Te Mana Whakamaru Tamariki Motuhake | Independent Children's Monitor

Agency Compliance with Regulations 69 and 85 of the Oranga Tamariki (National Care Standards and Related Matters) Regulations

November 2020

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Introduction

Poipoia te kākano kia puāwai
Nurture the seed and it will blossom

For many of us, 2020 challenged the way we work, learn and live. With this has come opportunities for new ways of thinking and engaging. For the Monitor, we have continued to develop, build capability and test our monitoring approach with the assistance of many.

I would like to thank Oranga Tamariki, Open Home Foundation, Barnardos and Dingwall Trust for the spirit in which they approached working with us. This mahi is new for us all. While the Monitor is independent, and has a responsibility to hold agencies to account, this does not mean that we are distant. If the Monitor is to be successful at influencing change, it is important that we work together and maintain focus on what is best for tamariki, rangatahi and their whānau.

I also want to acknowledge everyone that we've met this year. We had the privilege of being out in the community, COVID willing, and met with over 100 stakeholders. We've held conversations with iwi, care agencies, non-government organisations, various government agencies, Kaupapa Māori and social service providers. We have been listening carefully, and these conversations are being reflected in the development of the Monitor. Thank you for the gift of your time and wisdom. We look forward to continuing our relationship in 2021.

This is the Monitor's third and final report focused on regulations 69 and 85 of the National Care Standards. As part of this report, the Monitor was able to capture the voice of a number of frontline staff. In the future, the use of data combined with the voices of rangatahi, whānau, carers, and those working alongside whānau and tamariki, will provide a rich understanding of the Oranga Tamariki system. This will provide insight into the quality of care, what works well and identify any barriers in the system.

This approach includes going back each year to monitor change. Maintaining focus over time drives continuous improvement. It also helps us to understand whether changes are improving the experiences and wellbeing of tamariki and rangatahi.

For the Monitor to be successful, we will continue to live our values. We will be courageous – kia maia, respectful – manaaki, trustworthy – kia pono, kia tika and reflective – kia huritao. Living these values supports us to be credible and worthy of the gift, taonga, of the words, feelings and stories that people share with us so we can help bring positive changes for those in care.

We are looking forward to the next phase of the journey.

Arran Jones, Executive Director

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Executive Summary

Purpose of the Report

This report provides an update to the Minister for Children and the New Zealand public on the extent to which the four agencies who have custody of children are compliant with regulations 69 and 85 (and, to the extent that it applies, regulation 86) of the National Care Standards (NCS) Regulations 2018 (NCS Regulations). The four agencies are Open Home Foundation, Barnardos, Dingwall Trust and Oranga Tamariki (the agencies).

This report covers the period from 1 July 2019 to 30 June 2020.

Regulation 69 outlines the duties of the Chief Executive when allegations of abuse or neglect are made about children and young people in custody and care. Regulation 85 requires information to be provided to the Independent Children's Monitor (the Monitor) and regulation 86 requires that the agency must monitor its own compliance with the NCS Regulations (see Appendix One).

The Monitor has previously published two reports, which are available on the Monitor's website[1]. This report provides an overview of 12 months of data, unless otherwise stated, from 1 July 2019 to 30 June 2020. As well as using data provided by the agencies, the Monitor visited three Oranga Tamariki sites and one Open Home Foundation service centre to talk with staff to gain insight and provide a frontline perspective.

This report completes Phase One of the Monitor's initial monitoring programme, which has focused solely on regulations 69 and 85 (and, to the extent it applies, regulation 86). The Monitor will start monitoring all the NCS Regulations from 31 December 2020.

The Requirement for the Oranga Tamariki System to Self-monitor

The role of the Monitor is to oversee the Oranga Tamariki system[2]. The Oranga Tamariki Act 1989 and NCS Regulations set out requirements that must be met for tamariki and rangatahi in care. They also require the chief executive of an agency with tamariki or rangatahi in its care or custody to monitor its own compliance with the NCS Regulations. Agencies must design self-monitoring systems that collect information to enable the Monitor to fulfil its monitoring

[1] https://www.icm.org.nz/reports/

[2] The term 'Oranga Tamariki system' is used to describe not only the early intervention, statutory care, protection, youth justice and transitions support systems as outlined in the Oranga Tamariki Act 1989, but also other agency services provided to children and young people under the Act (for example health, education and disability services, including by NGOs). It also includes services provided by Children's Agencies to the core populations of interest to Oranga Tamariki as defined under the Children's Act 2014, including children who have early risk factors for future involvement in the statutory care, protection and youth justice systems.

role and make sure that those systems provide for continuous improvement, as well as address areas of practice that require improvement.

The Monitor's role is to objectively assess compliance with the delivery of the NCS Regulations. The Monitor is therefore reliant on agencies having the necessary assurance systems and processes in place, as well as the ability to supply the Monitor with information that is necessary for it to carry out its functions.

High-level Summary Findings

This report provides an overview of the 12-month period from 1 July 2019 to 30 June 2020.

It includes information gathered from visiting a number of frontline workers at three Oranga Tamariki sites and one Open Home Foundation service centre. As described in the two previous reports, the Monitor's Outcomes Framework[3] is used to measure outcomes for tamariki and rangatahi in relation to the delivery of the NCS Regulations. Each of the regulations have been mapped to one of the six outcomes, with regulation 69 mapped to *Aroha*. The outcome of *Aroha* is defined as tamariki and rangatahi feel loved, supported, safe and cared for, and are capable of receiving kindness through love and giving love to others. How allegations of abuse of tamariki and rangatahi are handled is relevant to how they can feel loved, supported and safe.

In assessing compliance with regulation 69, the Monitor looks at an organisation's policies and procedures, as well as agency data that outlines how well those policies and procedures are complied with. From a policy and procedure perspective, all four agencies are compliant with regulations 69, 85 and 86.

Barnardos and Dingwall Trust reported that they did not receive any allegations of risk of harm caused by abuse or neglect for the 12-month period. Therefore, testing compliance or making a visit to one of their sites was not required for this report.

Open Home Foundation reported that it received 12 allegations of abuse or neglect about te tamaiti in their custody. The investigations into these allegations were carried out by Oranga Tamariki, with Open Home Foundation providing support to the tamariki, rangatahi, whānau, and caregivers through the process. In nine of the 12 cases, abuse was not found. Two of the investigations were ongoing at the time of receiving this data and, in one case, abuse was substantiated. Open Home Foundation followed its own policy and procedures through the investigations and these actions were compliant with regulation 69. In visiting a community-based Open Home Foundation service centre, the Monitor's staff noted the positive working relationship between its centre and the local Oranga Tamariki site.

Oranga Tamariki reported that it received 1,831 allegations of risk of harm caused by abuse or neglect regarding tamariki and rangatahi in its care or custody. In 612 cases, a decision was made at the National Contact Centre or at the local site that no further assessment was required. Accordingly, 1,219 cases needed further investigation.

Over the last year, Oranga Tamariki has continued to show a higher level of compliance when initially responding to an allegation of abuse or neglect. In 84 percent of cases the initial safety

[3] The Monitor's Outcomes Framework is available at: www.icm.org.nz/nga-kete-rauemi/

screen was completed on time, in 81 percent of cases a child's plan was reviewed following the allegation and in 87 percent of cases recording was completed correctly.

Oranga Tamariki provided information to the Monitor about the 1,092 allegations with a finding that had been reviewed by the Safety of Children in Care Unit. Overall, Oranga Tamariki was partially compliant with regulation 69.

Data provided by Oranga Tamariki showed that recorded compliance was low when:

- informing the child of the outcome of an investigation (28 percent compliance)
- informing the parent/guardian of the outcome of an investigation (32 percent compliance)
- completing investigations or assessments on time (41 percent compliance).

Oranga Tamariki reported on data relating to the number of tamariki and rangatahi where all relevant aspects of regulation of 69(2) (a-d) were met. As defined in its *Overview of Care Standards Regulation 69 and 85 Practice Requirements, Monitoring Approach and Measures and Reporting Mechanisms* (practice requirements)[4], it has 12 practice requirements relating to this regulation. It reported that only one percent of all cases had recorded that all 12 practice requirements met. In 39 percent of cases, fewer than six requirements were met.

Informing tamariki and rangatahi of the outcome of an assessment or investigation is important so they feel that they have been heard and that the concerns were taken seriously. For tamariki and rangatahi to achieve the outcome of *Aroha*, it is especially important for them to feel safe and cared for.

Although performance has remained largely unchanged across the year, Oranga Tamariki has made improvements to its assurance processes and reported a greater focus on compliance with regulation 69. For example, Oranga Tamariki has reported a range of activities to improve timeliness and created a new role to provide oversight across all reports of concern for children in care. In addition, three new assurance processes have been put in place and are referred to later in the report.

It was reported by staff at three Oranga Tamariki sites that positive local leadership has assisted in building capability of staff in relation to the processes associated with regulation 69. Some staff spoken with noted the need for further training and development to improve practice. The Monitor acknowledges that the number of staff it was able to engage with during the visits was small.

Through reporting and from monitoring visits, all agencies noted the positive relationships with local iwi, and the collaborative approach to building and growing these relationships.

[4] This document is available in *Appendix B* of the Monitor's initial report (December 2019). https://www.icm.org.nz/reports/

In the Monitor's previous reports, it was noted that there was a lack of visibility over the initial decision-making at the National Contact Centre or local site and, in particular, the cases where a *No Further Action* decision was made. Oranga Tamariki reported that changes have been made and that they began sampling decisions this year. They also advised that the National Contact Centre is reviewing processes to build increased visibility of these decisions.

From this sampling, Oranga Tamariki reviewed 69 reports of concern between 1 April 2020 to 30 June 2020 where a *No Further Action* decision was made. They reported that of these decisions, only 14 were classified as relating to incidents alleging possible abuse or neglect for children in care. The balance was identified by Oranga Tamariki as 'reporting errors' (20), 'non-abuse events' (33) or 'relating to incidents that occurred prior to coming into care' (2).

Having looked at the decision-making of the 14 cases, Oranga Tamariki determined that in nine cases the rationale for the *No Further Action* decision appeared inaccurate. This prompted further follow up with sites, to either ensure that records properly reflected the decision-making, or to ensure that an assessment or investigation occurred.

Due to the high number of cases where inaccuracy was apparent, the Monitor will continue to seek data and information on action Oranga Tamariki is undertaking to improve decision-making. This will be an area of ongoing focus for the Monitor's future reports.

Continuous Improvement Observations

Each agency was required to provide to the Minister for Children a response to the Monitor's second report, dated June 2020. The agencies responded positively to the report and have demonstrated a commitment to undertaking continuous improvement activities to embed policy and practice that comply with the NCS Regulations. The agencies' individual responses are available in full on the Monitor's website[5].

