 order without notice. However, as [Figure 15 below](#) shows, this consultation was not recorded in over three-quarters of the case files I reviewed.

Evidence of legal consultation

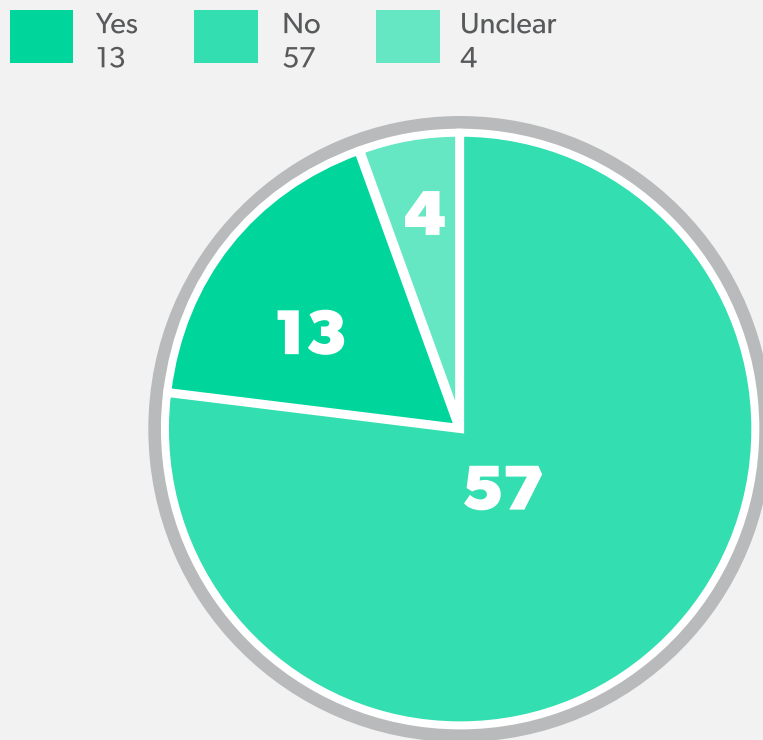


Figure 15: Evidence of legal consultation

While all the applications under section 78 were submitted to the Court by the Ministry’s solicitors, in over three-quarters of the case files I examined, there were no records demonstrating that there had been prior consultation with the Ministry’s solicitors in advance of the decision to seek a section 78 interim custody order without notice. This is entirely incompatible with the Ministry’s own expectation that there would be consultation with the Ministry’s solicitors in these decisions and a clear record of the legal advice received.

Partnering with external professionals, iwi, and organisations

Aside from the CPRP consults, the case files show little evidence of involvement of external professionals in assessment and decision making.



Figure 16 below shows that just 20 of 74 cases (27 percent) had a record of a professionals meeting.²⁸⁸

Evidence of Professionals Meetings

 Yes	 No	 Not recorded
20	47	7

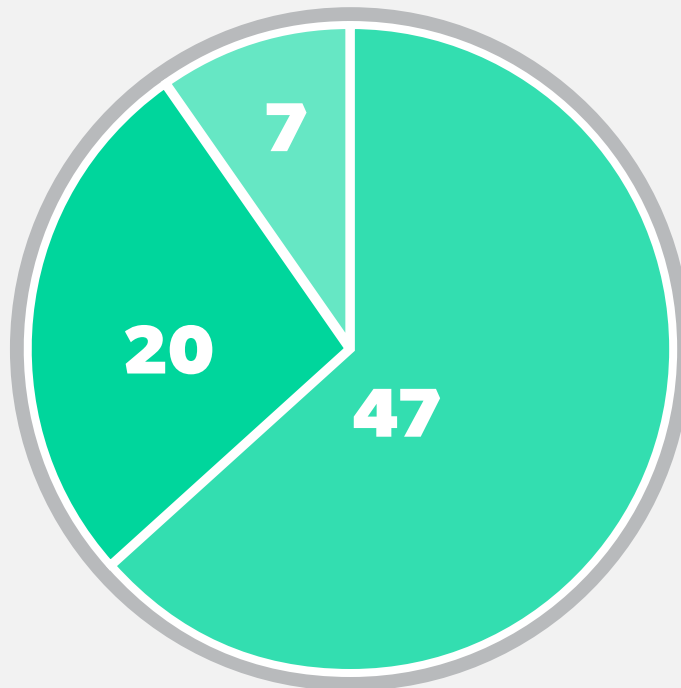


Figure 16: Evidence of Professionals meetings

Evidence of external professionals meetings was also checked as part of the Ministry's *s78 Casefile Analysis* to understand if this form of expected consultation was occurring. This found evidence of professionals meetings in under half (46 percent) of the 153 sampled cases.²⁸⁹

There was also little evidence of the involvement of external professionals and organisations in the Child and Family Consult process.

Based on information from interviews, the degree of partnering with iwi and/or Māori organisations is also site dependent, as noted above.²⁹⁰ Of the nine sites visited for my investigation, just two sites had purposefully established formal working partnerships with iwi or local Māori organisations.²⁹¹ However beyond

288 Refer also to Table 15 at page 225 of this report.

289 *s78 Casefile Analysis*, above n 20, at 12.

290 Refer to comments under the heading '*Barriers to effective partnership*' at page 110 of this report.

291 This is distinct from the strategic agreements with iwi at a National Office level.





that, the site-level interviews and case files that formed part of my investigation demonstrated no, or limited, partnering with Māori organisations. Third-party interviews confirmed this.

I find this very concerning, given the Ministry's statutory obligations, and its own expectations of best practice that it will use partnering to fully understand the needs of whānau. This is crucial to effective assessment and decision making.

Tuituia Framework

As I have reported above,²⁹² in around 50 percent of the section 78 case files reviewed for this investigation, the Ministry did not complete a Tuituia report within the 36-day timeframe of a care and protection assessment. Further:

- in 45 percent of the cases, it took more than 50 days for a Tuituia report to be completed; and
- no Tuituia report was completed at all in 7 percent of cases (five).

This reflects poorly on the timeliness and value given to core assessment.

The Ministry's *s78 Casefile Analysis* did not consider the occurrence or quality of the Tuituia assessments and reporting. While I have not looked closely at the quality of the written assessments themselves, if the Tuituia framework was being used to inform a robust assessment, I have no doubt it would have prompted engagement with whānau and family, as well as the professionals involved with them. As already discussed, my investigation found this did not routinely occur.

Further, except in extreme situations, an intervention such as an FGC or an application for interim custody should not be made without a robust assessment. However, in 16 cases (22 percent), section 78 applications were made either before the Tuituia assessment was completed (11 cases) or seemingly without the Tuituia assessment having been completed at all (five cases).

Tuituia assessments were 'completed' before most FGCs. However, in some cases, the Tuituia report was empty except to note that it would be completed in the intervention phase. In total, 13 cases (18 percent) were referred to FGC without the Tuituia assessment having been completed.

Professional supervision

My investigation has found that the occurrence and quality of supervision is variable, despite supervision being key to robust decision making, a requirement for social worker registration, and required as the Ministry's Practice Standard (*a bottom line*).

Interview feedback about supervision at some of the sites related the value of supervision to challenging thinking and decision making, as well as support for wellbeing. Case consults (where they occur) predominantly involve the supervisor

292 Refer to comments under the heading 'Formal timeframes' at page 120 of this report.



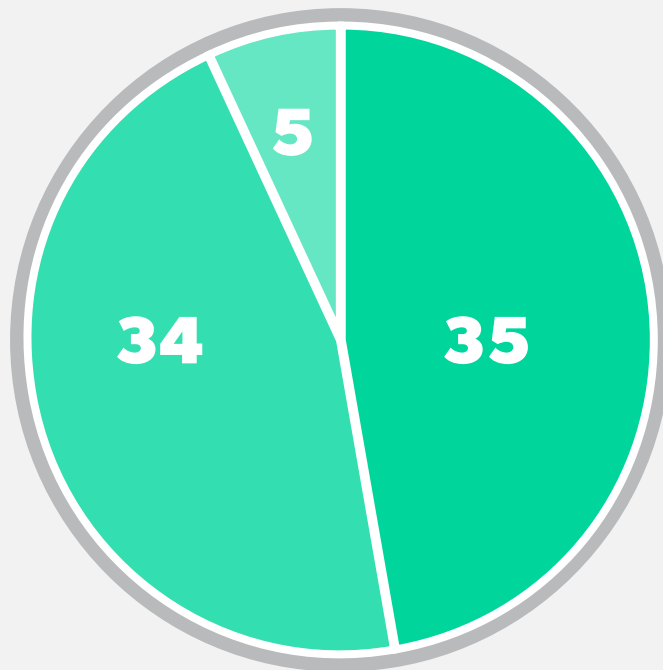
and provide opportunities for challenge and reflection at an individual case level. The Ministry's staff interviewed generally reported that decisions to apply for a section 78 order were made as a team, and included the supervisor.

However, the case files contained very little documentation of one-on-one supervision demonstrating critical reflection and reflective practice. Where there was a record of supervision, this was primarily task oriented.

As [Figure 17](#) shows, 34 of the 74 case files (46 percent) contained no record of supervision occurring between a supervisor and social worker. Of those 34 cases, 21 cases (28 percent) contained no supervisor record whatsoever, and 13 cases (18 percent) contained a note from the supervisor recording case-related tasks and actions but no interaction with the social worker allocated to the case.²⁹³

Evidence of professional supervision

Yes 35
 No 34
 Unclear 5



Quality of supervision is an ongoing concern.

Figure 17: Evidence of professional supervision

293 Refer also to [Table 16](#) at page 225 of this report.



In 39 cases,²⁹⁴ a supervision record or note made reference to supervision between the supervisor and social worker. However, as highlighted in [Table 17](#),²⁹⁵ in 35 of these cases (90 percent) the record reflected a focus only on tasks, actions and next steps, rather than the key aspects required for professional supervision as outlined earlier.²⁹⁶

My finding that 46 per cent of case files examined show an absence of supervision differs from that found by the Ministry's *s78 Casefile Analysis*. That found evidence of supervision in 73 percent of cases.²⁹⁷ However, I note the Ministry's analysis did not identify the nature of supervision evidenced, nor is it apparent whether the Ministry's review counted supervision as a supervisor making a note of tasks and actions. In any case, the Ministry's conclusion from its review of section 78 cases (for newborn pēpi and tamariki of all ages) is that effective supervision is not used consistently to inform decision making.²⁹⁸

The issue with quality of supervision is an ongoing concern, and was recognised in the Ministry's site-level Practice Checks from 2017/2018. Across eighteen sites reviewed, only two-thirds (an average of 64 percent) of supervisees surveyed indicated that they had regular supervision in accordance with the Ministry's policy. As [Table 18](#) shows,²⁹⁹ 16 of the 18 sites identified that supervision was inconsistent, variable and/or compromised.

Three sites identified that the quality and consistency of supervision was significantly compromised. Issues identified were that:

- supervision was not occurring because of capacity and other competing priorities; and
- supervision was mostly task focused and transactional, with little opportunity for reflection.

These were similar to the issues commonly identified across the interviews conducted for my investigation.

294 In one case, it was unclear whether supervision had occurred.

295 Refer to [Table 17](#) at page 226 of this report

296 Refer to comments under the heading 'Professional supervision' at page 133 of this report.

297 *s78 Casefile Analysis*, above n 20, at 12.

298 *Section 78 Practice Insights for Operational Groups*, above n 21, at 9.

299 Refer to [Table 18](#) at page 226 of this report.



Interview with Ministry staff member

I don't have regular supervision. I go to her quite often [the Supervisor] and sit at her desk and we talk through a lot, but I don't have ... I'm meant to [have supervision] weekly and I don't think I've ever had that ... at the start I didn't realise because I was getting talked through everything. But now I've kind of been left on my own.

...

I think that's something that I need to be a bit more staunch on, and say 'hey I actually need this' [supervision] ... after [the case is] done you kind of get 'good job'. But it's just ... you move on with it, you don't get that time to actually think.

Interviewees also described a lack of cultural supervision, though there was some divergence of views expressed about whether or not there was a need for it.

Interview with Ministry staff member

Cultural supervision, and that's another gap here. Cultural supervision ... and that's Oranga Tamariki, if the manager thinks it's important ... cultural supervision should be a weekly thing for all social workers, especially those working with our Māori children. There is a lot of work in this office to be done around cultural competence.

Interview with Ministry staff member

I've been told that cultural supervision, we can have it at any time that we want, but it's not in place yet, so we haven't got access to it yet...

Interview with Ministry staff member

There's no cultural supervision for our staff. Our Supervisors, who are all Pākehā or tauwiwi, are expected to culturally supervise, and they don't have the skills to do it.

While the Ministry has recently invested in supervisor training, interviews with the Ministry's staff at its National Office indicated there was a lack of confidence in the consistent quality of supervision, and that this reflected who the supervisors were at any particular site and the nature of site leadership.



Interview with the Chief Social Worker

...there needs to be a deep exploration about: 'ok, are we practising in the right way?' ... and that is thinking about what governs social work so it's not just our policies and operating policies ... social worker code of ethics for example, that's the types of conversation that needs to be taking place in supervision. Am I confident they're taking place that often? No ... and I think that's why I've insisted that we build supervision into that site practice check...

We have invested quite a bit in supervisor training ... In a site, if you get the site manager wrong ... There is a clinical element of supervision where you're actually taking an indepth look at cases and then ... talking to them [social workers] about them, referencing some of those deeper things like the code of ethics, 'are we practising social justice', ... 'are we being fair', 'how we arrived at decision', 'what might be some of the risks within that' ... 'talk about your background and how ... that might shape or colour how you've decided on things' ... So ... that takes a certain level of skill and intellect, and I think that that would be variable across the country.



Contributing factors

It appears there are common factors influencing the lack of universal application of the core mechanisms designed to ensure safe, robust social work practice, accountability, and transparency. These relate to:

- capacity and competing priorities due to high workloads;
- poor record keeping;
- capability; and
- insular practice linked to the Ministry’s child protection focus.

Capacity and competing priorities due to high workloads

The Ministry’s frontline staff identified that a key reason why CPRP meetings, case consults, and supervision were put off, or not held, was the need to prioritise other social work duties due to high workloads.

The culture and leadership of a site were also seen as influencing the prioritisation of different processes.

In the case of CPRP meetings, interviewees reported that these were often cancelled because the CPRP members were themselves too committed with other work and their non-attendance meant that a quorum could not be achieved.³⁰⁰

Panel had to be cancelled on several occasions due to insufficient referrals from social workers or insufficient panel members available to attend.

Variable use of the CPRP appeared to reflect the view expressed by some Ministry staff that they did not get value from the CPRP and therefore did not prioritise it.³⁰¹

However, it was also clear that staff were under enormous pressure and it was difficult for them to see coming to Panel wasn’t a little wasteful of their time.

...

There have been significant staffing issues and they are under pressure ... Be good if new recruits could be made aware of legal requirements.

Poor record keeping

There was a gap between what the Ministry’s staff said about use of processes and what was recorded on the case files I reviewed. It is likely that poor record keeping is influencing this to some extent. For example, despite hearing in interviews with frontline staff that case consults and legal consultation were commonplace and important, my analysis demonstrates gaps in the application of these practices.

There was a gap between what the Ministry’s staff said about use of processes and what was recorded on the case files.

300 This is an excerpt from a site-level CPRP Annual Report completed in 2019.

301 These are excerpts from two different site-level CPRP Annual Reports completed in 2019



The requirement to keep accurate records is one of the Ministry’s Practice Standards and a requirement for all registered social workers. Further, the Public Records Act 2005 also places obligations on the Ministry to create and maintain full and accurate records of its affairs.³⁰²

In the context of the work the Ministry does, the records kept represent the reasons why pēpi stayed with their parents or not. As well as the importance of record keeping to accountability, transparency, and evidence of decision making, the Ministry has a responsibility to scrupulously document its use of coercive powers. It must also be in a position to provide a clear rationale for life-changing events for those most affected by its actions and use it as an accurate reference tool to provide context for future decision making. The lack of adequate records makes this impossible.

Capability

Capability issues were raised by interviewees in relation to the constitution of CPRPs and the quality of supervision.

Commonly, the lack of relevance of the CPRPs was attributed to their constitution, both in terms of insufficient representation of relevant parties such as Māori and health representatives, and due to members who did not, or were unable to effectively, contribute.

The CPRP was described in some interviews as a ‘tick-box’ exercise by both Ministry staff and panel members.

The Ministry has a responsibility to scrupulously document its use of coercive powers

Interview with Ministry staff member

It’s kind of like a mechanical process around here that ... the social workers suffer through and it’s not frightfully useful.

Some interviewees indicated that they did not get value from the CPRP because it did not offer new ideas, or it challenged without offering alternatives. Not all panel members were considered to understand child protection and/or to be up to date with the Ministry’s policies and requirements.³⁰³

Some of the CPRP site-level annual reports also identify possible reasons why the Ministry’s staff may see the CPRP as a tick-box exercise. These identified that social workers, particularly new social workers, have not had training about the purpose and value of the panel and the statutory requirement of bringing cases to the CPRP.

302 Section 17 of the Public Records Act 2005. In addition, the Ministry is obliged to meet the principles outlined in the *Information and records management standard* issued under section 27 of the Public Records Act 2005; Archives New Zealand *Information and records management standard* (July 2016). This is available at <archives.govt.nz/>

303 Panel members interviewed identified a lack of appropriate training from the Ministry.



However, at some sites, the CPRP was positively valued for its community and whānau knowledge, and the insights provided about services used by, or beneficial to, whānau and family.

In terms of professional supervision, as identified in the previous section, the view from some interviewees is that supervision quality is adversely affected by workload stress and the variable capability of supervisors to facilitate reflective and cultural supervision.

Insular practice linked to the Ministry’s child protection focus

The Ministry’s staff and third parties frequently described tensions with external professionals, who were seen as representing the interests of parents and whānau. Their positions were considered to conflict with, or go beyond a central focus on, the immediate safety of pēpi.

The Ministry’s staff described external professionals not understanding their work as child protection social workers. They described tensions regularly experienced when external professionals were concerned that the Ministry was failing to remove pēpi they considered to be at risk, or, conversely, where the Ministry’s actions were considered disproportionate or inappropriate.

Such tensions appeared to influence the Ministry’s limited information sharing and involvement of external professionals in the assessment and decision making process. Some external professionals and organisations described to my investigating staff a perceived culture of professional arrogance and mistrust on the Ministry’s part.

Interview with social service provider

We’ve ... see them [social workers] struggle ... they’re too overworked you know, so I’ve been going over there and saying ‘we’ve got a bit of capacity here...we’ll do the visits on your behalf’.

That was a shut-down ‘no, that’s our work’. So, there’s a level of professional arrogance ... which is, you know, ‘we’re the statutory social workers, you’re just community people, what do you know about it’.

A number of third parties, such as staff from a DHB and social service providers, also raised concerns about the impact of systemic or institutional racism. They referred to the factors in place that have established and maintained advantages for non-Māori, resulting from the history of colonisation and misappropriation of land and resources—leading to poorer health, education, economic, and social outcomes for Māori, and thus making them more susceptible to being in state care.³⁰⁴

304 A useful discussion of institutional or structural bias can be found in the Health Quality and Safety Commission’s May 2019 report, *He tirohanga ki te ōritenga hauora o te Māori: A view on Māori health equity*, above n 21, at 9.

The Ministry’s staff described external professionals not understanding their work as child protection social workers.





My investigation has found some sites are partnering well with Māori, and they are more outwardly focused and community oriented. However, at those sites, relationships with other organisations were driven by the individual site leadership, rather than an overall national strategy or policy. Those leaders understood that quality practice, and their obligations to whānau, hapū, and iwi, required partnering to take place. In those sites, the staff frequently talked of looking outwards for solutions, and being accountable to their community if pēpi were removed. What was clear is that the staff in those sites saw themselves as part of that community, as opposed to statutory officers working from the outside.

Impact

I have observed widespread variability in the Ministry's practices in relation to the required key checks and balances. In this regard, I refer to the Ministry's own insights:³⁰⁵

Effective Supervision and case consults are not consistently being used to inform decision-making ... It is critical that supervision and case consults act as a robust check on the assessment and planning process... Where these mechanisms are unavailable or ineffective, it can significantly work against whānau who have improved safety and protective factors and reduced risk factors being given an opportunity to care for their own tamariki.

This is a systemic issue I have identified across the 74 cases reviewed as part of my investigation.

The insular nature of the Ministry's practice and limited external accountability evident in many of the cases I examined raises concerns about the quality of social work practice overall. In my view, this has fuelled the public criticisms of the Ministry and, in particular, the perceptions of an underlying bias in the Ministry's assessment and decision making.

I have seen examples of good practice in areas where the Ministry's policies and procedures were followed and well embedded. However, this was not consistent across all of the nine sites visited or the 74 case files I reviewed.

The lack of accountability also calls into question the appropriateness of the Ministry's use of without notice section 78 applications. These are meant to be reserved for urgent cases where all other options to ensure the immediate safety of pēpi have been exhausted. I will address the use of section 78 applications below.

Understand and comply with law

All of the cases I reviewed used a without notice application to seek an interim custody order. As I have set out in the legal framework section of this report, where a parent is at risk of having pēpi removed from their care, the starting point

The insular nature of the Ministry's practice [...] has fuelled the public criticisms

305 Section 78 Practice Insights for Operational Groups, above n 21, at 9.





is that the parent has a right to know the allegations against them that form the basis for the application for a section 78 order, and to respond. Applying without notice is contrary to this right but is permitted in limited circumstances.

In this part of the report I will explain what those circumstances are, and describe the Ministry's practices as observed from the case files I examined. I will also discuss the Ministry's practices as these relate to subsequent children provisions (sections 18A to 18D of the Act).

What should happen

The Act includes a number of options that permit the Ministry to act quickly to remove a pēpi who is at immediate risk of serious harm. There is a hierarchy of relevant responses—from a place of safety warrant, which is applied for without notice and lasts a maximum of five days, to final custody orders made after an FGC has been held and a declaration made that a pēpi is in need of care or protection. A section 78 orders sits between the two. It is an interim custody order and it is intended to be temporary.

Rule 218 of the Family Court Rules 2002 requires all applications, including an application for interim custody of tamariki, to be on notice. This is consistent with the requirements of natural justice, which includes the right of a party to know and respond to allegations against them. It also reflects Article 9(2) of UNCROC, which states that in any proceeding to separate a child from their parents against their will:

...all interested parties shall be given an opportunity to participate in the proceedings and make their views known.

Applications for custody can be made on notice, but with the usual procedural steps shortened to enable decisions to be made more quickly. This includes reducing the time for filing a defence, and holding a short hearing (known as a 'Pickwick' hearing) to resolve an application quickly.

The law does allow for applications to be made without notice in exceptional circumstances (emphasis added).³⁰⁶

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

The reference to the need for '*fast and decisive action*' is consistent with the legal requirements for a without notice application. Those cases must meet the criteria in the Family Court Rules: an application can only be made without notice if the '*delay that would be caused by making the application on notice*' would or might entail.³⁰⁷

306 Hastings Practice Review, above n 23, at 47.

307 Rule 220(2)(a)(i) Family Court Rules 2002.



...serious injury or undue hardship, or risk to the personal safety of the child or young person who is the subject of the proceedings, or any person with whom that child or person is residing, or both.

