Report to Hon Paula Bennett, Minister for Social Development and Employment

Following An Inquiry Into The Serious Abuse [illegible] Year Old Girl And Other Matters Relating To The Welfare, Safety And Protection Of Children In New Zealand

Conducted by Mel Smith CNZM

31 March 2011

M P (Mel) Smith CNZM

Hon Paula Bennett
Minister for Social Development and Employment

Dear Minister

On 25 January 2011, Cabinet noted that, after consultation with the Prime Minister and Minister of State Services, you had appointed me to conduct a Ministerial Inquiry into the serious abuse of a nine year old girl, and to report to you about that and any other matters that should be brought to your attention.

I have conducted my Inquiry in accordance with the Terms of Reference you directed to me and now I am pleased to submit to you my report and recommendations.

I note that during my investigation I have received very full, enthusiastic and helpful responses from the many individuals and representatives of organisations with whom I spoke and sought assistance. I register my appreciation of their help.

I have had the benefit of particular assistance in carrying out my Inquiry and framing the report from Dr Michael Stace and Alison Havill. I record my appreciation of their assistance.

Whilst I have had guidance and assistance, the contents of this report, its findings and recommendations are mine.

Mel Smith CNZM
31 March 2011

Cover photograph: “A swing without child”
Photographer: Alistair Eames

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Report to Hon Paula Bennett, Minister for Social Development and Employment

Following An Inquiry Into The Serious Abuse Of A Nine Year Old Girl And Other Matters Relating To The Welfare, Safety And Protection Of Children In New Zealand

1 Introduction

1.1 On 25 January 2011 Cabinet noted that you had announced, after consultation with the Prime Minister and the Minister of State Services, a Ministerial Inquiry into the case of the serious abuse of a nine year old girl.

1.2 You appointed me to conduct that Inquiry and required me to report my findings by 31 March 2011. The Terms of Reference for the Inquiry are attached as Appendix A.

1.3 My findings in accordance with the Terms of Reference follow, but it is necessary for me to preface those findings with comments which set the scene.

1.4 I have been involved with a number of Royal Commissions, Commissions of Inquiry and Ministerial Inquiries. Without wishing in any way to detract from the significance or importance of those Inquiries none, in my view, can have been as important and significant as this Inquiry. It is a sad commentary that here in New Zealand we have witnessed far too many cases of child abuse. In recent times there have been several high profile cases, some resulting in death and others, as in this case, in serious injury.

1.5 All of these cases have resulted in a strong response from politicians, public and media with questions of why, and what can we do to lessen this horrific behaviour and better ensure the safety and welfare of our children. Following the murder of the Aplin children in Masterton in 2001 by their stepfather, the Office of the Commissioner for Children carried out an investigation (2003). Before that there had been a similar inquiry by the then Commissioner for Children into the death of James Whakaruru (2000). There have been numerous responses from many sources on more recent cases but, prior to this, so far as I can ascertain

there has been no inquiry at the level of an inquiry under the Commission of Inquiries Act 1908, or a Ministerial Inquiry.

1.6 Your decision to initiate this Inquiry is timely, not only because it recognises the importance to New Zealand of the opportunity to find ways to better protect the safety and welfare of our children, but it coalesces with other significant and relevant developments in the areas of information sharing and criminal liability for the ill treatment or neglect of children. I deal with these matters as part of my Inquiry and Report.

1.7 The catalyst for the Inquiry was a case of serious physical abuse. Unfortunately this is not the only form of serious risk to the safety and welfare of our children from which they should have protection. For instance, children living in homes where methamphetamine is being manufactured, or where homes are being used for drug dealing, are also subject to the likelihood of risk to their safety and well-being. The discussion in this Report, and the proposals arising from it, will also have equal application to those situations. In addition, there is the issue of neglect, whether that is a failure to provide food and clothing, or a failure to ensure that a child attends school at all appropriate times. These situations must also be seen as having relevance to the welfare and safety of New Zealand's children.

1.8 During the course of my Inquiry I have spoken with a wide range of New Zealanders in a number of different environments and situations. I have never before experienced the depth of sadness, anger and frustration about the deliberate harm inflicted on some of our children. One has to be careful not to overstate the situation in New Zealand. The great majority of our children are loved and cared for in their living situation no matter what that may be. The sad fact however is that cases such as the Aplin children, James Whakaruru, Nia Glassie and the Kahui twins, and the case giving rise to this Inquiry, keep on occurring all too often. Further, the very recent case of Karl Perigo-Check demonstrates in stark reality the influence that drug taking can have in perpetrating the abuse of a child.

1.9 This level of deliberate cruelty cannot be easily understood. In speaking with people such as doctors, nurses, police, teachers and social workers who have been involved in this case, their distress with the injuries and indignities inflicted on this child is palpable. However, people who have not been involved are also distressed, both for what happened

to this young girl and what it means to our society and its standards, and to our national self image. To rephrase a famous statement attributed to Winston Churchill: A country will be judged by the way it treats its children**.** The question for us is "Are we doing well enough?" Recent experiences would certainly not give us a pass mark.

1.10 Your direction to me to conduct this Inquiry, and prepare this Report, is intended to assist in minimising such cases in the future. In so far as is possible, we should ensure that the work of agencies, both government and non-government, and individuals, is co-operative and directed primarily at improving the position of children. In particular, their work should focus on children's safety and welfare, and in the development of law, policies and practices which state plainly that the interests of the child are paramount in decision making. This Report will argue that the interests of children will be improved by more determined and effective multi agency and inter-professional liaison and cooperation, together with clear arrangements for the sharing of information among professionals and others, all of which will take place under dedicated leadership. It is the robust and consistent implementation of the law, social work practice, policies and processes which will drive the objective of keeping our children safe. The Report provides a package of proposals involving legislation, policy, process and practice, as well as relating to supervision and management matters.

1.11 It is appropriate that I note the response and generosity of so many New Zealanders in offering help and other assistance for the young girl following this terrible event. To me this indicates that many New Zealanders are saying "enough is enough".

1.12 In 2003, a UK report authored by Lord Laming was presented to Parliament following the murder of a young girl, Victoria Climbie, who had been subjected to extreme cruelty by her carers. It so happens that that young girl was of a similar age to the girl who is the subject of this Inquiry.

1.13 I have found that report, from which the phrase "Every Child Matters" was coined, the reviews that followed, including one in 2009, and other Serious Case Reviews in the UK, to be of particular value. There are parallels upon which I have drawn and I have taken note of the system developments which have occurred in the UK as a consequence.

1.14 Lord Laming said in his 2003 report.

> "I recognise that those who take on the work of protecting children at risk of deliberate harm face a tough and challenging task. Staff doing this work needs a combination of professional skills and personal qualities, not the least of which are persistence and courage. Adults who deliberately exploit the vulnerability of children can behave in devious and menacing ways. They will often go to great lengths to hide their activities from those concerned for the well-being of the child. Staff often have to cope with the unpredictable behaviour of people in the parental role. A child can appear safe one minute and be injured the next. A peaceful scene can be transformed in seconds because of a sudden outburst of uncontrollable anger.
>
> Whenever a child is deliberately injured or killed, there is inevitably great concern in case some important tell-tail sign has been missed. Those who sit in judgment often do so with the great benefit of hindsight. So I readily acknowledge that staff who undertake the work of protecting children and supporting families on behalf of us all deserve both our understanding and our support. It is a job which carries risks, because in every judgment they make, those staff have to balance the rights of a parent with that of the protection of the child."

1.15 My own experience, and knowledge gained from this Inquiry and other related work I have undertaken, endorses these views. In fact the picture painted by Lord Laming in the first paragraph I have quoted reflects my thoughts following this Inquiry.

1.16 Lord Laming went on however to deliver critical commentary on the performance of a number of agencies involved in the Climbie case. The case which is the subject of this Inquiry also involved multiple agencies and individuals, at least 25. That indeed might be part of the problem. On the other hand, if the knowledge and information held or known to all those involved was shared and collectively utilised, then that could have been part of the solution. I note in particular that in the six months immediately preceding the events which occurred in mid November 2010 there were 13 agencies or individuals involved in some way in dealing with the young girl and her mother. It also needs to be noted that from November 2001, just months after the young girl was born, and up until November 2010, there were 12 different Child, Youth

and Family (CYF) social workers involved. This aspect will also receive particular attention in my Report.

1.17 The Court appointed Counsel for the Child, who acted for the young girl and her elder brother from 2002, said to me in a specially prepared memorandum:

> "It is acknowledged that the gravity of what happened to this child was beyond all professional expectation."

1.18 Undoubtedly that was so. But if there were law, processes, practices and stronger supervision and management discipline in place such as I propose in my Report, and if this law was utilised and the practices observed, then I believe the outcome for this young girl may well have been different.

1.19 In undertaking this review I have had available to me a very substantial volume of papers. Some of these were the product of the CYF Chief Social Worker's Review of Practice and those papers have provided me with comprehensive information relating to this particular case. Within the time available I have also researched material from within New Zealand and other jurisdictions. It is no consolation, but the existence of serious child abuse cases in other not dissimilar jurisdictions has been noted.

1.20 I have also conducted, again within the time available, interviews with people who were involved with the young girl and her welfare over a period of years and up to the time of her hospitalisation. Additionally, I have spoken with a significant number of people including the District and Family Court judiciary, coroners, chief executives and people from relevant government and other agencies including the Law Commission, the ACC and non-government organisations (NGOs), members of the medical and teaching professions and their organisations, and others who were able to contribute. This has enabled me to respond to both the specific Terms of Reference and to the wider issues, and to propose law changes and processes designed to enhance child safety and welfare in New Zealand.

1.21 Details of what emerged from those discussions will be found in the body of my Report but I must say I was overwhelmed by the cooperation and contributions I have received. There can be no doubt that these professionals, and others who are involved in any way with child safety and welfare and protection issues, and who are concerned about the well-being of our children, are wanting outcomes

to improve. They have all made significant contributions to the proposals and recommendations I am making. Without exception all expressed the clear view that the child must be the centre of the law, policy, processes and practices with the desired outcome of what is best for the child.

1.22 Inevitably in an Inquiry such as this there will be criticisms of failures to act and of system deficiencies. As I indicate in my responses to the specific Terms of Reference there were failures at several levels in a number of agencies and with some individuals. I have not however approached my task as being one of laying blame. Rather I have taken the approach of analysing what appears to have happened and looking at what can be learned from the experience of this case, and indeed from some that have gone before both in New Zealand and overseas. As has been noted by Connelly and Doolan in their book *Lives Cut Short: child death by maltreatment* (2007), the strong and often vitriolic criticism of the government agencies involved, in particular the statutory agency ie CYF, and the staff in that agency, may result in the emergence of more risk-averse practices by child welfare professionals, rather than improvements in practice.

1.23 As will be observed from the Background section to follow, the history of the girl not yet aged 10, and her life experiences, and the involvement of the mother with a multitude of agencies throughout her life, tells us that identifying and managing risk and working to secure a child's safety and welfare, involves a complicated labyrinth of relationships, assessments and critical decisions. Unfortunately, there is not and cannot be either legislation or systems that are going to ensure that decisions based on a human judgement will always be the right one.

1.24 This notwithstanding, we must ensure that the law, in particular the Children, Young Persons, and Their Families Act 1989, and other legal provisions that are directed to the protection of children, are tested and regularly reviewed to make certain that the law remains relevant, and is as effective as can be in protecting children and in focussing on their safety and welfare.

1.25 Of equal importance, we must ensure that all policies, systems and processes within government agencies are comprehensive and up-to-date, are understood by all the individuals who have any responsibility within those agencies, and that staff recruitment, induction and ongoing training is at a high and sustained level. Social work is demanding and while the attainment of an appropriate

qualification is a necessary first step, experience accompanied by further training and supervision is essential in the development of skills.

1.26 The management at the regional and local level must also be focussed on issues relative to child welfare and safety, and supervision and compliance arrangements must be rigorously observed. Liaison and cooperation between critical agencies and professions, ie CYF, police, health professionals, teachers, and others, is crucial and must be organised and focussed both at the national and, equally importantly, at the regional and local levels.

1.27 In addition, there must be close dialogue with and training opportunities given, to the plethora of organisations and individuals working outside government agencies, including general medical practitioners, who work with families seen to be at risk, or who may become involved in a number of situations where issues surrounding the safety and welfare of a child could occur. In 2002, the Ministry of Health published useful reference booklets, including a recommended referral process for General Practitioners and one entitled *Family Violence Intervention Guidelines for Child and Partner Abuse.* I commend a very recently issued CYF publication, *An Interagency Guide to Working Together to Keep Children and Young People Safe.* This is an excellent practical publication that could have much wider use within the general community over and above the government agencies and NGOs recognised in the booklet.

1.28 The other essential component in furthering our knowledge and experience and which contributes to law and policy reform, as well as to process and practice, is focussed operational evaluation and research. I am concerned at the lack of research and hard data relating to child welfare, protection and at what is described as "kin placement". This lack often means that policies, including law, are created in a vacuum of knowledge and are guided by ideology rather than by factual data. I comment further on the absence of useful research later in this Report.

1.29 Within the timescale for reporting under my Terms of Reference the criminal proceedings where the mother has been charged with a number of offences of causing serious physical injury to the girl have not concluded. At this time the mother is in custody. The mother's partner, the girl's father, is also the subject of criminal proceedings and he is in custody pending a court hearing. There are also extant criminal proceedings alleging sex offences involving the girl by a previous caregiver which are alleged to have

occurred before the girl was handed over to her mother's custody.[1]

1.30 I decided, and took advice, that it would not be appropriate for me to interview any of those still subject to criminal proceedings, nor those people who were in the house at the time of the call to the police and present when police visited the home and found the girl in a cupboard. It is a matter of conjecture whether those people would have been captured by the criminal law had the proposed amendments to the Crimes Act as discussed in paragraphs 9.1.1 to 9.1.5 below been in place.

1.31 I was also concerned to ensure that people who had been directly involved with the mother and the girl and may potentially be involved in the criminal court proceedings, whether as a witness or otherwise, were not involved in my Inquiry. I have taken care to ensure that the public interest in the integrity of the criminal proceedings against the three individuals currently before the Court is not compromised by my Inquiry.

[1] Note that these charges were subsequently dropped

2 Background

2.1 (M) was born in West Auckland on 2001. She was the second child of (Mother) and (Father) The [sibling], was born 2000. [Sibling's] involvement with Child, Youth and Family (CYF) parallels that of M.

2.2 [Mother] and [Father] had a further children. Their relationship, both before and after M's birth, included some violent disputes to which the police responded on a number of occasions. The records report that [Mother] and [Father] separated in January 2007. While [Father] has supposedly lived elsewhere since then, the relationship has continued - at least to some degree - and [Father] was arrested for assaulting [Mother] in her home in June 2010. He pleaded not guilty and a condition of bail was to stay away from [Mother's] home. However, he was present on 15 November 2010, the day on which the police were called in regard to the severe assault on M. He was arrested for breaching a condition of bail and has pleaded not guilty to the offences he is facing arising from the November event. The Police advised that the charge of assault against [Father] arising from the June incident was later subsequently withdrawn when [Mother] declined to give evidence.

2.3 From the records and from the interviews I have undertaken, it has not been possible to determine the extent or the degree of the relationship between [Mother] and [Father] since the separation in January 2007. I was advised that he was often at the home, and perhaps taking care of one or more of the children, when agencies visited wanting to speak to [Mother]. Nevertheless, from what I was told, it was evident that decisions about the children and comments about them to the agencies were [Mother's] prerogative.

2.4 As a teenager, [Mother], M's mother, had an extensive involvement with CYF. She first came to notice in 1994 because of violence inflicted on her within the family, and later she appeared in the Youth Court.

2.5 In November 2001, when M was less than four months old, [Mother] sought help from the Waitemata District Health

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Board's ante-natal clinic because of M's repeated crying. This is the first Agency to which M was referred. [Mother] acknowledged to the clinic that she slapped M as her crying made her angry. In view of [Mother's] own history of physical abuse, the clinic was concerned that the physical abuse of M could continue. After discussion with [Mother], the clinic sought assistance from CYF, the second Agency to which M was referred. A "Developmental History" prepared by Marinoto dated 5 November 2010 (Agency 17 – see below) recorded that [Mother] had told them (in 2010) that, at the time she sought help in late 2001, [Father] was unemployed, drinking and "smoking weed".

2.6 The referral to CYF in 2001 by the ante-natal clinic was treated as a new referral by CYF. Following a Family/Whānau agreement in December 2001, CYF arranged counselling for [Mother] with the Anger Change Trust - the third Agency - and for M to be cared for by [a caregiver],

2.7 [Mother] saw the Anger Change Trust Counsellor on 16 occasions. It was also arranged for [Mother's] parenting skills to be assessed by Plunket (the fourth Agency) and Family Start (the fifth). Family Start was run in the area through Waipereira Pasifika, later known as the Waipereira Trust. A Plunket Nurse who visited the family in January 2002 described [Mother's] parenting skills as "almost nil" and she expressed concern about [Mother's] behaviour when angry with M.

2.8 On the basis that [Mother] had minimal parenting skills, had had a chaotic early life, had admitted that she could not cope with M and that she had threatened to take her children and run away, a Place of Safety warrant (s.39 Children, Young Persons and Their Families Act 1989 (CYP&F Act)) was sought, unsuccessfully, by CYF from the Waitakere Family Court (the sixth Agency). [Mother] advised Marinoto (Agency 17 - see below - as recorded in the 5 November 2010 report) that at the time she had taken M with her to South Auckland to avoid CYF but the Police had caught up with her and as the "alternative was seven years in jail", she handed M back. M was then placed with a non whānau caregiver (– the seventh Agency).

2.9 [Sibling] was uplifted by [Mother] and [Father] at the same time and for a while his whereabouts were unknown. I was advised by Counsel for the Children (Agency 8 – see below) that a missing person's report was filed with the

police by CYF and contact was made when [Mother's] benefit was cancelled.

2.10 On April 2002, an interim custody order (s.78) was granted from the Waitakere Family Court for both M and her older [sibling]. Pursuant to those orders, M remained with [caregiver] and [sibling] was placed with [caregiver]. In June 2002 barrister was appointed Counsel for the Children for both M and [sibling] (the eighth Agency). She continues in that role. The custody order was made permanent in March 2003.

2.11 A [meeting] was held on April 2002 to consider the placements for both M and [sibling] but there was no agreement by the family that the children were in need of care and control. In her written report confirming the information provided at the meeting, [a] Plunket Nurse wrote in regard to M:

> "[Mother] made us aware that she has a lot of issues from her past to deal with and a lot of anger towards her baby M. I believe M is at risk from her mother. I believe [Mother] will need extensive counselling and support before she has the competence to deal appropriately for these children and any other children she may have."