Oranga Tamariki acknowledged that further work is required to embed policies and processes regarding regulation 69 into practice. This was reflected in what staff told the Monitor during the monitoring visits. Some of the current improvements underway were detailed in its response and built into its multi-year transformation journey to ensure compliance with all NCS Regulations.

The Monitor acknowledges that the retrospective nature of current monitoring means that the impact of the actions taken in response to the previous report will not be realised within the timeframe of this report. However, if these initiatives have been successful the Monitor would expect to see evidence of improved performance by the time it next reports on compliance in late 2021 for the period 1 July 2020 to 30 June 2021.

[5] https://www.icm.org.nz/reports/

Update on the Establishment Activities of the Independent Children's Monitor

Background on the Role and Function of the Independent Children's Monitor

The Monitor was established on 1 July 2019. It carries out its role by monitoring, assessing and providing assurance of the extent and quality of compliance under the Oranga Tamariki Act 1989 and the associated NCS Regulations.

As noted previously, the Monitor's functions are being phased in over time and this report concludes Phase One, which focused on regulations 69 and 85 of the NCS Regulations. Phase Two, commencing from 31 December 2020, focuses on compliance with all aspects of the NCS Regulations. Phase Three is the intended longer-term expansion of the Monitor. This will broaden the scope of monitoring of compliance to the entire Oranga Tamariki system, at a date that is yet to be determined.

Building the Monitor's Capability

Since September 2020, the Monitor has increased the size of its Operations Team ahead of starting Phase Two monitoring. The Monitor has three new operational teams based in Tāmaki Makaurau, Whanganui-a-Tara and Ōtautahi[6]. These new teams will help the Monitor to grow and develop relationships with local communities.

Development of the Monitoring Approach to Support the Outcomes Framework

To support the Outcomes Framework, the Monitor has developed its Monitoring Approach. This includes the monitoring programme, monitoring requirements, assessment plans, operational policies and processes, as well as tools and resources. Within the Monitoring Approach an Assessment Matrix[7] has been developed for the Monitor to use when visiting communities to verify the data provided to it by the four agencies with statutory responsibilities.

[6] Tāmaki Makaurau – Auckland, Whanganui-a-Tara – Wellington, and Ōtautahi – Christchurch.

[7] The Assessment Matrix can be found at https://www.icm.org.nz/nga-kete-rauemi/

The five dimensions of the Assessment Matrix are:

1. People
2. Culture and Leadership
3. Tools and Resources
4. Services and support work well for me
5. Services and support work well together.

Pilot Programme

In preparation for Phase Two of the Monitor's function, the Monitor has been working with agencies and communities to undertake a pilot programme to test aspects of the Monitoring Approach. The Monitor has had the privilege to engage with three communities who are connected to, and work within, the Oranga Tamariki system. The insights gained from this mahi[8] will allow the Monitor to adapt processes and systems that will assist it to work in a way that is mana enhancing for the communities it visits. It is expected that the evaluation of this pilot will be completed in December 2020 and this will feed into the overall monitoring approach in 2021.

Ethics Code

The Monitor has finalised its Ethics Code[9] (the Code), which describes how it will ethically and safely engage with tamariki, rangatahi, whānau and caregivers.

The Monitor recognises that tamariki and rangatahi are at the centre of the work it does and seeks to reflect their views, as well as those of their whānau and caregivers. The Code recognises the vulnerability for these participants in sharing their stories and provides guidance and standards that will be applied during the Monitor's engagements.

The Code was developed by the Monitor following consultation with key agencies including Oranga Tamariki, Ministry of Social Development, Office of the Children's Commissioner and the expert services of Professor Tim Dare of the University of Auckland.

[8] Mahi – work

[9] The Ethics Code can be found at https://www.icm.org.nz/nga-kete-rauemi/

Context

Statistics New Zealand indicated in the last census that there are approximately 1.1 million New Zealanders under the age of 18, of which 27 percent are Māori[10]. In comparing the national population with the population of tamariki Māori and rangatahi Māori in State care there is a significant imbalance. As at 30 June 2020, there were 6,041 tamariki and rangatahi in the care and custody of Oranga Tamariki, including both care and protection, and youth justice[11]. Of the 6,041 tamariki and rangatahi in care and custody, 59 percent are Māori and a further 10 percent identified themselves as Māori/Pacific.

Data provided by the agencies shows the following number of children in their care and custody.

	Open Home Foundation	Dingwall Trust	Barnardos	Oranga Tamariki
Tamariki and rangatahi in care and custody	119	1	3	6,041

Table One – number of children in the care and custody of provider agencies and Oranga Tamariki as at 30 June 2020.

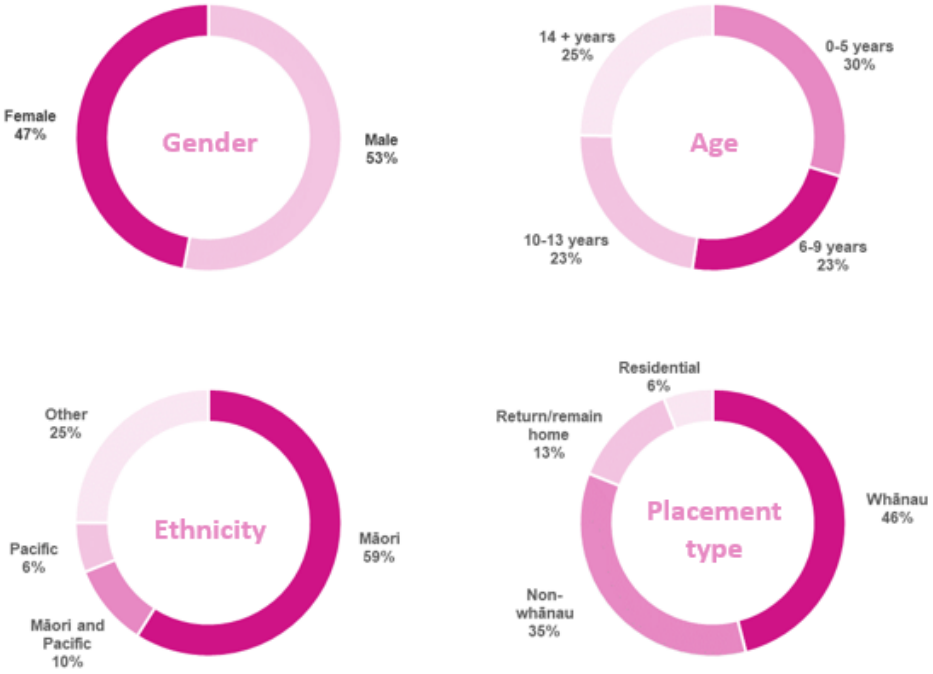
Demographic data, provided from each of the four agencies, outlines the characteristics of the tamariki and rangatahi in the care system.

Given the very small number of tamariki and rangatahi in the care and custody of Dingwall Trust and Barnardos, demographic data is only shown for those in the care and custody of Oranga Tamariki and Open Home Foundation.

[10] NZ Stats https://www.stats.govt.nz/topics/tangata-maori-population

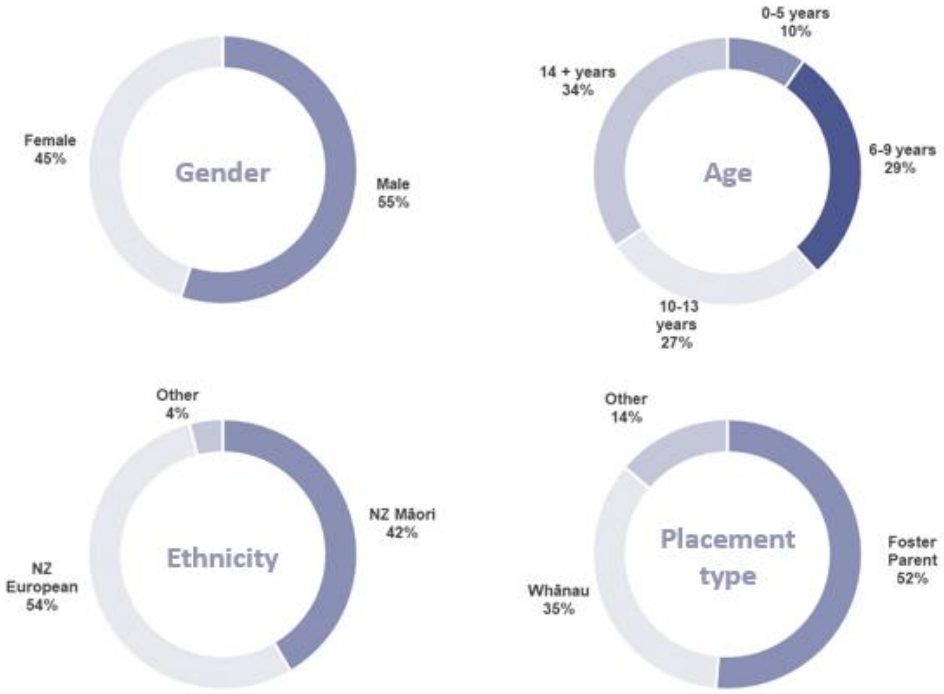
[11] The total number of children in the care and custody of Oranga Tamariki for care and protection reasons is 5,945 and those under youth justice care and custody is 96 as at 30 June 2020.

Oranga Tamariki Demographics



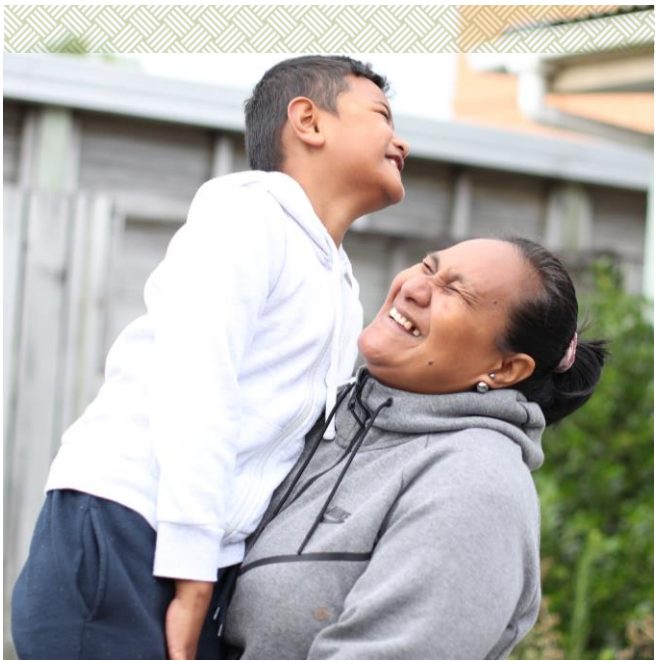
* Please note percentages do not add to 100 percent due to rounding.