I have emphasised the phrase above because the law requires the harm to pēpi must be linked to the **delay** involved in making the application on notice.³⁰⁸

Earlier in my report, I described the subsequent children provisions as set out in sections 18A to 18D of the Act.³⁰⁹ I also identified my concerns with both the provisions themselves and the Ministry's guidance earlier in my report.³¹⁰

To reiterate, the sections prescribe the process where a parent has a subsequent child after having a previous child permanently removed, or where the parent has been convicted for particular offences. In those cases, social workers must assess whether the parent is unlikely to 'inflict' or 'allow' the same harm on the subsequent child.³¹¹ The provisions are complex and, to assist, I have summarised them in a diagram in [Appendix 10](#).³¹²

Removing a newborn pēpi from their parents is an extraordinary use of the government's power, and, as a matter of fairness and law, those parents must have the opportunity to respond and have input in all but the most exceptional circumstances.

What is typically happening

As identified earlier, the Ministry was unable to identify the exact number of newborn pēpi removed without the parents and whānau being notified of the decision to seek interim custody. However, its own review of a sample of these cases identified that the majority of the parents and whānau were not given notice before the Ministry removed their newborn pēpi.³¹³

This has since been confirmed by the data made available by the Ministry of Justice, which showed that over 94 percent of the section 78 orders for 2017/18 and 2018/19 were granted on the basis of without notice applications by the Ministry.³¹⁴ This data also showed more applications were made without notice for Māori, with the ethnicity of a large number of tamariki recorded as 'unknown'.

Use of without notice applications

In all but two of the 74 cases I reviewed, the section 78 applications were made without notice. The two remaining applications were made on notice originally, but then made without notice when pēpi arrived unexpectedly.

308 *DE v Chief Executive of the Ministry of Social Development* [2007] NZCA 453.

309 Refer to comments under the heading 'Subsequent children provisions' at page 56 of this report.

310 Refer to comments under the heading 'Subsequent children' at page 70 of this report.

311 Section 18A(3) of the Act.

312 Refer to page 223 of this report.

313 *s78 Casefile Analysis*, above n 20; and *Section 78 Practice Insights for Operational Groups*, above n 21.

314 Exhibit VJC-2.2 of affidavit affirmed by Valmai Joy Copeland dated 20 March 2020 (Wai 2915, 2020) at [10].

Parents must have the opportunity to respond and have input in all but the most exceptional circumstances.



This appears to be in line with the Ministry’s general approach to section 78 applications. At interview, some of the Ministry’s staff said that applying without notice was the expected practice during the period covered by my investigation. Many staff explained that the Court would be unable to make an interim custody order in time if the application was made on notice.

In three cases I considered, the Ministry did not receive a report of concern until within one working day of the pēpi’s birth. In those circumstances, where the social worker had serious concerns for the pēpi’s immediate safety, it appears the delay in making an application on notice would have caused risk to their safety.

However, as I have already noted, in most cases, the Ministry was aware of the unborn pēpi for weeks or months before the birth of pēpi. In 57 of the 74 cases (77 percent), the Ministry was aware of the pregnancy for 60 working days before birth and in 18 out of the 74 cases (24 percent), there was more than 120 working days before the birth.³¹⁵ In these cases, had the Ministry been operating in accordance with the law, policy and Practice Centre guidance, there was sufficient time for the Ministry to have applied on notice.

Some of the Ministry’s staff said that applying without notice was the expected practice

315 Refer to comments under the heading ‘Formal timeframes’ at page 120 this report.



Figure 18 and Figure 19 below set out the number of working days between the application being made for interim custody and the pēpi's birth for the 74 cases I reviewed.³¹⁶

Section 78 applications made before birth (working days)

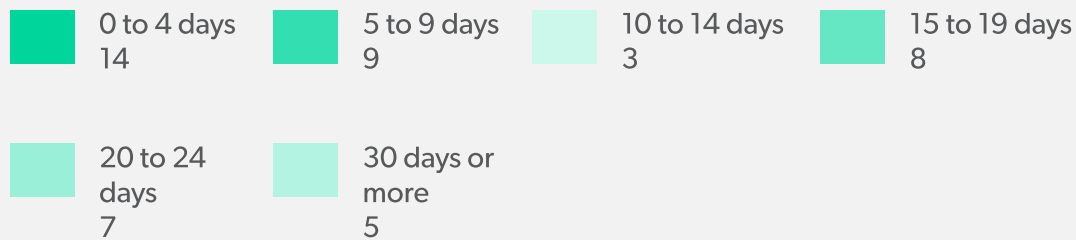


Figure 18: Section 78 applications made before birth (working days)

316 Refer also to Table 19 at page 227 of this report.

Section 78 applications made after birth (working days)

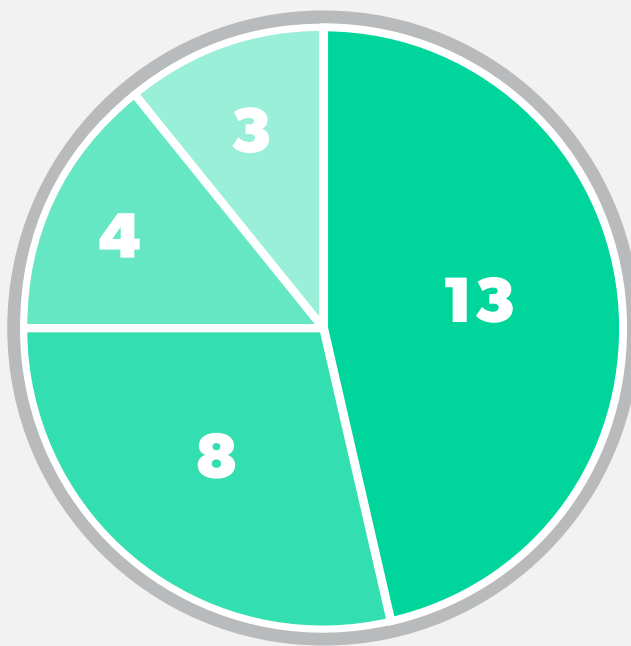
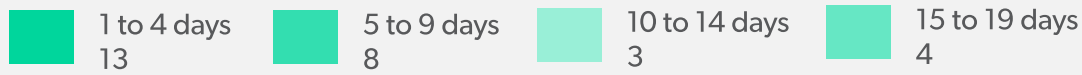


Figure 19: Section 78 applications made after birth (working days)

Figure 18 shows there were 12 without notice applications made 20 working days (approximately four weeks) or more before pēpi were born. While the concerns for the wellbeing of pēpi may have been serious, I can see no logical rationale to apply for interim custody on a without notice basis. In these cases, with pēpi in utero and not due to be born, I query whether there was a need to take ‘fast and decisive action’. Indeed, there is a certain irony in the claim that there was a need to take action immediately, yet planning, assessments, and engagement with whānau did not always occur with the level of urgency that was required.

Interview with Ministry staff member

Because it's an unborn list, it can sit there [on CYRAS] for months and months and months and there's actually no case notes on there at all. So ... if there's no case notes, you can pretty much know that nothing's happened. Because the first thing that social workers will do to get a case off their KPI is do a safety assessment, and there's no safety assessment, often nothing's happened in the case ... it could sit there for six months.



None of the cases I assessed showed any evidence of consideration given by the Ministry's frontline staff to:

- providing a limited opportunity for parents to respond to the applications by applying to reduce the time for filing a defence; or
- making a request for a Pickwick (shortened) hearing.

For those cases where the application was made after a pēpi was born, in most instances the urgency was contributed to by the Ministry's failure to engage and plan earlier. As Tables 4 and 18 show, generally the Ministry had been aware of the pregnancy for some time. However, where the situation was genuinely urgent, a place of safety warrant could have been obtained, enabling the pēpi to be temporarily removed. The five-day window of opportunity that this provided would have enabled the Ministry, the parents, and whānau to work together to identify options ensuring the safety of the pēpi.³¹⁷

I also note that no matter when the application was made, it rarely referred to how long the Ministry had known about the pregnancy and had concerns about the pēpi, in spite of the application form requiring the Ministry to declare that there had been no delay. Nor did the affidavits in support explain why no FGC had been held, if that was the case.

In most instances the urgency was contributed to by the Ministry's failure to engage and plan earlier.

Subsequent children provisions

During interviews, the Ministry's frontline staff explained that they understood the effect of section 18A to be that a parent who had a previous child removed had to prove they had changed and their pēpi would not be at risk of harm. Earlier in my report, I have addressed why I consider this to be unreasonable.³¹⁸

Fifteen of the cases I reviewed were flagged with specific reference to section 18A, even though a much higher number of cases involved parents who no longer had care of previous children. Despite the mandatory requirements of the Act and the Ministry's guidance, only one case included an assessment and application to the Court under section 18A of the Act. There were only three applications for a declaration that pēpi was in need of care or protection that relied on section 14(1) (ba), which refers to the subsequent child provisions.

On the basis of the information I reviewed, it was evident to me that the Ministry's frontline staff were unaware of:

- the policy to seek legal advice early to help assess whether a parent met the criteria under sections 18A and 18B;
- the legal requirements to assess the parent and tell them about that assessment; and
- the legal requirement to apply to the Court in **all** cases where section 18A applied.

317 This is consistent with the Court's findings in *DE v Chief Executive of the Ministry of Social Development* [2007] NZCA 453.

318 Refer to comments under the heading 'Subsequent children' at page 70 of this report





Notwithstanding this poor understanding and application of the legal requirements, across all of the cases I reviewed the Ministry relied heavily on a history of a previous child having been removed as a basis for removal of the next child. By doing so, it simply did not comply with its own policy or the mandatory statutory requirements set out in the Act.

Contributing factors

As identified above, high workloads, competing priorities and capacity are issues that had cumulative effect on the Ministry's ability to conduct timely assessments and planning. This, in turn, meant that the Ministry did not properly utilise the many opportunities to identify and assess other options to ensure the safety of a pēpi before the birth was imminent or had occurred.

It was apparent to me that the Ministry's frontline staff did not understand the law and the requirement to make a section 78 application on notice, apart from in exceptional circumstances. It is unclear whether this was because of lack of guidance/training or poor processes, or a combination of the two. Notably, the incorrect use of without notice processes was not identified until the Ministry undertook its Hastings Practice Review in late 2019.

I consider that the failure to understand the requirements of natural justice and Court rules is unacceptable for a state agency, particularly when the results are the removal of newborn pēpi from their parents.

As the diagram at [Appendix 10](#) shows,³¹⁹ the subsequent child provisions are complex. However, given the impact of this legislation, the Ministry should have taken steps to ensure its frontline staff understood the requirements. During the timeframe covered by my investigation, there was guidance available on the Practice Centre. However, from my review of case files and interviews with social workers, it seems the Ministry's frontline staff were unclear on when they should complete a section 18A assessment. There also appeared to be confusion as to whether there was an obligation on parents to prove safety, rather than there being an obligation on the Ministry to undertake a thorough assessment.

Impact

Without notice applications

In my view, one of the most perverse aspects of the timing of the Ministry's applications when the birth was imminent or had happened is that, based on their own childhood histories and/or interactions with the Ministry for previous children, the parents and whānau may have been aware of the possibility that the Ministry might take custody of their pēpi. However, the parents and whānau had no input over the timing of the application and no way to be heard.

319 Refer to page 223 of this report.



If an order is made prior to birth, the Ministry has the power to veto who attends the birth, whether the mother has skin-to-skin contact with her pēpi, how long parents can spend with pēpi, and whether the mother can breastfeed. After the birth, the Ministry decides how often a pēpi sees their parents and whānau, how long the access is for, and whether it is supervised.

As well as deciding the timing of the application, the Ministry also decides the information the Court has access to when it makes its decision on a without notice application. The Ministry is able to present information that supports the application, without other relevant evidence that may weigh against the removal. Some of the parents in the cases reviewed had the support of agencies who could have provided relevant evidence so the Court could make a fully informed decision. The Court is well placed to balance the evidence of a statutory social worker against other evidence from agencies working with whānau, but not if it does not hear from them.

At the beginning of this report, I described the people who are impacted by these decisions—in sum, parents are often living with multiple, complex issues such as family violence, drug and alcohol misuse, transience, and mental health needs. In contrast to the Ministry, these people are generally not in any position to advocate effectively for themselves.

In addition, most parents (97 percent) have had previous experience with the Ministry, either as tamariki themselves or being a parent of tamariki requiring involvement with the Ministry. The Ministry's current guidance acknowledges (emphasis added):³²⁰

Vulnerable tamariki and family/whānau have often experienced events or circumstances that feel like they threaten their survival, cause significant feelings of fear and distress and overwhelm their ability to cope.

- *Tamariki may be impacted by multiple forms of trauma over time including:*
 - *historical trauma and racism through colonisation in Aotearoa*
 - ***systemic trauma through interactions with systems of care***
 - *intergenerational trauma across families and generations*
 - *direct trauma to individuals.*
- *Cultural alienation and discrimination can intensify the trauma experienced by tamariki. Culture is closely interwoven with healing from trauma.*

320 This guidance is dated 1 July 2017 and is available at <practice.orangatamariki.govt.nz/our-work/practice-tools/the-tuituia-framework-and-tools/the-tuituia-framework-and-domains/health-tuituia-domain/>.



- ***Child welfare systems and practices can mitigate or exacerbate impacts of trauma.***

The evidence before me clearly indicates that without notice applications were the default practice for in utero or newborn pēpi considered to be at risk. This is in spite of the Act and case law mandating it to be rare and as a last resort.

In November 2019, the Ministry published new guidelines in response to the Hastings Practice Review that are intended to reduce the use of without notice applications.³²¹

The 74 case files reviewed demonstrated that without notice applications for removal were routinely supported by the Ministry's affidavits swearing that other options were not available, and that there had been no delay in making the application. However, the evidence before me suggests that there would have been minimal, if any, need for without notice applications if the Ministry had applied appropriately its legislation and policies, which required it to have:

- engaged with whānau, hapū, and iwi;
- planned early with parents and whānau to ensure appropriate supports were in place;
- met the expected screening and assessment timeframes;
- followed the required checks and balances on its assessment and decision making; and
- in urgent cases, used the legal alternatives in the form of shortened notice hearings and/or place of safety warrants.

I acknowledge that once an order is made, if parents are unhappy with the outcome and wish to contest it, they have to access legal advice and apply to the Court. However, it must be remembered that the court process is happening while the mother is either heavily pregnant or has just given birth and may be in a vulnerable emotional and physical state.

Subsequent child provisions

The subsequent children provisions significantly impact parents in two ways.

- Whether or not they meet the legal criteria, the Ministry works on the basis that if a previous child has been removed, the parents must prove they are safe to parent the next child.
- The Ministry is not following the requirements to carry out the assessment and apply to the Family Court. As a result, the parents do not get early access to legal advice and an opportunity to challenge the evidence.

321 The current guidance dated 7 August 2019 is available at <practice.orangatamariki.govt.nz/policy/without-notice-application-for-interim-custody-of-a-tamaiti-or-rangatahi/>.



In my opinion, the Ministry's processes and interpretation of the statutory provisions have given rise to a perception of bias against parents whose children have been removed before.

The Ministry's guidance does not explicitly address the need for ongoing support for parents and whānau subsequent to removal of tamati. This is despite the fact that there was a statutory duty on the Ministry to assist whānau, hapū, and iwi where the relationship with tamaiti is disrupted.³²² Had the Ministry complied with the requirement to apply to the Court whenever the subsequent child criteria were met, those parents could have had access to legal advice, or a litigation guardian where a parent had an intellectual disability; a lawyer for child; and ultimately a judge to independently scrutinise the evidence.

Summary: First phase—applications for without notice interim custody

The purpose of the legislation that the Ministry operates under includes promoting the wellbeing of pēpi and their whānau, and assisting whānau to prevent harm. In general, the Ministry has sufficient tools and processes that enable these objectives to be achieved. However, my investigation found that it did not consistently apply the available tools and processes in practice, and was instead resorting to removing these pēpi without notice.

In terms of engagement with parents and whānau, during the period covered by my investigation, the Ministry piloted new ways to engage, which were shown to be much more effective for Māori. Māori have a long history of problem solving in a way that allows things to be tika and pono—concepts understood and seen as beneficial by the Ministry's staff in how they engage successfully with Māori. Hui ā-whānau and FGCs are extensions of this and, if they are utilised in the way intended, could make a major impact on the outcomes for pēpi and whānau. Therefore, it is concerning that in over half of the 74 cases I reviewed, hui ā-whānau or FGCs did not occur prior to the birth of pēpi. It is also disappointing that, for the timeframe of my investigation, there appeared to be a lack of an agreed national strategy within the Ministry to promote and encourage Māori to take more of a lead in decisions affecting them.

The work done by kairāanga has been shown to be transformative. However, there were only 33 kairāanga engaged by the Ministry (as at April/May 2019) and the support given to them was not consistent across regions visited during my investigation. One of the barriers identified to using kairāanga was the lack of 'site readiness'. What site readiness means is that a site understands and accepts the expertise that specialist Māori positions bring. However, it is not clear how a site could be 'ready' until the specialist positions were effectively embedded to provide leadership in this space. The fact that progress to change was slow was self-perpetuating and appeared to reflect, and potentially inflame, a fundamental distrust of a different way of operating.

The work done by kairāanga has been shown to be transformative.

322 Section 4(c) of the Act at July 2017, since amended. There does not appear to be an exact equivalent in the current Act but ss 4(1)(d),(g),(h); 5(1)(b)(iv),(b)(vi),(c); and ;13(2)(b) could be interpreted collectively to give rise to similar obligations.





It also appeared to me that trauma-informed practice was not entrenched within the Ministry. There was no evidence that the Ministry’s staff saw the parents’ childhood histories, as well as experiences of being in care themselves and the Ministry’s prior removal of their children, as traumatic events for parents that required a different response.

I found disabled parents were a group that was poorly served by the Ministry. All the cases I reviewed involved a parent with a disability, ranging from intellectual disability to alcohol or drug misuse and other mental health needs. However, the Ministry did not demonstrate any understanding of their rights in this regard. Over 20 percent of the cases involved a parent with an intellectual disability, but less than 17 percent of those cases had up-to-date specialist assessments relating to this. This reflects a general failure by the Ministry to operate within a human rights framework and to recognise the social model of disability for parents who may have disability related needs.

When the Ministry has concerns about the wellbeing of an unborn pēpi, it is crucial that the Ministry takes advantage of the time before the pēpi is born to assess the situation and plan. This should start as early as possible, and involve whānau as well as other professionals and organisations supporting the parents and whānau. However, my investigation found that the Ministry did not take advantage of the unique opportunity to act early and work with whānau and external parties before pēpi were born.

In 77 percent of the cases I reviewed, the Ministry was aware of the pregnancy, and the reported concerns, 60 working days or more before birth of a pēpi. Yet, it took over 50 working days in nearly half of the cases to complete a Child and Family Assessment. This is well outside the maximum expected timeframe of 36 working days.

High caseloads and limited numbers of kairāanga appeared to be contributing factors to the delays in these cases. This was exacerbated by mixed caseloads where the focus was understandably on the immediate safety of other tamariki identified as at risk, rather than the long-term wellbeing of an unborn pēpi and their whānau. When combined with workload pressures, this appeared to result in cases involving unborn pēpi not being prioritised until the birth was imminent. Many of those interviewed described kairāanga as transformative, and said they made a difference in terms of finding and engaging with whānau early. Unfortunately, except in a few sites, they were either not available or struggling with acceptance or workload.

The outcome is that, in many cases, decisions for pēpi were being made late and without expert advice or whānau involvement. I also found that urgency and the need for without notice applications were created through the Ministry’s inaction and lack of capacity to follow its own processes in a timely and effective way. As a consequence, the parents were disadvantaged—first, by not having an opportunity to respond to the allegations or challenge the information relied upon by the Ministry **before** their pēpi were removed, and second, by having to challenge orders **after** they were made, and when the parents were vulnerable because they were either heavily pregnant or had just given birth.

The Ministry must be guided by the legislative presumption that tamariki are entitled to know and be cared for by their parents.



My investigation, and the Ministry's own reviews, identified much variability in the application and quality of key checks and balances. In particular, 20 percent of the cases I reviewed had no record of the matter being referred to a CPRP, despite this being a statutory obligation, and more than half of the cases were referred well outside the maximum expected timeframe of 36 working days to complete the Child and Family Assessment. In a third of the cases, there was no evidence on the files of the Ministry undertaking a Child and Family Consult, which was required in all cases where a removal was being considered. In 77 percent of cases I reviewed, there was no evidence of consultation with the Ministry's solicitors.

Professionals meetings did not occur in 64 percent of cases I reviewed, and, in half of the cases, the Tuituia report was not completed within the expected timeframe of 36 working days. Significantly, in 7 percent of cases, there was no Tuituia report completed at all. Further, in 46 percent of cases, there was no evidence of professional supervision. Where there were records of professional supervision, 90 percent of those were focused on tasks, actions, and next steps, rather than the required critical and reflective practice.

Overall, the failure to undertake the key checks and balances that have been built into the system severely compromised the quality, robustness, and transparency of the Ministry's decision making. This is particularly concerning because of the wide-reaching and coercive nature of the Ministry's powers, and the overwhelming impact the use of these powers can create.

The Ministry must act in a way that is lawful, fair and reasonable, transparent, and open. Crucially, the Ministry must be guided by the legislative presumption that tamariki are entitled to know and be cared for by their parents. Additionally, a parents' rights to know the allegations against them, and to have an opportunity to respond, are at the heart of Aotearoa's legal system, and are of central importance in the context of the coercive powers of the Ministry.

In practice, without notice applications seemed to be the default position in cases involving unborn or newborn pēpi. Although I accept that the applications were made because the Ministry had serious concerns for pēpi, it is essential that all Ministry staff understand the law, plan carefully and apply it consistently. I note that the Ministry accepted that without notice applications needed more oversight following the Hastings Practice Review.

The Ministry must ensure that the fundamental safeguards in the Act are understood and complied with. This is especially critical in the context of the subsequent child provisions where custody of a previous child has been removed. These have been interpreted by the Ministry as reversing the onus of proof, so parents have to prove that they are not a risk to their tamariki. This is highly problematic for parents who struggle to advocate for themselves. I consider that the issue was made worse because of the Ministry's failure to understand and follow the statutory requirements in applicable cases, resulting in the Court not having the oversight expected in these cases, and in parents not having access to independent advice and representation.



