# Children in care: complaints to the Ombudsman 2019–2023

**February 2024**

**Peter Boshier**

**Chief Ombudsman**
**Kaitiaki Mana Tangata**

Ombudsman

Tuia kia ōrite · Fairness for all

Children in care: complaints to the Ombudsman 2019–2023

A report identifying the themes emerging from complaints and enquiries made between 2019 and 2023 about Oranga Tamariki.

Te Kaitiaki Mana Tangata Aotearoa
The Ombudsman New Zealand

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# Chief Ombudsman's introduction

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***Kia whakatōmuri te haere whakamua***

*I walk backwards into the future with my eyes fixed on my past*

On 1 May 2023, the Oversight of Oranga Tamariki System Act 2022 came into force. With it comes new powers and responsibilities for the Ombudsman to investigate some of the bodies that care for our children/tamariki and young people/rangatahi. In passing this Act, Parliament has shown confidence in my office to see and make things right where they are not.

As Chief Ombudsman it is a responsibility I take very seriously, which is why I have been preparing for the past four years to take it on.

The Ombudsman in New Zealand has always had the ability to investigate the processes and practices of Oranga Tamariki – Ministry for Children and its predecessor government departments and ministries.

Since the request was first made by Parliament for my enhanced focus in 2019, I have dealt with more than 2000 complaints and other enquiries about Oranga Tamariki. Complaints and enquiries continue to increase year on year. These have included complaints from tamariki and rangatahi, either directly or through a trusted adult.

From time to time I publish case notes and opinions about complaints, and reports on my self-initiated investigations, where I consider that is in the public interest. My publications are for Parliament, the public, providers of services for tamariki and rangatahi, and for agencies to learn more about what should be best practice.

Now that I have wider investigative powers to look at complaints about Oranga Tamariki and care or custody providers, the Ombudsman is even more able to help achieve the best outcomes for our children, through identifying issues and lifting good practice.

To provide transparency, and accountability for the organisations involved, I have decided to publish more of my work in this area. In this report are themes I have encountered, case studies and outcomes I have achieved. Outcomes range from accountability and remedies for individuals, to systemic change within Oranga Tamariki.

The nature of the complaints being made, who makes them, the recommendations I make and the response from the organisations involved are all important to help people make decisions about pursuing their rights.

My role as the Chief Ombudsman is to help build trust in our government agencies. Oranga Tamariki is an important agency to keep a large number of tamariki safe when their wellbeing is at risk of harm. However, as I note in my concluding comments at page 102 at the end of this report, I cannot yet provide assurance Oranga Tamariki is consistently operating in accordance with good administrative practice, for a number of reasons.

For Oranga Tamariki to regain the trust it has lost from the people it serves and the wider public, it needs to change on a scale rarely required of a government agency. My challenge to the new Government is to drive this change.

In my conclusion, I provide my view on practice and process improvements that would make a material difference to the numbers of complaints I receive from people about Oranga Tamariki. They include an organisation-wide quality improvement plan, ensuring staff understand and apply legislation and policy, better attention to detail and accurate information in decision making, more training and supervision, regular tracking and reporting, and keeping better records overall.

I chose the whakatauki that begins my introduction because it reflects my past work about Oranga Tamariki in this area, some of which is published within this report.

I am also looking to the future, with these past complaints and investigations behind me, to my wider powers under the Oversight of Oranga Tamariki System Act. The complaints and issues that have come to me previously provide a strong base of experience and knowledge on which to build more capability within my office, provide more assurance to complainants, advocates, Parliament and the public, and provide learnings for agencies and organisations.

My hope is that by sharing the experiences of complainants – tamariki, rangatahi, parents, whānau, caregivers – more people will know that the Ombudsman is an office they can trust with their stories.

I mihi to the many people who have picked up the phone, or written an email or letter to me when they needed help to resolve an issue. I also acknowledge my staff for their mahi and the agencies and organisations which care for our tamariki.

**Peter Boshier**

**Chief Ombudsman**

21 February 2024

# Preamble

## Te Tiriti o Waitangi | The Treaty of Waitangi

I acknowledge the fundamental constitutional status of Te Tiriti o Waitangi / The Treaty of Waitangi and tikanga as a source of law in New Zealand.

Te Tiriti and tikanga are incorporated into my work in the following ways:

- I will consider whether the Crown is acting consistently with Te Tiriti and tikanga when undertaking my oversight functions.
- I will ensure my own processes, practices, and decisions are consistent with Te Tiriti (as appropriate for an entity outside of the Crown) and informed by tikanga.
- I will engage Māori to understand their views when considering matters that affect Māori rights and interests.
- Te ao Māori will be authentically and appropriately applied in overseeing any Māori entities and non-governmental organisations.

## Terminology and accessibility

**This report deals with issues about the care system for children that may be traumatising for some people.**

I acknowledge the importance of the language and terminology used in this report, particularly for people who are impacted by the Oranga Tamariki system. Explanations of the terms and abbreviations used in this report can be found in Appendix 1. Glossary.

The terms for children and young people, tamariki and rangatahi, (and other associated terms such as whānau/family) are used interchangeably throughout this report, recognising that the Māori terms for children and young people are used widely in everyday language. As I have removed all identifying information in this report, use of a term in a particular instance may not necessarily correlate to a particular individual's ethnicity.

The report has been written with a focus on being easy to read and understand. It is written in simple language, and has no footnotes or references. Where graphs have been included, alt text has been provided in Appendix 4. Alternative text versions – charts and graphs.

The content and case studies have been chosen with the intention of presenting information and findings that will resonate with readers, including from a te ao Māori viewpoint, those who may be impacted by trauma, and those who may be disabled.

## A note on Family Court proceedings

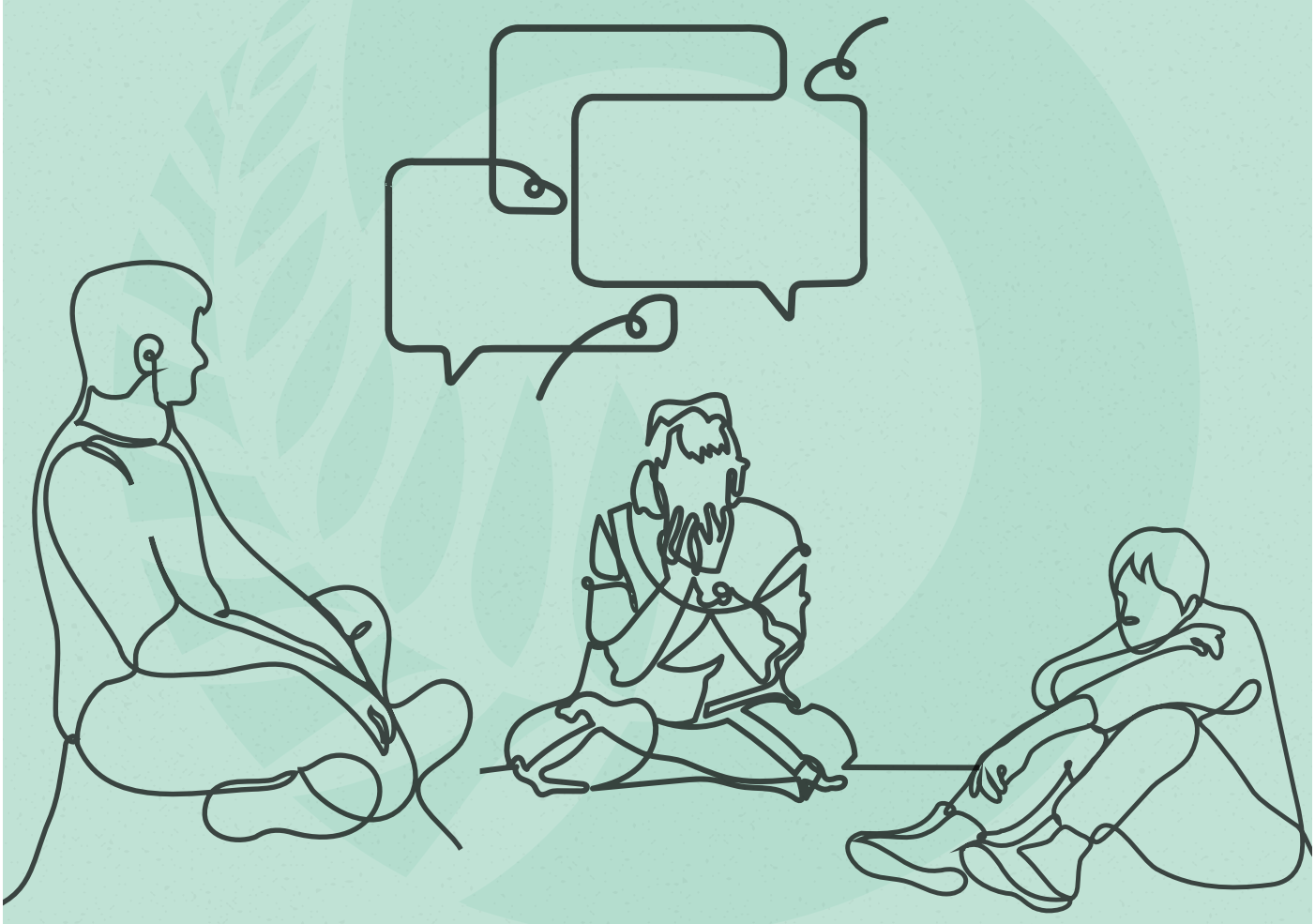
I am very aware of the requirements of section 11B of the Family Court Act 1980, which prohibits the publication of reports of particular types of proceedings of the Family Court, where those reports contain identifying information.

Some of the case studies in this report relate either directly or tangentially to matters in which the Family Court has had involvement. I have taken great care in ensuring these case studies do not contain identifying information about those involved, and do not breach section 11B.

The approach I have taken is to, on the one hand, preserve privacy and comply with the law, but on the other hand, as far as is possible, shine a light on aspects of Oranga Tamariki practice that have been the subject of complaints to my office in order to achieve accountability and lasting change.

That is, after all, part of my role as Chief Ombudsman.

# 1 The work of the Ombudsman for children in care



# The work of the Ombudsman for children in care

The Oversight of Oranga Tamariki System Act 2022 (Oversight Act), which came into force on 1 May 2023, brings with it certain expectations for the Ombudsman.

These are:

- Ensuring Oranga Tamariki – Ministry for Children (Oranga Tamariki) accountability and transparency.
- Providing reassurance to complainants, whānau, iwi, hapū and Māori organisations, providers, disabled people, their families and representative organisations, Parliament, the Government and agencies, other stakeholders and the public, that the Ombudsman is capable of dealing with such complaints, dealing with them in a timely fashion and providing a fair and reasonable outcome.
- Educating all stakeholders about what can be complained about, the process and the outcomes that can be expected.
- Demonstrating that I am carrying out the duties and powers Parliament has provided me in dealing with complaints, and in a way that meets the requirements under the Ombudsmen Act and the Oversight Act.
- Contributing to systemic service improvement.

Under the Oversight Act, complaints may be made direct to me about the acts and decisions of care or custody providers (section 396 providers). I also have a role to support care or custody providers to manage and resolve complaints themselves.

Section 39 of the Act says:

*When dealing with a complaint or an investigation involving Oranga Tamariki or a care or custody provider, an Ombudsman must—*

*a. operate in a way that recognises the importance of a child's or young person's family, whānau, hapū, iwi, and culture; and*

*b. ensure that the Ombudsman's complaints and investigations processes-*

*i. are visible and accessible to children and young people and their family, whānau, hapū, and iwi, or an individual or organisation supporting them; and*

*ii. incorporate a tikanga Māori approach; and*

c. *involve the child or young person, and their family, whānau, hapū, and iwi in their complaints or investigations processes, as appropriate.*

I have been preparing for these changes for the past four years. The planning has been meticulous and the implementation thorough.

Preparations include:

- Recruitment and training for complaint-handling staff (investigators) to ensure their interactions with tamariki, rangatahi, whānau and other complainants are appropriately child-centric, trauma-informed and considerate of their cultural and disability needs.
- An ongoing programme of engagement with tamariki and rangatahi in care or custody, caregivers, care or custody providers, advocates and their representative bodies, Oranga Tamariki staff, iwi groups, and others to ensure they are aware of the Ombudsman and my enhanced role, and how they can make contact.
- Since 2020, my investigators have travelled around New Zealand to more than 30 in-person meetings with complainants and others to ensure their voices are heard, in a culturally appropriate and trauma-informed way, and that they are being accurately represented.
- Producing child-centric and accessible information and resources on who the Ombudsman is, what people can complain about, how to make a complaint, the complaints process and what happens as a result. This includes specially designed information sheets and a dedicated stand-alone website that has been produced with tamariki and rangatahi in mind so they can better understand how I can help, and to explain the process.
- Simpler contact processes with a dedicated Children in Care complaints 0800 phone number and SMS service.
- Communication tools, services, and products in different languages and accessible formats are being developed, based on first-hand research commissioned specifically for my work with tamariki and rangatahi in care.
- Increasing my monitoring of critical and serious incidents, complaint trends and data, with an ability to investigate where necessary.
- Regular meetings with Oranga Tamariki chief executive and working with Oranga Tamariki senior managers.
- A self-initiated investigation into the removal of pēpi, and ongoing monitoring of Oranga Tamariki on my recommended actions for improvement.

- Developing guidance for Oranga Tamariki and care or custody providers on improving their own complaint systems.
- Working with Mana Mokopuna (Children and Young People's Commission) and Aroturuki Tamariki (Independent Children's Monitor) to develop a terms of reference for how we can work together in overseeing the Oranga Tamariki system.
- Development of joint communication products with Mana Mokopuna and Aroturuki Tamariki.
- Since 2019, I have dealt with more than 2000 complaints and other enquiries about Oranga Tamariki, including complaints from tamariki and rangatahi, their whānau, caregivers and others.
- I expect to receive an increasing volume of complaints and enquiries now that the Oversight Act has been passed.

# 2 Key impacts over the last four years

# Key impacts over the last four years

1 From July 2019 to June 2023 I received 2142 complaints and other enquiries about Oranga Tamariki. I completed or closed 1964 complaints and enquiries in the same period.

2 I resolved 86 complaints and completed final opinions in 117 investigations.

3 I found 109 formal deficiencies in 61 final opinions – 95 deficiencies in individual cases and 14 deficiencies in the Oranga Tamariki system.

4 I found no deficiencies in 56 final opinions. This is evidence of good practice by Oranga Tamariki in many cases.

5 I obtained 173 remedies for complainants and a further 37 remedies to improve the systems and processes at Oranga Tamariki.

6 I made 59 recommendations for apologies from Oranga Tamariki to individual complainants and/or their whānau. I have given clear guidelines to Oranga Tamariki on making an effective and meaningful apology, and have produced a guide for all agencies on this, He rauemi tātaki ea – A resource for offering an effective apology. This can be found in the resources section of my website.

7 I wrote 32 letters to the Minister for Children to report the outcome of my investigations and recommendations for improvement.

8 I published my report He Take Kōhukihuki | A Matter of Urgency. Since then, Oranga Tamariki has reported high compliance by staff with strengthened policies and processes for approval of without notice section 78 interim custody orders for at-risk unborn and newborn pēpi. It also reported the number of uplifts has dropped markedly.

9 A total of 42 decisions by Oranga Tamariki were changed or reconsidered as a result of my investigations.

10 I made 13 recommendations for financial remedies for complainants.

11 Oranga Tamariki reviewed its ex gratia (financial remedy) policy to ensure alignment and consistency with its values and practice frameworks, as well as wider cultural considerations.

12 I made four formal referrals to or consultations with the Chief Archivist under the Public Records Act about Oranga Tamariki record-keeping.

13 Oranga Tamariki agreed to update me and the Chief Archivist on policies, processes and training that reflect the requirement and importance of transferring records created on mobile devices to its records management systems. It has done this.

14 Oranga Tamariki agreed to scope a review of its practices and policies around involvement with disabled parents. The review was to be conducted with the involvement of disabled people-led organisations and in accordance with the United Nations Convention on the Rights of Persons with Disabilities (known as the Disability Convention). Oranga Tamariki advises it is in the process of implementing its disability strategy.

15 Oranga Tamariki amended its policies and procedures to ensure court documents include a comprehensive, balanced, and accurate analysis of the risks and benefits of placements and that all court documents are reviewed at an appropriate level before filing.

16 Oranga Tamariki amended its policies and procedures to ensure a full search for whānau, hapū and iwi is undertaken and documented as early as possible in the placement process.

17 Oranga Tamariki now has a section in its online Practice Centre on seeking the views of tamariki and rangatahi in decisions that affect them, including decisions about where they will live.

18 Oranga Tamariki made changes to its caregiver policy in relation to allegations of harm to clarify that all relevant concerns - such as historical or cumulative concerns - likely to be considered in an inquiry, are provided to the caregiver as soon as practical and in a way they would be able to understand.

19 Oranga Tamariki updated its casework policies when more than one site is involved following my recommendation to develop and publish policies when transfers occur between sites, in particular on timeframes and role responsibilities.

20 Oranga Tamariki published new practice guidance on its Practice Centre on advocacy for parents and whānau to help clarify whānau rights and wishes through an independent advocate in order to strengthen the family voice, uphold rights and reduce the likelihood of miscommunication and conflict.

21 Oranga Tamariki provided training to social workers and Family Group Conference co-ordinators on the purpose and differences between hui ā-whānau and Family Group Conferences. Training included how to explain the difference clearly to whānau and professionals involved, and how to ensure their understanding is evidenced on the online case recording system.

22 Oranga Tamariki reviewed its policy on financial support for whānau-nominated caregivers for children not in the care of Oranga Tamariki.

23 Oranga Tamariki developed guidance and training for staff around working with individuals who are correcting errors in their records in a trauma-informed manner.

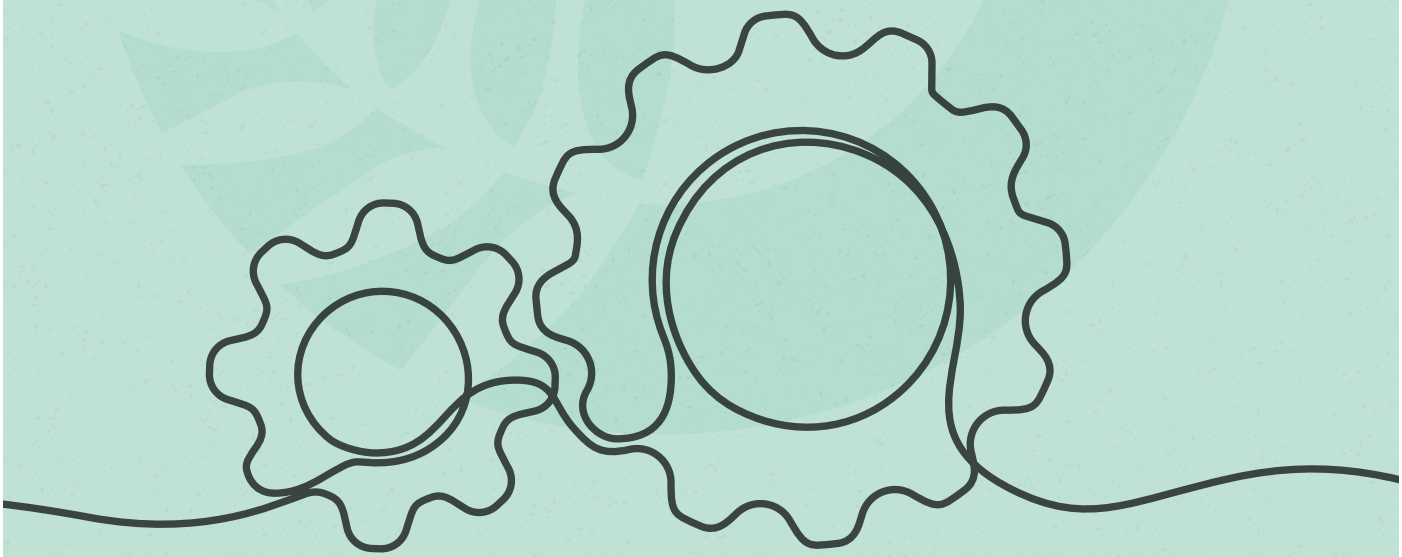
# 3 Key themes from complaints considered

# Key themes from complaints considered

Key issues arising in a number of complaints I considered from July 2019 to June 2023 are set out below. Further details, including relevant case studies, can be found in chapters 5 to 13 below.