Open Home Foundation Demographics



* Please note percentages do not add to 100 percent due to rounding.

Methodology



As noted in the Monitor's previous reports, Memoranda of Understanding were agreed with each agency outlining how the agencies work with the Monitor, and how information is shared and secured.

For the third report, the Monitor received data and information from each of the four agencies. The Monitor also made visits to three Oranga Tamariki sites and one to an Open Home Foundation service centre. The Monitor had planned to make further visits to sites but due to COVID-19 was unable to do so.

The Monitor notes that the data relied on in this report has been provided by each of the agencies and was not gathered from other sources. The Monitor received data and information in response to the third cycle reporting requirements (the final request for Phase One of the programme of the Monitor), for the 12-month period from 1 July 2019 to 30 June 2020. All data represents this time period unless specifically stated.

The Monitor reviewed the information received and prepared a second information request for Oranga Tamariki, to clarify and request additional information. For Open Home Foundation and Barnardos the Monitor sought to clarify information only.

Data sent to the Monitor is aggregated with no identifiable information and is stored securely on a separate database that is not visible or accessible to the Ministry of Social Development. Access to this database is limited to relevant team members of the Monitor.

Each agency was provided with draft versions of this report, with the information that applied to its agency, to review the information prior to its finalisation to:

- fact check the information relating to their agency
- respond to any potential adverse comment made by the Monitor in the report.

Due to the contracting relationships held by Oranga Tamariki, it was agreed that the Monitor would provide it with any potential adverse comment relating to Open Home Foundation, Dingwall Trust and Barnardos. This would be provided to Oranga Tamariki in advance, to enable it to consider a response. In the context of this report, no information of this nature needed to be provided.

Analysis of Information Provided by Agencies to Assess Compliance with Regulations 69 and 85

This section is based primarily on the information, data and analysis provided by each of the four agencies, as requested by the Monitor (refer to Appendices Two and Three). There was a small number of site visits made by the Monitor to understand the experience of frontline staff. The information requested focused on updates and continuous improvement work undertaken since the last report. Individual agency responses have been summarised under each heading and, where relevant, this includes responses to observations made in the Monitor's previous report.

Throughout the remainder of the report, the Monitor has included sub-sections entitled *Experience*. These are the stories and experiences of frontline staff the Monitor had the privilege to meet and kōrero[12] with.

Compliance in Relation to Regulation 69 – Open Home Foundation, Barnardos and Dingwall Trust

Open Home Foundation

Open Home Foundation reported 12 cases of abuse and neglect over the past 12 months. It noted that in all these cases it provided support to the tamariki, rangatahi, whānau and caregivers through the process. Of the 12 cases, nine resulted in no finding, one was substantiated and two were still ongoing at the end of this reporting period.

Open Home Foundation reported to the Monitor that its policies and procedures were followed during its response to allegations of harm for individual tamariki and rangatahi. It also reported that it has strengthened the requirement for care plans to be updated following the outcome of an investigation or assessment. From the information received from Open Home Foundation, the Monitor has found that it is compliant with regulation 69.

Barnardos and Dingwall Trust

Barnardos and Dingwall Trust did not have any allegations of abuse or neglect so are not included in this section.

[12] Kōrero – to tell, say, speak, read, talk, address

Compliance in Relation to Regulation 69 – Oranga Tamariki

Timeliness

As per regulation 69(2)(a), once an allegation of abuse or neglect has been made, Oranga Tamariki has the responsibility of deciding what action must be taken to address the concern. Its internal policy sets timeframes in which these processes must be carried out by.

When an Oranga Tamariki site receives a report of an allegation of abuse or neglect, it carries out a *Safety and Risk Screen*, which is the initial safety response, within the timeframes defined in its operational policies. The purpose is to review the safety of a child at that point in time and determine what steps or actions are required.

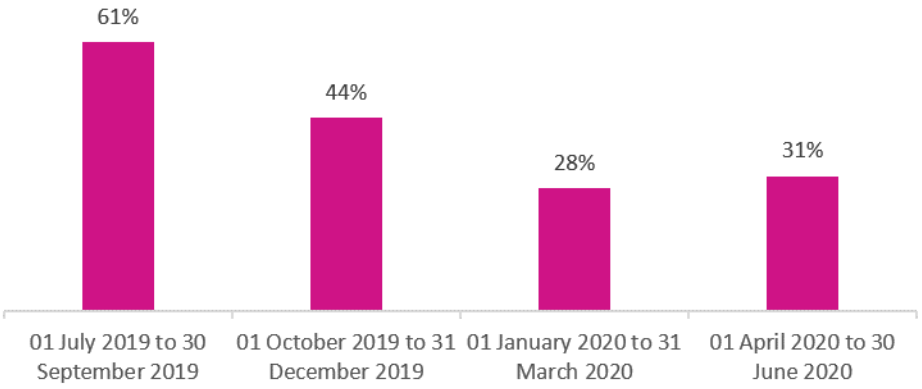
The following information was requested from Oranga Tamariki.

The June 2020 report noted that focus and improvement was needed in timeliness of investigations and assessments, and in letting tamariki and rangatahi know about the outcome of an assessment or investigation.

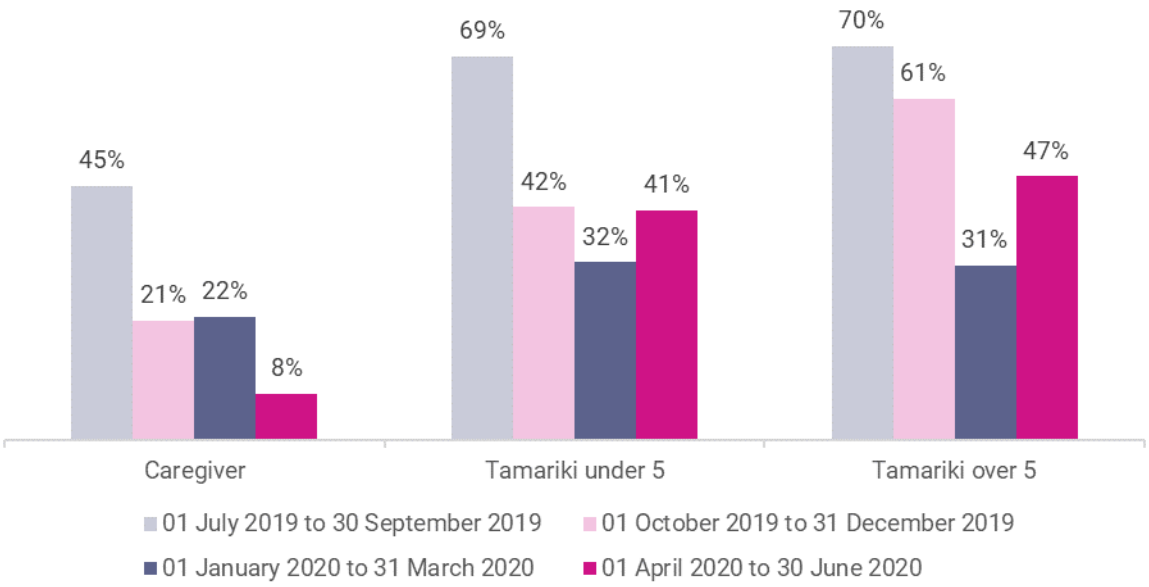
Please outline what action has been taken to improve:

- the timeliness of investigations and assessments carried out after an allegation has been made, including caregiver reviews
- practice to ensure tamariki and rangatahi are informed of the outcome of their allegation.

Reported data shows a high level of compliance with the safety screen requirements, with 84 percent completed within the required timeframe over the 12 months. However, data provided by Oranga Tamariki shows the timeliness of investigations and assessments of allegations of abuse or neglect is not consistently being achieved.



Graph One – Percentage of Child and Family Assessments or Investigations completed within the required timeframes.



Graph Two – Percentage of Child and Family Assessments or Investigations completed in time by relevant group.

Oranga Tamariki stated that some of the complicating factors resulting in delays to the timeliness of investigations include:

- administrative delays
- individual tamariki circumstances, nature of the day-to-day management of care arrangements for tamariki or mental health concerns for tamariki
- caregivers not wanting to meet with social workers or caregivers refusing to accept the findings of the draft report
- assessments that involve non-government organisation partners, which involve professionals jointly managing the relationship
- other more isolated examples of system issues, historical allegations or transfer of case between sites.

From the cases analysed, Oranga Tamariki reported that where the delay related to the tamariki circumstances, day-to-day care arrangements or mental health concerns, there were high levels of support offered or in place to manage care arrangements and provide stability.

To improve timeliness, Oranga Tamariki reported it has established continuous improvement activities to grow compliance with regulation 69(2)(a) of the NCS Regulations. Some of these have already been implemented while others are in the developmental stage.

- Monthly practice discussions with the regional senior advisors' groups.
- Engagement with regional teams to promote practice.
- Development and presentation of practice briefing materials for practice leaders.
- Mentoring and coaching support.

Oranga Tamariki informed the Monitor that its assurance activities are ongoing. The existing reporting mechanisms will be used to actively monitor and manage timeliness at a regional level. This is being supported by national policy documents, process charts and practice guidelines.

Oranga Tamariki advised the Monitor that it has established a role dedicated to providing national oversight of all reports of concern for children in care. This involves receiving regional updates and analysis, reviewing the data and providing feedback to regions. This role will be strengthened to include national oversight and feedback to sites around timeliness of investigations and providing feedback to te tamaiti. There has also been a new position established (Principal Advisor Care Standards) and their primary role is supporting the implementation of the National Care Standards.

Experience

In meeting with frontline staff at three sites, the Monitor was told that there are many different reasons why delays may occur. While staff comments do not reflect the views of the entire organisation, they do provide a snapshot of the experiences at those sites. The following are some of the views expressed by staff as to why delays can occur:

- Some staff have high caseloads, which require significant amounts of time and management.
- Social workers prioritise the needs of tamariki over paperwork.
- Police investigations do not always align with process and timeframes set in Oranga Tamariki policy.
- Caregivers accessing legal advice can extend timeframes.
- High turn-over of staff.

While visiting the three sites, the Monitor was told about the positive partnership when working with the New Zealand Police during investigations of abuse and neglect. The staff the Monitor spoke with stated that the collaboration and open relationships that happen at site offices with the Police are positive.

One social worker noted that their case load is “just so big” and when urgent cases come in, they do not have time to sit down with te tamaiti to explain the outcome to them. This task gets pushed down the list of things to do. “I am never on top of my work, a good day is when I am less behind in my work than I usually am.”

