New Zealand Government

PRACTICE REVIEW

Professional Practice Group

Practice Review into the Hastings Case

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FOREWORD

'Parapara waere a ururua, kia kitea te huarahi tika'

Clear away the undergrowth, so that the right path can be seen

Social work is underpinned by a commitment to supporting and realising change, within people, whānau, communities and the networks that influence them. This requires that social workers are able to engage, reflect, understand, challenge and act in ways that promote change and resilience. Nowhere is this endeavour more complex and the required professional judgments more finely balanced than in the field of statutory child protection.

The oranga of tamariki must be a shared endeavour. Practitioners must operate within systems of supportive challenge – within their own organisation, with partner NGOs and agencies and importantly with tamariki, parents, whānau, hapū and iwi. It is in this spirit that we have undertaken this review. I am deeply grateful for the leadership, collaboration and honest challenge that Ngāti Kahungunu, the Office of the Children's Commissioner and Shayne Walker have brought to our understanding of these events and the whānau involved. Together, they have helped us to ensure this review has the necessary level of rigour, balance and insight.

We have also undertaken this review in the spirit of the principles of mana tamaiti, whakapapa and whanaungatanga, as well as the Oranga Tamariki – Ministry for Children values. We have sought to uphold the mana and oranga of the review participants, while also seeking a clear understanding of the experiences of this pēpi and his whānau. It is my hope that this review contributes to the restoration of relationships and the mana of those involved and that it signposts opportunities to continue to build upon a shared commitment to supporting parents, whānau, hapū and iwi with the care of their tamariki.

Grant Bennett, Chief Social Worker / Deputy Chief Executive, Professional Practice

'Huakina te ngākau, kei wareware tātou'

Open the heart least we forget

The Chief Executive of Ngāti Kahungunu, the Senior Advisor from the Office of the Children's Commissioner, and I have endeavoured to ensure that this Review was conducted in a manner that was tika (correct and honest), pono (behaviours of integrity) and aroha (motivated by love). Our hope is that this review provides a whakawātea (clear pathway) for all of those involved in this process and the subsequent mahi with this whānau.

We are indebted to the 'on the ground reviewers' from the Professional Practice Group for upholding the mana of all of those who contributed their voices to this review.

Lastly, to all of those who provided the detail that forms this weave, your voices will have an impact on practice with whānau Māori.

Shayne Walker on behalf of Review Oversight Group

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EXECUTIVE SUMMARY

Context and approach

In early May 2019, the attempted removal of a baby from his mother's care in Hastings by Oranga Tamariki attracted significant public scrutiny and criticism. In response to these events, the Chief Executive of Oranga Tamariki commissioned a Practice Review from the Chief Social Worker / Deputy Chief Executive, Professional Practice, to examine the actions of Oranga Tamariki in relation to the baby, his parents and whānau prior to, and immediately following, the birth of the new baby.

The review has been undertaken with the oversight of the Chief Executive of Ngāti Kahungunu, a representative of the Office of the Children's Commissioner and an independent person agreed with Ngāti Kahungunu, Shayne Walker. The oversight group has been involved in all aspects of the review including the methodology, analysis, findings and recommendations.

This review has sought to understand what occurred, to identify what can be learned from both a local and national perspective, and to promote restorative actions. The focus has been on the quality of engagement, assessment and planning, practices for working with tamariki and whānau Māori, inter-agency working and the processes undertaken.

Reviewers used a combination of case notes and records, direct interviews and workshops to build an understanding of what occurred. This has involved engagement with the s 9(2)(ba)(i), Oranga Tamariki staff, Non-Governmental Organisational (NGO) partners who were working with the whānau, New Zealand Police, District Health Board representatives, the lawyer for the child s 9(2)(ba)(i) We respect and acknowledge the decision of the parents s 9(2)(a) not to engage in the review process.

This review has analysed these events against statutory, organisational and professional obligations that applied at the time of the events. The reviewers have also had an eye to the legislative changes that were introduced from 1 July 2019.

Understanding what happened

In November 2018, Oranga Tamariki learned that a young couple, who had had a new-born infant previously removed from their care, were expecting another child. In February 2019, Oranga Tamariki entered a Report of Concern for this tamaiti and, in mid-March, it made a referral for a Family Group Conference (FGC).

Two hui were held in March and April with the mother, various whānau and support people and the NGO practitioners working with her, to discuss the mother's aspiration to keep the new baby, options for the mother to build and demonstrate her parenting skills, and how the mother was progressing. The mother s 9(2)(a) and the baby was born on 1 May.

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On 2 May Oranga Tamariki sought and was granted a without notice s78 custody order for the baby.

On 6 May Oranga Tamariki made the first attempt to remove the baby from his parents' care. There was a disagreement about whether a plan had been previously agreed with Oranga Tamariki that would enable the mother to retain the care of the baby and it was agreed that the baby remain with the mother until a hui could be held the day following.

On 7 May the whānau and their supporters proposed a strengthened plan for the care of the baby. Oranga Tamariki decided, however, to proceed with the removal of the baby and a subsequent attempt was made that evening. The mother resisted these attempts and, after midnight on 8 May, Oranga Tamariki decided to withdraw and to hold a further hui later in the day. At that hui, agreement was reached on the plan for the mother and baby to go to a s 9(2)(a) and this occurred the following day.

Findings

There were legitimate concerns for the safety of this baby that warranted Oranga Tamariki involvement with these parents and the whānau.

Pregnancy is a period during which there is a known increased risk of escalation of family harm. This makes infants uniquely vulnerable prior to, and following, birth. Babies are also more susceptible to, and unable to protect themselves from, harm. The risk of serious injury (including death) is therefore immediately higher for them than older tamariki. Harmful events early in life can have a long-term developmental impact and affect wellbeing across a range of domains in the life of a child and into adulthood.

There were legitimate safety concerns s 9(2)(a), s 6(c)

There was an over-reliance on historical information and limited work to understand the current situation for the whānau.

Statutory care and protection practice requires continued assessment and re-assessment of care and protection concerns. Social workers need to be able to consider historical factors in a current setting. They must be able to reflect on positive steps taken to make changes in the lives of parents with previous parenting issues. Decision-making in this case, however, demonstrated an over-reliance on historical information and significant gaps in work to understand, weigh and verify information about the current situation for the mother, father and wider whānau.

Key assessment decisions were made without an understanding of the environment of care that the parents could provide and before engagement with the mother, whānau and other professionals working with the whānau. There was also inadequate documentation of the rationale for, and information underpinning, some key decisions.

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Additionally, although some parental and whānau strengths were identified during assessment, these were not used to build engagement with, or an understanding of, these parents and their whānau. Evidence from partner NGOs of the mother's desire for change in order to be able to parent this baby and of her engagement s 9(2)(a) was not given enough consideration.

Nor were the needs of the parents and the wider family and whānau fully explored. This meant opportunities to identify how meeting those needs could have mitigated against the risks for the baby were missed.

s 9(2)(a), s 6(c)

s 9(2)(a), s 6(c)

The options of parental or whānau, hapū or iwi care of the new baby should have been more fully explored.

Where there are concerns around the safe care of tamariki, the first priority is to determine if and how te tamaiti can be kept safe within the care of their parents. Safety planning can be particularly effective when working with chronic concerns, s 9(2)(a). Where, on the basis of a comprehensive assessment, the safety of te tamaiti can only be maintained by removing them to a safer care environment, social workers must ensure they are taking every opportunity to enable te tamaiti to be cared for within their family, whānau, hapū, iwi or family group. They must also have regard to the principles within the Oranga Tamariki Act 1989 which emphasise stability and the placement of children with their siblings.

A commitment to ensuring the baby would receive safe and stable care as early as possible and the importance of maintaining sibling relationships were strong motivators throughout Oranga Tamariki involvement with this baby.

Insufficient consideration was given, however, to if and how safety planning could be used with these parents and their whānau, despite indicators it may have been used effectively in this context. This includes a willingness to work closely with Oranga Tamariki, an acceptance that there were concerns to be addressed, and the identification by the parents and whānau of actions they could take to address these concerns. Hui a whānau and a Family Group Conference (FGC) would have provided the opportunity to build a shared understanding of the care and protection concerns and support needed for these young parents in their parenting role but these did not occur prior to the baby's birth.

The plan to place the baby *[outside of the whānau]* s 9(2)(a) was made without sufficient exploration of alternative care options

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with hapū or iwi or the baby's wider family group and there was no consultation with the parents and whānau about who the baby should be cared for if removal from parental care was necessary.

Oranga Tamariki needs to ensure social workers have a sound understanding of the circumstances in which the s18B 'subsequent children' provisions of the Oranga Tamariki 1989 Act relating to a specified and narrow category of parents apply and the processes to follow when they do apply. *[Wider whānau members]* s 9(2)(a) were inaccurately flagged as falling within the scope of these provisions. It is not clear, however, whether this impacted on decision-making in relation to whānau care options over and above the identified safety concerns.

Caregiving families who make their homes available to tamariki in need of safe care play an important part in the wider network of protection around tamariki. s 9(2)(a)

Engagement with this whānau should have built from a recognition of the values of significance to whānau Māori and the strength inherent in their culture.

Oranga Tamariki must work inclusively with tamariki and whānau Māori in a manner that strengthens links to Māori cultural values and beliefs (mana tamaiti), comprehensively identifies genealogical ties to people, place, whānau, hapū and iwi history (whakapapa) and values the right of tamariki to engagement with whānau, hapū and iwi and wider family networks (whanaungatanga). Whānau hui or family meetings and the appropriate use of tikanga are important mechanisms for engagement, assessment and planning with whānau Māori, for recognising the importance of whakapapa, and for enabling whānau to exercise their whanaungatanga responsibilities. For tamariki Māori, wellbeing (oranga), safety and protection (mana and tapu) are multi-dimensional and interdependent – physical safety and protection is critical but so too is the protection afforded by one's whakapapa.

Work to identify whakapapa connections for this baby was, however, limited and constrained by a view that *[some wider]* s 9(2)(a) whānau was difficult to engage with, the weight given to placement of this pēpi with his sibling, and a lack of active planning for a whānau hui or FGC. The *[preference of some wider whānau members]* s 9(2)(a) not to involve extended whakapapa networks is not unusual in whānau where there has been inter-generational trauma but the specialist skills required to work effectively in this context were limited at the site.

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. Although practitioners from NGO organisations had built relationships of trust with this whānau, the value of their knowledge, professional expertise and relationships with the whānau does not appear to have been recognised and built upon.

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These practitioners were not included in case consults, and their professional opinions were not routinely sought or considered.

The likely impact of prior trauma on the parents' behaviour was not sufficiently well understood and compromised decision-making and engagement. Opportunities to avoid re-traumatisation were missed.

Social workers need to recognise historical and inter-generational trauma when working with tamariki and whānau and to understand how that trauma may impact on the behaviour and support needs of tamariki and whānau.

The parents were both vulnerable young people with their own histories of trauma s 9(2)(a). Had this been better recognised a more realistic approach could have been taken to understanding the support these parents would have needed in order for them to care for their new baby.

s 9(2)(a)

s 9(2)(a)

Communication and engagement were not effective in building quality relationships with the mother, father, whānau and NGO partners.

Social workers need to invest time to understand and communicate with whānau in an open, honest and timely way. 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. Social workers also need to build effective and collaborative relationships with other professionals and to recognise the unique contribution they can make to understanding the circumstances of the whānau and to maintaining the safety of tamariki.

There was little evidence of work to build a relationship with the maternal whānau in relation to the second baby outside of contact visits with the older child. Nor is there evidence of a relationship being built with the father or his whānau who had a right to be involved in the plan for the new baby and to understand the concerns.

It was not recognised that *[Oranga Tamariki employee's]* s 9(2)(a) role in the removal of the previous child was a barrier to developing the trusting relationship necessary to be able to work effectively and openly with the mother through this pregnancy. *[Some*

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whānau members] s 9(2)(a) felt their concerns about engagement with extended whānau were not understood and that their commitment to, and efforts to achieve, change were not acknowledged or recognised.

Whānau were not told about arrangements for cover when *[Oranga Tamariki employee]* s 9(2)(a) was on leave and there was no pre-existing relationship between the whānau and the practitioners who attended the hospital first to check on the baby's welfare and who later attempted to remove the baby from the mother's care.

Communication with professionals appears to have been largely "one way" and concerns and key decisions were not shared with them in an open and timely way. s 6(c)

The statutory authority delegated to Oranga Tamariki social workers was not consistently well-understood or appropriately applied

Where a social worker has formed a view that the child needs care or protection, they must make a referral for an FGC. Although Oranga Tamariki had indicated to NGO partners there would be an opportunity to discuss the concerns and how to manage them through an FGC and a hui a whānau, neither of these forums were made available before custody orders were sought and granted. This was due to a delay in making a referral for an FGC and because of vacancies and s 9(2)(a) at the site in the FGC Co-ordinator role.

