ORANGA TAMARIKI
Ministry for Children

New Zealand Government

Report on s78 custody orders for unborn and new-born pēpi

Contents

Background

This report responds to recommendations by the Chief Ombudsman relating to the auditing and public reporting of information regarding Section 78 custody orders for unborn and new-born pēpi.

He Take Kōhukihuki, A Matter of Urgency[1] was released by the Chief Ombudsman in August 2020. It set out the findings and recommendations from his review of Oranga Tamariki policies and procedures relating to the placement of unborn and new-born pēpi into Oranga Tamariki custody (between 1 July 2017 and 30 June 2019).

The report had a number of recommendations, including that Oranga Tamariki:

- establish timeframes and reporting frameworks, quality assurance and monitoring to demonstrate ongoing compliance with all statutory requirements related to without notice removals of new-born pēpi (recommendation 1.e)
- report publicly against the monitoring framework (outlined above) every six months (recommendation 1.f)
- regularly audit case files to ensure compliance with policy and practice guidance (recommendation 2.o.) ("case file analysis").

Using the recommendations of *He Take Kōhukihuki* and the Hawke's Bay Practice Review[2], Oranga Tamariki developed a structured set of questions to investigate:

- compliance with policy and guidance
- the broader practice around s78 applications to provide a more comprehensive understanding of our practice and early intervention with pēpi, and support identification of strengths and improvements needed.

This report provides details on the results of this case-file analysis.

[1] Chief Ombudsman (2020) He Take Kōhukihuki | A Matter of Urgency | Ombudsman New Zealand
[2] Oranga Tamariki (2019) *Professional Practice Group Practice Review into the Hastings Case* Hawkes-Bay-Practice-Review.pdf (orangatamariki.govt.nz)

Setting the scene

This section provides summary data on Oranga Tamariki engagement with whānau with unborn or new-born pēpi.

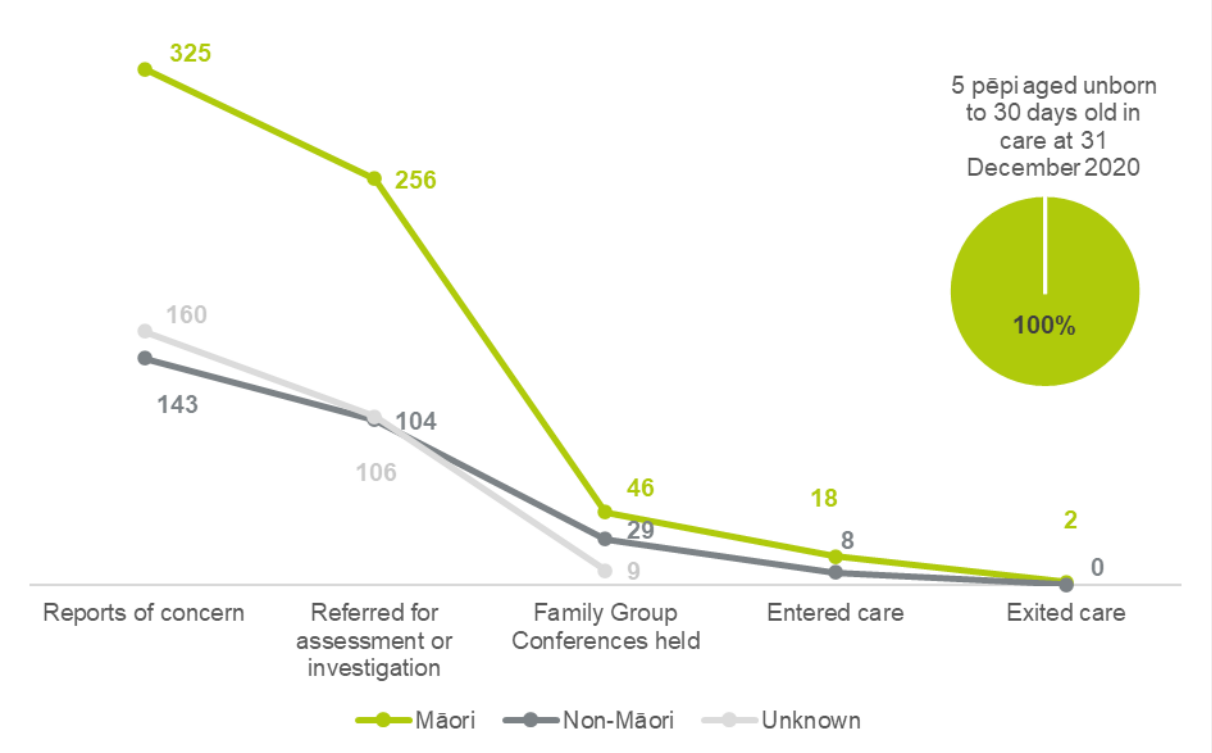
There are several different warrants and legal orders under the Oranga Tamariki Act 1989 (the Act) which can be used to place pēpi into the custody of Oranga Tamariki. The focus of the Ombudsman's report and this case file review is s78 care entries.

Section 78 of the Act allows for the Court to place a tamaiti in the interim care of Oranga Tamariki when there are immediate concerns for their safety and wellbeing. These custody orders can be applied for in two ways:

1. with notice where the application is served on the parent(s) before it is granted by the Court, and
2. without notice where parent(s) are not informed of the application before it is granted by the Court.

Oranga Tamariki engagement with whānau in relation to safety concerns for pēpi spans the initial receipt of a report of concern, subsequent engagement with whānau in those cases that warrant further assessment, and, for a small number of cases, application to the Family Court for a custody order. Figure One below provides data on the total number of unborn or new-born pēpi up to 30 days old who Oranga Tamariki was engaged with over the period that is covered by this review.

Figure 1: Number of unborn to 30-day old pēpi, by interaction type with Oranga Tamariki (1 September 2020 to 31 December 2020)



It shows that over these four months:

- safety concerns about 628 unborn and new-born pēpi were reported to Oranga Tamariki and 466 pēpi were referred for assessment
- for 84 new-born and unborn pēpi, care and protection concerns resulted in Oranga Tamariki convening a Family Group Conference with whānau
- for 26 pēpi, safety concerns resulted in them being placed into the custody of Oranga Tamariki.