Accordingly, I am not satisfied that, for the period covered by my investigation, the Ministry's decision making practices around applications for without notice interim custody of newborn pēpi under section 78 were reasonable. In particular, the evidence of the Ministry's practices that I have considered did not demonstrate that the Ministry had ensured:

- pēpi's right, as far as is possible, to know and to be cared for by their parents and whānau;³²³
- no pēpi was separated from their parents based on a disability of one or both of the parents;³²⁴
- the parents and whānau were provided assistance to support them in discharging their responsibilities to their pēpi;³²⁵
- (where possible) whānau, hapū, and iwi were able to participate in decision making and regard was given to their views;³²⁶
- (where possible) the relationship between pēpi and their whānau, hapū, and iwi was maintained and strengthened;³²⁷
- endeavours were made to obtain the support of pēpi's parents;³²⁸
- (where possible) decisions affecting pēpi were made and implemented within a timeframe appropriate to their age and development;³²⁹
- the primary role in caring for and protecting pēpi was with their whānau, hapū, iwi, and family group;³³⁰
- whānau, hapū, and iwi were supported, assisted, and protected as much as possible, and any intervention in family life was minimised.³³¹

323 UNCROC, arts 7 and 16.

324 UNCRPD, arts 3, 4(1), 5 and 23(4).

325 UNCROC, art 18(2); and UNCRPD, art 23(2).

326 Section 5(a) of the Act at July 2017, since amended. See s 5(1)(c)(v) at July 2019.

327 Section 5(b) of the Act at July 2017, since amended. See s 5(1)(c)(iv) at July 2019.

328 Section 5(e)(i) of the Act at July 2017, since amended. See s 5(1)(c)(vi) at July 2019.

329 Section 5(f) of the Act at July 2017, since amended. See s 5(1)(b)(v) at July 2019.

330 Section 13(2)(b) of the Act at July 2017, since amended. See s 5(1)(c)(i) at July 2019.

331 Sections 13(2)(b) of the Act at July 2017, since amended. See ss 13(2)(b) and 13(2)(e)-(i) at July 2019.



**Part Three: Second phase
—removal of newborn pēpi**

**Wāhanga Tuatoru:
Wāhanga tuarua
– te tangohanga o
ngā pēpi hou**





Part Three: Second phase—removal of newborn pēpi

Wāhanga Tuatoru: Wāhanga tuarua – te tangohanga o ngā pēpi hou

Having addressed the decision making practices when applying for without notice interim custody under section 78, I now move on to consider the Ministry's practices as these relate to the physical removal of newborn pēpi from their parents' care following the grant of an interim custody order.

The Ministry does not have any guidance and policy specifically developed for this process.³³² None of the memoranda of understanding between the Ministry and the DHBs referred to this process. Nor was it apparent from the material made available to me that the Ministry had agreements about the required or expected practice with other third parties who may be involved in or impacted by the removal processes.

Based on the material before me, I consider that the key elements of a reasonable and fair removal process for a newborn are:

- planning and engagement with colleagues, other professionals, parents, and whānau;
- support for the maintenance of breastfeeding; and
- minimising trauma in the removal and post-removal process.

These are reflected in the Ministry's Hastings Practice Review.³³³

332 There is some guidance relating to the maintenance of breastfeeding, which is addressed under the heading 'Breastfeeding' at page 83 of this report.

333 Hastings Practice Review, above n 23, at 47–48.



Planning

What should happen

As noted earlier, the Ministry has identified the importance of careful planning with colleagues, other professionals, and supportive whānau about the removal itself.

Both Ministry and the DHB interviewees consistently identified that good practice requires early, detailed pre-birth/removal planning with whānau and professionals. This should be documented in a clear and detailed written plan. They also identified the core considerations and matters that should be incorporated in a written plan. These include key concerns, risks and issues, specific restrictions and actions needed to ensure safety, and arrangements for skin-to-skin contact and breastfeeding, unless there were specific safety concerns. Interviewees also emphasised the importance of regular, prompt, and effective communication between the Ministry, the DHBs, and other professionals such as midwives and NGOs supporting parents and whānau.

At interview, representatives from the College of Midwives also emphasised the importance of planning early. They recognised that there will be times when pēpi cannot stay with their mother, but it is important those conversations happen before the birth.

The Hastings Practice Review recognised early, collaborative, and well-thought-through planning is core to minimising trauma and avoiding situations of uncertainty, as well as unsafe and compromised social work practice.

The Hastings Practice Review recognised early, collaborative, and well-thought-through planning is core to minimising trauma





What is typically happening

Interview with DHB staff member

I really don't like the without notice orders ... It's probably one of the worst things that you can actually do. And, I really don't believe that there's a massive need to have that without notice with every whānau ... It's a very traumatic experience for whānau, for the baby...for nursing staff, midwifery staff, it's very traumatic.

...

The DHB should be informed that actually this child is going to be uplifted so that the DHB can prepare and make sure that ... mum's got her own room with baby, to set that environment ... That potentially the midwife is around ... if she knows roughly what time ... they're going to come and serve the notice ... that someone from the Māori health team is around because it's really scary for ... a mum ... She doesn't know what to expect ... In my experience, that's happened without any support for that mum, and Oranga Tamariki, to be quite frank, don't care that there's no support for the mum ... What they've told us in the past is that the mum's not their responsibility.

...

When it is necessary [to remove] ... then they should involve the DHB. We can be trusted. We should be working in partnership.

Planning with parents and whānau

Evidence of planning with parents and whānau specifically about the removal was predominantly absent from the case files I reviewed. Only 15 out of 74 case files I reviewed (20 percent), or 8 of 56 cases where pēpi were actually removed (14 percent), record some input from whānau into a birth/safety plan.

I also note that the *Ministry's s78 Casefile Analysis* found evidence of consultation/meetings with whānau about placement in only 50 percent of its sample of 153 cases.³³⁴ Further, this analysis also found there was no case note describing the removal process in 55 percent of the cases sampled by the Ministry.³³⁵

334 Above n 20, at 5.

335 At 3.



I found a lack of documentation of the removal process generally. This suggests that the Ministry was either not involving parents and whānau in its planning for the removal, or it did not accurately record its actions in this regard, or some amalgam of the two. This is unsatisfactory, as the lack of documentation undermines confidence in the Ministry’s systems. This must be remedied to ensure that an effective transformation of the operating model is underway.

I found a lack of documentation of the removal process generally.

If the planning did occur without being documented, this is inconsistent with good administrative practice, as generally reflected in the Public Records Act 2005,³³⁶ as well as specifically required under the SWRB Core Competence Standards. As I have identified above, these Standards provide that ‘a competent social worker must demonstrate competence to practice within legal and ethical boundaries of the social work profession’, and this includes the requirement that the social worker:³³⁷

...keeps clear and accurate records and ensures these records are made at the same time as the events being recorded or as soon as possible afterwards.

Engagement and planning with professionals

The hospital setting was the main environment from which newborn pēpi were removed in the cases I reviewed. The Ministry’s *s78 Casefile Analysis* also found that over 80 percent of newborn removals occurred in a hospital setting.³³⁸

The hospital setting was the main environment from which newborn pēpi were removed

Again, I would have expected to see evidence of proper engagement and planning with the DHBs in the material I have gathered. However, this was not the case. Interviewees from the DHBs commonly identified the Ministry’s late pre-birth planning and communication of a written plan as a significant concern.

Many DHB interviewees expressed frustration that the Ministry relies on the estimated due date (based on a full-term pregnancy of 40 weeks) despite being aware that it is common for these mothers to give birth at 36 weeks gestation or earlier. Interviewees observed that this meant there were no plans developed by the Ministry in advance of the birth, or that hospitals remained unaware of the Ministry’s plans until the birth was imminent. Further, they noted that late planning often adversely affected the level of information included in the written plan.

Hospitals remained unaware of the Ministry’s plans until the birth was imminent.

336 Section 17(1) of the Public Records Act 2005.

337 The Social Workers Registration Board Core Competence Standards are available at <swrb.govt.nz/social-workers/competence/core-competence-standards/>.

338 Above n 20, at 4.





Interview with Ministry staff member – hospital liaison

That would be one of my big things, and that would be from having been in this role for so long and seeing the frustration ... most of our women birth at 36 weeks, they very rarely go to 40 weeks, because actually their life isn't calm and nurturing. It's chaotic and it's violent and the impact of that is that the baby's not going stay in utero for the long haul. And, the amount of times I've said 'Hospitals need to plan by 36 weeks' and then social workers go 'oh my gosh, I can't believe she's birthed'. I'm like 'really?' ... Of course there's the ones that turn up in labour or after, and ... that can't be helped ... but those that we do know about early, we need to be planning early.

At interview, representatives from the College of Midwives said often midwives are not aware of the Ministry's concerns and things are left to the last moment. They referred to the impact of this lack of planning being that things go 'pear-shaped'.

The views expressed by the DHBs' staff and midwives are consistent with what I have observed from the case files. In particular, pre-birth/removal planning by the Ministry was either late or non-existent for the majority of these case files. Of the 56 case files where newborn pēpi were removed from their parents' care, in 45 percent of the cases (25), there was either no documented plan by the Ministry, or it was only made upon or after the birth.³³⁹ This was despite there having been sufficient time to plan in most cases.³⁴⁰

In all 74 cases, including where pēpi remained in the parents' care, 42 percent (31) of the case files had either no documented plan by the Ministry, or the plan was made after the birth. Yet there were just four cases where the report of concern was received within two days of the birth, meaning that the Ministry had no or very little opportunity to plan.

The case files showed no record of professionals meetings in 77 percent of cases where pēpi were removed (43 out of 56). Just 13 out of those 56 case files showed that professionals meetings had been held or other information indicated these might have occurred.³⁴¹

Information communicated

Even where pre-birth/safety plans were provided to the hospital, the DHB interviewees raised concerns about the variability in the level of detail and quality of information provided in those plans as shared by the Ministry.

339 This includes if a plan was made on the same day that an induction of labour was scheduled.

340 As noted above, in 57 of the 74 cases (77 percent) of the cases reviewed the Ministry had over 60 working days to engage and develop plans with the parents and whānau.

341 By way of comparison, refer to comments under the heading '[Partnering with external professionals, iwi, and organisations](#)' at page 131 of this report.



Interview with DHB staff member

I will still get plans sent from some sites that I just get and go 'really!' ... There's no consistency about good plans or not good plans ... I still occasionally will get 'mother's not allowed to breastfeed' ... or 'not allowed to have skin to skin'.

Most DHB interviewees described being unaware of the Ministry's intentions. They considered that they did not receive full information to enable them to plan. Significantly, they were not updated when the Ministry's plans changed (including about whether or not a newborn was to be removed). The DHB interviewees also expressed frustration at being aware of care and protection concerns but being kept in limbo, as they waited for direction and substantive information, and for more detailed and appropriate birth/safety plans to come through from the Ministry.

In terms of planning with professionals, there was a common perception amongst the DHB interviewees that the Ministry was not communicating well.

Interview with DHB staff member

I think the communication and the willingness to engage is sometimes 'my cards I'm holding them close to my chest' ... they're very good at, sort of, ascertaining the most recent information from us, but not always as good at sharing the information back. And, these things only work on trust ... I think communication is key, and that's one thing that they don't do very well.

Initiatives to better engage

In most of the regions, the Ministry has appointed experienced social workers based in the hospital. This role is usually referred to as the 'hospital liaison social worker'.³⁴² Most interviewees recognised the Ministry's hospital liaison role as key in facilitating connections and communication between DHBs and the Ministry. This role was seen as providing a conduit for health professionals to use when they require information or have concerns about the Ministry's practices.

Most interviewees recognised the Ministry's hospital liaison role as key in facilitating connections and communication between DHBs and the Ministry.

Interview with DHB staff member

In the last 12 months, I would say a majority of those [removals] have gone really well, we've seen a real drastic improvement in how that has gone and I would put that hugely in part to the hospital liaison for Oranga Tamariki. That role is completely invaluable. We actually don't have anyone in that role currently. But that role is the binder between the DHB and Oranga Tamariki ... It's such a key role.

342 This is role was established under the memorandum of understanding signed between CYF, DHBs and Police in 2010/2011.



I understand from interviews with the DHBs and the Ministry that the hospital liaison social workers have been active in seeking to address late planning and communication issues during the two-year timeframe covered by my investigation. In some instances, there has been solid traction and better outcomes were reportedly achieved.

The key initiatives by DHBs and the Ministry's hospital liaisons that were discussed during interviews include:

- interagency sharing of lists of unborn pēpi where there are care and protection concerns;
- unborn clinics;
- guidance and templates for safety/birth plans; and
- individual DHBs' policies focused specifically on the situation where the Ministry is considering the possible removal of newborn pēpi.

I discuss each of these initiatives below. However, my concern is that this effort is not systemic and is instead driven by individuals in particular sites or regions. In the absence of an overarching organisational response from the Ministry, the ability to effect sustained change is fragile. It depends entirely on relationships: the individuals, politics, personalities, and ever-changing staff.

Numerous examples were provided about the variability of the Ministry's engagement in the processes that individual DHBs have sought to implement in this area.

Unborn lists

DHB interviewees described their initiative of having '*unborn lists*'. These lists record the mothers and unborn pēpi they regard as being vulnerable. They advised that a purpose of the list is to ensure hospitals are aware of the concerns when the mother presents to give birth. DHB interviewees explained that they are mindful that these lists might exclude babies on the Ministry's own unborn lists, and vice versa. They actively and regularly shared these lists with the Ministry's staff, and have asked them to add the names of unborn pēpi from its own lists. The aim of this process is twofold:

- to ensure that hospitals are aware of reports of concern for all unborn/newborn pēpi; and
- to enable the DHBs to be proactive in following up with the Ministry about its plans for these pēpi, when this information has not been forthcoming.

However, the success of this initiative is dependent on the Ministry's responsiveness. Interviewees indicated it was a significant challenge to get a response from the Ministry and this contributed to a lack of adequate pre-birth planning.



Interview with DHB staff member

I've been trying to get Oranga Tamariki to tell me who their unborn babies are. That's a really hard task. I don't know why ... If no one's done a report of concern, then I rely on Oranga Tamariki to tell me ... you wouldn't believe how much I've nagged. In fact twice I have sent out recently my list to practice leaders ... no one responded. So, I sent it out again saying 'this is my list, can you tell me does this cross match with yours' ... And so I've sent it out a second time ... out of that second one I've still only got two responses back and one of them ... was a big list of women we knew nothing about.

Unborn clinics

From the interviews, it was apparent that some DHB staff and hospital liaison social workers have instigated 'unborn clinics' at some sites. These clinics or meetings are held at the Ministry's sites and were usually attended by the hospital liaison social worker, the social worker allocated the case and that social worker's supervisors.³⁴³ Interviewees explained that the clinics were instigated by individual staff and are not part of a national strategy or agreement. The clinics were intended to encourage information sharing and early planning by the Ministry. Interviewees noted that this initiative had a positive impact on pre-birth planning. They reported that having frequent clinics enabled the Ministry's staff to focus on the progress being made in each case early and regularly during the mother's pregnancy. The clinics were also used as an opportunity to ensure that the Ministry's staff were connected with the mother's midwife.

However, it was also reported that the momentum of the clinics appeared to have stalled at some of the sites visited. This was because the hospital liaison role had either changed or ceased.

Interview with Ministry staff member – hospital liaison

Bulk [of the mothers] are known before. So, we do have an opportunity, a window of opportunity that we don't take advantage of. It has improved because it was one of my head banging issues ... I started clinics with the social workers and the supervisors for any cases that were on our list, 'what's the planning?'

And so, if they're like right at the beginning of their pregnancy (about 6 weeks), 'ok I'll leave you [the social worker] alone for a couple of weeks so you've got some time to figure that out, and I'll come back to you and I'll ask what's the planning?' ... But that's an initiative versus a policy, I would like to see that actually as a policy country-wide. That would be one of my big [suggestions for change].

[As a result of the clinics] I'm seeing plans come through. I'm seeing the hospital's stresses alleviated ... them knowing what's coming ... It means that when the women go in there there's not the panic around them as well. Everybody's really clear.

343 The participants of the clinic appeared to vary from site to site and may have include staff from the DHB. However, they did not include the pregnant mother.



Interview with Ministry staff member

In all of the time it [unborn clinics] has been working, we have just not had any of those last minute angst. Hospital ringing [and saying] 'look this baby's been born and we can't possibly release him and the risk is, you know, so so so great, why haven't you people done anything?'. We just have not had any of that, and there is nothing worse than those kind of dramas going on in delivery suite, because they ... snatch babies from their mother's rooms when you wouldn't have otherwise and there's no need for it.

Birth/safety plan guidance

Some DHB staff and hospital liaison social workers have actively engaged with relevant sites to communicate the core information that DHBs need to have in a birth/safety plan. This has included the development of templates to support the information provided by the Ministry, and to encourage consultation with other professionals to inform the plan.

Interview with Ministry staff member – hospital liaison

The catalyst for doing that was health, health reasons, because we were finding that, again, social workers weren't consulting ... with midwives or mental health professionals, or any other professional involved. There's often quite a few. So, the plan was to make sure that they [social workers] were having a good wide consultation before they come up with this plan ... if we are taking a [section] 78, how we can do that in the best possible way for the mum ... because I'm finding that social workers ... it's a big hurdle for them to think that mum can breastfeed ... they're [social workers] still thinking 'mum's been using meth, she can't breastfeed'. Well actually it's not our decision to make, it's the lactation consultant, it's the medical professionals and it's mum ... so it's constant re-education of social workers and even supervisors that don't get it.

Where the Ministry had provided core information to, and consulted with, other professionals, there was improved preparedness and reduced angst. However, as I have noted above, there remains much variability in respect of the Ministry's follow-through with these plans and the level of communication and information provided.

Interview with Ministry staff member

In that birthing template there would be: what the worries are, who the midwife is, who the family are, who are the supports ... is it a without notice or on notice ... are the family aware or not, because that always changes the dynamic, who can be present at birthing ... can mum breastfeed ... is skin-to-skin allowed ... So, it's really clear, there's none of that anxiety, unknowns.



DHBs' policies and guidance

Most of the DHBs have established, or are developing, their own internal policies and/or guidelines to set out expectations, and to inform their practices in the situation where the Ministry is considering removal of a newborn from its parents in the hospital setting. The guidelines include, for example, references to:

- the expectation of a comprehensive safety plan well in advance of the estimated date of delivery;
- clear roles and expectations;
- support for the parents before and after pēpi is born;
- breastfeeding and skin-to-skin contact; and
- preparing parents and whānau for pēpi's discharge.

In some cases, DHBs have developed guidance in response to traumatic removals.

Interview with DHB staff member

There is recognition of the both the child's rights for protection and safety, and the women's rights to be treated with dignity and respect and have that process of the baby leaving her care done in a way that preserves her as much as possible emotionally ... We try to recognise both rights, but the child's rights will be always privileged in terms of the right to safety.

Interview with DHB staff member

We've had some quite good outcomes where parents rather than [being] really angry at the child being removed ... they've felt involved ... part of that whole process.

The effectiveness of the DHBs' policies appears to be in relation to matters within the DHBs' control, such as setting of 'ground rules' or minimum requirements expected of the Ministry in the hospital setting. For example, some policies discourage removals from occurring in the weekend or evening, enable support from services in the hospital for the mother, and involve the parents in the planning for the discharge of pēpi to interim caregivers. One DHB provides the opportunity for mothers to stay in the hospital with pēpi for several days after birth to enable breastfeeding and continued skin-to-skin contact and time together. Representatives from the College of Midwives referred to this time as being potentially transformational for the mother, as well as being in the best interests of pēpi.

The policies are not universal, and are those of the respective DHBs, rather than the Ministry. This is despite much of the removal process and the post-removal impacts being shaped by the actions of the Ministry and the quality of its planning and decision making.



Interview with DHB staff member

For [our guidelines] to work, we ... need buy-in from the sites ... and sometimes that's not always there. Some sites work really well with us in terms of [our guidelines] and some sites don't ... It is dependent on sites and sometimes specific social workers as well, and maybe around their inexperience, and then they don't know the expectations, but what we do is ... we're very good at actually communicating that to the sites.

The Ministry has no formal agreement or memorandum of understanding with the DHBs to guide the specific situation where newborn pēpi are removed from parental care following the grant of interim custody orders under section 78.

Interview with Chief Social Worker

When Hastings [occurred] ... we looked ... [at what was] on the Practice Centre. And there is opportunity to strengthen that ... One of the things we haven't done, feature of the old office to be honest, is that we didn't work well with others ... so there's opportunity to work with others ... outside of Oranga Tamariki like the DHBs and the midwives for example ... we should be developing that [removal] guidance jointly.

...

One of the challenges is the individual DHBs, so it's getting buy-in around that from each individual DHB, because each DHB has its own unique sort of settings ... I'd be supportive of it [rolling out guidance on a national basis]. I think there's a bit of a 'tighten a loose framework' ... so having some things that are not mandatory but embedded in ... [for] consistency, but allowing enough flexibility for ... whatever the local circumstances might be.

I am concerned that, in the nine sites visited by my staff, with the exception of one site, the Ministry's staff did not refer to, or necessarily seem aware of, the relevant DHB's policies and guidelines for their area.

The Ministry also does not have an agreement with the organisations that represent midwives, including the College of Midwives and Nga Maia Māori Aotearoa.

Contributing factors

I acknowledge that the lack of evidence of planning with parents and whānau in the case files examined might partly reflect the 'without notice' nature of the Ministry's actions and decisions. However, I am concerned that it may also be indicative of the Ministry's poor record-keeping practices and its failure to appreciate and prioritise the importance of planning with parents and whānau.

The Ministry has no formal agreement or memorandum of understanding with the DHBs to guide the specific situation where newborn pēpi are removed.





Other key factors that appear to be impacting on the late planning of removals are those identified earlier in my report. These are the Ministry's failure to consistently meet expected assessment timeframes, and its failure to consistently hold pre-birth hui ā-whānau and FGCs. As I explained above, it seems the Ministry's practices have been shaped by its:

- inability to effectively identify and engage with whānau;³⁴⁴
- insular practice linked to the Ministry's child protection focus;³⁴⁵ and
- high caseloads.³⁴⁶

Interview with Ministry staff member

I think things happen because sometimes ... somebody's pregnant [and] we don't know it at once ... I think one of the barriers ... is that even [if] we might know that this mum is pregnant, because of our workloads we sometimes don't get the chance to really work the situation and be able to put things in place. And sometimes [it] kind of becomes right towards the end unfortunately. We try not to do that, but the pressure's on social workers because we have a huge caseload and sometimes ... we can't get to do things as quickly as we would like to.

It appears that the lack of national agreements about the removal process with key partners, including DHBs and the organisations that represent midwives, has contributed to inconsistent practice.

Impact

During interviews, staff of both the DHBs and the Ministry recognised that early and careful planning is a key mechanism to help minimise inherently traumatic situations. They also acknowledged that limited last-minute planning leads to situations of uncertainty and rushed decision making, as well as compromised, disrespectful, and unsafe practice, and escalation—essentially the very situations that should be avoided in the birthing context.

Interview with DHB staff member

We want early engagement so that we can all be on the same page and make it the best possible process that we all can, because these guys just come in and take the baby, literally give the papers ... but the impact is huge ... on a whole lot of people in this hospital ... It's human rights for all of us actually not just the unborn, it's about it being inhumane.

344 Refer to comments under the heading 'Engage with whānau, hapū, and iwi' at page 91 of this report.

345 Refer to comments under the heading 'Insular practice linked to the Ministry's child protection focus' at page 151 of this report.

346 Refer to comments under the heading 'High workloads and competing priorities' at page 125 of this report.



Third-party interviewees specifically identified that the ‘without notice’ cases were where the removal process was most traumatic. This was compounded where there had been an absence of proper planning by the Ministry with the DHBs. The DHBs’ staff reported that the lack of adequate planning meant they were placed in the position of being compromised and unable to fully meet their duty of care to the mother and to pēpi. They described cases where there had been:

- scenes of violence, screaming and crying in the hospital ward or corridors;
- heightened tension and fear amongst staff and other patients;
- compounded risks of violence and safety concerns for the parents and whānau involved;
- wards being placed in ‘lock-down’;
- unclear and uncertain expectations;
- no opportunity to pre-arrange support for the parents and whānau at a time when this was crucial;
- the lack of time for the DHB to arrange a private space for difficult conversations to take place; and
- increased and long-term trauma for all the parties involved.