Where social workers, following consultation with their legal team, form a belief that the only way to protect a child from serious harm is to apply for the custody of the child, those orders should be sought on an on notice basis unless fast and decisive action is required to ensure the immediate safety of a child. There should be a high bar for applying for orders on a without notice basis given the importance of enabling whānau to challenge decisions made by Oranga Tamariki and the far-reaching powers of the Court. The basis for applying for a custody order on a without-notice basis was, however, weak. A with-notice application should have been possible within a timeframe appropriate to the circumstances of this case and there is little evidence to suggest the mother was a 'flight risk' or that there were immediate safety concerns for this baby.

Once a custody order has been granted, and a decision has been made to place the child in Oranga Tamariki custody, social workers must undertake careful planning with their colleagues, other professionals and, wherever possible, supportive whānau members to make this process as safe and least traumatic as it can be for all parties. Wherever possible, social workers should ensure that the parents have an opportunity to say goodbye to their pēpi, to have support people present and to be provided with clear information about what the next steps are.

Inadequate planning and communication meant, however, that hospital staff were unclear about what would happen when and their role in supporting their patients through the removal. This put them in the position of having to compromise their own relationship of care with the mother and baby. The delay in acting on the orders created uncertainty for the hospital staff, whānau and their supports and created a window in which tensions built considerably and then played out when the first attempt to remove the baby was made.

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Social workers must have a good basic understanding of, and access to accurate advice around, the statutory powers and functions of Oranga Tamariki in relation to the serving of custody orders. Where te tamaiti is being removed from a setting such as a hospital, and if assistance from Police has been sought, it is also critical that all parties have clarity about who has authority to make which decisions. However, in this instance, inconsistent advice around options for the serving of the custody order created additional delay and confusion. Additionally, at times Oranga Tamariki deferred to other professionals in relation to decisions around the execution of the order despite this being a decision that rests with Oranga Tamariki.

Confusion was also created by *[a representative for the mother]* s 9(2)(a) advising she had been granted a mechanism to prevent the removal of the baby despite this mechanism not being available in the Family Court. The media presence at the hospital was in contravention of hospital policy and led to a decision by the hospital to go into lock down. This exacerbated tensions between the whānau and Oranga Tamariki.

The removal of a baby from parental care can be a complex, heightened and fast-changing situation. Social workers need to be able to access operational support from operational managers in these circumstances. They also need to be able to confidently exercise their own professional judgement, taking into account Oranga Tamariki values, in order to be responsive to events as they occur. In this instance, more direct support and leadership for staff was needed to manage the complex situation. While *[Oranga Tamariki employees]* s 9(2)(a) remained calm, in trying to maintain a focus on what were considered to be the needs of the baby, the needs of others were lost sight of. Consequently, some key Oranga Tamariki values, including aroha and respect for the mana of others, were not brought to life.

The combined adverse impact of these events on the mother, father and whānau was significant. s 9(2)(a)

The hospital was also adversely impacted by these events, including needing to move other mothers and their babies to another ward.

Mechanisms to ensure the appropriate exercise of Oranga Tamariki duties and powers were in place but did not operate effectively.

The legislative and organisational framework in which social workers operate is intended to help ensure the appropriate use of statutory powers and duties through the promotion of collaborative and consultative decision making. Given the complexity of statutory care and protection decision-making, and the impact of these decisions on tamariki, parents, whānau, hapū and iwi, it is critical that this framework acts as a robust check on the assessment and planning of Oranga Tamariki social workers.

Professional supervision promotes professional competence, accountable and safe practice, continuing professional development, critical reflection, and practitioner wellbeing.

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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.

Social workers are also required to consult with an independent Care and Protection Resource Panel (CPRP) as soon as possible after having commenced an investigation.

While a CPRP meeting and a high number of supervision sessions and case consults occurred at key points during assessment and planning, the concerns around the case work set out in this review were not identified through those sessions and there is little evidence of critical engagement with a number of aspects of the work in this case, including the nature of the assessments, decision-making and engagement with the whānau.

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Recommendations

Based on these findings, it is recommended that:

Restorative responses

- We acknowledge the serious adverse impact of these events on the parents and whānau and consider actions that contribute to the restoration of the mana of, and relationships with, the parents, their whānau and those supporting them, the prospective caregivers and the NGO and agency partners involved in these events. Support from tangata whenua (Ngāti Kahungunu) should be sought in relation to the best process for undertaking these actions.

Site-based responses

- We take steps to ensure that the mechanisms designed to promote safe statutory practice and to ensure a culture of accountability, reflection, challenge and transparency are operating as intended within the site involved with this whānau, including:
  - Supervision
  - Child and Family Consults
  - Legal consultation
  - Independent Care and Protection Resource Panels.

System-wide responses

- We strengthen the oversight of decisions to apply for a s78 custody order on a without notice basis
- We tighten processes relating to parents who are within the scope of s18A and s18B of the subsequent children provisions to ensure that the legislation is being applied correctly
- We provide additional professional development and guidance for practitioners on:
  - the appropriate treatment of historical concerns against current information
  - using safety planning and hui a whānau in the context of s 9(2)(a) [redacted] to create safety for tamariki
- We ensure the appropriate allocation of Family Group Conference Co-ordinator resources across sites

- We build a set of professional development tools that bring to life our operational policy and practice guidance in relation to whānau, hapū and iwi searching and whānau-hui and ensure the appropriate allocation of specialist whānau, hapū and iwi searching resources across sites
- We identify how best to articulate child-centred practice in the context of whānau as part of the future development of the Practice Framework
- We continue to prioritise work to ensure alignment between operational policy, guidance and outcomes measures for care permanency settings and our organisational s7AA objectives
- We work with strategic partners, the Ministry of Health, District Health Boards, key health-sector professional groups and the New Zealand Police to ensure consistent and co-ordinated practice across the country in relation to the removal of new-born babies in the hospital setting.

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OVERVIEW OF APPROACH

This section provides details of the review methodology and an overview of the key components of the foundational practice standards/requirements that create the framework for statutory social work practice within Oranga Tamariki – Ministry for Children (Oranga Tamariki).

Review purpose, scope and method

Context

In May 2019, the actions of Oranga Tamariki attracted significant scrutiny and debate in relation to the decision to apply for the custody of a new-born baby and the attempted removal of the baby from his mother's care on the basis of concerns for the baby's safety. Particular attention was paid to Oranga Tamariki staff's interaction with the parents, whānau and other professionals while at the hospital.

The whānau[1] at the centre of these events are Māori s 9(2)(a) and this triggered a wider discussion about the over-representation of Māori in the number of children already in the custody of Oranga Tamariki and the increase in the number of pēpi Māori being placed in custody between 2016 and 2018. This discussion linked these events to the history, stigma and trauma that for many Māori is related the removal of tamariki Māori from their home or whānau, hapū and iwi environments.

In response to these events, the Chief Executive of Oranga Tamariki commissioned a Practice Review from the Chief Social Worker / Deputy Chief Executive, Professional Practice, to examine the actions of Oranga Tamariki in relation to the baby, his parents and wider whānau prior to, and immediately following, the birth of the new baby. The review has been undertaken in collaboration with Ngāti Kahungunu as tangata whenua. The Terms of Reference for this review are provided in Appendix One.

Purpose and scope

A Practice Review is one of a set of quality assurance tools used by the Professional Practice Group (PPG) within Oranga Tamariki to understand the quality of practice.

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[1] The review team has chosen to refer to the wider family group as 'whānau' but note that unless otherwise specified this relates to both the baby's maternal and paternal whānau

Each review has a distinct purpose and scope, but they all feature detailed review of case file information and interviews and workshops with our practitioners and key NGO and agency partners. The views of children and whānau involved in the events under review are also always sought wherever possible.

This Practice Review had three specific objectives:

- to understand what has occurred from the perspective of the mother, father, whānau, our staff, iwi, community and other professionals involved
- to identify what can be learnt from a local and national perspective
- to promote restorative actions to address and strengthen local relationships and ways of working.

The review period covers from when Oranga Tamariki first became aware of this pregnancy in November 2018 to 9 May 2019 when the baby and mother were discharged from hospital. Prior involvement with the mother, father and whānau, and in particular the baby's sibling, was considered to the extent that it was assessed as relevant to Oranga Tamariki involvement with this baby.

The focus of review has been on:

- the engagement with the mother, father, whānau, iwi, other professionals and key stakeholders
- the quality of the assessment and planning for baby
- practices for working with tamariki and whānau Māori
- how Oranga Tamariki worked as part of a wider interagency group involved with the baby
- the manner and method of the processes undertaken.

Out of scope

As Oranga Tamariki has continued involvement in the safety and wellbeing of this baby particular care has been taken in defining the scope of this review. In particular, the following are out of scope:

- day-to-day management of the plan for the baby. This remains the responsibility of the Oranga Tamariki Services for Children and Families team in Hastings.
- matters that are subject to proceedings before the Family Court (although the process and quality of assessment and planning informing court action may be relevant to the review)
- any formal complaints processes associated with these events.

Oversight of the review

The review has been undertaken under the oversight of an independent oversight group. This reflects our commitment to working in a transparent, collaborative and accountable way.

The oversight group comprises:

- the Chief Executive of Ngāti Kahungunu
- Senior Advisor, Office of the Children's Commissioner

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- an independent person agreed with Ngāti Kahungunu, Shayne Walker. Shayne is Ngāti Kahungunu and Ngai Tāhu. He is currently based at Otago University and has a long history of social work practice and leadership.

The oversight group:

- contributes to, and oversees, the development of the methodology, analysis, findings and recommendations
- provides advice to the Oranga Tamariki review team around issues arising through the review and approaches to resolution
- provides advice to the review team on stakeholder engagement
- provides advice on the different perspectives of those involved in these events (specifically te tamaiti, te whānau, iwi, community, stakeholder and partner agencies).

Methodology

The review has been led by senior staff from the Oranga Tamariki Practice Advice and Māori Practice Advice teams (the PPG reviewers) with the oversight of the General Manager, Practice and the Chief Social Worker/Deputy Chief Executive Professional Practice.

The review process itself has been underpinned by the principles of mana tamaiti, whakapapa and whanuangatanga, as well as the Oranga Tamariki values. This meant ensuring that the mana and oranga of the review participants was upheld whilst seeking to understand the experiences of this pēpi and its whānau. A restorative approach has been taken to the extent that this was possible in order to facilitate strengthened relationships between those working with this whānau. It is hoped that the completion of the review will provide a foundation for further restoration of mana and relationships.

While the parents s 9(2)(a) have not participated in this review s 9(2)(a)

The review team acknowledge and respect the choice s 9(2)(a) not to engage directly in this review.

The review team used a combination of records from the primary Oranga Tamariki case management system (CYRAS) and case notes, direct interviews, workshops and visual recordings to build an understanding of what has occurred from the perspective of those who were involved with these events. Workshops were held with Oranga Tamariki staff, NGO partners who were working with the whānau and Police and District Health Board representatives. Some individual interviews were also held including with the lawyer for the child s 9(2)(ba)(i) . A full schedule of the workshops and interviews is provided in Appendix Two.

The review team has used this information to construct a timeline of known events during the period of the review. These events are detailed in *Understanding What Happened*.

The review team has undertaken an analysis of these events against statutory, organisational and professional obligations for Oranga Tamariki social worker. These are summarised below. This review has considered what happened against the policy and practice expectations that were applied at the time of the events, as well as having an eye to

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how these events might be considered in light of the legislative changes that were introduced from 1 July 2019. The findings from this analysis are set out in *Findings*.

Statutory, organisational and professional obligations for Oranga Tamariki social workers

Regulatory framework

The Oranga Tamariki Act 1989 is the main piece of legislation guiding the work of statutory social workers and their role in promoting the wellbeing of children, young persons, and their families, whānau, hapū, iwi and family groups.

Key principles in the legislation are[2]:

- the paramountcy of children's wellbeing and best interests
- the participation of children, family, whānau, hapū, iwi and family groups in decisions that affect them
- prompt decision-making within a timeframe appropriate to the child's age and development
- children's need for a safe, stable and loving home
- strengthening the child's family, whānau, hapū, iwi or family group to enable them to care for their children
- limiting the removal of children to circumstances where there is a serious risk of harm
- prioritising the care of children by family, whānau, hapū, iwi or family group wherever possible
- preferencing placing children with their siblings, wherever practicable
- the recognition of the impact of harm and taking steps to enable recovery
- endeavouring to obtain the support of children, family, whānau, hapū, iwi and family groups for key actions and decisions.

Statutory social work in Aotearoa New Zealand is regulated by international agreements that position the practice within a wider context of accountability.

The United Nations Convention on the Rights of the Child (UNCROC), to which New Zealand is a signatory, provides international guidance on best practice in meeting and promoting the rights of all children. The convention includes the right of the child to live with or stay in contact with their parents and whānau unless it is harmful, as well as to be protected from harm from parents or caregivers. It is also includes the right to be listened to and to have their views taken seriously.

The Universal Declaration on the Rights of Indigenous People (UNDRIP) sets out specific rights of tamariki and whānau Māori as indigenous people in Aotearoa.

