MINISTRY OF SOCIAL DEVELOPMENT

Te Manatū Whakahiato Ora

Bowen State Building, Bowen Street, Wellington 6011, PO Box 1556, Wellington 6140 • Telephone: 0-4-9 6 3300 • Facsimile: 0-4-918 0099

18 JUN 2013

Ruwani Perera
Senior Reporter, Native Affairs, Māori Television
PO Box 113-017
Newmarket
Auckland 1149
Ruwani.Perera@Maoritelevision.com

Dear Ruwani Perera

Thank you for your letter of 15 May 2013 requesting, under the Official Information Act 1982, the following:

> *"I am writing to request the Child Youth and Family Service case file, relevant information and associated evidential video interviews of Krystal from the Ministry of Social Development under the Official Information Act 1982 ...*
>
> *For this investigation we will also need what measures Child Youth and Family Service have put in place following her death so the likelihood of this tragedy occurring again is prevented."*

As you will be aware, your request for evidential video interviews was transferred to the Police on 29 May 2013.

In regards to your request for Krystal's Child, Youth and Family case file, I am refusing this request under section 9(2)(a) of the Act in order to protect the privacy of natural persons and their families. The need to protect the privacy of these individuals outweighs any public interest in this information.

In regards to your request for "*relevant information*" and the "*measures Child, Youth and Family have put in place following [Krystal's] death*", the Ministry of Social Development provided you with a media statement on 17 May 2013 which covers this request. I have enclosed a copy of the statement for your reference.

I hope you find this information helpful. You have the right to seek an investigation and review of my response by the Ombudsman, whose address for contact purposes is:

The Ombudsman
Office of the Ombudsman
P O Box 10-152
WELLINGTON 6143

Yours sincerely

pp

Bernadine Mackenzie
Deputy Chief Executive Child, Youth and Family

Media Statement, 9 May 2013
To be attributed to Nova Salomen, Deputy Chief Social Worker, Child Youth and Family:

Child, Youth and Family fully accepts the Coroner's findings into Krystal's death.

Put simply, we failed Krystal.

We agree with the Coroner that while there is no guarantee that Krystal's death could have been prevented, two of our social workers made mistakes that meant opportunities to help her were missed.

These mistakes were compounded by poor supervision.

This was a difficult and complex situation, but in focusing on the process of supporting eight children, social workers lost sight of Krystal and her needs.

We agree with the Coroner that this case is a reminder for social workers to focus on the needs of children rather than being process-focused.

We have apologised to Krystal's family for not supporting her properly

Her placement with Barnardos had begun to show some positive changes for Krystal, however in hindsight, it is clear that she was more emotionally fragile than anyone recognised.

We accept the Coroner's view that there were obvious pressures on Krystal that should have led us to seek a closer examination of her mental state.

We accept that the care plan provided to Barnardos fell well below the acceptable standard. The information given to Barnardos and its caregiver was confused, out of date and did not provide them with adequate information regarding Krystal's current well-being.

We acknowledge that while Krystal's screening test showed no suicidal ideation, the psychological distress result was misapplied, which understated the stress she faced. Had it been interpreted correctly, further intervention may have occurred to determine whether Krystal was suffering from a mental health disorder.

These failings point to poor social work practice at the office concerned. Following Krystal's death, we have worked closely with local staff to improve supervision of social workers.

The social worker who produced the sub-standard care plan left Child Youth and Family soon afterwards. The social worker who made the testing error has received extra training. We have also automated the scoring on these tests to remove the risk of human error.

As the Coroner pointed out, there were a number of missed opportunities to help Krystal and as an organisation we accept responsibility for that.

Over the past five years we have made a number of other changes to try and prevent a failure like this happening again:

- We have strengthened our care plans to improve key information provided to caregivers.
- When a child or young person is evidentially interviewed, there are now clear guidelines that require specific social work actions.
- We have implemented a specific assessment tool for social workers who work with children over the age of 12 years.
- We have made changes to our information systems for social workers to highlight suicide risk and critical risk checks.
- Gateway assessments are now used to assess the wider needs of all children in our care.

For further information on the practice guidance to support social workers working with vulnerable children and young people, see our Practice Centre at www.cyf.govt.nz.

In terms of the Coroner's specific recommendations, we have done the following:

- Social workers have been reminded that concerns about compromising the criminal process are not grounds for withholding support and counselling services from children and young people undergoing evidential interviews.
- We have liaised with Police in terms of clarifying this policy around evidential interviews.
- While we have already made improvements to ensure caregivers receive the information they need, we are considering how to make further improvements based on the Coroner's recommendations.

The period since Krystal's death in 2008 has seen big changes in the way we work with abused children to try and prevent a failure like this happening again.

Krystal's death was a tragedy for all who knew her and I extend my sincere condolences to her family.

Testing of Krystal using CAGE Kessler Suicide screening:

The CAGE Kessler Suicide screen ("CKS screen") contains three components: a CAGE screen for drug use; a Kessler Screen for psychological distress; and a Suicide screen for the risk of suicide or significant self-harm.

In respect of Krystal, the CAGE and Suicide screens were correctly applied.

However, the Kessler screen for psychological distress was misapplied. Instead of using the total score for the Kessler screen, the social worker chose the highest individual score and identified this as the total score. This resulted in a total score of 3 rather than 11. The procedure for a Kessler screen states that if a child has a total score of more than 4 they are likely to require further intervention to determine if they are suffering from a mental health disorder.

Suppression orders:

A number of suppression orders are in place in respect of this matter.

In the interim there are suppression orders prohibiting the publication of the names of the two social workers involved in the case around the time of Krystal's death. The coroner is currently seeking submissions from media as to whether suppression for the social workers should continue. The due date for them to respond to the Coroner is 22 May.

Permanent suppression orders have been made in relation to:

- the name of Krystal's Barnardos caregiver and any particulars which may lead to her identification
- Krystal's surname
- the names of her siblings and any particulars that might lead to their identification
- particulars which may lead to the identification of two persons (including their relationship to Krystal) against whom Krystal had made allegations of sexual abuse
- the content of Krystal's evidential interview
- Krystal's diary entries that were produced as evidence
- notes written by Krystal and her sister on the night before Krystal's death
- photographs of Krystal that were produced at the inquest

Publication of the details about the manner in which Krystal died is also prohibited under s71 of the Coroners Act 2006. It may be reported that her death was self-inflicted but not the manner of her death.