A significant consequence of late planning is that there was insufficient time for the Ministry to make a proper assessment of the parents and potential whānau carers and involve them adequately in decision making processes, as required by the Act and general Ministry policy and guidance.

In these situations, the location of the birth can shape the Ministry’s decision making, with this determining whether pēpi remains in the care of their parents and/or whānau, or is initially placed in non-kin care. This is because some hospitals have capacity for the mother to remain in the hospital with pēpi for several days, and in some cases up to a week. This provides time (and a safe space for the mother and pēpi) for the Ministry to plan for the ongoing safety and care of pēpi with the parents, whānau, and professionals.

Other hospitals cannot offer this. This may result in pēpi having to move to a temporary non-kin placement while the Ministry assesses other options.

In over half of the cases I reviewed, the Ministry initially placed pēpi with non-kin. For Māori pēpi, approximately 64 percent were initially placed with non-kin caregivers. For pēpi identified as non-Māori, approximately 52 percent were placed initially in non-kin care.

A similar outcome was found by the Ministry through its internal review of 153 case files. In that review, almost half of all pēpi were placed initially in non-kin households. While no analysis based on ethnicity was reported by the Ministry, it found that placement with whānau was significantly higher in cases which involved iwi/Māori including kairāranga.

For Māori pēpi, approximately 64 percent were initially placed with non-kin caregivers.





The Ministry also undertook an analysis in June 2019 of 62 cases where a newborn pēpi entered its custody. That review found that over half of the pēpi were initially placed with non-whānau carers.³⁴⁷

I have found that limited planning and engagement undertaken pre-birth, and the particular hospital where a pēpi is born, can influence whether or not the pēpi’s first placement is with whānau or non-kin, with this contributing to inequitable outcomes for Māori.

Also impacting initial placement decisions are the timing of referrals to, and variable availability across Aotearoa of, appropriate services (for example, drug treatment or residential parenting services) to support initial placement of pēpi with their parents while ongoing support and assessment is undertaken.

Interview with Ministry staff member

Sometimes what happens for a mum in the latter stages of pregnancy is we often have a period of her being drug free ... and if we could capture that window of opportunity where mum hasn't been using, and all of that early attachment has happened for baby and hopefully throughout the pregnancy, and we were able to get her into the right program, I would love to see that happen for more mums. And sometimes there just isn't ... availability. Baby has to go into a care situation whilst we try and get mum into rehab. But then mum's having to deal with the trauma of ... having her child coming out of her care and, understandably, lots of mums go back to using [drugs] ... So, there's a window of opportunity where this mum has this little new baby. There's all of this hope, and I would love this to be able to maximise it, really work with that.

Interview with Ministry staff member

We don't have places where mum and babies can go together ... we don't have those kinds of facilities where parents, mum and child, newborns, can stay together and be supported through. And, we don't have, lot of times, family options that might be suitable ... or we might identify little bit later that 'ok there is some family' ... so we have to place them with Ministry caregivers ... lack of resources is a big thing.

To summarise, the impact of late and limited planning is compromised social work practice, escalation and trauma. Most significantly, it may contribute to the Ministry’s initial placement of pēpi with non-kin in half of the cases I examined. This is at odds with the objects and principles of the Act and the obligations under international law.

The impact of late and limited planning is compromised social work practice, escalation and trauma.

³⁴⁷ *Babies and children entering Oranga Tamariki care*, above n 35, at 4.





Maintaining breastfeeding

What should happen

As I have explained above, the Ministry's Practice Centre contains specific guidelines on the expectation to support and maintain breastfeeding when pēpi are removed.³⁴⁸ In summary, that guidance requires that the Ministry:³⁴⁹

- makes all efforts to ensure that where pēpi are breastfeeding, this can continue;
- supports the mother and pēpi to meet regularly throughout the day;
- provides the mother with the practical necessities to express breastmilk and make arrangements for this to be provided to her pēpi;
- ensures considerations about feeding are discussed with the mother and others who have guardianship and consent obtained; and
- ensures consultation with medical professionals in cases where the mothers have illnesses or infections that could be passed through breastmilk, as well in situations where there are concerns about potential alcohol or drug use.

These recommendations accord with the expert lactation advice I received. Regarding the contact between a mother and her pēpi to maintain breastfeeding, the expert advice provided to me is as follows:³⁵⁰

Ideally this mother would be placed in a supervised environment so that she and baby are not separated, and all feeds could continue as breastfeeds.

...

I recommend that contact visits are as frequent as possible to maintain the mother/baby relationship and breastfeeding, ideally every day and for at least three hours each time. It would be best if the caregivers can hold off bottle feeding the baby prior to the visit or alternatively give the minimal amount possible so that baby will be awake and breastfeed at the visit. The contact visits would be in a private room and if supervision is required, by a person the mother is comfortable with. Skin to skin cuddles and breastfeeding would be encouraged by social work staff during these visits.

348 Refer to comments under the heading 'Breastfeeding' at page 83 of this report.

349 This guidance was last updated on 24 February 2017 and is available at <practice.orangatamariki.govt.nz/previous-practice-centre/policy/caring-for-children-and-young-people/key-information/maintaining-family-whanau-relationships/>.

350 Michelle Carter Report to the Ombudsman: *Evidence Based Lactation Best Practice—Oranga Tamariki Removal of Newborns* (16 April 2020).



What is typically happening

My review of the case files found very little information recorded or action taken to appropriately give effect to the specific expectations on the Ministry to support the maintenance of breastfeeding and attachment between pēpi and parents.

From the cases I reviewed, in at least 48 cases the mother had decided to breastfeed. I was not able to positively ascertain the mother’s wishes in the bulk of the remaining cases. Only 29 case files contained written plans that included a reference to breastfeeding. In 33 of the 48 cases (where it was clear that the mother had made a decision to breastfeed), the pēpi was removed. Of these, the initial contact between the mother and her pēpi following the removal (and post-hospital separation) was arranged as follows.

Table 1: Initial contact between mother and pēpi and mother following removal

Frequency of contact	Number of cases where mother planned to breastfeed
Daily	1
Four times a week	2
Three times a week	7
Twice a week	11
Once a week	4
Unclear /other	8

Therefore, despite it being explicit in the Ministry’s guidelines that the mother and her pēpi should be supported to meet regularly throughout the day for feeding, it was uncommon for the Ministry to allow contact more than three times a week. In nearly half of these cases, the initial contact was just once or twice a week.

When a mother wanted her pēpi to continue to receive breast milk after removal, in the absence of frequent contact to breastfeed, she needed to express milk and store it for delivery to the pēpi. The files show significant variance in the response from the Ministry to support this. For example, in some cases, the Ministry provided the mother a voucher to purchase a breast pump from a children’s retail outlet, or provided a breast pump prior to discharge from the hospital. There was also inconsistency in whether plans and arrangements had been made to store and transport milk to pēpi.

It was uncommon for the Ministry to allow contact more than three times a week.

Interview with DHB staff member

...the last uplift that we’ve had Oranga Tamariki have paid for a breast pump ... that is the first time that I’ve actually seen ... Oranga Tamariki ... acknowledged that actually it makes mums feel good that they are still providing something for their baby. It [breastmilk] continues to do all that self-immunisation stuff. And, for the baby there might be a transition onto formula and bottle-feeding because, of course, the baby would get the mother’s milk via a bottle.





Interview with DHB staff member

We always have that conversation during our meeting with Oranga Tamariki around ‘if mum is breastfeeding, how will the milk be transferred?’, and ‘who will do that?’, and ‘what will that look like?’, and ‘how often?’ so that we’ve got really clear guidelines ... If there’s not a plan for it, it just won’t happen ... But again, very social worker dependent ... because often it falls on the social worker to do the collecting or picking it up from the site or wherever it is, and taking it to the caregiver. So it’s an added responsibility for them that some are really onboard with and others are just not at all ... but the majority are quite supportive.

I have observed an expectation on the part of the Ministry that breastfeeding would only be sustained by the mothers for a short time. This was primarily expressed as judgements about the mothers’ lack of commitment or perseverance—reflecting concerns about their parenting abilities. There did not appear to be any appreciation that the ability to sustain breastfeeding could be due to a lack of, or limited, support from the Ministry to do so. This was despite the interim nature of the section 78 custody orders and the obligation of the Ministry to support breastfeeding.

Interview with Ministry staff member

But the reality of it is ... there wouldn’t be many mums that would follow through with that [providing breastmilk]. And if we actually perhaps were dealing with mums that were so determined to give fresh, non-contaminated breastmilk to their baby, they could probably still have the baby.

The material before me also suggests that the Ministry is responding inconsistently to mothers who wish to breastfeed where there is a concern that they are using, or may use, alcohol or drugs. The variability in Ministry’s practices ranges from seeking and being guided by the advice of medical professionals, to unilaterally prohibiting breastfeeding if drug taking is suspected.

Interview with DHB staff member

If there’s drug concerns then they say ‘well we’re not taking the breastmilk anyway’, despite us saying to them ‘actually if there’s small amounts of drugs in the breastmilk, that baby’s been exposed for nine months of pregnancy, it’s still ok to give it to it, and, actually, it’s probably helpful for that baby to withdraw’.

Contributing factors

Despite the importance of breastmilk to pēpi’s health, and the specific obligations under UNCROC, the Ministry did not consistently ensure that appropriate efforts were made so that breastfeeding could continue in the case files examined.

The Ministry did not consistently ensure that appropriate efforts were made so that breastfeeding could continue.





Typically, the Ministry did not prioritise support for mothers to maintain breastfeeding. Instead, the difficulties with adequate resourcing and practical requirements to support breastfeeding (for example, supervision of contact, transporting breastmilk, caregivers raising concern about frequent contact and the mother breastfeeding) undermined any commitment to breastfeeding.

Interview with DHB staff member

They never think about it prior. We brought up at that stage the breastfeeding and said ... 'mum's exclusively breastfed this baby, what are you going to do to continue that?' 'Oh we can't get a pump at this late notice' ... So there was no provision made for that. Sometimes they will make the provision if you have planned it in advance that they will get a pump, and have some sort of system that they might have a daily pick-up of the breastmilk ... A lot of the time these mums end up giving up breastfeeding.

There was variable understanding of expected practice in relation to facilitating contact between the mother and her pēpi to support breastfeeding.

Interview with Ministry staff member

We just set up access for mum and I think she was seeing [pēpi] I can't remember if it was two or three times a week but to allow for her ... to breastfeed during the visits as well as ... provide [or] bring along ... pumped milk if she wanted to, for it to be frozen and given to [pēpi] and we also spoke with her about a formula...

...There's not a set guideline [around access per week] ... as standard practice ... we generally say two to three times [a week]. It wouldn't be less than twice, but it would probably not be more than three ... and breastfeeding of course is really important, so that decides [access] as well.

Where there are concerns about alcohol or drug use by the mother, the information before me suggests that the pēpi's access to breastmilk is arbitrary and dependent on the views of individual Ministry staff members, rather than being consistently guided by medical advice.

Interview with DHB staff member

You can't really say a woman can't breastfeed. That should be on the judgement of the medical staff at the time. Because even if a woman had used meth the day before ... it's actually better for a baby to have [breastmilk]. Unless she's had the baby and raced out and gone and had another hit, then obviously you wouldn't be letting her breastfeed ... A little bit would probably let the baby come down as she does rather than having a sudden drop off ... it [methamphetamine] does come through [the breastmilk] but there's not enough research.

Limited knowledge of the research in this area and individual staff preferences appear to influence the Ministry's decision making in these circumstances.



While the Ministry has issued guidance to its staff on breastfeeding, as noted in an earlier part of my report, this material does not explicitly refer to the rights to breastfeeding as provided for under UNCROC. In my view, the lack of a clear and unequivocal statement in the Ministry's guidance about the right to breastfeeding and the benefits of breastmilk may also be contributing to the inconsistency of the Ministry's practices.

Impact

Overall, I am not satisfied that the Ministry is taking sufficient steps to support exclusive breastfeeding where the mother desires it.

This is of concern for a number of reasons, including the potential loss of health benefits of breastfeeding for pēpi. Most significantly it means a failure to meet the obligations under Article 24(2)(e) of UNCROC.

It is worth emphasising that the denial of these rights and health benefits for pēpi occur in the context of interim decisions about custody and placements, which have been made without notice to the parents and where they have not been provided advocacy and the right to be heard. As no final decisions have been made about custody and placement, any interim decision making by the Ministry that does not support parents to maintain breastfeeding where that is their preference, is likely to have significant long-term implications, and to negatively impact the health and wellbeing of pēpi and bonding and attachment with their mother.

Minimising trauma

What should happen

The Ministry has no specific practice guidance for its staff on how to provide support for parents after they have had pēpi removed to help deal with the immediate trauma, grief and loss, and to look at their support needs going forward. However, for the period I am investigating, one of the key legislative purposes of the Act was to:³⁵¹

...[assist] children and young persons and their parents, family, whanau, hapu, iwi, and family group where the relationship between a child or young person and his or her parents, family, whanau, hapu, iwi, or family group is disrupted.

The Ministry has noted that in the context of removals 'social workers should ensure parents have an opportunity to say goodbye to pēpi, have support people present, and be provided with clear information about what the next steps are'.³⁵² In addition, this information should also be recorded in CYRAS.

351 Section 4(c) of the Act, at July 2017, since amended.

352 Hastings Practice Review, above n 23, at 48.



In my view this means that when a removal is executed by the Ministry, it should provide parents and whānau with the opportunity for ngākau maharatanga me te ngākau aroha; a period of 'quality time' that reflects consideration, empathy, sympathy and love.

DHB interviewees gave evidence of the grief, trauma, and support needs of parents after a pēpi has been removed.

Interview with DHB staff member

And the grief that we have to endure ... the keening that happens is unbelievable, and the whole ward hears ... they're victims these women ... but they're treated like they're criminals, but they've got no rights.

...

It is for them like a baby has died.

Predominantly this was conveyed by staff from the DHBs in the context of parents' needs being unmet and the lack of certainty about who should be supporting them.

The intense trauma and grief of having pēpi removed is documented in the literature:³⁵³

It is impossible to describe and capture the extent of the emotional devastation that is involved in temporarily losing custody and then permanent removal and loss of custody of your children. The pain of the process of initial loss, and then watching other women provide mothering for your children, of being judged by all of those around you, and finally, of knowing that your life will be devoid of the presence of your children forever.

What is typically happening

There is little information documented about trauma-informed practice and support in the case files I have examined. This is despite the practice expectation of good record keeping. The case files contain little recorded information about the removal process, to understand the steps put in place by the Ministry to meet practice expectations and to minimise the trauma for the parents and whānau when pēpi are removed. As such, it is difficult to see how the Ministry assures itself of quality practice in this profoundly difficult and traumatising area of social work practice.

353 Marsha Carolan, Kathleen Burns-Jager, Katie Bozek & Rocio Escobar Chew "Women Who Have Their Parental Rights Removed by the State: The Interplay of Trauma and Oppression" (2010) 22 Journal of Feminist Family Therapy 171 at 183.



Indeed, this was a similar finding of the Ministry's own analysis of 153 case files. That analysis looked at whether there was a case note describing the removal process. Over half of the cases (55 percent) did not have such a case note. Therefore, the Ministry concluded it was not possible to draw a conclusion about that aspect of the process.³⁵⁴

In approximately 70 percent of the 56 case files that I have reviewed where a pēpi was removed from their parents' care, it was not apparent whether whānau had time with the pēpi to prepare for the removal. In nine cases, this clearly did not happen. In another nine cases, whānau did have time with the pēpi to prepare for removal—notably, four of these cases were in two sites where other key elements of good practice were observed.

Similarly, in approximately 70 percent of the 56 cases, it was not clear what level of contact the mother had with her pēpi prior to the removal. In the 17 cases where there was information about this, 13 mothers had 24 hours or more with their pēpi, and four had less than 24 hours.

It was also difficult to identify whether support people were present for the removal. Interviews conducted for my investigation indicated that where there is support provided, it is largely put in place by either the hospital or the midwife and not by the Ministry.

Similarly, based on interviews, it seemed that the level of engagement with the parents about their preferences for saying goodbye and how this is done came down to either individual Ministry staff or the guidelines and approaches of individual DHBs.

Support for parents after the removal of pēpi post-birth is a key unaddressed gap that the Ministry's staff are aware of, but where the Ministry has taken no apparent action. This is despite there being an unequivocal understanding that many parents are caught in a cycle of themselves being, or having been, in the Ministry's care, and having more than one child removed.

Interview with Ministry staff member

Most of the ones we've got coming through have got history. They've all got history [with the Ministry]. And you just sit there and you think 'what did you expect?' ...Without good, robust intervention, they come through as damaged people, and there's not the counselling services out there ... disordered attachment and attachment and bonding issues. [Services are] not there.

Hospital staff described practices where their mental health services may seek to extend the standard two-week timeframe to provide support to the mother, but this is ad hoc and has varying success. Individually, the DHB staff will make community referrals for the mother, though typically options are limited.

³⁵⁴ s78 Casefile Analysis, above n 20, at 3.



The finding in the Hastings Practice Review is universally applicable in relation to the Ministry's practice across all the case files I have reviewed:³⁵⁵

There is no clear evidence of consideration of the mother's therapeutic or support needs or of the likely impact that removal of another child would have on her wellbeing.

During interviews and in the case files reviewed, there was little evidence that the Ministry's staff were exercising trauma-informed practice or taking action to identify and connect parents to services and support to respond to their grief, trauma, and healing needs.

Contributing factors

Despite the clear expectations, as explained in the Hastings Practice Review and the Ministry's guidance on trauma-informed practice, many of the Ministry's staff did not appear to consider that they are responsible for assessing the needs of parents and identifying and connecting parents to appropriate supports once pēpi were removed, let alone ensuring that the appropriate supports were accessible and relevant.

As I have noted previously, the Ministry's frontline staff frequently stressed that their focus was pēpi. However, such a narrow view fails to take into account that:

- there was a statutory obligation on the Ministry to assist whānau when the relationship with pēpi 'has been disrupted';³⁵⁶
- these are interim orders only;
- the wellbeing of pēpi is interlinked to the wellbeing of their parents; and
- the ongoing trauma and harm will prevail in future pregnancies and potentially result in continued involvement of the Ministry.

There was little evidence that the Ministry's staff were exercising trauma-informed practice.

The wellbeing of pēpi is interlinked to the wellbeing of their parents.

Interview with Ministry staff member

We don't really have the funding for that [working with parents]. We offer things like parenting skills and all that sort of thing. But we don't offer them counselling, as in trauma counselling or anything like that. I mean, our focus of our work is children and young people, it's not the parents.

Some interview participants indicated that since the Ministry was responsible for the removal, it is not well placed to help with the healing.

Interview with DHB staff member

The midwife ... will work with mum and follow mum ... post-natally. The social worker can, but often once they've discharged that's it. Because ... the mums don't want to continue having any kind of contact and relationship with a process ... that has just been awful.

355 Hastings Practice Review, above n 23, at 43.

356 Section 4(c) of the Act, at July 2017, since amended.





A key barrier identified was that most social services offered would only be available to the parents if they had pēpi in their care.

Interview with DHB staff member

Most social services only take families with kids ... most of them are funded government contracts ... if there's no CYFs contract, you'll find [services] will pull out. They're allowed to work with them [parents] for so many weeks afterwards and that's it, door shut. Maternal mental health are the same ... as soon as the person loses their child, they can only work with them for probably about two weeks and then they've got to close the case ... we [try to] often stretch the things that we should be stretching.

Impact

Limited case file recording makes it very difficult for me to be satisfied that the Ministry has ensured that, before executing the removal, the parents and whānau were provided with the opportunity for ngākau maharatanga me te ngākau aroha; a period of 'quality time' that reflects consideration, empathy, sympathy and love. In addition, the Ministry did not ensure that the parents and whānau had their support people present. Nor did it provide them with clear information on next steps.

The situation and need are well summarised in the following excerpt by researchers from the United Kingdom, who have studied the experiences of mothers in these situations:³⁵⁷

All of the women in interview described an escalation of problems following child removal. This included homelessness and housing instability, further interpersonal violence, instances of criminal behaviour and unplanned repeat pregnancy ... Descriptions of suicidal thoughts were common, and in the majority of cases, women described self-harming behaviours, typically excessive drinking or drug taking and entering into very negative intimate relationships.

My investigation has also seen such ongoing problems forming the grounds for subsequent removals. It is critical therefore that the Ministry assists mothers to address their issues to reduce the risk to any future pēpi and, ideally, to enable that pēpi to remain with her.

It is difficult for me to be satisfied that [...] the parents and whānau were provided with the opportunity for ngākau maharatanga me te ngākau aroha.

357 Broadhurst and others *Vulnerable Birth Mothers and Recurrent Care Proceedings: Final Main Report*, above n 54 at 102.





Interview with DHB staff member

The missing part ... is that real therapeutic approach of sort of addressing the unresolved trauma that's kind of gone on.

...

I think for prevention and early intervention, I think this is where health and Oranga Tamariki should be actually working closely together and pooling their resources for that really early stage.

Summary: Second phase—removal of newborn pēpi

I found minimal evidence that parents and whānau had been involved by the Ministry in planning the removal process. Late and limited pre-birth planning, communication and information sharing with DHBs, and variable information provided in safety/birth plans are also key issues that I identified.

I observed that where there have been good planning and improvements in practice, these have flowed from the efforts of individual staff. The Ministry had no set guidance or established agreements with its health partners to identify the expected or required practice for social workers specifically in the area of newborn removals.

I am concerned about the consequences of poor planning on parents and on hospitals. For parents, it was likely to cause uncertainty, fear, and anxiety. In the hospital setting, interviewees were concerned that the Ministry's late planning resulted in uncertain, rushed decision making, which compromised practice and increased escalation.

Insufficient support was offered to breastfeeding mothers. In around half of the cases where the mother planned to breastfeed, initial contact with pēpi was just once or twice a week. The Ministry's guidance in this regard was not followed. I am not satisfied that the Ministry was prioritising and taking sufficient steps to support exclusive breastfeeding where that was appropriate and desired by the mother. The Ministry's practices were inconsistent with UNCROC obligations and the recommendations of the World Health Organization and Ministry of Health around exclusive breastfeeding for the first six months of pēpi's life.

When a removal decision was executed, I found that parents and whānau were not provided with opportunity for ngākau maharatanga me te ngākau aroha; a period of 'quality time' that reflects consideration, empathy, sympathy and love. In addition, the Ministry did not ensure that the parents and whānau had their support people present. Nor did it provide them with clear information on next steps. There was no record of support offered to parents and whānau to deal with the trauma and grief of child removal, or to help their healing. There was little evidence that that trauma-informed practice had occurred consistently.

Where there have been good planning and improvements in practice, these have flowed from the efforts of individual staff.