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[2] See s4A, s5 and s13 Oranga Tamariki Act 1989

Additional protections are provided under the United Nations Convention on the Rights of Persons with Disabilities and, in specific circumstances relating to Oranga Tamariki secure care settings, the Convention Against Torture and Optional Protocol on Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Organisational context

The nature of the implicit and explicit powers and duties of statutory social workers, including the fact that engagement with whānau is typically non-voluntary, require strong mechanisms to ensure accountable practice that meets regulatory, professional and organisational standards. These mechanisms need to both guide and promote best practice as well as minimising the risk of harm through the inappropriate exercise of those duties and powers. This is particularly important for Oranga Tamariki as, despite being a new organisation, for many Māori statutory child protection and youth justice work carry a particular history, stigma and trauma. Mechanisms for ensuring accountable and quality practice for Māori are, therefore, particularly important.

Oranga Tamariki has a range of new and strengthened mechanisms for guiding and promoting best practice. The Oranga Tamariki values underpin the organisational culture and positive mana enhancing behaviours for practice[3]. Operational policy supports the translation of the legislation into practice. Practice guidance provides further detail on its application. The practice standards were introduced at the end of 2017. These provide a practice benchmark and clearly identify the foundational expectations for all practice throughout the organisation[4]. Significant changes to operational policy and practice guidance were introduced in the middle of 2019 (after the events that are within the scope of this review) to support the implementation of the 1 July 2019 legislative changes. The Practice Centre has been re-platformed and re-designed to support access to this content, both from within and from outside of the organisation.

Memoranda of Understanding and other formal relational agreements (national and local) set out how Oranga Tamariki works with local communities, professionals, NGOs, other agencies, Crown Entities and Iwi/Māori to ensure relevant safe and effective interventions. These also help to share some of the power of Oranga Tamariki.

Professional supervision promotes professional competence, accountable and safe practice, continuing professional development, critical reflection, and practitioner wellbeing. The Oranga Tamariki supervision policy sets out requirements in relation to the role of supervisors, frequency of supervision and recording of decisions[5]. Social workers use the Child and Family Consult mechanism to engage with their colleagues in a structured professional discussion to identify and consider indicators of danger/harm alongside

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[3] Oranga Tamariki Values https://www.orangatamariki.govt.nz/about-us/overview/

[4] Oranga Tamariki Practice Centre – Practice Standards https://practice.orangatamariki.govt.nz/practice-standards/

[5] Oranga Tamariki Practice Centre - Supervision Policy https://practice.orangatamariki.govt.nz/policy/professional-supervision/

indicators of safety and strengths that they might not necessarily have considered themselves[6].

Oranga Tamariki has built an enhanced quality assurance system and new mechanisms for gathering the voices of children and whānau to help understand areas of practice strength, areas for improvement and how practice is changing over time. This includes a range of new and strengthened self-assessment and semi-independent assessment tools and processes.

Practice with tamariki Māori

The Treaty of Waitangi underpins the bicultural relationship and obligations between the Crown and Māori as tangata whenua in Aotearoa New Zealand. 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. This includes enabling them to participate in their culture, customary practices and language, and to experience appropriate support and culturally responsive services and practice that meet their needs.

The principles in the Oranga Tamariki Act 1989 also reinforce the position of Māori as tangata whenua and working in ways that reflect Treaty-based relational practices. From July 2019 new amendments to the Act reinforce Oranga Tamariki obligations to active implementation of the Crown and Treaty of Waitangi relationship with Māori and to seek to address and reduce these inequities[7]. In particular, Oranga Tamariki must use responsive cultural practices that apply the principles of mana tamaiti, whakapapa and whanaungatanga in order to foster the resilience of tamariki and whānau Māori. The practice standard Whakamana Te Tamaiti was introduced ahead of these changes in 2017 and anticipated the s7AA(2)(b) legislative changes in relation to mana tamaiti, whakapapa and whanaungatanga.

These changes reinforced provisions that were introduced in 1989 which emphasised the requirement for services to have particular regard for the values, culture and beliefs of the Māori people and, wherever possible, that the relationship between the child and their family, whānau, hapū, iwi and family group should be maintained and strengthened[8]. The principles also emphasised that, wherever possible, a child's family, whānau, hapū, iwi and family group should participate in decisions affecting the child.

Children are central to society and highly valued within all cultures. There are many accounts inherent in tangata whenua collective histories that show how important tamariki are within Māori social structures. Traditionally the safety, protection and care of tamariki was viewed very seriously, not least because the survival of the Iwi relied on it. Whānau committed to the long-term development of tamariki to meet their full potential through cultural practices to ensure their safety and wellbeing. Unfortunately, in Aotearoa New Zealand today, due to a range of complex contributing factors, both historical and current, that impact on whānau Māori, tamariki Māori are significantly over-represented in the care

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[6] Oranga Tamariki Practice Centre - Child and Family Consult https://practice.orangatamariki.govt.nz/our-work/practice-tools/other-practice-and-assessment-tools/childyoung-person-and-family-consult/

[7] See s7AA Oranga Tamariki Act 1989

8 See s4, s5 and s13 Children, Young Persons and Their Families Act 1989

and protection and youth justice systems. Consequently, tamariki and whānau Māori now comprise the largest group of tamariki and whānau Oranga Tamariki works with.

From a Te Ao Māori worldview all tamariki are born with a range of innate factors contributing to their wellbeing. These include; whakapapa (genealogical connections to people, significant places and cultural values), mana (intrinsic value and potential both inherent and developed derived from whakapapa), a state of tapu (sacredness maintained through protective practices and restrictions) and whanaungatanga (purposeful carrying out of responsibilities and obligations to wider kinship ties). When nurtured and protected their wellbeing will flourish. If tamariki experience trauma in their journey, a violation of their personal tapu, a trampling of mana and disconnection of whakapapa may occur damaging their personal wellbeing and relationships with whānau and others.

Professional ethics, standards and codes of conduct

All Oranga Tamariki social workers work within the national professional ethics, standards and codes of conduct for social workers in Aotearoa New Zealand.

The Social Work Registration Board regulates social work in Aotearoa New Zealand through the implementation of the Social Work Registration Act, 2019. Its purpose is to protect the safety of the public by providing mechanisms to ensure that social workers are fit and competent to practice and are accountable for their practice.

Outside of the registration system the responsibility for detecting and addressing harmful practice or misconduct falls to the social worker's employer. As a result, all Oranga Tamariki social work practitioners must be either registered or on a pathway to registration.

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UNDERSTANDING WHAT HAPPENED

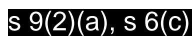
This section provides a brief summary of Oranga Tamariki prior involvement with the mother, father and older sibling of the new baby. This information is provided as it is relevant to understanding aspects of the interaction between Oranga Tamariki and the whānau in relation to the new baby.

It also provides details of the events leading up to the birth of the new baby after Oranga Tamariki became aware that the mother was pregnant with her and the father's second child.

The section finishes with details of events after the baby was born leading up to the discharge of the mother and baby from hospital.

Prior involvement with the mother, father and older sibling

s 9(2)(a), s 6(c)



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s 9(2)(a), s 6(c)

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Involvement from when Oranga Tamariki first knew of the second pregnancy to the baby's birth

s 9(2)(a), s 6(c)

s 6(c)

On 7 February 2019 a Report of Concern was entered by Oranga Tamariki after tests had confirmed the mother's pregnancy. This was allocated to *[Oranga Tamariki employee]* s 9(2)(a) The concerns identified in the report were about s 9(2)(a), s 6(c) It was also noted that the mother was engaged s 9(2)(a)

The whānau were unaware that a Report of Concern had been made and no specific contact was made with the mother about her plans for the new baby. s 9(2)(a)

s 9(2)(a)

On 13 March 2019, *[an agency]* s 9(2)(a) contacted Oranga Tamariki to confirm their involvement with the mother, stating they would be able to continue involvement if the mother kept her baby. The case notes record that *[Oranga Tamariki employee]* s 9(2)(a) set out the context for the removal of the first child as the basis for the concerns regarding this child and said the plan was to have a hui a whānau and Family Group Conference (FGC) in relation to the unborn child.

A Tuituia assessment report was completed on 14 March. This supported the referral for a Family Group Conference. The referral was made on 15 March 2019. Whānau were not aware, however, of the intention to refer for an FGC, or that the referral had been made

s 9(2)(a)

s 9(2)(a)

The mother entered s 9(2)(a).

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s 9(2)(a)

Between 3 and 11 April a number of consultations and supervision sessions took place on site. The initial plan, s 9(2)(a)

At some point over these eight days, the approach changed to an agreement that a without notice order for custody and declaration be sought to facilitate the baby's placement with s 9(2)(a) A Child and Family consult held on 9 April 2019 identifies a number of strengths, including the mother's engagement with supporting agencies s 9(2)(a)

A case note on 11 April 2019 documents that a case consult was held and a decision was made to apply for a section 78 custody order. Apart from the *[Oranga Tamariki employee's]* s 9(2)(a) repeated worries about baby's safety s 9(2)(a) it is not clear what evidence supported this change, as no updated police checks nor reassessment were completed.

During the week of 15 April 2019 another meeting, s 9(2)(a)

s 6(c)

s 9(2)(a)

s 9(2)(a), s 6(c)

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Involvement from when the baby was born to discharge from hospital

On 1 May 2019 the mother gave birth to a healthy baby boy, s 9(2)(a)

2 May

Ex parte applications for Declaration and Interim Custody of the baby were filed in the Hastings Family Court signed by *[an Oranga Tamariki employee]* s 9(2)(a) after consultation with Oranga Tamariki legal advisors. The s78 custody order was granted late that afternoon. s 6(c)

The covering social workers visited the mother and baby at the request of hospital staff.

Because an extended stay in hospital had been agreed to for mother and baby s 6(c) Oranga Tamariki instructed the hospital to alert police and Oranga Tamariki if the parents tried to leave the hospital with the baby. s 9(2)(a) asked what the plan for the mother and baby following the baby's birth. A usual plan would include how to maintain breast-feeding, who can have contact with the baby, were there any safety issues they needed to be aware of, what would happen following the birth. s 6(c)

s 9(2)(a)

3 May

A copy of the custody order was left with hospital staff in the event that it was required to be served over the weekend should there have been a change in circumstances.

5 May

The *[health practitioner]* s 9(2)(a) Manager was called to the ward to meet with the whānau who were upset after learning about the custody order for the baby through the *[health practitioner]* s 9(2)(a) who had been informed about the order by a member of the hospital staff. s 9(2)(a)

6 May

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Unexpected events meant [Oranga Tamariki employee] s 9(2)(a) was not able to return from leave and a decision was made by Oranga Tamariki to execute the order.

When [Oranga Tamariki employees] s 9(2)(a) entered the mother's hospital room to remove the baby from his mother, midwives and whānau began filming them on their mobile phones. s 9(2)(a) that an injunction had been granted preventing the execution of the orders. The [Oranga Tamariki employees] s 9(2)(a) queried this s 9(2)(a), s 9(2)(h) Whānau and s 9(2)(a) repeatedly referred to the plan that they believed had been agreed to at the meeting with s 9(2)(a) the week of 15 April 2019 for the mother and baby to return to s 9(2)(a) . s 9(2)(a)

Hospital staff described the scene at the hospital, which started with [a health practitionerl] s 9(2)(a) walking through the ward declaring "not one more Māori baby taken", as "chaos". A room was allocated to the social workers to make phone calls to legal services and managers to consult about how they could resolve the impasse.

Calls were made between staff at the hospital, site leadership, and the local legal team. s 9(2)(h) Concerns then emerged about whether there was sufficient supervision at [support agency] s 9(2)(a) overnight because it was understood that staff were generally not on site overnight.

After multiple phone calls to solicitors and [Oranga Tamariki employee] s 9(2)(a), [Oranga Tamariki employee] s 9(2)(a) agreed to withdraw until a hui a whānau could be held the following day when [Oranga Tamariki employee] s 9(2)(a) was back at work. There was an agreement for the baby and mother to be discharged to [support agency] s 9(2)(a) with additional staff and family support until the hui could be held. The mother ultimately stayed the night at the hospital, however, following consultation with [health practitioners] s 9(2)(a).

[Oranga Tamariki employees] s 9(2)(a) were advised that whānau had blocked hospital exits to ensure the baby could not be removed and that a reporter was at the Hospital. This resulted in the matter being escalated to the Police, though it is not clear who made the decision to call the Police.

7 May

The [Oranga Tamariki employee] s 9(2)(a) returned from leave.

A dispute occurred over where the hui should be held. After the media arrived at the hospital, Oranga Tamariki made the decision to hold the hui [away from the hospital] s 9(2)(a) to avoid media intrusion instead of the hospital whare which was the venue preferred by the whānau. This meant that the parents could only participate by phone. However, in the heated discussion at the hui, nobody present at the hui remembered to link the parents in by phone. A large number of whānau members were present at the hui.