Reporting Outcomes to Tamariki, Rangatahi and Associated Parties

In relation to regulation 69(2)(c), the previous report indicated the Monitor would seek further clarification on how concerns about reporting outcomes are being addressed.

Closing the circle and reporting back to tamariki, rangatahi and their whānau is an important part of the allegation of abuse or neglect processes. Regulation 69 requires that the tamariki and rangatahi at the centre of an allegation are informed of the outcome of the investigation. International research indicates that after a disclosure of abuse, a meaningful response includes "post disclosure, the young person/child should be updated by telling them the outcome and a failure to do so exacerbates feelings of helplessness. Fear of a lack of action is also stated as a main reason why children don't disclose"[13].

The data provided to the Monitor by Oranga Tamariki over the 12-month period showed 28 percent of tamariki and rangatahi received feedback of the outcome of the investigation.

Experience

From meeting staff at the three sites, the Monitor heard from frontline staff that it is always the intent to inform people of the outcome of the investigation; however, there is inconsistency in the ways to record the outcomes of an investigation.

Some Oranga Tamariki staff commented that a combination of high caseloads and turnover of staff means that social workers from other teams may be allocated tamariki and rangatahi for short periods of time. This results in relationships not being formed and sometimes case notes are not up to date, so social workers find it difficult to engage.

Oranga Tamariki staff highlighted some of the issues that get in the way of telling tamariki and rangatahi about the outcomes, including administrative delays, a child's wellbeing and safety, the potential impact on a child's mental health and shared care arrangements.

One social worker said to the Monitor, "if I had more time to spend with a smaller number of rangatahi, I could provide support to a whānau or caregiver under stress, so we don't end up with a report of concern."

Information is Recorded and Reported in a Consistent Manner

Regulation 69(2)(b) requires agencies to ensure that information is recorded and reported in a consistent manner. Oranga Tamariki provided the Monitor with data that has been gathered and analysed by the Safety of Children in Care Unit. This focused on the number of findings that were reviewed as 'inaccurate' and the number of findings recorded as 'information missing'. 'Inaccurate', in this case, has been defined as either abuse not recognised or a non-

[13] Palmer, Sally E; Brown, Ralph A; Rae-Grant, Naomi I; Loughlin, M Joanne. *Child Welfare; Arlington* Responding to children's disclosure of familial abuse: What survivors tell us, Vol. 78, Iss. 2, (Mar/Apr 1999): 259-82

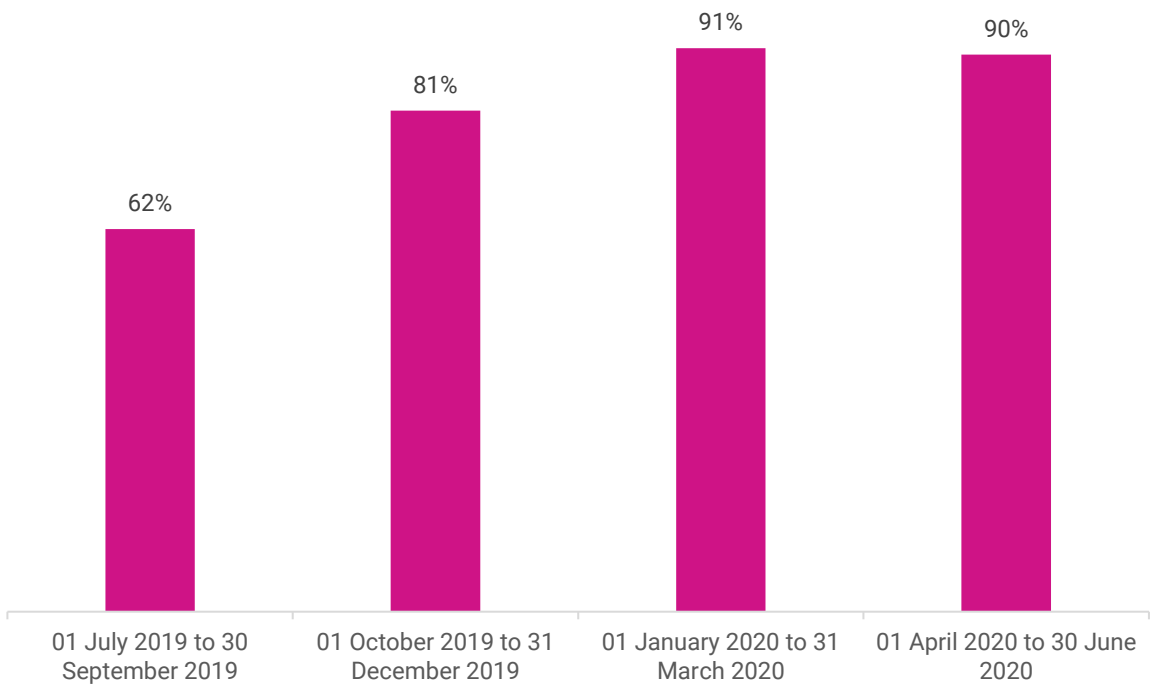
abuse event wrongly assessed as abuse, or wrong abuse type defined. 'Information missing' included missing dates, and alleged abuser information and placement type wrongly captured or absent.

Data shows compliance is 87 percent for findings being entered correctly. However, in 54 percent of cases, records had information missing.

Update of Care Plans Following an Investigation

Oranga Tamariki reported that updating the care plan of tamariki and rangatahi following an investigation is an area of high performance and an area it has continued to improve on during the year.

Data provided shows Oranga Tamariki is 81 percent compliant with updating the care plan for te tamaiti following the outcome of a Child and Family Assessment or Investigation.



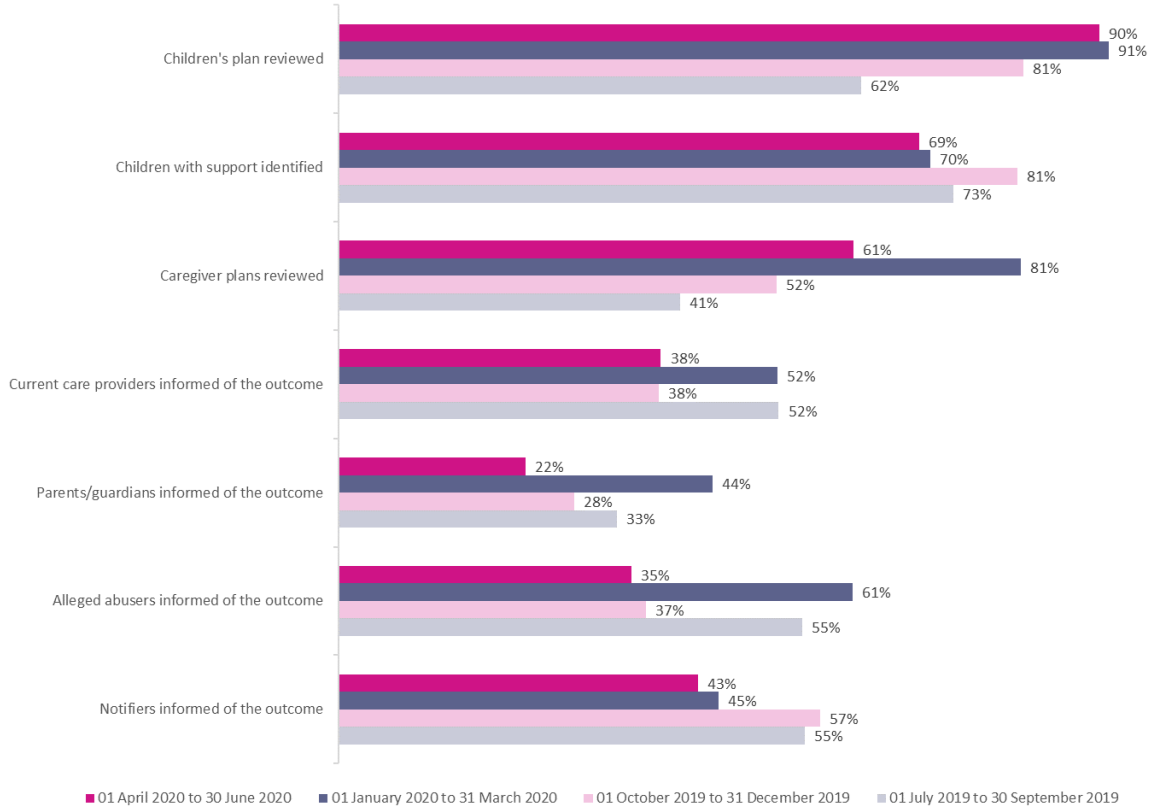
Graph Three – Percentage of care plans updated for te tamaiti following the outcome of a Child and Family Assessment or Investigation.

Experience

Some staff from the three sites told the Monitor they felt pressure and tension between visiting tamariki and rangatahi and completing paperwork on time. What was apparent across all sites is that the social workers we spoke to were passionate about the needs of the tamariki coming first.

Appropriate Steps are Taken

The following data showing compliance with individual requirements was provided by Oranga Tamariki.

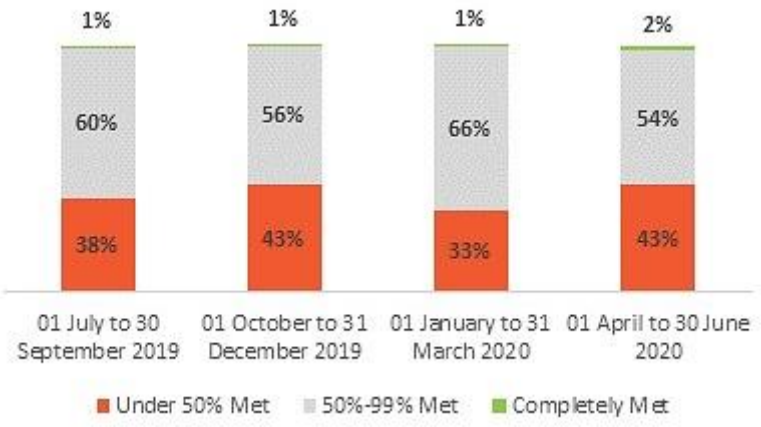


Graph Four – Percentage of incidents that complied with each appropriate step.

Oranga Tamariki Performance Requirements as per its Definition

Oranga Tamariki analysed its data to identify the percentage of cases where all aspects of the practice defined in its *Overview of Care Standards Regulation 69 and 85 Practice Requirements, Monitoring Approach and Measures and Reporting Mechanisms* (practice requirements) were met in response to allegations of harm for individual tamariki and rangatahi[14].

[14] Oranga Tamariki defines regulation 69 as emotional, physical and sexual abuse and neglect. Risk of harm caused by abuse or neglect when applied within regulation 69 is limited to abuse or neglect that is caused whilst in care or custody and therefore will not apply to the harmful impact of previous trauma arising from abuse or neglect prior to entry to care. For full definitions please refer to the Monitor's initial report pages 69-74 https://www.icm.org.nz/reports/report-one/



* Please note percentages do not add to 100 percent due to rounding.

