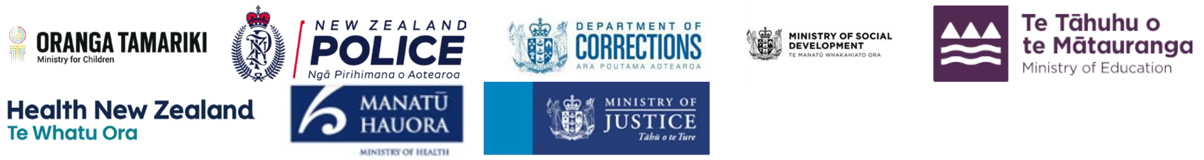
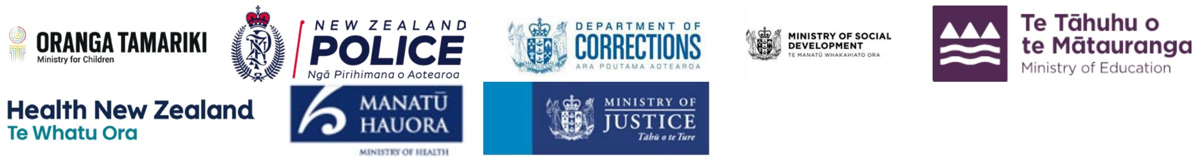


Progressing Dame Karen Poutasi's recommendations

A multi-agency update to inform Aroturuki Tamariki | the Independent Children's Monitor of existing and future work programmes relevant to Dame Karen Poutasi's recommendations



Multi-Agency Response

Aroturuki Tamariki - the Independent Children's Monitor ("The Monitor") has released its report 'Towards a stronger safety net to prevent abuse of children' ("the Report"). This provides observations on the first 12 months of progress against recommendations in the November 2022 report by Dame Karen Poutasi into the children's system's response to abuse, following the murder of five-year-old Malachi Subecz by his caregiver in 2021.

As Chief Executives, we commissioned the review in recognition that Malachi was let down by the system that should have protected him. Our agencies have carefully begun the complex task of changing the system for the better, and the Report demonstrates the breadth of the work that is necessary and underway.

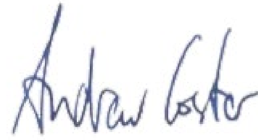
System-wide improvements to reduce child abuse call for careful understanding of the interconnected requirements and consequences of change across each of its parts, including preventing, recognising, reporting and responding to child abuse, as well as reviewing how the system performs. There are no easy solutions when the roots of our national child abuse problem lie in deprivation, intergenerational trauma, and other unmet needs; and there are rarely easy responses when the state is called to intervene in families and whānau in the hope of protecting those who are most at risk.

Our agencies are working together on these hard issues and remain as committed as ever to the challenge ahead of us. The significant complexity of children's system change means it will take time, it will require ministerial decisions, and it will necessitate choices about highest impact priorities in our resource-constrained environment. However, all of us want to finish the good work we have started, and make sure the right decisions are made for each of Dame Karen Poutasi's recommendations.

We have undertaken engagement with iwi and community partners on some key recommendations, reflecting our commitment to Te Tiriti o Waitangi, and the significant impacts of change in communities. Updates on the specific recommendations in the Dame Karen Poutasi Report are provided in the below table.

Child abuse is a problem we must all tackle together – families, communities and government agencies – to keep tamariki and rangatahi safe.

Chappie Te Kani
Chief Executive
Oranga Tamariki



Andrew Coster
Commissioner
New Zealand Police

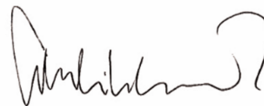
Jeremy Lightfoot
Chief Executive
Department of Corrections