2.12 M remained with [caregiver] for nearly four years – from March 2002 until December 2005. The records speak positively about the quality of [caregiver's] care. There was some thought given to making M's placement with [caregiver] permanent with [caregiver's] concurrence even though she described M as "the most strong willed child I've had". The papers also record, first, that [Mother] at various times indicated that she wanted M back in the future, and secondly, that there was debate among some of the professionals whether a placement for M with whānau, rather than with [caregiver], would be preferable for cultural and identity purposes.

2.13 Counsel for the Children opposed the plan for placement with whānau in submissions to the Waitakere Family Court in November 2004, while CYF wanted M placed with whānau according to the principles in s.13 of CYP&F Act. When M was seen at the Marinoto Clinic in September 2010, her Counsellor (– see below Agency 11) recalled that [caregiver] had moved to Australia at the time and had wanted to take M with her but [Mother] had not wanted her to go.

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2.14 In the papers for the review by the Court held on December 2002, the social worker stated that [Mother] was made aware that if she wanted the children back in her care, she would need to complete a residential parenting course. However, the papers also report that, in October 2003, the Merivale programme for parenting did not accept [Mother] because of her lack of interest and motivation to attend.

2.15 In mid 2005, [Mother] and [Father] put forward the names of two whānau members as permanent caregivers for M. They were CYF records, dated July 2005, stated that were "Nationally Approved Department Caregivers". [The whānau caregivers] had been assessed as caregivers in Hastings in September 2004 when they and [whānau caregiver's] parents, who shared the same home, applied as a foursome to care for [whānau caregiver's] cousin. The applicants were described as pleasant, cooperative and open, and it was recommended that they be approved as caregivers.

2.16 After their names had been put forward by [Mother], a CYF social worker noted that she had met [whānau caregivers] in Auckland and that they had a strong commitment to having M in their permanent care, and the transition for M from [caregiver] was spread over some months and completed in December 2005.

2.17 M remained with [whānau caregivers] for three years - December 2005 to December 2008. Access for [Mother] and [Father] was arranged during this time and this occurred under the supervision of IOSIS Family Solutions (the ninth Agency) in Manurewa. The records indicate that access initially was sporadic and the relationship between the caregivers and [Mother] was volatile at times. In the Developmental History for Marinoto dated 5 November 2010 (see below - Agency 17), [Mother] said that she had not been allowed access by [whānau caregivers] unless she "brought bread, milk, food or weed".

2.18 By early 2007, [Mother] had separated from [Father], she had signed a tenancy agreement for a home in Massey, and she was receiving support from a Family Start worker ( ) at the Waipereira Trust. Family Start had been involved on an ongoing basis from about March 2003 following the

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birth of [Mother] and [Father's] third child. The records also disclosed that from early 2007 the CYF social worker at that time (SW1) was working to return M to her mother's care. In March 2007, the Court appointed Counsel for M pointed out to CYF (SW1) that she had not been consulted about the proposal to return M to her mother's care and that it was contrary to previous plans when a permanent placement with [whānau caregivers] was the target.

2.19 On ☐ July 2007, [Mother] applied to the Waitakere Family Court for the custody order in favour of CYF to be discharged. The Court's decision, dated ☐ September, recorded that counsel for all the parties had agreed to ask the Court to seek an update of the psychologist's report (the tenth Agency) under s.178 of CYP&F Act on the matters outlined by Counsel for the Child. This report is dated ☐ March 2008. Earlier reports from the Court Appointed Psychologist to the Family Court are dated ☐ May 2003, ☐ October 2003 and ☐ August 2004.

2.20 Noting in the ☐ March 2008 report that M was confident and strong willed and that it would be especially difficult for [Mother] as a single parent to cope with her emotional needs, the psychologist on this occasion suggested:

> "If the children are placed back with their mother, this should be done in a stage by stage approach. Since M is settled in her placement unlike [sibling], [sibling] be placed back first … . Only once [sibling] is successfully transitioned should M's transition be commenced."

2.21 CYF filed a Review of Plan Report dated ☐ May 2008. It recorded that the object in the April 2007 plan for [whānau caregiver] to apply for custody of M had not been achieved and that [whānau caregiver] now did not intend to do so as she felt it would be disloyal to her [sibling]. The Review also recorded that the psychologist's report had been discussed at a meeting between SW1, [whānau caregivers] and Counsel for the Child. CYF noted that M said she wanted to live with her mother, and implicitly supported that proposal.

2.22 CYF records contain an account of an access meeting from the IOSIS access supervisor dated ☐ May 2008, the following week after the Review had been filed, in which M seemed withdrawn and told her mother, first, that ☐ ☐ ([whānau caregiver]) had said that [Mother] smoked P and dope, and secondly, that [Mother] had to fight for her as [caregiver] was planning to take her to Australia. [Mother's] lawyers also wrote to CYF expressing her

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concern about that encounter. In a later letter the lawyers noted that CYF did not respond to this letter.

2.23 Counsel for the Child wrote to CYF (June 2008) about the Review dated May expressing concern that it did not include a proposal for counselling for [whānau caregiver] and M, and pointing out that these were matters which had been discussed with SW1 at their meeting. It was argued that counselling would assist [whānau caregiver] to provide guidance in dealing with M and in managing her challenging behaviour, and counselling for M would help to explain the placement decision. She also wrote that there was a need for ongoing monitoring by the social worker.

2.24 The CYF record of the Court Hearing held on August 2008 in Waitakere stated that Counsel for the Child had been successful in her application for a Judge-led Mediation Conference and had submitted that M should stay with her caregivers and that there should be more supports put in place. In its submission, CYF said SW1 considered that M could return to her mother's care if [sibling's] placement was successful. The Judge directed CYF to clarify its position prior to the mediation conference.

2.25 M's case was dealt with October 2008. In its report, CYF noted that although the Plan approved in April was based on M continuing her placement with [whānau caregivers], [Whānau caregiver] had advised a Whānau Hui on October of his and [whānau caregiver's] plans to move to Australia to join his family, that he could not take M with him, and that he wanted to make sure that M was back in her mother's care by Christmas 2008. M and her siblings, [Mother], [Father], SW1 [whānau caregiver], and (the support person with the Waipereira Pasifika Family Start) attended the Hui at CYF's Manurewa offices. There is no record suggesting that Counsel for the Child was invited to the Hui.

2.26 October 2008, CYF advised that the placement of M with her mother on an overnight basis began shortly after the Hui. [Mother] stating that she had had M in her care every weekend since the Hui four weeks previously and that "has been working well" and that she was seeking permanent placement of [sibling] and M; a letter from Waipereira Pasifika Family Start outlining the services that it offered; and a memorandum from Counsel for the Child. Without expressing a view, Counsel for the Child said that

the options for M were to stay with her caregivers or be transitioned back to [Mother], and that there was a need for supports to be put in place for either scenario.

2.27 The CYF records of the hearing noted that the Judge directed that the current orders regarding custody were to continue, that a review was take place within six months and that the psychologist's report be released to [whānau caregivers]. By way of comment in regard to M, CYF recorded that the judge noted that [Mother] had a lot going on in her life and although the current caregivers had made it clear that they were moving to Australia, it was important that adults did not build up expectations that M would return to her mother. In view of this comment, I consider that the judge did not accept that it was inevitable that M would be returned to [Mother], and Counsel for the Child recalled that she understood that CYF were looking for other whānau members with whom she could be placed.

2.28 After a number of weekend visits, M spent Christmas with her mother, who had just given birth to her fifth child, and with her brothers and sisters. She did not return to her previous caregivers in January when they could not be located at the time. When [whānau caregiver] made contact later, CYF reported, he advised that they were ready to move to Brisbane and he was pleased that M was doing well with her mother. CYF records note that Counsel for the Child, when advised on [early] February 2009 that M was in the care of [Mother], had expressed concerns but would agree with whatever the Court decided.

2.29 On [mid] February 2009, SW1 based in Manurewa applied to transfer M's case to Waitakere in which she wrote; "Plans were made for M to spend six weeks with her mother for the school holidays and now [whānau caregiver] has said their plans have moved forward and they will be moving to Brisbane as soon as they can, they are unable to take M back in their care." The social worker said the case work goal was to support [Mother] to care for M. The transfer was declined as the family was residing in the Whenuapai area rather than in Waitakere. In a later case note dated ☐ February, the social worker observed that [whānau caregivers'] plans to leave for Australia were taking place much faster than expected and, consequently, M was in [Mother's] care " a lot sooner than expected".

2.30 At a review meeting at the Waipereira Trust on ☐ April 2009 attended by [Mother] but at which Counsel for the Child was not present, the Trust worker (☐), reported that she had arranged counselling for M and that M had shown

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both good and bad behaviours at home. The meeting was also told that M's attendance at school was "very good".

2.31 The counselling proposal was contained in the Review Plan (s.128) put before the Family Court on [ ] May 2009. Counsel for the Child noted that she found out that M had been placed with [Mother] on a permanent basis shortly before she received notice of the plan review. The review proposed that the s.101 Custody Order in favour of CYF continue, and the plan be reviewed again in six months. The goal for the implementation of the Care and Protection Order was permanency of M with [Mother]. The Review was approved by the Court on [ ] July.

2.32 At about the same time, on [ ] April 2009, a review of plan hearing was heard in the Waitakere Family Court in regard to [sibling] at which Counsel for [Mother] and CYF argued, contrary to Counsel for the Child's submission, that the s.101 Custody Order in regard to [sibling] should be discharged. Counsel for the Child told me with some amazement that CYF had argued vigorously that, despite the facts that M had recently returned home and that a new baby had been born in December 2008, it was not a matter where a total family solution needed to be considered. The Judge accepted Counsel for the Child's submission and declined to discharge the custody order.

2.33 Counselling with [Counsellor] of [ ] [ ] (the eleventh Agency) began in June 2009 and, at the second session, M disclosed sexual abuse while with her previous caregivers - [whānau caregivers]. CYF (SW1) was advised but did not follow up on that letter until further letters in August and September from the Court Appointed Psychologist and Counsel for the Child respectively containing the same information. An evidential interview was carried out in December 2009 at the Puawatahi – an agency of the Auckland Central Police attached to the Auckland District Health Board (Agency 12) - and, later, [whānau caregiver] was arrested for sexual abuse. He has been charged with unlawful sexual connection - 2 charges - and indecent assault on a child under 12 - 2 charges. He has pleaded not guilty and the trial is to be held in Manukau District Court on 12 September 2011.[2]

2.34 In February 2010, M was treated at [ ] Hospital (the thirteenth Agency) for a laceration to her left hand, said by her mother to be the result of a fall.

[2] Note that these charges were subsequently dropped.

2.35 report is dated March 2010 and based on interviews and observations with the family and interviews with a number of professionals. It repeats earlier concerns about [Mother's] parenting abilities and understands that problems about M's physical aggressiveness since her return home had been largely resolved. . It recommended ongoing monitoring of M's progress, continued counselling – preferably with [counsellor], parental education for [Mother], and counselling for [Father].

2.36 Counsel for M and [sibling] wrote to CYF and [Mother's] counsel on 6 April 2010 with some proposals to put before the Judicial Conference, then scheduled for 5 May. She proposed that the children stay with [Mother] and that a s.101 custody order be made in her favour. She also proposed that CYF provide counselling for M and her parents with the present Counsellor, and that CYF provide the following support, assistance and monitoring:

a) Monitoring in the form of obtaining verbal and written updates from the school, doctor, and Counsellor on a 4 monthly basis and to visit the home;
b) Parenting education for [Mother] to be undertaken by [counsellor] as suggested in report
c) The Service fund [sibling] and M attending a school holiday programme during the school term holiday;
d) The Service to fund a sport or activity for both children until the next review period.

2.37 Counsel pointed out that the final two items were in a plan dated July 2008 and had never been implemented. She expected an informal review of the plan after three months.

2.38 At the end of April 2010 M had a swollen cheek and swollen hand, and a friend of [Mother] told the Police, when interviewed in November 2010, that [Mother] had said those injuries had happened when she "lost it"

2.39 On 5 May, the Court adjourned the scheduled Judicial Conference until 19 May and it was recorded that the

review documents would be dealt with on the papers provided a new plan was filed and approved by Counsel for the Children and Counsel for [Mother].

2.40 The review put before the Court by SW2 for the 19 May hearing noted CYF's earlier inadequate response to the sexual abuse allegation. The review reported that M was showing some "very challenging behaviour" at home which had increased now that the Police were investigating the allegations of sexual abuse against her last caregiver. Nonetheless, the social worker thought that the necessary actions were being taken. This included weekly counselling sessions with [counsellor]. It also noted that currently [Mother] was expressing concerns about some of M's behaviours, and that M had weekly counselling sessions with [counsellor], financed by Work and Income. The goal to discharge the s.101 Custody Order and to replace it with a s.91 Support Order was accepted by the Court. The assistance advanced by CYF, which the Court approved, was to include monitoring and support at home and, in addition, to seek written updates from the school, general practitioner, and the Counsellor. Further, CYF was to arrange an informal review of the plan in three months time and formal review after six.

2.41 The CYF's senior solicitor's record of the hearing, which was attended by Counsel for the Children, counsel for [Mother], and SW2 noted that the s.128 Plan for each child had been approved, that the s.91 Support Order was put in place for M, a Review was to take place in six months, and the Plan had been amended to include CYF funding of counselling for M in regard to her challenging behaviour.

2.42 The Waitakere Family Court advised the parties in July that the informal review would take place on 19 August. On that date, Counsel for the Child advised the Court that she had written to CYF regarding the informal review, but had not received a response and she asked the Court to adjourn the matter for three weeks to enable the social worker to conduct that review. In view of the events in early September, that review did not take place.

2.43 At the same time as the May Review Plan proceedings were underway [Mother], on 5 May 2010, wrote to the Prime Minister expressing concern that M had been abused while in CYF custody and in care arranged by CYF. In her response dated 17 June, the Minister of Social Development and Employment outlined the assistance CYF had

undertaken to supply as part of the Care and Protection Plan approved by the Family Court on 19 May 2010.

2.44 On 23 May 2010, a public health nurse (Agency 14) visited the home after receiving a referral from the School (Agency 15) through Home Care for Kids Service (Agency 16). M had spent 2009 at School and began at in 2010. Because of her concerns after talking to [Mother], the nurse contacted CYF seeking support for the family. CYF did not respond to the nurse and, in June, the school made a referral directly to Marinoto Child and Family Services, the Child Health Unit at the Waitemata DHB (Agency 17).

2.45 Later in June, on the 26th, [Mother] called the police after a confrontation at her home with the children's father, He was arrested and claimed that he was protecting the children from [Mother]. The police saw no evidence of violence other than a mark on M's nose. Nevertheless, the police in their report (POL400) of the incident to CYF expressed concern about the state of the home, the adequacy of the children's care and their school attendance. As noted in para 2.2, the police advised that the charge against [Father] was withdrawn later when [Mother] refused to give evidence.

2.46 On 7 July 2010, Marinoto advised both the school and CYF that it had declined the school's referral. CYF (SW2) spoke by phone about this decision to [Mother] who said that M's behaviour was getting worse and, now, she did let M out of her sight. However, she added, she and the Counsellor were dealing with it. CYF arranged for M to be seen by Auckland Specialist Services (Agency 18).

2.47 After seeing M and [Mother] on 9 August 2010, Specialist Services Psychologist recorded that M's behaviour, such as putting dish washing liquid into the baby's bottle, posed risks to her family and herself. It observed that this behaviour appeared to be increasing, and that the building of a relationship between M and [Mother] was impeded by their respective histories. It was recommended that M receive therapeutic intervention, in liaison with the counselling she was currently receiving from [counsellor], and Specialist Services said, arrangements for this were underway.

2.48 On 30 August 2010, it is recorded, M set fire to a mattress in the garage On 1

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September, CYF social workers, apparently advised by School, visited [Mother] at her home and spoke to M alone who admitted lighting the fire.

2.49 On 2 September, the school advised CYF that M had a swollen face and she said that she had had a fork stuck in her cheek. An emergency meeting was arranged for the afternoon of 2 September at Marinoto (agency 17 – see above)' and another on the 3rd. At the meeting of the professionals involved on the 3rd, it was recorded that Marinoto was advised by [counsellor] (Agency 11), who was at the meeting, Marinoto wrote: "It is concluded that M is not suffering from Psychosis or Disassociation. Her behaviours are directly related to the extreme trauma that she has suffered at the hands of her previous CYF – Whānau caregivers". Oversight of M at home was arranged through trackers provided by Senate Nursing (Agency 19).

2.50 On 8 September 2010, M was seen by a public health nurse at school on a routine visit as her teacher was worried about an infected foot. She was admitted to Waitakere Hospital - Rangatira Ward (Agency 20) for an infected blister which was not considered suspicious. She was transferred to Starship, the children's ward at Auckland Hospital (Agency 21) on the 13th for suspected cellulitis, operated on and, on the 15th, discharged.

2.51 Home Care For Kids (Agency 22) is a Waitemata DHB service for children who are discharged from hospital following an infection related health issue. On 17 September 2010 a nurse visited M at home and there was a follow-up phone call with [Mother]. The CYF Practice Review noted that no issues were identified and M was discharged from the service.

2.52 The next steps to be undertaken by Marinoto in regard to M's therapy were discussed at a meeting of professionals at Marinoto on 28 September 2010. Representatives from CYF and Specialist Services attended. It was agreed that Marinoto would provide diagnostic clarity and complete an assessment report. It was also agreed that Marinoto would work with Counsellor and that [counsellor] would work with M in Marinoto's playroom while a Marinoto psychiatrist and psychologist observed. That took place on 29 September. The Marinoto staff were joined by M, [Mother] and [counsellor]. The record noted: "We were concerned that [Mother] provided information in front of M

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as though she was not there to hear it. M was very alert to all that was going on".

2.53 Also on the 29th, M, in the company of [Mother], was medically examined by [doctor] for alleged sexual abuse while in the care of [whānau caregivers]. The examination included a registered paediatician at Te Puaruruhau (attached to Auckland Hospital – Agency 22), concluded: "The lack of any diagnostic findings neither confirms nor refutes the allegations.

2.54 On the following day, the 30th, [Mother] took M to her local doctor (Agency 23) as she said she was concerned She did not see her regular doctor and advised the doctor she saw of the previous day's examination. The doctor was reluctant to carry out a further examination but did so as he felt some "coercion" from [Mother].

2.55 On 14 and 21 October 2010, [counsellor] conducted counselling sessions with M at Marinoto which were observed by Marinoto staff through a one way mirror. A professionals' meeting on the 27th reviewed progress and it was recorded: "M seems to be no longer in crisis and appears to have settled at home. Her destructive behaviours have stopped. Theories for this were varied – she is feeling safe, feeling listened to, father is off the scene, cultural input". The next meeting was set for 24 November.

2.56 At that time SW3 had taken over from SW2. On 2 November 2010, SW3 met M and [Mother] at the Counsellor's rooms and she also talked to the staff at Marinoto. [Mother] went by herself to the counselling session the following week – the 9th. SW3 again attended and [Mother] complained about bullying of M at school which the social worker said she would take up. The papers do not disclose why M was not brought to the session.