Graph Five – Percentage of allegations of abuse or neglect that had a finding that complied with all aspects of regulation 69.

As noted in graph above:

- all 12 practice requirements were recorded as being met for approximately one percent of tamariki and rangatahi
- 59 percent of allegations were recorded as having six or more of the practice requirements met
- 40 percent of allegations were recorded as having fewer than six of the practice requirements met.

From its own 12 practice requirements, Oranga Tamariki identified three areas of practice that it sees as potentially being of greatest importance for tamariki. These are:

- to review a child's plan
- to ensure that support mechanisms are in place to address the impacts of harm
- to confirm the communication of outcomes to tamariki.

It reported that its compliance has improved from 19 percent compliant in the period 1 July 2019 to 30 September 2019, against these three measures, to 29 percent in the period 1 April 2020 to 30 June 2020. While there has been some improvement in the measure, records show that 71 percent of tamariki and rangatahi did not have these three most important practice requirements met.

Initiatives Implemented to Support Outcomes for Tamariki and Rangatahi in Relation to Regulation 69

The following information was requested from all agencies.

Provide information on any initiatives that have been implemented to support better outcomes for tamariki and rangatahi in relation to regulation 69.

Oranga Tamariki

Experience

Across the three Oranga Tamariki sites visited, staff indicated the working relationship with iwi has set in place a strong foundation from which tamariki, rangatahi and their whānau can be supported. This has been highly valued by staff at all levels.

A social worker at one site said, "it's great we just pop down to the local [iwi] provider and we are always welcome. We work together as we all want our moko to thrive." Reciprocally, the local iwi provider is often at the local Oranga Tamariki site and have a desk they can use. There has been a great deal of effort put into strengthening the relationship and building trust between the two groups. This foundation has led to them working together to support all involved when there is an allegation of abuse or neglect.

In relation to regulation 69, staff at one Oranga Tamariki site said that support from its local leadership has created an opportunity to operate in a te ao Māori way. They told us that the site has adopted a strength and solutions-based process, which enhances positive outcomes. This includes processes associated with allegations of abuse and neglect.

Barnardos

Barnardos has developed a set of measures with the aim of reducing disparities for Māori tamariki and rangatahi. It has been designing ways to capture information on its client management system.

It has amended its foster care induction training to support cultural components of s7AA[15]. In this way, it hopes to better equip prospective caregivers to meet and respond to the needs of tamariki and rangatahi in a culturally appropriate way.

[15] Section 7AA is the duties the Chief Executive must carry out to recognise and provide a practical commitment to the principles of Te Tiriti o Waitangi – Oranga Tamariki Act 1989.

Barnardos advised that its Foster Care s7AA Action Plan addresses the need for an additional competency specifically focused on the cultural needs of tamariki and rangatahi in care, and how caregivers can be supported to achieve this. This discussion has included the need for ongoing cultural oversight from partners.

Barnardos reported several initiatives that it has implemented to better support outcomes for tamariki and rangatahi in relation to regulation 69, in line with s7AA:

- Tamariki and caregiver plans are reviewed every three to six months in conjunction with Oranga Tamariki. These are then approved by either the Barnardos team leader or senior management. In this way, Barnardos ensures quality assurance and maintains oversight of the placement stability and potential risk factors.
- Incident reporting is entered via the client management system, which must now be approved by a team leader or senior management. This enables data collection that provides information towards self-monitoring for continuous improvement and national visibility of incidents.
- A monthly staff webinar is held to introduce local iwi connections.
- Appointment of cultural advisors to work with Barnardos rangatahi to find and connect with their iwi links. These advisors also support staff in their knowledge of te ao Māori, and weaving this into everyday practice.
- Development of a National Action Plan with the National Manager Māori is underway, to build relationships with local hapū and iwi with the intention of being able to return rangatahi home.

Open Home Foundation

Open Home Foundation reported that it is in the process of building relationships with many iwi and Māori groups throughout New Zealand, which will help ensure tamariki and whānau get the best and most appropriate support in the event of allegations being made.

It has also adjusted its Abuse Allegations of a Child or Young Person in Care policy and process adding the requirement that if the rangatahi or tamaiti is Māori then the Te Kaiwhakahaere Matua (General Manager Māori) is to be consulted. This will help ensure that the response and support provided is culturally appropriate for te tamaiti, their whānau and/or those caring for them.

Assurance Processes for Barnardos, Dingwall Trust and Open Home Foundation

The following information was requested from the three agencies.

Provide any evidence of assurance that the systems and processes in place to identify any allegations of abuse or neglect are working as per your policy; in particular, the assurance processes relating to whether all/any allegations have been identified and reported.

Please provide any insights from analysis of data that have resulted in a change to practice and any action plans that have been put in place to improve performance relevant to regulation 69.

These agencies have a differing role to that of Oranga Tamariki regarding an allegation of abuse or neglect. Oranga Tamariki carries out the investigation and the relevant agency supports te tamaiti, whānau and caregivers through the process, and updates tamariki and caregiver plans following the outcome of the investigation. All agencies have an obligation to report any allegation regarding a child in their care or custody to Oranga Tamariki as soon as staff are made aware of the concern.

Due to the differing roles, different questions were asked of the three agencies. These were based around the systems, processes and assurances used when involved in an allegation of abuse or neglect.

Barnardos

Barnardos reported that it had not received any allegations of risk of harm caused by abuse or neglect over the last 12-month reporting period. As such, the Monitor did not carry out validation activities.

In reporting to the Monitor, Barnardos noted it has created a risk of harm spreadsheet and updates its records into its updated client management system. The spreadsheet provides all staff a national view of child protection incidents or serious incidents that meet the threshold of regulation 69. Barnardos reports it continues to regularly review and update policies to respond to an allegation of abuse or neglect, and it can respond quickly and safely.

Dingwall Trust

Dingwall Trust also reported that it did not receive any allegations of risk of harm caused by abuse or neglect over the last 12-month reporting period for children in its custody. As such, the Monitor did not carry out validation activities.

From its reporting, Dingwall Trust stated that the responsibility for incident reporting currently sits with its social work team. The Trust is trialling an incident reporting application, *PeopleSafe*.

Dingwall Trust reports it continues to regularly review and update its policies to respond to an allegation of abuse or neglect, and it can respond quickly and safely.

Open Home Foundation

Open Home Foundation reported that its Abuse Allegations of Child or Young Person in Care policy and associated process has been updated. The Monitor undertook a site visit to hear the experiences of staff in dealing with regulation 69.

It was reported by Open Home Foundation that, resulting from analysis of its processes, it has updated its policies to state that foster parents must be informed that there is a possibility that the Police may become involved in an allegation of abuse or neglect.

Open Home Foundation discussed with the Monitor that it is the role of Oranga Tamariki to undertake the investigation of an allegation of abuse or neglect. The role of Open Home Foundation is to report any allegation to Oranga Tamariki, ensure that all the standards under regulation 69 are undertaken, and support tamariki, rangatahi, their whānau and the caregiver. Following the outcome of the investigation, Open Home Foundation develops and implements revised child and caregiver plans. Open Home Foundation staff told the Monitor they appreciated the strong working relationship with their local Oranga Tamariki site. Throughout the process, the agency is updated on developments by Oranga Tamariki.

Open Home Foundation reported that it has been improving its systems and processes, and this has brought greater clarity for its frontline social workers. The client management system has been updated to enable leadership to track the progress of any allegation of abuse or neglect in real time and is actively used. Staff are given comprehensive training to ensure that tamariki wellbeing is at the centre of the process.

It was also reported that staff support tamariki, rangatahi and caregivers both during and after the investigation. The social worker for the child will consult with the social worker for the caregiver to ensure that when they review the plans they work well together.

Experience

The Monitor spoke to several members of the team at one Open Home Foundation service centre. Like the engagement with Oranga Tamariki sites, the views of the Open Home Foundation staff do not reflect the views of all staff but do provide a snapshot of the mahi undertaken at that service centre.

The staff reported to the Monitor that as an organisation it does not deal with many allegations of abuse. The team members the Monitor spoke with had sound knowledge of the organisation's policies and procedures regarding regulation 69.

These staff reported that the policies and procedures were clear and allowed them to work quickly and collaboratively, and the way the organisation has set up this process allows staff to feel confident when dealing with an allegation of abuse or neglect. A staff member commented to the Monitor that they feel supported and do not have to do anything alone.

Assurance Processes for Oranga Tamariki

Under the Memoranda of Understanding between the Monitor and the agencies, it was agreed to provide information and data around their internal self-monitoring. The Monitor has used the agencies' own analysis to answer questions relating to the processes and systems to support compliance with regulation 69.

Oranga Tamariki has also provided its internal self-assessment and analysis as part of the data request made by the Monitor.

Oranga Tamariki has implemented three new assurance processes to provide a complete view of regulation 69.

- Routinely reviewing a random sample of tamariki in care to ensure that where allegations are raised these are formally recorded.
- Reviewing a sample of reports of concern where a decision was made that *No Further Action* was required to assess the appropriateness of this decision.
- Reviewing a sample of cases 12 months after a finding of harm to establish whether the longer-term actions needed to address the impact of harm experienced by tamariki were implemented. This work commenced in October 2020.

The following information was requested from Oranga Tamariki.

- Provide a detailed flowchart or process map describing the assurance processes in place to meet the requirements of regulation 69 relating to decision-making at the National Contact Centre and sites
- Provide any evidence of assurance that the systems and processes in place to identify any allegations of abuse or neglect are working as per your policy, in particular the assurance processes relating to whether all/any allegations have been identified and reported.

Please also provide:

- any insights from analysis of data that have resulted in a change to practice and any action plans that have been put in place to improve performance
- an update on the Performance Management Framework, including the development of the new reporting suite that allows sharing of performance information across the organisation, as detailed in Oranga Tamariki feedback to the Monitor (Second Reporting Cycle Supplementary Questions)
- any information and data relating to site self-assessments relevant for regulation 69
- information, results and reporting relating to the Quality Practice Tool, and site quality practice checks relevant to regulation 69.

Additional assurance activity is undertaken by Oranga Tamariki through the Safety of Children in Care Unit, the Professional Practice Group (PPG) and frontline practice leaders using the Quality Practice Tool (as defined under Quality Practice page 35 of this report).

The June 2020 report noted that Oranga Tamariki introduced a new assurance process over the decision-making regarding allegations of abuse or harm at the National Contact Centre.