Figure Two below shows the total number of s78 custody orders issued for unborn and new-born pēpi over the review period, for both Māori and non-Māori, and whether they were issued on a with or a without notice basis.

Figure 2: S78 interim custody orders issued for unborn to 30-day old pēpi by filing method (1 September to 31 December 2020)

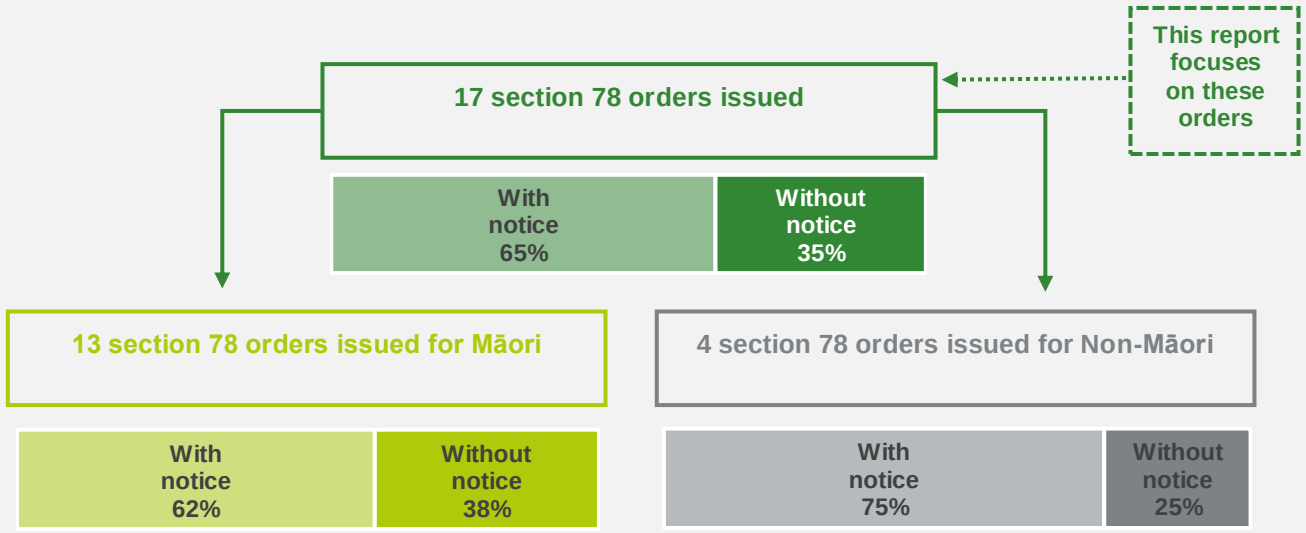
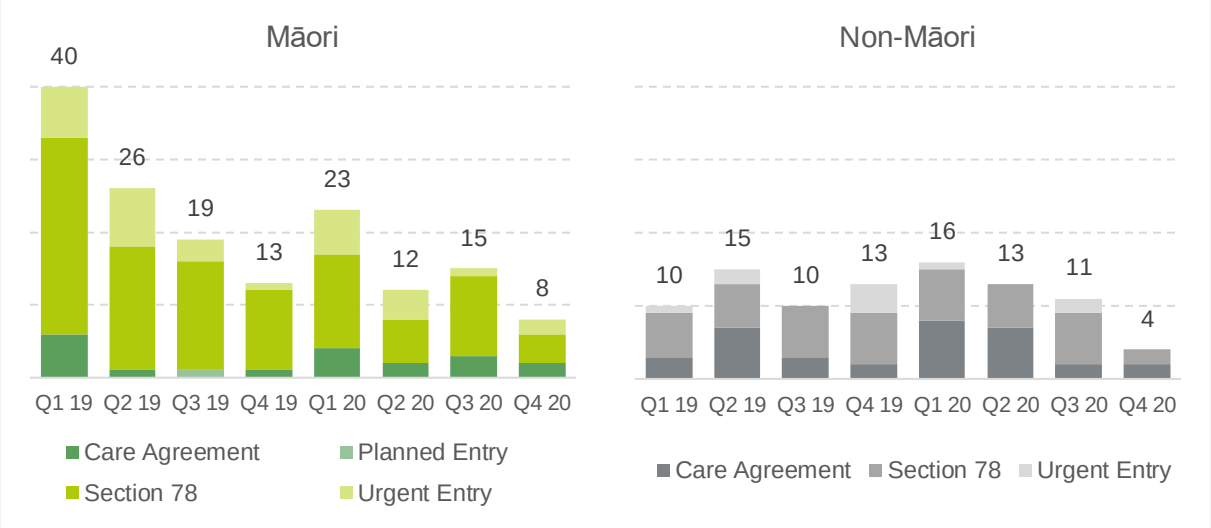


Figure Three provides information on changing patterns of care entry for pēpi over the last two years, specifically the total number of care entries for pēpi, by the type of custody order, for both Māori and non-Māori. This includes s78 orders, temporary custody entries that are agreed between parents and Oranga Tamariki (s139 and s140) and urgent place of safety warrants (s39).

Figure 3: Entries to care for unborn to 30-day old pēpi, by ethnicity of pēpi and entry type (1 January 2019 to 31 December 2020)



The figure shows that:

- the total number of custody orders issued for pēpi each quarter has reduced by over three quarters (from 50 over Jan - March 2019 to 12 over Oct – Dec 2020)
- the reduction in care entries is apparent across all custody orders
- reductions in custody orders have been most pronounced for pēpi Māori. Pēpi Māori continue, however, to be disproportionately represented.

This reduction in care orders for pēpi mirrors, but is more pronounced than, reductions in care entries across all age groups since 2017. Further information on this can be found here Entries into Care.