2.57 Further on the 9th, after SW3 had left, [Mother] told the Counsellor that M alleged that [Father] had assaulted her. The Counsellor asked [Mother] to bring M in to talk about the allegation directly. [Mother] did not bring M in for that appointment.

2.58 Marinoto had planned a school observation for the 9th but when Marinoto was advised that M was absent with a stomach complaint, the observation was deferred until the

11th. The visit did not place on the 11th as the school passed on the message from [Mother] that M was at a tangi in Wellington. It was ascertained subsequently that the tangi excuse was false.

2.59 Also on the 9th November, [Mother's] home was inspected by Housing NZ (Agency 24) and, as all the children were home, the inspector notified ISAP - the Improving School Attendance Programme (Agency 25).

2.60 Between 10 – 15 November 2010, [Mother] inflicted severe violence on M as, [Mother] told the police, she had become angry at the way M was behaving and because of the allegations against her father. This included the use of hands, fists, broom handle and table leg The police were called by [Mother's] mother on the 15th and M was found in a cupboard. In large letters, [Mother] had written the following words on M's body:

2.61 In a lengthy interview with the Police on Monday 15 November 2010, [Mother] recounted some of M's behaviours she had displayed and said that she and M had been fighting since the previous Wednesday (the 10th). During that time, [Mother] said in her statement to the Police, among other things, she had picked M up and thrown her to the floor, had torn off a partially detached toe nail and put salt and hot water on the wound, and had thrown a hammer at her foot – but not, she emphasised because it was potentially fatal, at M's head. She was arrested for assault on a child.

2.62 On 16 November 2010, CYF filed a without notice application for custody of the five children.

2.63 On 18 November 2010, Interim Custody Orders (s.78) were made by the Waitakere Family Court, and was appointed as Counsel for the five Children.

2.64 on 9 December 2010 to discuss the care and protection needs of [Mother's] five children. It was attended by 17 family members (including [Mother]) and the seven professionals comprised a paediatrician, two police officers, three social workers and Counsel for the Children. It was agreed that the children were in need of care and protection and that Custody Orders should be made (under s.101) in favour of the Chief Executive of CYF. Meanwhile the children were to remain in the care of an approved caregiver. The record later noted

that M's father, [Father], advised that he had not attended in view of a Protection Order he understood that [Mother] had taken out against him.

2.65 On the 9 December 2010 the Waitakere Family Court, pursuant to the Family Group Conference decision, ruled that the children were in need of care and protection. It was also noted that [Mother], while agreeable to that declaration, was opposed to the s.101 Custody Order.

2.66 On 15 December 2010 CYF arranged for M to continue counselling with her previous Counsellor and a plan was made to transition M over a period of three months to Specialist Services for ongoing therapeutic care.

2.67 By way of summary of these events in M's life, it is apparent from the voluminous records that M's mother, frequently overshadowed her daughter. While it is perfectly understandable for a mother to support and guide a young child, and that is how [Mother's] actions were often perceived by those with whom she dealt, [Mother's] actions not infrequently amounted to more than benign maternal interest and guidance. Rather, in the pursuit of her own interests, [Mother] exercised, or tried to exercise, a high degree of control over M's behaviours and her interactions with others. It is also apparent that [Mother] has learnt from her experiences with agencies over many years, first, to ensure that the she received the attention that she believed she deserved, sometimes at the expense of her daughter, and secondly, to ensure that her concerns were treated with the degree of seriousness that she considered that they justified.

2.68 The following comment on this issue was included in CYF's Practice Review dated 17 January 2011:

> "Although [Mother] did not admit to maltreating M or the other children she impressed a number of professionals as being concerned about M, asking for assistance, contacting the Prime Minister with her concerns, and being open to new referrals and supports. It is now apparent that [Mother] was very skilled at presenting as a concerned parent, while actively concealing what appears to be ongoing maltreatment of M and her siblings. In addition, extended family members and friends appear to have been aware that M was at serious risk from her mother, but they did not pass this information on to CYF or any other professional."

2.69 The Practice Review expressed the opinion that the professionals on this occasion, because in part owing to [Mother's] manipulative skills, did not anticipate that [Mother] was a risk to M.

2.70 I observe that this comment is neither an excuse nor a harsh criticism of the CYF social workers who were working with [Mother] and her children. [Mother's] attitude towards CYF was essentially hostile as she seems to have worked on the assumption that CYF "had taken" both M and [sibling] and, despite her efforts and those from one or more of the "understanding" professionals, CYF had resisted for some time allowing her to regain full custody and oversight of them. [Mother's] approach to Counsel for the Child was similar as she was seen as an impediment to what [Mother] regarded as her legitimate wishes as a concerned and caring mother.

2.71 Antagonism towards CYF is not an excuse or a criticism of social workers as they are working in a statutory environment where there are legislative criteria and policy and procedures to be followed. It is acknowledged, however, that hostility may impede some aspects of their work. Nevertheless, that is not unusual and, in my opinion, it is an environment where it is even more important for CYF social workers to receive competent supervision and to remember that the best interests of the child are always paramount.

3 The Agencies

3.1 Terms of Reference 2.1 and 2.2 require me to investigate:

> 2.1 whether the multiple agencies and individuals involved in the family to the lead-up to her abuse took all appropriate actions to ensure her safety.
>
> 2.2 whether those individuals and agencies were sufficiently child-centred in their actions and approach in this case.

3.2 A total of 25 agencies - including one individual (caregiver [ ] - have been identified. These agencies were, in some way, involved in M's life from the age of four months until the events which gave rise to this Inquiry. Those events took place when M was aged a little over 9 years. I acknowledge that there may well be other agencies with whom M has been in contact during her first nine years (for example the Salvation Army supervised a centre in West Auckland where [Mother] had access to M as a young child). However, the roles of these other agencies appear to be only on a passing basis and I have not explored them further. Some of the agencies identified are part of the same overall structure. For example, there are separate entries for different parts of the Waitemata District Health Board where each part treated M on distinct occasions. These include: Waitakere Hospital (Rangatira Ward), the DHB ante-natal clinic, and Marinoto Child and Family Services which is the Child Health Clinic at the DHB.

3.3 While it is not unusual for all children to have contact with a small number of agencies as they grow up, for example, Plunket, a pre-school care provider, a school (or two), a doctor (or two), and perhaps a hospital or some other specialised service, the number identified on this occasion is definitely unusual.

3.4 Caregivers have been dealt with in the following way. The one caregiver ([caregiver]) who was identified by CYF is treated as an agency because she was independent of the family. On the other hand, the whānau caregivers who were nominated by the family have not been treated as an Agency. Taking into account the point that a caregiver nominated by the family must be assessed by CYF before a placement takes place, it is acknowledged that this is a somewhat arbitrary distinction. Nevertheless, because their involvement is through their family connection to M, not as

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an agency of the state or as an independent non-government organisation (NGO), these caregivers have not been identified as a distinct agency.

3.5 Apart from two agencies (Family Start and Housing NZ are the exceptions) M was the focus of the concern expressed or the assistance sought in each instance and I shall comment when necessary to the extent that M remained the focus in practice because, as noted above, [Mother] had learnt to manipulate agencies to what she saw as her advantage.

3.6 Some of the agencies identified have touched M but she has moved on. I have not investigated further the role of the following 12 agencies:

Waitemata DHB – ante natal clinic
Anger Change Trust
Plunket
the independent caregiver – March 2002 - December 2005
IOSIS Family Solutions
Middlemore Hospital
Public Health Nurse
Home Care for Kids
Improving School Attendance Programme
Waitakere Hospital – Rangatira Ward
Starship Hospital
Te Puaruruhau

3.7 I have considered further the actions of the 13 agencies listed below, all of which were involved with M in 2010 and, with the exception of the Court Appointed Psychologist, were in contact with her at some stage in the six months leading up the severe beatings in mid November 2010.

CYF
Waipereira Trust (Family Start)
Waitakere Family Court
Counsel for the Child
Court Appointed Psychologist
[Counsellor]
Marinoto Child and Family Services
School
- General Practitioner
Auckland Specialist Services - CYF
Police
Senate Nursing
Housing NZ

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3.8 Any discussion about the role of each these agencies cannot be dealt with in isolation from one or more of the other agencies. Indeed, sadly, one of the recurrent themes in reports about incidents of violence to children in New Zealand and the UK is the lamentable inadequacy of the liaison between the agencies involved. It is an issue recognised in Terms of Reference 2.3 and 2.4 which require me to investigate:

> 2.3 whether all these individuals and agencies collaborated effectively.
>
> 2.4 whether the individuals and agencies involved in the case shared information effectively, and if not, whether the individuals had a clear understanding of the law around information sharing.

3.9 I shall also address these issues to the extent that they are relevant in my comments about each of the agencies.

3.10 CYF

3.10.1 M was first referred to CYF in November 2001. In March 2002, CYF took interim custody of M and, on 23 February 2003, was granted full custody under s.101 of the Children, Young Persons, and Their Families Act 1989 (CYP&F Act). At CYF's request, the Custody Order was replaced by a Support Order (s.91) in May 2010. Since November 2001, M's case has been the responsibility of 11 different social workers.

3.10.2 Pursuant to a Custody Order under which the Chief Executive takes custody, the Chief Executive has the role of providing day-to-day care for the child as if he were the child's parent (s.104). Under a Support Order, the Chief Executive shall monitor the standard of care, protection and control provided to the child and shall provide such services and resources to ensure the provision of appropriate care, protection and control (s.93). CYF made it clear to me that it sees its responsibility for ensuring the care and protection of a child as being the same whether the child is the subject of a Custody Order or a Support Order.

3.10.3 There are seven aspects of CYF's involvement on which I intend to comment. The first is the ongoing search for suitable whānau caregivers; the second is CYF's unsatisfactory response in 2009 to the report from the Counsellor of sexual abuse of M by the previous care

givers; the third is the discharge of the Custody Order in 2010; the fourth is CYF's response to its obligations in the Support Order put in place in May 2010; the fifth is an accumulation of concerns two to five and questions the standard of social work between late 2008 and mid 2010; the sixth is the inadequacies in the collaboration by CYF with other agencies; and the seventh, which follows on from the sixth, relates to the sharing of information with other agencies. These last two points are explored further in my discussion under Terms of Reference points 2.3 and 2.4 (below).

3.10.4 The CYP&F Act provides explicitly that the administration of the Act shall be guided by "the principle that, wherever possible, the relationship between a child or young person and his or her family, Whānau, hapu, iwi, and family group should be maintained and strengthened" (s.5(b)). It is a provision which responds to concerns in the past that child welfare practice reflected Pakeha values unduly and, indeed, middle class Pakeha values. I would be most reluctant to suggest its repeal. Nevertheless, as with many aspects of social policy, the pendulum, when justifiably swung away from one unsatisfactory entrenched code of practice, on occasions swings too far in the other. Whānau caregivers may now not be subject to the same degree of investigation and later supervision as applies to non-whānau caregivers.

3.10.5 I have commented on this in detail in my recommendations below.

3.10.6 I make this observation in view of M's specific circumstances. The most settled period of her life was the nearly four years she spent with a non-whānau caregiver – from the age of seven months until nearly four and a half. For the next nearly five years, first while with whānau caregivers and then with her mother, M's life ranged from unsettled to drastically unsettled and, finally, she was physically abused. As reported in the background above, this issue had arisen when M was with the non-whānau caregiver when there was discussion between CYF and Counsel for the Child about the applicability and the boundaries of the statutory direction.

3.10.7 I also note that in a recent undated CYF publication, *why you should care: a plan for children in care*, it is recorded that approximately 3,300 of the children and young persons in care live with extended family/whānau or with foster parents. It continues:

Around 1,100 Māori children are living with extended family/whānau, and around 630 are in non-kin care with foster families

Around 670 non-Māori children are with extended family/Whānau, and around 870 are living with non-kin foster families.

3.10.8 The second observation relates to the unsatisfactory way that CYF responded when notified by the Counsellor that M had been sexually abused while in the care of [whānau caregivers]. Because of their concern at the lack of response by CYF, the Court Appointed Psychologist and Counsel for the Child also wrote to CYF. The Practice Review prepared by CYF's Chief Social Worker dated 17 January 2011 regarding these events wrote: "The delay is believed to have been due to administrative changes in the site and performance issues surrounding the social worker at the time." This is both unacceptable and unsatisfactory. In view of the delay, the evidential interview in this matter did not take place until December 2009, and the medical examination until September 2010.

3.10.9 The third observation relates to the recommendation to the Family Court for the discharge of the Custody Order and its replacement by a Support Order on 19 May 2010. On the whole, I have found the CYF records comprehensive and thorough. However, I found a paucity of information on this point, and it was a step taken when, although there was some progress with M, her home and her behaviour were far from a stable. For example, as the CYF Practice Review noted, on 14 May, less than a week before the discharge of the s.101 order, [Mother] had advised CYF that she had seen M put cleaning products into the family's food. There was a failure by the CYF and its social worker to recognise the duty that s.93 of the Act imposes on the Chief Executive. The law is quite clear. In this case the Chief Executive was legally required to monitor the standard of care, protection and control being provided to, or exercised over, M.

3.10.10 My fourth observation arises from the Support Order dated 19 May 2010 which replaced the Custody Order. The Order, at the request of Counsel for the Child, included a provision that written reports were to be obtained from the school, the doctor and the Counsellor. These reports were required both in anticipation of an informal review in mid August and as a means of monitoring to assist with the compliance of the care and protection aspect of the Support

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Order. There is no evidence that any of these reports were sought.

3.10.11 I detected while carrying out this Inquiry a feeling of distrust between CYF and many within the medical profession. It seems that this is partly based on CYF's ability (under s.66 of the CYP&F Act) to require doctors to provide information but, the medical profession said, it seldom received any response or heard to what use the information had been put. On the other hand, this criticism did not apply when the medical profession knew the social worker with whom they were dealing.

3.10.12 I shall comment later on the value apparent from the placement of experienced social workers in DHBs. At this point, I observe that the process of seeking reports would probably build up relationships between specific doctors and social workers which will most likely be of great value to the person with whom each was dealing. This is one reason for the sharing of information. Furthermore in this case with regard to the seemingly overlooked court order, there is no evidence that CYF were ready for the review in mid August.

3.10.13 Moreover, seeking such reports could well have avoided the later disagreement about the extent in this case of the interaction in 2010 between M's primary school and CYF as there was a gap in the records as to the information exchanged between CYF and the school. The Practice Review dealt in some detail with CYF's responsiveness to the School as M's school teacher raised her concerns with the media in December 2010, and I shall return to this point when addressing the role of School as another agency in M's life.

3.10.14 All I intend to say at this stage with regard to CYF's relationship with School is that I accept that there were issues about CYF's responsiveness to some issues raised by the school staff. I note that this issue reflects some of the concerns I heard while preparing this Report. In summary, there is a definite need for a considerable improvement in the relationship between CYF and individual schools. I shall address this broader matter further both in my comments about School and in my recommendations.

3.10.15 The fifth point refers to the standard of social work between late 2008 and mid 2010 when the three matters addressed in points 2, 3, and 4 arose. In addition during that time, M was returned home permanently in December 2008. Although

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that was the broad aim of the social worker at the time (SW1), it had not been agreed to by the Family Court and it was not supported by Counsel for the Child. Perhaps circumstances played an unexpected role when the caregivers to whom M was to be returned to in January 2009 could not be located. It meant that M was returned home without a full transition programme and without supports for either M or [Mother] being put in place. On the other hand that arrangement certainly met the wants of [Mother] and was favoured by the social worker and the Family Start worker.

3.10.16 Supervision of the return was left to the Family Start worker from the Waipereira Trust, who was focused on the family and [Mother] and, later, she requested CYF to arrange counselling for M. Counsel for the Child was not advised that the return home had become permanent until some time after it had occurred.

3.10.17 During much of 2010 there was the unsatisfactory relationship between the social worker (SW2) on the one hand and the school and the public health nurse on the other and only after the report of some dangerous behaviour in June and the school's abortive attempt to refer M to Marinoto did the social worker seemingly give M's case the attention it so obviously deserved. These events between December 2008 and June 2010 question the skills of the social workers involved and the quality of the supervision they received. In addition, the social work practiced at this time continued to overlook a gap which had been apparent for a number of years and that was the role that the father – – played in the family.

3.10.18 I want to repeat that my Inquiry is not to "Blame and Shame". The criticisms I have made about CYF are not insignificant but CYF is not the only institution where there have been some lapses in practice. As I have observed from the information available to me, [Mother] was a difficult, demanding and manipulative client. As a result, CYF seemed at times focused more on [Mother] than on M, contrary to its statutory imperative that the interests of the child shall be paramount, and that while it collaborated and shared information with some individuals, it did not do so with all of them all of the time.

3.10.19 It is with considerable sadness that I record the following comments with regard to Terms of Reference 2.1 – that is as to whether, in the lead-up to the abuse, the agencies had taken all appropriate actions to ensure M's safety. With the benefit of hindsight, it is apparent that there are questions

about some of CYF's actions between late 2008 and mid 2010 and that some of these actions may be seen to have contributed to an unsatisfactory situation.

3.10.20 However, despite the less than satisfactory actions during this period, I believe, in the four months before the abuse, CYF had taken appropriate steps. It had called on Specialist Services for specialised assistance, which then stepped aside in view of Marinoto's subsequent involvement. From October a new social worker, presumably with competent supervision, was building a relationship with M and her mother and some of the other agencies involved. There was a long history to deal with and improvement in M's behaviour would have been slow and only apparent over a long time. Nevertheless, some feelings of optimism would have been justified in view of the positive comments recorded by Marinoto in October 2010 (see 2.55 above). Undoubtedly, some of CYF's practices can be improved and, it is hoped, such improvement will lessen the chances of similar events recurring.

3.10.21 Further, by way of a positive note, CYF's actions after July 2010 indicated that it had taken, at least temporarily, a leadership role in ensuring that M was dealt with in a way that acknowledged her needs. Leadership is important when a number of agencies are involved in complex cases. It is an issue I shall return to when advancing my recommendations relating to multi agency collaboration.

3.10.22 As my final comment with regard to CYF, I point out that I have already made use on a number of occasions of the Practice Review from CYF's Chief Social Worker dated 17 January 2011 and shall do so again. I want to record my admiration at the extent of the information contained in a report put together essentially just before and over the Christmas break.

3.11 Waipereira Trust - Family Start

3.11.1 CYF's Practice Review notes that the Trust, as the provider of Family Start, was involved with the family in 2000, and then from 2003, after the birth of [Mother's] third child, until March 2008, when that child went to school. However, the Review reports, the Family Start whānau worker continued to support [Mother] on an informal basis until July 2010, visiting the home on a regular basis. The very untidy state of the home is one matter raised in the whānau worker's notes on a number of occasions and it is

also recorded that she discussed [Mother's] gambling practices with her.