Current Oranga Tamariki policy states that all allegations of abuse or neglect in relation to children in care will be referred to the site. The Monitor requested a process map to show how Oranga Tamariki assures itself that the correct decisions were being made for those cases where it was decided that *No Further Action* was required.

Oranga Tamariki provided the Monitor two process maps outlining the assurance steps taken in relation to allegations of abuse and neglect. The first is for the National Contact Centre, the second for all sites (refer to process maps – Appendix Four).

The National Contact Centre Assurance Process Map demonstrates process steps; however, it does not explain the assurance measures. The map showed only "optional" or "may" consultation or reviews occur. Oranga Tamariki has stated that this fits with its random sampling technique. It does not limit the number of cases that are checked at either of these stages and a new social worker, for example, may have more assurance checks completed at each of the decision-making points than others.

This method, while demonstrating development of practice, does not provide consistency of assurance checks. In contrast, the Site Assurance Process Map shows that the supervisor reviews and approves the decision-making element of the process and this is then reviewed by the Care and Protection Resource Panel.

Experience

During the Monitor's visits, a staff member said the introduction of the NCS Regulations has focused their work, as the introduction of the standards highlighted that they did not have a good process to manage an allegation of abuse or neglect. As a result, the site has created its own checklist to ensure it is undertaking best practice as per the guidelines and policy set by Oranga Tamariki.

No Further Action Decision-Making

In response to regulation 69(1), the June 2020 report highlighted a new process implemented by Oranga Tamariki for allegations of neglect or abuse. This process is related to tamariki or rangatahi in care where it is determined that no further investigation or assessment is required.

The Monitor wrote in the June 2020 report that Oranga Tamariki had begun sampling decisions where no further investigation was required. This was being done to assess the quality of decision-making. Of the 1,831 allegations received, in 612 cases a decision was made at the National Contact Centre or a local site that *No Further Action* was required. Putting the assurance process in place is a positive step as Oranga Tamariki need to have confidence that decision-making is robust.

Oranga Tamariki undertook a review of a sample of the 156 reports of concern for children in care from 1 April 2020 to 30 June 2020. The random sample size was 69 entries, relating to 51 distinct incidents. The nature of concerns and subsequent rationale for the *No Further Action* required response were classified as per the following graph.

Graph Six – Results of reviewed allegations of abuse or neglect that resulted in *No Further Action* needed[16].

From its own data and analysis, Oranga Tamariki reported that 14 instances reflected allegations of abuse or neglect for children in care. After further analysis, five out of the 14 cases were reported by Oranga Tamariki to have been accurately determined as requiring *No Further Action*. Considering the number of cases where the decisions were inaccurate, the Monitor has asked Oranga Tamariki what steps it is taking to improve decision-making accuracy.

For the nine cases where the decision appeared inaccurate, Oranga Tamariki contacted local sites to follow up with these tamariki and rangatahi and their whānau.

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- Abuse of Children in Care (AOCIC) – entries that related to incidents alleging possible abuse or neglect whilst the child was subject to a custody status and therefore would require an assessment or investigation
- Report of Concern (ROC) error – those where a report of concern was wrongly created
- Non Abuse Event – those that did not require a Child and Family Assessment or Child Protection Protocol investigation with Police
- Pre Care – concerns related to incidents that occurred prior to children being subject to a custody status and therefore not reportable under requirements of regulation 69.

Oranga Tamariki stated, '*Our Business Implementation and Operational Support teams provide targeted support to NCC, Sites and Regions when trends and issues like this are identified. The monitoring of NFA decision making is being strengthened. There is no intention to expand the sampling at this stage.*'

The Monitor recognises that Oranga Tamariki will continue regular assurance and assess how its quality control of reaching the decision of *No Further Action* is determined. Due to the high number of cases where Oranga Tamariki reported the decision appeared inaccurate, the Monitor will continue to seek data and information on what Oranga Tamariki is doing to improve decision-making. This will be an area of ongoing focus for the Monitor's future reports.

Experience

In meeting with staff at the three sites, the Monitor was given insight into the assurance processes carried out at each stage of managing an allegation of abuse or neglect. The Monitor acknowledges that this is not a full representation of all staff working across Oranga Tamariki.

Staff were able to demonstrate that they had a working knowledge of the process that applies to regulation 69. At some sites that were visited, copies of flow charts, process maps and checklists, which have been developed to suit their site, were provided to the Monitor as evidence of their knowledge.

During the Monitor's visits, frontline staff identified that further training and clarification of roles and responsibilities when dealing with regulation 69 would be beneficial to their social work practice.

Performance Management Framework

Oranga Tamariki reported that it is currently in the process of refreshing its framework to ensure decision-makers and social workers have access to the data and information. The framework is in the late stages of development, and the initial tools to support sites to drive performance are in the prototype phase at two of its 60 sites.

The framework tools will cover the key elements of the NCS Regulations and, in most cases, directly replicate key metrics that will be monitored. This will allow sites to manage their own data and make improvements as needed. The initial focus of these tools is to support sites to lift performance when working with tamariki and rangatahi in care. Oranga Tamariki expects framework tools to be widely available across the country in early 2021.

This work aligns with regulation 86(1)(a).

Quality Practice

As well as using the site self-assessment tool, as required in regulation 86(1)(a) and (b), Oranga Tamariki reported that it initiated another continuous improvement process. The Quality Practice Tool. This covers the Oranga Tamariki Practice Standards[17], the NCS Regulations and one thematic area of interest each quarter. It also focuses on the quality of practice in order to support continuous improvement in case work. The tool is used monthly, with one month in three focused on the National Care Standards. It provides a structured mechanism for sites to track their progress by applying a set of questions quarterly[18] to a random sample of children in care by practice leaders and it uses a rating scale for each question from fully to not applicable.

The purpose of this tool is to provide feedback to staff, and monitor trends and themes identified in practice across a site, enabling additional practice improvement opportunities to be identified and addressed. At a national level, this information is used to support strategic and operational decision-making.

A further level of assurance has been undertaken by the PPG within Oranga Tamariki. The PPG undertook a random sample of 281 case files of tamariki in care or custody for longer than three months and reviewed whether there was a new allegation of abuse or neglect while still in State care. If the finding was yes, the PPG undertook a further investigation to confirm if a new report of concern had been entered.

[17] Practice standards are the benchmarks for social work practice for Oranga Tamariki. For more information see the Oranga Tamariki website https://practice.orangatamariki.govt.nz/practice-standards/

[18] A period of three months.

In 36 out of 281 cases (13 percent), the PPG found information that indicated there were circumstances of potential harm that required further assessment in the previous 12 months.

It was found that a new report of concern was not made for 15 of these cases where it would have been the appropriate response. When PPG-led case file reviewers identify a case in which it appears that an allegation has been made, but a report of concern has not, the case is escalated to the site for their follow up.

Experience

When visiting Oranga Tamariki sites, the Monitor noted that practice varies from site to site, which allows for sites to respond flexibly to local needs, relationships and initiatives. For example, one site initiated a change in process at that site that meant the practice leader no longer had oversight of individual allegations of abuse or neglect. Previously when they had oversight of a case, the practice leader was able to identify gaps in practice that would then lead to tailored training for staff at that site. In contrast, another site holds a cross-team case consult when an allegation of abuse or complaint is made. At these consults, the social worker takes the lead in addressing the allegation and the case is then further reviewed by the site leadership team to ensure any practice gaps are identified.

The Safety of Children in Care Unit

The ongoing work of the Safety of Children in Care Unit is a positive step forward for Oranga Tamariki as it looks to improve the outcomes for tamariki and rangatahi in State care. Oranga Tamariki reported that the Unit's role is to ensure a greater understanding of harm and the circumstances in which it happens. It can identify emerging trends and patterns to inform continuous practice improvement across Oranga Tamariki. This enables Oranga Tamariki to focus on the areas of practice that are under-performing for tamariki and rangatahi in care, as well as their whānau and caregivers.

The establishment of this Unit and its continuing work is a tangible demonstration of the commitment Oranga Tamariki has made to continuous improvement.

Continuous Improvement Programme – Oranga Tamariki

Oranga Tamariki has undertaken a programme of continuous improvement activities and acknowledges the need for further improvements in consistency of practice related to the implementation of the NCS Regulations. From its own internal self-assessment, it has already set some immediate areas for focus as follows.

- Responding to allegations of harm and ensuring that areas for practice improvement can be targeted and prioritised.
- Prioritising immediate actions needed to ensure the safety of tamariki where allegations of harm were raised.

The following information was requested from Oranga Tamariki.

In line with your continuous improvement programme, in relation to the 12 performance measures identified in Oranga Tamariki operational policies for compliance with regulation 69(2) (a-d), please outline:

- which (if any) measures you consider to be areas for improvement
- which (if any) measures you consider to be areas of high performance
- what your target percentage for compliance cases against each measure is for the next reporting year
- if any measures have been identified as areas for improvement and provide your action plan for how you will aim to improve performance.

Areas for Improvement

The measurement of harm for children in care work carried out within the Safety of Children in Care Unit, regional sites and across all Oranga Tamariki, enables a thorough understanding of how it responds to allegations of harm and ensures that areas for practice improvement can be targeted and prioritised.

Oranga Tamariki has detailed an action plan for continuous improvement.

- Increased oversight of allegations against caregivers, including a particular focus on the timeliness for caregiver investigations.
- Providing coaching and support to specific sites through its internal quality assurance processes.
- Strengthening information and reporting for operational leaders, which will enable them to oversee and drive continuous improvement in practice at a local level. There is a particular focus on consistency of decision-making, communicating outcomes, accuracy of recording and timeliness.
- Developing additional resources for frontline supervisors to support them to oversee and assure the quality of investigations and assessments for tamariki.
- An increased engagement with frontline leaders to support them in their role in leading and championing best practice.
- Developing guidance for frontline practitioners on communicating outcomes of investigations and assessments for tamariki.
- Strengthening responses to return/remain home placements.

Tamariki Plans

Oranga Tamariki indicated that, from 1 July 2019, the requirement for *Caregiver Support Plans* and *All About Me Plans* provided social workers with a much stronger mechanism to explore the needs of tamariki and caregivers following an incident of harm. It continues to embed these tools and expects to see this area of practice improved.

The review conducted by the Safety of Children in Care Unit provides opportunities to understand how the needs of tamariki, rangatahi and their whānau were considered and responded to, and how Oranga Tamariki engaged with whānau when allegations of abuse were assessed.

The Monitor notes that the retrospective nature of monitoring means that the impact of the actions taken in response to the June 2020 report will not be realised within the timeframe of this report.

Recording and Reporting Consistency

Reduce the impact of harm

Part of the internal analysis of data by Oranga Tamariki found that there was a higher proportion of risk to tamariki and rangatahi who returned to or remained at home. To address this, Oranga Tamariki has introduced more support and resourcing for tamariki and rangatahi during transitions. This is a positive step that provides more support to family and whānau.

