Sensitive

Office of the Minister for Children

Cabinet

FINAL REPORT BY DAME KAREN POUTASI ON THE DEATH OF MALACHI SUBECZ

Purpose

1 I am briefing you on the final report by Dame Karen Poutasi for the Joint Review into the Children's Sector: Identification and response to suspected abuse. This draws on the events leading up to the death of 5-year-old Malachi Subecz.

2 Dame Karen is releasing her report later this week (currently scheduled for Thursday 1 December). Six agencies have also undertaken reviews into their parts of the system, which will bed at the same time.

3 This is a noting paper only. I will return to Cabinet for any policy decisions next year.

Background

4 On 12 November 2021, 5-year-old Malachi Subecz died as a result of physical abuse from his caregiver.

5 In May 2022, the Chief Executives of six public sector agencies[1] commissioned Dame Karen Poutasi to conduct a review of the children's sector as a whole, to identify ways to improve the system to better protect any child in Malachi's circumstances in future. Dame Karen has now submitted her final report – *Ensuring strong and effective safety nets to prevent abuse of children* – to those six agencies, and to the Ministry of Justice.

6 Dame Karen finds that Malachi fell through safety nets designed to protect him and was allowed to be invisible. The sytem focused on the adults around Malachi rather than on him and what he needed. Her report makes a series of recommendations designed to ensure this does not happen in future.

Dame Karen has identified five critical gaps and made 14 recommendations

7 In her report, Dame Karen finds that there were both proactive and reactive opportunities for children's sector agencies[2] and the system to help Malachi

[1] Those agencies that interacted with Malachi, his whānau or his caregiver, or regulated providers that interacted with Malachi, in the months leading up to his death. The six agencies are: Oranga Tamariki−Ministry for Children, NZ Police, Corrections, Ministry of Social Development, Ministry of Education, and Ministry of Health.

[2] The children's sector is not formally defined, but is generally described as those agencies and partners who share responsibility for protecting and advancing the wellbeing and rights of children and young people. This

that were missed. A system of mutually reinforcing safety nets is essential to offering the protection and care that we all owe children like Malachi. She finds that children's sector agencies do not interact effectively, instead operating with a narrow focus and without effective information sharing, which creates gaps in the safety nets.

8 Dame Karen identifies five critical gaps in the safety nets that she considers need to be addressed in the children's system, and 14 accompanying recommendations that are focused on fixing those gaps. The critical gaps and associated recommendations are set out below and the recommendations are copied in **Appendix 1**. A timeline for events is **Appendix 2**.

Critical gap	Key issues	Recommendations
Identifying the needs of a dependent child when charging and prosecuting sole parents through the court system	There were no processes in place to support Malachi's mother in determining care for her child when it became apparent that she would be serving a jail sentence, nor was there anything in place to review whether her choice of caregiver was appropriate (and continued to be appropriate). There was also no consideration of the voice of Malachi or his whānau. There are inadequate safety nets in place to protect children of sole care parents in the charging, bail or sentencing stages of a prosecution and within the courts.	Oranga Tamariki should be engaged in vetting a carer when a sole parent of a child is arrested and/or taken into custody. Oranga Tamariki should be engaged in regular follow-up checks and support for such an approved carer while the sole parent remains in custody. See recommendations 1 and 2.

includes children's agencies, agencies who have responsibilities under the Child and Youth Wellbeing Strategy and the Oranga Tamariki Action Plan, those who deliver services to children, young people and their families, and those who have a role in ensuring those responsibilities are performed.