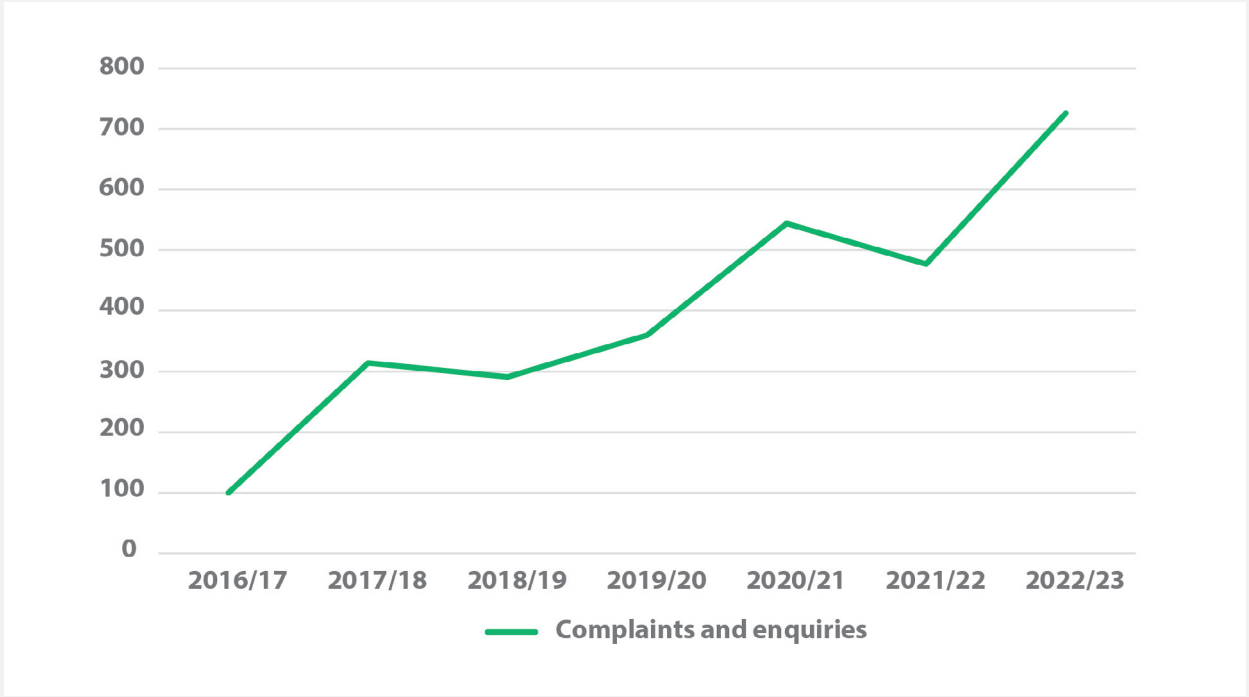
- Young people said they had not been listened to when they complained about an issue.
- Reports of Concern were not acted on, recorded properly, or responded to adequately.
- Information provided to the Family Court was inaccurate, outdated, incomplete or biased.
- Issues around uplifts of children including:
  - Not fully searching for whānau or failing to consult whānau
  - The treatment of parents as disabled people
  - Failing to seek the views of the child.
- Disabled parents and children were not consulted on decisions affecting them, or assumptions were made about their abilities which impacted on decisions.
- Failure to respect and engage with Māori in a culturally appropriate way, including not engaging with whānau, hapū and iwi, failing to consider tikanga-informed practice, and not considering Māori cultural frameworks or Te Tiriti o Waitangi.
- Failure to consider financial payments as a remedy, inadequate financial assessments, and declining to reassess amounts.
- Inadequate or unreasonable apologies.
- Inadequate record-keeping, transfer of information.
- Inadequate communication and support for parents.
- Lack of natural justice opportunities (such as opportunities for comment before a decision is made).

# 4 Data



# Data

## Complaints and enquiries to the Ombudsman about Oranga Tamariki 2016 to 2023




Find the text alternative version of this chart in Appendix 4.

## Complaints and enquiries about Oranga Tamariki received 1 July 2019 to 30 June 2023

| Nature of issue | Total |
|---|---|
| General complaint (Ombudsmen Act) | 847 |
| Information request complaint (Official Information Act) | 136 |
| Enquiry | 1154 |
| Advice request from Oranga Tamariki | 5 |
| **Total** | **2142** |

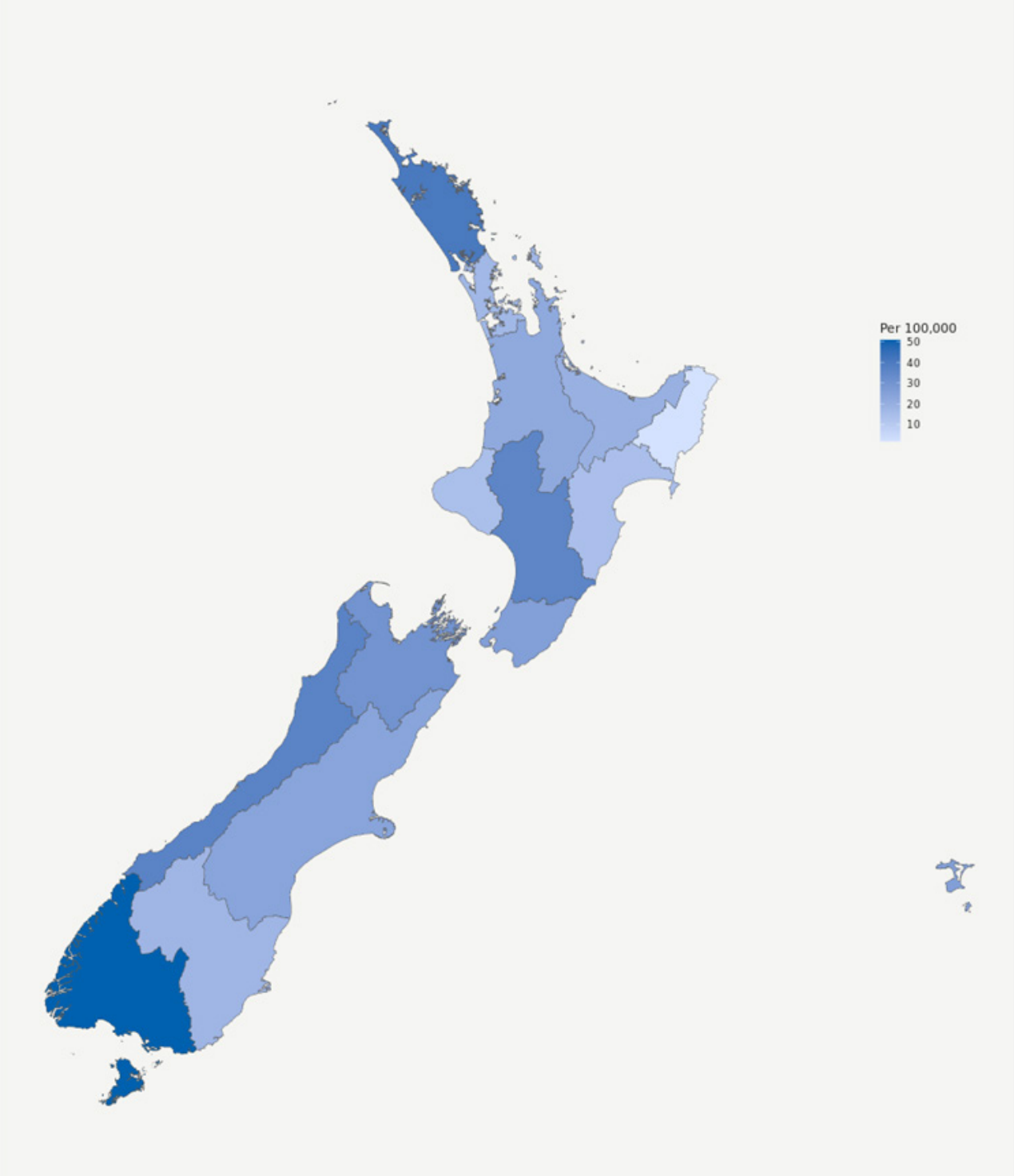
| Who raised the issue | Total |
|---|---|
| Individual | 2089 |
| Media | 16 |
| Company or association | 12 |
| Oranga Tamariki | 10 |
| Advocate or special interest group | 6 |
| Ombudsman | 5 |
| Review agency | 4 |
| **Total** | **2142** |

## Complaint and enquiry numbers by region 1 July 2019 to 30 June 2023

*Note, more than one person may have raised a complaint.*

| Location of person raising issue | General complaint | Information request complaint | Enquiry | Total |
|---|---|---|---|---|
| Northland | 40 | 5 | 37 | 82 |
| Auckland | 143 | 19 | 121 | 283 |
| Bay of Plenty | 39 | 2 | 27 | 68 |
| Waikato | 70 | 5 | 39 | 114 |
| East Cape | 1 | - | - | 1 |
| Taranaki | 6 | - | 12 | 18 |
| Hawke's Bay | 8 | - | 18 | 26 |
| Manawatu/Whanganui | 47 | 9 | 37 | 93 |
| Wairarapa | 7 | - | 3 | 10 |
| Wellington (inc Chatham Islands) | 64 | 12 | 55 | 131 |
| Total North Island | 425 | 52 | 349 | 826 |
| Nelson/Marlborough | 30 | - | 20 | 50 |
| Westland | 5 | 1 | 6 | 12 |
| Canterbury | 23 | - | 34 | 57 |
| Christchurch | 54 | 5 | 42 | 101 |
| Otago | 10 | 2 | 9 | 21 |
| Dunedin | 14 | 1 | 7 | 22 |
| Southland | 26 | 2 | 24 | 52 |
| Total South Island | 162 | 11 | 142 | 315 |
| Location not known | 329 | 75 | 684 | 1088 |
| Overseas | 3 | 1 | 4 | 8 |
| **Total** | **919** | **139** | **1179** | **2237** |

Complaints and enquiries to the Ombudsman by region as a proportion of the population 1 July 2019 to 30 June 2023

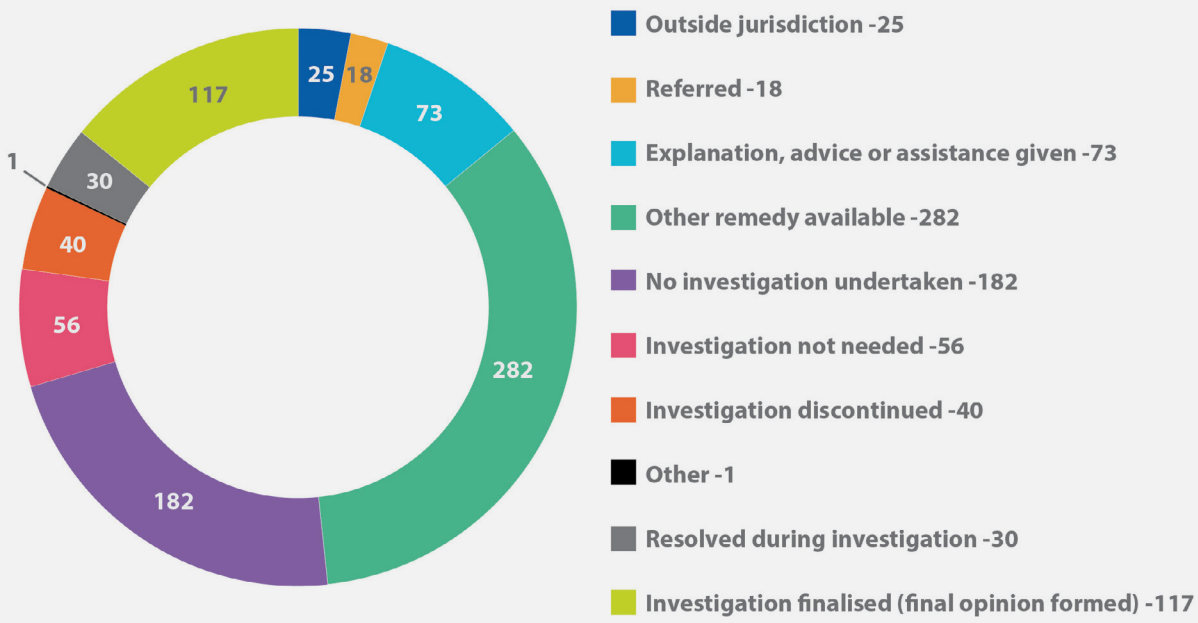



Find the text alternative version of this chart in Appendix 4.

## Complaints and enquiries completed 1 July 2019 to 30 June 2023

| Nature of issue | Total |
|---|---|
| General complaint (Ombudsmen Act) | 720 |
| Information request complaint (Official Information Act) | 104 |
| Enquiry | 1135 |
| Advice request from Oranga Tamariki | 5 |
| **Total** | **1964** |

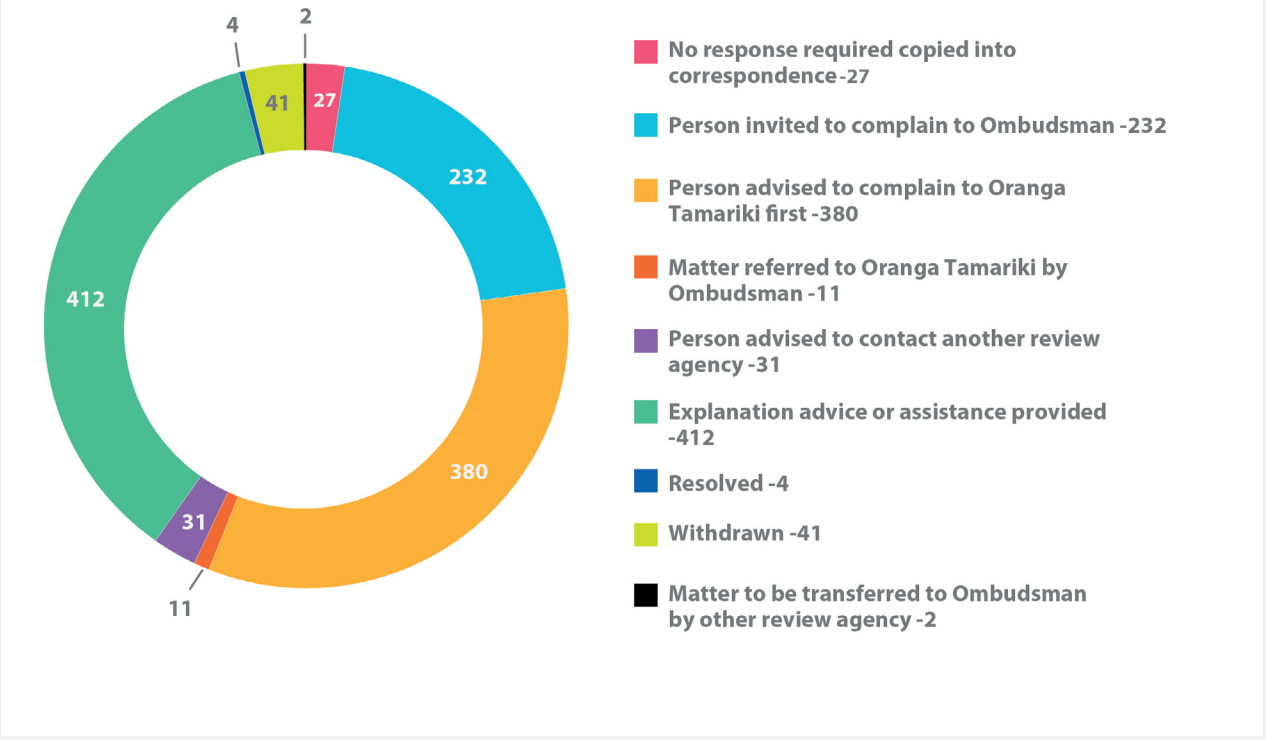
## What happened to complaints 1 July 2019 to 30 June 2023




Find the text alternative version of this chart in Appendix 4.

| What happened to complaints 1 July 2019 to 30 June 2023 | Total |
|---|---|
| **Outside jurisdiction** | **25** |
| **Referred** | **18** |
| Referred to Privacy Commissioner | 16 |
| Referred to Health and Disability Commissioner | 1 |
| Referred to Independent Police Conduct Authority | 1 |
| **Explanation, advice or assistance given** | **73** |
| **Other remedy available** | **282** |
| Right of appeal available to court or tribunal | 9 |
| Other remedy available – complain to Oranga Tamariki first | 221 |
| Other remedy available – complaint referred to Oranga Tamariki by Ombudsman | 35 |
| Other remedy available – recourse to other agency | 17 |
| No investigation undertaken | 182 |
| Withdrawn or no response from complainant | 125 |
| Insufficient personal interest by complainant | 1 |
| **Investigation not needed** | **56** |
| Investigation discontinued | 40 |
| Withdrawn or no response from complainant | 15 |
| Further investigation not needed | 11 |
| Oranga Tamariki to review | 14 |
| Resolved during investigation | 30 |
| Remedial action to benefit the complainant | 25 |
| Provision of advice/explanation that satisfies complainant | 5 |
| Investigation finalised (final opinion formed) | 117 |
| Administrative deficiency found and recommendations made | 37 |
| Administrative deficiency found but no recommendations made | 24 |
| No administrative deficiency identified | 56 |
| Other | 1 |
| **Total** | **824** |

## What happened to enquiries 1 July 2019 to 30 June 2023

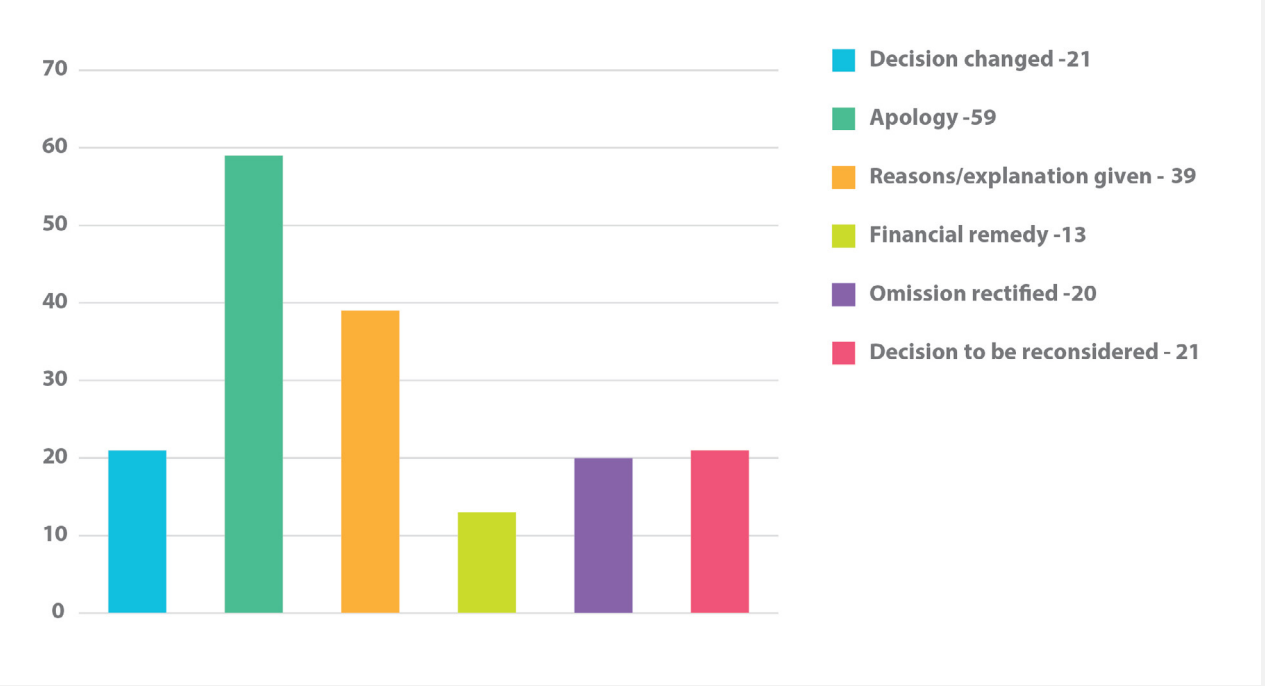



Find the text alternative version of this chart in Appendix 4.

| What happened to enquiries 1 July 2019 to 30 June 2023 | Total |
|---|---|
| **No response required, eg: copied into correspondence** | **27** |
| **Person invited to complain to Ombudsman** | **232** |
| **Person advised to complain to Oranga Tamariki first** | **380** |
| **Matter referred to Oranga Tamariki by Ombudsman** | **11** |
| **Person advised to contact another review agency** | **31** |
| Referred to Privacy Commissioner | 21 |
| Referred to Health and Disability Commissioner | 4 |
| Referred to other review agency | 6 |
| **Explanation, advice or assistance provided** | **412** |
| **Resolved** | **4** |
| Remedial action to benefit the person | 3 |
| Remedial action to benefit the person and improve state sector administration | 1 |
| **Withdrawn** | **41** |
| **Matter to be transferred to Ombudsman by other review agency** | **2** |
| **Total** | **1140** |

| Deficiencies identified from final opinions on complaints | Total |
|---|---|
| **Administrative deficiency in an individual case** | **95** |
| Unreasonable, unjust, oppressive or discriminatory act, omission or decision | 26 |
| Procedural deficiency | 20 |
| Inadequate advice, explanation or reasons | 13 |
| Wrong action or decision | 4 |
| Unreasonable delay | 5 |
| Legal error | 5 |
| Factual error or mistake | 8 |
| Unprofessional behaviour or misconduct by an official | 3 |
| Information request refusal not justified | 4 |
| Information request timeframe issues | 7 |
| **Administrative deficiency in the agency or system of government** | **14** |
| Flawed agency processes or systems | 8 |
| Government or agency policy - unreasonable or harsh impact | 4 |
| Inadequate knowledge or training of agency staff | 2 |
| **Total** | **109** |