Communication of outcomes to tamariki and rangatahi

As noted previously in the report, communication with tamariki and rangatahi is part of its continuous improvement activities.

Experience

As noted previously, Oranga Tamariki has committed to work with its frontline staff to improve levels of recording. A small number of Oranga Tamariki staff the Monitor met with indicated that the system does not support accurate recording and often aspects of an allegation of abuse or neglect are only recorded in the child's plan or case notes on CYRAS[19]. Staff told the Monitor they feel that their first duty is to respond to the needs of tamariki and rangatahi. With high case numbers, it means that they can fall behind on administrative tasks, such as case-note recording.

Leadership, Relationships and Culture

The Monitor conducted three site visits to hear how frontline staff are making improvements to the system.

Experience

Leadership at sites and team culture play an important part in continuous improvement when working through an allegation of abuse and neglect.

The following information was requested from Oranga Tamariki.

Provide information on any other initiatives that have been implemented to support better outcomes for tamariki and rangatahi in relation to regulation 69.

During site visits, the Monitor noted that leadership across the sites was committed to improving practice as a team. Most staff noted that they felt supported and cared for. At one site, staff noted the positive role management played in embedding Oranga Tamariki values, and they felt this has greatly improved practice and the working environment. One staff member said, "it is so easy now to just walk over to another team and say, 'can you give me an update on this te tamaiti.'"

Leadership teams said that they have built and strengthened relationships with community-based organisations, government agencies and, importantly, with hāpu and iwi.

[19] CYRAS – The national database used by Oranga Tamariki

At three sites, the Monitor heard that there is tension about the volume of policy and practice directions coming from National Office. Staff felt this was a constant issue and not just because of national emergencies and incidents. Staff felt that this information does not always go to the right person to implement, and policy and procedures seem to change often. This has meant that social workers are not sure if they are using current practice. Staff indicated that this was about all policies, including policy and practice for regulation 69.

At the sites the Monitor visited, they have a set time for training, although sometimes not all social workers can attend due to work demands and high needs of tamariki and rangatahi. All staff the Monitor met with felt that if this could be addressed, they would be able to improve their practice including better compliance with regulation 69.

Staff at the National Contact Centre indicated that they often felt the tension in managing call wait-times alongside undertaking good social work practice. When a challenging allegation about abuse or neglect is reported, staff utilise a peer support system alongside the normal supervision process. Through this process they seek their colleague's advice and support on how to manage the allegation.

At the National Contact Centre, staff said that professional development and training has to fit around the work and is not always a priority due to high call volumes. One social worker stated, "peer-to-peer support can be a good tool to use but it also has its limitations as to who is available at the time and is dependent on the capability and capacity of staff."

Staff at the National Contact Centre identified a gap that some staff, particularly those who work the nightshift or weekends, did not have access to the practice leads. The practice leads have addressed this by changing their working hours to cover some of the different shifts, so all staff have access to their knowledge base.

Appendix One: National Care Standards Regulations

Regulation 69 – Duties in relation to allegations of abuse and neglect

(1) The chief executive must ensure that any information disclosed passing on concerns in relation to a risk of harm caused by abuse or neglect of a child or young person in care or custody is responded to.

(2) In carrying out the process for responding to the information, the chief executive must ensure that –

a. The response is prompt; and

b. The information is recorded and reported in a consistent manner; and

c. Where appropriate, the child or young person is informed of the outcome; and

d. Appropriate steps are taken with the parties to the allegation, including a review of the caregiver's plan

Regulation 85 – Provision of information to independent monitor

The chief executive must ensure that information is provided to the independent monitor on –

a) Reports of abuse or neglect that the chief executive has received under regulation 69; and

b) How those reports were responded to

Regulation 86 – Self-monitoring

(1) The chief executive and an approved organisation with a child or young person in care or custody must monitor their own compliance with these regulations (self-monitoring) by—

(a) having systems in place for continuous improvement that identify and address areas of practice that require improvement; and

(b) using a system for self-monitoring designed to ensure the collection of information that will support the independent monitor to fulfil its monitoring role.

(2) The Minister may at any time require the chief executive or any approved organisation with a child or young person in care or custody to report on the matters referred to in subclause (1).

Appendix Two: Oranga Tamariki Information Requirements in Relation to Regulations 69 and 85 (and 86, as relevant) of the NCS Regulations

Section One: Phase One – Third Reporting Cycle Information Request – Oranga Tamariki

Ref	Question	Provider response (plus other information)
1	Provide a detailed flowchart or process map describing the assurance processes in place to meet the requirements of regulation 69 relating to decision-making at the National Contact Centre and sites.	
2	Provide detailed information, analysis of data, sampling results and any reports to Oranga Tamariki leadership on the sampling results from the assurance processes undertaken of cases that came into the National Contact Centre that did not go on to have a safety screen or further action as signalled in the Monitor's June 2020 report.	
3	The June 2020 report noted that focus and improvement was needed in timeliness of investigations and assessments, and in letting tamariki and rangatahi know about the outcome of an assessment or investigation. Please outline what action has been taken to improve: • the timeliness of investigations and assessments carried out after an allegation has been made, including caregiver reviews • practice to ensure tamariki and rangatahi are informed of the outcome of their allegation.	
4	Please also provide: • any insights from analysis of data that have resulted in a change to practice and any action plans that have been put in place to improve performance	

Ref	Question	Provider response (plus other information)
	• an update on the Performance Management Framework, including the development of the new reporting suite that allows sharing of performance information across the organisation, as detailed in Oranga Tamariki feedback to the Monitor (Second Reporting Cycle Supplementary Questions) • any information and data relating to site self-assessments relevant for regulation 69 • information, results and reporting relating to the Quality Practice tool, and site quality practice checks relevant to regulation 69.	
5	In line with your continuous improvement programme, in relation to the 12 performance measures identified in Oranga Tamariki operational policies for compliance with regulation 69(2)(a-d), please outline: • which (if any) measures you consider to be areas for improvement • which (if any) measures you consider to be areas of high performance • what your target percentage for compliance cases against each measure is for the next reporting year • if any measures have been identified as areas for improvement and provide your action plan for how you will aim to improve performance.	
6	Provide any additional information that you wish to in relation to regulations 69 and 85 that supports the agency's compliance with those regulations.	
7	Provide information on any other initiatives that have been implemented to support better outcomes for tamariki and rangatahi in relation to regulation 69.	

Section Two: Phase One – Third Reporting Cycle Data Request – Oranga Tamariki

We are requesting data about the population of children in care, as well as operational reporting, compliance data and assurance data that relates specifically to allegations of abuse or neglect of tamariki and rangatahi in care. If any data is unable to be provided or Oranga Tamariki considers it inappropriate to provide, please provide a clear explanation and rationale for this decision. For all sections, unless otherwise specified, please provide the relevant data for the full year from 1 July 2019 to 30 June 2020, split by each quarter. Please provide the following:

General information for children and young people in custody as at the last day of a reporting period.	1) Number of tamariki or rangatahi in custody as at 31 March 2020 and 30 June 2020 for care and protection and separately for youth justice and a breakdown of those tamariki and rangatahi by site, region, age, ethnicity, gender, disability, placement type and agency with care (for s396 placements). 2) Break down of tamariki and rangatahi in custody as at 30 September 2019 and 31 December 2019 by site, region, age, ethnicity, gender, disability, placement type and agency with care (for s396 placements).
Operational reporting data and information on all allegations of abuse or neglect in relation to tamariki and rangatahi in care received by Oranga Tamariki. Please provide separate data for reporting period 01 January 2020 to 31 March 2020 and 01 April 2020 to 30 June 2020.	3) Number of reports received in relation to allegations of abuse or neglect of tamariki or rangatahi in care received by Oranga Tamariki (including reports made by s396 providers). 4) Number of reports of concern assessed as requiring further action in relation to allegations of abuse or neglect of tamariki or rangatahi in care. 5) Number of reports of concern closed without a Child and Family Assessment (C&FA) or Child Protection Policy (CPP) investigation in relation to allegations of abuse or neglect of tamariki and rangatahi in care. 6) Number of reports of concern received by site that have had a safety screen completed in relation to allegations of abuse or neglect of tamariki and rangatahi in care. 7) Number of C&FA or CPP investigations completed in relation to allegations of abuse and neglect of tamariki and rangatahi in care.
Findings data for all allegations of abuse or neglect reviewed by the Safety of	8) Number of tamariki and rangatahi with findings of harm recorded (abuse or neglect). 9) Number of findings recorded for each abuse type (emotional, physical, sexual and neglect).

Children in Care Unit (SoCiC Unit). Please provide separate data for reporting period 01 January 2020 to 31 March 2020 and 01 April 2020 to 30 June 2020.	10) Number of tamariki and rangatahi with findings within each abuse type (emotional, physical, sexual and neglect). 11) Number of tamariki and rangatahi with 'not found' recorded (no abuse/neglect). 12) Number of tamariki and rangatahi with relationship/behavioural difficulties recorded (no abuse/neglect). 13) Breakdown of findings by age, gender, ethnicity and site. 14) What the placement arrangements (placement type) were for the child at the time of abuse incident. 15) Where the abuse occurred – in or out of placement. 16) Who is responsible for harming the tamaiti or rangatahi – alleged abuser type.
Data for all allegations of abuse or neglect reviewed by the SoCiC Unit. Please provide separate data for reporting period 01 January 2020 to 31 March 2020 and 01 April 2020 to 30 June 2020.	17) Number of safety and risk screens completed on time with narrative summary. 18) Number of C&FA or CPP investigations completed on time with narrative summary. 19) For C&FA or CPP investigations not completed on time with narrative summary, please provide a breakdown of time taken to complete. 20) Number of findings that were reviewed as inaccurate (either abuse not recognised or non-abuse event wrongly assessed as abuse or wrong abuse type defined). 21) Number of findings with information missing (dates, alleged abuser info or placement type info wrongly captured or absent). 22) Number of appropriate placement changes with narrative summary that incorporates any safety planning limitations. 23) Number of tamariki and rangatahi with care plan reviewed. 24) Number of tamariki and rangatahi with supports in place to address impact of harm. 25) Number of caregivers with support plans reviewed (where appropriate – i.e. not for tamariki in return/remain home or residential placements or some non-family care provision-FGH /SGH). 26) Number of tamariki and rangatahi informed of outcome where appropriate or not informed where inappropriate. 27) Number of parents/guardians informed of outcome where appropriate or not informed where inappropriate.