3.11.2 It is apparent that the whānau worker and CYF social worker involved between September 2006 and September 2009 (SW1) worked together closely. While there is no suggestion that the whānau worker was delegated the role to visit the home on an eight weekly basis (CYF's practice requirement for a child in care), she reported on her visits to the social worker and those visits seem to have been considered sufficient to comply with CYF's requirement. In assisting with carrying out CYF's responsibilities to [Mother], the whānau worker was instrumental is arranging counselling for [Mother] and M when M returned home in 2009.

3.11.3 As the whānau worker may be involved in the ongoing court proceedings, I have refrained from speaking to her as part of this Inquiry. The CYF Practice Review notes that the worker saw "her role as one of advocacy and support for [Mother]". She reported that she helped [Mother] have regular contact with M and [sibling] reinstated and that she 'pushed' for [sibling] and M to return to [Mother's] care. It is recorded that she continued to visit on an informal basis after the case was closed and said that she never saw any violence from [Mother] towards M. The manager of Family Start told CYF that he was not aware that the whānau worker continued to visit [Mother] and provide her with support in 2009 and 2010, adding: "there were long-standing issues with the whānau worker's practice and boundaries referring to this as "classic enmeshment."

3.11.4 The frequently heard criticism that agencies are confined to their silos did not apply totally in this case as there was close cooperation, for some of the time between two staff of these agencies. However, it is not clear whether the agencies were singing from the same song sheet, as the best interests of the child and the mother's best interests were not necessarily always the same. It is a situation in which the social work shibboleth about the absolute need for supervision is manifest. In this case it is clear that input from others was necessary. That input, that supervision, must come from others with some detachment from the day-to-day issues. It is a matter I shall return to in my recommendations.

3.12 Waitakere Family Court

3.12.1 The Family Court provides oversight to CYF when it carries out its functions under the CYP&F Act to take custody of or administer some other type of order over a child or young person. M has been under the Family Court's mantle since March 2002. In practice, a social worker puts a plan before the Court (s.128) which is subject to ongoing review at the times set by the Court. Family Courts work in both an adversarial and investigative environment. While the best interests of the child is always the paramount concern, a Family Court may be required to rule on opposing views as to what are the child's best interests. There may be disagreements between CYF and the family or disputes between CYF and different members of the family and, sometimes, disputes within the family.

3.12.2 To ensure that the child's best interests are advanced thoroughly, a Counsel for the Child will have been appointed. To assist in making decisions, the judge may well have requested a medical, psychiatrist or psychological report from a court appointed specialist under s.178 of the Act.

3.12.3 In the current case, a Counsel for M and [sibling] was appointed in 2002 (and I make no comment whether each should have had a separate counsel) and regular updates were sought from the Court Appointed Psychologist. Neither medical nor psychiatrist reports were required. While these processes may be sufficient in many cases, I consider that the judge should have the ability in cases which raise complex issues to ask that a multi agency meeting take place. I envisage that this would take the specialist's report one step further. At present, the specialist collects the views of other professionals and may express a tentative opinion about the next steps to take place. There may be disagreements about the next appropriate steps and the meeting of professionals would endeavour to resolve any conflicts, or at least clarify the issues in dispute and make absolutely clear the rulings which judges would, in their discretion, be required to make.

3.12.4 There are provisions in the Act for urgent action where necessary, and that occurred after [Mother] and [Father] were arrested. My proposal is not directed at the situation where speedy action is required but aims to improve the deliberative rulings the Family Court is required to make when deciding on plans for the future when the

professionals, for whatever reason, are unable to agree or where a collaborative decision is better for the child than a report from a single professional.

3.12.5 The Family Courts are a division of the District Court and the Family Court judges are District Court judges who hold a specific warrant to preside in the Family Court. I have commented on a number of occasions and will do so again about how the CYP&F Act is both "family" and "child" focused and whether there is a need for some clarity for everyone, especially CYF workers. I shall return to the matter later but note in passing that whether the earlier change in name from "Children's Court" to "Family Court" has contributed to the current opaqueness sometimes apparent in the application of the legislative principles. I make specific proposals later in this report (paragraph 11).

3.13 Counsel for the Child

3.13.1 Barrister [redacted] of Auckland was appointed Counsel for M (and [sibling]) in June 2002. She continues to hold that position and, indeed, in December 2010, she was appointed Counsel for [Mother's] three younger children. [Counsel's] distinguishing feature is the fact that she is the professional with the longest continuous involvement in M's life. She gave me a memorandum outlining her involvement which I found most useful and I have drawn on it in preparing my Report.

3.13.2 In paragraph 4 of her report, [Counsel] wrote:

> "This case illustrates many of the problems that currently exist within the [CYF] Service; in particular the high turnover of social workers; the lack of social work; the prevailing attitude of returning children to their family of birth without providing adequate support; lack of follow up; the premature closing of files; lack of child focus and lack of historical knowledge about the case."

3.13.3 This is a damning indictment and she goes on to substantiate her concerns, explaining why she opposed the plans to return M to [Mother] at various stages. She is particularly critical of the process by which M was returned home in late 2008. She had understood that CYF, on being advised that [the whānau caregivers] were moving to Australia, was seeking an alternative whānau caregiver. However, in April 2009, she found out that M had been returned home permanently following a Family Hui

decision to that effect in early October 2008 which was a meeting to which she had not been invited.

3.13.4 [Counsel] emphasised the efforts she had made at the Family Court hearings to ensure that the plans for M administered by CYF included both active monitoring of the children's progress (M and [sibling]) and counselling for M and parenting education for [Mother] (in which [Father] would also be involved). She considered that CYF, possibly because of its focus on the family rather than the child, had carried out insufficient monitoring. CYF's role, she argued, was to protect children and that sometimes meant going against a mother's wishes. That had not occurred on this occasion and she expressed disappointment that monitoring, which was supported by her and the Court Appointed Psychologist, did not appear to have been carried out. [Counsel] concluded:

> "The impression I gained from the social workers was that my interventions (in keeping the Service involved) was unnecessary. I do not believe they took my concerns seriously. As a result I do not believe they collaborated effectively with other professionals; they did not listen."

3.13.5 I am not surprised that there is some degree of disagreement between Counsel for the Child and CYF or, indeed, with other parties involved in a child's care and protection. Counsel's responsibility is unambiguously towards the child, whereas CYF is also involved in balancing the child's and the family's interests. I am concerned in this instance, however, that it is possible that Counsel was not invited to the family Hui in October 2008 where it was apparently decided to work to return M to her mother and, given the judge's comment in late October "that it was important that the adults did not build up expectations for M that she would return home", that the plan then formulated was not put forward to the Judge-led Mediation Conference held some four weeks later. Given the time constraints and the limitations of this Inquiry in view of the ongoing criminal proceedings, I make no explicit finding on this point.

3.13.6 I have already indicated the importance I attach to the collaboration of professionals, which [Counsel] suggested as well, and I shall return to this in my recommendations. Although highly critical of some of her past liaison with CYF, when I spoke to her [Counsel] praised the cooperation she had received from CYF since the events in November.

3.14 Court Appointed Psychologist

3.14.1 Psychologist [redacted] first report under s.178 of the CYP&F Act, as a Court Appointed Psychologist in regard to M and [sibling], is dated 2 May 2003 and [sibling] is the focus of her first and second reports. Her subsequent reports are dated 8 October 2003, 24 August 2004, 4 March 2008 and 27 March 2010. [The psychologist] remarked that five reports about the same family were most unusual and she attributed the number to Counsel for the Child's perseverance to ensure that the best interests of the child did not become subsumed to the interests of the more assertive mother.

3.14.2 The Act provides that the Family Court may request a medical, psychiatric or psychological report if it appears expedient that such a report is available to the court. When preparing such a report, the psychologist is not a therapist. The report is made available to all parties to the proceedings and their counsel, to Counsel for the Child, to CYF and "to any person whom the Court considers has a proper interest in receiving a copy of the report" (s.191(d)). The Court may withhold disclosure in appropriate cases. (s.192).

3.14.3 The Act does not outline the process by which a report is prepared. In the present situation, the psychologist spoke – in person or by telephone – to a wide range of the parties involved – both members of the immediate and wider family, and to a number of professionals who had dealt with M and [sibling]. She also read the relevant papers.

3.14.4 With regard to the most recent report dated 27 March 2010, this included lengthy individual interviews with M and [sibling], with [Mother] and observation sessions in the home with all the children, and phone interviews with some other family members, a CYF social worker, two police officers, the Counsellor, a public health nurse, the general practitioner, the school principal, Counsel for the Child, and the whānau worker at Waipereira Trust. A series of relevant documents were also examined.

3.14.5 It is a lengthy report which, with regard to M, suggested continued counselling for M and [Mother] in view of, among other matters, M's emotional difficulties. After a caustic observation as to its ability to comply with time limits in view of the length of time it took CYF to respond to the sexual abuse allegation, the psychologist nevertheless recommends regular monitoring by CYF of M's and [sibling's] progress, through the use for example of six

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monthly written updates from the school, the doctor and the Counsellor. She recommended that counselling be continued by [counsellor] in view of the relationships between M, [Mother] and the Counsellor and that [Mother] also receive parental guidance. It also recommended that the report be released to [counsellor].

3.14.6 Three months after the report was put before the Court, the Custody Order was discharged. It is not an issue addressed although it mentioned [Mother's] antagonism, first, towards CYF for putting M in a place where she suffered abuse, and secondly towards Counsel for the Child for arguing that CYF remain actively involved. I observe, also with a touch of irony, that M was placed with [whānau caregivers] when the names were put forward by [Mother] and [Father] because they were Whānau.

3.14.7 These reports offer the Court a view which is at least detached to some extent from the day-to-day immediate issues. On a cautionary note, I wonder whether the fifth report in seven years, while building on past knowledge, suffers from too much familiarity with the issues. I raise this point for two reasons: first, as the psychologist acknowledged, M did not report the sexual abuse which was then taking place when interviewed for the assessment in 2008; and secondly, she recommended that [counsellor] counsel both mother and child. This may well give rise to a conflict of interest for the Counsellor as the conflict between M and [Mother] was a major issue to be addressed during counselling. With regard to the first point, the psychologist pointed out that it was not uncommon for abused children not to speak of the abuse while in the environment where the abuse was taking place. As for the second, she pointed to the practicalities of shared knowledge.

3.14.8 Because I am concerned about the same Counsellor dealing with both mother and child, I raised the issue with the Psychologists Board. I was told that because of the potential conflict of interest issues, it would not be regarded as ethical behaviour. It is not difficult to see the attraction for the same person to counsel both mother and child. They can be seen together or separately and information from one will probably assist in the approach taken to the other. But, not only do the skills for counselling adults differ from those which apply to children, there is almost an inevitable power imbalance between parent and child. It is not sufficiently child-centred practice.

3.14.9 Returning to the issues of child focus and collaboration, I am impressed with the extent of the psychologist's efforts to ensure her report sought M's views and put her perspective before the court. While distribution of the psychologist's report beyond the parties is at the discretion of the Family Court, the psychologist on this occasion sought its release to an independent professional, and on an earlier occasion, had suggested its release to the caregivers then looking after M. The psychologist's concern for M's best interests can be seen as the motive for her suggestion in each case.

3.14.10 When spoken to, the psychologist shared some of the concerns advanced by Counsel for the Child, adding that because of the rate of staff turnover a high number of social workers working with the same child was a regular occurrence in CYF. She also thought that CYF sometimes pursued the principle of returning children home without considering all the alternatives, particularly where whānau was involved, and she saw it as her role to raise flags in her reports about concerns which arose when she spoke to a broad range of people involved in a case. The lesson she had learnt from this case was to explore the issue of possible abuse further, especially when speaking to children.

3.15 The Independent Counsellor

3.15.1 [ ] of [ ] [ ] has a counselling qualification, is a registered ACC sexual abuse Counsellor, and operates her own counselling service in West Auckland. [Counsellor] was involved as a Counsellor for [Mother] in the mid 1990s. She began seeing M in June 2009 and provided the CYF Practice Review with the following information regarding counselling hours:

> "Counselling hours for M with [counsellor] - June 2009 face to face – 12 hours; 2010 face to face – 30 hours; 2010 Marinoto assessments and whānau interviews; - Meetings CYF, disclosures. Police – 6 hours; - Phone contact – 4 hours."

3.15.2 In view of the possibility that [counsellor] could be involved in some way with the criminal charges that [Mother] is facing because of her treatment of M and her long involvement with [Mother] as a Counsellor, I have not spoken to her as part of this Inquiry.

3.15.3 In her written comments to the CYF Review, she referred to M's return to [Mother] at the end of 2008 about which I have expressed concern in my comment about CYF. She pointed out that M returned home at that time "with no statutory monitoring, no transitional care plan, and no additional support". She added that she "was 'hoha' with the CYF/Courts dumping M back in the community. I can't have been the only person who knew this whānau had an extensive history with CYF". As a general comment, she is concerned that CYF had not kept her informed about the other services put in place, such as the use of Specialist Services, as she felt the sharing of information among professionals would have been to M's benefit.

3.15.4 M disclosed sexual abuse at her second counselling session (in June 2009) and [Counsellor] advised CYF. CYF's unsatisfactory response to that notification has been dealt with. In March 2010, the Court Appointed Psychologist in her report recommended that M continue to receive counselling from [Counsellor]. When M was referred to Marinoto, she carried out some counselling with M while Marinoto staff viewed through a one way mirror. [Counsellor] saw M at her rooms on 2 November with [Mother] and her siblings. The social worker newly assigned to M also visited that day. A week later, on 9 November, [Counsellor] again saw the social worker and [Mother]. M had not accompanied her mother for that session. After the social worker had gone, [Mother] told [Counsellor] that M had said that her father, [ ] had abused her. The CYF Practice Report records:

> "[Counsellor] told [Mother] to bring M in to speak with her directly about the allegation, as M had never previously mentioned [ ] abuse by [Father]. [Counsellor] did not report the allegation to CYF although she says she intended to advise Marinoto … about the allegation at a scheduled meeting on 11 November 2010. When the scheduled meeting was subsequently cancelled she did not tell Marinoto ,… or CYF about the allegation. … When asked why she did not report the [ ] allegation to CYF [Counsellor] advised that it was her usual process to discuss these allegations directly with the child concerned before advising others."

3.15.5 I have included this summary in some detail as CYF advised that a notification of [ ] assault to its reporting centre will almost inevitably involve an immediate response – within 24 hours. [Mother's] assault on M began on 10 November. A report of the [ ] abuse on 9 November,

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accordingly, would have minimized the extent of, or perhaps avoided [Mother's] attack on M. [Counsellor's] inaction is the one step which could well have had an impact of M's safety.

3.15.6 I discussed the expected practice with the Psychologists Board. I was told that a report of assault by a third party would not necessarily call for an immediate official notification. It would not be unusual practice for the psychologist to decide to speak to the victim first.

3.15.7 My concern about the same Counsellor dealing with both mother and child has been addressed above when discussing the role of the Court Appointed Psychologist and, specifically, the impact on retaining a paramount focus on the child.

3.15.8 I have spoken to the ACC about the qualification "ACC sexual abuse Counsellor". First, it was a standard which was put in place some years ago and is now considered to be in urgent need of updating, Secondly, it was designed for the counselling of women, not for children to whom different criteria apply.

3.15.9 Accordingly, I am not convinced that [Counsellor's] counselling was child-centred to the degree that could be expected. As for the sharing of information with and from [Counsellor], the issue of sharing of information by NGOs with government agencies raises complex issues. For example, NGOs may well be given information just because they are not part of the government and disclosure of that information may well be regarded as contrary to ethics. I shall return to this matter in my recommendations. In this situation, I understand that [Counsellor] gave and received information seemingly openly with other professionals because it was seen to be in the best interests of the family - if not solely the child - to do so.

3.16 The General Practitioner –

3.16.1 Since her return to her mother's care in December 2008, M has been seen by the same doctor who sees [Mother] and M's siblings. M saw the doctor on seven occasions in 2009 and at least five in 2010. She presented with common childhood ailments which included on one occasion an injury to her hand - for which she was treated at Middlemore Hospital - and a foot infection, for which she received treatment first at Waitemata Hospital and then at Starship in Auckland.

3.16.2 The Practice Review records that the doctor was aware of M's involvement with CYF and the sexual abuse. There is however, no documented contact between CYF and the [Doctor] since M's return to her mother's care. I note that although the doctor was aware of CYF's involvement, she appeared to have had no concern about non-accidental injuries. I also note that the s.91 Support Order, dated 17 May 2010, listed as one of the methods of assistance for M and monitoring by CYF in its support of M was to seek written updates from the general practitioner, amongst others. That had not taken place before November 2010.

3.16.3 M was last seen at the surgery on 30 September 2010 and it is a consultation which causes me some concern. M's usual doctor, [redacted] was away and she was examined by another doctor from the clinic. The CYF Practice Review explains:

> At this appointment [Mother] reported that [redacted] [redacted] she wanted M examined and treated. She reported to the doctor that a specialist examination had been completed the previous day by a Te Puaruruhau paediatrician but that she was still concerned. Because an examination had been completed the previous day, the doctor was reluctant to complete a further [redacted] procedure, however felt some coercion from [Mother] to do so. Other than potential hygiene issues the examination noted nothing of significance. There were no injuries to M noted during this examination.

3.16.4 While I observe at this point the records indicate clearly that [Mother] was a formidably demanding client, I also note the comment in Practice Review that the doctor believed that [Mother] ensured that the children received regular medical attention in order to demonstrate to CYF that she cared for her children. The issue of information sharing, or the inadequacy of such sharing, is again relevant. Although aware of CYF's involvement and she recalled speaking to a psychologist who she thought was with CYF, the doctor's participation in a multi agency meeting of the professionals who had dealt with M would have enabled her to advance her perspective and allowed her to incorporate the perspective of others in her treatment of M.

3.16.5 [Doctor] recalled that she had been aware of CYF's involvement initially but there had been no exchange of information with the school or the Counsellor. It was

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regarded as a "high needs" family and she was adamant that there was the exchange of information between agencies to assist each agency when they were aware of the involvement of others. She reported that the practice had used the [redacted] as a learning experience and, she added, she thought specialised training in child protection on an annual basis would be valuable for all general practitioners. She also expressed concern that information sharing between general practitioners and public health nurses was badly deficient.

3.17 Marinoto Child and Family Services

3.17.1 Marinoto, the Waitemata DHB Child and Health Clinic, was first involved when, on 24 June 2010, it received a referral of M from the Deputy Principal at [redacted] School. The clinic sought comment from the school, CYF and [Counsellor]. The school advised that M was socially isolated and it had made the referral as M had been putting poison in the family's food. [Counsellor] told Marinoto that she had considered making a referral for the same reason, and commented that she thought CYF was no longer involved with the family. When contacted by Marinoto, CYF (SW2) also sought an assessment to assess M's impulse control issues.