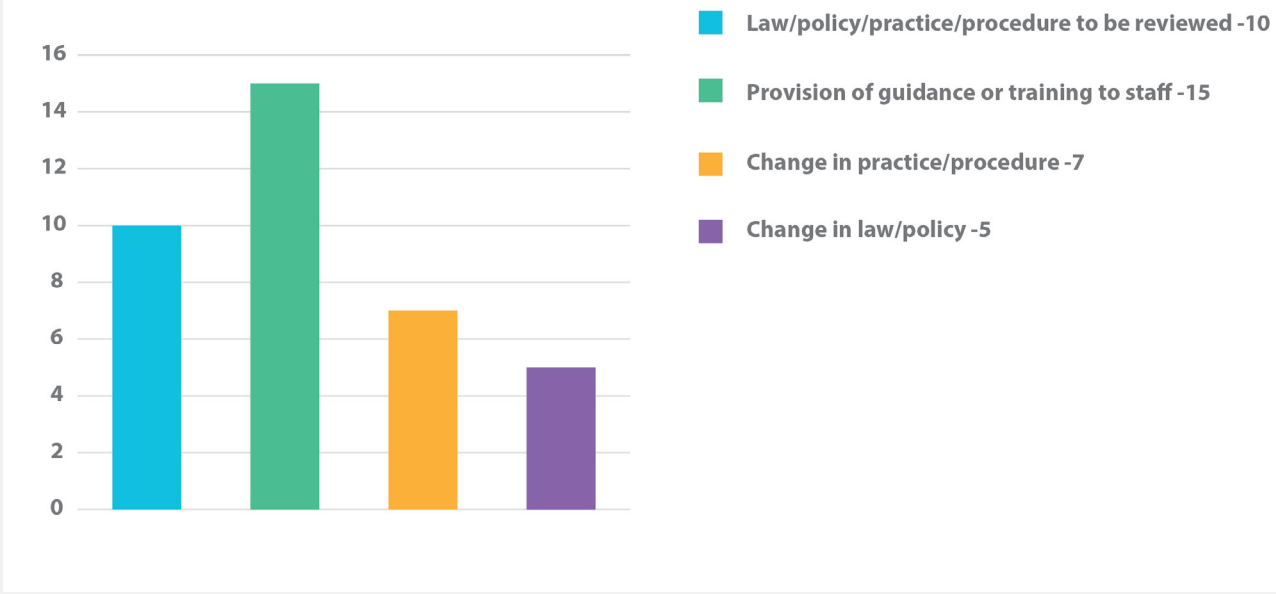
## Remedies achieved for complainants 1 July 2019 to 30 June 2023




Find the text alternative version of this chart in Appendix 4.

| Remedies achieved for complainants 1 July 2019 to 30 June 2023 | |
|---|---|
| Decision changed | 21 |
| Apology | 59 |
| Reasons/explanation given | 39 |
| Financial remedy | 13 |
| Omission rectified | 20 |
| Decision to be reconsidered | 21 |
| **Total** | **173** |

## Remedies to improve systems and processes at Oranga Tamariki 1 July 2019 to 30 June 2023




Find the text alternative version of this chart in Appendix 4.

| Remedies to improve systems and processes at Oranga Tamariki 1 July 2019 to 30 June 2023 | |
|---|---|
| Law/policy/practice/procedure to be reviewed | 10 |
| Provision of guidance or training to staff | 15 |
| Change in practice/procedure | 7 |
| Change in law/policy | 5 |
| **Total** | **37** |

## Complaints made directly to Oranga Tamariki, compared with complaints and enquiries to the Ombudsman

| Year | Oranga Tamariki | Ombudsman |
|---|---|---|
| 2020/2021 | 1400 | 544 |
| 2021/2022 | 1147 | 477 |
| 2022/2023 | 1194 | 726 |

An important part of the Ombudsman's complaint process is that most complaints are considered by Oranga Tamariki first. The ongoing relationship of trust between the parties must be restored, and the step provides Oranga Tamariki the opportunity to address the matter at the lowest possible level, without an Ombudsman's intervention. Where a concern cannot be resolved or the complainant is unhappy with the outcome, they can complain to the Ombudsman.

It is important to note that tamariki and rangatahi who approach the Ombudsman with a complaint about Oranga Tamariki are dealt with immediately, and do not have to go to Oranga Tamariki first.

# 5 Complaints from tamariki and rangatahi

# Complaints from tamariki and rangatahi

Among the complaints I receive about Oranga Tamariki are some that come directly from tamariki and rangatahi, often with the guidance of a trusted adult such as a parent, caregiver or advocate.

With the Oversight Act coming into force on 1 May 2023, and my outreach efforts, I anticipate more complaints will come to me directly from tamariki and rangatahi over time.

I have been preparing for this and I am ensuring that I am accessible and my complaints process is easy to understand and navigate. See my complaints process for tamariki and rangatahi explained in Appendix 3.

Unlike other people who complain to me, who I usually ask whether they have tried to resolve the issue with the agency concerned first, tamariki and rangatahi can come straight to me. They will speak to experienced and well-trained staff who will handle their complaints immediately.

Issues I have identified when investigating complaints from tamariki and rangatahi include Oranga Tamariki:

- Failing to seek or listen to the views of the tamariki or rangatahi
- Failing to act on concerns
- Not acting immediately on a complaint.

The key remedies and outcomes I have achieved ranged from:

- Apologies
- Needs being met
- Solving issues quickly, without the need for a formal investigation.

Complaints and enquiries from tamariki and rangatahi cannot be a lengthy process in which they have to tell their story multiple times in order for their issues to be resolved.

A complaint from a rangatahi in a care and protection unit shows the hoops they had to jump through before their concerns, and future care and residence, was sorted out.

In that case, the rangatahi contacted Oranga Tamariki, the residence grievance panel, the then Office of the Children's Commissioner, and Voyce Whakarongo Mai (an advocacy organisation for children and young people who are, or have been in care), before they came to me. No rangatahi should have to try so many avenues in order to feel secure about their home and care.

In te ao Māori, it is important for a person's taha hinengaro and taha wairua (mental and spiritual wellbeing) to feel safe in their environment.

It is crucial that tamariki and rangatahi have someone they can complain to and know that they are listened to. The feedback I receive from tamariki, rangatahi and their trusted adults following my intervention often reflects a sense of relief.

I provide kaitiakitanga and whakamana (guardianship and empowerment) through the work of my investigators. Examples of these follow.

### Case study - Complaint about a rangatahi in care

The caregiver of a rangatahi who complained to me about issues with Oranga Tamariki, wrote:

> *For myself …thank you … seems something so small to say to you for listening and supporting [XX]. [they have] now stopped sleeping with [their] light on for all the fear that has happened in [XX]. We have a long road to go … but knowing people like you that are out there helping [them] makes it so much easier and gives us as whānau strength.*

The rangatahi and their caregiver complained to me that Oranga Tamariki delayed providing them clothing, bedding and a bed, and art supplies. My investigators met with the rangatahi and their caregiver to understand the issues first hand.

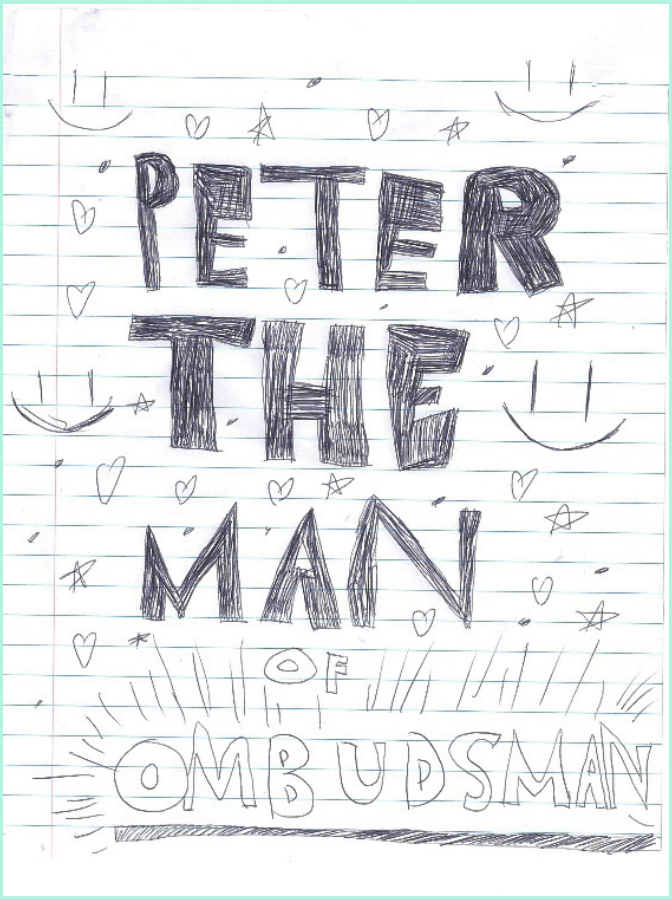
After enquiries by my investigators, Oranga Tamariki said it would meet the rangatahi and caregiver to apologise, and the bedding, clothing and art supplies were confirmed to have been provided.

No investigation was required after this early resolution to the complaint. I give credit to Oranga Tamariki for immediately responding to my investigators and minimising further trauma to the rangatahi by acting with common sense to solve the problem.

## Case study - Complaint from tamariki disconnected from whānau

Two siblings living with a relative wrote to me seeking my help in bringing them together with their other brothers and sisters, some of whom they had never met.

With the help of advocacy group Voyce Whakarongo Mai, the tamariki wrote letters to me outlining what they were seeking and how they felt not being able to see their whānau.




A law change meant the tamariki had the right to access whānau under section 7AA of the Oranga Tamariki Act. Oranga Tamariki had previously tried to organise for the pair to meet their siblings but for various reasons this had not occurred.

My investigators travelled to meet with the tamariki and understand what they were seeking.

After meeting investigators from my office, Oranga Tamariki, showing empathy and flexibility, agreed to a number of actions to bring the siblings closer and improve the situation for the whānau, including more visits and Facetime with siblings, buying birthday and Christmas gifts for siblings, more contact with their parent, and family therapy for the extended whānau.

I wrote to the two siblings to tell them what had been done and they wrote back to me, with a lovely response and a hand-drawn picture.

## Case study - Complaint from a rangatahi in a Care and Protection Residence

I received a complaint from a rangatahi in a Care and Protection Residence. They had previously been in the residence for 18 months, and this was now their second time there. When I received the complaint in 2020, the rangatahi had been there for about seven months.

When they went into the residence for the second time, they were told it would be for a short time.

Towards the end of 2019, it looked like a placement had been found but after waiting more than a month, the rangatahi was concerned about how long it was taking to hear back, and they made a complaint to the residence grievance panel. Their grievance was upheld, and Oranga Tamariki made further enquiries to the placement provider to try to speed up the process.

However, just before Christmas, the provider advised it had declined the placement.

The rangatahi then asked the then Children's Commissioner to review the grievance. The Children's Commissioner agreed the complaint was justified and recommended Oranga Tamariki make sure that the rangatahi continued to be updated, that planning continue for a placement, and that they be put in touch with Voyce Whakarongo Mai.

The rangatahi was still unhappy with the amount of time passing, and wanted further consideration of their complaints. The Children's Commissioner helped them to make a complaint to me.

The rangatahi said they were upset by the length of time spent in the residence, especially as this was their second time there. They watched others come and go, and felt as though they were losing their teenage years. They felt the environment was bad for their mental health.

**What I found**

Oranga Tamariki said it had been difficult to find a placement because when the rangatahi first returned to the residence, youth justice was involved.

Oranga Tamariki had hoped the rangatahi could go home until a placement was found, but this was not possible.

It appeared Oranga Tamariki had not always acted as urgently as it could have, and while it was recognised very early on that a bespoke placement would be required, this was not immediately pursued.

The harmful effects of residence in a secure care facility are well known. Young people should enter a Care and Protection Residence only if there is no other option, and should be there for the shortest amount of time possible.

I considered Oranga Tamariki may have been prioritising the ease of ensuring the safety of rangatahi at the residence, without properly considering their views and the effects of spending so long in the residence.

I acknowledged positive changes had been made by both the placement provider and Oranga Tamariki. Processes and guidance had been updated to ensure that in future cases similar issues would not occur, and matters would progress more quickly.

Oranga Tamariki had started these changes before the rangatahi made their complaint to me.

**Outcome**

I formed the opinion that Oranga Tamariki had acted unreasonably. The rangatahi had been in the residence too long, and at times Oranga Tamariki had not taken action as quickly as it could have. There should have been better oversight of the circumstances of the rangatahi, and communication could have been better.

**Recommendations and remedies**

During my investigation, Oranga Tamariki advised that it had been able to secure a new bespoke placement. Oranga Tamariki had also spoken to the previous provider and an apology had been made to the rangatahi.

Because of this I did not make recommendations about reassessing where the rangatahi should reside while waiting for the new placement to begin.

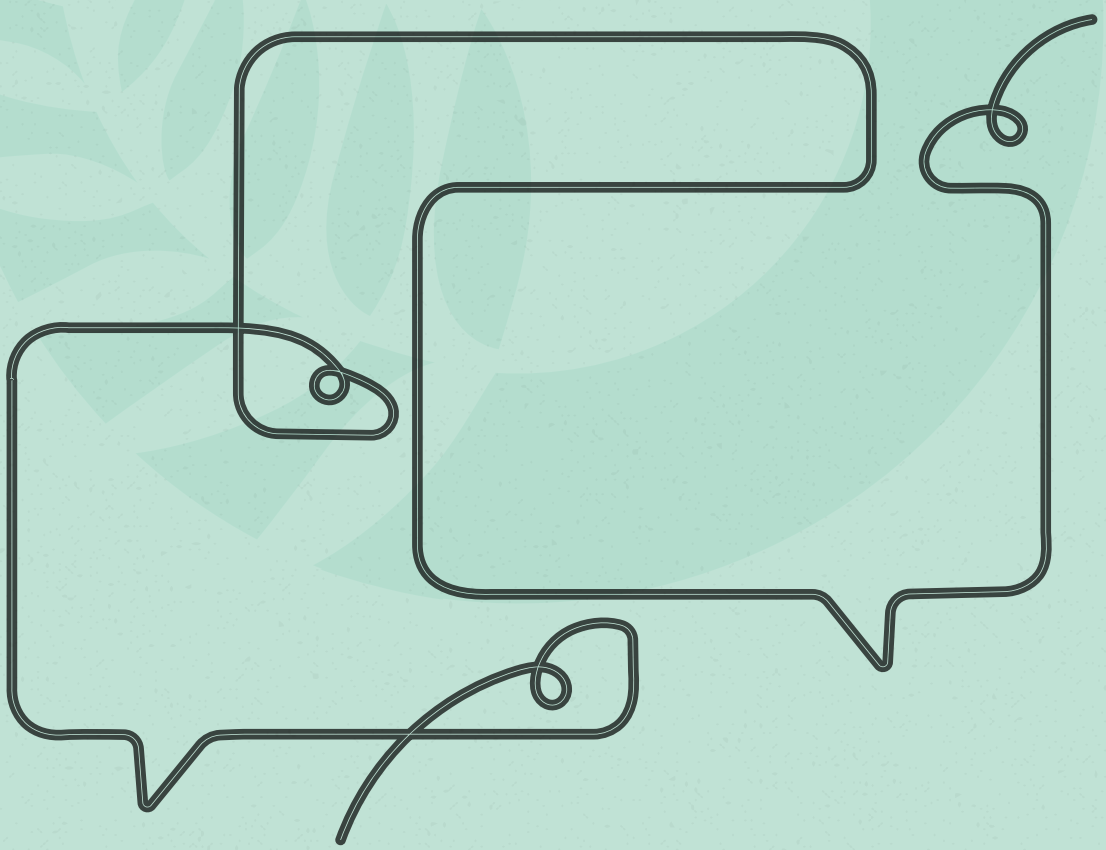
Instead, I recommended:

- regular updates were to be provided to the rangatahi on the progress of the placement and steps set out for them in an appropriate way;
- fortnightly reports be made to me on the progress of the placement; and
- when the rangatahi left the residence, they received an acknowledgment that the length of time they spent there was not good enough.

Oranga Tamariki accepted my recommendations. It secured a bespoke placement for the rangatahi and apologised to them when they left the residence. It also, on its own initiative, took steps to improve the process of the external provider, and its own internal processes.

Regular updates on progress were provided to me and the rangatahi.

# 6 Reports of Concern



# Reports of Concern

Anyone who is worried about a child can make a Report of Concern to Oranga Tamariki or Police. It is often the first step taken by anyone concerned for the safety of a child.

For some complainants I deal with, making a Report of Concern can be extremely distressing, so it is critical that they are dealt with sensitively and the information they provide is taken seriously and acted on swiftly.

When they are not, it can have devastating consequences. We need not look far to find examples – the case of Malachi Subecz, who was five when he died at the hands of his caregiver. His cousin made a Report of Concern to Oranga Tamariki but for a number of reasons this was not acted on properly.

I receive a number of complaints about various aspects of Reports of Concern made to Oranga Tamariki each year.

Issues I have identified include:

- Failing to record a Report of Concern
- Inaccurately recorded and unverified Reports of Concern
- Inadequate assessment of Reports of Concern
- Failing to consider multiple Reports of Concern holistically
- Inadequate responses to Reports of Concern
- Failing to adequately engage with Police following a Report of Concern.

The key remedies and outcomes I have achieved ranged from:

- Apologies to complainants
- Financial remedies
- Reviews of practices and policies around recording, assessing and acting on Reports of Concern
- Reviews of inter-agency relationships with a view to strengthening the Report of Concern process
- Training for Oranga Tamariki staff
- Referrals to the Chief Archivist on record-keeping issues.

## Systemic remedies achieved by the Ombudsman in relation to Reports of Concern

| Remedy | Current status |
|---|---|
| Oranga Tamariki provides:<br><br>a. Comprehensive reminders and training to a regional site covering the issues I identified in a complaint about a Report of Concern, about:<br><br>i. Legislative requirements to create and maintain records;<br><br>ii. Case-recording policy;<br><br>iii. Family Group Conference plans;<br><br>iv. Report of concern intake and recording; and<br><br>v. Report of concern assessment and pathway.<br><br>b. Confirmation to me when the above has occurred, including copies of reminders and an overview of training provided. | Issued 30/6/23<br><br>**In progress as at December 2023** |
| Oranga Tamariki updates me and the Chief Archivist on policies, processes and any associated training in place that reflects the requirement and importance of transferring records created on mobile devices to its record management systems.<br><br>*Note, this remedy can also be found in the chapter on policies and practice.* | Issued 30/6/23<br><br>**Completed** |

| | |
|---|---|
| Oranga Tamariki, with the guidance of an appropriately experienced social worker, provides me with a report that assesses all practice and policy gaps I identified regarding the response to Reports of Concern from four individuals involved in one case.<br><br>The report is to:<br><br>a. include how Oranga Tamariki has addressed, or is planning to address, each practice and policy gap and timeframes when practice and policy improvements have or will be implemented; and<br><br>b. identify whether any actions missed at the time still need to be taken. | Issued 6/4/23<br><br>**Completed** |
| Oranga Tamariki reports to me whether and how its practice review findings in the case of Malachi Subecz will influence its policies, practice and guidance. | Issued 29/9/22<br><br>**Completed** |
| Oranga Tamariki reports to me, within three months of the systems review in the case of Malachi Subecz, whether and how those findings will influence its policies, practice and guidance. | Issued 29/9/22<br><br>**Completed** |
| Oranga Tamariki provides me the following:<br><br>a. Confirmation of the dates that training sessions have been held with regional site staff covering the following:<br><br>i. policy on sharing information about tamariki and rangatahi; and<br><br>ii. policy on disclosing information.<br><br>b. A copy of updated guidance for sharing information sent to staff. | Issued 12/9/22<br><br>**Completed** |

## Case study – Significant failures in responding to Report of Concern

In October 2022, I published my opinion in the case of five-year-old Malachi Subecz.

The circumstances of Malachi's death have been well-covered in the media. In my final opinion, following my investigation of complaints to me from Malachi's uncle and cousin, I described the response by Oranga Tamariki to a number of safety concerns as a 'litany of failures'.

It was my opinion that Oranga Tamariki acted contrary to its own policies which require the wellbeing of children and their families to be central to decision-making. Oranga Tamariki did not appear to have fulfilled the bare minimum of the process required to ensure Malachi's safety.

I formed the opinion that Oranga Tamariki acted unreasonably and wrongly in addressing a Report of Concern made by Malachi's cousin. Oranga Tamariki also acted unreasonably in providing incorrect information to Malachi's uncle about their complaints process.

I recommended:

- Oranga Tamariki apologise to both Malachi's uncle and cousin at a time and in a way they agreed. The apologies from Oranga Tamariki should recognise the impact of their actions and serve to appropriately restore Malachi's uncle and cousin to a state of balance (ea). I referred to my guidance in He rauemi tātaki ea – A resource for offering an effective apology.
- Oranga Tamariki report to me in a timely manner on its proposal for making the apologies and considers any comments I have before it proceeds.
- Oranga Tamariki provide me a copy of its practice review once complete, and report to me within one month of completion about whether and how the practice review findings will influence Oranga Tamariki in terms of its policy, practice and guidance.
- Oranga Tamariki report to me, within three months of the wider system review by Dame Karen Poutasi, which was released on 1 December 2022, whether and how the system review findings will influence its policy, practice and guidance.