On the whole, I am not satisfied that the Ministry's practices, relating to the physical removal of newborn pēpi from their parents' care following the grant of a section 78 interim custody order, met the objects and principles of the Act as well as the obligations under international law. In particular, the evidence of the Ministry's practices that I have seen does not demonstrate that the Ministry ensured:

- pēpi's right, as far as is possible, to know and to be cared for by their parents and whānau,³⁵⁸
- the parents and whānau were provided assistance to support them in discharging their responsibilities to their pēpi;³⁵⁹
- the primary role in caring for and protecting pēpi was with their whānau, hapū, iwi, and family group,³⁶⁰
- (where possible) whānau, hapū, and iwi were able to participate in decision making and regard was given to their views;³⁶¹
- (where possible) the relationship between pēpi and their whānau, hapū, and iwi was maintained and strengthened;³⁶²
- endeavours were made to obtain the support of pēpi's parents;³⁶³
- pēpi and their mothers were supported in their rights to breastfeeding;³⁶⁴ and
- parents and whānau were given assistance when their relationship with pēpi was disrupted.³⁶⁵

358 UNCROC, arts 7 and 16.

359 UNCROC, art 18(2); and UNCRPD, art 23(2).

360 Section 13(2)(b) of the Act at July 2017, since amended. See section 5(1)(c)(i) at July 2019.

361 Section 5(a) of the Act at July 2017, since amended. See section 5(1)(c)(v) at July 2019.

362 Section 5(b) of the Act at July 2017, since amended. See section 5(1)(c)(iv) at July 2019.

363 Section 5(e)(i) of the Act at July 2017, since amended. See section 5(1)(c)(vi) at July 2019.

364 UNCROC, art 24(2)(e).

365 Section 4(c) of the Act at July 2017; since amended.



Part Four: Conclusion

**Wāhanga Tuawhā:
Whakakapi**





Part Four: Conclusion

Wāhanga Tuawhā: Whakakapi

The Oranga Tamariki Act 1989 (the Act) includes a number of options that permit the Ministry to act quickly to remove pēpi who are at immediate risk of serious harm. There is a hierarchy of relevant responses, from a place of safety warrant (which is applied for without notice and lasts a maximum of five days) to final custody orders made after a family group conference (FGC) has been held. A section 78 order sits between the two. It is an interim custody order and it is intended to be temporary. In sum, section 78 interim custody applications are meant to be reserved for urgent cases where other options to ensure safety of pēpi have already been considered by the Ministry.

Removing a newborn pēpi from their parents is an extraordinary use of the government’s power, and as a matter of fairness and law those parents must have the opportunity to respond and have input in all but the most exceptional circumstances. Accordingly, the expected norm is that the Ministry’s section 78 applications should be made with notice, meaning parents and whānau are informed and can respond.

What I found is the Ministry routinely applied for without notice interim custody of unborn and newborn pēpi. All of the 74 custody cases I examined, from 2017 to 2019 across nine of the Ministry’s sites, involved without notice applications. The Ministry’s own review of section 78 cases identified that the majority of the parents and whānau were not given notice before the Ministry removed their newborn pēpi. This has also been confirmed by data supplied by the Ministry of Justice which showed that over 94 percent of **all** section 78 orders for 2017/18 and 2018/19 were granted on the basis of without notice applications.

My investigation found that the Ministry was usually aware of the pregnancy and reported concerns for a significant period before the birth of pēpi. In 77 percent of the cases I examined, the Ministry had 60 working days or more to assess and explore options, and to develop plans to ensure the safety of pēpi. However, the Ministry did not consistently utilise the available tools and mechanisms, such as hui ā-whānau and FGCs, to engage early with parents and whānau.

The Ministry also did not use that window of opportunity to plan early with professionals and external parties. In most of the cases, the Ministry did not meet the formal timeframe for completing its assessments. I also found variable use of the key checks and balances, such as referrals to Care and Protection Resource Panels, use of the Child and Family Consult, professionals meetings, completion of the Ministry’s assessment tool (Tuituia) and professional supervision.

The outcome is that in many cases decisions were being made late and without expert advice or independent scrutiny, and, most concerningly, without whānau involvement.



I found that urgency was created through the Ministry's inaction and lack of capacity to follow processes in a timely and effective way. As a consequence, parents were disadvantaged—first, by not having an opportunity to respond to the allegations or challenge the information relied upon by the Ministry **before** their pēpi were removed, and second, by having to challenge orders **after** they were made, and when the parents were vulnerable because they were either heavily pregnant or had just given birth.

I found that the rights of disabled parents were not visible in either policy or practice. All the cases I reviewed required a disability rights based response from the Ministry but this did not occur. That is a significant breach of the United Nations Convention on the Rights of Persons with Disabilities.

In terms of the Ministry's practices relating to the physical removal of newborn pēpi, my investigation also found there was late or limited planning and engagement with parents and whānau and other external professionals. I also found limited support was offered to mothers who wished to breastfeed. Finally, I am not satisfied that, when the removal was executed by the Ministry, it provided parents and whānau with the opportunity for ngākau maharatanga me te ngākau aroha; a period of 'quality time' that reflects consideration, empathy, sympathy and love. In addition, the Ministry did not ensure that the parents and whānau had their support people present. Nor did it provide them with clear information on next steps. There was no support offered to parents and whānau to deal with the trauma and grief of child removal, or to help their healing.

My opinion

In my opinion, the content of the Ministry's overall operating policies and guidance, effective during the period covered by my investigation, were generally adequate and reflective of the objects and principles of the Act. However, I identified some gaps in the Ministry's policies and guidance.

In particular, my opinion is it was unreasonable that:

- there was no comprehensive guidance on the use of without notice section 78 applications, and the available guidance on emergency powers did not articulate clear criteria for how staff were meant to identify and assess the viability of other options to secure the safety of pēpi;
- the subsequent children provisions, and the Ministry's corresponding guidance, have placed the responsibility on parents for gathering evidence to demonstrate that the risk of harm has been satisfactorily removed;
- there was limited specific guidance for unborn and newborn pēpi, and the available guidance did not:
 - include reference to trauma-informed social work practice vis-à-vis assessing the parents' own childhood histories of abuse and/or neglect, as well as experiences of being in care themselves, and the Ministry's prior removal of their children as traumatic events for



- parents that required a different response; or
- reflect the legal obligation on the Ministry to ensure that, where pēpi are at risk, parents and whānau are provided assistance to support them in discharging their responsibilities to pēpi;
- the rights of disabled parents were not reflected in the Ministry's overarching Practice Standards;
- there was an overall lack of guidance in respect of disabled parents, and the available guidance:
 - did not identify that alcohol or drug misuse and other mental health needs of parents require a disability rights-based response;
 - in relation to parents with intellectual disability:
 - › appeared to be based on an outdated medical (deficits-based) model of disability;
 - › did not emphasise that IQ should not be used as a sole measure of parenting capacity;
 - › did not specify the obligation under international law that no pēpi is separated from their parents based on a disability of one or both of the parents;
- with the exception of breastfeeding, the Ministry did not have any guidance and policy specifically developed for the process of removing pēpi once section 78 interim custody orders are granted;
- the available guidance on breastfeeding did not include explicit acknowledgements of:
 - the rights to breastfeeding as provided for under the United Nations Convention on the Rights of the Child; and
 - the recommendations of the World Health Organization and the Ministry of Health on exclusive breastfeeding for the first six months of pēpi's life.

It is also my opinion that, during the period covered by my investigation, the Ministry's decision making practices connected with the removal of newborn pēpi under section 78 of the Act were unreasonable. The evidence I have considered did not demonstrate that the Ministry consistently met the objects and principles of the Act and the obligations under international law.

In particular, I do not consider that the Ministry had adequately ensured:

- without notice applications for interim custody were reserved for urgent cases where all other options to ensure the safety of pēpi had been considered;



- a pēpi’s right, as far as is possible, to know and to be cared for by their parents and whānau;
- no pēpi was separated from their parents based on a disability of one or both of the parents;
- the primary role in caring for and protecting pēpi was with their whānau, hapū, iwi, and family group;
- the parents and whānau were provided assistance to support them in discharging their responsibilities to their pēpi;
- (where possible) whānau, hapū, and iwi were able to participate in decision making and regard was given to their views;
- (where possible) the relationship between pēpi and their whānau, hapū, and iwi was maintained and strengthened;
- endeavours were made to obtain the support of pēpi’s parents;
- (where possible) decisions affecting pēpi were made and implemented within a timeframe appropriate to their age and development;
- the primary role in caring for and protecting pēpi was with their whānau, hapū, iwi, and family group;
- whānau, hapū, and iwi were supported, assisted, and protected as much as possible, and any intervention in family life was minimised;
- pēpi and their mothers were supported in their rights to breastfeeding; and
- parents and whānau were given assistance when their relationship with pēpi was disrupted.

Recommendations

Pursuant to section 22(3) of the Ombudsmen Act 1975 I recommend the following:

- 1 The Ministry:
 - a ensures its current policies, training material and practices make explicit that without notice interim custody applications are reserved for exceptional urgent cases where all other options to ensure the safety of pēpi are unavailable;
 - b develops comprehensive guidance with clear criteria to enable its staff to assess the viability of other options to ensure the safety of pēpi in urgent cases;
 - c exercises best endeavours, in all but the most exceptional of cases, to use a place of safety warrant or truncated notice period when the Ministry learns of a pregnancy at a late stage and determines pēpi to be at imminent risk;



- d takes immediate measures in terms of reports of pēpi at risk to ensure that all statutory requirements are met, and in particular:
 - i commences an investigation as soon as practicable (section 17(1)(a) of the Act);
 - ii consults a Care and Protection Resource Panel in all cases and as soon as practicable after an investigation has commenced (section 17(1)(b) of the Act) and at subsequent stages where required (sections 21(1)(a) and 31(1)(e) of the Act);
 - iii convenes a family group conference (section 18(1) of the Act);
 - e establishes timeframes, reporting frameworks, quality assurance and monitoring to demonstrate appropriate ongoing compliance with all statutory requirements as these relate to without notice removals of newborn pēpi; and
 - f reports publicly against the framework for monitoring detailed in recommendation 1(e) every six months.
- 2 Additionally, the Ministry:
- a reviews its processes to ensure that all cases involving unborn or newborn pēpi are given the necessary priority;
 - b reviews its policies and practices to ensure whānau engagement is prioritised in all cases involving unborn or newborn pēpi, including family group conferences and hui ā-whānau where appropriate;
 - c develops, in partnership with iwi and other Māori groups, a national strategy for:
 - i effective engagement with whānau, hapū, and iwi, including provision for localised relationship-based implementation with centralised support; and
 - ii enhanced cultural competency of staff;
 - d develops memoranda of understanding with the Ministry of Health, the DHBs, midwifery representatives, and other relevant parties to ensure appropriate information sharing, clear and defined roles, and effective early planning for at-risk pēpi;
 - e works with the relevant providers to ensure that all social workers are trained in, and engage, trauma-informed practice that is underpinned by te ao Māori, and consults with the Social Workers Registration Board to assist with the achievement of this;
 - f develops specific guidance for cases involving unborn and newborn pēpi that:
 - i requires trauma-informed social work practice when parents have experienced childhood abuse and/or neglect, been themselves in



- care or had tamariki previously removed by the Ministry;
- ii reflects the obligations on the Ministry to ensure that where pēpi are at risk, parents and whānau should be provided assistance to support them in discharging their responsibilities to pēpi;
- g develops clear guidance, with supporting tools, for social workers to ensure all legislative and procedural safeguards are engaged with respect to subsequent tamariki, pending the outcome of the Ministry's review of the subsequent children provisions;
- h amends its policies and practices relating to the subsequent children provisions to make clear that social workers are responsible for actively seeking out up to date information and conducting a full assessment of the parents' current circumstances;
- i works with relevant agencies to assist parents who have had previous tamariki removed with access to independent advocacy during the Ministry's assessment and intervention phases;
- j amends its overarching Practice Standards, as well as its policies, procedures, and practices to recognise the rights of disabled parents and ensure full compliance with the United Nations Convention on the Rights of Persons with Disabilities;
- k ensures all its policies, procedures, and practices are consistent with the social model of disability and a rights based framework by:
 - i providing reasonable accommodation;³⁶⁶
 - ii explicitly recognising that drug and/or alcohol misuse and mental health needs require a disability rights based response;
 - iii ensuring disabled parents have access to specialist advocacy during the assessment and intervention phases;
- l in implementing recommendations 2(j) and (k) above, closely consults with and actively involves disabled people, their whānau and organisations that represent disabled people, as well as other relevant agencies within the system;
- m ensures all parents have information about their legal rights, including information about accessing legal aid, in an accessible format;

³⁶⁶ Refer to page 239 of this report for an explanation of reasonable accommodation.



- n develops specific policies and procedures for the process of removing newborn pēpi, once section 78 interim custody orders are granted, that:
 - i ensure, to the fullest extent possible, planning, communication and information sharing with parents, whānau, DHBs and midwives;
 - ii ensure, to the fullest extent possible, the removal of pēpi takes place in a manner that reflects ngākau maharatanga me te ngākau aroha, a period of quality time that encompasses consideration, empathy, sympathy and love; minimises trauma; and provides parents and whānau with support and clear information on next steps;
 - iii explicitly recognise the right of pēpi to be breastfed consistent with the United Nations Convention on the Rights of the Child, as well as guidance from the World Health Organization and the Ministry of Health;
 - iv reflect best practice to support breastfeeding;
 - v ensure appropriate therapeutic and other support is available to all parents who have had pēpi removed from their care; and
 - o regularly audits case files to ensure compliance with policy and practice guidance.
- 3 The Ministry reports back to me on its achievement of recommendations 1 and 2 on a quarterly basis for the next year, with the first report by **4 November 2020**.

My office is available to assist the Ministry with the implementation of these recommendations.



Appendix 1. Glossary of Terms
Āpitianga 1:
He Rārangi Kupu





Appendix 1. Glossary of Terms

Āpiti hanga 1: He Rārangi Kupu

Terms	Description
Care and Protection Assessment	Assessment phase triggered once the Ministry receives a report of concern.
Child and Family Assessment	Undertaken if the Ministry receives a report of concern alleging that <i>'the care, safety or wellbeing of te tamaiti'</i> is at risk, but does not include abuse that may amount to a criminal offence. The purpose is to determine whether te tamaiti is in need of care or protection. ³⁶⁷
Child and Family Consult	Ministry's tool intended to help structure thinking about what is happening in the whānau, taking into account issues such as dangers, strengths, complicating factors and areas of ambiguity.
Casefile or case file	A collection of documents, records and notes held by the Ministry about a particular child's circumstances.
Care and Protection, Youth Justice, Residential and Adoption Services (CYRAS)	Electronic database used by the Ministry to record and manage casefiles.
Care and protection resource panel (CPRP)	Group of local community experts who provide guidance and advice to frontline Ministry staff. Each site has a CPRP.
Child, Youth and Family (CYF)	Predecessor of the Ministry for Children – Oranga Tamariki.
Department of Social Welfare (DSW)	Predecessor of Child Youth and Family.
Family Group Conference (FGC)	Statutory process involving a private whānau or family group meeting convened by a Care and Protection Co-ordinator. Participants formulate a plan addressing care and protection concerns.
Hapū	<i>'Kinship group, tribe, subtribe or pregnant, expectant'</i> . ³⁶⁸
Hawkes Bay/Hastings Practice Review	A review conducted by the Ministry's Chief Social Worker (with oversight from a Ngāti Kahungunu representative and the Office of the Children's Commissioner) into events occurring at Hastings Hospital in mid 2019.
Hui ā-whānau	The aim of hui ā-whānau is <i>'to support and enhance the rights, participation and decision-making of tamariki and their whānau, hapū, iwi and support network as early possible'</i> . ³⁶⁹

367 Further information about the Child and Family Assessment can be found on the Ministry's Practice Centre available at <practice.orangatamariki.govt.nz/our-work/practice-tools/other-practice-and-assessment-tools/childyoung-person-and-family-consult/>.

368 Kaiwai and others, above n 62, at 84.

369 This definition is taken from the Ministry's Practice Centre available at <practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/hui-a-whanau/>.



Terms	Description
Intellectual disability	Other terms include tangata whaikaha hinengaro or learning disability. Parents with an intellectual disability may have difficulty understanding new or complex information, living independently and learning new skills.
Interim custody order	Temporary Family Court order relating to the custody of pēpi that is in effect until the Court makes a final care or protection order (see section 78 application).
Investigation	Undertaken if the Ministry receives a report of concern alleging abuse that may amount to a criminal offence.
Iwi	Tribe.
Kaimahi	Workers, staff, employees.
Kairāanga ā-whānau or kairāanga or kairangahau	A specialist Māori role meaning 'a person who is a weaver of family connections'. ³⁷⁰ The role may have different names depending on tikanga of mana whenua.
Litigation guardian	In recognition that Court process presents a barrier for some parents with disabilities and/or mental health needs, the Family Court appoints a person to assist the parent or parents with understanding their involvement in legal proceedings.
Manaakitanga	The Ministry's Practice Centre explains this to be 'about caring for and giving service to enhance the potential of others ... display acts of support, care, hospitality and protection to others, reciprocity comes in the form of collaborative mutually beneficial human interactive engagements'.
Newborn	Pēpi aged 0-30 days old.
Ngākau maharatanga me te ngākau aroha	Consideration, empathy, sympathy and love
Partnered sites	Ministry site which has formed and signed a partnership agreement with local iwi.
Pēpi	Baby or babies.
Place of safety warrant	If the District Court is satisfied that a child is experiencing harm, it authorises a Police constable or Ministry worker to enter and search any home or vehicle for the child. In serious cases, the child can be removed and placed in Ministry custody.
Pono	Honest, genuine or sincere.
Practice Centre	A virtual resource for Ministry practitioners containing 'must-dos, how-tos and guidance in their work with tamariki and their families/whānau'. ³⁷¹
Practice standards	Written benchmarks for the Ministry's staff.
Rangatahi	Young person.

370 Further information about this role can be found on the Ministry's Practice Centre at <practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairanga-a-whanau/>.

371 See <practice.orangatamariki.govt.nz/>.



Terms	Description
Rangatiratanga	<i>'Leadership, chieftainship, right to exercise authority'</i> . ³⁷²
Removal or uplift	The action of physically taking pēpi into care.
Report of Concern (RoC)	Information shared with the Ministry by any person involving particular concerns they have around the safety of pēpi, child or young person.
Safety plan / safety planning	Documented arrangements and planning around the safety and needs of whānau and pēpi in the pre and post-birth period.
Section 78 (of the Oranga Tamariki Act 1989) application or order	Once the Ministry believes pēpi is in need of care or protection, it applies to the Family Court for an order (under section 78) placing pēpi in its own care on an interim basis. The Court generally grants this order on the same day. This may be with or without notice.
Site	Where a Ministry office is located; used to describe a place of operations.
Site-level	Localised operations carried out by frontline Ministry staff, key partners and other third parties.
Site-readiness	The level to which a site is able and/or prepared to undertake something.
Subsequent child provisions	Describes criteria used to assess the parent of pēpi whose older sibling or siblings have been removed.
Tamariki	Children.
Te tamaiti	Child, linked to tamariki.
Te Pūao-te-Ata-Tū	Ministerial Advisory Committee 1988 report produced from a Māori perspective about the Department of Social Welfare.
Te Toka Tumoana	The Ministry's framework for working with Māori.
Tika	Correct, proper, just or fair.
Trauma informed practice	Recognition that some whānau, hapū, iwi, family, family groups and individuals experience the <i>'lasting adverse effects'</i> of past and/or present traumatic events. ³⁷³
Tuituia	The Ministry's assessment tool; includes the Tuituia framework, recording tool and report. Method for filtering information which aims to cover all areas and create a full picture of te tamaiti and whānau's circumstances.
The Ministry for Children – Oranga Tamariki	Government agency responsible for child welfare and protection in Aotearoa.
Whakamana te tamaiti	<i>'Practice empowering tamariki Māori. Focuses on actively supporting, promoting and advancing the mana of te tamaiti Māori. Mana refers to the power, potential, honour, prestige, authority, self-esteem and influence of te tamaiti Māori (the Māori child or young person).'</i> ³⁷⁴

372 Kaiwai and others, above n 62, at 86.

373 Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma and Justice Strategic Initiative (2012) at 2, as cited in SAMHSA Trauma-Informed Care in Behavioural Health Services (TIP 57, 2014) at 7.

374 Further information is available from the Ministry's Practice Centre at <practice.orangatamariki.govt.nz/practice-standards/whakamana-te-tamaiti-practice-empowering-tamariki-maori/whakamana-te-tamaiti-practice-empowering-tamariki-maori-guidance/>.



Terms	Description
Whakamanawa	The Ministry's Practice Centre describes this as <i>'about supporting tamariki and whānau Māori, in their journey from states of oppression (all forms of abuse) to emancipation'</i> .
Whakapapa	<i>'the multi-generational kinship relationships that help to describe who the person is in terms of their mātua (parents), and tūpuna (ancestors), from whom they descend'</i> . ³⁷⁵
Whānau	<i>'Family, extended family'</i> . ³⁷⁶
Whānau Ora	Agency which delivers social and health services for Māori whānau.
With/on notice	The parent or parents receive the Ministry's section 78 application before the Family Court grants the custody order. This means that the parent or parents have an opportunity to respond by giving the Court their own written information.
Without notice	The parent or parents are not given the Ministry's section 78 application before an order is granted, and are not able to respond by sharing their own written information with the Court.
Pickwick hearing	After the Ministry applies without notice, the parent or parents have the opportunity to share their information in person before a Family Court judge (without submitting written documents).

375 Section 2 of the Act.

376 Kaiwai and others, above 62, at 86.



Appendix 2. Investigation methodology

**Āpitihanga 2:
Ngā tikanga o te
tūhuratanga**





Appendix 2. Investigation methodology

Āpitianga 2: Ngā tikanga o te tūhuratanga

General principles

An Ombudsman is not required to follow any particular process for investigating a matter. An Ombudsman has the ability to hear or obtain information from such persons, make such enquiries, and regulate their procedures as they see fit.³⁷⁷ An Ombudsman follows an inquisitorial process by first seeking to gather evidence and assemble all the facts considered relevant to the matters at issue, and then forming an opinion on the agency's actions.

An Ombudsman is required to abide by the principles of natural justice before reaching their final opinion.³⁷⁸

An Ombudsman's investigation is also subject to the confidentiality and secrecy provisions of the Ombudsmen Act 1975. In particular, every investigation by an Ombudsman must be conducted in private, and an Ombudsman must maintain secrecy and may only:³⁷⁹

...disclose such matters as in the Ombudsman's opinion ought to be disclosed for the purposes of an investigation or in order to establish grounds for the Ombudsman's conclusions and recommendations.

Finally, it is important to note that an Ombudsman does not have authority to examine:

- the decisions of the Court;
- the conduct of the police;
- the actions of the lawyers employed by or instructed to act for the Ministry; or
- decisions made by Ministers of the Crown.