3.17.2 Marinoto later advised CYF that it did not accept the referral because it believed that it was a matter of care and protection and that M's behaviours were not indicative of a mental health issue. In view of M's history of severe trauma, it recommended an assessment by Specialist Services. CYF went ahead with this course. [Mother] expressed her disappointment to CYF at Marinoto's decision, noting that she would now not allow M out of her sight. CYF also advised Counsel for the Child of Marinoto's decision.

3.17.3 On 2 September 2010, M was assessed by Marinoto as a crisis referral in the company of her mother, her Counsellor and SW2. The Counsellor outlined M's history and her mother spoke of M's recent behaviour. CYF said that it had organised a 24 hour tracker service so that [Mother] could get some sleep. On the following day, M was seen by a psychiatrist, and M and her mother were seen by others. The psychiatrist ruled out any diagnosis of psychosis or depression and considered that the best remedy was intensive therapy which was likely to be spread over some years.

3.17.4 After her treatment in hospital for an infected foot the following week and time at a tangi in Taranaki, M next visited Marinoto on 29 September. [Mother] advised them that M had an appointment for an [ ] examination at Starship for [ ] abuse later that day. On14 October, Marinoto staff observed a session between [Counsellor] and [Mother] and M. Regular meetings took place, which are fully summarised.

3.17.5 On 8 November 2010 Marinoto spoke to [ ] School to arrange observation times. That did not occur on the 9th as M was absent with a "stomach bug". It did not take place on the 11th as Marinoto was told that M was away at a tangi. This was subsequently found to be untrue. On the 16th, Marinoto was advised of the abuse which had taken place and, on the 17th, participated in a meeting which included contributing to plans for ongoing therapy for M.

3.17.6 I have dealt with Marinoto's involvement in some detail as, in my opinion, it provides an exemplar of meeting the child-centred standard raised in my Terms of Reference. I make this comment although I am aware that the severe beating took place soon after the Marinoto's involvement with M began and, I also note, it was the second referral. At Marinoto, the focus was on M, and there was a concern that appropriate actions in regard to safety were in place, and there was collaboration (and information sharing) between the agencies of which Marinoto was aware and plans were under way to involve a wider range of agencies. And for my purposes, the extent of the record keeping allowed me to reach my conclusions with some confidence.

3.17.7 When I spoke to a number of Marinoto staff, they expressed a concern that information sharing with CYF, in the past, had too often involved all take by CYF and little give. However, with the appointment of a liaison social worker by CYF to the Waitemata DHB, the situation had improved substantially. In a comment about the possible conflict of roles for [Counsellor] in counselling both [Mother] and M, in this case, Marinoto advised that there had been a trusting rapport which enabled the real child to be viewed. Furthermore, I was told, [Counsellor] had used the appropriate language for a child during the sessions.

3.17.8 I also acknowledge that action on this scale is resource intensive. Involvement to this degree with many of the individuals and family currently in the care or under the supervision of CYF is unrealistic. But that is not what I seek, and nor do I recommend it. Rather, it is relevant to the small number of cases where it is considered necessary

because these families and individuals have been identified by multi agency meetings. In practice, a multi agency professionals meeting would have been held, which focussed on the child or the family member in need of care, and reached a decision that this degree of action was considered appropriate, after a full discussion using all the information collected by the different parties.

3.18 School

3.18.1 M started at School shortly after the beginning of the 2010 school year. Her absences were frequent and totalled 60 days, and they tended to be in blocks of 5 – 8 days. There was some contact, albeit sporadic, between the school and CYF. The Home Care For Kids Service was involved as well and in May 2010, a Public Health Nurse visited the home at this Service's request. The Nurse sought assistance from CYF and in the absence of any response, in June 2010 the school referred M to Marinoto. Marinoto declined to accept the referral but, in early July, CYF acknowledged the seriousness of the behaviour M was displaying and, following the recommendation from Marinoto, referred her to the Auckland Specialist Services.

3.18.2 At the beginning of September, M arrived at school with an injury to her cheek. The school referred it to CYF along with M's explanation that it had been caused by [Mother] after M had set fire to a mattress in the garage and it was one of the events relevant to the urgent referral to Marinoto.

3.18.3 Through the Public Health Nurse, the school was also active a few days later in arranging treatment for M for an injury to her foot. Plans for Marinoto staff to observe M at School in early November were postponed when [Mother] advised, first, that M was absent as she had a stomach bug, and secondly, two days later, that M had gone to a tangi in Wellington. That was subsequently found to be untrue.

3.18.4 The school advised me that an unannounced visit by Counsel for the Child to see M at school resulted in an angry response from [Mother] who insisted that the visit should not have been allowed without her permission. As a result, the school said, it did not allow visits by other professionals to speak to M without [Mother's] prior permission.

3.18.5 As M's class teacher raised concerns in the media in December 2010 about what she regarded CYF's inadequate

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responses during the year to the school's concerns about M, it is an issue covered thoroughly in the Practice Review from CYF's Chief Social Worker. That Report stated:

> "Over the course of 2010 there were regular communications between CYF and the school and the school was proactive in seeking support for M. Their concerns appear to have centred primarily around the lack of attendance of M and her siblings, the presentation and behaviour of the children at school and generalised neglect concerns. It is understood that while the school reported concerns to CYF and follow up action occurred, they remained concerned that the situation for M and her siblings at home was not improving."

3.18.6 When spoken to, the senior staff at the School noted that perhaps 15% of the pupils had some CYF involvement and that they received at least weekly one formal request for information. Some frustration was expressed at the difficulty of contacting specific social workers and, at times, calls were made to supervisors. The possibility of a liaison social worker was greeted enthusiastically.

3.18.7 I did not explore the specifics of the relationship of the school with CYF in regard to M. Moreover, CYF in its Report is inconclusive about whether all the school's concerns about injuries to M were passed on to CYF. I consider that it would be difficult to reach a finding without a much more thorough investigation than I have either the time for or the resources to carry out.

3.18.8 As I have indicated elsewhere in my Report, the relationship between schools and CYF is one of the issues which can and should be dealt with promptly. Put succinctly, the current relationship, overall, between CYF and schools is not satisfactory. I find this disappointing as both institutions have the best interests of the child at heart. From the point of view of the schools, the view was expressed that CYF did not take their concerns seriously and/or did not tell them what action was taken on the complaint. The schools argued that it was very difficult to determine what CYF's threshold for action was. The schools added that it was a major step for them to lodge a notification with CYF which, they believed in view of the time taken to respond, if there is a response at all, was not acknowledged. Further as a notification was such a serious step for them, the schools wanted to be told what action was being taken. They wanted to know not only for practical reasons, such as preparing for a visit by an angry parent, but

also because they wanted to see what action was undertaken in the child's best interests.

3.18.9 CYF denies that it does not take notifications seriously. It pointed to the fact that it operates a 24 hour report centre manned by social workers who decide on the appropriate action for each complaint. CYF also stressed that it operated a triage system where serious complaints received urgent attention – within 24 hours – and those at the other end of the scale might be passed on to community groups to deal with. CYF accepted that it was possible that some complainants might not be advised how the notification was being dealt with, but that did not mean that it was not dealt with. The number of notifications has been increasing in recent years from 40,939 in 2003/04, to 71,927 in 2006/07, and 124,921 in 2009/10. Further action was required in 2003/04 on 35,350, in 2006/07 on 43,845, and in 2009/10 on 55494. These figures need to be explored further by CYF's management.

3.18.10 Although some schools said that the relationship was satisfactory with a named local social worker, there were major concerns about the CYF relationship with each primary school and, overall, it was a problem. I am of the opinion that a lack of communication is at the core of the problem between schools and CYF.

3.18.11 I consider that the process put in place between CYF and the District Health Boards provides a model which should meet the needs of both parties. Over the last few years, CYF has stationed one of its experienced social workers within each DHB. These social workers deal with the medical staff in the hospitals and provide a link between the hospital and CYF. Many CYF clients use hospital facilities, ranging from Accident and Emergency to maternity. CYF social workers in hospitals ensure that their clients who are in hospital are seen as the same person – not as a medical question on one hand and as a behavioural matter on the other. I have been told by DHBs, the Ministry of Health and CYF that this arrangement is valuable and working well.

3.18.12 I believe that the same can and should be done with schools. A social worker would be appointed to liaise with a cluster of schools, to get to know the staff in each, and to explain CYF's role. The social worker would also learn what social workers can reasonably expect from schools and vice versa.

3.18.13 "Taking Kids" is the broad brush image which applies to CYF. It is the view held not only by clients but also by other professionals, such as doctors, nurses and teachers. While CYF has a statutory function and taking custody of children occurs albeit in extreme cases, much of its work is within the community helping families and individuals. Closer liaison between these groups will fundamentally assist in broadcasting that message.

3.18.14 In addition, I would hope that the multi agency meetings of professionals proposed will increase each agency's understanding of each other. But there is an urgent need for a better understanding between schools and CYF and I believe that social workers dedicated to liaising with a cluster of schools will be of immediate and considerable benefit.

3.19 The Police

3.19.1 The Police had occasion to visit [Mother] and [Father] reasonably frequently both before and after M's birth in 2001 – although the visit on 15 November 2010 was the first in which she was the centre of attention. Most of these visits arose because of incidents of family violence (ie what used to be termed a domestic dispute) and, apart from the dispute in June 2010, no one was arrested. [Father] was arrested in June, and pleaded not guilty. The charge was later withdrawn when [Mother] declined to give evidence.

3.19.2 The Police complete the form POL400 after attending a family violence incidence and, when children are involved or witness the dispute, the Police practice is to send a copy of this form to CYF for its information. The form includes the names of the children.

3.19.3 I understand that the number and issues raised by the Police call outs to see [Father] and [Mother] between 2000 and 2006 were not sufficiently frequent, and the conflict was not sufficiently intense, to raise any flags and moreover, the event in June 2010 was the first occasion the Police had been called since 2006. [Mother] and [Father] separated in 2007 and although they have kept in touch, as SL's records reveal (the whānau worker), and although [Father] has assisted with caring and transporting the children, as I explained in para 2.3, I am unclear to what extent the couple shared the home.

3.19.4 In June last year, [Father] told the Police that he was protecting the children from [Mother] but, apart from a

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mark on M's nose, the attending police officers were unable to see any signs of violence. [Father] was required to stay away from [Mother's] home as a condition of bail. I am also unsure how often he visited the home between the 9th and 15th November, but he was there when the police arrived on the 15th and was arrested for breach of his bail conditions.

3.19.5 M was spoken to for the purpose of an evidential interview in regard to the allegation of sexual abuse against [whānau caregiver] at Puawatahi in December 2009. It is an agency of the Auckland Central Police.

3.19.6 Because of their involvement at the scene of crimes and their involvement in any subsequent court proceedings, I consider it is important that the police liaise with other agencies.

3.19.7 Having spoken to the Waitakere Police for the purpose of this Inquiry, and taking into account the comments made by others whom I have spoken to, I applaud the high priority that the Waitakere Police give to incidents of family violence generally and to child abuse in particular. It is also apparent that the Waitakere Police cooperate fully with a number of agencies in order to deal effectively with the issues that arise. I also note that there have been no questions about the competence of the Police's investigation of the events in November.

3.19.8 I am also of the view that the action taken by the Police when called by [Mother] to an incident of family violence in June 2010 was also appropriate and complied with the Child Protection Protocol (CPP). In view of [Father's] allegation about [Mother's] violent abuse of the children, the children were examined, and the mark on M's nose was not considered to have substantiated [Father's] excuse. As is the practice, the attending officer completed a POL400, in which he referred to the matter, and which was passed on to CYF for the action it considered appropriate. It was referred to SW2 who brought up the issues in a telephone conversation with [Mother].

3.19.9 The Police and CYF have signed a protocol dated 15 April 2010 entitled the Child Protection Protocol (CPP). What I find of particular relevance to my Inquiry are the principles to which both organisations are committed. They are the principles, and the order in which they are presented, I would argue should be explicit in CYF's practice when dealing with the care and protection of a child. They provide:

"The welfare and the best interests of the child is the first and paramount consideration including identifying and seeking support from family members or others who can help.

Work will be conducted collaboratively with other agencies.

Staff undertaking the functions of the CPP will be suitably skilled and trained.

Investigations will be concluded in a child centred timeframe.

Perpetrators will be held to account wherever possible."

3.19.10 Intelligence is central to policing. Much of the information gathered by the Police is garnered while in the community and such information, when shared with that collected by other agencies, can be very important ion ensuring that the appropriate actions are taken when deciding on the best interests of individuals and families. I have no criticism of the Police participation in [Mother's] life. Further, I believe that it is important that the Police take part in the multi agency meetings that I recommend.

3.20 Auckland Specialist Services – CYF

3.20.1 When Marinoto declined the referral of M from [ ] School, it recommended that M be referred to Specialist Services. It noted that M "has a history of severe trauma which is being addressed through counselling with ACC", but that a non-urgent assessment could be undertaken by Specialist Services. In early July 2010 SW2 spoke with [Mother] about this option and she agreed to it. During the same discussion, [Mother] denied hitting the children (as [Father] had alleged when arrested).

3.20.2 Accompanied by [Mother], M was seen by a Specialist Services psychologist on 12 August 2010. After speaking to M and [Mother] and gathering other information, the psychologist strongly recommended therapeutic intervention and named a therapist she had spoken to who had indicated her availability and who recognised the need to work in conjunction with [Counsellor], M's current therapist.

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3.20.3 In view of the mattress fire incident on 30 August and the urgent referral to Marinoto which followed, that counselling never started. A representative from Specialist Services attended meetings of professionals at Marinoto on 23 and 28 September and apart from making available the information they had, including the assessment undertaken, acknowledged that it had no immediate active role.

3.20.4 Following the incidents in November, the psychologist observed the forensic interview of M on 18 November 2010 and Specialist Services is now involved in the ongoing treatment of M and her siblings.

3.20.5 It is not for me to decide whether Specialist Services should have been called in earlier, indeed much earlier, to assess M and develop a programme to meet her therapeutic needs. I observe that the process initiated once Specialist Services was involved seems to have centred on M and, this participation later included, in M's best interests, sharing the information it had gathered.

3.21 Senate Nursing

3.21.1 The Senate Nursing Bureau was contracted by CYF to provide support for [Mother] by monitoring M in the home between 2 and 8 September 2010. The Practice Review records that three women were employed on a rotational basis to complete this role and all reported that M was a lovely child. None of them reported any concerns about safety to their manager.

3.21.2 On 22 December one of these women spoke on Radio Live about her time in the house and described it as a "pig sty", and said that M and the baby had sores on them. When interviewed for the Practice Review, two of the women described the house as "disgusting", but neither was concerned about any physical harm to the children. All three women advised that they had not raised any concerns with their manager, nor had they reported the condition of the home to CYF. And, one added, she was "just doing her job".

3.21.3 The Senate Nursing manager apologised to CYF for the woman's public comments in contravention of its policy on confidentiality.

3.21.4 It is understandable, I suppose, that workers in this situation describe their approach as just doing a job. It was the condition of the home, not the children, which were

obviously deplorable. Nonetheless, such information may well be otherwise difficult to obtain. In regard to the state of [Mother's] home, she declined to allow the Court Appointed Psychologist to see the children's bedrooms on the basis that it was tapu. The psychologist commented in her report on that occasion that the cultural advice she later obtained was that [Mother] had used this as an excuse as she had not wanted the psychologist to see the state of the rooms. As this point was contained in the psychologist's report, [Mother's] ruse to avoid the court and other parties being advised about the state of the bedrooms was unsuccessful on this occasion. The whānau worker's case notes record that she helped tidy up the home adding specifically on one occasion, that this was done in view of an anticipated visit by CYF.

3.21.5 I would think that in future, as one of the lessons to be learnt from the current events, CYF in its contracts with Senate Nursing and other similar organisations will include a provision requiring them to report back on the conditions in the home and conditions of the children in the home.

3.21.6 Indeed, I am pleased to report that Senate Nursing has decided to take such action. While in the past, the manager said, she had reported concerns to CYF when on the rare occasions her workers had told her about an issue, after the current case she now requires her workers to report any signs of abuse and, furthermore, she intends to ask them also to report signs of neglect.

3.22 Housing New Zealand

3.22.1 [Mother] began the tenancy of her Housing NZ home in January 2007. The house was inspected on 9 November 2010. It has been reported to me that this inspection took place after several previous attempts to visit when the tenant ([Mother]) apparently was not at home.

3.22.2 The children were at home and the inside of the home, of which I have seen photographs, was not only excessively untidy, but also very filthy. The inspector reported the children's absence from school to the ISAP (Improving School Attendance Programme). While Housing NZ had been aware from the January 2007 that CYF was involved with the family, the inspector did not contact them on this occasion and there is no record of any communications between CYF and Housing NZ over the years.

3.22.3 While a notification to the CYF call centre about truancy and the condition of the house instead of one to ISAP may not have evoked an urgent response, I note that the inspection took place on the day before the start of [Mother's] severe beating of M. I also note that Housing NZ has protocols in place to respond to concerns for the safety of children. It reinforces the importance that one agency take leadership with regard to families which come to the attention of a number of agencies, and that this leadership include a role of collecting information from all the relevant agencies and being the repository of that information.

4 Terms of Reference 2.1

2.1 whether the multiple agencies and individuals involved in the family to the lead-up to her abuse took all appropriate actions to ensure her safety.

4.1 As I explained earlier (paras 1.22 and 3.10.18) I do not see my task as being to "shame and blame". In regard to the current events, it is important to remember that, for a number of years, [Mother] was determined to regain care and supervision of M and, later, her custody. [Mother] sought supervised access to M both when she was with [caregiver] and when she was with whānau caregivers in South Auckland. Access was intermittent over the years but, in October 2008, the whānau caregivers announced that they had decided to move to Australia and that they wanted M to return to her family.

4.2 Access which included overnight stays in [Mother's] home was initiated and this arrangement became a permanent placement by Christmas 2008, in part owing to CYF's inability to locate the whānau caregivers in January 2009. This meant, until the time of the events in November 2010, that M had been living with [Mother] and her four siblings for just less than two years. While the permanent placement had the support of social worker 1 (SW1) at CYF and the whānau worker at the Waipereira Trust, there was some concern apparent among other professionals, especially with the speed at which it occurred and the lack of preparation for the transition.

4.3 The Court Appointed Psychologist had earlier considered that M should not be transitioned home until the transition of [sibling] was complete. Counsel for the Child did not support M's return to her mother's care because of the concerns she felt about [Mother's] own background and her suspect parenting ability. Taking into account the reality that from December 2008 M had been living at home with [Mother] with her siblings, but bearing in mind [Mother's] questionable parenting ability and that [Mother] was evasive about making appointments for a time when she could visit M at home, Counsel for the Child stressed at the court hearings held in 2009 and 2010 that M should be the subject of intense monitoring.