Oranga Tamariki accepted my recommendations and has completed three of them. The apology to Malachi's uncle and cousin and action to restore balance have not yet been completed to their satisfaction.

I continue to monitor this case closely. I have held regular meetings with the chief executiveof Oranga Tamariki and receive regular updates on progress.

## Case study - Safety plans for at-risk tamaiti not monitored by Oranga Tamariki

A person complained to me in 2020 following the placement of te tamaiti with a whānau caregiver. They and two other relatives told Oranga Tamariki there were issues of abuse within the whānau.

Despite Oranga Tamariki receiving Reports of Concern, the involvement of Police, a family violence incident and a child psychologist employed by Oranga Tamariki raising further safety issues, te tamaiti remained in the home and was removed only after the placement broke down. In total, three safety plans were created for te tamaiti in little over a year.

### Reports of Concern and the Child Protection Protocol

When considering a Report of Concern, Oranga Tamariki must adhere to its obligations under the Child Protection Protocol (CPP). The CPP is a joint process followed by Police and Oranga Tamariki when they respond to actions or behaviour which may be a criminal offence.

The initial steps of the protocol are summarised below:

1. A CPP referral is made by Oranga Tamariki to Police, or vice versa, depending on who receives the concerning information.

2. After a CPP referral is made, Police and Oranga Tamariki have a consultation. Any concerns which fall within the CPP cannot be deemed to require no further action unless this consultation has happened. Also, the consultation must be recorded.

3. If a decision is made during consultation that the matter meets the CPP definitions, then Oranga Tamariki and Police will form an Initial Joint Investigation Plan (IJIP).

### Safety plans

Safety plans involve Oranga Tamariki, other agencies and professionals, and the whānau, assessing the risk of harm to a child and developing ways to ensure their care and protection.

Oranga Tamariki has advised that the purpose of a safety plan is to build safety around tamariki and rangatahi they work with. If there are no safety concerns, then a plan is not needed.

A safety plan should outline how it will be monitored, who is responsible for monitoring and how people will be kept informed.

### What I found

I formed the opinion that Oranga Tamariki acted unreasonably in its implementation of the safety plans, and in the adequacy of its responses to concerns and complaints from the complainant and whānau.

It was my view that Oranga Tamariki did not do all it could and should have done in response to the Reports of Concern. It also didn't consider other concerning information, and its safety plans were ineffective.

When Police made a referral to Oranga Tamariki under the CPP, Oranga Tamariki said there were no disclosures or concerns from te tamaiti. When Police then requested an IJIP from Oranga Tamariki, it declined for the same reason.

It appeared from the information available to me that Oranga Tamariki relied solely on whānau to monitor the safety plans and there was no apparent process for the whānau to keep Oranga Tamariki updated. There was also only one instance where Oranga Tamariki checked that a safety plan was being followed.

Oranga Tamariki did not properly assess other information, and failed to act when its own psychologist said the safety plans were ineffective. It disregarded its duty of care and protection by failing to take appropriate measures to ensure the safety of te tamaiti in the caregiver's home. It also acknowledged that its communication with a concerned whānau member was poor and damaged the relationship.

**Recommendations**

I recommended Oranga Tamariki:

- provide a report on policy and practice gaps, how it will address these, and identify whether any actions it did not take at the time should be taken now;
- meet the complainant to help them understand what happened and offer restorative action and support where appropriate;
- keep a copy of the report on policy and practice gaps on file in the event te tamaiti wanted it at a later date; and
- apologise to the complainant and their whānau for the way it dealt with the safety issues around the placement, and for its response to the complaint.

Oranga Tamariki accepted all the recommendations and is working to progress them.

### Case study – Oranga Tamariki did not record, did not act on, Report of Concern

I received a complaint from a parent whose tamariki were in the care of a family member.

Among their concerns were that that Oranga Tamariki did not act on a Report of Concern about one of the tamariki which they made via phone call or text message to a social worker. They made a second Report of Concern two months later on the same issue and raised it again seven months after that. It was not until that point that the second Report of Concern was assessed and the following month the parent was told Oranga Tamariki would take no further action on it – some 10 months after the original Report of Concern was made.

From my review of the information, it appeared Oranga Tamariki did not follow its policy and procedures following receipt of the second Report of Concern, including that the national contact centre failed to inform the local site that a Report of Concern had been received, and there was no follow-up to the parent to seek further details.

It was my opinion that Oranga Tamariki acted unreasonably in deciding no further action was required.

Oranga Tamariki also advised it had no record in its system of the first Report of Concern made by the parent, via phone call or text to the allocated social worker at the time. However, I identified from information provided to me by Oranga Tamariki, evidence that the phone call or text had indeed been made. It should therefore have been immediately recorded and raised in the system as a Report of Concern.

Regardless of how communication with Oranga Tamariki is made it must, under the Public Records Act, document it and maintain records.

In this case it was my opinion that Oranga Tamariki acted contrary to law by not recording discussions between the social worker and the parent, including via text messages.

I recommended, and Oranga Tamariki accepted, that it provide comprehensive reminders and training to the site on:

- the legislative requirement to create and maintain records;
- case-recording policy;
- Report of Concern intake and recording; and
- Report of Concern assessment and pathway.

I also recommended Oranga Tamariki update me and the Chief Archivist on policies, processes and any training in place that reflect the requirement and importance of transferring records created on mobile devices to its records management systems.

Oranga Tamariki accepted all the recommendations and is working to implement them. It apologised to the parent and agreed to carry out an assessment for a financial remedy. To date that assessment has not been carried out.

Oranga Tamariki advised that since this case, it has introduced mandatory practice training for social workers at its national contact centre on Reports of Concern, including information-gathering, assessment and decision-making.

### Case study - Oranga Tamariki submitted unverified and inaccurate report to the Family Court

I received a complaint over concerns about Oranga Tamariki failing to accurately record and/or verify information from a relative who made a Report of Concern about tamariki.

The relative was concerned that Oranga Tamariki failed to verify their Report of Concern before referring it to a professional service for action. The relative said the report contained inaccuracies and left out other information.

They also complained that they did not have input into a report requested by the Family Court. The report was provided to the court by Oranga Tamariki the next month.

The Family Court can request a report, under section 132 of the Care of Children Act 2004, from Oranga Tamariki when considering care and protection issues for tamariki and rangatahi.

**What I found**

While Oranga Tamariki said the relative had a number of opportunities to raise their concerns about verification of the Report of Concern, the referral was made to the professional service the day after the Report of Concern was received by Oranga Tamariki.

In relation to the section 132 report, there was contact between Oranga Tamariki and the relative before the Family Court hearing, and the relative did have an opportunity to follow up with Oranga Tamariki. However, the onus was on Oranga Tamariki to acknowledge the relative's concerns about the accuracy of the information and make further contact with them rather than simply moving to complete the report.

The Family Court Judge required Oranga Tamariki to complete an updated section 132 report to capture the relative's views.

My final opinion was that Oranga Tamariki acted unreasonably when it failed to verify the relative's Report of Concern before referring it to a professional service. It also acted unreasonably by submitting a section 132 report to the Family Court without seeking the relative's further input, or looking at possible inaccuracies on file.

**Recommendations and remedies**

I recommended:

- Oranga Tamariki apologise to the relative;
- as part of the apology, an explanation was to be given to them about the education and reminders to the Oranga Tamariki site covering the policy about sharing information about tamariki and rangatahi, and its disclosure policy;

- confirmation be given to me that training had been provided to site staff on these policies; and
- Oranga Tamariki give the relative the opportunity to write a letter correcting the information they provided in their Report of Concern, with a copy to be put on the files of Oranga Tamariki and of the professional service which received the referral.

Oranga Tamariki accepted these recommendations and has made progress in implementing them. It has confirmed training had occurred at the site and an apology was made.

# 7 Family Court documents

# Family Court documents

The quality and accuracy of information provided to the Family Court is very important. Judges deciding whether tamariki and rangatahi should be removed from their caregivers, where they should live and other crucial decisions impacting them are made, in part, on the information provided by Oranga Tamariki.

It is therefore concerning that in a number of complaints I have dealt with, I have found that Oranga Tamariki has provided the Family Court out of date, factually incorrect, or just inadequate information to support the actions it seeks to take.

The fallout for the tamariki, rangatahi and their whānau is immense. In some cases it has resulted in families being separated unnecessarily and natural justice being denied.

Issues I have identified about information provided to the Family Court by Oranga Tamariki include:

- Outdated information that has not been checked for current relevance
- Incomplete information that does not show the full picture of a caregiver's dealings with a child
- Incorrect, unverified or misleading information
- An approach that unfairly favours one party over another.

The key remedies and outcomes I have achieved ranged from:

- Correction of information for and to the Family Court
- Apologies to complainants
- Reassessments of information provided to the Family Court
- Updated guidance for Oranga Tamariki staff on preparing documents for the Family Court.

My recommendations around updating and correcting information provided to the Family Court in individual cases have received mixed responses from Oranga Tamariki. In some cases it has corrected information to the Family Court. In others, it has not.

My view is that where incorrect information has been provided to the Family Court, it ought to be corrected, in every case where it is discovered. Whether this is by filing a memorandum with the court or providing a copy of my opinion, Family Court Judges should be made aware when incorrect information has been provided to them.

I have previously considered whether, as a matter of good practice, I provide my opinions to the Family Court when issues of this kind arise. I have had discussions on this issue with the Principal Family Court Judge and I understand Oranga Tamariki has also done so.

Oranga Tamariki has accepted that it has a responsibility to correct information to the Family Court when I find instances that the Court has been misled in previous proceedings.

## Systemic remedies achieved by the Ombudsman in relation to information provided to the Family Court

| Remedy | Current status |
|---|---|
| Oranga Tamariki use information about practice gaps identified in a case, in which assessments for a report to the Family Court showed apparent bias favouring one party over another, for learning in site-wide practice sessions. | Issued 2/6/23<br><br>**Completed** |
| Oranga Tamariki confirm training for site staff on sharing information about tamariki. | Issued 12/9/22<br><br>**Completed** |
| Oranga Tamariki provide a report that identifies all practice and policy gaps regarding the removal of a baby from parents' care, in a case in which my opinion was that it did not provide full or balanced information to the Family Court.<br><br>The report is to include how Oranga Tamariki has or is planning to address each practice and policy gap. | Issued 12/7/22<br><br>**Completed** |
| Oranga Tamariki makes any necessary amendments to policies and procedures to ensure:<br><br>• all court documents include a comprehensive, balanced, and accurate analysis of the risks and benefits of placements; and<br><br>• all court documents are reviewed at an appropriate level before filing. | Issued 24/3/22<br><br>**Completed**<br><br>These policies were amended and published on the Oranga Tamariki Practice Centre. It consulted with me to ensure the intent of my recommendations was captured. |
| Oranga Tamariki begin a review of section 131A reporting (reports prepared for the Family Court), and report back to me on work arising from that review, including requirements for new guidance and any associated changes in practice, processes or procedures. | Issued 29/7/20<br><br>**Completed** in accordance with agreed requirements. |

## Case study - Oranga Tamariki acted unreasonably and contrary to law over pēpi uplift

A couple had their newborn pēpi uplifted at birth by Oranga Tamariki through a section 78 without notice order.

One parent complained to me that Oranga Tamariki had relied on historical information about them to justify the uplift of the baby.

The couple's other children had been removed from their care earlier.

When Oranga Tamariki learned the couple were expecting another pēpi, an assessment of the parents was carried out. Oranga Tamariki applied to the Family Court for a section 78 without notice custody order, and was granted custody orders for the unborn baby. The pēpi was uplifted when it was born.

**What I found**

It was not appropriate for me to provide an opinion on whether the pēpi and its siblings ought to have been removed from their parents' care.

The parents met the criteria of the 'subsequent child provisions' under section 18A of the Oranga Tamariki Act, noting Oranga Tamariki is obliged to involve the parents 'where practicable'.

In He Take Kōhukihuki | A Matter of Urgency, I said it was the responsibility of Oranga Tamariki under section 18A to assess whether the parent is unlikely to inflict or allow harm to a subsequent child. I also said that a fair and balanced decision-making process requires a case-by-case assessment of the risk posed to subsequent children at that time.

Based on information provided, it appeared concern held by Oranga Tamariki for the unborn child were based on historical information about the couple and the removal of their older children.

The assessment report was not comprehensive. It had no insights into the couple's current situation, no cultural considerations, no views from the family or professionals involved, and the social worker did not complete a comprehensive assessment for the unborn pēpi, saying it would be done at a later date.

There appeared to have been minimal effort made by Oranga Tamariki to engage with the parents at the earliest opportunity, and no reason why their views and current situation were not included in the assessment and decision-making process by Oranga Tamariki.

I saw little evidence of supervision and guidance during the assessment process from the social worker's supervisor, practice leader, site manager, legal team and cultural advisor.

I acknowledged that while Oranga Tamariki had concerns for the safety of the unborn pēpi, it over-relied on historical information and failed to consider the views of the couple and their wider family, or the couple's current situation. I found that it had acted unreasonably and contrary to law.

**Recommendations and remedies**

I recommended that Oranga Tamariki:

- review the information it provided to the Family Court when it sought the section 78 without notice custody order, and advise me how it intended to update the Family Court with full and balanced information;
- provide a report that identified each policy and practice gap in the uplift of the pēpi; how it would address each gap and a timeframe for doing so and discuss these gaps with the parents; and provide the report to me within three months of receiving my final opinion;
- offer to meet the parents to apologise and provide a written apology; and
- file a copy of its report and make it available to the child if it requested it later.

Oranga Tamariki accepted the recommendations and implemented them. To its credit, it advised within four months of my opinion that it had filed a memorandum with the Family Court which fulfilled the intent of the first recommendation.

My recommendations can lead to positive change in the practice of Oranga Tamariki. In one case, my recommendations led to a practice change that I hope will minimise future errors in information provided to the Family Court.

In this complaint, which is not detailed in this report because of sensitivities surrounding it, I found that incorrect and misleading information had been put before the Family Court to support the decision by Oranga Tamariki to uplift tamariki.

My recommendations in this complaint included that Oranga Tamariki review its policies and procedures and make any necessary amendments to ensure:

- all court documents include a comprehensive, balanced and accurate analysis of the risks and benefits of placements; and
- all court documents are reviewed at an appropriate level before filing.

I also recommended Oranga Tamariki provide me with the draft revised policies and procedures for my comment.

In response to my recommendations, practice advice has been updated in the online Oranga Tamariki practice centre. As a result, section 78 without notice applications to the Family Court now have to be approved by a site manager and documents must be either approved by an Oranga Tamariki solicitor, or an explanation given why not.

I am happy to see that Oranga Tamariki has tightened this process to help ensure court documents are approved from a practice and legal standpoint before they are filed.

Oranga Tamariki has recently acknowledged that its Family Court policy needs 'thorough revision' and is in its future work programme, with my input welcome.

## Case study – Oranga Tamariki admitted bias in parents' assessment

A parent complained to me after te tamaiti was uplifted and given over to the custody of the other parent.

Te tamaiti was later put into the care of non-whānau caregivers after being present at an alleged violent incident.

The parent who complained had concerns that the assessments by Oranga Tamariki of adults in the case were neither thorough nor prudent, and resulted in te tamaiti residing in what was considered an unsafe environment with the custodial parent.

The complainant also said they were not kept informed about the safety of te tamaiti in their Oranga Tamariki placement.

Te tamaiti was later returned to the complainant's care.

**What I found**

In response to my initial provisional opinion, Oranga Tamariki made a frank acknowledgement that its assessments were not balanced in this case.

Oranga Tamariki said that although it initially identified concerns about the custodial parent, it showed personal views/bias when it concluded the custodial parent was 'safe to care for' te tamaiti in their household without any new assessment or changes in circumstances.

Oranga Tamariki acknowledged that because of these actions, harm came to te tamaiti.

Oranga Tamariki admitted that many policies were not followed in the assessments of the custodial parent and their household.

In contrast, the complainant underwent a fuller assessment. Oranga Tamariki admitted there was 'apparent bias favouring one parent over the other'.

Oranga Tamariki also advised that there was a 'lack of focus on identified tamariki needs being appropriately met by the suitable parent'.

My final opinion in this complaint was that Oranga Tamariki acted unreasonably in its assessments.

**Recommendations and remedies**

Oranga Tamariki agreed to:

- provide a full and meaningful written apology to the complainant over the incomplete assessments and communication about the safety of te tamaiti;
- provide a financial remedy for the complainant, and for te tamaiti, to take into account practice failures and any trauma caused; and
- use the information about the practice gaps in the assessments for staff learning at the Oranga Tamariki regional site's practice sessions.

Oranga Tamariki accepted these recommendations and has completed the apology and staff learning sessions. However, Oranga Tamariki advised it was revising its ex gratia (financial remedy) policy which stalled the financial remedy in this case.

# 8 Uplifts and placements

# Uplifts and placements

The uplift of tamariki and rangatahi should always be the last resort, not one of the available options of first resort. I have seen, through my investigations, the damage inadequate practice can cause to tamariki and rangatahi, their parents, caregivers and whānau.

Issues I have identified with Oranga Tamariki practice include:

- Inadequate efforts to search for whānau before making decisions to place tamariki and rangatahi into non-whānau homes
- A lack of consultation with whānau, hapū and iwi before making decisions
- Misleading statements or distortion of facts to the Family Court to support changes in placement
- Unfair treatment of a parent as a disabled person
- Failing to seek the views of tamariki and rangatahi about where they will live
- Failing to support a parent to have children returned home following uplift.

The key remedies and outcomes I have achieved ranged from:

- Apologies
- Financial remedies
- The scoping of a review by Oranga Tamariki on its involvement with disabled parents, in accordance with the Disability Convention and conducted with the involvement of disabled people-led organisations
- A commitment by Oranga Tamariki to carry out a case-file review of all placements between 1 March 2021 and 2 February 2022:
    - where tamariki who were placed with non-whānau caregivers on an enduring basis were subsequently moved to permanent whānau care; or
    - where tamariki have been placed with non-whānau caregivers on a permanent basis.

In relation to seeking the views of tamariki and rangatahi about where they will live, Oranga Tamariki now has a section in its online Practice Centre on seeking the views of tamariki and rangatahi in decisions that affect them, including decisions about where they will live. This is in line with feedback provided as part of a recommendation in one of my investigations.

It is a right enshrined in section 11(2) of the Oranga Tamariki Act - that all tamariki and rangatahi have the right to have their views sought and heard, regardless of any difficulties such as disability or culture may pose for Oranga Tamariki.

Oranga Tamariki carried out the case-file review of all placements moving from or to non-whānau caregivers between 1 March 2021 and 2 February 2022, against key aspects of the *'Ensuring a safe, stable and loving home for tamariki in care'* policy.

It provided me with a summary of findings in September 2023.

Under the *'Ensuring a safe, stable and loving home for tamariki in care'* policy introduced in February 2021, when placements are being considered, preference must be given to a suitable home within family, whānau, hapū, iwi or family group. The policy clarifies the exceptional circumstances in which non-kin care can be considered. Where tamariki are already living with non-whānau caregivers, commitment by Oranga Tamariki needs to be honoured unless there is a significant change in the circumstances of the child or the caregiver.

The case-file review found there were differing interpretations across Oranga Tamariki sites as to what constituted a significant change in the circumstances of the child or caregiver, including whether a previously unknown whānau member coming forward was such a change.

The rationale for the change was not always clearly spelled out in records, and there was evidence of differing views within sites themselves.

However, there was evidence that social workers' collaborative decision-making with family/whānau about permanent care arrangements had significantly improved, as had support for non-whānau caregivers.

## Systemic remedies achieved by the Ombudsman following complaints in relation to uplifts and placements

| Remedy | Current status |
|---|---|
| Oranga Tamariki to review policies and procedures and make any changes needed to ensure a full search for whānau, hapū and iwi is undertaken and documented as early as possible in the placement process.<br><br>*Note, this remedy can also be found in the later chapter on Tikanga-informed practice.* | Issued 24/3/22<br><br>**Completed**<br><br>Oranga Tamariki advised these policies have been amended and published on its Practice Centre. I was consulted to ensure the intent of my recommendations had been captured. |
| Oranga Tamariki scopes a review of its practices and policies around involvement with disabled parents, and identifies areas requiring amendment or development of practice, and potential timeframes.<br><br>*Note, this remedy can also be found in the following chapter on the disability community.* | Issued 23/7/20<br><br>**Completed** |
| The scoped review of Oranga Tamariki practices and policies around involvement with disabled parents is to reflect Article 4.3 of the Convention on the Rights of Persons with Disabilities, in particular General Comment 7 (2018) by the Committee on the Rights of Persons with Disabilities - *they involve disabled people-led organisations in any changes that affect disabled people.* This means Oranga Tamariki should consult such organisations.<br><br>*Note, this remedy can also be found in the following chapter on the disability community.* | Issued 23/7/20<br><br>**Completed**<br><br>The implementation of a disability strategy is in progress |

## Systemic investigation – He Take Kōhukihuki A Matter of Urgency

In 2020 I published a comprehensive investigation report – He Take Kōhukihuki | A Matter of Urgency.