Case-file analysis

Overview

The population of interest is all unborn pēpi and pēpi up to 30 days old placed in Oranga Tamariki custody under s78 with and without notice orders between 1 September and 31 December 2020 (17 cases in total).

The review period for each case was from the initial report of concern until four weeks after the s78 order was granted.

The initial case file analysis was a desk-based exercise focussed solely on information recorded in the record for the pēpi in the main Oranga Tamariki case management system, CYRAS. Questions focussed on those areas of practice that are required to be clearly documented.

As legislative, policy and practice requirements continue to evolve, particularly in those areas where the Ombudsman identified gaps (mainly disabilities, supporting breastfeeding and recording requirements relating to the circumstances in which any pēpi are removed), we will adjust review questions to ensure they remain aligned with practice expectations.

At the end of the case file analysis, further investigation was undertaken to gather additional information about casework in those cases where key pieces of information were missing from the record for pēpi on CYRAS.

The case file analysis reviewed two key phases of work:

1. Practice prior to the decision to apply for custody of pēpi focussing on:
    - the early work with whānau to seek solutions and provide supports prior to the decision to apply for custody of pēpi
    - the decision-making process to apply for custody of pēpi and identifying whānau caregivers.
2. Practice following pēpi being placed in our custody focussing on:
    - the process of removing pēpi, where removal was required
    - the work occurring immediately following pēpi being placed in custody.

Profile of the s78 cases

As set out earlier, a total of 17 s78 orders for unborn and new-born pēpi were granted over the review period and were included in this review.

Eleven s78 orders (65%) were with notice and six (35%) were without notice.

Of the 17 cases reviewed, 12 pēpi were Māori (70%), one Māori and Pacific (6%), one Pacific (6%) and three New Zealand European/other (18%).

Thirteen (76%) of the 17 reviewed cases had extensive prior involvement with Oranga Tamariki (other tamariki of parents previously or currently in care), three (18%) had significant prior involvement (multiple non-care interventions) and one (6%) had moderate prior involvement (multiple assessments but no interventions).

No pēpi were identified as within the provisions of s18B Oranga Tamariki Act 1989[3] (the 'subsequent children' provisions) on CYRAS.

The cases reviewed were all complex and high risk. Most often the initial concerns raised reflected the same issues that had led to safety planning and interventions to address care and protection needs for the older children within the family.

The most common risks identified in the applications for a s78 order were the presence of family harm (13 of 17 cases (76%)), and substance abuse (10 of 17 cases, (59%)). In no cases were historical concerns the sole basis upon which Oranga Tamariki sought a s78 order.

Reviewers also reported that transience and unstable housing were a feature in several cases.

In all cases reviewed, the mother of pēpi was pregnant at the time the report of concern was made. Three reports of concern (18%) were received in the first trimester, eight in the second trimester (47%) and six in the third trimester (35%).

Findings

This section of the report sets out:

- Core policy and practice requirements for Oranga Tamariki practitioners, from receipt of the first report of concern for pēpi through to the initial weeks after pēpi was placed in our custody.

- Our findings in relation to core policy and practice requirements and any evidence on if and how practice has changed since the Ombudsman's Office undertook its review.

- Summary of further actions underway to continue to strengthen practice.

Initial assessment

In this section we investigate whether initial concerns about the safety of the pēpi were responded to in a timely way.

What is required?

Once a report of concern has been received by Oranga Tamariki, social workers are required to complete an initial Safety and Risk Screen. This identifies whether the safety and wellbeing concerns are such that they require further assessment or investigation to determine if immediate action is required.

The timeframe this screen must be completed within (the 'criticality response timeframe') is determined when the report of concern is first made. During the period under review in this report, options were < 24 hours, < 48 hours, < 7 days, < 10 days, or < 20 working days.

[3] The subsequent child provisions (sections 18A to 18D) of the Oranga Tamariki Act 1989 outline what Oranga Tamariki must do when working with a child whose parent who has been convicted of the murder, manslaughter or infanticide of a child or young person who was in their care at the time of their death or has had a tamaiti permanently removed from their care with no realistic prospect of return home due to abuse or neglect in the past.

The screen is completed once a social worker has engaged with the tamariki, their whānau and professionals/others who know them. This helps to ensure that engagement builds from a basis of openness and trust and information on the current circumstances for the whānau.

If it is not possible to complete the initial Safety and Risk Screen within timeframes, the reason why, as well as what efforts were made to do so, should be recorded in the case management system, CYRAS, through an exception case note. There are a number of reasons for such an exception, including because the whānau cannot be located, the whānau are resistant to engaging in the assessment process, or the Police are already investigating the situation and engagement may put the tamariki at risk.

What happened over the review period and how has practice changed since the Ombudsman's review?

In 12 of the 17 cases reviewed (70%), the initial Safety and Risk Screen was completed within the assigned timeframe.

Of the five cases when it was not completed within the timeframe, three were due to difficulties in engaging with parents and whānau and the remaining two were unclear from recording. This finding is comparable with results from the Ombudsman's investigation which found that the timeframe for completing the Safety and Risk Screen was met in 78% of cases reviewed.

In six of the 12 cases that were completed within the timeframe, there was no recorded engagement about the report of concern with parents or whānau before the initial screen was completed. Subsequent follow up with sites in relation to these cases shows that in two of the six cases, Oranga Tamariki was already engaged with the parents and whānau as they had other children in custody, but this was not evident in the record for pēpi. In the remaining cases there was a lack of understanding of the purpose of the initial Safety and Risk Screen and when to use it.

Delays in engagement with whānau are often caused by the length of time it can take to allocate a social worker after a report of concern has been received. It is also clear that working with whānau in these circumstances is a complex area of practice. Successful engagement requires sustained effort which takes account of the context for whānau, their circumstances, any previous experiences of state intervention in their lives and the difficulties in addressing the complex concerns that are raised.

Further strengthening practice

Oranga Tamariki has introduced new policy requirements around assessment designed to ensure the most appropriate response times to individual circumstances. This includes a strengthened focus on early engagement with whānau. The impact of this policy change will be considered in our next review of s78 care entries for pēpi and we will consider whether further changes are required in light of those findings.