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A strengthened plan, which addressed concerns held previously *[by Oranga Tamariki employee]* s 9(2)(a) about overnight supervision at *[the support agency]* s 9(2)(a) *[Oranga Tamariki employees]* s 9(2)(a) advised the whānau that they would consult with management to seek approval for the plan and report back to them on the outcome later in the day. The whānau did not, however, receive any information on the outcome of these consultations on site.

The consultation took place that afternoon s 9(2)(a)

s 9(2)(a) However, when *[Oranga Tamariki employees]* s 9(2)(a) and police attempted to remove the baby from his mother, she would not let him go. By 9.30 pm hospital security had locked down access to the hospital because the media had breached agreed protocol, and *[health practitioners]* s 9(2)(a) and whānau were grouped outside the hospital entrance. Nine Police Officers were in attendance at the hospital.

The *[health practitioners]* s 9(2)(a) whose access to the building had been blocked by the DHB tried to enter through the Emergency Department with whānau. Media representatives stationed outside the DHB grounds were warned by police that they would be trespassed if they set foot on DHB premises. Other mothers had been moved to another ward and a number of key DHB managers and advisors had been alerted and were present on site.

An impasse ensued with the mother in her room holding her baby for over five and a half hours, while her whānau and *[health practitioners]* s 9(2)(a) were outside the building, s 9(2)(a)

The *[Oranga Tamariki employee]* s 9(2)(a) contacted National Contact Centre for advice. The Contact Centre staff were told that a decision had been made that the baby needed to be removed, that there were no other options and that she was unable to get in contact with her management. The *[Oranga Tamariki employee]* s 9(2)(a) was advised there was no point involving the *[Oranga Tamariki employees]* After Hours s 9(2)(a) as they would not be able to get into the hospital. However, *[Oranga Tamariki employees]* After Hours s 9(2)(a) from Napier and Hastings site were contacted and arrived later that night. They were let in by the Police.

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8 May

By 1.40 am on 8 May after the matter had been escalated to the Oranga Tamariki Site Manager it was agreed that Police and Oranga Tamariki would withdraw and a further hui would be held later that day. The *[Oranga Tamariki employees]* two after hours s 9(2)(a) and two police remained outside the mother's hospital room until the hui a whānau was held. Whānau members were not permitted to enter the room to see the mother and baby until the following morning.

At 10 am key Oranga Tamariki representatives met with DHB and *[support agency]* s 9(2)(a) representatives. The Oranga Tamariki Site Manager apologised to *[support agency]* s 9(2)(a) staff who felt their professional judgement had been disrespected and their mana trampled on.

At 1pm the hui a whānau, facilitated by the DHB *[employee]* s 9(2)(a), was held at the DHB whare. The mother did not attend as Oranga Tamariki told the mother that she could not take her baby to the hui because of concern that the baby would be exposed to conflict and hostility between whānau and Oranga Tamariki.

The hui enabled whānau to air their grievances about the way they had been treated and the Site Manager apologised to the whānau. Agreement was reached on the plan for the mother and baby to go to *[a support service]* s 9(2)(a) and this occurred the following day.

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FINDINGS

This section analyses the summary of the events set out under *Understanding What Happened* against statutory, organisational and professional obligations for Oranga Tamariki social workers. This analysis is grouped around eight key findings.

For each of these findings we summarise what we would have expected to see based on our foundational practice obligations. We then provide an analysis of Oranga Tamariki practice as it occurred.

Legitimate safety concerns existed which warranted Oranga Tamariki involvement with this whānau.

What should have happened?

Pregnancy is a period during which there is a known increased risk of escalation of family harm. This makes infants uniquely vulnerable prior to and following birth. Babies are also more susceptible to, and unable to protect themselves from, harm. The risk of serious injury (including death) is therefore immediately higher for them than older tamariki. Harmful events early in life can have a long-term developmental impact and effect wellbeing across a range of domains in the life of a child and into adulthood[1].

Historical concerns are significant sources of information, which must be well understood and social workers must take particular care not to discount them while also actively looking for evidence of sustained change over time.

Because of these complexities, risk assessment and decision making about unborn babies, particularly to new parents can be very finely balanced decisions for social workers to make. Early, robust and inclusive engagement, assessment and planning with parents, whānau and those working with them is critical as is regular consultation and effective supervision.

First-time parents will need to be able to learn new skills to enable them to parent safely. In these cases parenting capacity is untested and therefore there are limited opportunities to balance the risk arising from the parents' own history and background alongside demonstrable evidence of the safety of pēpi into the future. Social workers should actively seek out, refer to and work collaboratively with NGO and agency partners and providers whose primary focus is building the capability of parents, particularly very young parents.

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[1] Oranga Tamariki Practice Centre – Vulnerable Infants - https://practice.orangatamariki.govt.nz/previous-practice-centre/knowledge-base-practice-frameworks/vulnerable-infants/

What did we find?

There was a strong motivation to protect this pēpi from harm on the basis of s 9(2)(a) ***within the whānau and between the parents.***

A strongly held concern about the safety of this pēpi heavily influenced the assessment and decision making for pēpi. It was appropriate and necessary to consider that there were factors that could impact the safety of this baby and to respond to them in a comprehensive manner.

s 9(2)(a), s 6(c)

s 9(2)(a), s 6(c)

Based on these concerns it is reasonable to conclude that Oranga Tamariki needed to be involved in working with this whānau around baby's safety and wellbeing.

Assessing the capacity of these parents who had never previously cared for a child in the context of historical safety concerns presents a unique set of assessment challenges.

These parents had not had the opportunity to develop or demonstrate safe parenting in respect of the older child and s 9(2)(a)

There was a need to form a current view of this baby's safety by understanding historical safety concerns within the context in which they occurred (including within the parents' own context of trauma), the level of insight the parents had about the safety worries and what they might need to change in order to parent this child safely, and what others had noticed about the changing circumstances of the parents and their skills, strengths and knowledge.

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There was an over-reliance on historical information and limited work to understand the current situation for the whānau.

What should have happened?

The process of assessment begins when Oranga Tamariki has received a Report of Concern about a child. Assessment is a core social work process whereby social workers gather information from a wide range of sources in order to assess the safety of tamariki, identify the strengths of their parents and whānau, assess unmet needs and identify services that could respond to those needs.

Te Toka Tūmoana[9] and the Oranga Tamariki Māori cultural framework[10] guide quality assessment when working effectively with Māori. Va'aifetu[11] is the framework that contributes to the development of quality assessments for Pacific children. The engagement principles that underpin these tools are critical in the relationship between the child, family and practitioner as the assessment process is undertaken.

During assessment, social workers gather information from the child themselves (wherever possible), their parents, whānau and those working with them and any information available in their agency's own records and requested from others (such as understanding historical family violence concerns). It is important that wherever possible information is sought and discussed widely with whānau and with others working with the whānau. This helps the social worker to understand information in context and to appropriately balance factors which might evidence safety concerns alongside those that demonstrate strengths which can be built upon in their work with whānau.

Social workers assess this information through a framework, known as Tuituia[12] which helps the social worker to develop a balanced assessment of the strengths, risks and needs for tamariki in the context of their whānau. Risks are considerations that can, if unaddressed, directly compromise the safety of tamariki, and must be mitigated. Strengths are the existing resources, potential and opportunities within the whānau that can be used to create safety. Needs are areas which require support from others, and which when left unattended can increase risk for tamariki but when properly addressed directly contribute to their immediate and long term wellbeing.[13] These are dynamic and change over time, therefore social workers must regularly review, re-assess and plan, particularly when new information becomes apparent.

A Tuituia report is the written record of an assessment generated at a point in time which enables the social worker to compare what is happening with te tamaiti now and in the past and can support different points of decision making from assessment to care. There are a

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[9] Oranga Tamariki Practice Centre -Te Toka Tūmoana https://practice.orangatamariki.govt.nz/practice-standards/working-with-maori-te-toka-tumoana/

[10] Oranga Tamariki Website – Māori Cultural Framework https://orangatamariki.govt.nz/news/our-maori-cultural-framework/

[11] Oranga Tamariki Practice Centre - Va'aifetu https://practice.orangatamariki.govt.nz/practice-standards/working-with-pacific-peoples-vaaifetu/

[12] Oranga Tamariki Practice Centre - Tuituia Assessment Framework https://practice.orangatamariki.govt.nz/our-work/practice-tools/the-tuituia-framework-and-tools/the-tuituia-framework-and-domains/

[13] Oranga Tamariki Practice Centre – Written Assessment and Plan Practice Standard https://practice.orangatamariki.govt.nz/practice-standards/create-implement-and-review-a-written-assessment-and-plan/

number of requirements around the assessment process in relation to the manner and nature of engagement with the whānau[14].

There are additional considerations when the assessment involves an unborn or child[15]. 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.

Capturing the voice of tamariki is an intrinsic aspect of an assessment[16]. When assessing the needs of the unborn child this 'voice' has to take account of what is known about their needs. Known needs for infants include the need for good pre- and post-natal health care, safe, loving and nurturing parenting, the right to be cared for in the context of their family group, and, for tamariki Māori, the need to take account of mana tamaiti. The physical connection between a baby and their mother, father and whānau at birth should only be terminated in the most extreme circumstances.

When an assessment occurs in the context of prior knowledge about a whānau, particular care must be taken in the assessment process. If a social worker assumes the meaning of new information based on prior knowledge, there is a risk that they may wrongly interpret that information as indicating that either the child is safe when they are not (and therefore increase the likelihood of serious harm) or assume that the child is at greater risk than they are (and therefore inadvertently cause harm through over intervening).

s 9(2)(a), it is important to recognise the potential impact upon the emotional, psychological and physical wellbeing of tamariki and that this impact is generally more acute and enduring for younger children, particularly infants. Understanding that s 9(2)(a) can occur across a family system, not just within the primary parenting relationship is also important. Undertaking a thorough assessment means understanding the nature, frequency and history of s 9(2)(a) what services may have been provided in the past to s 9(2)(a) Being aware of periods of increased stress, concurrent risk factors including s 9(2)(a) is also important[17].

What did we find?

[14] Oranga Tamariki Practice Centre - Assessment Policy https://practice.orangatamariki.govt.nz/policy/assessment/

[15] Oranga Tamariki Practice Centre – Unborn Babies https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/strengthening-our-response-to-unborn-babies/

[16] Oranga Tamariki Practice Centre – See and Engage Tamariki Guidance https://practice.orangatamariki.govt.nz/practice-standards/see-and-engage-tamariki/see-and-engage-tamariki-guidance/

[17] Oranga Tamariki Practice Centre – s 9(2)(a)

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There were significant gaps in work to understand the current situation for the mother, father and wider whānau.

Site practice meant that where a report of concern was received for a family where there was already involvement by a social worker from the intervention team with another sibling the case would be allocated to that social worker. This approach is likely to have meant that there was less focus on assessment prior to a decision being reached that intervention would be required. Such an approach undermines one of the critical components of assessment: the act of weighting historical concerns against any change over time and taking into account the current context. It also indicates that a pre-determined view may have already been taking shape in the early stages of the pregnancy.

On 7 March a plan was entered into CYRAS called an assessment plan[18]. This outlined a set of risk statements based on the concerns held for the older child and indicated the plan to hold a hui a whānau and /or a Family Group Conference. This same day the matter was referred to the independent Care and Protection Resource Panel[19]. While this is called an assessment plan, it does not detail the planned set of activities to be undertaken by the social worker in order to understand the current needs, strengths and risks. Instead it described the historical concerns which had been relied upon to form the basis of decisions for the older child as justification for a set pathway for this child.

Oranga Tamariki needed to take the concerns expressed in the Report of Concern and utilise the assessment framework to come to a point in time view of this child's potential safety based on the information gathered along the way. This meant building a thorough understanding of the environment of care that the parents could provide. Importantly, this should have included the physical environment but there is no evidence in the case records of attempted home visits.

The Tuituia report dated 14 March was developed only one month after the Report of Concern and there was no evidence of engagement with relevant parties such as whānau and other professionals in that month. Therefore, the assessment report was based only on the views held by *[an Oranga Tamariki employee]* s 9(2)(a), as was the FGC referral made on 15 March which was approved by *[an Oranga Tamariki employee]* s 9(2)(a).

Oranga Tamariki policy requires that the Tuituia assessment is updated when a decision is made to seek a custody order and that the report of this assessment must be approved by a supervisor[20]. Notes recorded by *[an Oranga Tamariki employee]* s 9(2)(a) dated 11 April stated that a consult had occurred and a decision had been made to apply for a s78 custody order. No clear rationale for this decision was included in these notes. There was no updated assessment after the 14 March Tuituia report and before an application was made to the Family Court for custody in May.

More analysis of the needs, strengths and risks for this unborn baby in their own right was needed.