The report looked at the policies, practices and procedures for the removal of newborn pēpi by Oranga Tamariki.

I decided to examine whether there were systemic issues in Oranga Tamariki with their practices for the removal of newborn pēpi under section 78 without notice interim custody orders. I investigated following some concerning cases and the resulting sense of distrust by the public in Oranga Tamariki.

My investigation involved analysing the case files for 74 newborn and unborn pēpi for whom Oranga Tamariki had applied for interim custody without notice during the period 1 July 2017 and 30 June 2019.

### Outcome of my investigation

I found that Oranga Tamariki had routinely applied for without notice interim custody of unborn and newborn pēpi. All of the sample cases I examined, from 2017 to 2019 across a number of sites, involved without notice applications. Other data confirmed that over 94 percent of all section 78 orders for 2017/18 and 2018/19 were granted on the basis of without notice applications.

Oranga Tamariki was usually aware of the pregnancy and reported concerns for a significant period before the birth of pēpi. However, Oranga Tamariki did not consistently utilise that window of opportunity to engage early with parents and whānau; and to plan early with professionals and external parties. I also found varied use of key checks and balances. The outcome was that in many cases decisions were being made late and without expert advice or independent scrutiny, and without whānau involvement.

Urgency was created through the inaction of Oranga Tamariki and their lack of capacity to follow processes in a timely and effective way.

As a consequence, parents were disadvantaged—first, by not having an opportunity to respond to the allegations or challenge the information relied upon by Oranga Tamariki before their pēpi were removed. Secondly, parents had to challenge orders after they were made, and when they were vulnerable because they were either heavily pregnant or had just given birth.

The rights of disabled parents were not visible in either policy or practice. In addition, all the cases I reviewed required a disability rights-based response from Oranga Tamariki but this did not occur. The lack of tailored responses was a significant breach of the Disability Convention.

Finally, I was not satisfied that Oranga Tamariki provided parents and whānau with the opportunity for ngākau maharatanga me te ngākau aroha; a period of 'quality time' that reflects consideration, empathy, sympathy and love. In addition, Oranga Tamariki did not ensure that parents and whānau had their support people present, and it did not provide them with clear information on next steps. There was no support offered to parents and whānau to deal with the trauma and grief of child removal, or to help their healing.

I made 32 comprehensive recommendations to ensure better outcomes of pēpi and their whānau. Oranga Tamariki accepted all recommendations and reported regularly to me on their implementation.

## Status of recommendations

The recommendations I made in He Take Kōhukihuki | A Matter of Urgency in 2020 are now completed after more than two years of formal monitoring and consultation with Oranga Tamariki.

Since 2019, Oranga Tamariki has made a number of changes to its section 78 practice. These include:

- increasing the number of kairaranga-a-whānau, Māori specialist roles which support searching for whānau and engagement with whānau;
- updating its guidance on whānau-searching/whakapapa research and on strengthening its response to unborn and newborn pēpi, introducing a site assurance process for Reports of Concern relating to newborn and unborn pēpi; and
- developing a framework for auditing and analysing case files of newborn and unborn pēpi entering care under a section 78 order.

Oranga Tamariki reports high compliance by staff with its strengthened policies and processes for approval of without notice section 78 interim custody orders for at-risk unborn and newborn pēpi. It also reports that the number of uplifts has dropped markedly since my report was published.

I continue to monitor the issue of pēpi uplifts and I will step back in if there is evidence through complaints to me that Oranga Tamariki policies and processes are not being followed.

## Status of recommendations made in He Take Kōhukihuki | A Matter of Urgency

| | Recommendation: *That Oranga Tamariki:* | Current status |
|---|---|---|
| 1(a) | ensures its current policies, training material and practices make explicit that without notice interim custody applications are reserved for exceptional urgent cases where all other options to ensure the safety of pēpi are unavailable | **Completed** |
| 1(b) | develops comprehensive guidance with clear criteria to enable its staff to assess the viability of other options to ensure the safety of pēpi in urgent cases | **Completed** |
| 1(c) | makes best endeavours, in all but the most exceptional cases, to use a place of safety warrant or shortened notice period when Oranga Tamariki learns of a pregnancy at a late stage and determines pēpi to be at imminent risk | **Completed** |
| 1(d) | takes immediate measures in terms of reports of pēpi at risk to ensure that all legal requirements are met, and in particular:<br>i. begins an investigation as soon as practicable;<br>ii. consults a Care and Protection Resource Panel in all cases and as soon as practicable after an investigation has begun, and at later stages where required; and<br>iii. convenes a family group conference | **Completed** |
| 1(e) | establishes timeframes, reporting frameworks, quality assurance and monitoring to show ongoing compliance with all legal requirements related to without notice removals of newborn pēpi | **Completed** |
| 1(f) | reports publicly against the framework for monitoring detailed in recommendation 1(e) every six months | **Completed (and ongoing)** |
| 2(a) | reviews its processes to ensure all cases involving unborn or newborn pēpi are properly prioritised | **Completed** |
| 2(b) | reviews its policies and practices to ensure whānau engagement is prioritised in all cases involving unborn or newborn pēpi, including family group conferences and hui ā-whānau where appropriate | **Completed** |
| 2(c) | develops, in partnership with iwi and other Māori groups, a national strategy for:<br>i. effective engagement with whānau, hapū, and iwi, including provision for localised relationship-based implementation with centralised support; and<br>ii. increased cultural competency of staff | This recommendation has been used to inform the new strategic direction of Oranga Tamariki. |

| | | |
|---|---|---|
| 2(d) | develops memoranda of understanding with the Ministry of Health, [former] DHBs, midwifery representatives, and other relevant parties to ensure appropriate information-sharing, clear and defined roles and effective early planning for at-risk pēpi | **Completed** |
| 2(e) | works with relevant providers to ensure all social workers are trained in, and engage, trauma-informed practice underpinned by te ao Māori, and consults with the Social Workers Registration Board to help achieve this | **Completed** |
| 2(f) | develops specific guidance for cases involving unborn and newborn pēpi that:<br><br>i. requires trauma-informed social work practice when parents have experienced childhood abuse and/or neglect, been themselves in care or had tamariki previously removed by Oranga Tamariki;<br><br>ii. reflects the obligations on Oranga Tamariki to ensure that where pēpi are at risk, parents and whānau should be provided assistance to support them in their responsibilities to pēpi | **Completed** |
| 2(g) | develops clear guidance, with supporting tools, for social workers to ensure all legislative and procedural safeguards are used in relation to subsequent tamariki, pending the outcome of the review by Oranga Tamariki of the subsequent children provisions | **Completed** |
| 2(h) | amends its policies and practices relating to the subsequent children provisions to make clear that social workers are responsible for actively seeking out up to date information and conducting a full assessment of the parents' current circumstances | **Completed** |
| 2(i) | works with relevant agencies to assist parents who have had previous tamariki removed to access independent advocates during the assessment and intervention phases | **Completed** |
| 2(j) | amends its overarching practice standards, as well as its policies, procedures, and practices, to recognise the rights of disabled parents and ensure full compliance with the United Nations Convention on the Rights of Persons with Disabilities | This recommendation was used to inform the development of the Oranga Tamariki disability strategy and disability work programme. |

| | | |
|---|---|---|
| 2(k) | ensures all its policies, procedures, and practices are consistent with the social model of disability and a rights-based framework by:<br>i. providing reasonable accommodation;<br>ii. explicitly recognising that drug and/or alcohol misuse and mental health needs require a disability rights-based response; and<br>iii. ensuring disabled parents have access to specialist advocates during the assessment and intervention phases | This recommendation was used to inform the development of the Oranga Tamariki disability strategy and disability work programme. |
| 2(l) | in implementing recommendations 2(j) and 2(k) above, closely consults with and actively involves disabled people, their whānau and organisations that represent disabled people, as well as other relevant agencies within the system | This recommendation was used to inform the development of the Oranga Tamariki disability strategy and disability work programme. |
| 2(m) | ensures all parents have information about their legal rights, including information about accessing legal aid, in accessible formats | **Completed** |
| 2(n) | develops specific policies and procedures for the process of removing newborn pēpi, once section 78 interim custody orders are granted, that:<br>i. ensure, as much as possible, planning, communication and information-sharing with parents, whānau, [former] DHBs and midwives;<br>ii. ensure the removal of pēpi takes place in a manner that reflects ngākau maharatanga me te ngākau aroha, a period of quality time that encompasses consideration, empathy, sympathy and love; minimises trauma; and provides parents and whānau with support and clear information on next steps;<br>iii. explicitly recognise the right of pēpi to be breastfed consistent with the United Nations Convention on the Rights of the Child, as well as guidance from the World Health Organization and Ministry of Health;<br>iv. reflect best practice to support breastfeeding; and<br>v. ensure appropriate therapeutic and other support is available to all parents who have had pēpi removed from their care | Recommendations 2(n)(i), (ii), (iii), and (iv) **completed.**<br>Recommendation 2(n)(v) has been used to inform the new strategic direction of Oranga Tamariki. |
| 2(o) | regularly audits case files to ensure compliance with policy and practice guidance. | **Completed** |

### Case study - Call to avoid the pending removal of a newborn pēpi – good practice by Oranga Tamariki

I received a call from a mother who had recently given birth. She and her pēpi were still in hospital but her baby was about to be discharged and uplifted by Oranga Tamariki.

The mother had agreed to Oranga Tamariki having custody and uplifting the child on the basis that her family were not sure they could care for the baby, and because there was a likelihood it may be born with health complications.

However, the baby was born healthy and family members decided that they would be willing to care for it. The mother believed that her baby should stay with her family and not go to non-kin caregivers.

She explained that she also wanted to breastfeed, and removal of her baby outside of the family would prevent this.

She also advised that she had not spoken to her social worker yet, but that her social worker had been talking to other family members about what was happening.

Just because Oranga Tamariki has custody of a child, it does not necessarily need to take physical custody of the child. In cases like this where Oranga Tamariki has custody, I can seek information from the agency to see that the proper process has been followed and that arrangements have been made for things like breastfeeding, ongoing contact, and meetings to review arrangements.

In this case, I explained the mother's worries to Oranga Tamariki and asked:

- Could the baby stay in hospital while the mother was still there?
- What was happening now that family members were able to care for the baby?
- What arrangements had been made to make sure the mother could still breastfeed?
- When would a family meeting take place?

In an example of what I regard as good practice, Oranga Tamariki confirmed it had already been working with the hospital so that mother and baby could spend another night together. It was able to achieve this and the pēpi stayed with the mother for another night.

Oranga Tamariki then worked to urgently approve the family members that had agreed to care for the baby. When the baby was discharged from the hospital, it was allowed to go home with family.

Arrangements were also made for daily contact and breastfeeding by the mother and for further meetings to review arrangements to take place. As a result, I did not need to take any further action.

I acknowledge the good response by Oranga Tamariki in this case. It was responsive and flexible in its approach and it provides a good example of an agency being nimble enough to achieve an outcome that lessened the trauma for the mother, the pēpi and the whānau.

## Case study - Treatment of disabled mother and uplift of pēpi

In 2014, Child, Youth and Family (CYF), then a unit of the Ministry of Social Development, uplifted a five-day-old pēpi from its disabled mother, while she remained in hospital.

This occurred after CYF obtained a section 78 without notice interim custody order from the Family Court.

A section 78 interim custody order gives immediate custody pending decisions about the permanent care of the pēpi. It is intended to be used only in the most urgent and exceptional cases when no other option is available to ensure the child's safety. 'Without notice' meant the mother wasn't aware the section 78 application was being made.

CYF had become involved with the mother due to concerns that she would be unable to safely parent her child.

The child was placed with a caregiver and ultimately entered a 'home for life' arrangement.

In 2015 the mother made a complaint to CYF believing that she was discriminated against due to her disability. CYF did not uphold her complaint.

She and another relative made further complaints to CYF as they believed there had been no attempt to understand the mother and the nature of her disability, that CYF staff had predetermined that the child should be permanently removed, and ultimately that there had been no opportunity for the mother to show that she could parent her child.

A complaint was made to me, which was initially resolved when Oranga Tamariki (as it was called by then) agreed to complete a review of the complainants' concerns.

The review, in 2019, considered the complainants' concerns about:

- CYF's response to the original complaint about discrimination;
- the treatment of the mother as a disabled person;
- whether there had been an opportunity for the mother to show that she could parent;
- whether there was a predetermined intention to permanently remove the child;
- whether hospital staff had been unjustly placed on 'high alert' by CYF;
- comments made by the social worker to a psychologist who was preparing a report on the matter;

- failing to identify or provide services that could mitigate some of CYF's concerns; and
- the way the mother's childhood history with CYF was portrayed throughout the file, and in its handling of the complaints.

The review concluded the concerns were not substantiated. The complainants then complained to me about the review by Oranga Tamariki and the conclusions it had reached.

**What I found**

I formed the opinion that CYF had acted unreasonably in its treatment of the child's mother. This included the lack of action during and after pregnancy to identify available supports, communication with hospital staff, failure to understand the mother's strengths as a disabled person and the nature of her disability, and the early decision for a permanent 'home for life' placement.

I also formed the opinion that CYF and Oranga Tamariki failed to address the concerns of the complainants, which had been raised as early as 2014.

Practice at Oranga Tamariki, as the agency is now called, has changed since the uplift of the mother's pēpi. In particular, the Hawkes Bay Practice Review following another, high-profile, attempted uplift of a newborn pēpi at Hastings Hospital in 2019 has resulted in changes to practice.

These changes include:

- an expectation that all section 78 custody applications are to be made 'on notice' unless there is a clear need for action in order to protect a child from immediate and imminent danger;
- if a without notice section 78 application is to be made, the application must have additional checks completed by a regional legal manager, site manager and practice leader;
- practice leaders at each site review all Reports of Concern for unborn and newborn pēpi;
- a new service broker role to improve services across sites;
- when working with disabled parents, sites are encouraged to contact their regional disability advisor, engage with the wider sector, including the Needs Assessment and Service Coordination Services; and engage with the site lawyer if a court process is going to involve disabled parents.

**Recommendations and remedies**

Taking these changes and the circumstances of the complainants into account, I recommended Oranga Tamariki:

- scope a review of its practices and policies around involvement with disabled parents, to then be agreed with me;
- that the review is to involve disabled people-led organisations and be in accordance with the Disability Convention;
- apologise to the complainants; and
- provide a financial remedy to the complainants, noting that it was now impossible to be certain that the mother was unable to parent the child, and that the passage of time and subsequent decisions meant that there was no prospect of te tamaiti being returned.

Oranga Tamariki accepted these recommendations and is still in the process of implementing some of them, in particular its ongoing development of a disability strategy.

More detail about the development and implementation of a disability strategy can be found in the following chapter about the disability community.

# 9 The disability community

# The disability community

In my 2020 report He Take Kōhukihuki | A Matter of Urgency, I noted Oranga Tamariki had very limited guidance on the needs of disabled parents. The rights of disabled parents were not reflected in the overarching practice standards, there was an overall lack of guidance, and available guidance had a number of gaps.

Oranga Tamariki has advised that my recommendations in that report have been used to help inform the development of its disability strategy and disability work programme.

Among the gaps identified in my report was that there was nothing in its guidance to remind staff of the obligation under international law that no tamariki should be separated from their parents based on a disability of one or both parents.

So it is heartening to see that in April 2023, Oranga Tamariki updated its practice guidance on responding to Reports of Concern about unborn or newborn pēpi to include:

- No pēpi should be separated from their parents based on a disability of either the pēpi or one or both of the parents.

I am reassured by the inclusion by Oranga Tamariki in its practice guidance, but there is more work to be done in response to my recommendations to strengthen practice and processes in relation to disabled parents and children.

Oranga Tamariki advised me in July 2022 of the following changes in relation to one recommendation – that Oranga Tamariki scopes a review of its practices and policies around involvement with disabled parents:

> *A key enabler of this practice approach is the refreshed Practice Framework. On 30 August 2021, the Practice Framework was updated on the Practice Centre.*
>
> *This is currently only available to those people with an Oranga Tamariki login. We are working towards making it available to the public.*
>
> - *The Practice Centre will have a disability page that lays the foundation for inclusive and rights-based practice and sets out our obligations. It will also cover te ao Māori and Pacific concepts of disability, and the social model of disability.*
> - *Applying a disability lens to practice guidance. The guidance on Strengthening our Response to Unborn and Newborn Pēpi is an example of this approach and includes specific disability considerations.*
> - *Developing disability-specific guidance, including practice with intellectually disabled parents.*

As at December 2023, the Practice Centre is now available to the public.

Oranga Tamariki has advised that with the foundations of the practice shift now in place, it is progressing to more detailed disability guidance with a focus on continuous improvements.

The Oranga Tamariki leadership team agreed to the development of a disability strategy in partnership with the disability community, as I recommended. It invited expressions of interest from Disabled Persons Organisations (DPOs) and the members of the disability community to participate in a disability advisory group.

It says the disability strategy and guidance will support and help give effect to the practice shift already underway.

The Oranga Tamariki disability strategy has recently been published with public feedback invited, although progress has been at a slower pace than I would have liked, to fully meet the needs of disabled parents and their tamariki. I continue to engage with Oranga Tamariki on this and I look forward to seeing it progress to a point where a full and coherent strategy, which complies with the United Nations conventions on the rights of children and disabled people, is implemented, fully available to the public and followed by staff.

Issues I have identified during my investigations of complaints in this area include Oranga Tamariki:

- Failing to seek the views of disabled parents, or of disabled tamariki and rangatahi, on decisions made about them
- Making assumptions about the abilities of disabled parents and children that impact on decisions that affect them
- Failing to meet obligations under the Disability Convention.

The key remedies and outcomes I achieved ranged from:

- Apologies to complainants and children
- Financial remedies
- The development by Oranga Tamariki of a disability strategy.

## Systemic remedies achieved by the Ombudsman in relation to disability issues

| Remedy | Current status |
|---|---|
| Oranga Tamariki ensures my findings inform its ongoing review of practice standards, policies, procedures and practices in line with recommendation 2(j) of my He Take Kōhukihuki \| A Matter of Urgency report, which says "Oranga Tamariki … amends its overarching practice standards, as well as its policies, procedures, and practices to recognise the rights of disabled parents and ensure full compliance with the United Nations Convention on the Rights of Persons with Disabilities". | Issued 17/3/22<br><br>**Completed**<br><br>The implementation of a disability strategy is in progress. |
| Oranga Tamariki scopes a review of its practices and policies around involvement with disabled parents, to be agreed upon with me.<br><br>The review is to reflect Article 4.3 of the Convention on the Rights of Persons with Disabilities – that disabled people-led organisations are consulted on any changes that affect disabled people.<br><br>*Note, this remedy can also be found in the previous chapter on uplifts and placements.* | Issued 27/3/20<br><br>**Completed**<br><br>The implementation of a disability strategy is in progress. |

## Case study - Disabled rangatahi institutionalised through flawed decision-making

A parent who sought help from Oranga Tamariki with their rangatahi, who has complex intellectual, behavioural and physical needs, complained to me in 2021 after Oranga Tamariki had custody of the rangatahi since 2015.

In 2015, the parent sought help with their rangatahi and it was agreed with Oranga Tamariki that the rangatahi would spend some weeks in respite care.

It was then agreed that the rangatahi would spend a year at the facility, under a section 141 agreement. A section 141 agreement is an extended care agreement for disabled tamariki and rangatahi in which custody is signed over to Oranga Tamariki.

However, in 2016 after the agreement lapsed, Oranga Tamariki sought custody of the rangatahi so they could remain at the facility. They remained there, for most of the time, until 2021 when they returned home.

Their parent and older sibling sought on a number of occasions in this time, to have them returned to the family, saying they were concerned the rangatahi had been institutionalised against their will.

They were also concerned that the rangatahi had been excluded from any decision-making and their views had not been sought.

The parent and sibling complained to me that Oranga Tamariki acted unreasonably in failing to consider the wellbeing of the rangatahi, their best interests and wishes; ignored their rights under two United Nations conventions (Convention on the Rights of the Child and Convention on the Rights of Persons with Disabilities); failed to act on a Report of Concern from their parent; failed to provide adequate social work and support services to the rangatahi; refused to plan for a return home in favour of continued institutionalisation; and provided incorrect or misleading information to the Family Court.

### What I found

During my investigation I reviewed files from Oranga Tamariki and information from the complainant, gathered information from professionals who worked with the rangatahi and parent, and spoke to professional services and wider family.

The most important consideration in any decision by Oranga Tamariki is the best interests of the child. It was apparent from the evidence I had that Oranga Tamariki did not make enough effort to fully understand the wellbeing of the rangatahi, their best interests or their own wishes. In fact, the records showed little consideration of the wellbeing of the rangatahi outside of their medication regime and physical wellbeing at the facility.

I was particularly concerned by a record showing an intention in 2020 to keep the rangatahi at the facility until they could transition to an adult disability service, against their will and that of their family.