Debbie Power
Chief Executive
Ministry of Social Development

Iona Holsted
Chief Executive
Ministry of Education

Fepulea'i Margie Apa
Chief Executive
Health New Zealand | Te Whatu Ora

Dr Diana Sarfati
Director-General of Health
Ministry of Health | Manatū Hauora



Andrew Kibblewhite
Pou Whakarae mō te Ture
Secretary for Justice

Recommendation		Lead and supporting agencies	Update
Critical gap 1: In identifying the needs of a dependent child when charging and prosecuting sole parents through the court system			
1	*Oranga Tamariki should be engaged in vetting a carer when a sole parent of a child is arrested and/or taken into custody. Police (or other prosecuting agency) in the first instance, and the Court in the second, will need to build into their processes time for this to occur.*	**Oranga Tamariki** Ara Poutama – Department of Corrections (Corrections) Te Tāhū o te Ture – Ministry of Justice (Justice) Ngā Pirihimana o Aotearoa – New Zealand Police (Police)	**The Monitor states there has been little progress in vetting carers** It became clear early on in this work, that recommendations 1, 2 and 6 were closely related so needed to be examined together. This led to the development of a working group, that provided a combination of advice across the three recommendations. Corrections has made technology changes that will enable them to record the number of dependent tamariki with a parent in Corrections' custody in the future. A Cabinet Paper[1] identified this recommendation as requiring further consideration because of the significant implications that could arise from implementation. Oranga Tamariki will shortly be providing advice to the Minister for Children for consideration and further discussion.
2	*Oranga Tamariki should be engaged in regular follow-up checks and support for such an approved carer while the sole parent remains in custody. Resourcing must be addressed to enable this to occur.*	**Oranga Tamariki** **Corrections** **Justice** **Police**	**Refer to recommendation one**

[1] [Final report by Dame Karen Poutasi on the death of Malachi Subecz (orangatamariki.govt.nz)]

Recommendation		Lead and supporting agencies	Update
Critical gap 2: In the process for assessing risk of harm to a child, which is too narrow and one dimensional			

3	*Multi-agency teams working in communities in partnership with iwi and NGOs, resourced and supported throughout the country to prevent and respond to harm. There are examples of this happening already across the country. Implementation in all localities must be a priority so that locally relevant teams can help assess, respond to the risk to a child and provide support.*	**Oranga Tamariki**
		
		Police
		
		Te Manatū Whakahiato Ora – Ministry for Social Development (MSD)
		
		Ministry of Health - Manatū Hauora
		
		Health New Zealand - Te Whatu Ora
		
		Te Puna Aonui
			The Monitor highlights multi-agency teams are not in place in all communities.
			
			Agencies accept that not every community in New Zealand has multi-agency teams but progress has been made towards making sure there are more now than when Dame Karen Poutasi completed her review. Appendix 2 of this Cabinet paper[2] sets out a full list of work programmes that Oranga Tamariki, Police and Health agencies are doing to work towards better multi-agency teams across the motu.
			
			The Monitor acknowledges the good progress achieved through:
			• *Te Aorerekura - National Strategy and Cross Agency Action Plan to Eliminate Family Violence and Sexual Violence,* hosted by Te Puna Aonui is an Interdepartmental Executive Board. Te Puna Aonui works in partnership with specialist sector, communities, and iwi to systematically look at ways to improve coordination and enable a collective response to family and sexual violence. It is a cross-sector mechanism the Government can utilise to deliver this recommendation, enabling whole-of-government approaches to address root causes of inequities, and prevent and respond to family violence and sexual violence.
			
			• *The Integrated Community Response (ICR) Programme,* coordinated by Te Puna Aonui Business Unit, has funded and supported localities to grow their infrastructure, capacity, and capability to run local multi-agency tables and responses in five locations;
			  • Whiria te Muka in Te Hiku (Kaitaia)
			  • South Auckland in Counties Manukau
			  • Waikato Tainui
			  • Manaaki Tairāwhiti in the Tairāwhiti region and
			  • Canterbury
			
			In addition to the five current localities, three further sites are being supported to begin developing their integrated-community response approach:
			  • Dunedin
			  • Hauraki
			  • Hawkes Bay

[2] CAB-23-MIN-0398-Report-to-Cabinet-on-the-progress-made-against-the-recommendations-of-the-Dame-Karen-Poutasi-system.pdf (orangatamariki.govt.nz)