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[18] Oranga Tamariki Practice Centre – Conducting an Assessment https://practice.orangatamariki.govt.nz/our-work/assessment-and-planning/assessments/conducting-an-assessment/

[19] Oranga Tamariki Practice Centre – CPRP https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/working-with-the-care-and-protection-resource-panel/

[20] Oranga Tamariki Practice Centre - Assessment Policy https://practice.orangatamariki.govt.nz/policy/assessment/

Some parental and whānau strengths were identified both at the time of the Report of Concern, in the Tuituia report and in a Child and Family Consult on 9 April. These related to the mother's engagement s 9(2)(a) were willing to have the mother and baby in their programme. It was important to understand the parents' views and wishes relating to the unborn baby s 9(2)(a) Asking the baby's parents, whānau and the professionals working with them what they thought this pēpi needed now and in the future could have helped give a voice to the pēpi within the context of this assessment.

Identified strengths were not, however, seen as building blocks upon which [Oranga Tamariki employee] s 9(2)(a) could develop further engagement and understanding with the mother and with those agencies. A different approach, based on acknowledging and building upon the views of extended whānau and other professionals, as well as the positive steps the mother was taking, could have changed the approach taken with this baby and whānau.

The needs of the parents and the wider family and whānau were also not fully explored or well understood, nor the extent to which addressing these unmet needs could impact upon the identified areas of risk for baby. s 9(2)(a) and there may have been missed opportunities to respond to these needs in a manner that could promote the wellbeing of tamariki within the whānau context. s 9(2)(a) examples of areas of need known to Oranga Tamariki and which could have been responded to more proactively.

The dynamics of the relationship built with the parents after the removal of the first child were not considered through the assessment of the next unborn child's needs. New information about the mother and whānau that was shared with Oranga Tamariki but which was not consistent with the historical information appears to have been discounted, over-looked or not pursued. Unsubstantiated information that should have been more thoroughly considered was instead treated as confirmation of historical concerns.

The presence and risk of s 9(2)(a) was not fully explored despite being heavily relied upon as the basis of the conclusion that the parents could not adequately care for, or protect, this child

s 9(2)(a), s 6(c)

s 9(2)(a) It also does not allow for the

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possibility that, with education and challenge, s 9(2)(a) .

s 9(2)(a), s 6(c)

s 9(2)(a) Statutory care and protection practice requires continued assessment and re-assessment of care and protection concerns in order to develop a balanced and current picture when making critical decisions about future care of tamariki.

s 9(2)(a), s 6(c)

s 9(2)(a) Statutory social workers have to be able to consider historical factors in a current setting. They must be able to reflect on positive steps taken to make changes in the lives of parents with previous parenting issues for future tamariki in their whānau. This is particularly important as incremental change can enable parents to safely care for tamariki despite their own trauma histories.

New information was not appropriately weighted against historical information

The professionals and NGO's working directly with this whānau had more direct and recent knowledge of the parents than Oranga Tamariki and could have provided a critical source of information. s 9(2)(a) The practitioners provided a unique insight into this mother's strong desire to make changes in order to maximise her chances to parent this second child. *[Support agency]* s 9(2)(a) was also engaged with the father and he too expressed a wish to be actively involved in parenting.

[This agency] s 9(2)(a) assessed that both parents were keen and willing to engage in a plan to keep the pēpi in their care and this assessment was expressed to the social worker. The mother *[was working with support agency]* s 9(2)(a) All of these community programmes offered an opportunity to contribute to the social work assessment.

[21] Oranga Tamariki Practice Centre – s 9(2)(a)

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Despite this information being known, there is little evidence that it was adequately considered in determining whether this baby would be at imminent risk s 9(2)(a)

The options of parental or whānau (and hapū and iwi) care of the new baby should have been more fully explored.

What should have happened?

When social workers identify issues that could impact on the safe care of tamariki, their first priority is to determine how te tamaiti can be kept safe within the care of their parents and within the wider network of protection provided by extended family or whānau, hapū and iwi networks.

'Safety planning' is used by social workers to create a network of protection around the child and their whānau[22]. Effective safety planning can prevent the need for tamariki to come into care, even when it is recognised that safety concerns exist, because it provides a means to build a safe environment for te tamaiti within their own home rather than removing te tamaiti to another home. Safety planning can be particularly effective when working with chronic concerns, such as s 9(2)(a).

Social workers need to ensure they have a sound understanding of when the subsequent parent / children provisions of Oranga Tamariki 1989 Act apply[23]. Under very specific conditions, including the requirement that a Family Court has made a determination, a parent will be deemed a 'subsequent parent'. In such cases, Oranga Tamariki are required to undertake an assessment of risk to future children in that parents' care, oriented to preventing further harm such as had occurred historically. Social workers need to work with parents to explore evidence of strength and change over time that will support safe parenting. It is critical that social workers do not misapply the subsequent children provisions, in particular being clear that simply having a child previously placed in Oranga Tamariki custody does not meet the legislative test.

There are occasions where, on the basis of a comprehensive assessment, the safety of te tamaiti can only be maintained by removing them to a safer care environment. This decision must be carefully made and requires social workers to balance the dimensions of physical, cultural and psychological safety and wellbeing. Where it is determined that custody orders are required, social workers must ensure that they are taking every opportunity to enable te tamaiti to be cared for within their family or whānau, hapū or iwi. They must also have regard to the principles within the Oranga Tamariki Act 1989 which emphasise stability and sibling relationships.

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[22] Oranga Tamariki Practice Centre - Safety planning https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/building-safety-around-children-and-young-people/

[23] Oranga Tamariki Practice Centre - Subsequent children https://practice.orangatamariki.govt.nz/our-work/assessment-and-planning/assessments/child-and-family-assessment-or-investigation/subsequent-children/

In practice social workers achieve this by undertaking whānau searching[24], working with specialists such as kairaranga-a-whānau[25] to complete whakapapa searching[26] and to make substantial use of whānau hui as a mechanism for sharing concerns and developing plans which keep tamariki safe. It also means using the FGC at the earliest opportunity to facilitate plans to support whānau to care for tamariki and meet their needs[27].

Caregiving families who make their homes available to tamariki in need of safe care play an important part in the wider network of protection around tamariki. The current care system enables potential caregivers to identify their preference to provide transitional care (care that is time limited) or permanent care.[28] s 9(2)(a)

All prospective caregivers, whether whānau or non whānau, undergo a specific assessment to ensure they are able to provide safe care for any tamariki in the custody of the Chief Executive. The assessment process should be collaborative and is designed to explore the potential caregiver's motivation, approach to caring for tamariki and any support needs which they may have. Undertaking the assessment provides a fair and transparent process for decision making as to whether or not individuals are able to assume the caregiving role.

What did we find?

An opportunity to work with the parents and their whānau to build safety was missed because the nature of the s 9(2)(a) ***within the whānau system had not been well understood or explored***

A commitment to the physical safety of pēpi and a desire to ensure that the baby would receive safe and stable care were strong motivators throughout Oranga Tamariki involvement with this baby. s 9(2)(a)

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[24] Oranga Tamariki Practice Centre - whānau searching https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/whanau-searching/ NB this guidance was updated 1 July 2019

[25] Oranga Tamariki Practice Centre - kairaranga-a-whānau https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairaranga-a-whanau/ NB this guidance was updated 1 July 2019

[26] Oranga Tamariki Practice Centre - Whakapapa research https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/whakapapa-research/ NB this guidance was updated 1 July 2019

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

[28] Oranga Tamariki Practice Centre - Types of care https://practice.orangatamariki.govt.nz/our-work/care/caregivers/assessing-and-approving-caregivers-and-adoptive-parents/types-of-care/

s 9(2)(a) As a result, little consideration was given to how safety planning could be used with these parents and their whānau. This is demonstrated by the absence of home visits to either the maternal or paternal home and the apparent complete lack of engagement with the father of the child and his whānau.

s 9(2)(a), s 6(c)

s 9(2)(a) and the professionals working with the parents provide a strong indication of how safety planning could have been used with these parents. s 9(2)(a) The whānau intention and desire to work closely with Oranga Tamariki to address safety concerns is also noted.

The onus was effectively placed on the parents to prove they were safe to care for the baby

On at least three occasions, the mother and those working with her sought Oranga Tamariki support for the plan for the mother to enter s 9(2)(a) and on each occasion Oranga Tamariki neither endorsed nor rejected the plan. s 9(2)(a) no clear indication was given to the whānau about what would be required to demonstrate sufficient safety in the face of the historical concerns and perceived risks.

Although two informal hui were held at the instigation of NGO partners between Oranga Tamariki, the mother and various members of her whānau and network of support, hui a whānau and an FGC did not occur prior to baby's birth. These would have provided an opportunity to transparently and intentionally build a shared understanding of the care and protection concerns and support needed for these young parents in their parenting role and to develop a plan of support together with the whānau and other professionals.

The capacity of the grandparents, other whānau, hapū and iwi to care for the baby was not fully explored. s 9(2)(a)

The site valued decisive and timely decision making to facilitate stable and permanent care as early as possible for young children, particularly infants. This is consistent with an

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organisational view that it is in the best interests of tamariki for decisions about their care to be made in a child-oriented timeframe[29]. The recognition of the importance of sibling relationships is also evident in the thinking about who should care for this baby[30]. s 9(2)(a)

[A wider whānau member] s 9(2)(a) recalls some interactions in respect of the older child in regards to the application process to be a caregiver, there was no evidence of renewed efforts to search for or assess whānau, hapū or iwi members who could care for this baby. Without undertaking a formal caregiver assessment *[of the wider whānau]* s 9(2)(a) it is difficult to understand how Oranga Tamariki was able to conclude that there were no safe whānau to care for baby at birth. There appears to have been a belief that those options had been explored and exhausted in relation to the older child. This is discussed further in the following section in relation to whakapapa searching.

Oranga Tamariki also (incorrectly) identified *[wider whānau members]* s 9(2)(a) as 'subsequent parents' and this was explicitly referred to in case notes. It is not clear, however, if and how this affected the assessment of the *[wider whānau members]* s 9(2)(a) to care for this pēpi.

s 9(2)(a) Given that, at this point, the whānau were not aware that Oranga Tamariki had obtained custody from the Family Court, it is clear that this decision had been reached without consultation with the whānau about who the baby should be cared for if removal from mother's care was deemed necessary. s 6(c) s 9(2)(a)

Engagement with this whānau should have built from a recognition of the values of significance to whānau Māori and the strength inherent in their culture

What should have happened?

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[29] Oranga Tamariki Practice Centre - Noho Ake Oranga Permanency Policy https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/noho-ake-oranga/

[30] Oranga Tamariki Practice Centre – siblings https://practice.orangatamariki.govt.nz/our-work/practice-tools/the-tuituia-framework-and-tools/the-tuituia-framework-and-domains/attachments-tuituia-domain/

The practice standard 'whakamana te tamaiti'[31] (empowering the Māori child) requires social workers to work inclusively with tamariki Māori and their whānau, hapū, iwi and family grouping in a manner that strengthens their sense of cultural identity and connectedness.

Social workers must recognise the significance of strengthening tamariki links to their Māori cultural values and beliefs (mana tamaiti), comprehensively identifying genealogical ties to people, place, whānau, hapū and iwi history (whakapapa) and valuing their right of engagement with whānau, hapū and iwi and wider family networks (whanaungatanga).

Whakapapa researching or exploring genealogical bloodlines is often used to establish identity, strengthen interconnectedness and understand belonging in human relational patterns of tamariki Māori (to their whānau, hapū and Iwi) and s 9(2)(a) children to their families and s 9(2)(a)

These concepts should inform each aspect of a social worker's involvement with whānau Māori, from engagement, through to assessing needs and risks and the development of plans with them. Tikanga practices need to be implemented on a kanohi te kanohi basis (face to face). These practices are especially important at critical times of engagement with whānau Māori.

For tamariki Māori wellbeing (oranga), safety and protection (mana and tapu) are multi-dimensional and interdependent – physical safety and protection is critical but so too is the protection afforded by one's whakapapa. Balancing these dimensions is complex and can introduce a risk where individual elements may be over- or under- emphasised in the course of assessment. It is important that social workers apply tools that support their understanding of these more intrinsic elements of safety. Oranga Tamariki practitioners should be guided by an understanding of Māori principles of wellbeing as described in the organisation's cultural competency framework and practice tools such as Te Toka Tūmoana.

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 open help inform consideration of if and how the safe care of tamariki can be realised.

What we found

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[31] Oranga Tamariki Practice Centre - Whakamana te Tamaiti practice standard https://practice.orangatamariki.govt.nz/practice-standards/whakamana-te-tamaiti-practice-empowering-tamariki-maori/ . The practice standard was introduced in 2017 and anticipated the s7AA(2)(b) legislative changes introduced on 1 July 2019 in relation to mana tamaiti, whakapapa and whanaungatanga. Since the introduction of these legislative changes, additional guidance has been introduced to guide practitioners in their whakamana te tamaiti practice.

Skilled whakapapa searching and the use of tikanga Māori would have supported better engagement with, and understanding of, the whānau and whakapapa links

The practice of identifying whakapapa connections (both maternal and paternal) was limited and seems to have been constrained by a number of factors in this instance[32]. The s 9(2)(a) with and, as they had been assessed as not able to provide care for the older sibling, there does not seem to have been foundational work to re-consider that assessment in relation to this baby.

s 9(2)(a) This is not unusual in whānau where there has been inter-generational trauma and it requires sensitive, highly-skilled and on-going enquiry by practitioners with strong cultural and whakapapa knowledge to determine if networks of safety within the whānau can be found. However, the allocated Kairaranga role at site dedicated to identifying whakapapa was stretched because of staff absences at the site.