377 Sections 18(3) and 18(7) of the Ombudsmen Act 1975.

378 Sections 18(3) and 22(7) of the OA.

379 Sections 18(2), 21(3) and 21(4) of the OA.



Overview of process

I formally notified the Ministry's Chief Executive of my investigation on 6 June 2019.³⁸⁰ I publicly announced my investigation on 19 June 2019 when appearing before Parliament's Governance and Administration Committee.³⁸¹ I subsequently issued an updated Terms of Reference for my investigation on 18 July 2019.³⁸²

My investigation involved:

- meetings with senior officials from the Ministry;
- requests for information held by the Ministry;
- review and analysis of the documentation supplied by the Ministry;
- interviews with the Ministry's staff at selected care and protection sites, as well as those in national and regional roles;
- interviews with third parties engaging directly with some of the selected sites including iwi social service providers and organisations, DHBs, Police, and Family Court judges;
- interviews and meetings with other stakeholders and interested parties, including:
 - the Principal Family Court Judge;
 - People First New Zealand Inc Ngā Tāngata Tuatahi;
 - IHC New Zealand;
 - the Disability Rights Commissioner at the Human Rights Commission;
 - National Māori Women's Welfare League;
 - Nga Maia Māori Midwives Aotearoa;
 - the New Zealand College of Midwives;
 - VOYCE Whakarongo Mai;
 - the Public Service Association;
 - the Social Workers Registration Board;
- in-depth review and analysis of the case files provided by the Ministry;
- review and analysis of guidance issued by District Health Boards;

380 This step is required by s 18(1) of the Ombudsmen Act 1975. This investigation has been conducted pursuant to ss 13(1) and 13(3) of that Act.

381 Office of the Ombudsman "Chief Ombudsman to conduct wide-ranging investigation into the removal of newborn babies" (press release, 19 June 2019).

382 An initial Terms of Reference dated 6 June 2019 was provided to the Ministry when it was notified of the investigation. The updated terms of reference refined the purpose and scope of the investigation. This is available at <www.ombudsman.parliament.nz/resources/oranga-tamariki-newborn-removal-investigation-terms-reference>.





- desktop research, including the identification and consideration of:
 - relevant international law, domestic legislation, and case law;
 - the Ministry’s guidance and expectations of best practice primarily sourced from its online Practice Centre³⁸³ and its findings in the Hastings Practice Review,³⁸⁴
 - guidance on best practice from other jurisdictions;
 - previous reports and reviews into statutory care and protection issues in Aotearoa, including:
 - › *Te Pūao-te-Ata-Tū* by the Ministerial Advisory Committee on a Māori Perspective;³⁸⁵
 - › the report by Ken Mason in 1992;³⁸⁶
 - › the report by Michael Brown in 2000;³⁸⁷
 - › the reports published by the Families Commission;³⁸⁸
 - › the reports of the Modernising Child, Youth and Family Expert Panel in 2015;³⁸⁹
 - › the inquiry undertaken by Whānau Ora;³⁹⁰
 - the publicly available written and oral evidence presented to the Royal Commission of Inquiry into Abuse in Care,³⁹¹ as well as the publicly available evidence presented to the Waitangi Tribunal in respect of its urgent inquiry into the Ministry;³⁹²
- expert advice from a registered nurse and lactation consultant.

383 Oranga Tamariki—Ministry for Children Practice Centre is available at <practice.orangatamariki.govt.nz/>.

384 Oranga Tamariki—Ministry for Children *Practice Review: Professional Practice Group, Practice Review into the Hastings Case* (5 November 2019). Referred to as the Hastings Practice Review.

385 The Ministerial Advisory Committee on a Māori Perspective *Te Pūao-te-Ata-Tū* (Department of Social Welfare, September 1988)

386 Kenneth Mason *Review of the Children, Young Persons and their Families Act 1989* (Department of Social Welfare, February 1992).

387 Michael JA Brown *Care and Protection is about adult behaviour: The Ministerial Review of the Department of Child, Youth and Family Services, Report to the Minister of Social Services and Employment Hon Steve Maharey* (December 2000).

388 Anne Kerslake Hendricks and Katie Stevens *Safety of subsequent children: International literature review* (Families Commission, January 2012); and Fiona Cram *Safety of Subsequent Children: Māori children and whānau—a review of selected literature* (Families Commission, January 2012).

389 Ministry of Social Development *Modernising Child, Youth and Family Expert Panel: Interim Report* (31 July 2015); and *Expert Panel Final Report: Investing in New Zealand’s Children and their Families* (April 2016).

390 Hector Kaiwai and others *It’s Time for Change: A Māori Inquiry into Oranga Tamariki* (Whānau Ora Commissioning Agency, February 2020).

391 This is available at <www.abuseincare.org.nz/public-hearings/about/contextual-hearing/>.

392 Waitangi Tribunal *The Oranga Tamariki Urgent Inquiry* (Wai 2915, 2020).



Site selection

At 1 July 2017, the Ministry had 49 care and protection sites in 11 regions.³⁹³

Over the course of the investigation, nine of the Ministry's sites were selected for visits, with the purpose of seeking to understand the perspective of the Ministry's frontline staff. This selection was based on data supplied by the Ministry, as summarised in Table 2 below. This data was also broken down by site and ethnicity.

Table 2: Data provided by the Ministry on the number of section 78 orders and removals

Reporting Year	Number of newborn pēpi in the Ministry's custody under section 78	Number of newborn pēpi removed by the Ministry
2017/2018	199	175
2018/2019	164	121
Total	363	296

Notes on data

The Ministry has acknowledged it does *'not have accurate structured data on the total number of applications to the Court for s[ection] 78 interim custody orders'*.

Information published by the Ministry in June 2019, suggested that in the period between 1 July 2017 and 30 June 2018 there were 242 cases where pēpi under 30 days old were placed in the Ministry's custody. This information did not specify whether these pēpi were the subject of section 78 custody orders, warrants for removal, voluntary agreements, or some other type of custody applications.

The data initially provided to me by the Ministry in August 2019 indicated that for the period between 1 July 2017 and 30 June 2019:

- there were 363 newborn pēpi in its custody under section 78 orders; and
- 296 newborn pēpi were removed from the care of their parents under section 78 orders.

It was later reported there were 309 newborn pēpi in the Ministry's custody under section 78 orders for that same period.³⁹⁴

393 Since July 2017, there have been changes to the number of sites, with some merging and others splitting. According to the Ministry's Annual Report for the year ending June 2018, there were 63 sites in 11 regions: Oranga Tamariki—Ministry for Children *Annual Report 2017/18* (October 2018) at 44.

394 "Oranga Tamariki inquiry: 'serious consequences' over attempted removal of baby" (8 November 2019) Radio New Zealand.



The Ministry appears to be aware of this apparent inconsistency and has offered this explanation:

The data provided to you comes from an operationally dynamic database. This means that the data for the same period may differ when run at a different point in time due to backdated entries. This data is not comparable to data on the website or Official Information Act responses as that data considered the first legal order in a period where the data included in this dataset includes all s[ection] 78 orders, regardless if this is the first legal status or not. However, given the age of the children in your information request, it is unlikely they would have been subject to 2 or more s[ection] 78 orders.

The data provided about the number of newborn pēpi in the Ministry's custody was produced:

...by counting the number of newborns and unborn children who had a s[ection] 78 legal status recorded between the period 1 July 2017 and 30 June 2019. This means that:

- Where an application was filed on a without notice basis during the period, but the Court placed the application on notice and a decision was not made before the child turned 30 days old, the child will not be counted in this dataset.*
- Where we have applied on notice but the Court has not granted a s[ection] 78 custody order before the child is 30 days old, this is not counted in this dataset.*
- If a recording error has occurred, the data may not be accurate (i.e. if a child does not have a legal status recorded but they are in our custody).*

In terms of the number of newborn pēpi removed:

...we have used the first placement type as the measure. When a child enters into a placement (such as a foster carer, whānau care, or child and family support service), we record their placement type and we have used this as a measure to calculate if we have given effect to a placement authority pursuant to s[ection] 81. This means that:

- We are not able to capture if we initially left a child in their parents' care but then subsequently removed them from their parents' care.*
- The data is operational data and may result in some recording errors.*
- 15 per cent of children (57 out of 363) were recorded as remaining in their parent's care following the granting of the s[ection] 78 custody order.*
- No placement type was recorded for 10 babies. These have not been included...*



In terms of the data on ethnicity, the Ministry advised:

Oranga Tamariki recognises the importance of all aspects of a child's identity and we do not report by primary ethnicity, in line with Statistics New Zealand standards on the use of ethnicity data and with how individuals identify themselves. The need for all ethnicities to be reported has been driven by our work with iwi groups and their interest in understanding the iwi affiliation for tamariki and rangatahi in care. The ethnicity data provided is based on all ethnicities recorded for each child or young person. The ethnicity groups used for reporting reflect the population that we are working with and our desire to improve outcomes for those groups in particular. Descriptions of the ethnic groups used for reporting are:

- *Māori children who identify Māori (but not Pacific) as one of their ethnicities*
- *Māori and Pacific children who identify both Māori and Pacific as their ethnicities*
- *Pacific children who identify Pacific (but not Māori) as one of their ethnicities*
- *Other children who do not identify Māori or Pacific as any of their ethnicities*

This means the total number of tamariki Māori entering care is the sum of the Māori group and the Māori and Pacific group. Similarly, the total number of Pacific children entering our care is the sum of the Pacific group and the Māori and Pacific group. In most cases the parent(s) have identified the ethnicity, and in some cases Oranga Tamariki may have identified the ethnicity. The ethnicity data provided is based on all ethnicities recorded for each child.

Following an analysis of the data provided by the Ministry, I selected operational sites where there were:

- proportionally higher and lower number of newborn pēpi entering the Ministry's custody under section 78 orders;
- proportionally higher and lower number of newborn pēpi removed by the Ministry as a result of orders granted under section 78; and
- discernible differences in the data for each of the two reporting years—for example, where the number of entries into care (or removals) had either significantly increased or decreased over the course of the two-year period.

I also considered population characteristics of the site or region, such as ethnicity and socioeconomic deprivation indicators, as well as geographical spread across the country to cover both the North and South Islands, and both rural and urban settings.

Initially, I selected five sites as a representative sample based on location and the type of communities serviced. Subsequently, a further four sites were selected, in order to understand some of the different processes and outcomes that were being observed across the country. In particular, this was to understand how specialist Māori roles were being utilised at some of these sites.



Site visits

Relevant staff from the Ministry at each site were interviewed at the site visits. Typically, this included staff in the following key positions.

Position	Purpose ³⁹⁵
Site Manager	<p><i>Build and lead a high performing team to deliver high quality proactive care and protection services to families. Ensure service delivery and practice are enhanced and risks are monitored, assessed and managed effectively.</i></p> <p><i>Manage and monitor the site’s financial, staffing and asset resources to maximise performance. Implement and embed nationally agreed protocols, processes and systems to enable full and effective delivery of services from the Site.</i></p>
Practice Leader	<p><i>The Practice Leader role is integral to strengthening practice within sites. The role works as part of a wider team to provide professional leadership, influence and direction in order to maintain and enhance the level of practice excellence and capability...The primary purpose of this role is to act:</i></p> <ul style="list-style-type: none"> <i>To ensure a clear focus on key strategic practice priorities.</i> <i>To lead the transfer of knowledge and our evidence base to site practice.</i> <i>To ensure the strengthening of practice competency on site.</i> <i>To work with the Site/Youth Justice Manager to ensure professional site plans are appropriate and facilitated.</i> <i>To support the provision of quality professional supervision.</i>
Supervisor	<p><i>The Supervisor is responsible for the effective management of a team of social workers and support staff to ensure the efficient delivery of case work that fulfils Oranga Tamariki’s service delivery responsibilities...The Supervisor will implement and maintain protocols, processes and systems to enable full and effective delivery of social work services to meet the KPI’s and business plan requirements. This includes close communication and collaboration with the Site Manager and Practice Leader.</i></p>
Social worker	<p><i>To provide statutory social work services which promote the protection, wellbeing and best management of children and young persons in safe families. The Social Worker will work toward this goal through the delivery of a range of intervention strategies designed to meet desired outcomes, specified by the Minister for Children.</i></p>

395 Except where indicated, this information has been obtained from the respective job descriptions.





<p>Hospital Liaison Social Worker/Practice Leader</p>	<p>A senior Social Worker/Practice Leader employed by the Ministry but working within a hospital setting to enhance the relationship and information sharing between the Ministry and the relevant DHB. The Memorandum of Understanding with the DHBs describes the purpose of the role is to:</p> <p><i>...contribute to improved outcomes for children experiencing (or being assessed for possible) abuse and or neglect by working in partnership with health services staff to deliver two key objectives:</i></p> <ul style="list-style-type: none"> <i>Ensuring that CYF and DHB work together for all children when there are care and protection concerns</i> <i>the early identification and appropriate response for children at risk of abuse and or neglect.</i> <p><i>The CYF DHB liaison social worker will work in collaboration with DHB staff to consider and address:</i></p> <ul style="list-style-type: none"> <i>specific case issues, ensuring that action is taken to support the best possible outcome for children and young people</i> <i>strategic issues, looking at how systems and processes can be enhanced to support the best outcomes for children and young people.</i>
<p>Care and Protection Resource Panel (CPRP) members³⁹⁶</p>	<p>CPRP comprise of members from the local community. They have professional, community and cultural knowledge and experience working with children and young people. The role of CPRP is to provide advice and support to social workers about care and protection matters and to provide a process for review.</p>
<p>Kairārangā ā-whānau³⁹⁷</p>	<p><i>Kairaranga ā-whānau is a specialist Māori role. The literal meaning of the term is: a person who is a weaver of family connections.</i></p> <p><i>Their role includes:</i></p> <ul style="list-style-type: none"> <i>identifying and engaging significant whānau, hapū and iwi members in decision-making for their tamariki (as early as possible)</i> <i>supporting and/or facilitating hui ā-whānau and assisting Oranga Tamariki staff to integrate appropriate cultural knowledge and practice into the decision-making processes, such as in the case consult etc.</i>

396 Further information about CPRP members can be found on the Ministry's Practice Centre <practice.orangatamariki.govt.nz/practice-standards/work-closely-in-partnership-with-others/care-and-protection-resource-panel/>.

397 A description of this position is now located on the Practice Centre <practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairaranga-a-whanau/>.



Communication with key third parties at the sites

Interviews were undertaken with staff of other agencies who are directly involved in the removal of newborn pēpi—namely, the staff of the local hospital and the police.

In addition, some sites identified local social service providers and other organisations that they routinely work with. Interviews were also held with representatives from these organisations to understand their perspective on the issues.

Further, there was an opportunity to meet with some Family Court judges residing in the associated areas to discuss their views on the Ministry's practices.

Request for the Ministry's case file records

I made a request to the Ministry for the case files of newborn (and unborn) pēpi from six of the selected sites where, during the period under review, the Ministry:

- applied for an interim custody order under section 78 and the application was sought on a without notice basis, including:
 - where the court granted an interim custody order under section 78 placing pēpi in the Ministry's custody; and
 - where the court declined to grant an order under section 78 on a without notice basis;
- removed a newborn pēpi as a result of a court order that was made under section 78 which was sought on a without notice basis; and
- prepared an application for an interim custody order under section 78 to be sought on a without notice basis, but the application was abandoned/not filed with the Court.

In response, the Ministry explained that, due to the manner in which data was stored in its case management system,³⁹⁸ it was unable to efficiently distinguish the section 78 applications made on a without notice basis from those made on notice. The Ministry also noted that, without undertaking a manual review of all its files, it could not identify the cases where the section 78 applications had been declined by the Court, or where such applications had been prepared but later abandoned/not filed with the Court. However, the Ministry advised that both these situations were quite rare.

398 The main case management system used by the Ministry is known as CYRAS, which stands for 'Care and Protection, Youth Justice, Residential and Adoption Services'. CYRAS is used by the Ministry's staff to record the actions taken, information collected, and response made in respect of a particular report of concern.



I made a second request for case file information to the Ministry in respect of three of the selected sites. Since different outcomes had been observed within these sites, this request was much broader, as it included the files for newborn (and unborn) pēpi where, during the period between 1 July 2017 and 30 June 2019, the Ministry had received a report of concern and had progressed the matter through to an assessment. In some instances, this included where the Ministry had applied for interim custody under section 78 during the relevant period.

In total, in relation to both requests, the Ministry supplied case files for over 120 newborn (and unborn) pēpi. The material provided were extracts of CYRAS and, as such, did not constitute the entirety of the Ministry's involvement with that pēpi or their whānau. Instead, the files were limited to the period from when a report of concern was received by the Ministry to a period following the removal of pēpi, where that occurred.

Review and analysis of the Ministry's case file records

From the 120 case files supplied, 74 were selected for an in-depth analysis, as these were cases where the Ministry had applied for interim custody under section 78 during the period between 1 July 2017 and 30 June 2019. In particular, each of these 74 case files were analysed to ascertain:

- the ethnicity of the newborn pēpi;³⁹⁹
- whether the Ministry's section 78 application was made on notice or without notice;
- the relevant key timeframes, including:
 - when the Ministry first became aware of the pregnancy and/or concerns about the newborn pēpi;
 - the timing of the section 78 application; and
 - when the Ministry completed its Safety and Risk Screen and its Child and Family Assessment;
- the extent of the kairāranga's involvement;
- the use of hui ā-whānau and family group conferences;
- the nature of the parents' previous history with the Ministry;

399 This was based on the information recorded in the case files about the ethnicity of pēpi and his or her parents. This data was broken down into two categories; Māori and non-Māori. The former includes the cases where the information suggested that the ethnicity of pēpi and/or his or her parents was both Māori and another ethnicity. The latter category includes all cases where the ethnicity was unclear.



- the issues that were the legal and factual basis for the application for interim custody under section 78, including the reasons for applying without notice;
- whether there was evidence of disability related needs for the parents;
- compliance with the core decision making tools, including:
 - referral to the Care and Resource Protection Panel;
 - use of the Child and Family Consult tool;
 - evidence of partnering with other professionals and iwi;
 - use of the Tuituia Assessment Framework; and
 - evidence of professional supervision; and
- the process and planning for removal of the newborn pēpi, if that occurred, including:
 - evidence of a birth or safety plan;
 - involvement of police or security;
 - the types of support provided to maintain breastfeeding;
 - the pēpi's contact with their parents following removal; and
 - post-birth support provided to the parents following removal.

Foreword

Executive Summary

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Part One

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Part Three

Part Four

Appendices





Appendix 3. Overview of changes since July 2019 as reported by the Ministry

**Āpitihangā 3:
Tirohanga whānui o
ngā huringa mai i te
Hōngongoi 2019 e ai ki
te pūrongo a Oranga
Tamariki**





Appendix 3. Overview of changes since July 2019 as reported by the Ministry

Āpitihanganga 3: Tirohanga whānui o ngā huringa mai i te Hōngongoi 2019 e ai ki te pūrongo a Oranga Tamariki

The Ministry has reported that since July 2019 it has made changes relating to the use of without notice applications for section 78 interim custody orders and the removal of newborn pēpi. Whilst these are outside the timeframe of my investigation, it is important that I acknowledge the Ministry's comments.

In response to my provisional findings, the Ministry advised the following:

- There are more Kairāranga already in place and, with additional funding, full roll-out of the position is expected to be achieved by 2022/23. The Ministry has agreed kairāranga should be established as a core practice role across the country. In addition, it is exploring options for expanding access to these roles and discussions about the location (i.e. whether within the Ministry or iwi based) of the role will be made at a local level in partnership with mana whenua.
- The Ministry has partnerships with some iwi (Ngāti Porou, Rangitāne–Wairarapa and Tararua, Ngāti Kahungunu–Hawkes Bay, Ngāti Raukawa–Horowhenua, and Ngāti Toa–Porirua) to ensure wider whānau are part of the Family Group Conference and hui ā-whānau processes. The Ministry intends to build on these existing relationships and create more.
- In response to a separate [investigation](#) by my Office, the Ministry has already agreed to complete scoping and developing a work programme to enhance its working relationship with the disability sector in order to make changes that reflect the obligations under the United Nations Convention on the Rights of Persons with Disabilities.
- The Ministry has agreed to enter into a strategic partnership with the Māori Women's Welfare League.
- As result of the Hasting Practice Review, the Ministry introduced the following:
 - the expectation that all section 78 interim custody applications will be made on notice unless there is a clear need for action to protect tamariki from immediate and imminent danger;
 - additional levels of checks for all without notice applications in-



- cluding the relevant Regional Legal Manager, Site Manager and Practice Leader;
- Practice Leaders are required to monitor all reports of concern for unborn/newborn pēpi on a monthly basis to ensure early visibility, planning and identification of alternatives to custody; and
 - an update to internal guidance in December 2019 to strengthen early engagement, assessment and planning via Family Group Conference and hui ā-whānau.
- The Ministry has been in the process of implementing a new Intake and Early Assessment model to ensure more accurate and in-depth information gathering and clearer decision points across three assessment phases starting from when a report of concern is received.
 - The Ministry is looking at the local make-up of Care and Protection Resource Panels to ensure they are fit for purpose and that members are able to provide the independent assistance required to support decision making.
 - Since 1 July 2019, average caseloads have reduced from 25 to 21 tamariki per social worker. In addition, the Ministry has increased net social worker FTEs by around 400. It has also introduced digital tools to enable a more mobile and flexible workforce.
 - The Ministry is commencing major collaborative intensive intervention projects in four sites; two of which will go live in August/September 2020 and the other two in early 2021. In addition, the Ministry has small intensive intervention 'start-ups' which are currently supporting 340 whānau across the country.
 - The Ministry is continuing to develop a new Practice Framework that is designed to build practice depth, and support changes and improvements to practice behaviour as well as strengthen Māori centred practice. The Ministry is testing and refining the Practice Framework with key stakeholders including a tangata whenua advisory group and its own kaimahi Māori.



Appendix 4. Tables
Āpitianga 4:
Ngā ripanga



Appendix 4. Tables

Āpiti hanga 4: Ngā ripanga

The tables set out in this Appendix relate to the Figures 1–19 of the report. Accordingly, tables 1 and 2 have not been included here.