4.4 After M's return home in December 2008, counselling for M was arranged by the Whānau worker with Counsellor

who had counselled [Mother] some 15 years previously and her counselling of M began in June 2009. In her letter dated 7 January 2011 to the CYF Practice Review, [Counsellor] wrote that, in June 2009 (and I repeat the comment recorded in para 3.15.3 above):

> M had been at home since Dec 2008 with no statutory monitoring, no transitional care plan, and no additional support … . I was 'hoha' with CYF/Courts for dumping M back in the community … . I can't have been the only person who knew this whānau had an extensive history with CYF.

4.5 It is CYF practice to visit, and view, children in its custody at least once every eight weeks. When asked for the Practice Review whether that had occurred after M had returned home, SW1 acknowledged that the whānau worker had done so on her behalf. That is contrary to CYF practice and explains why the Counsellor considered that "statutory monitoring" was not taking place. I am of the same view. There is no provision in law to allow the delegation of that function outside CYF.

4.6 The requirement for a visit at least once every eight weeks has been reinforced since I started this Inquiry. CYF's Deputy Chief Executive has directed that these visits are to be recorded in CYRAS (ie CYF's information recording system) and will be monitored as an aspect of supervision.

4.7 In June 2009, [Counsellor] reported to CYF M's complaint about sexual abuse while with the previous caregivers which, as noted above, was not dealt with by CYF appropriately. [Counsellor] also recorded that, at CYF's later request, her initial counselling focussed on transitioning M back home. Counselling continued through 2010 and [Counsellor] did not report M's allegation of abuse by her father made to her by [Mother] at a counselling session on 9 November 2010. She did not report it either to the CYF social worker (SW3) responsible for M (who had visited [Counsellor] and [Mother] earlier that very day) or to the CYF's contact centre. [Counsellor] advised CYF for the Practice Review that, on 9 November, she had asked [Mother] to bring M in to see her immediately, and had made an appointment, but it was not kept.

4.8 These actions by CYF and [Counsellor] stand out as being directly pertinent to the lead-up to M's severe beating. However, I do not regard them as unduly heinous in themselves. M's problematic behaviour was known to the

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Court Appointed Psychologist but she did not recommend that M be taken away from [Mother] in her report dated 27 March 2010. The psychologist commented on a number of concerns she had about [Mother], including the point that [Mother] "appears to have been significantly comprised due to the background of her own history of severe childhood sexual and physical abuse, as well as her history with CYF foster placements, motherhood at a young age, and consequent social/emotional disadvantage". Nevertheless, taking into account the Counsellor's support, the psychologist decided: "Overall, [Mother] appears to be coping much better than before as a parent."

4.9 There were concerns expressed by the School and the Counsel for the Child in 2010 (but not by M's doctor) and, after what can be seen as some tardiness on CYF's part, M was referred in July by CYF to Specialist Services. Specialist Services recommended counselling, not revising the placement and, later, after the fire to the mattress on 30 August an urgent referral to the Marinoto Clinic was accepted. Marinoto's programme was similar to that of Specialised Services. In view of the intense action then taken between July and October, it is understandable that the professionals believed, by late October 2010 (as Marinoto noted in para 2.55) "M seems to be no longer in crisis and appears to have settled at home. Her destructive behaviours have stopped."

4.10 There have been lapses in CYF's administration of the care and protection aspects of the Support Order. In particular, the degree of monitoring of the care and protection aspects of, first, the Custody Order, and later the Support Order during much of the time after M had been returned home can be regarded, with hindsight, as barely adequate. However, by late October 2010, the agencies believed, and were entitled to believe in view of Marinoto's summary, that M was being helped out of the chasm into which she had fallen.

4.11 There is no distinct incident or action or inaction by a specific professional which can be regarded as mainly culpable in the lead-up to the severe beating in November 2010. I have been advised that, because of this case, CYF, the general practice at which M was a patient, and Senate Nursing, have made changes to their practices. I applaud those changes which, I am told, are aimed to enable those involved in the protection of children to carry out their responsibilities in a way which enhances collaboration between CYF and government and non government

agencies and will reduce the chance that similar events will recur.

5 Term of Reference 2.2

2.2 whether those individuals and agencies were sufficiently child-centred in their actions and approach in this case.

5.1 For the most part, actions taken by the professionals in regard to M have been reasonably child-centred. This is especially apparent during the early years when M was in CYF custody, and again from July 2010 to the current time. I make that observation although the severe assault took place in November 2010. That event, as I have noted earlier, occurred when M was the subject of attention from a number of agencies, many of which were clearly child-centred in their approach.

5.2 It is also apparent that the attention of the agencies which were involved with M from late 2008 until June 2010 did not always adopt a child-centred approach. I have covered this period in the discussion dealing with CYF and Waipereira Trust.

5.3 Although I have commented about what seems on occasions to be a slavish adherence by CYF to the interests of Whānau, as outlined in the CYP&F Act - possibly at the expense of the interests of the child which are paramount according to the CYP&F Act - in this case I accept that there was a strong argument that M should be allowed to develop her cultural identity through whānau ties, rather than be raised by a pakeha woman in Australia. Further, in view of CYF's practice which is to aim to return children to their parents, [Mother's] interest in retaining custody of M (albeit apparently rather spasmodic at times) no doubt influenced CYF to look for whānau caregivers.

5.4 The differing expectations in the CYP&F Act create a dilemma for the social worker. Moreover, different expectations may well be highlighted by the professionals involved in the care and protection of a particular child. The child's interests will be advanced by Counsel for the Child. The child is likely to be the subject of a Custody or a Support Order because of deficiencies in the quality of supervision provided by the family; but the Act contains an important focus on family. I discuss the issue of differing expectations in the CYP&F Act in section 10 below.

5.5 In this case, the mother wanted to regain custody of her child and had the support of the Family Start worker in so doing. Further, [Mother] seemed to believe that the behavioural difficulties that M displayed after her return home in December 2008 arose from events which had occurred when M was in a placement which CYF had approved and supervised. While it is not at all clear as to what kind of support [Mother] was given by the Waipereira Trust whānau worker, in view of Family Start's focus on families and the family as a unit, I do not criticise the Family Start worker for not taking a child-centred approach.

5.6 Because the pressures of social work are difficult for individual social workers to deal with on their own, there is considerable emphasis on supervision to enable the individual social worker, first, to stand back and to reflect on the approach adopted, and secondly, to ensure that best practice is followed. I am not convinced that the social workers involved with M between October 2008 and June 2010 always received high quality supervision. Further, I am not convinced that these social workers had a comprehensive understanding of the history of [Mother's] relationship with M.

5.7 As I have noted on a number of occasions, M returned home to [Mother's] care in December 2008. While the placement was apparently meant to be for the Christmas period only, it became in fact the start of a placement which continued until mid November 2010.

5.8 December 2008 was also the time of the birth of [Mother's] youngest child and she was responsible, as a solo parent, for five children then aged eight or less. These events increased the pressures in [Mother's] life and by mid 2010, when the pressures were exacerbated by aspects of M's behaviour, [Mother's] life was, to put it mildly, very unsettled. The stress within the family culminated in the setting of the fire to the mattress at the end of August, which M acknowledged to SW2 was her doing, and from early September a wider range of agencies, with a strong child focus, were involved.

5.9 From June 2009 to August 2010, M was counselled regularly by [Counsellor]. Although M complained to [Counsellor] about the abuse she said she had suffered with the previous caregivers and although Marinoto staff commented positively on [Counsellor's] engagement with M, I am reluctant to describe this counselling overall as sufficiently "child-centred". [Counsellor] had counselled

[Mother] and [Mother] was responsible for bringing M to the counselling sessions. I understand that [Counsellor] sometimes saw them together or, if separately, it appears that at least on some occasions she discussed that matters raised by M with her with [Mother].

5.10 It is unfortunate that for over eighteen months – December 2008 to July 2010 – that the monitoring of the care and protection of M by CYF did not always meet the standards which could be expected from professional social work. However, the social work and therapeutic intervention received by M from August 2010 - first by Specialist Services and then from Marinoto - seem to have been in M's best interests. None of the professionals involved anticipated [Mother's] violence towards M. In view of the intense efforts they were clearly making, I do not criticise them. Rather, I express sadness that despite the skills held by this range of professionals, they were able to anticipate, and thus prevent, these dreadful actions.

6 Term of Reference 2.3

2.3 whether all these individuals and agencies collaborated effectively.

6.1 I do not intend to repeat the points made in my discussion about the role of specific agencies involved in M's life (see section 3 above). It is apparent from that review that the effectiveness of the collaboration ranged from reasonable to abysmal.

6.2 CYF has been responsible for M after she was uplifted in 2001, first pursuant to a Custody Order (s.101) and since May 2010, under a Support Order (s.91). I reiterate the point that CYF, under both Orders, is responsible for the care and control of the child. Under a Support Order it cannot determine where the child lives but, and it deserves to be stressed, the first requirement of a Support Order is "to monitor the standard of care, protection and control being provided to, or exercised over" the child (s.93(a)). As the central agency, CYF bore considerable responsibility for the standard of care and protection for M and, consequently, it was responsible for an effective relationship, and where appropriate, effective collaboration, with the agencies involved in M's life.

6.3 The main feature of the collaboration in practice in M's life from late 2008 until mid 2010 is the existence of two reasonably distinct, albeit overlapping, processes. On the one hand, there were the day-to-day professionals which were mainly CYF, the Waipereira Trust and the Counsellor. On the other, there was the Family Court group, comprising CYF, Counsel for the Child, Counsel for [Mother], the Court Appointed Psychologist, and the Family Court judge. These groups were linked. CYF, as a member of the first group, reported to its representative on the second who reported to the Family Court judge and then as a member of the first group, supposedly, complied with the directions it received from the judge which were made after evaluating the submissions put by the other members of the second group. CYF's representative at the second, advised its member of the first group of the directions which had been made.

6.4 The other agencies involved at this time, for example the school, which called on the truancy services and the public

health nurse, tried to inform CYF, largely unsuccessfully, as a member of the first group, of their concerns. The Police have a formal process in place to advise CYF of its actions and that happened as expected. The family doctor was, and remained, on the outside – despite the decision from group two asking the CYF member of the first group to seek her involvement.

6.5 Following the school's referral of M to Marinoto in June 2010, albeit declined, and the incident of family violence at which [Father] was arrested, CYF, as a member of the first group, became more active both in pursuing social work goals and in improving collaboration with at least some other agencies. By doing so, it seemed to be acknowledging that the previous collaboration had been inadequate. Following the second and successful referral to Marinoto, the degree of collaboration improved considerably. This was perhaps a result of Marinoto's expectations and CYF, Marinoto, Specialist Services, and the Counsellor began to work together in a child-centred way.

6.6 While the school, the general practitioner, and the participants in the Family Court group, other than CYF, were not involved in the discussions from September 2010 about the appropriate way to deal with M, it is reasonable to expect that the Court group would be informed of the action underway when the next Plan Review was put before the Family Court. Further a process for involving the school was clearly in place by both CYF and Marinoto in November.

6.7 The collaboration which occurred after September, I was told, was aided considerably by the recent CYF practice of placing an experienced social worker with each DHB, That step drew very positive comments from a range of agencies.

6.8 I consider that the practice of placing an experienced social worker with each DHB should be extended to primary schools and a recommendation to that effect follows.

6.9 It was clearly evident from my discussions with [redacted] [redacted] School, the School Trustees Association, and two groups representing teachers that, overall, the current relationship between CYF and teachers is unsatisfactory.

6.10 When a school had a serious concern about a child's welfare, I was told, the usual practice was to make a notification to the CYF call centre but, too often, the teachers' representatives said, the concerns seemed to

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disappear into a black hole. First, schools did not know what criteria were used to decide what action, if any, was appropriate, and secondly, they seldom heard what had been CYF's response to the notification.

6.11 I am not suggesting that this was always the response but it happened sufficiently frequently to not be considered unusual. Where the school knew the social worker who might be involved with the child, contacting that person was the preferred approach. Nevertheless, that might be unsatisfactory in urgent cases as by the time the social worker received the message, the school might be closed for the day.

6.12 I understand that the relationship in the past between CYF and DHBs was subject to similar complaints. The remedy adopted was to appoint an experienced social worker to each DHB who could explain to the DHB staff what CYF could do, and ensure that CYF did in fact do what it was able to do. In the current case, the liaison CYF social workers at the Waitemata and the Auckland DHBs were praised for their work and, in particular, for the information about cases they brought to the meetings.

6.13 I consider that CYF should establish a similar process for primary and intermediate schools. It would involve the appointment of an experienced CYF social worker to a cluster of primary schools. The liaison social worker would visit the schools and explain the criteria on which CYF based its decisions after a notification. The explanation would advise when CYF itself decided to act, or when it decided to refer the case to a community group, or when it decided to take no action. The social worker would also be available to schools to advise, to share information about, and to deal with individual cases.

6.14 **I recommend** that the Chief Executive of the Ministry of Social Development, through the Deputy Chief Executive responsible for CYF, take appropriate action to establish the appointment of an experienced social worker to a cluster of primary and intermediate schools as is currently the process for the appointment of experienced social workers to District Health Boards. This may need to be progressive but should initially concentrate on areas with clusters of low decile schools.

6.15 Information sharing is the undoubted strength of collaboration. There are too many incidents in M's life story, unfortunately, where agencies not only have not known of another agency's involvement but even worse in

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my opinion where child protection is the issue, have been reluctant to share information. I deal with that matter further under Terms of Reference 2.4 below. At this point, I indicate that I regard the use of multi agency professional meetings in appropriate cases as an important recommendation that I intend to make. It appears that the problems which arose in this case occurred in part because many of the agencies were confined to their silo.

6.16 I conclude this section by raising two questions: first, would a return home for M been the outcome of a multi agency meeting had such a meeting been held in late 2008 or early 2009 and, if that had been the decision accepted by the Family Court, what monitoring and reporting requirements would have been put in place? Secondly, what would have been the outcome of a multi agency meeting with all the agencies then involved with M, had one been held in June/July 2010 in view of the school's concerns and the incident of family violence and again what monitoring provisions would have been put in place in the interests of M's care and protection?

7 Term of Reference 2.4

2.4 whether the individuals and agencies involved in the case shared information effectively, and if not, why not, and whether the individuals had a clear understanding of the law around information sharing.

7.1 My response to Term of Reference 2.5 below is comprehensive. The detail in that response effectively answers 2.4 but the comments which follow respond to the direct questions.

7.2 From the information available to me it is clear that all information relating to the custody, welfare and protection of the young girl over the period during which she was in care, and during the period immediately before and subsequent to her being returned to her mother's care, was not fully shared between all those who were involved with her and her mother, and what information may have been shared was not shared effectively.

7.3 Had all of the known information been properly and clearly entered in CYRAS (the CYF information recording system) and accessed and effectively shared and discussed between all those who were involved, in other words, social workers, people employed by an NGO, teachers and other individuals who were at some point involved with the girl, her parents and family, then the decisions which led up to the young girl's placement back with her mother, and her ongoing custody with her mother would in all probability not have taken place. The records indicate that the search for alternative whānau caregivers seems to have been given little weight. Had another placement been found, then the physical and other harm done to her would in all probability not have occurred.

7.4 I observe that if the return had been agreed on after all the information had been shared and assessed, I have no doubt that the conditions imposed, and their monitoring, would have been stringent.

7.5 There were people and organisations that did provide information both voluntarily and on request, eg medical and teaching professionals, and they cannot be criticised in this

context. The issue is: was the information provided by such people shared, and how was it acted on. I emphasise in this context the vital role that those in the medical and education sectors must play. These two groups must be significant players in interagency planning, consultation and response, as participants in the processes related to children's safety and welfare. From information given to me during my Inquiry it seems that not all CYF social workers recognise that.

7.6 At this point in time, I cannot answer the question as why the information was not shared effectively. As I indicated in my introduction there are extant criminal proceedings that do, or may, involve people who could possibly provide answers. However I can say that the failure to share effectively does not, from the information available, have much, if anything, to do with the law. Rather it tells us of failures at the process level and poor practice within and between agencies and others, and of a failure to focus on the child, the child's needs and the risks that the child may face. Such a shared focus would ensure that all information and knowledge is shared and appropriately acted on.

7.7 Although not directly relevant to this term of reference I am concerned that there was a failure by one of the CYF social workers (no longer with CYF) to record essential information on the central record known as CYRAS. This system provides a comprehensive historical and working record of cases currently active within the CYF mandate. It provides the source of intelligence for what has happened in any particular case and provides assistance in making assessments and reaching decisions. In my view (and I visited the Centre during my investigation), CYRAS is an excellent system albeit needing review in some aspects, but it can only be as good as the information put into it. Any failure to record essential actions, decisions and the reasons therefore, and any information gathered, compromises the worth of the system. That can be especially important when critical decisions as to a child's future are made based on the information recorded in that system. The involvement of multiple staff, as in this case, makes it absolutely critical that information is recorded for others to utilise.

7.8 The information recorded in CYRAS is also a central supervision and management tool for monitoring essential social worker activities, eg home visits and the conclusions reached as a result of those visits. The failure to record all relevant information negates that management internal control process.

7.9 This is a process and system failure at the social worker level that may or may not be widespread. It is an issue for supervision and management and must be an active concern at the regional and site levels of CYF.

7.10 **I recommend** that the Chief Executive of the Ministry of Social Development, through the Deputy Chief Executive with responsibility for CYF, take appropriate action to review existing processes and systems relating to social workers inputting information into CYRAS and that the thoroughness of the training practices be examined as part of that review process.

8 Term of Reference 2.5

2.5 whether any changes to the processes and legislative framework are required to ensure open and appropriate information sharing about children judged to be at risk of child abuse or neglect.

8.1 An experienced social worker with whom I spoke said:

> Sharing information to ensure the well-being of a child is so simple. Why is it made so difficult?

8.2 The Chief Social Worker in her Practice Review (17 January 2011) wrote:

> Protecting vulnerable children requires professionals from across a range of sectors to work together. To do this effectively, professionals from health, education, and social services sectors, working for public, private and not for profit organisations, need trust and a shared commitments to common goals. It is evident (in this case) that there were pieces of the picture known to multiple agencies, but it is only with the benefit of a full review that the complete picture is revealed.

8.3 I have discussed the issues surrounding sharing of information in the context of child safety and welfare with a wide range of organisations such as the Law Commission, and the Privacy Commissioner, and individuals from the Ministry of Justice, Police, Ministry of Health, New Zealand Psychologists Board, Ministry of Social Development, and the School Trustees Association. I have also spoken to medical practitioners and their organisations, people working within CYF and NGOs, teachers and their organisations, and to other people who have involvement with child safety and welfare issues or with privacy in general.

8.4 The responses have been almost universally positive in expressing the view that whatever needs to be done, must be done, whether that be way of amendments to the law, policy, practices, procedures and, perhaps most importantly, thorough training. The general view is that we must ensure that any information that might impact on the safety or welfare of a child is not withheld only by reason of any real or perceived limitation in the law or otherwise.