The parent repeatedly asked for the views of their rangatahi to be taken into account, but despite this being a legal requirement and there being support from the parent for this to occur, there are multiple statements through the Oranga Tamariki file that indicate the views of the rangatahi were not sought, with a variety of justifications given for this.

Barriers to communication do not absolve Oranga Tamariki of its obligation to obtain a child's views. They actually create an additional obligation to provide support to ensure the child's views are known and considered in decisions about them. A child's right to be heard is protected under the Convention on the Rights of the Child.

Underlying the decision-making in this case was a determination by Oranga Tamariki that the rangatahi should live at the facility, and instead of seeking the views of the rangatahi, surmised their views, through indirect information such as the demeanour or mood of the rangatahi, as interpreted by staff.

It was not until July 2020, four years after Oranga Tamariki directed that the rangatahi live at the facility, that Oranga Tamariki documented where the rangatahi had said they wished to live. The rangatahi had in fact been clear that they wished to be with their parent and not return to the facility.

In spite of this, their wishes were overridden by Oranga Tamariki which required them to continue to live at the facility. Requiring them to live in an institution in these circumstances was an unjustifiable breach of their right to choose where they lived and to be cared for by their parents.

I also considered the documentation that Oranga Tamariki provided to the Family Court was very unsatisfactory. My concern related to the quality of the information Oranga Tamariki provided to the Court to help it make decisions about the care of the rangatahi. Such documents should be accurate and complete, and should not rely on opposing parties to point out any issues.

I formed the opinion that Oranga Tamariki acted unreasonably and in an improperly discriminatory manner, and potentially contrary to law, by failing to appropriately consider the wellbeing of the rangatahi, their best interests and wishes; failing to and take part in decision-making; failing to provide adequate social work and support services; refusing to plan for a return home in favour of institutionalisation; and providing unsatisfactory information to the Family Court.

**Good practice by Oranga Tamariki**

While I found a number of failings on the part of Oranga Tamariki as described above, I would point out actions since the rangatahi returned home for which Oranga Tamariki should be commended.

Oranga Tamariki advised me in January 2022, in response to my provisional opinion, that a number of encouraging steps had been taken to resolve the issues of concern.

The rangatahi had been living at home since 2021, with wraparound disability support and now had a plan which included a funded communications assistant/ speech/language therapist.

The rangatahi also had a social worker with disability qualifications and another with lived experience of caring for disabled people.

Oranga Tamariki demonstrated that with proper support to manage their needs, the parent could care for the rangatahi at home.

**Recommendations**

I recommended Oranga Tamariki:

- provide a full and meaningful apology to the parent for the failures I identified;
- provide me with copies of updated Oranga Tamariki documentation relating to the rangatahi;
- apologise to the rangatahi in a manner they would be comfortable with and understand, if the parent and sibling considered it appropriate and in the interests of the rangatahi;
- consult me on the proposed process and content of any apologies before they are made;
- amends its overarching Practice Standards, as well as its policies, procedures and practices to ensure full compliance with the Disability Convention; and
- report back to me on progress on these recommendations within five months.

Oranga Tamariki accepted these recommendations.

Although some of the recommendations have been implemented, the apologies have not yet been made. I understand there have been difficulties in the relationship between Oranga Tamariki and the whānau but I do think a full and unconditional apology to the complainants and the rangatahi would go a long way to healing this relationship.

# 10 Tikanga-informed practice

# Tikanga-informed practice

Some complaints I receive are about the way Oranga Tamariki engages with Māori, either tamariki and rangatahi or their whānau. It is my role within the laws I operate under to determine whether correct and reasonable processes and practices have been followed. Where my opinion is that they have not, I can make recommendations for systemic change and to make amends to individuals.

Issues I have identified related to tikanga-informed practice during my investigations include Oranga Tamariki:

- Failing to respect and engage with Māori in a culturally appropriate way
- Failing to search widely for whānau during the management of a placement of tamariki
- Failing to engage with whānau, hapū and iwi to ensure placements keep tamariki connected to whakapapa
- Not considering a tikanga-informed process to return tamariki to whānau, or the impact of removal on their connection with whānau
- Failing, when considering financial remedies, to consider its own values; Māori cultural frameworks or Te Tiriti obligations, resulting in not being able to recognise different harms to Māori.

The key remedies and outcomes I achieved range from:

- Apologies, carried out in a way that restores mana and rebalances wairua
- Financial remedies
- Agreement from Oranga Tamariki to review its ex gratia (financial remedy) policy to ensure alignment with its own values, practice frameworks and cultural considerations
- A review of policies and procedures around Family Court documents
- Full searches for whānau, hapū and iwi done and documented as early as possible in the placement process.

## Systemic remedies achieved by the Ombudsman in relation to tikanga issues

| Remedy | Current status |
|---|---|
| Social workers and Family Group Conference co-ordinators receive training on the purpose and differences between hui ā-whānau and Family Group Conferences. Training should include how to explain this clearly to whānau and professionals involved and how to ensure their understanding is evidenced on CYRAS (Oranga Tamariki online case recording system). | Issued 9/11/22<br><br>**Completed** |
| Oranga Tamariki provide me with an update on a review of policy about financial support for whānau-nominated caregivers for children not in the care of Oranga Tamariki. | Issued 9/11/22<br><br>**Completed** |
| Oranga Tamariki reviews its policies and procedures and makes any necessary amendments to ensure a full search for whānau, hapū and iwi is done and documented as early as possible in the placement process.<br><br>*Note, this remedy can also be found in the chapter on uplifts and placements.* | Issued 24/3/22<br><br>**Completed**<br><br>These policies have been amended, in consultation with me, and published on the Oranga Tamariki Practice Centre. |
| Oranga Tamariki review its ex gratia (financial remedy) policy, with a view to ensuring alignment and consistency with Oranga Tamariki values and practice frameworks, as well as te Tiriti o Waitangi obligations.<br><br>*Note, this remedy can also be found in the following chapter on financial remedies.* | Issued 11/5/21<br><br>**Completed**<br><br>Oranga Tamariki accepted this recommendation but later advised a new policy incorporating broader 'cultural considerations' was in progress. It advised it had adopted a new standard operating procedure in October 2023. |
| Oranga Tamariki develop guidance for staff around working with individuals who are correcting errors in their CYRAS records in a trauma-informed manner. This should be provided to me for review. | Issued 23/11/20<br><br>**Completed**<br><br>Oranga Tamariki has produced resources and guidance for individuals correcting errors in their information, and has provided training to staff. |

## Case study – Failure to engage in a culturally appropriate way

A caregiver complained to me in 2020 about a number of matters after te tamaiti was removed from their care by Oranga Tamariki.

In their emailed complaint to me, they said *'As a Māori my character and integrity is already determined.'*

Oranga Tamariki has Māori practice frameworks in place. It is concerning that even just one complainant may feel judged for being Māori.

One of the caregiver's complaints to me, which I investigated and formed a final opinion on, was that they had requested te tamaiti see a Māori therapist as a Pākehā therapist's world view would not meet their needs.

They were advised that Oranga Tamariki would check whether a Māori therapist was available, and there was mention of *'having a discussion with a Māori colleague'*.

The caregiver followed up twice more with Oranga Tamariki but during my investigation there appeared to be no evidence that Oranga Tamariki acted on its assurance to follow up on the request.

In my final opinion on this case I found that, among other things, Oranga Tamariki acted unreasonably in its failure to respect and engage in a culturally appropriate way. I recommended Oranga Tamariki apologise to the caregiver for not communicating with them over the request.

Oranga Tamariki accepted these recommendations.

## Case study - Unreasonable actions throughout dealings with custodial caregiver

The complainant, the custodial caregiver of their mokopuna, complained to me about the removal of their grandchild from their care, and the actions by Oranga Tamariki, after a review of the case by the Oranga Tamariki Chief Executive's Advisory panel.

I investigated the complainant's concerns, and also investigated whether Oranga Tamariki had worked with them in a manner consistent with their values and needs as Māori. I found Oranga Tamariki had acted unreasonably throughout its dealings with the complainant.

The unreasonable actions by Oranga Tamariki included: using incorrect and unverified information about the complainant; failing to perform due diligence before removing their mokopuna; a review of the case by the Chief Executive's Advisory Panel failing to cover the wide-ranging issues that the complainant raised; and Oranga Tamariki failing to implement recommendations from the review fairly.

### Trauma-informed practice

Among the recommendations made by the Panel was that Oranga Tamariki invite the complainant to identify and correct information held about them in its records. The complainant was asked to go through their paper file themselves and attach Post-it notes to the incorrect information.

The complainant indicated that this was an issue for them, as it was overwhelming and difficult due to the amount of information and the trauma it triggered. There was no evidence that Oranga Tamariki worked with them to help correct the record in a way that reflected their needs.

I was disappointed this issue was not dealt in a way that was responsive to the complainant's mental health needs. I expect Oranga Tamariki to work with all complainants in a trauma-informed way, without assuming that they are able to review a large amount of potentially traumatic and triggering information on their own.

### Cultural consideration

During the complainant's dealings with Oranga Tamariki, they had requested a hui kanohi ki te kanohi (face to face meeting) with those involved at a site level. This was raised with Oranga Tamariki on two occasions as a means of resolving the complaint to me. The importance of this hui to the complainant was explained to Oranga Tamariki. However, it refused to participate, and queried the usefulness of such an approach. When the complainant raised it again they received this response from a staff member:

*"You received a letter of apology from the Chief Executive regarding the issues you raised about the failure of staff to follow best practice. As this has already been acknowledged and addressed I will not involve any remaining staff in a meeting with you."*

A hui could have been an important step in resolving the complainant's concerns in a tikanga-informed way. I found it unreasonable that Oranga Tamariki staff were not willing to meet with, and work with, them to resolve the complaint in this way even after I explained its importance.

From a te ao Māori perspective, hui kanohi ki te kanohi are often how conflicts are resolved. In my opinion, it was unreasonable that this was the response received.

Oranga Tamariki staff should be supported to manage conflict in situations like this by responding in a culturally appropriate way. At the very least the complainant could have been asked what such an approach would look like to them. They had already said they sought a hui kanohi ki te kanohi.

I formed the final opinion that Oranga Tamariki acted unreasonably in responding to the complainant, in particular as a Māori who asked specifically to be engaged appropriately.

**Recommendations**

I recommended Oranga Tamariki:

- arrange and fund further counselling sessions for the complainant;
- reconsider the request for a financial remedy, noting that there appeared to be a range of practice failures;
- place a copy of my final opinion on the complainant's file, in addition to providing more time for them to complete their correction letter;
- develop guidance for staff around working with individuals who are correcting errors in their computer records, in a trauma-informed manner; and
- make an appropriate apology to the complainant.

Oranga Tamariki accepted all my recommendations and has mostly implemented them.

It advised it was developing guidance for staff to prompt awareness and consideration of the potential trauma individuals may experience when reviewing information released to them. This was intended for all information releases and is not specific to individuals requesting errors be corrected in their computer records.

Staff now have access to resources and guidance to support a trauma-informed approach to the release of information.

## Case study - Cultural practice of Oranga Tamariki

A social services provider complained to me on behalf of a couple over their dealings with Oranga Tamariki.

The provider complained about the length of time it took for Oranga Tamariki to investigate a Report of Concern, and the quality of that investigation.

It also said Oranga Tamariki failed to use a culturally appropriate approach to the case in that it continued to push for a Family Group Conference when several hui ā-whānau had already been held and where plans had been agreed.

The provider said Oranga Tamariki failed to keep whānau together and support them, and Oranga Tamariki remained in the lives of the whānau despite no custody orders being applied or granted for the tamariki.

**What I found**

In an example of good practice, Oranga Tamariki responded appropriately within 24 hours to a Report of Concern. It engaged with Police while a formal investigation was underway, and kept in touch with the parents and whānau.

Records also showed that the actions taken by Oranga Tamariki were appropriate under section 7AA of the Oranga Tamariki Act, which requires Oranga Tamariki to take a Māori-centred approach for tamariki and rangatahi in a practical application of Te Tiriti o Waitangi principles.

Oranga Tamariki supported the whānau to find a member to care for the tamariki while the investigation was under way to prevent them going into care. The whānau was kept informed of progress during the investigation and was involved in decision-making in convening the hui ā-whānau.

The social services provider disagreed with Oranga Tamariki that a Family Group Conference was required. However, Oranga Tamariki is required to ensure the safety of tamariki, and Family Group Conferences are a legislative requirement if there are care and protection concerns. In this respect, Oranga Tamariki did not act unreasonably.

However, it was my opinion that Oranga Tamariki failed to ensure that the reason or legislative requirement for the Family Group Conference was explained to the facilitator, social services provider and whānau.

Moving the tamariki from their parents during the investigation phase was discussed with the parents, and the whānau were supported to decide who the tamariki would stay with.

It does not appear, however, that the whānau caregivers were told of the options for financial support they could be eligible for, and there is evidence that the whānau reported stress about the financial situation. My opinion was that Oranga Tamariki was unreasonable in not explaining the financial support available. Oranga Tamariki acknowledged the policy could be clearer and work was being done on this.

**Recommendations and remedies**

Oranga Tamariki accepted my opinion and agreed that:

- social workers and Family Group Conference coordinators would receive training on the purposes and differences between hui ā-whānau and Family Group Conferences, with the training to include how to explain the differences clearly to whānau and others involved;
- the Family Group Conference national advisor would explain the differences to the regional Oranga Tamariki site and iwi; and
- Oranga Tamariki and the social service provider would meet regularly to maintain good relations.

I also recommended Oranga Tamariki give me an update on amendments to its policy and/or guidance on financial support. In response, Oranga Tamariki advised that action had been taken to address this.

# 11 Financial remedies

# Financial remedies

Among the complaints that are made to me about Oranga Tamariki are concerns about financial remedies.

Oranga Tamariki may decide itself to offer a financial remedy to a person affected by their actions. I can also, as part of my opinion following an investigation into a complaint, make a recommendation that Oranga Tamariki consider a financial remedy.

Such matters can be contentious. Many of the complaints I receive about financial remedies are that they are inadequate sums.

While I am not able to order Oranga Tamariki to increase what it offers, I can investigate how the sums were arrived at to ensure Oranga Tamariki has followed the correct process. When I consider it has not, I can recommend a reassessment of the amount offered or that a different amount should be offered.

I can also investigate a refusal to offer a financial remedy.

Issues I have identified with financial remedies include:

- Inadequate assessments
- Failing to consider a financial remedy
- Declining to reassess offers
- Failing to consider assessments in line with its Māori frameworks and Te Tiriti obligations.

The key remedies and outcomes I have achieved ranged from:

- Financial remedy offers being made
- Reassessments of financial remedies
- Reconsideration of financial remedies and offers.

## Systemic remedies achieved by the Ombudsman in relation to financial remedies

| Remedy | Current status |
|---|---|
| Oranga Tamariki review its ex gratia (financial remedy) policy, with a view to ensuring alignment and consistency with its values and practice frameworks, as well as Te Tiriti o Waitangi obligations.<br><br>*Note, this remedy can also be found in the previous chapter on tikanga-informed practice.* | Issued 11/5/21<br><br>**Completed**<br><br>Oranga Tamariki accepted this recommendation but later advised a new policy incorporating broader 'cultural considerations' was in progress. It advised it had adopted a new standard operating procedure in October 2023. |

### Case study – ex gratia offer made for Family Group Conference failings

One example of a positive outcome of my work in this area is my investigation into the failings of the former Child, Youth and Family during a Family Group Conference process. Child, Youth and Family operated as part of the Ministry of Social Development at the time.

The investigation concluded that there were several failures by Child, Youth and Family in relation to the Family Group Conference including its organisation, poor management and the lack of information provided to the participants. A key issue following the Family Group Conference was that the family was not provided with information about the consequences of agreeing to the outcome proposed by case workers at the conference.

The outcome was found by the Oranga Tamariki Chief Executive's Advisory Panel to have been 'forced through'.

As a result of the investigation, the Ministry apologised and made an offer of an ex gratia (financial remedy) payment to the family for the harm caused both at and after the Family Group Conference and in the many years it had taken for the family to have its complaint resolved.

## Case study - Payment inadequate for multiple failings by Oranga Tamariki

A parent of two tamariki sought help from the then Child, Youth and Family in 2013. The parent agreed to have the tamariki go into care. They were not uplifted.

The parent made a number of complaints about the service provided and in 2019 the Oranga Tamariki Chief Executive's Advisory Panel considered the complaints. It identified 10 practice failings and made a number of recommendations which Oranga Tamariki accepted.

Among the practice failings were poor record-keeping, poor communication with the parent, and not providing consistent counselling for the tamariki.

The parent waited 15 months to regain custody of one tamaiti after Oranga Tamariki delayed completing a parenting assessment.

Among the 11 recommendations made by the Chief Executive's Advisory Panel was that the Oranga Tamariki chief executive agree that the way to rebuild the relationship with the parent and their whānau, and to restore their mana, was through face to face engagement (kanohi ki te kanohi) in a kaupapa Māori setting.

The Panel recommended Oranga Tamariki apologise for its harmful actions in the past and agree on what could be done to help the whānau put the past behind them. The apology should be made in a way that met the needs of the parent, who chose a face to face meeting on a marae.

The panel said Oranga Tamariki should also provide the parent with insights into how their change programme fitted with the parent's hopes for improvements in its work.

It also recommended the chief executive note the parent's request for an ex gratia payment (financial remedy) for the harm caused by the failings of Oranga Tamariki.

The parent made a complaint to me that the ex gratia (financial remedy) offer from Oranga Tamariki was unreasonable.

**What I found**

Oranga Tamariki, in arriving at a payment amount, had compared the circumstances with two other cases involving similar amounts. However, it was my opinion that the decision-making around this was flawed.

The earlier cases differed significantly from that of the parent in this case. Although the parent voluntarily entered into a partnership arrangement with Oranga Tamariki where communication should have been a big part of the relationship, they were not consulted on a number of important aspects of the lives of their tamariki.

Decisions, including medical decisions, were made without their knowledge. The lack of communication from Oranga Tamariki appeared to be caused by practice errors and ommissions.

Poor or non-existent social work records meant there was no picture of the history, needs or views of the tamariki. The parent said there were many times when they were unable to monitor the wellbeing and affairs of their tamariki.

The lack of communication, poor record-keeping and delay in carrying out a parenting assessment had a significant negative impact on the parent.

The parent also carried the burden of helping their tamariki heal following abuse while in care, for which they did not receive adequate therapy.

Oranga Tamariki failed to acknowledge all types of harm to wellbeing, including hauora, when assessing the ex gratia (financial remedy) amount.

Oranga Tamariki says it is committed through its various te ao Māori frameworks to bicultural practice and the promotion and value of Māori culture, and staff are expected and encouraged to engage in culturally appropriate practice.

However, when it came to assessing financial remedies, this commitment was absent, and in this particular complaint, the personal and collective responsibility for wellbeing in te ao Māori was ignored. The assessment considered only the harm to the parent's hauora, and was not extended to their tamariki.

I formed a provisional opinion that the offer to the parent appeared to be unreasonable. Oranga Tamariki requested time to reassess the offer before I formed a final opinion. The amount was then reassessed and a new offer made to the parent, which was accepted.

**Recommendations and remedies**

I formed the final opinion that the decision by Oranga Tamariki on its original offer was unreasonable but I made no recommendation due to the revised and accepted offer.

I recommended there was a review of the Oranga Tamariki ex gratia (financial remedy) policy, with a view to ensuring alignment and consistency with its values and practice frameworks, as well as Te Tiriti o Waitangi obligations.

Oranga Tamariki accepted this recommendation and advised in July 2021 that it had reviewed the policy and expected the new policy, which ensured alignment and consistency with its values, practice framework and Te Tiriti o Waitangi obligations, to be in place by the end of 2021.

## Progress on ex gratia (financial remedy) policy

In an update in May 2023, Oranga Tamariki advised that the ex gratia policy was *'being revised as part of a broader piece of work around establishing an interim claims process. We anticipate having a new ex gratia policy formally approved and in place within a few months'*.

It also advised that *'cultural considerations (including obligations under Te Tiriti o Waitangi) are now expected to be taken account of at a broad level, and may be considered relevant to any factor'*.

In a further response to my inquiries as to how it was implementing my recommendation that the review of the policy should have a *'view to ensuring alignment and consistency with their values and practice frameworks, as well as Te Tiriti o Waitangi obligations'*, Oranga Tamariki advised:

> *The ex gratia policy is drafted to be broad and to not get into specific details … [O]ur ex gratia policies are used to assess a very broad range of harms, and it is important that assessments can scale accordingly while remaining consistent with the policy.*
>
> *The process for assessing ex gratia has been significantly improved over the last three years. All of the matters you raise have been successfully incorporated into relevant ex gratia payments since the original assessment of [name of complainant] … [T]hese ex gratia payments now form part of our precedent base, and that precedent base plays a role in guiding future assessments. This includes:*
>
> - *Assessments that have provided payments to whānau collectively to recognise whānau harm;*
> - *Assessments that have provided payments to children (where those children would not otherwise have a legal claim) even where not requested by the complainant; and*
> - *Assessments that expressly address practice frameworks, where those frameworks have been relevant.*
>
> *The implementation of the policy relies on training, peer review and clear sign out processes that ensure, as far as we are able, that these matters are taken into account when they are relevant.*

At the end of October 2023, Oranga Tamariki advised that it had a new ex gratia Standard Operating Procedure (SOP), which would focus on service delivery failures a complainant experienced rather than the harm they suffered.