Table 3: Critical factors facing parents as reported by the Ministry in the 74 case files reviewed

Issue	Number of total cases	Total percentage
Family violence	70	95%
Previous children removed	60	81%
Drugs	46	62%
Alcohol	41	55%
Parent's previous involvement with the Ministry as a child	41	55%
Mental health needs	36	49%
Transience	36	49%
Disability related needs	23	31%

Table 4: Hui ā-whānau and FGCs in the 74 case files reviewed

Process	Timing	Māori	Non-Māori
Hui ā-whānau	Pre-birth	9 (20%)	7 (24%)
	Post-birth	13 (29%)	4 (14%)
	None found	23 (51%)	18 (62%)
FGC	Pre-birth	10 (22%)	11 (38%)
	Post-birth	33 (73%)	18 (62%)
	None found	2 (5%)	0 (0%)
Both hui ā-whānau and FGC held	Pre-birth	4 (9%)	1 (3%)
	Post-birth	12 (27%)	5 (17%)
Total		16 (36%)	6 (20%)



Table 5: Parental involvement with the Ministry in the 74 case files reviewed

Nature of involvement	Māori (45)	Non-Māori (29)	Total (74)
As a child themselves	4	6	10
Their previous child involved with the Ministry	17	10	27
Both	22	9	31
Total	43/45	25/29	68/74

Table 6: Working days between the Ministry becoming aware of pregnancy and birth for the 74 case files reviewed

Number of working days between becoming aware of pregnancy and birth	Māori	Non-Māori	Total
0-20	3	3	6
21-40	5	1	6
41-60	4	1	5
61-80	8	7	15
81-100	8	5	13
101-120	7	4	11
More than 120 days	10	8	18
Total	45	29	74

Table 7: Safety and Risk Screen timeframes for the 74 case files reviewed

Timeframe	Number of cases	Number meeting time frame
20 days (low urgency)	50	41
7 days initially then changed to 20 days	4	4
7 days	14	11
48 hours	1	1
24 hours	2	1
Unclear	3	n/a
Total	74	58





Table 8: Working days to complete Child and Family Assessment—from the investigation phase dates for the 74 case files reviewed

Working days	Māori	Non-Māori	Total
0-10	2 (4%)	4 (14%)	6 (8%)
11-36	11 (24%)	6 (21%)	17 (23%)
37- 50	7 (16%)	2 (7%)	9 (13%)
More than 50 days	24 (54%)	17 (58%)	41 (55%)
No investigation phase noted	1 (2%)	0 (0%)	1 (1%)
Total	45	29	74

Table 9: Working days to complete Child and Family Assessment—from the investigation phase opening date to completion of Tuituia report for the 74 case files reviewed

Working days	Māori	Non-Māori	Total
0-10	5 (11%) ⁴⁰⁰	3 (10%) ⁴⁰¹	8 (11%) ⁴⁰²
11-36	12 (27%)	8 (28%)	20 (27%)
37- 50	4 (9%)	3 (10%)	7 (9%)
More than 50 days	19 (42%)	14 (49%)	33 (45%)
No investigation phase start date	1 (2%)	0 (0%)	1 (1%)
No Tuituia completed	4 (9%)	1 (3%)	5 (7%)
Total	45	29	74

400 One completed before investigation phase started.

401 One completed before investigation phase started.

402 Two completed before investigation phase started.

Table 10: Overview of compliance with required key mechanisms in the 74 case files reviewed

Evidence of required mechanisms	Yes	Unrecorded but mentioned or unclear
Evidence of CPRP occurring	59 (80%)	-
Evidence of CPRP 'as soon as practicable' (within 36 days)	33 (45%) ⁴⁰³	-
Evidence of case consults (pre-birth/section 78)	43 (58%)	-
Evidence of case consults (post-birth/section 78)	9 (12%)	-
Evidence of legal consultation	13 (18%)	4 (5%)
Evidence of professionals meetings	20 (27%)	7 (9%)
Evidence of Tuituia completed (within 36 days)	28 (38%)	1 (1%)
Evidence of supervision	35 (47%)	5 (7%)

Table 11: Evidence of CPRP consults in the 74 case files reviewed

Evidence of CPRP consults	Māori (number)	Non-Māori (number)	Total (number)
Yes	36 (80%)	23 (79%)	59 (80%)
No	9 (20%)	6 (21%)	15 (20%)
Total	45	29	74

Table 12: Timeframe for CPRP consults in the 74 case files reviewed

Working days	Number of cases presented to CPRP by working days	Cumulative number of cases presented to CPRP by working days
Within 10 (2 weeks)	8 (11%)	8 (11%)
11 - 20 (3 - 4 weeks)	7 (9%)	15 (20%)
21 - 36 (5 - 7 weeks)	18 (24%)	33 (45%)
37 - 60 (8 - 12 weeks)	15 (20%)	48 (65%)
60-plus (13 weeks plus) ⁴⁰⁴	11 (15%)	59 (80%)
No evidence to show the case went to CPRP	15 (20%)	-

403 Of the remaining 41 cases, 15 cases did not go to a CPRP at all, and the remaining 26 were outside 36 working days.

404 Includes eight cases considered beyond 80 days.



Table 13: Evidence of Child and Family Consults in the 74 case files reviewed

Evidence of consult	Māori (number)	Non-Māori (number)	Total (number)
Yes (pre-birth, pre-section 78) ⁴⁰⁵	27 (60%)	16 (55%)	43 (58%)
Yes (post-birth, post section 78) ⁴⁰⁶	5 (11%)	4 (14%)	9 (12%)
No	13 (29%)	9 (31%)	22 (30%)
Total	45	29	74

Table 14: Evidence of legal consultation in the 74 case files reviewed

Evidence of legal consult	Māori (number)	Non-Māori (number)	Total (number)
Yes	9 (20%)	4 (14%)	13 (18%) ⁴⁰⁷
No	33 (73%)	24 (83%)	57 (77%)
Possible, unclear	3 (7%)	1 (3%)	4 (5%)
Total	45	29	74

Table 15: Evidence of professionals meetings in the 74 case files reviewed

Evidence of professionals meetings	Māori (number)	Non-Māori (number)	Total (number)
Yes	13 (29%)	7 (24%)	20 (27%)
No	30 (67%)	17 (59%)	47 (64%)
Unrecorded but mentioned	2 (4%)	5 (17%)	7 (9%)
Total	45	29	74

Table 16: Evidence of professional supervision on individual case files in the 74 case files reviewed

Evidence of professional supervision	Māori	Non-Māori	Total
Yes	21 (47%)	14 (48.5%)	35 (47%)
No	20 (44%)	14 (48.5%)	34 (46%)
Unrecorded but mentioned	3 (7%)	1 (3%)	4 (5%)
Unclear	1 (2%)	0 (0%)	1 (2%)
Total	45	29	74

405 The majority of these 43 consults occurred pre-birth and pre-order, or, if they did not, it was because there was little time for the consult to take place.

406 The consults occurred post-birth and/or post-order (seven actual and two probable).

407 Eight of the 13 case files with evidence of legal consultation were from two sites in one region.



Table 17: Focus of supervision in the 74 case files

Focus of supervision	Tasks, actions, next steps	Case decision	Review practice	Advice
Number of cases	35	2	1	1

Table 18: Site-level quality and consistency of supervision identified by the Ministry’s practice checks

Site level descriptions of supervision taken from the Ministry practice checks	Number of sites
Quality and consistency of supervision is inconsistent / variable / compromised	9
Significantly compromised	3
Supervision is generally meeting needs but compromised in some pockets	4
Quality is improving	1
Quality is high	1





Table 19: Working days between section 78 application and birth in 74 case files reviewed

Number of working days	Total	Running total	Average working days between Report of Concern and section 78 application
30 or more (before birth)	5	5	83 for Māori 25 for Non-Māori
25-29	0	5	N/A
20-24	7	12	65 for Māori 59 for Non-Māori
15-19	8	20	85 for Māori 115 for Non-Māori
10-14	3	23	91 for Māori 100 for Non-Māori
5-9	9	32	101 for Māori 118 for Non-Māori
0-4	14	46	86 for Māori 99 for Non-Māori
1-4 (days after birth)	13	59	74 for Māori 61 for Non-Māori
5 – 9	8	67	63 for Māori 88 for Non-Māori
10-14	3	70	151 for Māori 48 for Non-Māori
15-19	4	74	81 for Māori 63 for Non-Māori

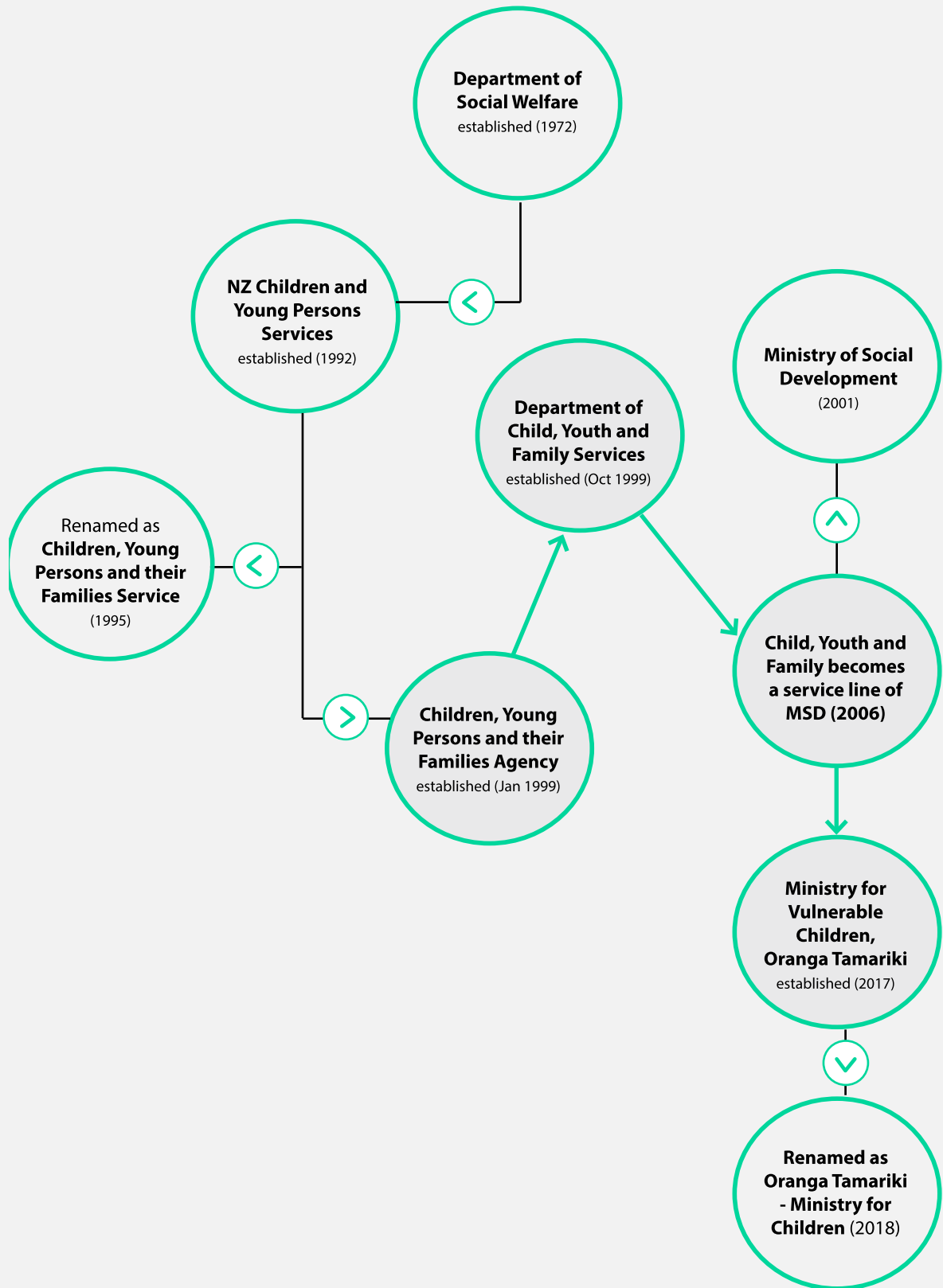


Appendix 5. Structural changes
Āpitihangā 5:
Ngā huringa hanganga





Appendix 5. Structural changes Āpitihangā 5: Ngā huringa hanganga





**Appendix 6. Obligations under
Te Tiriti o Waitangi and
international law**

**Ngā here i raro i Te
Tiriti o Waitangi
me te ture ā-ao**





Appendix 6. Obligations under Te Tiriti o Waitangi and international law

Āpitihianga 6: Ngā here i raro i Te Tiriti o Waitangi me te ture ā-ao

Te Tiriti o Waitangi

It is essential to first acknowledge te Tiriti o Waitangi. It is part of Aotearoa’s unique constitutional framework and provides the basis for the relationship between the Crown and Māori. The significance and role of te Tiriti o Waitangi is eloquently expressed by the Waitangi Tribunal in its report *Ko Aotearoa Tēnei*:⁴⁰⁸

What we saw and heard in sittings over many years left us in no doubt that unless it is accepted that New Zealand has two founding cultures, not one; unless Māori culture and identity are valued in everything government says and does; and unless they are welcomed into the very centre of the way we do things in this country, nothing will change. Māori will continue to be perceived, and know they are perceived, as an alien and resented minority, a problem to be managed with a seemingly endless stream of taxpayer-funded programmes, but never solved.

We adjure those with the power to look to the Treaty of Waitangi for the guidance and vision necessary to avoid this path of failure. It is in the fact that the agreement at Waitangi took the form of a treaty that we see mutual respect for each other’s mana, and it is in the Treaty’s words that we find the promise that this respect will last forever. That is the essential element of the Treaty partnership confirmed time and again in the courts and in this Tribunal. There are many reasons to take this partnership principle and build it into all of our national institutions. It gives us our sense of right and place, grounding us in the traditions of the Pacific and the West at the same time. It provides the centre of gravity around which our multicultural nation can coalesce. It is essentially optimistic in outlook and it relieves both Māori and Pākehā of the burden of a troubled past. It is the precondition for unlocking Māori potential for the benefit of the country as a whole. It is the core of our national identity. And it is unique.

408 Waitangi Tribunal *Ko Aotearoa Tēnei: A Report into Claims Concerning New Zealand Law and Policy Affecting Māori Culture and Identity* (Wai 262, 2011) at xxiv–xxv.





In July 2019, the Oranga Tamariki Act 1989 was amended to include specific duties ‘to recognise and provide a practical commitment to the principles of the Treaty of Waitangi (te Tiriti o Waitangi)’.⁴⁰⁹ As a public sector agency acting on behalf of the Crown, the Ministry has always been expected to act in a way that upholds the intentions of the articles of te Tiriti o Waitangi.

It has been suggested that the recommendations contained in *Te Pūao-te-Ata-Tū*, which gave rise to the current legislative framework, broadly align with the three articles of te Tiriti o Waitangi:⁴¹⁰

...The prescribed devolution of control of welfare services to Māori can be appreciated as recognition of the second article guarantee to Māori of tino rangatiratanga over taonga. The recommendations directed to whānau, hapū and iwi consultation on placement of children and standing to be heard in proceedings can be similarly framed by the second article or the third article guarantee to protect tikanga. Indeed, the committee identified the third article as a possible vehicle to [a] more culturally ... equitable society.

While made up of a preamble and three articles, te Tiriti o Waitangi must be viewed in its entirety when considering its applicability to service provision, including the care and protection of children.

International law

Right to family life

International human rights law has long recognised that family is entitled to protection and assistance by the State. A clear and unequivocal expression of the right to family life is set out in the Universal Declaration of Human Rights, which was adopted by the United Nations General Assembly in 1948:⁴¹¹

The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

This statement is repeated in the International Covenant on Civil and Political Rights (ICCPR) as well as the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁴¹² Aotearoa ratified both the ICCPR and ICESCR in December 1978.

409 Section 7AA of the Oranga Tamariki Act 1989.

410 Sharyn Otene “Care and Protection: Past, Present and Future” in *Oranga Tamariki Act—Changes* (paper presented to New Zealand Law Society seminar, June 2019) at 3.

411 *Universal Declaration of Human Rights* GA Res 217A (1948), art 16(3).

412 International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), art 23(1); and International Covenant on Economic, Social and Cultural Rights 993 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976) art 10(1).



The role of family is also explicitly acknowledged in the preamble to the United Nations Convention on the Rights of the Child (UNCROC), which was ratified by Aotearoa in April 1993.⁴¹³

...the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.

Similar language is contained in the preamble to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which was ratified by Aotearoa in September 2008.⁴¹⁴

...the family is the natural and fundamental group unit of society and is entitled to protection by society and the State, and that persons with disabilities and their family members should receive the necessary protection and assistance to enable families to contribute towards the full and equal enjoyment of the rights of persons with disabilities.

Rights of the child

UNCROC provides a useful starting point for understanding Aotearoa's international obligations in respect of the removal of newborn pēpi. Aotearoa ratified UNCROC in 1993.

There are a number of articles of UNCROC that are relevant to my investigation. In particular, Article 3(1) provides that '[i]n all actions concerning children ... the best interests of the child shall be a primary consideration'. States Parties are also required to (emphasis added).⁴¹⁵

*...respect the responsibilities, rights and duties of parents or, where applicable, the **members of the extended family or community** as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.*

UNCROC recognises that '[p]arents ... have the primary responsibility for the upbringing and development of the child'.⁴¹⁶ In this regard, States Parties are required to (emphasis added).⁴¹⁷

413 Convention on the Rights of the Child (UNCROC) 1577 UNTS 3 (opened for signature 20 November 1989, entered into force 2 September 1990, preamble.). See also CRC Committee, Day of General Discussion, *Role of Family in the Promotion of the Rights of the Child*, CRC/C/24, 7th Session, 10 October 1994, at 2.1–2.2, retrieved from <www.ohchr.org/EN/HRBodies/CRC/Documents/Recommandations/family.pdf>.

414 United Convention on the Rights of Persons with Disabilities (UNCRPD) 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008), preamble at (x).

415 UNCROC, art 5.

416 UNCROC, art 18(1).

417 UNCROC, art 18(2).



...**render appropriate assistance** to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

In terms of the separation of families, the *Implementation Handbook for the Convention on Rights of the Child* provides the following guidance:⁴¹⁸

Removal of children from their parents without justification is one of the gravest violations of rights the State can perpetrate against children. At the same time, the State has a responsibility to protect children from parental harm. For this reason, the Convention requires that such actions be governed by clear and just procedures, as specified in article 9.

Article 9 of UNCROC provides:

1. *States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents...*
2. *In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.*

The requirement to enable participation in proceedings aligns with other well-established principles of our legal system: the right to due process and the right a fair hearing by a competent and impartial tribunal. The *Implementation Handbook for the Convention on Rights of the Child* states (emphasis added):⁴¹⁹

*This aspect of a proper judicial review—the need to hear from all relevant parties—is given special emphasis within the Convention for good reasons. It reminds States that **both parents must be heard**, even when one parent has not had primary care of the child (for example in a case of child neglect by the child’s mother, even a non-resident father of the child should be given an opportunity to show he is able and willing to look after the child) or when one parent is out of the country. **It also enables other ‘interested parties’ to participate in the proceedings—for example members of the child’s extended family, or professionals with specialist knowledge of the***

418 United Nations Children’s Fund *Implementation Handbook for the Convention on the Rights of the Child* (3rd ed, September 2007) at 127, retrieved from <www.unicef.org/publications/index_43110.html>.

419 At 129.



child. *'Interested parties' is undefined within the Convention, so that interpretation is left to domestic law or the judge of the case; however, it should be assumed that **the widest possible interpretation is needed, since a sound decision on best interests of the child is dependent on having the fullest possible information.***

In light of the obligations arising from te Tiriti o Waitangi and the language of the Oranga Tamariki Act 1989, *'interested parties'* must extend to whānau, and to hapū and iwi.

In February 2010, the United Nations General Assembly adopted *the Guidelines for the Alternative Care of Children*.⁴²⁰ While these Guidelines do not have the force of an international agreement, they provide advice on how a State Party, like Aotearoa, should give effect to the rights enshrined under UNCROC. The following is an extract of the Guidelines that highlights some of the key issues relevant to this investigation (emphasis added):

9. *As part of efforts to prevent the separation of children from their parents, States should seek to ensure appropriate and culturally sensitive measures:*
 - i. *To support family caregiving environments whose capacities are limited by factors such as disability, drug and alcohol misuse, discrimination against families with indigenous or minority backgrounds...*
10. *Special efforts should be made to tackle discrimination on the basis of any status of the child or parents, including poverty, ethnicity, religion, sex, mental and physical disability, HIV/AIDS or other serious illnesses, whether physical or mental, birth out of wedlock, and socio-economic stigma, and all other statuses and circumstances that can give rise to relinquishment, abandonment and/or removal of a child.*
11. ***All decisions concerning alternative care should take full account of the desirability, in principle, of maintaining the child as close as possible to his/her habitual place of residence, in order to facilitate contact and potential reintegration with his/her family and to minimize disruption of his/her educational, cultural and social life***
...
14. ***Removal of a child from the care of the family should be seen as a measure of last resort and should, whenever possible, be temporary and for the shortest possible duration.***
Removal decisions should be regularly reviewed and the child's return to parental care, once the original causes of removal have been resolved or have disappeared, should be in the best interests of the child...

420 United Nations Guidelines for the Alternative Care of Children GA Res 64/142 (2010) at II.B.14.



15. **Financial and material poverty, or conditions directly and uniquely imputable to such poverty, should never be the only justification for the removal of a child from parental care**, for receiving a child into alternative care, or for preventing his/her reintegration, but should be seen as a signal for the need to provide appropriate support to the family.

...

39. Proper criteria based on sound professional principles should be developed and consistently applied for assessing the child's and the family's situation, including the family's actual and potential capacity to care for the child, in cases where the competent authority or agency has reasonable grounds to believe that the well-being of the child is at risk.

40. Decisions regarding removal or reintegration should be based on this assessment and should be made by suitably qualified and trained professionals, on behalf of or authorized by a competent authority, **in full consultation with all concerned** and bearing in mind the need to plan for the child's future.

41. States are encouraged to adopt measures for the integral **protection and guarantee of rights during pregnancy, birth and the breastfeeding period**, in order to ensure conditions of dignity and equality for the adequate development of the pregnancy and the care of the child. Therefore, support programmes should be provided to future mothers and fathers, particularly adolescent parents, who have difficulty exercising their parental responsibilities. Such programmes should aim at **empowering mothers and fathers to exercise their parental responsibilities in conditions of dignity and at avoiding their being induced to surrender their child because of their vulnerability**.

In terms of breastfeeding, UNCROC 'recognises the right of the child to the enjoyment of the highest attainable standard of health'.⁴²¹ States Parties are required to take appropriate measures:⁴²²

[t]o ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding.

421 UNCROC, art 24(1).

422 UNCROC, art 24(2)(e).



Rights of disabled people

The rights of disabled people are a significant issue for this investigation.⁴²³ Aotearoa's international obligations in this regard are set out in UNCRPD. The purpose of this Convention is to:⁴²⁴

...promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

The Convention makes it explicit that States Parties must ensure the full realisation of all human rights and fundamental freedoms for all people with a disability, on an equal basis with others, and without discrimination of any kind on the basis of disability.⁴²⁵

Article 23 is especially relevant for this investigation, as it addresses the rights of family and children for disabled people (emphasis added):

2. *States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. **States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.***

...

4. *States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. **In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.***

While there is no universally accepted definition of disability, an approach consistent with Aotearoa's international obligation is to take a non-exhaustive view of disability, as suggested by Article 1 of UNCRPD:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

423 This also aligns with my role as one of three independent mechanisms responsible for promoting, protecting and monitoring Aotearoa's implementation of UNCRPD. This responsibility is accorded to me under Article 33(2) of UNCRPD.

424 UNCRPD, art 1.

425 UNCRPD, arts 4(1) and 5. However, this has been a feature of Aotearoa's law since 1993 under the Human Rights Act of that year.



The *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol* states (emphasis added):⁴²⁶

*The Convention **does not explicitly define the word ‘disability’; indeed, the Preamble to the Convention acknowledges that ‘disability’ is an evolving concept** . . . Nor does the Convention define the term ‘persons with disability.’ However, the treaty does state that the term includes persons who have **long-term physical, mental, intellectual or sensory impairments that, in the face of various negative attitudes or physical obstacles, may prevent those persons from participating fully in society** (article 1).*

*The recognition that ‘disability’ is an evolving concept acknowledges the fact that society and opinions within society are not static. Consequently, the Convention **does not impose a rigid view of ‘disability,’** but rather assumes a dynamic approach that allows for adaptations over time and within different socio-economic settings.*

*The Convention’s approach to disability also emphasizes **the significant impact that attitudinal and environmental barriers in society** may have on the enjoyment of the human rights of persons with disabilities. . .*

*The Convention indicates, rather than defines, who are persons with disabilities. Persons with disabilities ‘include’ those persons with long-term physical, mental, intellectual or sensory impairments; in other words, the Convention protects at least those individuals. **Implicit in this indication is the understanding that States may broaden the range of persons protected to include, for example, persons with short-term disabilities.***

Such a view of disability is also consistent with the New Zealand Disability Strategy, which was co-designed with disabled people. This Strategy states:⁴²⁷

Disability is something that happens when people with impairments face barriers in society; it is society that disables us, not our impairments, this is the thing all disabled people have in common. It is something that happens when the world we live in has been designed by people who assume that everyone is the same. That is why a non-disabling society is core to the vision of this Strategy.