As a result of this review exercise, we have also identified the need to clarify and strengthen our guidance around the use of exemption case notes and better understanding of the purpose of the safety and risk screen and when to complete this.

In all six cases where there is no record of whānau engagement as part of the safety and risk screen for pēpi, discussions have been held with relevant practitioners around policy requirements, including those relating to recording.

Mechanisms to support whānau-led decision-making

In this section we consider the use of hui-a-whānau and Family Group Conferences.

What is required?

Where the initial Safety and Risk Screen identifies there are safety and wellbeing concerns that need to be more fully understood, social workers are required to undertake a further assessment or investigation, depending on the nature of the concerns.

Practice guidance underlines the importance of early whānau engagement through hui-a-whānau as part of this next phase of work to ensure whānau strengths are understood and can be drawn on to create safety for pēpi.

Where a social worker believes, after having completed a core assessment, that pēpi needs care or protection[4], they are required to make a referral to a care and protection coordinator for a Family Group Conference (FGC).[5]

A FGC is a formal meeting where Oranga Tamariki, whānau and other professionals providing support work together to develop a plan to ensure pēpi is safe and well cared for. Safety planning[6] is used by social workers to create a network of protection around the child and their whānau and is required prior to holding a FGC.

Applications for custody can be made prior to an FGC if safety for pēpi cannot be secured in the interim.

What happened over the review period and how has practice changed since the Ombudsman's review?

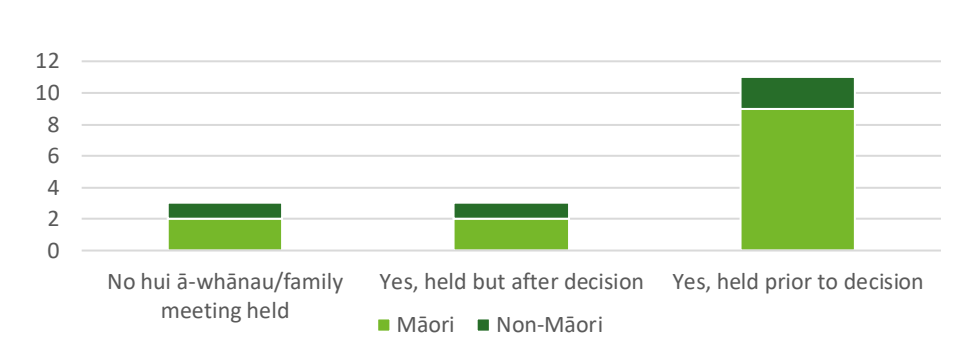
A hui ā-whānau or family meeting was held prior to the application for a s78 order in 14 of the 17 cases (82%). 11 of those 14 were held prior to a social worker forming a belief in their core assessment about whether pēpi needed care and protection.

In three cases (18%), reviewers found no evidence of a hui ā-whānau or family meeting having been held. However, in one of these cases a FGC was held within six weeks of the report of concern being received. In the remaining two cases there were difficulties in engaging parents and whānau before the birth of pēpi and within the timeframe for this review.

Of the 13 cases of pēpi Māori, 11 (83%) had a hui ā-whānau or family meeting in the review period. Nine of these were held prior to a decision about whether pēpi needed care and protection during assessment.

[4] as defined by s14(1) of the Oranga Tamariki Act 1989.
[5] under s18(1) of the Oranga Tamariki Act 1989.
[6] Oranga Tamariki Practice Centre - Safety planning https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/building-safety-around-children-and-young-people/

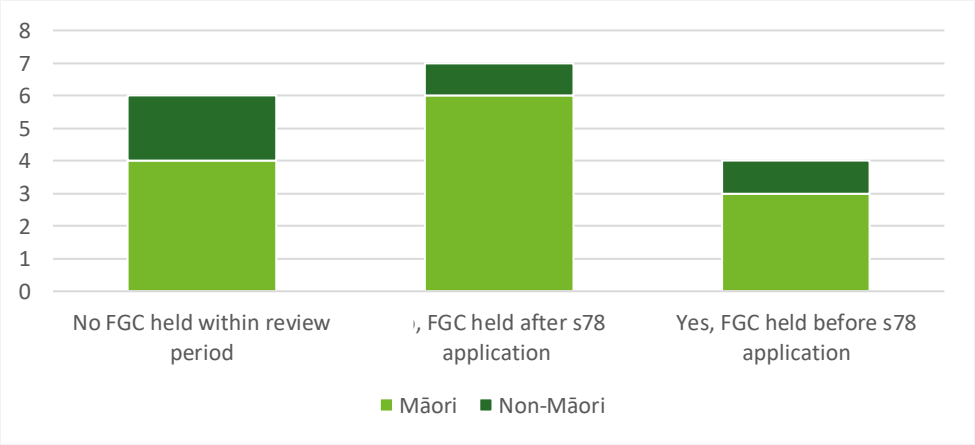
Figure 4: Hui ā-whānau or family meeting held prior to making a decision during assessment



On the basis of these results, engagement with whānau prior to making a s78 custody order through the use of hui-a-whānau has strengthened. Specifically, over the period covered by this review, hui-a-whānau were held in over 80% of cases prior to the application, compared with less than 25% of cases over the 1 July 2017 to 30 June 2019 period that was the subject of the Ombudsman's review.

A FGC was held prior to the application for a s78 order in four cases (24%) and held after the application in seven cases (41%). In six cases (35%), there was no record of a FGC being held within the review period.

Figure 5: Family Group Conference held prior to the application for the s78 order



These results are similar to the findings by the Ombudsman.

Of the 13 cases in which a FGC was not held prior to the application for the s78 order, nine cases recorded reasons for this including:

- awaiting confirmation of paternity
- pēpi being delivered early
- delays in obtaining a litigation guardian where the parent had a cognitive disability

- risks to pēpi in delaying the s78 order (often where the report of concern was received late in the pregnancy) and
- being unable to contact or engage with parents or whānau.