Recommendation		Lead and supporting agencies	Update
			Further roll out will continue. Of the locations above, in perpetuity funding was received for the two Integrated Safety Response (ISR) teams in Waikato and Canterbury and Whāngaia Ngā Pā Harakeke (WNPH) multi agency responses in Tairawhiti, Counties Manukau and the Northland Whiria Te Muka model. • Te Puna Aonui are developing the second Te Aorerekura Action Plan, which is due for finalisation this year. This will incorporate the delivery of the Minister for the Prevention of Family Violence and Sexual Violence priority to improve the current response system by strengthening the locally and regionally based multi-agency crisis response models already in place across New Zealand. There are currently 40 multi-agency response sites across 12 regions that meet regularly depending on the needs of their community that will be looked at in relation to this priority. • The *Enabling Communities* programme delivered under the Oranga Tamariki Future Direction Plan which is working to restore and empower iwi and communities to lead the prevention of harm for tamariki, rangatahi and their whānau. It is a mechanism through which Oranga Tamariki is directly responding to Recommendation 3.
4	*Medical records held in different parts of the health sector should be linked to enable health professionals to view a complete picture of a child's medical history.*	**Te Whatu Ora**	**The Monitor acknowledges that the linking of medical reports is expected in 2026** Health New Zealand Data & Digital resources and funding have been prioritised to deliver a national equivalent of the legacy Shared Electronic Health Record (SEHR). This is currently only available in some regions and of variable quality, scope and accessibility and only in the location where the child is enrolled with a General Practitioner. The national SEHR will integrate Patient Management System (PMS) data from the primary care sector with other information already held by Health New Zealand, such as immunisation records, medicines and medical warnings. This will lessen the current constraints around access to medical records and will give clinicians access to selected information about tamariki (and whānau) from outside their area. This basic SEHR will be nationally available to clinicians in both hospital and community settings, and is expected to be completed by June 2025. The basic SEHR is the first step in responding to recommendation 4. Expanding the scope to build a more comprehensive health record for tamariki and whānau will be subject to the Health Minister's approval of a formal business case and 10-year plan in early 2025.

Recommendation		Lead and supporting agencies	Update
5	*The health sector should be added as a partner to the Child Protection Protocol between Police and Oranga Tamariki to enable access to health professionals experienced in the identification of child abuse, and to facilitate regular joint training.*	**Ministry of Health** **Te Whatu Ora** Oranga Tamariki Police	**The Monitor states that no decision has been reached on health involvement in the Child Protection Protocol** While a final decision has yet to be reached about Health New Zealand joining the Child Protection Protocol (CPP), agencies have put considerable effort into understanding how the two stated outcomes of Dame Karen Poutasi's recommendation (facilitating joint training and improving access to suitably qualified health professionals) would improve the way the three agencies work together and ultimately benefit tamariki at risk of harm. There is broad agreement that joint training between Health New Zealand, Police and Oranga Tamariki at the local level would help to promote good working relationships and for each party to understand the other's roles and processes, enabling more effective collaboration as services work in tighter partnership. Health New Zealand is currently working to establish what type of training would be most useful to achieve the above objective and which health professionals might attend and deliver training. Given Health New Zealand clinicians have trusted access to even the most at-risk families, prevention of child abuse by support and upskilling is a core health action. These opportunities for early intervention and identification make health a key partner with skills to assess risk and train others. Health New Zealand clinicians already provide training to Police child abuse investigation teams and this training could potentially be extended to local CPP groups. However, joining the protocol will not of itself enable greater access to health professionals experienced in the identification of child abuse, particularly in rural areas, given workforce shortages. While Starship hospital has a fully staffed child protection roster, other hospitals always have a general paediatrician on-call and we are looking to ensure CPP partners are aware of and able to access this service.
Critical gap three: In agencies and their services not proactively sharing information, despite enabling provisions			
6	*The Ministry of Social Development should notify Oranga Tamariki when a caregiver who is not a lawful guardian, and who has not been reviewed by Oranga Tamariki or authorised through the*	**Oranga Tamariki/MSD** Corrections Justice Police	**The Monitor acknowledges that progress on recommendation six will first require decisions on recommendations one and two** When working groups were established, it was agreed that recommendation 6 would be considered after recommendations 1 and 2 because of the dependencies between the recommendations. After Ministerial advice and/or feedback has been received for recommendations 1 and 2, MSD, with the support of Oranga Tamariki, will consider the circumstances in which referrals may be appropriate, and other opportunities within MSD's current processes to improve placement safety.