Every human being is a unique individual. Even if we have the same impairment as someone else, we will experience different opportunities and barriers because of where we live and how we are treated by those around us. The time and context in our lives when we may acquire our impairment(s) also informs what barriers or opportunities we may experience.

426 United Nations *From Exclusion to Equality: Realising the Rights of Persons with Disabilities, Handbook for Parliamentarians* (Geneva 2007) at 12–13.

427 Office for Disability Issues *New Zealand Disability Strategy 2016–2026* (Ministry of Social Development November 2016) at 12.



Where the State identifies that an impairment may affect a person's ability to parent, it then comes under an obligation to provide reasonable accommodation.⁴²⁸ This is defined as:⁴²⁹

...necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.

Factors that can be taken into account when considering what amounts to reasonable accommodation are:

- the effectiveness of any adjustment in assisting disabled people;
- whether it is practical to make an adjustment;
- the financial or other costs of the adjustment;
- the availability of resources to undertake an adjustment; and
- how much disruption, if any, will be caused to other people by the adjustment.

428 UNCRPD, art 5(3).

429 UNCRPD, art 2.



Appendix 7. Section 14 – a child in need of care or protection

**Āpitihanganga 7:
Wāhanga 14 – he tamaiti me tiaki,
me whakamaru rānei**





Appendix 7. Section 14 – a child in need of care or protection

Āpitihangā 7: Wāhangā 14 – he tamaiti me tiaki, me whakamaru rānei

Section 14 of the Act defined a ‘child or young person in need of care or protection’:⁴³⁰

- (a) the child or young person is being, or is likely to be, harmed (whether physically or emotionally or sexually), ill-treated, abused, or seriously deprived; or
- (b) the child’s or young person’s development or physical or mental or emotional well-being is being, or is likely to be, impaired or neglected, and that impairment or neglect is, or is likely to be, serious and avoidable; or
- (ba) the child is a subsequent child of a parent to whom section 18A applies, and the parent has not demonstrated to the satisfaction of the chief executive (under section 18A) or the court (under section 18C) that he or she meets the requirements of section 18A(3); or
- (c) serious differences exist between the child or young person and the parents or guardians or other persons having the care of the child or young person to such an extent that the physical or mental or emotional well-being of the child or young person is being seriously impaired; or
- (d) the child or young person has behaved, or is behaving, in a manner that—
 - (i) is, or is likely to be, harmful to the physical or mental or emotional well-being of the child or young person or to others; and
 - (ii) the child’s or young person’s parents or guardians, or the persons having the care of the child or young person, are unable or unwilling to control; or
- (e) in the case of a child of or over the age of 10 years and under 14 years, the child has committed an offence or offences the number, nature, or magnitude of which is such as to give serious concern for the well-being of the child; or

430 Section 14(1) of the Act at July 2017, since amended. See section 14(1) of the Act at July 2019.



- (f) the parents or guardians or other persons having the care of the child or young person are unwilling or unable to care for the child or young person; or
- (g) the parents or guardians or other persons having the care of the child or young person have abandoned the child or young person; or
- (h) serious differences exist between a parent, guardian, or other person having the care of the child or young person and any other parent, guardian, or other person having the care of the child or young person to such an extent that the physical or mental or emotional well-being of the child or young person is being seriously impaired; or
- (i) the ability of the child or young person to form a significant psychological attachment to the person or persons having the care of the child or young person is being, or is likely to be, seriously impaired because of the number of occasions on which the child or young person has been in the care or charge of a person (not being a person specified in subsection (2)) for the purposes of maintaining the child or young person apart from the child's or young person's parents or guardians.



Appendix 8. Care and protection process

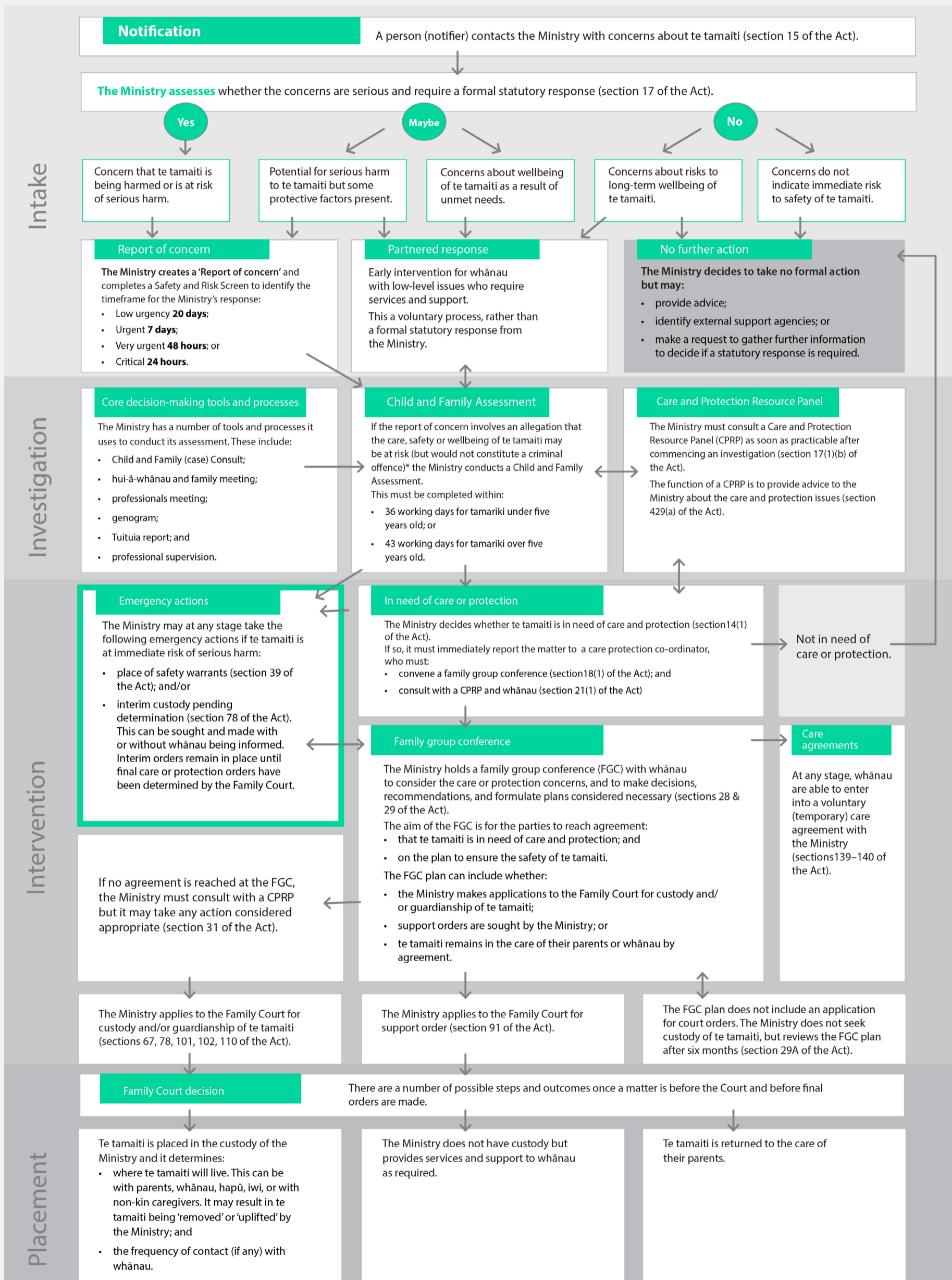
**Āpitihangā 8:
Tukanga tiaki me
te whakamaru**





Appendix 8. Care and protection process

Āpiti hanga 8: Tukanga tiaki me te whakamaru



* For allegations of abuse that may constitute a criminal offence, the Ministry works with the police under the Child Protection Protocol.



**Appendix 9. Subsequent children
statutory provisions**

**Āpitianga 9:
Ngā whakaritenga
ture tamariki o
muri mai**





Appendix 9. Subsequent children statutory provisions

Āpitihianga 9: Ngā whakaritenga ture tamariki o muri mai

The following are the subsequent children statutory provisions as set out in the Act at July 2017.

18A Assessment of parent of subsequent child

- (1) This section applies to a person who—
 - (a) is a person described in section 18B; and
 - (b) is the parent of a subsequent child; and
 - (c) has, or is likely to have, the care or custody of the subsequent child; and
 - (d) is not a person to whom subsection (7) applies.
- (2) If the chief executive believes on reasonable grounds that a person is a person to whom this section applies, the chief executive must, after informing the person (where practicable) that the person is to be assessed under this section, assess whether the person meets the requirements of subsection (3) in respect of the subsequent child.
- (3) A person meets the requirements of this subsection if,—
 - (a) in a case where the parent's own act or omission led to the parent being a person described in section 18B, the parent is unlikely to inflict on the subsequent child the kind of harm that led to the parent being so described; or
 - (b) in any other case, the parent is unlikely to allow the kind of harm that led to the parent being a person described in section 18B to be inflicted on the subsequent child.
- (4) Following the assessment,—
 - (a) if subsection (5) applies, the chief executive must apply for a declaration under section 67 that the subsequent child is in need of care or protection on the ground in section 14(1)(ba); or
 - (b) in any other case, the chief executive must decide not to apply as described in paragraph (a), and must instead apply under section 18C for confirmation of the decision not to apply under section 67.
- (5) The chief executive must apply as described in subsection (4)(a) if the chief



executive is not satisfied that the person, following assessment under this section, has demonstrated that the person meets the requirements of subsection (3).

- (6) No family group conference need be held before any application referred to in subsection (4) is made to the court, and nothing in section 70 applies.
- (7) This subsection applies to the parent of a subsequent child if, since the parent last became a person described in section 18B,—
 - (a) the parent has been assessed under this section in relation to a subsequent child and, following that assessment,—
 - (i) the court has confirmed, under section 18C, a decision made under subsection (4)(b); or
 - (ii) the chief executive applied for a declaration under section 67 that the child was in need of care or protection on the ground in section 14(1)(ba), but the application was refused on the ground that the court was satisfied that the parent had demonstrated that the parent met the requirements of subsection (3); or
 - (b) the parent was, before this section came into force, subject to an investigation carried out by a social worker under section 17 in relation to a child who would, at that time, have fallen within the definition of a subsequent child, and—
 - (i) the social worker did not at that time form the belief that the child was in need of care or protection on a ground in section 14(1)(a) or (b) (as in force at that time); or
 - (ii) a family group conference was held, the parent addressed the concerns raised to the satisfaction of the chief executive, and the parent subsequently maintained care of the child.

18B Person described in this section

- (1) A person described in this section is a person—
 - (a) who has been convicted under the Crimes Act 1961 of the murder, manslaughter, or infanticide of a child or young person who was in the person's care or custody at the time of the child's or young person's death; or
 - (b) who has had the care of a child or young person removed from that person on the basis described in subsection (2)(a) and (b) and, in accordance with subsection (2)(c), there is no realistic prospect that the child or young person will be returned to the person's care.
- (2) Subsection (1)(b) applies, in relation to a child or young person removed from the care of a person, if—



- (a) the court has declared under section 67, or a family group conference has agreed, that the child or young person is in need of care or protection on a ground in section 14(1)(a) or (b); and
 - (b) the court has made an order under section 101 (not being an order to which section 102 applies) or 110 of this Act, or under section 48 of the Care of Children Act 2004; and
 - (c) the court has determined (whether at the time of the order referred to in paragraph (b) or subsequently), or, as the case requires, the family group conference has agreed, that there is no realistic possibility that the child or young person will be returned to the person's care.
- (3) If a person is a person described in this section on more than 1 of the grounds listed in subsection (1), the references in section 18A(3) to the kind of harm that led a person to being a person described in this section is taken to be a reference to any or all of those kinds of harm.

18C Confirmation of decision not to apply for declaration under section 67

- (1) An application under this section for confirmation of a decision under section 18A(4)(b) relating to the parent of a subsequent child must include—
- (a) information showing that the person is a person to whom section 18A applies; and
 - (b) an affidavit by the person making the application setting out the circumstances of the application and the reasons for the person's belief that the parent meets the requirements of section 18A(3).
- (2) The application must be served in accordance with section 152(1) as if it were an application for a declaration under section 67.
- (3) When considering the application, the court may (but need not) give any person an opportunity to be heard on the application and, if it does, may appoint a barrister or solicitor (under section 159) to represent the subsequent child.
- (4) After considering the application, the court may,—
- (a) if subsection (5) applies, confirm the chief executive's decision under section 18A(4)(b) not to apply for a declaration under section 67; or
 - (b) decline to confirm the chief executive's decision under section 18A(4)(b), in which case section 18D applies; or
 - (c) dismiss the application on the ground that it does not relate to a person to whom section 18A applies; or



- (d) adjourn the hearing and require the chief executive to—
 - (i) provide such information as the court specifies, within the period specified by the court; or
 - (ii) reconsider all or any aspect of the assessment and report to the court within a period specified by the court.
- (5) The court may confirm the decision of the chief executive under section 18A(4)(b) only if it is satisfied, on the basis of the written material before it (and, if the court has heard any person under subsection (3), any other material heard), that the parent in respect of whom the application is made has demonstrated that the parent meets the requirements of section 18A(3).
- (6) Except as provided in this section, nothing in Part 3 applies in respect of an application for, or a decision of a court on, confirmation of a decision made under section 18A(4)(b).

18D Court declining to confirm decision

If, under section 18C(4)(b), the court declines to confirm the chief executive's decision under section 18A(4)(b), the court must give written reasons for its decision, and the application for confirmation—

- (a) must be treated as an application for a declaration under section 67 on the ground in section 14(1)(ba); and
- (b) must be served and heard in accordance with Part 3 and the rules of court, except that, although section 70 does not apply, if a family group conference is convened pursuant to section 72(3), the chief executive (or the chief executive's representative) is entitled to attend the conference as if the chief executive were entitled to do so under section 22(1)(a) to (h).



Appendix 10. Subsequent children process

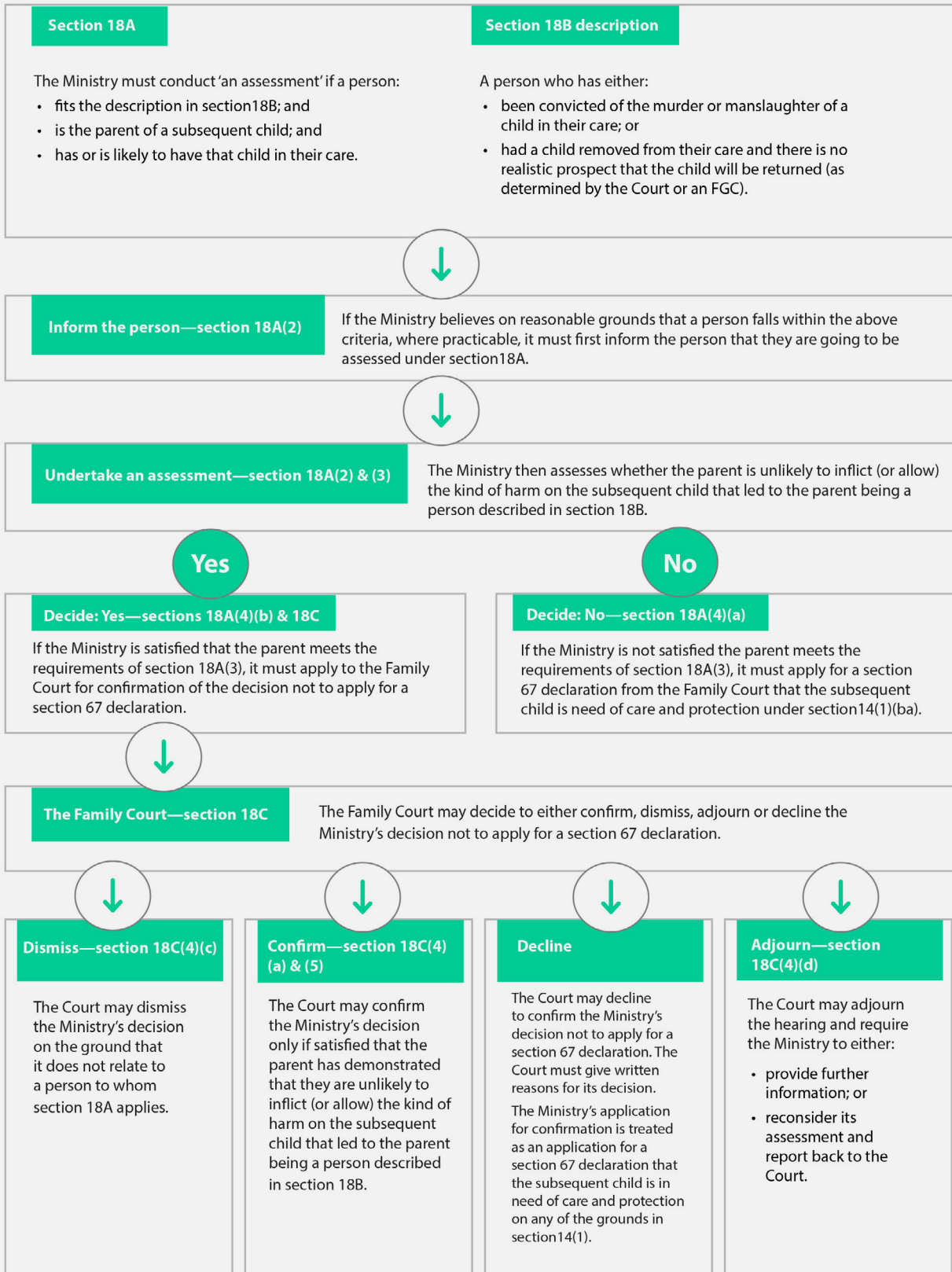
**Āpitianga 10:
Te tukanga mō ngā
tamariki o muri mai**





Appendix 10. Subsequent children process

Āpitihangā 10: Te tukanga mō ngā tamariki o muri mai





**Appendix 11. Extracts of the
Ministry's s78 Casefile Analysis**

**Āpitianga 11:
Ngā tangohanga o te
Tātari Kōnae Kēhi o te
Wāhanga 78 a Oranga
Tamariki**



Appendix 11. Extracts of the Ministry's s78 Casefile Analysis

Āpitihianga 11: Ngā tangohanga o te Tātari Kōnae Kēhi o te Wāhanga 78 a Oranga Tamariki

The following tables were extracted from the Ministry's s78 Casefile Analysis completed in November 2019.⁴³¹

Q1.8 Was there a process for sharing concerns with whānau about wellbeing of the baby prior to entry to care?

Q1.8	High Volume		Sites with partnered practice		Rest of NZ		All	% of sampled cases	Weighted Values	Estimated % of population
Home Visit	11	17%	3	10%	2	3%	16	10%	21	7%
Hui-a-whānau	8	13%	6	20%	9	15%	23	15%	46	15%
Family meetings	5	8%	4	13%	8	13%	17	11%	38	12%
FGC	6	10%	5	17%	10	17%	21	14%	47	15%
Other (please specify)	19	30%	11	37%	13	22%	43	28%	77	25%
No evidence	14	22%	1	3%	17	28%	32	21%	76	25%
Non-answer	0	0%	0	0%	1	2%	1	1%	4	1%
Total	63		30		60		153		309	

The sites with partnered practice were higher for there having been a process for sharing information. The level of 'no evidence of sharing' was low at 1 case, 3%, compared to around a quarter for other sites.

Figure 20: The Ministry's analysis of its efforts to engage.⁴³²

431 Oranga Tamariki—Ministry for Children s78 Casefile Analysis, above n 20.

432 Above n 20, at 10.



Q1.11 What support service were provided to mum/and or whānau with a focus on preventing removal from parental care?

Q1.11	High Volume		Sites with partnered practice		Rest of NZ		All	% of sampled cases	Weighted Values	Estimated % of population
Unable to be determined	19	30%	8	27%	20	33%	47	31%	99	32%
Other (please specify)	14	22%	7	23%	15	25%	36	24%	75	24%
Alcohol and/or drug treatment	12	19%	6	20%	8	13%	26	17%	47	15%
Residential Parenting programme	3	5%	3	10%	8	13%	14	9%	35	11%
Home visiting	3	5%	2	7%	2	3%	7	5%	12	4%
Day based parenting programme	2	3%	2	7%	1	2%	5	3%	8	3%
Mental health support	2	3%	0	0%	1	2%	3	2%	6	2%
Family Violence Interventions	1	2%	1	3%	1	2%	3	2%	6	2%
Non-answer	7	11%	1	3%	4	7%	12	8%	22	7%
Total	63		30		60		153		309	

In around a third of cases it was not possible to identify from case notes what support services, if any, were offered. Many in the other category reflected limited engagement between mum and Oranga Tamariki. There is no obvious variation between sites.

Figure 21: The Ministry's analysis of support services provided.⁴³³

433 Above n 20, at 11–12.





Q2.1(a) Prior to S78 was there a family meeting/hui a whānau:

Q2.1_a	High Volume		Sites with partnered practice		Rest of NZ		All	% of sampled cases	Weighted Values	Estimated % of population
Yes	25	40%	16	53%	20	33%	61	40%	113	37%
No	31	49%	12	40%	32	53%	75	49%	158	51%
No record	7	11%	2	7%	8	13%	17	11%	38	12%
	63		30		60		153		309	

In 51% of all cases there was no family meeting/hui a whānau. The 'Rest of NZ' sample group had the highest rate (53%) of NOT having a family meeting/hui a whānau. The sites with partnered practice had the lowest rate (40%) of NOT having a family meeting/hui a whānau.

Figure 22: The Ministry's analysis of the use of hui ā-whānau.⁴³⁴

Q2.2 Did an FGC take place prior to making the custody order and developing a plan for this whānau?

Q2.2	High Volume		Sites with partnered practice		Rest of NZ		All	% of sampled cases	Weighted Values	Estimated % of population
Yes	17	27%	12	40%	22	37%	51	33%	108	35%
No FGC on record	39	62%	16	53%	33	55%	88	58%	174	56%
Other (please specify)	7	11%	0	0%	5	8%	12	8%	25	8%
Non-answer	0	0%	2	7%	0	0%	2	1%	2	<1%
Total	63		30		60		153		309	

In a third of cases an FGC was held prior to the s78 custody order. High volume sites had a lower instance of FGC than other sites. The main reasons provided for not holding an FGC included rapid application for orders, difficulty finding or engaging parents and whānau, or where there were delays completing an assessment.

Figure 23: The Ministry's analysis of FGC occurrences prior to birth.⁴³⁵

434 Above n 20, at 13.

435 Above n 20, at 13–14.





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