Subsequent investigation into the four remaining cases in which a reason was not recorded identified similar reasons for why a FGC was not held. These factors should have been evidenced clearly on the record for pēpi.

Further strengthening practice

Oranga Tamariki is continuing to expand the number of Kairaranga-a-whānau across the country[7]. Kairaranga-a-whānau play an important role in supporting early engagement with whānau Māori, facilitating hui-a-whānau and enabling more whānau participation in our decision-making process.

In 2020, 13 new FGC Team Leaders were appointed in response to the recommendations in the Hawke's Bay Practice Review. These Team Leaders are now provided with weekly data on FGC timeliness, and they work with their FGC Co-ordinators to manage workflow and improve responsiveness to whānau. National training was undertaken with FGC Team Leaders in July 2021 and that included a focus on timeliness.

Information on FGC timeliness is also provided on a monthly basis to Regional Managers to support their leadership of this area of work.

Mechanisms to support whānau care

In this section we investigate how Oranga Tamariki worked with whānau to enable parents to retain care of their pēpi or to support whānau to care for the pēpi where the parents were not a safe care option

What is required?

When social workers identify issues that could impact on the safe care of tamariki, their first priority is to determine how te tamaiti can be kept safe within the care of their parents and within the wider network of protection provided by extended family or whānau, hapū and iwi networks.

'Safety planning' is used by social workers to support whānau to create a network of protection around the child.[8] Effective safety planning can prevent the need for tamariki to come into care, even when it is recognised that safety concerns exist, because it provides a means to build a safe environment for te tamaiti.

Practitioners outside of Oranga Tamariki can assist in helping whānau to create safety for te tamaiti. They are often better positioned to engage and build meaningful relationships with whānau who access these services by choice. Māori NGOs often bring different and valuable perspectives, grounded in a restorative approach, and underpinned by a Māori-principled worldview. They may also make use of cultural practices that are familiar and safe for whānau Māori. As a result, whānau may be more likely to be open about their aspirations, challenges, and successes with these

[7] practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairaranga-a-whanau/

[8] Oranga Tamariki Practice Centre - Safety planning https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/building-safety-around-children-and-young-people/

practitioners. When these insights are available, Oranga Tamariki social workers can gain a richer view of how whānau are progressing and it can often help inform consideration of if and how the safe care of tamariki can be achieved.

There are occasions where, based on a comprehensive assessment, the safety of te tamaiti can only be maintained by moving them to a safer care environment. Where it is determined that custody orders are required, social workers must ensure that they are taking every opportunity to enable te tamaiti to be cared for within their family or whānau, hapū or iwi. They must also have regard to the principles within the Oranga Tamariki Act 1989 which emphasise stability and sibling relationships. Custody orders can form part of the safety plan and can be used to support family or whānau, hapū or iwi to create safety and stability for pēpi while further assessment and support is undertaken with parents.

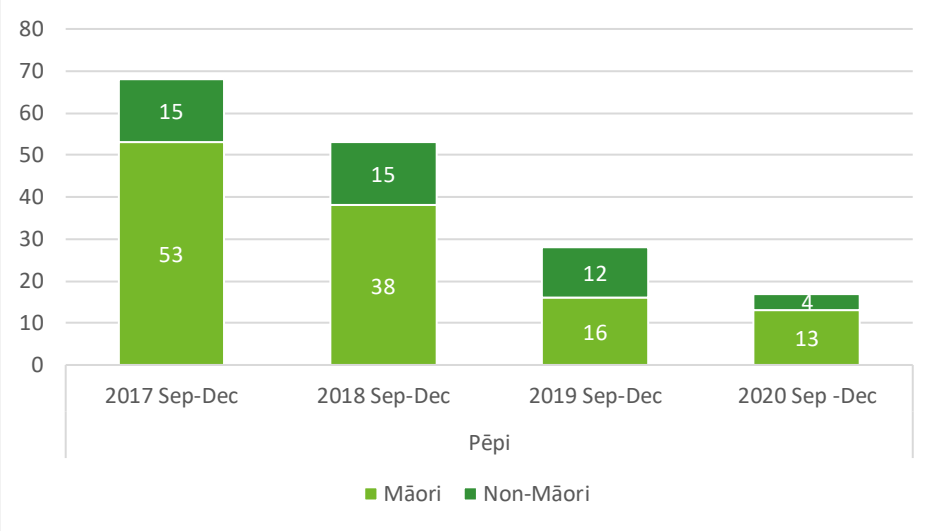
In practice social workers achieve this by undertaking whānau searching,[9] working with specialists such as kairaranga-a-whānau[10] to complete whakapapa searching[11] and making substantial use of whānau hui as a mechanism for sharing concerns and developing plans which keep tamariki safe. It also means holding FGCs at the earliest opportunity to facilitate plans to support whānau to care for tamariki and meet their needs.[12]

What happened over the review period and how has practice changed since the Ombudsman's review?

As set out earlier, most of the situations in which we are working with whānau where there are care and protection concerns do not result in pēpi coming into the custody of Oranga Tamariki. Additionally, Figure 6 below shows that the number of situations in which a s78 custody order was sought in order to achieve safety has reduced since 2017.

[9] Oranga Tamariki Practice Centre - whānau searching https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/whanau-searching/
[10] Oranga Tamariki Practice Centre - kairaranga-a-whānau https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/kairaranga-a-whanau/
[11] Oranga Tamariki Practice Centre - Whakapapa research https://practice.orangatamariki.govt.nz/our-work/working-with-maori/how-to-work-effectively-with-maori/practice-for-working-effectively-with-maori/whakapapa-research/
[12] Oranga Tamariki Practice Centre – FGC Standards https://practice.orangatamariki.govt.nz/policy/family-group-conferencing-practice-standards/

Figure 6: Total number of s78s for unborn and new-born pēpi, Sep – Dec, 2017 - 2020



In all 17 s78 cases reviewed, a safety plan was developed to establish safety for pēpi. Whānau were involved in safety planning in 12 cases (70%). In most cases, formal safety planning occurred in the intervention phase as part of the birth plan, though there was also evidence in a number of these cases that social workers were undertaking early work about how to create safety with parent(s) and whānau.