Recommendation		Lead and supporting agencies	Update
	Family Court, requests a sole parent benefit or other assistance, including emergency housing support, from the agency for a child whose caregiver is in prison.		
7	*The enhancement of understanding of the information sharing regime in the Oranga Tamariki Act 1989, to educate and encourage child welfare and protection agencies and individuals in the sector to share information with other child welfare and protection agencies on an ongoing basis.*	**Oranga Tamariki** **Corrections** **Justice** **Police** **MSD** **Ministry of Health** **Te Whatu Ora** **Te Tāhuhu o te Mātauranga – Ministry of Education (Education)**	**The Monitor states that information sharing between agencies remains an issue.** A multi-agency working group was established to consider this recommendation. The Monitor has acknowledged that work is still underway in this area, and that the working group has agreed to a range of actions to ensure respective agency frontline staff understand and use the information sharing provisions. Progress has been made on: • Delivering updated information sharing guidance, communication, and other resources to frontline staff so that there is shared advice and clear understanding about information sharing. For example, ongoing learning and development opportunities for professional groups. • Highlighting information sharing work in regional leadership meetings that reach a range of stakeholders, convened by Regional Public Service Commissioners. Oranga Tamariki is working with the Regional Public Service office to support this action by providing communications through their regular newsletter, attending monthly hui and linking resources.
Critical gap four: In a lack of reporting of risk of abuse by some professionals and services			
8	*Professionals and services who work with children should be mandated to report suspected abuse to Oranga Tamariki. I recommend this be legislated by defining the professionals and service providers who are to be classed as 'mandatory reporters', to remove any*	**Oranga Tamariki** Corrections Justice Police MSD Ministry of Health	**The Monitor has acknowledged that it is not clear what impact mandatory reporting would have in Aotearoa New Zealand** The Monitor has acknowledged other gaps must first be addressed before mandatory reporting should be considered. Mandatory reporting could risk over reporting and over surveillance of Māori and Pacific families. Meanwhile, live examples of mandatory reporting in Victoria and New South Wales demonstrate its limitations, with staff 'drowning' because of reporting volume. Early on in this workstream it became clear that recommendation eight and nine should be considered together due to their connectedness, and so a multi-agency working group was established to consider this.

Recommendation		Lead and supporting agencies	Update
	uncertainty around their obligations to report.	Te Whatu Ora Education Education Review Office (ERO)	Agencies have worked together to develop advice related to mandatory reporting which is under active consideration. This has involved: • undertaking a period of targeted engagement with child protection experts and impacted population groups to understand contemporary views on the policy approach, and to consider what a mandatory reporting regime could look like in the New Zealand context • the development of a background policy paper considering the international evidence-base and lessons learned for New Zealand • undertaking detailed gap analysis of the wider system safeguards for recognising, reporting and responding to the abuse and suspected abuse. These activities highlighted the importance of addressing wider system gaps and barriers, such as low uptake of child protection training among children's workforces. Increased reporting is only useful if the rest of the system is functional, resourced and responsive. Key themes from engagement highlighted that: • there is a gap in child protection training across frontline professional groups and varying degrees of awareness about how to identify and report abuse, which needs to be addressed with or without mandatory reporting • quality reporting relies on access to consultation and liaison mechanisms, which are ad hoc across the children's system (for example, through dedicated child protection liaison roles) • mandatory reporting, if pursued, must be only one part of an integrated national strategy for recognising and responding to child abuse This broad approach to engagement provided insights on aspects of Recommendation 9, such as training. Consideration of how to better support for frontline staff will be part of ongoing work regardless of decisions on Recommendation 8. Agencies also note the strong views, substantial risks and possible Te Tiriti o Waitangi implications associated with mandatory reporting which necessitate a robust consideration and engagement process, especially given indications that mandatory reporting disproportionately affects indigenous populations[3]