It advised that it did not expect the amounts offered to complainants to be impacted by this change in focus, but would provide complainants with a clearer understanding of the basis for an ex gratia payment – the failure itself rather than any harm caused by the failure.

I will be closely monitoring complaints made to me about the Oranga Tamariki ex gratia policy to see what impact, if any, these changes have on the number and nature of complaints in relation to ex gratia (financial remedy) payments.

# 12 Apologies

# Apologies

One of the most common recommendations I make following an investigation is an apology.

An apology is one of the simplest and most effective things anyone, including agencies, can do when they have made an error.

Successive Ombudsmen have found an effective and authentic apology is sometimes enough to satisfy someone who has made a complaint. It is what an agency should do when it has made an error or their actions have caused hurt to a person or a number of people. An effective apology will go some way to restoring the mana, dignity and self-respect of the complainant.

That's why I will almost always make a recommendation for Oranga Tamariki to apologise to people whose complaints I have looked into and found deficiencies that have affected them.

I often make it part of my recommendation that the apology come to me first for feedback. Apologies need to be genuine and contain elements that make them acceptable to the complainant.

I have complainants return for assistance when they receive an apology they are not satisfied with – it does not feel genuine, or it fails to address the errors they complained about in the first place.

When people come to me to complain about an apology from Oranga Tamariki, I will consider the actions it has apologised for, and the way the apology has taken place.

Issues I have identified include:

- Inadequate and unreasonable apologies.

The key remedies and outcomes I have achieved ranged from:

- Reconsideration of previous apologies
- Further apologies acknowledging the hurt or harm caused, setting out steps to fix the issues and expressing genuine remorse
- Delivering apologies in culturally appropriate ways, including consideration of the language, the method of delivery and the setting
- The restoration of complainants' mana and dignity.

I have produced He rauemi tātaki ea– A resource for offering an effective apology, which can be found on my website. It aims to help agencies including Oranga Tamariki make apologies that meet the needs of the person wronged.

The concepts and principles underpinning te ao Māori provide a path to ensure any apology is authentic, addresses the complaint and is delivered in a culturally appropriate way.

For example, it is an important aspect of tikanga Māori that an apology be carried out kanohi ki te kanohi (face to face).

This has been made more difficult over the past few years by the lockdowns that occurred as a result of the pandemic but given it is such an important part of any apology, I would expect every effort be made to do this if that is what the complainant wishes.

An effective apology will include the following elements:

| | |
|---|---|
| Recognition<br>Kia mōhio | • An adequate description of the wrong.<br>• Recognition that it was wrong and why (for example, it was incorrect, inappropriate or unreasonable). |
| Responsibility<br>Ka noho haepapa | • Acknowledgement of responsibility for the wrong and harm caused. |
| Reasons<br>Nā konā tonu | • An explanation of the reasons or cause, or a promise to investigate the cause.<br>• It may be appropriate to indicate any mitigating circumstances, but be careful not to make excuses.<br>• If there is no valid explanation, don't offer one. Just say that there is no excuse for the offending behaviour. |
| Regret<br>Ka kōhautia | • An expression of sincere sympathy, sorrow, remorse and/or contrition or, at the very least, an expression of regret. |
| Redress<br>Whakaoranga | • A statement of the action taken or proposed to address the wrong, for example:<br>- taking action if there has been a delay;<br>- reconsidering or changing a decision;<br>- amending records;<br>- providing a financial remedy for loss;<br>- changing policies, procedures or practices.<br>• An undertaking that measures have been put in place to prevent the wrong occuring in future. |
| Release (optional)<br>Murunga | • A request for forgiveness. |

## Case study - Unreasonable actions by Oranga Tamariki over relative's concerns

Oranga Tamariki was involved with a whānau for just over a year. During this time there were also Family Court proceedings under the Care of Children Act 2004.

A whānau hui was held where concerns were raised about a child and a safety plan was developed. A referral for further discussions also said there were concerns for the child.

After further discussions, it was then decided there were no ongoing care and protection concerns for the child and the case would be closed.

A relative of the child complained to me that there was no midway review; that Oranga Tamariki did not gather evidence before determining the child was no longer in need of care and protection; and about the adequacy of an apology Oranga Tamariki made after the relative complained.

### What I found

Oranga Tamariki acknowledged there were issues in the social work practice in relation to the midway review and evidence-gathering and acknowledged that the social worker did not organise a midway review.

From the evidence it appeared to me that the social work practice did not meet some practice standards.

I considered the apparent lack of verified information presented to support the decision-making and the lack of a midway review meeting was unreasonable.

All information should have been gathered and verified before being presented to the whānau, and before it had an impact on decision-making.

### Apology

An appropriate apology acknowledges the mistakes made but also the impact of the mistakes or errors. The apology that had been provided in this case appeared to attribute the issues to a 'very new social worker', rather than Oranga Tamariki taking responsibility as a whole for how the situation occurred.

There was no acknowledgement of the factors within Oranga Tamariki that allowed the practice failings to occur. The only comment on preventing this happening again was that the very new social worker *'has a lot to learn however [they have] been open to this feedback and is resolved to ensure that [their] engagement with families is more meaningful and purposeful in the future'.*

There was minimal acknowledgement of the impact the practice had on the relative and whānau aside from the acknowledgment that it was 'frustrating'.

I would expect such an apology to outline what steps were being taken to support new social workers and ensure practice issues like this do not reoccur. However, the apology instead appeared to focus on the social worker making changes and being spoken to, rather than any systemic change that could provide a mechanism to prevent such mistakes.

I formed the opinion that Oranga Tamariki acted unreasonably in failing to undertake a midway review; failing to gather evidence before determining the child was no longer in need of care and protection; and in the apology provided to the relative.

**Remedies**

I did not make formal recommendations as Oranga Tamariki accepted and implemented my suggested remedies, which were:

- An apology that recognises the wrongs that occurred, acknowledges Oranga Tamariki was responsible for the wrong and the harm caused, explains the cause of the issue, provides an expression of regret for the wrongs that occurred and the harm expressed by the complainant; and provides a statement of the action, or proposed actions, to address the wrong.
- Oranga Tamariki finds out how the relative would like this apology to be provided.
- Oranga Tamariki sends the draft apology to me for review and comment within one month of my opinion.

# 13 Oranga Tamariki policies and practice

# Oranga Tamariki policies and practice

The policies, frameworks, practice and processes Oranga Tamariki operates under are essential tools to ensure a consistent approach to dealing with cases and the issues within them.

However, there are occasions when it is apparent that a rigorous application of these has not been followed. A number of complaints made to me contain issues that point to an inconsistent approach by Oranga Tamariki, or in some cases, a lack of adherence to their own policies and practices, or legislation.

Issues I have identified include:

- Inadequate communication or engagement with tamariki, rangatahi and their whānau
- Inadequate responses to complaints from tamariki, rangatahi and their whānau or caregivers
- Inadequate oversight of placements for tamariki and rangatahi in care
- Failing to provide opportunities for natural justice
- Inadequate or delayed support for parents and caregivers
- Inadequate record-keeping
- Failing to uphold agreements made at Family Group Conferences
- Inadequate transfer of cases between sites.

The key remedies and outcomes I have achieved ranged from:

- Genuine and effective apologies
- Correcting inaccurate information in records or to the Family Court
- Connecting tamariki and rangatahi to advocacy groups such as Voyce Whakarongo Mai
- Referrals of record-keeping issues to the Chief Archivist
- Financial remedies
- Provision of explanations for Family Court Agreements not being upheld

- Practice reviews of cases
- Changes in policies and processes to improve them
- More training for staff.

Record-keeping is one area where I find shortcomings by Oranga Tamariki on a regular basis. If full and proper records are not kept, it can have substantial effects on the people Oranga Tamariki is interacting with.

Section 17 of the Public Records Act requires every government agency to *'create and maintain full and accurate records of its affairs, in accordance with normal, prudent business practice'*. Where I find record-keeping practices that appear contrary to law, I will refer the matter to the Chief Archivist.

As well as the recording of information received, Oranga Tamariki must also ensure that it is providing information accurately and in a timely manner to the people it works with.

### Case study – Caregiver complaint led to change in policy

A caregiver complained to me about a number of issues relating to their involvement in the care of a child and the uplift of that child by Oranga Tamariki and subsequent investigation. Among the caregiver's grievances was that their status as an approved caregiver was removed without a fair and proper process.

I investigated the complaint and formed the opinion Oranga Tamariki acted unreasonably when it failed to tell the caregiver as soon as it could that it was carrying out an investigation and what it would be looking at.

My review of records indicated that Oranga Tamariki had concerns about the care of te tamaiti for over a number of years but it did not appear these concerns were discussed with the caregiver, nor were they given the chance to address them.

It was my opinion that failing to give the caregiver clear information about a build-up of concerns and historical pattern of behaviour which were at the core of the investigation denied them a meaningful opportunity to respond to the concerns, contrary to the principles of natural justice.

As a result of my investigation and recommendations, Oranga Tamariki made changes to its caregiver policy to clarify that all relevant concerns - such as historical or cumulative concerns - are communicated to the caregiver as soon as practical, and in a way they would be able to understand.

## Systemic remedies achieved by the Ombudsman in relation to policies and practice

| Remedy | Current status |
|---|---|
| Oranga Tamariki provide a report to me with specific details of what supervision and supports are available to site social workers to ensure correct actions are taken and there is equitable treatment between interested parties. | Issued 30/6/23<br><br>**Completed** |
| Oranga Tamariki, update me and the Chief Archivist on policies, processes and any associated training in place that reflects the requirement and importance of transferring records created on mobile devices to its record management systems.<br><br>*Note, this remedy can also be found in the chapter on Reports of Concern.* | Issued 30/6/23<br><br>**Completed** |
| Oranga Tamariki amend the caregiver allegation policy to clarify that all relevant concerns likely to be considered as part of the investigation are to be outlined to the caregiver as soon as practical – particularly where the investigation relates to cumulative harm and considers historical information. | Issued 4/7/22<br><br>**Completed**<br><br>Oranga Tamariki has updated its policy on its practice centre. |
| The relevant site practice leader complete a reflective session with staff around practice standards, guidance policy and legislative obligations in relation to record-keeping and provide me with a short report on this training once complete. | Issued 30/6/22<br><br>**Completed** |
| Consideration by Oranga Tamariki of whether timeframes should be included in Care and Protection Family Group Conference policy or guidance, specific to the time between referral and convening of a Conference, and:<br><br>a. If changes are required, confirmation of those changes be provided to me; or<br><br>b. If timeframes are not considered an appropriate addition, a comprehensive rationale for this to be provided to me. | Issued 30/6/22<br><br>**Partially complete as at December 2023**<br><br>Oranga Tamariki has agreed in-principle and there is ongoing work to implement this. |
| Oranga Tamariki develop and publish policy regarding the transfer of cases from one site to another, including timeframes and role responsibilities. | Issued 14/3/22<br><br>**Completed**<br><br>The policy was updated and published on Oranga Tamariki Practice Centre on 27/10/22. |

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| Oranga Tamariki ensure the relevant site carries out refresher training on policy and practice in dealing with tension and communication difficulties between Oranga Tamariki, family/whānau and caregivers; and social workers receive support and guidance from their supervisors, and this guidance is recorded. | Issued 14/3/22<br><br>**Completed** |
| Oranga Tamariki update its Chief Executive's Advisory Panel fact sheet to clarify the reimbursement process for complainants attending panel meetings in Wellington. | 3/6/20<br><br>**Completed** |

## Case study - Lack of record-keeping appeared contrary to law

A parent of tamariki who sought support from the then Child, Youth and Family (CYF) in 2016 lost custody of their children, some of them permanently, when they were removed from their care and put into the custody of CYF.

The parent complained to me in 2020 that Oranga Tamariki, (as the agency was then named) failed to provide them support when they requested help with the children and following their removal, with the aim of having them returned. In the course of my investigation I found issues with the adequacy of the response to the parent's complaint to Oranga Tamariki, no remedy for its acknowledged practice failures, and the adequacy of its record-keeping in the case.

The parent believed that if they had been given the support they asked for in 2016, and concerns CYF had about them following the removal of their tamariki had been addressed, they would not have been removed.

The parent complained to Oranga Tamariki in 2019. Oranga Tamariki identified practice failings but did not apologise to the parent, nor offer any remedy. No action was taken to discuss the findings with the parent.

At the time of the parent's complaint to me in 2020, some tamariki were living with their other parent while one tamaiti had returned voluntarily to the complainant.

### What I found

It was my opinion that Oranga Tamariki acted unreasonably when it failed to provide support to the parent before and after the tamariki were uplifted. It acted unreasonably when it responded to their complaint in 2019, and acted in a manner contrary to the law by failing to keep and maintain adequate records as required under the Public Records Act.

The actions and decisions by Oranga Tamariki were not transparent, were not recorded, and by its own admission, were inadequate. This had a significant impact on the parent, the tamariki and the actions the parent took to try to have them returned.

### Oranga Tamariki record-keeping obligations

The response Oranga Tamariki to the 2019 complaint identified that there was a lack of records in relation to:

- a clear rationale for seeking to uplift the tamariki;
- formal assessment processes and decision-making associated with the decision to uplift the tamariki;
- the views of some of the tamariki;

- the views of their school;
- the view of the wider family;
- what, if any, supports were offered in 2016; and
- details about why supports were not offered in 2017, when concerns escalated.

I noted with great concern that Oranga Tamariki did not capture what would be considered critical details of decision-making that significantly impacted the lives of the parent and the tamariki. Keeping such records is part of 'normal prudent business practice' as outlined by the Public Records Act.

Because of this, my final opinion was that the failure of Oranga Tamariki to create and maintain such records appeared to have been contrary to law.

**Remedies**

Oranga Tamariki agreed that it had acted unreasonably and accepted my opinion in full. It agreed to and implemented the following remedies:

- Apologise to the parent for its practice failures, inadequate response to the 2019 complaint, a lack of support following the removal of the tamariki, and the lack of critical records.
- Provide the parent a summary of the general improvements to legislation, policy and practice since their experiences.
- Provide a financial remedy.

## Case study - Poor communication led to tensions with parent

A parent of children in care complained to me about a number of issues concerning their relationship with Oranga Tamariki and the caregivers of their tamariki.

They said they were left out of decisions they should have been involved in. For example, one child's medical specialist appointment, at which the impact of their health issues were discussed, was attended by the caregiver rather than the parent. This was at a time when the parent usually took the child to appointments, was allowed unsupervised access, and the case direction was a return home. The parent was not informed or updated about the child's medical appointment.

The parent also advised Oranga Tamariki that they did not want their children to take part in some activities. However, one of the requests took four months to pass on to the caregivers.

A transfer process between two Oranga Tamariki sites took 18 months to complete, causing delay and access and communication issues for the parent and their tamariki.

The parent had trouble when seeking access to their children.

On one occasion the parent and another relative, who had travelled to be there, were not able to see one of the children on their birthday, but had not been told prior that the visit could not go ahead.

**What I found**

It was clear to me that poor communication with the parent, and some poor practice by Oranga Tamariki, raised tensions between the parties.

I formed the final opinion that Oranga Tamariki acted unreasonably in its communication with the parent, how it managed access, how the parent's concerns about the caregivers was handled, and the management of conflict. There was no clear case management plan.

I found issues with site practice in relation to guardianship rights, communication difficulties with the parent and problems caused by tensions between the parties. I was not aware of any specific measures being taken to address these issues.

There were also clear issues with record-keeping and helping the parent with access to their children.

**Recommendations**

I recommended Oranga Tamariki:

- make an apology to the parent and the children that acknowledged the failure and impact of the lack of communication and delay in progressing the children's social work plan and case direction in a timeframe that was in the children's best interests;
- the apology should also acknowledge the failure and impact on the parent of not including them in all guardianship matters relating to the care, development and upbringing of their children;
- carry out a practice review to consider whether the social work practice and social work supervision included guardianship rights and responsibilities, and if and how these were put into practice;
- ensure the site carries out refresher training on policy and practice in dealing with tension and communication difficulties between Oranga Tamariki, family/whānau and caregivers, social workers receive support and guidance from their supervisors, and this guidance is recorded; and
- develop and publish policy on the transfer of cases between sites, including on timeframes and role responsibilities.

Oranga Tamariki updated its casework policies when more than one site is involved on its online Practice Centre in October 2022 following my recommendation. It said:

> *The policy has been strengthened to emphasise a continuous and responsive social work service throughout the transfer process for te tamaiti or rangatahi and their whānau or family. The case transfer section has a greater focus on communication and information-sharing.*

The ability to transfer cases between Oranga Tamariki sites with minimal disruption to the whānau is essential. Spelling out the role responsibilities of the staff involved helps ensure this is carried out smoothly and in a timely fashion.

As a result of the practice review Oranga Tamariki carried out in the case above, new practice guidance has been published on its online Practice Centre on advocacy for parents and whānau to help staff clarify whānau rights and wishes through an independent advocate.

Oranga Tamariki said this should strengthen the family voice, uphold rights and reduce the likelihood of miscommunication and conflict.

In cases where tamariki are in care and where their parents and/or whānau have views and wishes for that care, tension and conflict may arise.

I am reassured by the willingness of Oranga Tamariki to recognise the problem, review the issues, suggest solutions and implement them, in a swift and mature way. It gives me confidence that Oranga Tamariki has the ability to pivot quickly to resolve issues, and to provide training and support to staff to ensure new or amended practices and policies are bedded in well.

# 14 Conclusion

# Conclusion

This report contains case studies of complaints that I have dealt with. They are an indication of the depth and breadth of the complaints people make to me. They are examples of some of the most concerning treatment vulnerable people have received at the hands of the agency tasked to protect our tamariki.

All of those whose stories are told in these case studies have generously allowed it. In speaking to them ahead of publication of this report, it is clear they are still traumatised and some are now only grieving for what they have lost – be it their tamariki, time, dignity, trust.

One complainant told me:

> *Today we are still healing. The kids and I have spent the last five years just building, decolonising, separating from the culture of a system that embedded itself and imprinted on us all. We have been rebuilding what was stripped away from us. No help, it was us who had to do that.*

Another said:

> *We had no voice. The Ombudsman gave us a voice and I have so much gratitude for that. I will take it to my grave.*

My role as the Chief Ombudsman is to help build trust in our government agencies, through my independent oversight which ensures accountability and transparency. To my great regret, I cannot yet provide assurance that Oranga Tamariki is consistently operating in accordance with good administrative practice. Although it has, through many positive outcomes and the compassion of some of its social work, shown it is capable as an agency of supporting whānau, tamariki and rangatahi, it is often undone by underlying culture and practices which are not flexible or of good quality, which are not child-centric, and which are not culturally sound.

For Oranga Tamariki to regain the trust it has lost from the people it serves and the wider public, it needs to change on a scale rarely required of a government agency.

My wero (challenge) to the new Government is to drive this change, to consider the purpose of Oranga Tamariki, whether it is fulfilling it, and to have the courage to address the shortcomings I have identified in my report.

My own view of what is required now, as a starting point for change to embed good practice, are the following measures:

- Implementation of an organisation-wide quality improvement plan, informed by regular reporting and analysis of issues as they arise.

- Understanding and implementation of relevant legislation, policy and procedure by staff in all actions and decisions.
- Attention to detail in the provision of accurate information, both internally and externally, including to the Family Court.
- Careful review of all relevant information (i.e. whole case history) in decision-making.
- Training and guidance for staff in good decision-making practices, including to keep an open mind and gather all relevant information before making decisions.
- Effective recording and tracking of progress on Reports of Concern, and identification and escalation when timeliness issues arise.
- Effective supervision and review processes, including by managers and legal advisors.
- Centrally led and cross-site enabled regular quality assurance processes, including random and targeted audits of Reports of Concern and other case work.
- Strategic oversight of and investment in good record-keeping.
- Identification of resource needs and effective escalation processes for managers and sites where resource is an issue.
- Effective warning and escalation processes to enable staff to raise issues, including with head office, when teams or sites are struggling.

As the independent watchdog for our Parliament, my office will continue oversight of Oranga Tamariki and will continue to report on its actions and decisions.

The Oversight of Oranga Tamariki System Act 2022, which gives the Ombudsman expanded responsibilities and obligations, came into force on 1 May 2023. I have a comprehensive programme of work that has supported me to implement these legislative changes. My own processes will continue to be improved to ensure the Ombudsman is as accessible and child-centric as possible to tamariki, rangatahi, their family/whānau, and caregivers.

This report represents the first time a Chief Ombudsman has published a significant amount of the work on complaints about Oranga Tamariki.

It will not be the last. My intention is that the Ombudsman will continue to publish such reports. My hope is that in future, the Ombudsman will uphold far fewer complaints, and will be able to report more favourable outcomes and positive, empowering practice by Oranga Tamariki.