In 10 of the 17 cases reviewed (59%), there was evidence that whānau were engaged with cultural supports from both within and outside of Oranga Tamariki. Of the 13 cases of pēpi Māori, cultural supports were provided in nine cases (69%). Of those nine cases, six were engaged with a Kaupapa Māori Service, four had support from a kairaranga ā-whānau or the site rōpū, and one had cultural support from the hospital.

Whānau searching had occurred in all 17 cases reviewed where pēpi was placed in our custody under a s78 order.

In 14 of these cases (82%), initial plans for care arrangements were to support parent(s) and whānau to care for pēpi. In the remaining three cases (18%), an early decision was made that pēpi would not be cared for by parents or whānau. In two of these cases, social workers faced challenges in identifying whānau and in the remaining case, the mother of pēpi decided that she wished to formally adopt pēpi out.

At the time the s78 order was made, nine out of 17 pēpi (53%) remained in the care of parent(s) and/or whānau.

In the remaining eight cases (five of which were pēpi Māori), pēpi was initially placed with non-kin caregivers. In two of these cases, the caregivers were already caring for the siblings of pēpi, and it was agreed with parent(s) and whānau that pēpi would also be placed with them.

Since the completion of this review, three of these eight pēpi have subsequently transitioned into care placements with whānau or iwi. Two of these pēpi are Māori. A total of 12 pēpi (70%) are now with whānau, hapū or iwi and five pēpi remain in non-whānau care.

Further strengthening practice

The Whānau Care kaupapa is part of how Oranga Tamariki is changing its approach to find and support whānau caregivers for tamariki Māori. This is to ensure tamariki Māori in care are connected through their whakapapa by well-supported caregivers who are their whānau, hapū and/or iwi. The Whānau Care team supports iwi and kaupapa Māori partners to determine their own care models and delivery approaches. The Whānau Care team is working closely with sites in the parts of the country where we currently have partnerships.

In collaboration with the Whānau Ora Commissioning Agency, Te Puni Kōkiri, and the Accident Compensation Corporation (ACC), Oranga Tamariki has developed a whānau-centred early support prototype, Ngā Tini Whetū. This programme is designed to strengthen and build whānau resilience and improve the safety and wellbeing of tamariki, through partnering with Māori.

Oranga Tamariki is also working with the Child Wellbeing Unit, Department of the Prime Minister and Cabinet, and Te Puni Kōkiri to develop sustainable and locally led approaches to early support services for whānau, as part of the next stage of work under the Child and Youth Wellbeing Strategy.

Guidance in strengthening our response to unborn and new-born pēpi has been updated. It strongly emphasises a rights-based approach to whānau, hapū, iwi and family groups being supported to care for pēpi so that any intervention is the minimum necessary to ensure safety and protection of pēpi. The mother's vulnerability and parents' own potential trauma histories are emphasised for consideration in our assessment and support needs offered.

Further investigation to better understand practice around early plans, whānau searching and support for whānau to create safety will be included in the next case file review of s78 for unborn and new-born pēpi.

Supporting parents with disabilities

In this section we investigate support and advocacy for parents with disabilities where there were concerns for the safety of pēpi

What is required?

The United Nations Convention on the Rights of Persons with Disabilities is clear that no tamaiti should be separated from parents based on a disability of one or both parents. Parents with a disability should also be provided with advocacy support as well as support to discharge their parental responsibilities.

The Ombudsman's report identified Oranga Tamariki had a lack of adequate practice guidance and policy to support parents with disabilities and needed to work in partnership with the disability sector to take a disability rights lens to develop new guidance.

What happened over the review period and how has practice changed since the Ombudsman's review?

In four of the cases reviewed (24%), the report of concern or assessment identified parenting needs associated with the cognitive functioning of the mother of pēpi. In all of these cases, there were additional care and protection concerns and cognitive

disability was not the sole reason for the s78 application. The additional care and protection concerns included family violence, substance abuse, neglect, sexual harm, and mental health concerns.

In all four cases, advocacy support was requested to support the mother of pēpi to understand and make decisions. However, there was no evidence regarding engaging the mothers of pēpi with disability supports to support parenting needs.

Further strengthening practice

As part of work to embed its new Practice Framework, Oranga Tamariki has engaged with disabled people's organisations, VOYCE Whakarongo Mai and its own practice expert Advisory Group about ensuring disability-aware, inclusive and rights-based practice is undertaken. This work is continuing.

New guidance on our response to unborn and new-born pēpi includes content on:

- the rights of disabled parents and pēpi to an ordinary family life and to create and maintain families.
- the need for assessments and plans to consider the parents' strengths and how these can be developed in their parenting role, and how their disability needs are being met or could be met.
- the need to work with disability, mental health, and addiction services to share appropriate information and develop joint plans that address the safety needs of both pēpi and the parents.
- when parents are not engaged with specialist services, and we believe that a referral is required, the need to talk to the lead maternity carer and agree next steps with the consent of the parents.

The expected timeframe for the completion of this guidance is August 2021.

We are also updating existing Fetal Alcohol Spectrum Disorder (FASD) guidance to reflect 'Fetal Alcohol Spectrum Disorder: Essential Skills' – this is an external resource for frontline practitioners and was developed in collaboration with people with FASD, whānau and professionals. The revised guidance will include content on helping to prevent FASD, supporting pregnant woman and mothers who are drinking, and engaging with addiction services. The expected completion timeframe is November 2021.

Work is also underway to consider potential advocacy improvements for all parents, including parents with disabilities, and a disability work programme is under development that will include a specific workstream around identifying improvements to support for parents. Wider work across government to transform the health and disability sector is also key to improving access to support for parents with disabilities.

Mechanisms to ensure appropriate decision-making by Oranga Tamariki practitioners

In this section we investigate the nature of the consultation and decision-making between practitioners within Oranga Tamariki, professionals from other agencies, and other partners

Social workers are required to exercise their individual professional judgement, obligations, and ethics in the context of a legislative and organisational framework designed to help ensure the appropriate exercise of Oranga Tamariki powers and duties through the promotion of collaborative and consultative decision making.