The lack of active planning for a whānau hui or FGC meant that the work to identify significant whānau, hapū, iwi and family groups for both the Māori s 9(2)(a) whānau who could participate in decision making was not made a priority in the case work. It is also likely that the weight given by the site to the placement of this pēpi with his sibling negated the perceived need for seeking whānau, hapū, iwi or family group caregivers.

Understanding the dynamics of whānau norms and how these are manifested need to be the starting point for identifying whānau strengths and safety planning. Decision making and recording by Oranga Tamariki provides little evidence of the recognition of Māori values and beliefs in the work with this whānau. By contrast, NGOs working with the whānau had discovered a greater range of strengths to build from by using a holistic view of whānau wellbeing.

Whānau-hui or family meetings are important for all whānau Oranga Tamariki works with. They are particularly significant when working with whānau Māori as they are an important mechanism for recognising the importance of whakapapa and for enabling whānau to exercise their whanaungatanga responsibilities. The reason for not having whānau hui or family meeting with the whānau was based on a view that this whānau did not want to engage with Oranga Tamariki and did not want to involve their extended whānau, hapū, iwi or family group.

Practitioners from Māori NGOs had built relationships of trust with this whānau. The value of their knowledge, expertise and relationships does not appear to have been recognised and built upon.

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[32] s 9(2)(a)

[33] s 9(2)(a)

Prioritising a perceived risk of potential physical harm at the exclusion of a broader view of tamariki and whānau wellbeing had the effect of marginalising the voices of parents and whānau, and may also the have also limited consideration of the perspective of NGO partners working with the whānau. This may have undermined trust between practitioners and could have impacted the objective of working together to strengthen the tamaiti within their whānau.

Multiple sources of knowledge about the whānau from other professionals appear not to have been given weight in the assessment and decision-making process. *[Support agency employees]* s 9(2)(a) working with the whānau were experienced, registered social workers with expertise in working with very young infants and their whānau. They were also practitioners who were adept at working in a kaupapa Māori or Māori-centred way. Given the difficulty Oranga Tamariki had in building a relationship with the mother and whānau, the relationship *[support agency employees]* s 9(2)(a) had built with them should have been highly valued and utilised in processes such as whānau hui. Despite their close working relationship with the mother, these practitioners were not included in case consults, and their professional opinions were not routinely sought or considered where critical decisions were being made.

The likely impact of prior trauma on the parents' behaviour was not sufficiently well understood and compromised decision-making and engagement. Opportunities to avoid re-traumatisation were missed.

What should have happened?

It is important that social workers recognise and respond to trauma when working with tamariki and whānau. Trauma can occur across families and generations, within social systems and directly to individuals. Complex trauma describes multiple, enduring experiences that threaten or cause harm to wellbeing. This often results from physical, emotional and sexual abuse, neglect, conscious/unconscious bias and discrimination, conflict and oppression, and the effects of colonisation: loss of culture, language, identity, land and collective wellbeing[34].

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

[34] Oranga Tamariki Practice Centre – Trauma informed practice https://practice.orangatamariki.govt.nz/practice-standards/practice-framework-knowledge-and-evidence-base/trauma-informed-practice/

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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.

It is important that social workers are able to recognise that the childhood experiences of parents and whānau, whether positive or negative, can impact upon their parenting capacity. For parents who have s 9(2)(a) history, social workers should fully explore and understand their history by reviewing files, talking to parents and to previous social workers and professionals wherever possible[35]. Particular care, skill and sensitivity needs to be demonstrated in the process of whakapapa searching and identifying extended whānau for hui a whānau and FGCs where parents have identified s 9(2)(a) with whānau members and may not want them involved.

They should also 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. This impact of parental trauma history on risk to a child's safety and wellbeing also needs to be considered.

What did we find?

Both the parents and their whānau had experienced historical trauma and continued to be impacted by its effects in a way that needed to be better understood.

Both parents s 9(2)(a) were still very young. They therefore should have been seen as vulnerable young people who needed support in their own right. The failure to recognise this led to an unrealistic expectation of the parents being exclusively responsible for being able to parent their child(ren) independently. The NGO organisations supporting these young parents highlighted that they had been able to engage with both parents and the mother had progressed while in *[support service]* s 9(2)(a) These factors could have been viewed by Oranga Tamariki as early signs of increased resilience had these actions been viewed within the context of both parents' previous experiences.

[Wider whānau members] s 9(2)(a) had indicated their desire to care for the older sibling s 9(2)(a) . However, concerns s 9(2)(a) within wider whānau relationships were not seen in the context of earlier experiences with the statutory child protection system, intergenerational trauma, or the impact of colonisation and discrimination often experienced by whānau Māori.

s 9(2)(a)

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[35] Oranga Tamariki Practice Centre – Unborn Babies https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/strengthening-our-response-to-unborn-babies/

s 9(2)(a)
also indicated her resilience and capacity for change.

Had *[wider whānau members]* s 9(2)(a) been viewed as sufficiently protective, and had there been more work to understand their support needs, arrangements may have been able to be developed to enable *[them]* s 9(2)(a) to provide the necessary support to the parents to help them care for the baby.

Additionally, taking the action of isolating themselves from their extended whānau was a protective measure linked to earlier s 9(2)(a) This needed to be understood to analyse the reasons why s 9(2)(a) was reluctant to engage s 9(2)(a) extended whānau, hapū and iwi members into the process and to seek out other means of providing formal and informal support to the whānau.

The removal of the previous child from these parents' care had created further trauma which substantially impacted the mother's ability to engage with Oranga Tamariki. This was compounded by the efforts to remove this child.

The [*Oranga Tamariki employee*] s 9(2)(a) for this child was the [*Oranga Tamariki employee*] s 9(2)(a) who was involved in the removal of the older sibling from s 9(2)(a) mother's care earlier in 2018. This was therefore always going to be a difficult relationship to re-build. The circumstances in which the baby was removed was traumatic and has had a continued impact on this mother. s 9(2)(a)

s 9(2)(a)

s 9(2)(a) interpreted as further evidence of a risk to the child, rather than an understandable attempt to protect herself and her baby from further trauma. s 9(2)(a) first baby was both a source of joy and a trigger for her trauma. 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.

Furthermore, there is no clear evidence of consideration of the compounding impact of s 9(2)(a)

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s 9(2)(a)

This trauma would have been compounded by the events of 2 to 6 May where efforts were made to remove this baby from the mother's care.

Communication and engagement were not effective in building quality relationships with the mother, father, whānau and our NGO partners.

What should have happened?

The practice standards emphasise the importance of relationships – with tamariki[36], their parents, whānau[37], caregivers and those that support and work with them[38]. When social workers communicate with whānau in an open, honest and timely way, they are more able to build trust and overcome any barriers whānau may have in engaging with them and in plans for their tamariki. Social workers can achieve this by listening carefully, being upfront about concerns or difficulties, acknowledging progress and achievements and being reliable and consistent in their responses.

Building these relationships takes time and happens most effectively when social workers seek to understand the culture, worldview and prior experiences of the whānau they are working with and how this might be different to their own. Bringing whānau together (both maternal and paternal) to share information, including about any safety concerns should happen at the earliest opportunity and provides a means by which the social worker, whānau and others supporting them can take a shared approach to building a plan to achieve safety for te tamaiti.

Social workers also need to build effective and collaborative relationships with other professionals and recognise the unique contribution that they make to maintaining the safety of tamariki. By sharing information with them, seeking their professional judgement in assessment and decision making and working with them to involve whānau in decision making processes, the quality of social work assessments and plans is strengthened.

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. This is also true of s 9(2)(a) families where accessing the knowledge of s 9(2)(a) professionals can assist in the quality of engagement.

What did we find?

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[36] Oranga Tamariki Practice Centre -Practice Standard See and Engage Tamariki
https://practice.orangatamariki.govt.nz/practice-standards/see-and-engage-tamariki/

[37] Oranga Tamariki Practice Centre – Practice Standard See and Engage Whānau
https://practice.orangatamariki.govt.nz/practice-standards/see-and-engage-whanau-wider-family-caregivers-and-when-appropriate-victims-of-offending-by-tamariki/

[38] Oranga Tamariki Practice Centre – Practice Standards Working in Partnership with Others
https://practice.orangatamariki.govt.nz/practice-standards/work-closely-in-partnership-with-others/

There is limited evidence of efforts to build upon engagement with the parents beyond that which had been established in relation to Oranga Tamariki involvement with the older child

The main attempts to engage with the mother were during s 9(2)(a) contact visits with the older child which she attended with s 9(2)(a) and which the *[Oranga Tamariki employee]* s 9(2)(a) supervised. Contact outside of this context was primarily through text or phone calls. *[Wider whānau member]* s 9(2)(a) felt Oranga Tamariki engagement with *[them]* s 9(2)(a) was often disrespectful. There were no specific visits to let the whānau know that a Report of Concern had been made or to discuss the concerns about the unborn baby.

It was not recognised that the *[Oranga Tamariki employee's]* s 9(2)(a) role in the removal of the previous child was a barrier to developing the trusting relationship necessary to be able to work effectively and openly with the mother through this pregnancy. Had this been recognised, it would have been understood that attempting to have serious discussions about the second pregnancy was always going to be difficult and potentially distressing in this context. Expectations that she "open up" and discuss her pregnancy during contact visits with the older child were not only unrealistic but unsafe for the mother. s 9(2)(a) did not want to talk to the *[Oranga Tamariki employee]* s 9(2)(a) about the pregnancy because she wanted to keep her baby and get her other child back. s 9(2)(a)

Nor is there evidence of a relationship being built with the father or his whānau who had a right to be involved in the plan for the new baby and to understand the concerns. Other social workers who had managed to build effective relationships with the father in the past could have been consulted with about the best approach. s 9(2)(a), s 6(c) These do not appear to have been considered or acted upon. s 9(2)(a), s 6(c) his views as a parent and the role he could play in the life of pēpi was not given much weight.

Decisions were made by Oranga Tamariki without the involvement of the whānau and those working with them. There were missed opportunities to share these decisions with them also.

Communication with whānau and professionals appears to have been largely "one way" - there was an expectation that whānau and community provide information to Oranga Tamariki, but this was generally not reciprocated. Oranga Tamariki did not provide records of critical meetings or disclose its intentions despite early evidence of a plan to place the new baby outside his whānau, hapū, iwi or family group.

Assumptions about whānau unwillingness to engage in hui a whānau before the birth were influenced by a lack of understanding of their previous experience s 9(2)(a) This left them feeling frustrated: "…we are not a hard family - we were willing to work with Oranga Tamariki ….. we're sick of plans …we did everything they asked us to…. but it made no difference….." These issues could have been better understood if an effective relationship had been built with the whānau.

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Communication with parents, whānau and other professionals about concerns was not undertaken in an open and timely way. The decision to apply for the custody of the baby, despite already having been made, was not disclosed at the meeting convened by *[support agency]* s 9(2)(a) in mid-April, nor was a record of what was agreed provided at the time. A retrospective record of the meeting did not contain an agreed outcome or plan, and was not available to whānau, professionals or s 9(2)(a) *[Oranga Tamariki employees]* who were covering in the *[Oranga Tamariki employee]* s 9(2)(a) absence which coincided with the birth of baby.

Cover for the *[Oranga Tamariki employee]* s 9(2)(a) was provided by *[Oranga Tamariki employee]* s 9(2)(a) to the extent that they would become involved in the event of baby arriving before the *[Oranga Tamariki employee's]* s 9(2)(a) return. There was no pre-existing relationship between the whānau and the practitioners who attended the hospital first to check on baby's welfare and later to attempt to remove baby from mother's care. The absence of appropriate handover processes and a lack of clear recording of previous discussions with the whānau[39], meant these staff did not have sufficient knowledge about what had been proposed previously to assess the adequacy of plans put forward by the mother, her whānau and support people.

Information provided by other professionals to Oranga Tamariki (particularly with respect to the meeting in mid-April) was used to support the court application without sufficient context. This would later have a significant impact on the trust and confidence that the parents and whānau had built with these professionals, as well as the professional's relationships with Oranga Tamariki staff. It would have been good practice for Oranga Tamariki to provide NGO partners the opportunity to verify this information. The review team found that the failure to verify the information was not typical of site processes and that there would usually be more infomration sharing and engagement between the site and NGO partners.

The statutory authority delegated to Oranga Tamariki social workers was not consistently well-understood or appropriately applied.

What should have happened?