The process of addressing the risk of harm to a child is too narrow and one dimensional	A series of reactive safety nets were needed to identify and react swiftly to the growing risks for Malachi. However, there was no ability to bring a shared view of the risk that Malachi was facing, and no opportunity for the whānau and community to bring their knowledge and intelligence to the table. The current safety nets within government failed Malachi by focusing on individual agency requirements, rather than inquiring into his reality. The addition of a health lens could have helped to identify follow-up action to the Report of Concern made by his family, and joining up medical records could have helped to identify that Malachi was carrying signs of abuse.	There should be multi-agency teams working in communities in partnership with iwi and NGOs, resourced and supported throughout the country to prevent and respond to harm. Medical records held in different parts of the health sector should be linked. The health sector should be added as a partner to the Child Protection Protocol between Police and Oranga Tamariki. See recommendations 3, 4 and 5.
Agencies are not proactively seek or share information, despite enabling provisions	Information was not shared sufficiently to protect Malachi. Agencies had opportunities to critically consider the information they held and proactively share this information with one another. However, information was not shared, sought or consolidated to allow a thorough view of what was happening for Malachi, despite the existing system settings (including enabling provisions in the Oranga Tamariki Act 1989) allowing for this. There is a high degree of uncertainty and a lack of understanding in the system of what information can and should be shared under the existing framework. There is a significant lack of ownership for proactively sharing information across the system at multiple opportunities.	The Ministry of Social Development should notify Oranga Tamariki when a caregiver who is not a formal guardian, and who has not been reviewed by Oranga Tamariki or authorised through the Family Court, requests a sole parent benefit or other assistance, including emergency housing support, from the agency for a child whose sole parent is in prison. Enhance understanding of the information sharing regime in the Oranga Tamariki Act 1989, to educate and encourage child welfare and protection agencies and individuals to share information with each other on an ongoing basis. See recommendations 6 and 7.
There is a lack of reporting of risk of abuse by some professionals and services	There were several opportunities for professionals to help Malachi that were missed, and processes that should have connected that did not. For example, Malachi's childcare centre saw evidence of harm, which under their Child Protection Policy should have triggered a Report of Concern to Oranga Tamariki. However, the harm was not reported.	Mandatory reporting from designated agencies and professionals who work with children should be introduced as part of a package that includes mandatory training and agreed definitions of what the indicators of abuse are that require reporting. There should be active monitoring of the implementation by early

	There is considerable uncertainty across the system in its understanding of what agencies and professionals can and should do when they identify risk of harm.	childhood education services of their required child protection policies. See recommendations 8, 9 and 10.
Allowing a child to be invisible	At the centre of everything in the review sits Malachi. Even when he was sitting in front of adults, Malachi was not properly seen. The views of Malachi were not actively sought or seriously considered at any point. Agencies and professionals defaulted to a focus on the adults around Malachi and whether their needs were met, assuming this would also meet his needs. Agencies exist with vertical accountabilities, when we need horizontal responsibility, especially for children at risk of harm.	The system needs to be knitted together with a focus on at-risk children. A specific responsibility is needed that categorically unites an effective children's system by explicitly stating in each agency's founding legislation that it shares responsibility for checking the safety of children. See recommendations 11 and 12.

9 Dame Karen notes that many previous reviews into child deaths and abuse in New Zealand have reached similar findings regarding the gaps in the system, concluding that it is "unacceptable that I need to once again make similar findings about how the system is – or is not – interacting." She repeats the words of Children's Commissioner Laurie O'Reilly when he investigated the death of 4-year-old Riri-o-te-Rangi (James) Whakaruru 22 years ago:

Everyone has a piece of the jigsaw, but no-one has the full picture.

Five of the recommendations are operational or within the authority of Chief Executives to support and progress (with some already being worked on)

10 Two recommendations are underway: multiagency teams working in partnership with iwi and NGOs to prevent and respond to harm (recommendation 3), and linking medical records held in different parts of the health sector to enable health professionals to view a complete picture of a child's medical history (recommendation 4).

11 Three further recommendations can be progressed by relevant Chief Executives, which are to:

11.1 enhance understanding of the information sharing regime in the Oranga Tamariki Act 1989 (recommendation 7)

11.2 undertake regular public awareness campaigns so the public is attuned to the signs and red flags that can signal abuse and are confident in knowing how to report this so children can be helped (recommendation 13) (note that this is an existing legislative requirement in the Oranga Tamariki Act 1989)

11.3 add the health sector as a partner to the Child Protection Protocol (CPP) between Police and Oranga Tamariki (recommendation 5).

12 Officials will provide advice to relevant Ministers on how these will be implemented, associated timeframes and any resourcing issues or trade-offs.