	28) Number of caregivers informed of outcome (caregiver providing care at time of assessment and not necessarily time of incident) where appropriate or not informed where inappropriate. 29) Number of alleged abusers informed of outcome (including caregivers where appropriate) where appropriate or not informed where inappropriate. 30) Number of notifiers informed of outcome where appropriate or not informed where inappropriate.
Data relating to the number of tamariki and rangatahi where ALL relevant aspects of reg 69(2) (a-d) were met for them as per Oranga Tamariki definitions.	Please provide separate data for following reporting periods: 31) 01 July 2019 to 30 September 2019 32) 01 October 2019 to 31 December 2019 33) 01 January 2020 to 31 March 2020 34) 01 April 2020 to 30 June 2020 Please provide any analysis carried out.

Appendix Three: Approved Organisations' Information Requirements in Relation to Regulations 69 and 85 (and 86 where relevant) of the NCS Regulations

Section One: Approved Organisations Phase One – Third Reporting Cycle Information Request

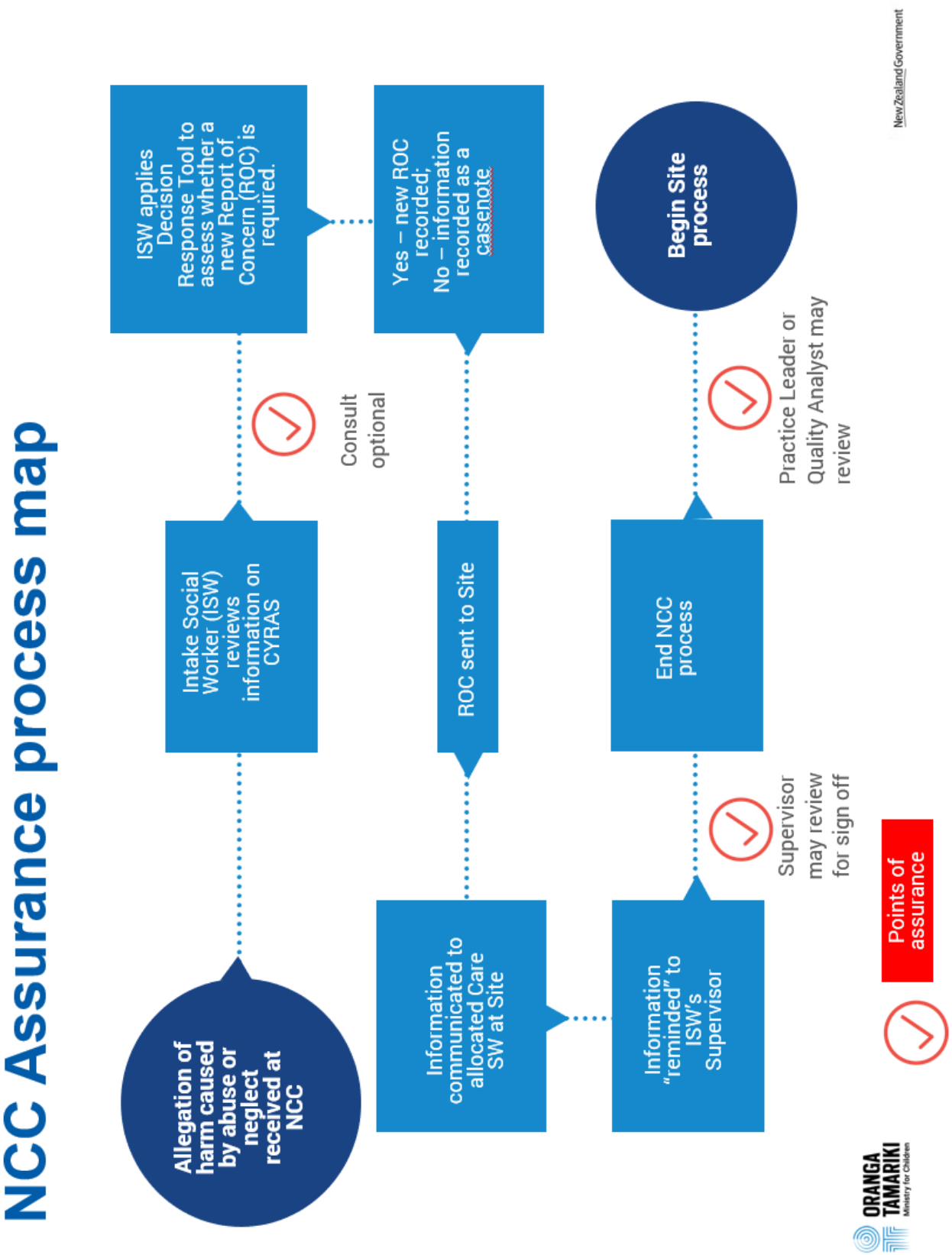
Ref	Question	Provider response (plus other information)
1	Provide any evidence of assurance that the systems and processes in place to identify any allegations of abuse or neglect are working as per your policy; in particular, the assurance processes relating to whether all/any allegations have been identified and reported.	
2	Please provide any insights from analysis of data that have resulted in a change to practice and any action plans that have been put in place to improve performance relevant to regulation 69.	
3	Provide information on any initiatives that have been implemented to support better outcomes for tamariki and rangatahi in relation to regulation 69.	
4	Provide any additional information that you wish to in relation to regulations 69 and 85 that supports the agency's compliance with those regulations.	

Section Two: Approved Organisations Phase One – Third Reporting Cycle Data Request

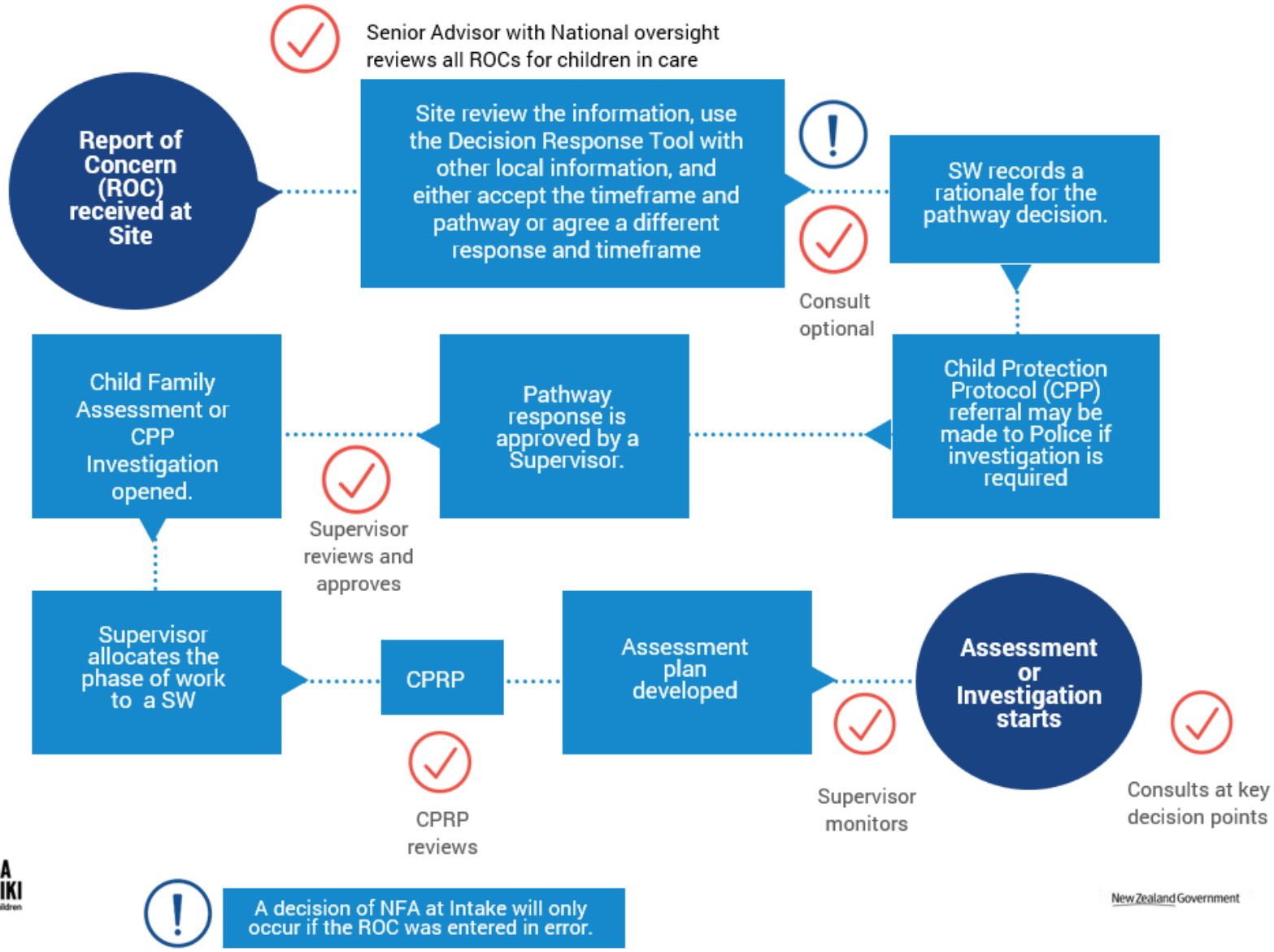
We are requesting data about the population of children in the custody of your agency, as well as operational reporting, compliance data and assurance data that relates specifically to allegations of abuse or neglect of tamariki and rangatahi in care. For all sections, unless otherwise specified, please provide the relevant data for the full year from 1 July 2019 to 30 June 2020 split by each quarter. Please provide the following:

General information for children and young people in custody as at the last day of a reporting period. For Open Home Foundation only.	1) Number of tamariki or rangatahi in custody as at 31 March 2020 and 30 June 2020 and a breakdown of those tamariki and rangatahi by site, region, age, ethnicity, gender, disability, placement type and agency with care (for s396 placements). 2) Break down of tamariki and rangatahi in custody as at 30 September 2019 by site, region, age, ethnicity, gender, disability, placement type and agency with care (for s396 placements).
Information on all allegations of abuse or neglect in relation to tamariki and rangatahi in care received by your agency and reported to Oranga Tamariki. Please provide separate data for reporting period 01 January 2020 to 31 March 2020 and 01 April 2020 to 30 June 2020.	3) Date the allegation was disclosed. 4) Date the allegation was reported to Oranga Tamariki. 5) Date your agency was notified whether the case would proceed to an assessment or investigation. 6) Whether any findings were determined in relation to the case and, if so, what they were. 7) Whether the tamaiti or rangatahi had their plan reviewed. 8) Whether the tamaiti had supports in place to address impact of harm. 9) Whether the caregiver had their support plan reviewed. 10) Whether an alternative placement was required for the tamaiti.

Appendix Four – Oranga Tamariki Assurance Process Maps



Site Assurance process map



Te Mana Whakamaru Tamariki Motuhake | Independent Children's Monitor

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