Where a social worker has formed a view that a child is in need of care and protection they must, with a few exceptions, report the matter to a care and protection co-ordinator who must convene an FGC[40]. The FGC provides the opportunity for the whānau, family group and the child (if they are old enough) to meet with social workers and other professionals to discuss what needs to happen to ensure the child can be made safe and well. It is increasingly good practice to work with whānau and those supporting them to hold hui a whānau prior to an FGC being held[41]. A hui a whānau is a family-led process which can be

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[39] Oranga Tamariki Practice Centre – Practice Standard Keeping Accurate Records https://practice.orangatamariki.govt.nz/practice-standards/keep-accurate-records/

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

[41] Oranga Tamariki Practice Centre – hui a whanau https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/hui-a-whanau/ NB this guidance was updated 1 July 2019

used to generate an understanding of the issues and potential options to address them which can be built upon further in the FGC.

Generally, where social workers form a belief that the only way to protect a child from serious harm is to bring the child into the custody of the chief executive, an application is made for a care or protection order. The social worker is expected to consult with an Oranga Tamariki solicitor when considering urgent court action and this is particularly important when court action is considered to be warranted to secure the safety of a child. Consultation and legal advice should have regard to the appropriateness of proposed applications, with specific regard to the strength of the evidence relied on to support the application, the nature of the order being sought and the extent to which alternatives to court applications have been adequately explored[42].

Applications for custody with notice should generally be made after an FGC has already been held. In certain circumstances the Court still has the ability to grant a custody order pending determination of proceedings whilst these steps are occurring. 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.

There should be a very high bar for applying for orders on this basis because of the principles in the legislation that prioritise whānau, hapū, iwi and family group participation in decision-making. The opportunity for the views of Oranga Tamariki practitioners to be considered by the Courts and to be open to challenge by whānau and other professionals is crucial, particularly given the potential risk of assessment information being under- or over-weighted by practitioners and the far-reaching powers of the Court in relation to children's custody.

Where without-notice orders have been granted, parents and guardians must be served with the order and application as quickly as possible and are able to make direct submissions to the Court directly thereafter.

Once a social worker is aware that a custody order has been granted, they should have particular regard to any directions made by the court. A custody order does not automatically require that the child is removed from parental care, obtaining custody can provide a framework of additional legal protection. In those cases where the decision has been made to remove the child from their parents' care, each situation is unique and requires social workers to plan ahead. In some cases, such as where there is a strong indication that parents may leave with the child, social workers will need to exercise discretion as to how much information can be shared. Working with their supervisor, other professionals and, wherever possible, supportive whānau members will assist in making this process as safe and least traumatic it can be for all parties.

If te tamaiti is being removed from a setting such as a hospital, and if assistance from Police has been sought, it is very important that all parties have clarity about the extent and limits of their powers, who has authority to make which decisions and what escalation

[42] Oranga Tamariki Practice Centre – Family Court Orders https://practice.orangatamariki.govt.nz/our-work/interventions/family-court-orders/applying-for-care-or-protection-orders/

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pathways are in place that can be used to resolve difficult circumstances[43]. Oranga Tamariki will always retain the authority to determine whether or not te tamaiti should be removed using the custody order. Police, however, will have specific responsibilities around public safety. Health staff are ultimately responsible for the safety and wellbeing of those within the hospital, including their patients, that is, mother and baby.

No matter how well planned, removing a new-born infant from its parents' care will always be distressing. Unless immediate safety dictates otherwise, social workers should ensure that the 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. Planning also needs to include considerations such as how breastfeeding will be maintained and attachment between baby and parents supported during this critical period[44].

Given that these are often fast changing and dynamic situations, social workers need to be able to access support and advice from those in leadership roles and to rely on their own professional judgement in order to be responsive to events as they occur. Applying the Oranga Tamariki values[45] will also support practitioners to do what is right, in particular for the child, in a way that demonstrates empathy, aroha and respect for the mana of those involved and which promotes outcomes that have a long-term benefit. These values can also help to navigate differences of professional opinion between practitioners from differing disciplines and organisations.

What did we find?

Parents and whānau did not have an opportunity to participate in key decisions

Family Group Conference

Oranga Tamariki had indicated to NGO partners there would be an opportunity to discuss the concerns and how to manage them through an FGC and a hui a whānau. However, neither of these forums were made available to the whānau before Oranga Tamariki applied for and was granted a custody order.

There were several reasons why an FGC was not held before the custody application was made. There was a delay between being notified of the pregnancy in mid-November, a Report of Concern being entered in February, and the decision to make a referral for an FGC in mid-March. Additionally, by the time the referral was made a vacancy and s 9(2)(a) at the site in the FGC Co-ordinator roles meant it was near impossible for the FGC to be convened in time for quality decisions to be made before the baby was born.

Oranga Tamariki had not given a clear indication of whether it supported the plan proposed by the mother, whānau and NGOs for the mother to retain the care of the baby *[with support agency]* s 9(2)(a), or whether it considered that the plan did not sufficiently address safety concerns. *[A wider whānau member]* s 9(2)(a)

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[44] Oranga Tamariki Practice Centre – Unborn Babies https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/strengthening-our-response-to-unborn-babies/

[45] Oranga Tamariki Values https://www.orangatamariki.govt.nz/about-us/overview/

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and NGO partners reported that they therefore understood that Oranga Tamariki had accepted their proposed plan. This set the stage for a confrontation with the whānau, the Lead Maternity Carer and the NGOs when Oranga Tamariki came to execute the order in the hospital.

s 6(c)

Inadequate communication and planning, operational issues, and a misunderstanding about aspects of Oranga Tamariki duties complicated the attempt to remove the baby from the mother's care.

Inadequate planning and communication made the situation more difficult for hospital staff than it needed to be. Initially hospital staff were not informed about the custody order but were asked to call Oranga Tamariki and the Police if the mother attempted to leave the hospital. When they were informed there was a custody order they were told they were not to share this information with the whānau. However, as no plan had been developed or shared around plans for the removal of the baby, hospital staff were unclear about what would happen when, how they could best support the mother through and after the removal process, and how to reinforce the messages in the plan to help address any confusion with the mother. Hospital staff felt this put them in the position of having to compromise their professional ethics and standards and their own relationship of care with the mother.

The initial decision not to execute the orders until *[Oranga Tamariki employee]* s 6(c) returned, despite having s 6(c) ndicates insufficient preparation through transition planning to take on this case work. The decision created uncertainty for the hospital, whānau and their supports and created a window in which tensions built considerably and then played out when the first attempt to remove the baby was made.

Part of the reported "chaos" at the hospital associated with the first attempt to remove the baby resulted from the conflicting advice received from within Oranga Tamariki. Incorrect advice was provided to the social worker that, because Oranga Tamariki had secured the custody of the baby, the baby needed to be removed from the care of the mother. However,

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the custody order could have been served while the mother retained the day-to-day care of the baby.

There were other questionable judgements made over these few days. For example, the parents did not attend the hui at the hospital whare because the mother was told that she could not take her baby to the hui because of concerns about the baby being exposed to tensions and conflict between Oranga Tamariki and the whānau. This decision did not take into account that there were several protective adults in the hui (including other professionals) who could, in all likelihood, have been relied on to intervene appropriately to prevent this occurring. The complexity, novelty and heightened nature of the situation may have compromised staff decision-making. More direct support and leadership may have helped staff manage some of these stressors more effectively.

Given the level of confusion and complexity associated with the first attempted removal it is difficult to understand why, on the second attempted removal, there was not a clear plan in place if the mother continued to resist Oranga Tamariki attempts to remove her baby. In particular, there does not appear to have been clear escalation pathways in place when the impasse continued on the second attempt – *[Oranga Tamariki employee]* s 9(2)(a) was not able to initially make contact with local operational managers and resorted to seeking advice from the National Contact Centre.

This was exacerbated by confusion about the respective roles and responsibilities of Oranga Tamariki, the New Zealand Police and DHB staff.

At times Oranga Tamariki deferred to other professionals in relation to decisions around the execution of the order despite this being a decision that rests with Oranga Tamariki. For example, Oranga Tamariki continued to pursue the second attempted removal of the baby at the hospital on the basis that not only this was the decision was taken at the case consult but also because the hospital indicated they needed the removal to happen to end the situation so normal operations could resume and because the Police advised that because Oranga Tamariki had an order social workers needed to remove the baby.

The large number of uniformed police at the hospital is likely to have exacerbated tensions. It is not clear why uniformed officers arrived when whānau first blocked hospital exits and we have not been able to establish who made the decision in the first instance to call the Police. It is clear, however, that hospital staff had concerns about the impact events could have on the wellbeing of other patients also in the hospital and that Police were compelled to respond to these wider concerns.

The media presence and the nature of the s 9(2)(a) ***advice from the mother's [representative]*** s 9(2)(a) ***added to the confusion and tensions at the hospital***

s 9(2)(a) As that is not a mechanism used in the Family Court, Oranga Tamariki staff were initially confused and 'caught off guard' by this information. Oranga Tamariki made a number of requests s 9(2)(a) This did not happen.

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The media presence at the hospital was in contravention of hospital policy whereby media are expected to get hospital agreement before filming on site. The hospital decision to lock down access to the hospital because of the media presence was understandable in this context. However, it had the effect of denying whānau, midwives and other supporters, including a senior community representative, access to the mother and this heightened tensions between the whānau and their supporters and Oranga Tamariki, Police and hospital staff. So too may have the decision for social workers and police officers to remain outside the room for the remainder of the night.

The media presence also influenced the Oranga Tamariki decision to hold the first hui s 9(2)(a) to avoid media intrusion instead of at the hospital whare which was the venue preferred by the whānau. This meant that the parents could only participate by phone. However, in the heated discussion at the meeting, the parents were not linked into the hui by phone. Other whānau members were, however, present.

This created unnecessary trauma for the mother, father and whānau and adversely impacted on hospital operations.

In the confusion and complexity of the situation at the hospital, Oranga Tamariki [*employees*] s 9(2)(a) remained calm. However, in trying to maintain a focus on what were considered to be the needs of the baby, the needs of others were lost sight of. As a consequence, some key Oranga Tamariki values, including aroha and respect for the mana of others, were not brought to life.

Opportunities to minimise the impact of the impasse at the hospital on the mother, father and whānau were missed. This was a prolonged impasse, with a young mother who had already experienced an attempt by Oranga Tamariki and Police to remove her new baby the previous day and which continued throughout the night. s 9(2)(a) This was, however, denied by police and Oranga Tamariki as it was thought the presence of supporters might exacerbate the situation based on earlier events.

s 9(2)(a)

The impact for the hospital of these events was significant: other mothers were moved to another ward and a number of key DHB managers and advisors had been alerted and were present on site. Because of the difficulty managing the situation, the DHB cultural team were also denied access to support the mother by the Police who had brought in the police negotiation team to negotiate the safe handover of baby.

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Mechanisms to ensure the appropriate exercise of our duties and powers were in place but did not operate effectively.

What should have happened?

Social workers are required to exercise their individual professional judgement, obligations and ethics in the context of a legislative and organisational framework designed to help ensure the appropriate exercise of Oranga Tamariki powers and duties through the promotion of collaborative and consultative decision making.

Social workers have a professional obligation to ensure they recognise how and when their own values and beliefs may be influencing their professional judgement and decision making. They can take a reflective approach in their own practice by asking themselves questions such as whether they have taken into account their positional power, whether they have placed sufficient value on the role of whānau as experts and leaders, how they might seek to understand the culture and worldview of those they are working with, and how they might share decision-making with them.

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[46]. Practitioners are required to exercise their professional judgement in complex circumstances and sometimes amidst apparently competing or contradictory objectives and opinions. Supervisors and other leaders of practice can support clarity and integration of thinking, by encouraging the practitioner to remain focussed on foundational practice, as set out in the Oranga Tamariki Practice Standards. The whakamana te tamaiti practice standard in particular emphasises the concepts of mana tamaiti, whakapapa and whanaungatanga and how they should be applied to promote the safety and wellbeing of tamariki Māori. As a whole, the standards provide a helpful framework to test the rigour of decision making, identify areas for further exploration and generate confidence in the actions required with respect to tamariki and whānau.

Social workers can use the Child and Family Consult[47] to help them structure their thinking about what they understand is happening in the whānau. By engaging in a structured professional discussion with colleagues, the consult helps social workers to identify and consider indicators of danger/harm alongside indicators of safety and strengths that they might not necessarily have considered themselves. When used appropriately, the consult can support robust, open and transparent decision making, bring 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.

If supervisors and Practice Leaders have concerns about the approach a social worker is taking to a particular case that cannot be addressed through supervision and/or case

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[46] Oranga Tamariki Practice Centre - Supervision practice standard https://practice.orangatamariki.govt.nz/practice-standards/use-professional-supervision/

[47] Oranga Tamariki Practice Centre - Child and family consult https://practice.orangatamariki.govt.nz/our-work/practice-tools/other-practice-and-assessment-tools/childyoung-person-and-family-consult/

consults, they should consider whether the concerns are sufficiently serious that a more direct degree of intervention is required to ensure the wellbeing of the child involved. This could include the option of either assigning a co-worker to the case or a different social worker to lead the work. This decision needs to be balanced against the potential adverse effect of assigning a new social worker where case continuity can be impacted by a lack of knowledge about the child and family group and the need to build new relationships.