8.5 The sharing of information and dialogue between the holders of information is a critical, if not the most critical, component of multi agency and inter-professional liaison and cooperation as argued earlier in this report. As has been indicated in investigations into earlier cases, opportunities for appropriate interventions have been lost because no single agency, or others involved in any particular case, has comprehensive knowledge or a complete understanding of risk, potential or otherwise, to the safety and welfare of a child. Time and again it has been argued that professionals working in isolation from each other have prejudiced an outcome when they failed to recognise the need to focus on the safety and welfare of a child.

8.6 I have inspected what are variously described as interagency agreements, protocols and memoranda of understanding that provide a comprehensive dossier for formal arrangements between CYF and a range of agencies across Courts, Police, Health, Education, Corrections and other organisations relating, to child protection reporting and information sharing. I have also inspected a document (September 2010) providing guidelines for developing child abuse reporting protocols.

8.7 These formal arrangements and guidelines are generally comprehensive and suitable to establish appropriate relationships and arrangements as between the several agencies and others. Most have been reviewed comparatively or very recently, eg Police in 2010. Other protocols or MOUs in critical areas are currently being reviewed eg Plunket Society (currently 2002).

8.8 I note with concern that a very critical arrangement between CYF and the Ministry of Health providing a commitment to collaborative practice in child protection is dated December 1997. This arrangement, in what is a critical component for the detection of child abuse, is long overdue for review.

8.9 **I recommend** that the respective Chief Executives be directed to review and renew this arrangement as a matter of urgency.

8.10 I do note however that the Ministry of Health, through its Chief Advisor Child and Youth Health, has undertaken significant work itself, some in cooperation with CYF and the Police and some with District Health Boards. There have been policies, information publications and guidelines, developed to assist clinicians in dealing with child abuse and neglect.

8.11 Because the situation in New Zealand is similar to that in the UK, I have adopted the view strongly expressed in Lord Laming's report in 2003 (to which I referred in my introduction). He pointed out that despite the clear guidance that has been given over the years by the Privacy Commissioner and others, the law, policies and processes are still not well understood. In practice many working in the area of child protection, and children's safety and welfare, are concerned that by sharing information about a child's safety or welfare they may breach confidentiality or the privacy law.

8.12 It seems that the law, policies and processes are still not well understood, particularly by front line staff and their managers. Different agencies (and their legal advisers) often take different approaches. This is perhaps symptomatic of the wider issue of inter-agency liaison and cooperation. In spite of the comprehensive protocols and the like described above, there appears to be no understood and consistent approach to information sharing across all agencies in the operational context.

8.13 Whilst the law rightly intends to preserve an individual's privacy, the law should not be used, and it was never intended to be so used, as a barrier or prohibition to appropriate information sharing between professionals. In my view the safety, welfare and interests of the child must be paramount. Accordingly, agencies and others involved in any process relating to the safety and welfare of a child may lawfully share information of whatever nature about the child, parent, caregiver or person having responsibility for a child. I suggest also that there is a public duty aspect to the sharing of information where that information may protect a child from harm or may promote a child's welfare. The safety and welfare of the child must be paramount and uncompromisingly so.

8.14 In my opinion, there must be no impediment to the sharing of information where there is any issue involving child safety or welfare. The quote stencilled on the window of the New Zealand Court of Appeal from Earl Warren, one-time Chief Justice of the United States, is apposite. He said:

> It is the spirit not the form of the law that keeps justice alive.

8.15 The organisation with statutory responsibility for the safety and welfare of children, ie the Ministry of Social

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Development through the Child Youth and Family Service, has the responsibility of ensuring that all staff in every site, from front-line practitioners to managers understand their responsibilities about sharing information. Further, I consider that the Ministry has the responsibility to ensure that legal advisers in all state agencies, the voluntary sector and others who may be involved with children, including medical practitioners, teachers and counsellors, understand their responsibility to report child abuse. It is important that the organisations understand the issues about sharing information and their ability to disclose information with others who are involved in child safety and welfare matters. There can be no ifs, buts, or maybes!

8.16 Whilst I commend the thoroughness of the formal arrangements as described in paragraph 8.6 above, such arrangements are generally at the chief executive with chief executive level. Implementation and ongoing training at the coal face of these organisations throughout New Zealand is absolutely critical to ensure that the intention of these arrangements are in fact understood at the operational level, and are being observed in practice.

8.17 **I recommend** that the Chief Executive of the Ministry of Social Development implement a review to develop protocols about information sharing at the local level and that processes are put in place to ensure compliance by all the parties to those arrangements.

8.18 As I understand it every state sector organisation should have an appointed senior officer responsible for privacy matters. In the context of child safety and welfare matters the Chief Executive of the Ministry of Social Development, through that organisation's privacy officer, and appropriately delegated officers in the regions, must have the responsibility to liaise with equivalent officers in all relevant agencies to ensure that all agencies understand the obligations for information sharing between their agency and others involved with the welfare and safety of children, and further that appropriate training programmes are in place and actively followed.

8.19 I note that s.66 of the CYP&F Act provides that every government department, agent or instrument of the Crown and every statutory body may be required to supply information to CYF. I found during my inquiry that this provision is considered within CYF to be an information gathering provision rather than an information sharing provision. While I understand how the provision in interpreted in that way, I suggest this rather narrow

approach does not meet what I am proposing. Further, I note the Law Commission's definition of "sharing" which is the disclosure of information about an individual by one agency to another. Such a definition if applied to s.66 would enable it to be seen as one of the processes within a privacy law package.

8.20 Even if s.66 was so amended, there is a question as to whether it would be broad enough. For example should it specifically include private sector counsellors who are involved with a child or its family, or say NGOs and Whānau Ora organisations.

8.21 Section 66 needs to be examined to consider whether it, even if amended some 21 years after it came into force, would be sufficient in today's environment. If it is to be used as a process for information sharing then it needs to reflect the current environment and align with provisions in the privacy law.

8.22 Although, s.66 is a powerful and explicit provision, I have been told, there are agencies, and individuals within agencies, who are reluctant to comply and hide behind the Privacy Act to avoid providing information to be used for the purposes envisaged by the CYP&F Act. That cannot be allowed to continue.

8.23 I have discussed the issue of sharing of information in the context of child safety and welfare issues with the Law Commission and have had the benefit of reading the Commission's indicative paper on information sharing dated 2 February 2011. I am in agreement with the proposals outlined in that paper but have noted the view that:

> "In the first instance, the proposed regime should apply only to sharing between government agencies, although in appropriate cases it might be extended to include the *receipt* of information by NGOs."

8.24 Using the case that is the subject of this inquiry as an example, I am strongly of the view that more is needed. As I have made clear above it is my opinion that, in the context of child safety and welfare, the law should not inhibit information sharing by any agency or person who has information that may impact on the safety or welfare of a child.

8.25 I have also noted the views expressed by the Independent Experts Forum on Child Abuse which you established last year. In its report the Forum said:

> "Information sharing between agencies happening as a matter of course is crucial in the prevention of child abuse, and [cases have been] identified where agencies had access to some information about a child but not all information."

8.26 I agree with the Forum but note that their comment refers to sharing only between agencies. However as I have noted above and based on the experience of this case, arrangements for information sharing need to cover a much wider range of organisations including NGOs and individuals such as private sector counsellors.

8.27 I note and endorse a view recently expressed by the Ministry of Social Development about the relationship between privacy issues and preventing harm and protecting vulnerable children. The Ministry said:

> "We require certainty and clarity. Agencies working with vulnerable individuals and families cannot afford for there to be disagreement on what privacy means, and whether information can be shared. If there is disagreement or uncertainty, important opportunities will be lost."

8.28 A 2009 Victoria University study (Lips et al) concluded:

> "… not having a legal provision for sharing critical information on individuals at risk, leads to ambiguous situations around legal boundaries of information sharing in dealing with other agencies (public service providers, agencies with a public safety mandate, and community service providers). As a result professionals experience uncertainty about whether, and if so what information can be shared, and therefore often decide not to share critical information… "(My emphasis)

8.29 I also note, as advised by the Ministry of Justice, that the current review being undertaken by the Law Commission and the State Services Commission as part of the "Service Link" initiative, that the proposals from those organisations are silent on how information can be shared with community, local government and private sector providers.

8.30 The Ministry of Justice is cognisant of the issues I have outlined above and is proposing to the Minister of Justice

that work proceed with the objective that a Bill, The Privacy (Information Sharing) Amendment Bill, be introduced by 12 July 2011.

8.31 I fully support the Ministry of Social Development view that the existing law is not as clear as it could be and that agencies, and indeed all others, ie NGOs, the medical profession, teachers and individuals working in the field, need greater clarity and certainty.

8.32 I agree with the Ministry of Justice approach and recommend your support for the proposed changes and the timetable for introduction.

8.33 I reiterate however the views I have expressed earlier in this Report. As has been found there is no clear understanding of the current privacy law in relation to sharing information about child abuse, safety, welfare and protection. Certainly the law needs to provide more clarity and certainty but, in tandem with law changes, there needs to be a concerted and ongoing programme of education and information provision about the law, its extent and its practical application.

8.34 I have belatedly become aware of papers reporting to you in September and October 2010 about information sharing in respect of vulnerable children and the child welfare responsibility.

8.35 There is nothing in those papers that is inconsistent with the views I have expressed above. My Report and the papers before you emphasise, in different ways, the importance of information sharing in the context of children at risk. This Report also emphasises that the requirement to share information, when the welfare or safety and protection of a child is involved, must extend beyond government agencies to include all those who are working in the field. The quotes from a social worker and the Chief Social Worker's report which introduce this Term of Reference are apposite.

8.36 With the work going on in the Law Commission, Ministry of Justice, State Services Commission, Ministry of Social Development and elsewhere there needs to be a decision as to whether the law in respect of information sharing relating to the protection and safety of children should be provided in the Privacy Act or, in effect, codified in the CYP&F Act. I see significant advantages in having provisions for sharing as discussed above, to be provided in the CYP&F Act. This will have the advantage of codifying the law, and providing clarity and certainty in respect of information sharing between all those involved with child welfare and

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protection. It will also provide a "one stop shop" for legislative provisions relating to the sharing of information between professionals and others working in the area of child welfare and safety.

8.37 I have discussed this proposed approach to information sharing in the context of child protection with the Law Commission. The Commission supported that approach and saw merit in codifying the law in respect of child welfare, safety and protection information in the relevant Child Welfare legislation.

8.38 As emphasised by the Ministry of Justice, the need for these law changes is urgent.

8.39 **I recommend** that no matter which vehicle is considered to be appropriate, ie the CYP&F Act or the Privacy Act, that the timetable proposed by the Ministry of Justice is accepted and acted on.

8.40 **Mandatory Reporting:** Although not specifically referred to in the term of reference, the issue of mandatory reporting compels recognition in this Report.

8.41 I note that Term 2.5 refers to changes to the legislative framework "to ensure open and appropriate information sharing…" (my emphasis).

8.42 Mandatory reporting is of particular relevance to the medical profession and the arguments about it, either for or against, throw up complex issues and have raged (to put not too fine a point on it) for many years.

8.43 It is my view that, if we are serious about taking all opportunities to reduce the incidence of child abuse, then mandatory reporting by all professionals where child abuse is suspected, should be provided for as part of any process to ensure open and appropriate information sharing. Mandatory reporting will certainly not be the total solution to issues of child abuse. But again, using the same argument for inter-agency collaboration and cooperation, it adds to the opportunities to detect and act on child abuse in the interests of children's safety and welfare. There is, so I understand, such a process in Australia, Canada and much of the United States.

8.44 The issue has been the subject of Parliamentary consideration previously, although not in recent years. It was discussed during debates prior to the passing of the 1989 Act and again in 1994. At that time an amendment to

the Act was considered by a Select Committee but not proceeded with following advice that education focussing on information and public awareness, along with the provision of protocols, would be a preferable process.

8.45 Although I feel compelled to raise this important issue as part of my Report I am not able to pursue the issues and arguments within the timeframe available. In any event it is an issue that requires considerable consultation with the medical profession and their organisations and with other professional organisations. Such a process would, I believe, carry with it resource implications. There is still a well argued view presented to me that public awareness and the provision of information approach is to be preferred. I appreciate those arguments but suggest that we may have reached the point where mandatory reporting is an issue of such fundamental importance in making progress against New Zealand's high incidence of child abuse, that it is time to consider its suitability again.

8.46 **I recommend** that the possibility of a legislative requirement for mandatory reporting should be examined again with urgency. It should not however delay progress on the introduction of the Bill referred to in the previous recommendation.

9 Term of Reference 2.6

2.6 any other matters that should be brought to the attention of the Minister.

Review of Part 8 of the Crimes Act 1961

9.1 In late 2008, in response to a number of high profile cases involving the worst forms of child abuse, neglect and non-accidental death, the Minister of Justice required the Ministry of Justice and the Law Commission to expedite a review of Part 8 of the Crimes Act 1961. This review was to have particular regard to offences directed to the protection of children from assault, neglect, and ill-treatment and the adequacy of the maximum penalties.

9.2 The Law Commission's report, prepared in consultation with the Ministry of Justice, was submitted to the Minister of Justice on 30 November 2009. I understand that the Minister has decided to proceed only with the provisions relating to children and vulnerable adults, and certain other unrelated provisions. There is a timetable to bring a paper to the Cabinet Legislative Committee early in April 2011. I strongly support that approach and such a timetable.

9.3 In my view the proposed changes to the criminal law are significant and of considerable importance. As I understand it the proposed new law will make it an offence for those who live with a child to fail to take reasonable steps to protect the child from the risk of death, grievous bodily harm, or sexual assault. The law will capture people in sufficient proximity to a child who are neither parents (thus who are already under a duty), nor the perpetrators of the offences, nor parties to it in a legal sense, but who nonetheless will have a duty to the child because of their proximity. These people will have a legal culpability that the law at present does not at present recognise.

9.4 I cannot say with any certainty, had such provisions been in existence during the period after the young girl was returned to and in the custody of her mother, that the physical abuse that occurred would have been notified prior to the events on 10 - 15 November 2011. However, on the information known to me there were certainly people in the house from time to time, and who were in sufficient proximity to the children in the house, including the young girl, who would probably be captured by the proposed law

if they had failed to notify the existence of a risk of physical injury to those children.

9.5 These proposed changes clearly demonstrate the Government's strong commitment to doing what can be done through the law to improve the protection of children at risk. During the course of my Inquiry I detected a very strong general support for a provision in the criminal law that will encourage people to report situations where a child is at risk of physical injury or abuse in the home.

9.6 **I recommend** that the Government proceed with the proposed legislation to amend the Crimes Act as a matter of urgency and progress the Bill through the cabinet committee stages to permit introduction and passing within the 2011 legislative programme.

9.7 **I recommend** also that, immediately on passing such a law, there be an intensive public communication programme to ensure there is wide coverage of these important changes to the law relating to the protection of vulnerable children.

10 Children, Young Persons and Their Families Act 1989: Its Objects and Principles

10.1 At the time of its passing and its coming into force on 1 November 1989 the provisions in the Children, Young Persons, and Their Families Act were considered far-sighted and world leading. The objects and the some of the principles to be applied in its administration were ground breaking. In many respects those provisions are still considered to be at the forefront of thinking in relation to children and young persons' welfare and management. Other countries have emulated the approach that New Zealand took back in 1989.

10.2 However New Zealand society has changed significantly in the 21 years since the Act came into force. Much has changed in the structure and behaviour in New Zealand society. Much has changed in the thinking related to the administration and management of children and young persons' issues. Much has changed in social work practice. Over that period there have been significant developments in NGOs, and with private sector counsellors working in the field of children and young persons' welfare.

10.3 You asked me to identify any other matters that I concluded should be considered by you in the context of child safety and welfare. I put the matter of the legislation, particularly in relation to the principles in the Act, before you as one of the issues that has been raised with me during the course of my Inquiry, and which I see as very significant. The people who raised this question were not able to identify clearly whether their concern related to the law as it is, or the administration, management and application of the law. Their concern as presented to me was however genuine. They saw the issue as very important in the context of the welfare and safety of children and they saw the need to reinforce the focus on the best interests of the child as being the principle of paramount applicability.

10.4 The substantive issue raised with me related to what is perceived to be a conflict, in practice if not in the law, with the principle "in exercise of powers conferred by this Act" as provided in s.6 of the Act, with the principles provided in s.5, and the guiding principles for any Court in exercising its powers under the Act as set out in s.13.

10.5 In short the concerns expressed to me revolved around whether the provisions in the law read as a whole, and the

administration, application and management of the law as it is now practiced, had resulted in the loss of focus on the interests of the child as being paramount. They questioned whether it remained the first and foremost principle when a decision was made affecting the child. There was concern that too often it appeared as though the wishes of a parent or parents, and/or family or Whānau, prevailed over the immediate and long term best interests of the child.

10.6 It has been argued to me, not unreasonably, that the case the subject of this Inquiry is a case in point. There is a view that the social workers, counsellors, family/whānau and some of the others who were involved in this case, tended to look past or over the child, and could see only the persons arguing for family or whānau placement. As a general rule, it was postulated to me that the provisions in ss.5 and 13 have become dominant in the minds and in the practices of social workers, and other involved in the process, to the possible detriment of the safety, welfare and interests of the child.

10.7 Section 6 of the Act is explicit. It says:

> "In all matters relating to the administration or application of this Act .....the welfare and interests of the child or young person shall be the first and paramount consideration, having regard to the principles set out in sections 5 and 13. "(my emphasis)

10.8 Section 5 says inter alia:

> "Subject to section 6 any Court or person who exercises any power conferred by or under the Act, shall be guided by the following principles:
>
> (a) the principle that, wherever possible, a child's family, Whānau, hapu, iwi, and family group should participate in the making of decisions affecting that child or young person, and accordingly that, wherever possible, regard should be had to the views of that family, Whānau, hapu, iwi, and family group." (my emphasis)

10.9 Section 13 says inter alia:

> "Subject to sections 5 and 6, any Court or person who exercises powers ....shall be guided by the following principles:

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(a) the principle that children must be protected from harm, their rights upheld, and their welfare promoted;
(b) the principle that the primary role in caring for and protecting a child lies with the child's family, Whānau, hapu, iwi and family group
(c) the principle that it is desirable that a child live in association with his or her family, Whānau, hapu, iwi, and family group…….
(d) where a child is considered to be in need of care or protection, the principle that, wherever practicable, the necessary assistance and support should be provided to enable the child to be cared for and protected within his or her own family, Whānau, hapu, iwi or family group.
(e) the principle that a child should be removed from his or her family, Whānau, hapu, iwi, and family group only if there is a serious risk of harm to the child…" (my emphasis)

10.10 Similar provisions are to found in the Care of Children Act 2004 providing principles relevant to a child's welfare and best interests.

10.11 As "the interests of the child are paramount" is a cornerstone of administration and application of the law and practice regarding the custody, care and welfare of a child, I am surprised that nobody has been able to direct me to any relevant research or assembled experience to provide at least some answers on how the principles in ss.5, 6, and 13 are being administered and applied. Because of the complexity and indeed the politics of the issues, the absence of well researched and analysed experience render it impossible to develop sound, reasoned and developmental arguments on which to base law and policy.