# Appendix 1. Glossary

## Terms and definitions

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|---|---|
| **All About Me plan** | The primary plan for tamariki or rangatahi in the care or custody of Oranga Tamariki which contains information about the child and addresses the needs identified in a Tuituia assessment. |
| **Care of Children Act 2004 (CoCA)** | Defines and regulates the duties and responsibilities of parents to their children and the court's power in relation to the care of children. Encourages agreement on care arrangements and provides for the resolution of disputes. It also implements the Hague Convention. |
| **Chief Executive's Advisory Panel** | The former internal review body for complaints made to Oranga Tamariki about its decisions or actions. |
| **Child-centric** | An approach in which the child is at the centre and an active participant. Their perspectives, and needs are at the forefront of decision-making. |
| **Child Protection Protocol (CPP)** | Joint operating process agreed with Police when a Report of Concern is made to Oranga Tamariki of potential harm, abuse or neglect that may be a criminal offence, or a complaint is laid with Police. |
| **Child, Youth and Family (CYF)** | Predecessor agency (until 2017) of Oranga Tamariki – Ministry for Children. |
| **CYRAS** | The Oranga Tamariki electronic case management system. |
| **Ex gratia assessment/ payment (financial remedy)** | Oranga Tamariki may assess a complainant for financial payment or other benefit such as counselling to recognise harm done but not a legal obligation or compensation for harm. |
| **Family Group Conference (FGC)** | Statutory process involving a private whānau or family group meeting convened by a Care and Protection Co-ordinator. Participants come up with a plan dealing with care and protection concerns. |
| **Frameworks** | Oranga Tamariki operates under a number of frameworks – the structure of ideas, concepts, philosophies that underpin its work. |
| **Hapū** | Kinship group, tribe, subtribe; or pregnant, expectant. |
| **Hauora** | Māori view of health and wellbeing, supported by four dimensions of taha hinengaro – mental health and emotions; taha wairua – spiritual health, taha tinana – physical health, and taha whānau – whānau as the epicentre of one's wellbeing. |

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| **Hawkes Bay Practice Review** | A review by the Chief Social Worker of Oranga Tamariki (with oversight from a Ngāti Kahungunu representative and the Office of the Children's Commissioner) into events that happened at Hastings Hospital in 2019. |
| **Home for Life** | A permanent placement in the home of a caregiver, sometimes a wider whānau member. Oranga Tamariki provides ongoing support and some financial assistance. |
| **Hui ā-whānau** | Meeting which aims to support and enhance the rights, participation and decision-making of tamariki and their whānau, hapū, iwi and support network as early as possible. |
| **Initial Joint Investigation Plan (IJIP)** | An agreement under the Child Protection Protocol between Oranga Tamariki and Police to work together to ensure the immediate safety of te tamaiti and make sure any evidence is collected. |
| **Intellectual Disability** | People with an intellectual disability may have trouble understanding new or complex information, living independently or learning new skills. Other terms include tāngata whaikaha hinengaro or learning disability. |
| **Iwi** | Tribe. |
| **Kaupapa** | Principle or policy. |
| **Mahi** | Work. |
| **Mihi** | Greeting, welcome speech, expression of thanks. |
| **Office of the Children's Commissioner** | An independent Crown entity that advocates for the interests and wellbeing of New Zealand's children and young people. From 1 July 2023 – Mana Mokopuna \| Children and Young People's Commission. |
| **Ombudsman** | A gender-neutral word of Swedish origin, the name of New Zealand's independent Parliament watchdog for central government and local government agencies.<br>An Ombudsman's role includes:<br>• Investigating the administrative conduct of public sector agencies<br>• Reviewing decisions by public sector agencies and Ministers on requests for official information<br>• Acting as a National Preventive Mechanism to examine places of detention under the Crimes of Torture Act 1989<br>• Part of the Independent Monitoring Mechanism for New Zealand under the Disability Convention<br>• Recommending remedial action be taken where agencies have acted unfairly<br>• Acting as an appropriate authority for whistleblowers under the Protected Disclosures Act 2000<br>• Providing advice and guidance relating to all of the above |

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| **Ombudsmen Act 1975** | Under the Act, Ombudsmen can investigate conduct by a public sector agency (central or local government) that relates to a matter of administration affecting any person in a personal capacity. |
| **Oranga Tamariki – Ministry for Children** | Government agency responsible for child welfare and protection in New Zealand. |
| **Oranga Tamariki Act 1989** | The Act sets out the principles and processes that promote the well-being of children, young people and their families, whānau, hapū, iwi, and family groups. |
| **Oranga Tamariki system** | The system that provides services or support to children and young people, their family/whānau under or connected with the Oranga Tamariki Act 1989. The Act applies to the delivery of services or support by agencies and their contracted partners within the system. |
| **Oversight of Oranga Tamariki System Act 2022** | Widened the Ombudsman's powers to investigate care and custody providers. The Act provides enhanced oversight by the Ombudsman of the Oranga Tamariki system. |
| **Parenting assessment (s18A)**<br><br>**See Section 18a (of the Oranga Tamariki Act 1989) assessment** | Assesses whether a parent is unlikely to inflict, or allow to be inflicted, on a subsequent child the kind of harm inflicted on a previous child or young person. |
| **Pēpi** | Baby or babies. |
| **Place of Safety Warrant** | If the District Court is satisfied that a child is experiencing harm, it authorises a Police constable or Oranga Tamariki worker to enter and search any home or vehicle for the child. In serious cases the child can be removed and placed in Oranga Tamariki care. |
| **Pono** | Truth, honesty, validity, sincerity. |
| **Practice Centre** | An online resource for Oranga Tamariki practitioners containing the rules and guidance for their work dealing with tamariki and their whānau/caregivers. |
| **Practice standards** | Written benchmarks for Oranga Tamariki staff. |
| **Rangatahi** | Older child, youth, teenager. |
| **Recommendations and remedies** | The terms recommendations and remedies are used together in this report:<br>• A recommendation is the Ombudsman's formal statement of what they think should be done to fix a problem following an opinion that the agency has acted unreasonably or wrongly (etc)<br>• A remedy may be agreed by an agency or as a result of the Ombudsman's recommendation and may come about when the complaint is resolved or the Ombudsman forms an opinion on the issues |

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| **Report of Concern (ROC)** | Information shared with Oranga Tamariki by any person about concerns they have around the safety of pēpi, child or young person. |
| **Safety Plan** | Documented arrangements and planning for the safety and needs of pēpi and whānau in the pre-and post-birth period and more generally. |
| **Section 18a (of the Oranga Tamariki Act 1989) assessment** | Under section 18a of the Oranga Tamariki Act 1989, an assessment is carried out to assess whether a parent is unlikely to inflict, or allow to be inflicted, on a subsequent child the kind of harm inflicted on a previous tamaiti or rangatahi. |
| **Section 131A report** | A Family Court-ordered report under the Care of Children Act detailing the nature and extent of any involvement of Oranga Tamariki with the parties to an application for a guardianship or parenting order which may help the proceedings. |
| **Section 132 report** | A Family Court-ordered report under the Care of Children Act detailing care and protection issues involving a child and can include cultural issues, parenting and whānau information. A judge determines the scope of the report. |
| **Section 7AA (of the Oranga Tamariki Act 1989)** | An obligation on Oranga Tamariki to recognise The Treaty/ Te Tiriti and provide a practical commitment to improve outcomes for tamariki and rangatahi Māori, including a recognition of the importance of whakapapa and whanaungatanga. |
| **Section 78 (of the Oranga Tamariki Act 1989) application or order** | Once Oranga Tamariki believes te tamaiti or tamariki need care or protection it applies to the Family Court for an order (under section 78) placing them in Oranga Tamariki care on an interim basis. The court generally grants this order on the same day if it agrees this is needed. The application may be made with or without notice to the parents. |
| **Section 141 agreement** | An agreement under the Oranga Tamariki Act 1989 for extended out of home custody and care of severely disabled tamariki or rangatahi (now repealed). |
| **Site** | Where an Oranga Tamariki office is located, used to describe a place of operation. |
| **Subsequent child provisions** | Describes criteria used to assess the parents of pēpi whose older sibling or siblings have been removed (see also Section 18a (of the Oranga Tamariki Act 1989) assessment). |
| **Tamariki** | Children. |
| **Tāngata whaikaha** | Disabled people. |
| **Tāngata whaikaha Māori** | Disabled Māori. |
| **Te ao Māori** | The Māori world. |
| **Te Tamaiti** | Child. |

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|---|---|
| **Te Tiriti o Waitangi (Treaty of Waitangi)** | New Zealand's founding document, signed on 6 February 1840. It is an agreement, in Māori and English, made between the British Crown and about 540 Māori rangatira (chiefs). The two texts have different meanings. |
| **Tika** | Correct, proper, just or fair. |
| **Trauma-informed practice** | Recognition that some whānau, hapū, iwi, family, family groups and individuals experience the lasting adverse effects of past and/or present traumatic events. |
| **Tuituia** | The Tuituia framework is an assessment tool used by Oranga Tamariki and includes recording and reporting tools. It contains a method for filtering information which aims to create a full picture of te tamaiti and whānau circumstances. |
| **United Nations Convention on the Rights of the Child** | Ratified by New Zealand in 1993 and sets out the rights of all children and the responsibilities of the Government to ensure those rights are respected. |
| **United Nations Convention on the Rights of Persons with Disabilities** | Ratified by New Zealand in 2008 and sets out the rights of disabled people to enjoy the same human rights and opportunities as all other citizens. Sometimes referred to as the Disability Convention. To give effect to the Convention and the *'Nothing about us without us'* mantra of the disability community, the Government must ensure disabled people are actively involved in all matters affecting them. |
| **Uplift or removal** | The action of physically taking te tamaiti or tamariki into care. |
| **Wairua** | A person's spirit or soul. |

# Appendix 2. Previously published reports and complaint case notes

These cases can be found on my website (www.ombudsman.parliament.nz) by searching for the case number, or in the case of He Take Kōhukihuki, by searching for the title.

Alternatively, a list of these cases, along with a brief summary, can be found at the link https://www.ombudsman.parliament.nz/resources/children-care-published-outcomes-complaints.

1. Full Report: He Take Kōhukihuki | A Matter of Urgency

The Chief Ombudsman's investigation, published in August 2020, which looked at whether there were any systemic issues connected to policies, procedures and practices of Oranga Tamariki relating to the removal of newborn pēpi under without notice interim custody orders.

2. 566935 Complaint about the actions of Oranga Tamariki in relation to the death of a young child/tamaiti

The Chief Ombudsman's investigation following complaints about Oranga Tamariki from family members.

3. 524040 Cancellation of access between parent and rangatahi due to COVID Alert Level 4 lockdown

A parent had face-to-face access cancelled due to lockdown. Oranga Tamariki applied a blanket rule not required by Health Act notices and failed to consider their individual circumstances. Their access was reinstated and the Chief Ombudsman recommended an apology.

4. 523061 Complaint from a young person in a Care and Protection Residence

The Ombudsman received a complaint from a young person in a Care and Protection Residence. Planning for placement outside the residence and communication to the young person was found to be unreasonable. A placement was found during the investigation and an apology was made to the young person.

5. 522934 Complaint about the reimbursement of costs when attending the Chief Executive's Advisory Panel

A complainant was not informed of the process for reimbursement of costs to attend the Chief Executive's Advisory Panel. The information sheet provided to attendees was updated.

6. 521905 Call to avoid the pending removal of a newborn baby

Pending removal of newborn from hospital by Oranga Tamariki - family now willing and able to care for baby - Inquiries made and Oranga Tamariki able to make alternative arrangements—baby discharged from hospital with family

7. 519817 Full practice review of social work practice after notification of investigation

Parents complained about apparent failure by Oranga Tamariki to protect a vulnerable child. Oranga Tamariki reviewed the matter after notification of the Ombudsman's investigation and began a full case review. The Chief Ombudsman felt this was a satisfactory resolution.

8. 515226 Use of incorrect information, lack of trauma-informed practice, failure to assess children's safety

Oranga Tamariki used incorrect and unverified information about a caregiver, failed to assess the safety of the children, and did not use trauma-informed practice. It had a poor complaints-handling process and its apology to the caregiver was inadequate.

9. 511281 Unreasonable actions throughout dealings with custodial caregiver

A custodial caregiver complained to the Chief Ombudsman about Oranga Tamariki. The complaint concerned Oranga Tamariki removing a child from their care and its actions after reviewing the case. The Chief Ombudsman found Oranga Tamariki had acted unreasonably throughout its dealings with the complainant.

10. 506720 Treatment of disabled mother and uplift of newborn pēpi

A disabled woman and another relative complained to the Ombudsman after Oranga Tamariki uplifted her baby following birth because it believed she was unable to safely parent her child.

11. 407470 Ministry of Social Development's Advisory Panel will make administrative change as a result of complaint

The Ombudsman did not consider that a quorum of two panel members resulted in an unfair hearing of the complainant's complaints. The Ombudsman also found the appointment of the chairperson was not unreasonable. The Ombudsman was critical of the fact that the panel did not appear to consider the complainant's request for consideration of compensation.

12. W49783 Child Youth and Family's decision to remove child from care

Child, Youth and Family Services, now Oranga Tamariki, apologised and reimbursed a couple's legal fees following the Ombudsman's finding that its decision to decline custody of a child was unreasonable.

13. W46447 Request for file from Department of Child, Youth and Family Services

A caregiver's request for a file from Child, Youth and Family Services, now Oranga Tamariki, resulted in repeated undertakings to provide information by specific dates. It failed to supply the information or notify the caregiver it would not meet the timeframe. It acknowledged its error and apologised.

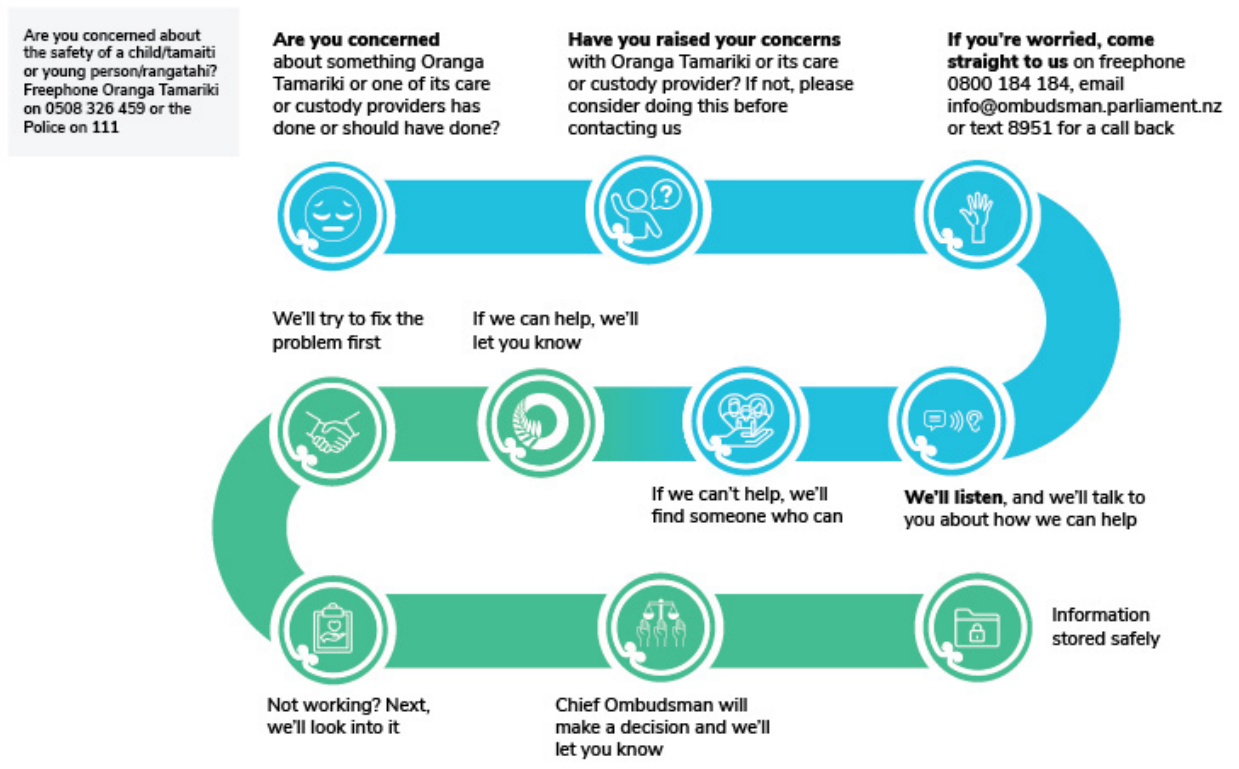
14. W45470 Request for affidavit of CYFS social worker

An Official Information Act request was made to Child, Youth and Family Services, now Oranga Tamariki, for an affidavit given by a social worker to the Family Court.

The request was refused under section 438 of the Children, Young Persons and their Families Act 1989 because it was a court document.

# Appendix 3.
# The complaints process

## The full complaints process for adults




## The complaints process for tamariki and rangatahi

# Appendix 4. Alternative text versions - charts and graphs

## Complaints and enquiries to the Ombudsman about Oranga Tamariki 2016 to 2023

| Year | Total Number of Complaints and Enquiries |
|---|---|
| 2016 to 2017 | 100 |
| 2017 to 2018 | 314 |
| 2018 to 2019 | 291 |
| 2019 to 2020 | 360 |
| 2020 to 2021 | 544 |
| 2021 to 2022 | 477 |
| 2022 to 2023 | 726 |

## Complaints and enquiries to the Ombudsman 1 July 2019 to 30 June 2023 as a proportion of the population

| Region | Total per 100,000 people |
|---|---|
| Northland | 40.7 |
| Auckland | 16.7 |
| Waikato | 22.2 |
| Bay of Plenty | 19.6 |
| Gisborne | 1.9 |
| Hawke's Bay | 14.2 |
| Taranaki | 14.1 |
| Manawatu-Wanganui | 36 |
| Wellington (including Chatham islands) | 25.9 |
| Nelson, Marlborough and Tasman | 30.3 |
| West Coast | 36.7 |
| Canterbury | 24.1 |
| Otago | 17.5 |
| Southland | 50.8 |

## What happened to complaints 1 July 2019 to 30 June 2023

| | |
|---|---|
| **Outside jurisdiction** | **25** |
| **Referred** | **18** |
| Referred to Privacy Commissioner | 16 |
| Referred to Health and Disability Commissioner | 1 |
| Referred to Independent Police Conduct Authority | 1 |
| **Resolved without investigation** | **56** |
| Remedial action to benefit the complainant | 52 |
| Remedial action to improve state sector administration | 1 |
| Provision of advice/explanation that satisfies complainant | 3 |
| **Other remedy available** | **282** |
| Right of appeal available to court or tribunal | 9 |
| Other remedy available – complain to Oranga Tamariki first | 221 |
| Other remedy available – complaint referred to Oranga Tamariki by Ombudsman | 35 |
| Other remedy available – recourse to other agency | 17 |
| **Explanation, advice or assistance given** | **73** |
| **No investigation undertaken** | **182** |
| Withdrawn or no response from complainant | 125 |
| Insufficient personal interest by complainant | 1 |
| Investigation not needed | 56 |
| **Investigation discontinued** | **40** |
| Withdrawn or no response from complainant | 15 |
| Further investigation not needed | 11 |
| Oranga Tamariki to review | 14 |
| **Resolved during investigation** | **30** |
| Remedial action to benefit the complainant | 25 |
| Provision of advice/explanation that satisfies complainant | 5 |
| **Investigation finalised (final opinion formed)** | **117** |
| Administrative deficiency found and recommendations made | 37 |
| Administrative deficiency found but no recommendations made | 24 |
| No administrative deficiency identified | 56 |
| **Other** | **1** |
| **Total** | **824** |

## What happened to enquiries 1 July 2019 to 30 June 2023

| | |
|---|---|
| **No response required, eg: copied into correspondence** | **27** |
| **Person invited to complain to Ombudsman** | **232** |
| **Person advised to complain to Oranga Tamariki first** | **380** |
| **Matter referred to Oranga Tamariki by Ombudsman** | **11** |
| **Person advised to contact another review agency** | **31** |
| Referred to Privacy Commissioner | 21 |
| Referred to Health and Disability Commissioner | 4 |
| Referred to other review agency | 6 |
| **Explanation, advice or assistance provided** | **412** |
| **Resolved** | **4** |
| Remedial action to benefit the person | 3 |
| Remedial action to benefit the person and improve state sector administration | 1 |
| **Withdrawn** | **41** |
| **Matter to be transferred to Ombudsman by other review agency** | **2** |
| **Total** | **1140** |

## Remedies for complainants

| **Remedy for individual person** | |
|---|---|
| Decision changed | 21 |
| Apology | 59 |
| Reasons/explanation given | 39 |
| Financial remedy | 13 |
| Omission rectified | 20 |
| Decision to be reconsidered | 21 |
| **Total** | **173** |

## Remedies to improve the systems and processes of Oranga Tamariki

| **Systemic remedy** | |
|---|---|
| Law/policy/practice/procedure to be reviewed | 10 |
| Provision of guidance or training to staff | 15 |
| Change in practice/procedure | 7 |
| Change in law/policy | 5 |
| Total | 37 |
| Decision to be reconsidered | 21 |
| **Total** | **173** |

Ombudsman

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