The Child and Family Consult

The Child and Family Consult process supports social workers to identify and consider indicators of danger and harm alongside indicators of safety and strengths. It supports decision-making at any point in the social work assessment, planning, intervention, and review process. The consult must be used during the assessment or investigation phase to inform the analysis and next steps.

Supervision

Effective supervision is a critical part of ensuring good outcomes for tamariki and whānau. It is also integral to ensuring safe social work practice and helping practitioners reflect on practice and decision making and develop skills.

Supervision has a range of functions and can occur in a range of ways. One of the functions of supervision is case specific discussions. These can occur during a structured professional supervision session as well as during more informal supervision such as real time case consultation with a supervisor, practice leader or peer.

Oranga Tamariki policy stipulates how often an individual practitioner must receive *professional supervision*. There are no specific requirements around the frequency of informal supervision that is directly case-related, and this typically happens on a day-to-day basis depending on the circumstances of the case or the needs of the staff involved. Supervision that involves case-related decisions needs to be recorded on CYRAS.

Care and Protection Resource Panels

Care and Protection Resource Panels (CPRP) are statutory bodies under the Oranga Tamariki Act 1989. Legislation provides for the establishment of these panels to provide external advice and guidance to social workers undertaking their responsibilities under the Act. When these panels effectively represent local communities (particularly local iwi/Māori) and the broader child wellbeing sector, they can provide a useful professional challenge to social workers' thinking and open alternative strategies and solutions to address tamariki safety.

Social workers are required to consult with the CPRP as soon as possible after having commenced an investigation.[13] FGC co-ordinators are also required to consult with the panel when they have received a referral for an FGC and if there is a non-agreement at an FGC.

Working in partnership

Social workers need to build effective and collaborative relationships with other professionals and recognise the unique contribution that they make to maintaining the safety of tamariki. By sharing information with them, seeking their professional judgement in assessment and decision-making, and working with them to involve

[13] Oranga Tamariki Practice Centre – CPRP https://practice.orangatamariki.govt.nz/previous-practice-centre/policy/assessment-and-decision-making/key-information/working-with-the-care-and-protection-resource-panel/

whānau in decision-making processes, the quality of social work assessments and plans are strengthened.

Oversight of without notice custody applications

In instances where fast and decisive action is required to ensure the immediate safety of a child, social workers may seek an interim custody order on a without notice basis. This involves the Family Court making an interim custody decision without representation from the child's parent(s) or guardians and prior to the appointment of the child's own counsel.

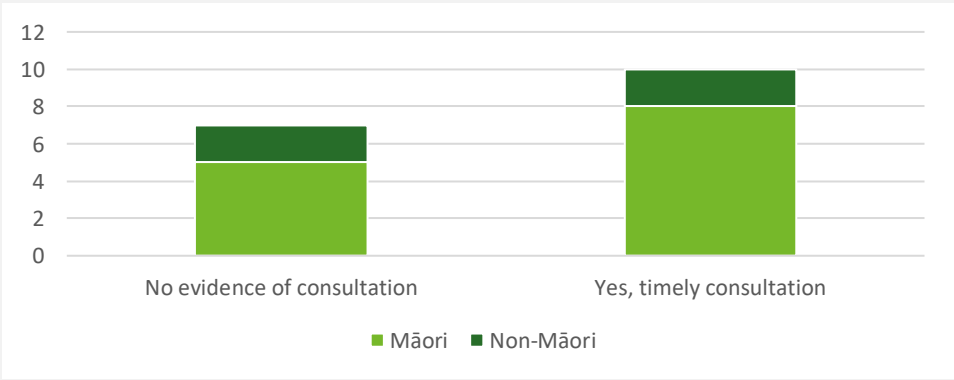
There is a high bar for applying for orders on this basis because of the principles in legislation that prioritise whānau, hapū, iwi and family group participation in decision-making. Following the Hawke's Bay Practice Review, which involved the use of a without notice custody order, Oranga Tamariki policy was amended to require that all s78 without notice applications be approved by the Site Manager, and the decision endorsed by the Site's Practice Leader and the Regional Litigation Manager, before they can be filed.

What happened over the review period and how has practice changed since the Ombudsman's review?

In 15 of the cases reviewed (88%), there was a Child and Family Consult prior to the s78 application. There was no evidence of a consult in two cases (12%). Practice has strengthened in this area, with the Ombudsman finding no evidence of a consult occurring in 30% of cases between 1 July 2017 and 30 June 2019.

In 10 of the 17 cases reviewed (59%), reviewers found evidence that the site's CPRP had been consulted during the assessment phase. In seven cases (41%), there was no evidence of consultation. In the review by the Ombudsman, there was no evidence of consultation with the Panel in 20% of cases, suggesting ongoing issues with the operation of these Panels.

Figure 7: Consultation with Care and Protection Resource Panel by social worker



Of the 17 cases reviewed, there was evidence of adequate case supervision between the social worker and the supervisor in the assessment phase in four cases (24%). There was inadequate evidence in CYRAS of case supervision in 13 cases (76%). It is important to note that we were not able to review whether these social workers were receiving professional supervision over this period, as this form of supervision is not recorded in CYRAS but in other records.

In all cases reviewed, other professionals were consulted with to inform the assessment. Most consultations were with a midwife or other maternity professionals (consulted in 15 cases (88%), followed by kaupapa Māori Services and Police (consulted in seven cases (41%) each).

In terms of the extent to which whānau had the opportunity to be heard in the Family Court, 11 of the 17 s78 applications (65%) were made on a with notice basis and six (35%) were made on a without notice basis.

There has been a significant practice shift in the use of without notice s78 applications for pēpi: over the period reviewed by the Ombudsman, almost all s78 orders were sought on a without notice basis.

In all six cases of without notice s78 applications, approval had been granted by the Site Manager and endorsed by the Practice Leader and Regional Litigation Manager.