[3] Ethnic inequalities in child welfare: The role of practitioner risk perceptions Emily Keddell | Ian Hyslop (2019)

Recommendation		Lead and supporting agencies	Update
			Ongoing advice and work pursuant to recommendations 8, 9, 11 and 12 will be combined into a single work programme which will focus on improving the "P4R framework" as a whole. P4R stands for stands for Preventing, Recognising, Reporting, Responding to, and Reviewing child abuse. This approach recognises child protection as a system of safeguards which needs to be addressed as a whole rather than by making isolated changes. Oranga Tamariki has developed advice which is under active consideration, setting out a range of options to address gaps across the P4R framework. This advice was based on the insights from the work above and analysis undertaken by agencies pursuant to recommendations 11 and 12. Recognising and responding to child abuse is New Zealand's collective responsibility, and not the sole remit of Oranga Tamariki.
9	*The introduction of mandatory reporting should be supported by a package approach that includes:* *A mandatory reporting guide with a clear definition of the red flags that make up a high risk Report of Concern, together with the creation of a 'High Report of Concern' category similar to the New South Wales 'Risk of Significant Harm' definition.* • *Defining mandatory reporters, all of whom should receive regular training.* • *In addition, for professionals deemed to be mandatory*	**Oranga Tamariki** Corrections Justice Police MSD Ministry of Health Te Whatu Ora Education ERO	**Refer to recommendation eight**

Recommendation		Lead and supporting agencies	Update
	reporters, there should be: o *undergraduate courses teaching risks and signs of child abuse* o *mandatory regular updated training regarding their responsibilities and the detection of child abuse, with practising certificates conditional on training and refreshers.*		
10	*There should be active monitoring of the implementation by early childhood education services of their required child protection policies to ensure they are providing effective protection for children. Therefore, the Ministry of Education and the Education Review Office should jointly design and administer a monitoring and review cycle for the implementation of Child Protection Policies in Early Learning Services.*	Education ERO	**The Monitor acknowledges that early learning services are already required to have child protection policies, and ERO check for this** The Monitor's report acknowledges the child protection policy requirements for early learning services and the working protocols in place that outline how ERO and the Ministry of Education work together when likely non-compliance is identified (p.29). Any shortfalls in compliance with child protection requirements are considered a serious risk and escalated for prompt response by the Ministry of Education's front-line licensing teams. The Monitor has also acknowledged work already undertaken by the Ministry of Education and ERO in response to Recommendation 10 (p.31): • Engagement with stakeholders including teachers and service owners, to understand the barriers to effective implementation of child protection policies. Key themes and suggestions from engagement were: o Better targeting of professional learning and development related to child protection

Recommendation		Lead and supporting agencies	Update
			○ Suggestions that child protection training be a requirement in teaching qualifications ○ Better support for staff on the correct reporting process and throughout the process ○ Greater clarity on Oranga Tamariki processes to help address myths and concerns about the consequences of notifications on the lives of tamariki and whānau ○ More visual and written resources to help people recognise and respond to child protection concerns (jointly provided by the Ministry of Education and Oranga Tamariki) • Development of a work programme based on these insights including a strengthened review cycle (dependent on regulatory setting change) and other actions to support child protection in the early learning sector. • Regular promotion of the Ministry of Education child protection module to the sector (ongoing) The Monitor has also acknowledged the relevance of the recently announced sector review into early childhood education being led by the Ministry for Regulation (p.31). The Ministry of Education will provide advice to Minister Seymour about a proposed work programme to strengthen child protection and safety in early learning settings. This will be done in consultation with the Ministry for Regulation and the proposed work programme will be progressed in parallel with the sector review. The Ministry of Education will review and confirm resourcing for the proposed work programme following Ministerial decisions and the final Ministry of Education decision on its savings programme. During its review of Recommendation 10 the Monitor also identified non-compliance with safety checking requirements as an area of concern. The Ministry of Education has identified similar issues and opportunities for improved practices amongst some groups of employers including in the early learning and schooling sectors. The Ministry of Education and partner agencies, are considering a system-wide approach to lifting practice and have developed a work programme which includes: • a coordinated update of guidance on child protection responsibilities (short term) • improvement and standardisation of oversight of safety checking (medium term)