Legislation provides for the establishment of Care or Protection Resource Panels (CPRP) to provide external advice and guidance to social workers undertaking their responsibilities under the Act. Social workers are required to consult with the CPRP as soon as possible after having commenced an investigation[48]. FGC co-ordinators are also required to consult with the panel when they have received a referral for an FGC. 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.

What did happen?

Supervision sessions and case consults occurred at key points during assessment and planning prior to the seeking of the custody order. These variously involved *[Oranga Tamariki employees]* s 9(2)(a) The case was also considered by the Care and Protection Resource Panel after the initial Report of Concern had been made by *[Oranga Tamariki employee]* s 9(2)(a) (though this was prior to the decision to seek custody for the baby was reached).

The approach discussed in supervision notes from 3 April was for the mother to *[be supported by support agencies]* s 9(2)(a) to provide an opportunity to see how she progressed with the baby and until an FGC could be held. There was also discussion of applying for a support order for the baby enabling Oranga Tamariki to provide support with the oversight of the Family Court. Two further case consults were held and then eight days after the initial supervision session, the supervision notes reference the decision to instead apply for a s78 custody order. There is no evidence of any new additional assessment being undertaken or new information being provided to Oranga Tamariki between these two dates and it is therefore difficult to understand on what basis the decision was made to switch to a custody order. During the course of the review, practitioners were unable to provide additional clarity as to what influenced the change in direction.

Additionally, a site hui was held after the first attempted removal and the whānau hui where a plan was proposed by whānau and s 9(2)(a) that the mother *[would be supported at support agency]* s 9(2)(a) Staff cannot recall whether this plan was presented at the site hui but the decision was made that the baby should be placed s 9(2)(a) This was after

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48 Oranga Tamariki Practice Centre – CPRP https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/working-with-the-care-and-protection-resource-panel/

Oranga Tamariki had agreed the previous day that the mother could go to *[support agency]* s 9(2)(a) with the baby until a whānau hui could be held the next day.

From the recorded case notes and information gathered from further interviews with staff during the course of this review, we have not been able to identify any evidence that the supervision and case consult exercises entailed sufficient engagement with the details of this case. The concerns around the case work set out in this review were not identified through those sessions and there is little evidence of critical engagement with key aspects of the case work, including assessment, decision-making and engagement with the parents and whānau. Leadership indicated that, in the context of supervision and case consults, *[Oranga Tamariki employees]* s 9(2)(a) were recognised as the 'experts on the whānau'.

The high number of case consults held on this case in the week between the initial supervision and the final decision to seek a s78 order, as well as earlier on in the case, was surprising. The reviewers could not determine what drove this dynamic or the change in the direction of the decision-making over the course of the weeks leading up to the application for a s78.

There should have been considerably more commitment to the practice standard of whakamana te tamaiti throughout site systems and practices than was evident in this case. While Māori staff on site were reported by their colleagues both within and external to Oranga Tamariki to have strong connections with the community (hāpori Māori) this did not translate into effective practice in this case.

Given well-established features of decision-making such as confirmation bias[49] it is critical that supervision and case consultation exercises act as a robust check on assessment decisions. Where these mechanisms are ineffective it can significantly work against whānau who have improved safety and protective factors and reduced risk factors from being given an opportunity to care for their own tamariki.

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[49] Confirmation bias is the tendency in a range of different settings for people to over-look or discount new information that is not consistent with an established view.

RECOMMENDATIONS

Based on these findings, it is recommended that:

Restorative responses

- We acknowledge the serious adverse impact of these events on the parents and whānau and consider actions that contribute to the restoration of the mana of, and relationships with, the parents, their whānau and those supporting them, the prospective caregivers and the NGO and agency partners in involved these events. Support from tangata whenua (Ngāti Kahungunu) should be sought in relation to the best process for undertaking these actions.

Site-based responses

- We take steps to ensure that the mechanisms designed to promote safe statutory practice and to ensure a culture of accountability, reflection, challenge and transparency are operating as intended within the site involved with this whānau, including:
  - Supervision
  - Child and Family Consults
  - Legal consultation
  - Independent Care and Protection Resource Panels.

System-wide responses

- We strengthen the oversight of decisions to apply for a s78 custody order on a without notice basis
- We tighten processes relating to parents who are within the scope of s18A and s18B of the subsequent children provisions to ensure that the legislation is being applied correctly
- We provide additional professional development and guidance for practitioners on:
  - the appropriate treatment of historical concerns against current information
  - using safety planning and hui a whānau in the context of s 9(2)(a) to create safety for tamariki
- We ensure the appropriate allocation of Family Group Conference Co-ordinator resources across sites
- We build a set of professional development tools that bring to life our operational policy and practice guidance in relation to whānau, hapū and iwi searching and whānau-hui and ensure the appropriate allocation of specialist whānau, hapū and iwi searching resources across sites
- We identify how best to articulate child-centred practice in the context of whānau as part of the future development of the Practice Framework
- We continue to prioritise work to ensure alignment between operational policy, guidance and outcomes measures for care permanency settings and our organisational s7AA objectives

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- We work with strategic partners, the Ministry of Health, District Health Boards, key health-sector professional groups and the New Zealand Police to ensure consistent and co-ordinated practice across the country in relation to the removal of new-born babies in the hospital setting.

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APPENDIX ONE

Final Terms of Reference: Professional Practice Group Review Hastings Case May 2019

Background

Oranga Tamariki, Ministry for Children, was granted interim custody of a baby in early May 2019, following the Court making an order pursuant to section 78 Oranga Tamariki Act 1989. The interim custody order was made due to safety concerns for the baby should mother and baby be discharged from hospital. Circumstances regarding the decision to bring the baby into care, including Oranga Tamariki staff's interaction with the mother, whānau and other professionals whilst at hospital have been the subject of significant scrutiny and public comment.

Purpose of review

The purpose of the review is to examine the actions of Oranga Tamariki in relation to the baby and the baby's mother prior to, and immediately following, the birth of the baby. The review will have a particular focus on the engagement with the mother, father, whānau, iwi, other professionals and key stakeholders. It will examine the quality of the assessment and planning, how Oranga Tamariki worked as part of a wider interagency group involved with the baby, and the manner and method of the processes undertaken.

Decisions around the custody of the baby are currently subject to Family Court proceedings. The review will consider whether the communication relating to the custody application was sufficient and whether it was appropriate for this to be made 'without notice'. The specific content of the section 78 application, the decision of the Court to grant an interim order and all other matters currently being considered by the Family Court are not within scope of the review and may not be considered.

The review will have three objectives:

- to understand what has occurred from the perspective of the mother, father, whānau, our staff, iwi and other professionals involved
- to identify what can be learnt from a local and national perspective
- to promote restorative actions to address and strengthen local relationships and ways of working.

Independence of the review process

The review will be led by senior staff from the Oranga Tamariki Practice Advice and Māori Practice Advice teams (the PPG reviewers) with the oversight of the Chief Social Worker/Deputy Chief Executive Professional Practice.

An oversight group has been established to act in an advisory capacity to the review team and Oranga Tamariki in regards to the completion of the review. Accountability for the review remains the responsibility of the Chief Social Worker / Deputy Chief Executive Professional Practice on behalf of Oranga Tamariki.

The oversight group comprises:

- the Chief Executive of Ngāti Kahungunu
- a representative of the Office of the Children's Commissioner

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- Shayne Walker, an independent person agreed with Ngāti Kahungunu.

The role of the Independent Review Oversight Group will be to:

- contribute to and oversee the development of the methodology, analysis and findings
- provide advice to the Oranga Tamariki review team around issues arising from the review and approaches to resolution
- provide advice to Oranga Tamariki regarding stakeholder engagement and in particular the approach to dissemination of findings to review participants
- provides advice on the different perspectives of those involved in these events (specifically te tamaiti, te whānau, iwi, community, stakeholders and NGO and agency partners).

The Children's Commissioner has been consulted on the Terms of Reference for this review and will provide input into the design, progress and findings from the review through his representative on the Independent Review Oversight Group.

Whānau engagement

Representatives of the baby's mother, father and whānau have been advised on the purpose and overall approach to the review (as set out in these terms of reference) and have been provided an opportunity to provide feedback on the approach we are taking.

The review will provide the opportunity for the mother, father and whānau to have their view of events leading up to and following the birth of the baby to be heard and considered, and to have those views inform the findings from the review. Current case work decisions around the baby will be outside of the scope of these engagements as will matters being considered by the Family Court.

We are in discussion with whānau representatives and Ngāti Kahungunu about the best way in which to support engagement of the mother, father and whānau in this work and the appropriate analysis of parental and whānau voices. We will seek advice from the Independent Review Oversight Group on how to proceed if whānau do not wish to engage in this review.

Stakeholder engagement

A stakeholder engagement plan will be developed as part of the review planning in consultation with the independent person.

The approach to engagement will include:

- initial phone and then written contact by Chief Social Worker / Deputy Chief Executive, Professional Practice explaining purpose and approach, co-existence of other processes and role of independent person(s)
- face-to-face engagement to be undertaken by PPG Reviewers
- a process to provide feedback to participants on findings.

Ideally the review process will conclude with a resolution / restorative focussed interagency hui with a focus on future ways of working. Whether and how this occurs will be informed by the engagement undertaken during the course of the review.

Scope

The focus of the review is the quality of Oranga Tamariki engagement, assessment and planning and our approach to inter-agency working.

The period covered by the review will be from when Oranga Tamariki became aware that the mother was pregnant with the baby to 9 May 2019 when the baby and mother were discharged from hospital. The review is limited to the period outlined above.

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Prior involvement with the mother, father and whānau, and in particular the baby's sibling, will be considered only to the extent it is relevant to the nature of the relationship between Oranga Tamariki the baby's mother and the quality of the assessment and planning for the baby.

The following is out-of-scope of the review:

- formal complaints processes associated with these events.
- day-to-day management of the plan for the baby. This remains the responsibility of the Oranga Tamariki Services for Children and Families team in Hastings.
- matters that are subject to proceedings before the Family Court (although the process and quality of assessment and planning informing court action may be relevant to the review).

Methodology

We will use a combination of direct interviews, practice workshops and visual recording to build an understanding of what has occurred. Our approach to the analysis of practice will be guided by the Independent Review Oversight Group and will be informed by our legislative framework and practice standards.

Final outputs from the review will be confirmed through the detailed design phase but will include a summary report of key findings, areas of learning and any further proposed resolution actions. Decisions around any public release of general findings from the review will be informed by the views of the mother, father and whānau and other stakeholders involved in this review.

We intend to complete the review towards the middle to end of July, recognising however that this work will need to progress at a pace appropriate to the needs of the whānau, our NGO and agency partners and the community.

The review will include the following phases.

Phase One: Detailed design, gathering information, preparation and initial engagement

- review and clarification of practice analysis provided by the site / region
- review of information recorded in Oranga Tamariki case management system
- development of a working timeline of case events
- design of practice workshop for Oranga Tamariki staff
- initial engagement with whānau, other key participants and scheduling of interviews
- design of plan for securing whānau voice through review process.

Phase Two: Engagement with participants

- engagement with representatives of the mother, father and whānau face-to-face discussion with key Oranga Tamariki staff
- face-to-face discussion with key representatives of:
    - DHB maternity staff
    - NZ Police
    - lawyer for child
    - midwives
    - relevant community providers working with the mother, father and whānau
    - Ngāti Kahungunu
    - any others identified in the course of the review
- practice workshop with Oranga Tamariki staff.

Phase Three: Review, analysis and writing

- review and analysis of information gathering
- draft findings report prepared.

Phase Four: Feedback and forward-planning

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- feedback of findings to participants and other key stakeholders as appropriate
- finalise report
- identification of further resolution / restorative actions.

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APPENDIX TWO

List of workshops, workshop participants and interviewees

Role / Organisation	Name	Type of engagement
Ngāti Kahungunu s 9(2)(ba)(i)		Discussions with review team members s 9(2)(ba)(i)
s 9(2)(ba)(i)		Māori NGO / professionals workshop
s 9(2)(ba)(i)		
s 9(2)(ba)(i)		
NZ Police	s 9(2)(ba)(i)	Initial meeting
NZ Police	s 9(2)(ba)(i)	Police / DHB workshop
DHB	s 9(2)(ba)(i)	Initial meeting
DHB	s 9(2)(ba)(i)	Police/DHB workshop

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	s 9(2)(ba)(i)	
Lawyer for child	s 9(2)(ba)(i)	Direct interview
s 9(2)(ba)(i)	s 9(2)(ba)(i) s 9(2)(ba)(i)	Direct interview
s 9(2)(ba)(i)		Direct interview
Oranga Tamariki Staff	s 9(2)(ba)(i)	Workshop and direct interviews

Invited but did not participate in Practice Review

Role / Organisation	Name	Type of engagement
s 9(2)(a)		
s 9(2)(a)		
s 9(2)(a)		
s 9(2)(a)		

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