Further strengthening practice

Regional Managers have identified supervision as one of the key focus areas for the coming financial year.

As part of the Practice Programme, the Professional Practice Group (PPG) has undertaken a survey of all Oranga Tamariki practitioners (including supervisors and supervisees) to understand the extent to which:

- practitioners are getting the supervisory support they need,
- the quality of that support and
- what is getting in the way of quality supervision.

These findings are being used to inform a plan to trial a new model of supervision.

In recognition of the need to shift supervision practice, 2021 delivery of the Supervisor Development programme shifted focus to ensure supervisors are receiving training in bicultural supervision. Working in partnership with Te Wānanga o Aotearoa, Oranga Tamariki has begun piloting the Kaitiakitanga Bicultural Supervision Post Graduate Diploma.

Alongside key stakeholders, Oranga Tamariki is updating guidance regarding Care and Protection Resource Panels to align with the Oranga Tamariki practice direction and wider legislative context.

Support for parents and whānau through the removal process, where removal is required

Is this section we review joint planning with others to support the removal process and support for parents and whānau through the removal

What is required?

In some instances where a s78 order has been granted, the parents retain the day-to-day care of pēpi or they support their whānau or other carers having the day-to-day care of pēpi until longer-term solutions are found.

In other circumstances, executing the order requires pēpi to be physically removed from the parents. This requires a planned approach that clearly identifies risks and ensures that all professionals involved understand their role. Practitioners must

effectively prepare and support parent(s) and whānau to minimise the impact of trauma on them – for example, by having time with pēpi and whānau before pēpi is removed.

What happened over the review period and how has practice changed since the Ombudsman's review?

Of the 17 s78 orders, pēpi was physically removed (uplifted) from parent(s)' care in seven cases. Reviewers defined 'uplifted' to be the situations where parent(s) did not retain the day-to-day care of the pēpi and did not accept that pēpi needed to be cared for by another caregiver.

In six of these seven cases (86%), reviewers found evidence of a plan established in advance for that process. In one case, there was no evidence of a plan on CYRAS. Of the six cases in which a plan was established in advance, the plan had been made by Oranga Tamariki with whānau and other professionals in two cases, and with other professionals only in the remaining four.

A review of information in CYRAS and subsequent engagement with sites around the circumstances in which the removal occurred, found that in six of these seven cases, parent(s) had been provided with dedicated time with pēpi and whānau before pēpi was removed from their care. The other case was highly complex and was led by the Police Negotiations team.

Further strengthening practice

We are refining our audit process for the next case file review to investigate in more depth how practitioners are using s78 orders to create safety in those cases where parent(s) retain the day-to-day care of pēpi.

New guidance has been developed that underlines the importance of ensuring parent(s) and whānau have special time with the pēpi where pēpi is going to be removed from their care and the importance of recording these events in the record for the pēpi. We are also reviewing our recording policy to ensure it is clear that the circumstances surrounding the removal of the pēpi are case noted on CYRAS.

The three regions of Tamaki Makaurau have entered a regional agreement with the Auckland DHB to support mothers who need to have pēpi removed from their care. This involves a planned time of up to two weeks for mothers to have time with pēpi in hospital preparing for the removal of pēpi. In addition, the Lower South Region are leading out some practice focus on supporting and involving mothers and whānau when pēpi need to be removed. They are actively involving whānau in these processes and, where possible and appropriate, encouraging whānau to travel with pēpi to meet caregivers.

Support for parents and whānau after the s78 order was made

What is required?

Practice guidance at the time of review recommended that any considerations about feeding need to be discussed with the mother and anyone else who has guardianship. All efforts should be made to ensure breastfeeding can happen if this is the mother's wish and is safe for pēpi.

Supports for parent/s and whānau, including to maintain and strengthen connections with their pēpi, are important considerations and should be identified throughout assessment, discussed as part of planning, and formalised within the FGC or Family Court plan.

What happened over the review period and how has practice changed since the Ombudsman's review?

Of the 13 cases where pēpi did not stay in the care of their parent(s), the mother of pēpi did not intend to breastfeed in five cases (38%) and the mother's intentions around breastfeeding were unclear from recording in four cases (31%).

In the remaining four cases (31%), the mother intended to breastfeed her pēpi.

In all four of those cases where the mother intended to breastfeed her pēpi, reviewers found evidence that supports were provided to the mother to assist her to breastfeed. These included maternity staff supporting the mother to breastfeed while in hospital, provision of a breast pump and transport of breast milk, and discussions with her about expressing frequency and hygiene.

Reviewers found an inconsistent approach to supporting breastfeeding where there was known or suspected substance abuse by the mother of pēpi.

In four of the 13 cases (31%) where pēpi was separated from their parent(s), reviewers found evidence of support(s) offered to parent(s) and whānau to help them to deal with the separation from pēpi. These supports included counselling and mental health support. In a further two cases, there was evidence of consideration of the support needs of parent(s) and whānau, but reviewers could not find evidence in recording of supports having been provided.

Further strengthening practice

Breastfeeding guidance has recently been updated to help address the inconsistent approach identified in this review. The guidance is rights-based and emphasises the importance of the concept of ūkaipō which refers to the physical, spiritual and emotional nurturing of pēpi. Further investigation to better understand practice alignment with the new guidance will be included in the next case file review of s78 for unborn and new-born pēpi.

As set out earlier, when Cabinet agreed to make changes to the subsequent children provisions it was noted that a key problem in this area of practice is the lack of supports for parents and whānau who are not in a position to provide long-term care for their tamariki. The Minister is scheduled to take a report to Cabinet in September 2021 to provide an update on this work and to set out options for providing these supports.

Next steps

Insights from the case file analysis will be used to continuously inform and strengthen practice in this area. This includes engaging directly with practitioners and sites where there are practice issues identified through the review and sharing insights with operational leadership.

The next round of case file analysis will cover the period between 1 January 2021 and 30 June 2021. It will be completed early in the first half of the 2021/22 financial year and results will be included in a public report published later in the year.