Recommendation		Lead and supporting agencies	Update
Critical gap five: In allowing a child to be invisible. The system's settings enabled Malachi to be unseen at key moments when he needed to be visible			
11	*The agencies that make up the formal Government's children's system should be specifically defined in legislation.*	**Oranga Tamariki** Corrections Justice Police MSD Education Ministry of Health Te Whatu Ora	**The Monitor acknowledges that the responsibilities of children's system agencies are clear, but may not be being routinely implemented.** Early on in this workstream it became clear that recommendation 11 and 12 would be best considered together due to their close connection, and a working group was established. This working group contributed to several key pieces of advice, including: • A briefing to the Minister for Children in August 2023 in relation to Recommendation 11, providing an overview of the existing formal children's system in New Zealand, and how it is set out across several key pieces of legislation • An interagency background paper in late 2023, detailing a proposed system-wide view of current settings and gaps for preventing, recognising, reporting, responding to and reviewing child abuse cases (the 'P4R' framework) • Advice to the Minister for Children in early June 2024, setting out a range of activity options to address gaps across the P4R framework. This considered approach reflects the complexity and interconnectedness of how the child protection system in New Zealand functions, including its legislative parts; the societal challenges linked to incidence of abuse that are difficult to address; and, the limited resources available across Government for preventing and responding to child abuse compared to the size of the challenge. Agencies also took into account other reviews and recommendations for the children's system including those of the Waitangi Tribunal and the Children's Commissioner. As noted above, ongoing advice and work pursuant to recommendations 8,9,11 and 12 will be combined into a single work programme which will focus on improving the "P4R framework" as a whole.
12	*These agencies should have a specific responsibility included in their founding legislation to make clear that they share responsibility for checking the safety of children.*	**Oranga Tamariki** MSD Corrections Justice Police	**Refer to recommendation eleven**

Recommendation		Lead and supporting agencies	Update
		Ministry of Health Te Whatu Ora Education	
13	*Regular public awareness campaigns should be undertaken so the public is attuned to the signs and red flags that can signal abuse and are confident in knowing how to report, this so children can be helped. Aotearoa society needs to hear the message 'don't look away'.*	**Oranga Tamariki /** multi agency	**The Monitor states that a public awareness campaign has not yet been developed** This recommendation is already in place under section 7 of the Oranga Tamariki Act 1989[4], which states that the Chief Executive has a duty to: "promote, by education and publicity, among members of the public (including children and young persons) and members of professional and occupational groups, awareness of child abuse, the unacceptability of child abuse, the ways in which child abuse may be prevented, the need to report cases of child abuse, and the ways in which child abuse may be reported" Oranga Tamariki are exploring other opportunities to advance child abuse prevention messaging. This includes working to promote prevention messages and resources in the lead up to, on and beyond Children's Day, as well as exploring cross-agency opportunities within Te Aorerekura (the National Strategy to Eliminate Family Violence and Sexual Violence). Oranga Tamariki are developing an awareness-building content stream on external channels/platforms with existing content that may have been developed by sector and/or community partners.
14	*So, change can be monitored, the recommendations made in this report should be reviewed in one year's time by the Independent Children's Monitor in its new system-wide role.*	Independent Children's Monitor	**The Independent Children's Monitor has completed its review.**

[4] Oranga Tamariki Act 1989 No 24 (as at 06 October 2023), Public Act 7 Duties of chief executive – New Zealand Legislation