10.12 I referred specifically in my Introduction to the absence of research into the placement of the child including what is described in the literature as "kin care".

10.13 The Office of the Children's Commissioner in its 2010 report into Children in Care said:

> "Despite New Zealand's leading role in the increased emphasis on kinship care, very little research has been undertaken and there are no longitudinal studies focussing on children's experiences in kin care or outcomes over time."

10.14 Referring to the international literature, the report adds:

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> "… that the growth of kinship care may have been ideologically driven in terms of family preservation rather than a focus on best outcomes."

10.15 In a 2003 paper by Marie Connelly, a former Chief Social Worker in CYF observed:

> " … it is important to note that there is a dearth of research in New Zealand (and Australia) relating to kinship care and it is important that policy is not developed in a research and information vacuum. "

10.16 Further she wrote:

> "Given the centrality of the safety issues, there is surprisingly very little research that has looked specifically at child safety within kinship care placements and what research there is tends to be contradictory."

10.17 I have nothing at my disposal and, in view of my deadline, do not have the time to research the issues and arguments. It is a complex and difficult issue for evaluation and research but I see it as fundamental to developing sound and progressive law and policy for the future welfare and safety of our children. As I have indicated little has been undertaken by way of research, or evaluation of current law and policies in relation to kinship care to enable us to know whether the current law and practices are meeting our children's needs, welfare and safety. This failure to know what is happening, because of the absence of quality research and evaluation, is a significant gap. It needs to be urgently addressed.

10.18 **I recommend** that urgent action be taken to commission evaluative research to inform legislative developments and changes in social work practice.

10.19 The view has been expressed that, for a variety of reasons, including the very significant philosophical and ideological changes following the introduction of the 1989 Act, previous processes such as the inter-agency case conference supported by a formal team structure, have fallen out of the process. I note comments made by Anne Caton published in *Social Work Now* (2000). That commentator argued that because of the requirements of the legislation (CYP & F Act 1989), there may be a risk during the investigation and assessment of a case. That might occur as social workers placed too much emphasis on forming and maintaining a

relationship with the family at the "expense of comprehensive information gathering and careful consideration of all facets of the child's situation".

10.20 I have argued earlier in this report in responding to Terms 2.2 and 2.3 that in my view there is a lacuna in the legislation in that it does not provide an ability for either the Family Court or a CYF social worker or senior CYF official, a police officer or other professional person eg a doctor or teacher, or any other person involved in a particular case concerning the welfare or safety of a child, to request an inter-agency meeting, or for the lead agency, ie CYF, to require a meeting of all those involved at the professional level to share information and discuss all issues that may, at that time, have an impact on the safety or welfare of a child.

10.21 Such an arrangement is not in my view in any way in conflict with the provisions for, or the operation of, a Family Group Conference (FGC) or any other whānau decision making process. One is not exclusive of the other but making provision in law for inter-agency meetings would have a three-fold purpose. First, it would compel interaction and consultation within a group of professionals, and secondly, it would provide an opportunity to add significantly to the informed and comprehensive knowledge about the situation of a child. Thirdly, it would enable a collegial view to be developed of what risks there might be for the child and what is in the best interests of the child.

10.22 Had such a process been available in law in this case, and had either the Family Court, CYF as the lead agency, or the professionals involved utilised it, it may well be that different decisions would have been made affecting the future placement and well-being of the young girl. From my discussion with Counsel for the Child, I expect that had such a provision and opportunity existed, she could well have requested such a professional's meeting.

10.23 I have discussed this concept with the Family and District Court judiciary, all of the government agencies involved in child protection, experienced people from NGOs and others active in the field. Without exception all were enthusiastic and supportive. As I have indicated none saw an arrangement such as this as being in anyway in conflict with the FGC process. All considered that providing a statutory base for such a process would emphasise the essential need to share information and knowledge and avoid any misconceptions about cooperation and integration of action at the professional level. The proposed process

was seen as an opportunity to enhance the principle established in s.6 of the Act emphasising that the interests and welfare of the child are paramount.

10.24 **I recommend**

(i) that a policy be developed as a priority by CYF in collaboration with other agencies involved from time-to-time in child welfare, safety, and protection, to establish a process for multi agency case consultation to occur among professionals involved in any particular case. This process shall include CYF as the lead agency, police, school principal, DHB representative, and any other government agency that may be involved in any particular case eg Housing NZ. The case consultation should include the CYF social worker involved but be chaired by a senior officer in the particular Site Office of CYF.

(ii) that a protocol be developed at both national and all local levels to mandate the policy and establish the process.

(iii) that the Principal Family Court Judge is informed of the policy and the process, and judges be invited to refer matters before them for such a case consultation by professionals involved in any case should the court so wish.

(iv) that at the Site level there are negotiations with NGOs or other organisations and individuals eg counsellors, involved regularly, or in any particular case, to participate in any professionals' case consultation.

(v) that provision is made in the CYP&F Act for such a case consultation process as discussed in this Report.

11 A Child Protection Court

11.1 This section begins by presenting a view expressed to me by a very experienced social worker who has spent a number of years working in similar jurisdictions overseas – particularly in Australia. The point was made during a discussion on the paramountcy of the child that the law is drawn to put the focus on family, whānau and kin in general. The argument was made, and I have sympathy for this view, that in New Zealand we do not have a court identified by title as a Child's or Children's Court. We have a Family Court as a division of the District Court and whilst I have no doubt that the judges in those courts apply the law with proper regard to the safety and welfare of the child, the public perception is on family and not on children. As is demonstrated in the case the subject of this Inquiry, this mind set may also prevail in some sectors involved with child welfare, safety and protection.

11.2 The benefit that would occur should there be such a court is that everyone involved in the process, ie judges, counsel, counsel for the child, social workers, psychologists, NGOs and other involved in matters of child safety, welfare and protection would be focussed more on the best outcome for the child. An increased level of expertise, experience and knowledge would result.

11.3 I have not been able in the time available to develop this issue nor to canvass appropriate opinion. It is an issue however that I consider to be worthy of serious and in-depth consideration.

11.4 **I recommend** that you refer the proposal to the Chief Executive of the Ministry of Social Development for investigation and report.

12 The Child, Youth and Family Service and its Management

12.1 I thought it appropriate that I provide you with some observations about CYF as a whole and in particular, about its management at both the national and local level. It is inevitable that at some point there will be criticism arising from this case of CYF couched in general terms and demanding radical changes in structure and organisation.

12.2 CYF has had a pattern of organisational re-structuring and re-arrangement over the past 10 years or so. At one point back beyond that, the functions were part of the Department of Education. Subsequently, and at the time of the current Act was passed, it was part of the Department of Social Welfare. Later, and for a relatively brief period, it was a stand alone government department and was then merged from 1 July 2006 with what is now the Ministry of Social Development. It is structured as an operationally independent arm of the Ministry with its financial provision being recognised as a service line in the appropriation of the Ministry of Social Development.

12.3 I consider that the present organisational and management arrangements are sound in terms of public administration and public sector governance and management. From the information available to me, and from my own experience, I observe that there have been substantial improvements in the overall level of management, including financial management, of CYF since bringing the organisation into the Ministry of Social Development. As an example I have noted the substantially improved financial performance over the past four years in an environment where notifications to the Contact Centre have risen from 66,739 in 2005/6 to 124,921 in 2009/10.

12.4 I have seen nothing during this inquiry, nor from my other experiences with the operation of CYF, that cause me to propose any re-arrangement of the existing organisational arrangements to resolve issues such as I have identified in this report. Nor do I believe that any changes in organisational structure at the national or regional levels are necessary as a response to the situation or circumstances that gave rise to this case.

12.5 Certainly there were, as I have identified in this report, system and process failures and deficiencies in supervision

and overall management in individual offices. There are improvements that must be made. But these failures were, in the main, human failures characterised by both circumstances and the complex involvement of others outside the CYF system. Most incidents such as the case of this young girl are tragic. However, other than the appalling act of violence to a child, these cases are unique in terms of the history of the people involved, and their involvement with CYF, various welfare and related agencies, and other with government agencies eg Police. It is this very fact that makes the milieu of child welfare, safety and protection work so complex and complicated. This labyrinth of relationships with the child, family and other professionals, and the range of assessments and critical decisions that are necessary and which may well have a profound effect for the child, demands very strong commitment to high quality social work practice, quality supervision and management arrangements at the local level, and focussed monitoring and control systems at the national level. This is not easy to achieve and most importantly maintain. But this is at the essence of the CYF role in relation to the welfare, safety and protection of children.

12.6 There was one aspect of the work of CYF which I believe should be clarified for social workers. As I noted in para 3.10.9, a Support Order under s.93 of the CYP&F Act not only imposes a duty to provide and coordinate services to a child, but also "to monitor the standard of care, protection, and control being provided to, or exercised over" the child.

12.7 Social workers are of course at the front line. The statement I have quoted by Lord Laming in my introduction at paragraph 1.14 exemplifies the difficulties of the role. I referred earlier in this report to the number of social workers who were involved with this case and the problems that this can create for the ongoing effectiveness of the social work function. I have obtained turnover data for social workers employed by CYF. This information discloses that nationally the turnover figure has dropped from some 15% in 2006/7 to an indicated 8-10% in 2010/11. The current figures compare favourably with the turnover rate across the whole occupational class for social, health and education workers. Such a reduction is positive and whilst there may be several reasons for this it nevertheless provides the opportunity for improvements in case work, a more experienced social work force and, importantly, the opportunity to concentrate on training and supervision developments. This is critical to future performance.

12.8 I cannot emphasise enough how important I see the role of the supervisors, practice leaders and site managers in local offices. It is these people who must be responsible for the quality of the work undertaken by social workers. It is these people collectively who must ensure, so far as is possible in the difficult environment in which they work, that the consultation processes, relationships with the plethora of people who might be involved in any one case work together so that the necessary assessments and decisions are well-founded and focussed on the welfare, safety and protection of the child. It is these people who must ensure that their records are translated into CYRAS so that all the critical information is stored there in a timely way and is relevant and consistent. CYRAS is the source upon which future assessments and judgements affecting a child will be made. The CYRAS record is also an essential tool for management to assess the quality of performance.

12.9 I have referred earlier to the essential need to lift the level of training at all levels in the organisation. From my discussions with them I am aware that the Chief Executive, the Deputy Chief Executive (CYF) and the Chief Social Worker all see this as a critical requirement to further improve the overall quality of social work and to ensure that the law, policy, processes and practice is of the highest order. Following on from this Inquiry and whatever decisions are taken by the Government as a consequence, **I recommend** that a training plan be developed covering all work undertaken in the regions and individual sites and focus on social work skills and practice, supervision processes and skills, and at all levels of operations at regional and site levels. With regard to the training of social workers, the requirements of Support Orders under s.93 of the CYP&F Act need to be emphasised.

13 Conclusion

13.1 This report identifies failures in social work, failures in consultation and coordination, failures in communication, failures in assessments, failures in supervision and management, failures in recording information, and, most seriously it seems, failures to focus on the child's safety, welfare and protection. Reasons can be found for all these things but that does not excuse the fact that the system may be seen as failing this child.

13.2 I have expressed particular concern about whether the principle of the best interests of the child are paramount and whether it is given sufficient consideration in determining issues of custody and the welfare and safety of the child. The Commissioner for Children has said to me:

> "There is a failure to ensure a child-centred approach. All of the professionals in this case had a primary relationship with the mother. <u>The importance of maintaining a child-centred approach cannot be overstated."</u> (emphasis added)

13.3 Based on this inquiry and knowledge from my wider experience I fully support this approach. My report discusses the issues of the law, and the absence of evaluation and quality research around this issue.

13.4 In conducting this Inquiry, I have spoken to a spectrum of people involved both in this case, and others having experience and knowledge of child safety and welfare law, practice and operations. All these people recognised the deficiencies that exist and have been forthright and helpful to me in providing a comprehensive package to you that I believe will assist in overcoming many of the problems that have emerged during this Inquiry. Training across the board in regional and site offices is critical.

13.5 As I said in my Introduction, although the Inquiry has revealed what are individual failures in many areas both within CYF and with others who were involved, the essence of my report is not to lay blame but to learn from and identify improvements in the law, practice, processes and management, that will make New Zealand a safer place for our children and enhance their welfare.

13.6 I reiterate that my report contains a comprehensive package of changes across the full spectrum of child welfare, safety and protection issues. It covers legislation, policies, practices, processes, management and operations, and

importantly training in individual CYF Sites. I urge that the Report be accepted as a package. Although implementation of the component parts may have to have different timetables, and some proposals, eg research and evaluation of certain of the CYP&F Act provisions may have a longer timeframe; it is the comprehensiveness of the proposals that will provide the benefits and system-wide improvements that are essential to our children's welfare and safety.

13.7 I have been provided with information from the Chief Executive of the Ministry of Social Development, the Deputy Chief Executive with responsibility for CYF, and the recently appointed Chief Social Worker, informing me of changes and developments they are now making in social work practice and supervision and management at the Site level. Those developments are entirely consistent with what I have identified in this Report and the recommendations I have made. I commend the Ministry for the initiatives it is taking and the speed with which it is implementing them.

13.8 It saddens me however to finish with a note of warning. All of us would I am sure want our children not to be harmed and their welfare assured. But no matter the censures in the law, no matter how the system is structured, and no matter how well all of those involved, including families and caregivers, perform their functions and responsibilities, there will, from time to time, be incomprehensible behaviour with a child as the victim. There are of course wider social issues in play. However the task and obligation of legislators, people who work within the system in no matter what capacity, and the whole New Zealand community, is to ensure that all are focussed on the welfare and safety of the child, and that the best interests of our children are paramount.

13.9 I reiterate my statement in the Introduction and earlier in this conclusion. The child must be the centre of the law, policy, processes and practices with a desired outcome of what is best for the child. There can be no resiling from this obligation on us all. Child safety and welfare is, I suggest, the collective responsibility of the whole of government and of the whole New Zealand community.

14 Recommendations

It became apparent during the early stages of my Inquiry that there is no "silver bullet" answer to the issue of child abuse in New Zealand generally, or regarding this particular case. Nevertheless, there are a number of important changes to law and practice contained in the following recommendations which, if implemented fully, should substantially reduce the instances of child abuse. In order to appreciate the import of each recommendation, I urge the reader to take into account the discussion leading up to and the context of each recommendation.

I recommend:

1. that you note the strong emphasis I have made throughout this Report on the incontrovertible need for all those involved in child safety, welfare and protection, to ensure a child-centred perspective that focusses on the child, and that all other considerations be subordinated to the principle in section 6 of the Children, Young Persons, and Their Families Act 1989.

Most of the following recommendations are intended to support that fundamental approach:

2. that the Chief Executive of the Ministry of Social Development, through the Deputy Chief Executive responsible for Child, Youth and Family, take appropriate action to establish the appointment of an experienced social worker to a cluster of primary and intermediate schools as is currently the process of the appointment of an experienced social worker to each District Hospital Board. (6.14)
3. that the Chief Executive of the Ministry of Social Development, through the Deputy Chief Executive with responsibility for Child, Youth and Family, take the appropriate action to review existing processes and systems relating to social workers inputting information into CYRAS, and that the thoroughness of the training practices be examined as part of that review process. (7.10)
4. that the Chief Executives of the Ministry of Social Development and the Ministry of Health, as a matter of urgency, be directed to review and renew the Memorandum of Understanding between the ministries with regard to child protection. (8.9)
5. that the Chief Executive of the Ministry of Social Development implement a review to develop protocols at the local level regarding the sharing of information between agencies, both government and non government, and to put processes in place to ensure compliance by all parties to those arrangements. (8.17)
6. that no matter which vehicle is considered to be appropriate, i.e. the CYP&F Act or the Privacy Act, that the timetable recently proposed by the Ministry of Justice with regard to changes in the law relating to information sharing is accepted and acted on. (8.39)

7. that the possibility of a legislative requirement for mandatory reporting should be examined again with urgency. It should not however delay progress on the introduction of the Bill relating to information sharing referred to in the recommendation in paragraph 8.39 (8.46)

8. that the Government proceed with the proposed legislation to amend the Crimes Act relating to the protection of children as a matter of urgency and progress the Bill through the cabinet committee stages to permit introduction and passing within the 2011 legislative programme. (9.6)

9. that, immediately on passing such a law, there is an intensive public communication programme to ensure there is wide coverage of these important changes to the law relating to the protection of vulnerable children. (9.7)

10. that urgent action is taken to commission evaluative research with regard to kinship care to inform legislative developments and changes in social work practice. (10.18)

11. (i) that a policy be developed as a priority by Child, Youth and Family in collaboration with other agencies involved from time-to-time in child welfare, safety, and protection, to establish a process for multi agency case consultation to occur among professionals involved in any particular case. This process shall include Child, Youth and Family as the lead agency, Police, School Principal, District Health Board representative, and any other government agency that may be involved in any particular case e.g. Housing NZ. The case consultation should include the Child, Youth and Family social worker involved, but be chaired by a senior officer in the particular Site Office of Child, Youth and Family.

    (ii) that the development of a protocol at both national and all local levels to mandate the policy and establish the process.

    (iii) that the Principal Family Court Judge is informed of the policy and the process, and judges be invited to refer matters before them for such a case consultation by professionals involved in any case should the court so wish.

    . (iv) that at the Site level there be negotiations with non government organisations or other organisations and individuals e.g. counsellors, involved regularly, or in any particular case, to participate in any professionals' case consultation

    (v) that a provision is made in the CYP&F Act 1989 for such a case consultation process as discussed in this report. (10.24)

12 that the Chief Executive of the Ministry of Social Development be directed to investigate and report as to the establishment in New Zealand of a Court known as the Child Protection Court. (11.3)

13 that the Chief Executive of the Ministry of Social Development, through the Deputy Chief Executive for Child, Youth and Family and the Chief Social Worker of Child, Youth and Family, develop a training plan covering all work

undertaken in the regions and individual sites which will lift the levels of social work skills and practice, supervision processes and skills throughout Child, Youth and Family. With regard to the training of social workers, the requirements of a Support Order under s.93 of the CYP&F Act need to be emphasised. (12.8)

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15 Appendix A

The following Terms of Reference for the Ministerial Inquiry have been extracted from the Cabinet Direction:

2.1 Whether the multiple agencies and individuals involved in the family in the lead-up to her abuse took all appropriate actions to ensure her safety.

2.2 Whether these individuals and agencies were sufficiently child-centred in their actions and approach to this case.

2.3 Whether all these individuals and agencies collaborated effectively.

2.4 Whether the individuals and agencies involved in the case shared information effectively, and if not, why not, and whether the individuals had a clear understanding of the law around information sharing.

2.5 Whether any changes to the process and legislative framework are required to ensure open and appropriate information sharing about children judged to be at risk of child abuse or neglect.

2.6 Any matters that should be brought to the attention of the Minister.