Officials have advised that three recommendations would require Ministerial and Cabinet approval and subsequent legislative amendments

13 These three recommendations are:

13.1 There should be active monitoring of the implementation by early childhood education services of their required Child Protection Policies to ensure they are providing effective protection for children. Therefore, the Ministry of Education and the Education Review Office should jointly design and administer a monitoring and review cycle for the implementation of Child Protection Policies in Early Learning Services (recommendation 10).

13.2 Defining in statute which Government agencies comprise the formal children's system (recommendation 11)

13.3 Enacting a specific responsibility in the founding legislation of each agency to make it clear that they share responsibility for checking the safety of children (recommendation 12)

14 The Ministry of Education is the early learning sector regulator and will have to enforce any breaches identified and reported by the Education Review Office. Designing how compliance will be assessed will be important from a regulatory practice perspective. Increased monitoring with a focus on implementation will also require changes to tertiary legislation.

15 When defining the children's system, which is currently not described in legislation, and enacting specific responsibilities for those agencies in the children's system, officials will need to consider whether the group of agencies defined in legislation as children's agencies should be extended beyond the current six agencies.[3] This will also require consideration of agencies' roles, including individually and as a collective, in the context of the broader children's sector.

16 I will report back to Cabinet in the new year on these recommendations, including the fiscal implications from any changes to monitoring and review practices.

Officials have advised that five recommendations should be the subject of further consideration because of the significant consequences that could arise from implementation

17 Officials have recommended further consideration of five of the recommendations before determining how to proceed because of the significant consequences that could arise from implementation. These

[3] These are: Oranga Tamariki, NZ Police, and the Ministries of/for Education, Health, Justice, and Social Development.

recommendations cover three key issues: the introduction of mandatory reporting, treatment of carers when a parent is arrested or in custody and a notification process by the Ministry of Social Development (MSD) to Oranga Tamariki. These recommendations require legislative change to implement.

Mandatory reporting

18 Dame Karen recommends the introduction of mandatory reporting and initiatives to support mandatory reporting (recommendations 8 and 9), so that children who are subject to serious abuse, ill-treatment or harm are made safe at the earliest opportunity. This would involve defining a group of staff working across the children's sector who work with children as 'mandatory reporters'. These mandatory reporters would be required to report concerns in relation to 'high risk abuse' to Oranga Tamariki for investigation.

19 Mandatory reporting has been considered in the past, but not introduced. A requirement for other mechanisms (such as child protection policies that contain provisions on the identification and reporting of child abuse and neglect, and public information campaigns to increase awareness of and the need to report child abuse) were introduced instead.

20 The main concern with mandatory reporting has been the risk that families and whānau in need of help will not seek that help, for fear their children will be reported for suspected child neglect.

21 I support the objective that children who are subject to serious abuse, ill-treatment or harm are made safe at the earliest opportunity. Given some states in Australia have implemented mandatory reporting, this is worth considering further. That said, there are also potential significant consequences that could arise from implementation. Accordingly, it is important that officials also consider whether there are ways of achieving these objectives that are more aligned with the direction of change underway for Oranga Tamariki and other agencies which aim to be seen as part of a connected network of community and government agencies.

22 This way of working aims to be more accessible for families and whānau, and facilitates whānau seeking or accepting help and support at the earliest opportunity (rather than avoiding it for fear of being notified). Ensuring that at-risk children become more visible (a key theme of Dame Karen's report) rather than less visible (through families and children avoiding seeking help) is key to preventing harm and will need to be carefully considered.

23 I will be asking officials to provide further advice on mandatory reporting in the new year.

Treatment of carers when a parent is arrested or in custody and a notification process by MSD to Oranga Tamariki

24 The recommendations relating to this are:

24.1 vetting the carer when the sole parent of a child is imprisoned (recommendation 1)

24.2 regular follow-up checks of an approved carer (recommendation 2)

24.3 MSD notifying Oranga Tamariki when a caregiver who is not a lawful guardian, and who has not been reviewed by Oranga Tamariki or authorised through the Family Court, requests a sole parent benefit or other assistance from the agency for a child whose caregiver is in prison (recommendation 6).

25 These recommendations are part of the safety net that Dame Karen suggests creating, which attempts to support a child at risk of serious abuse or neglect before there is any evidence or concerns of abuse or neglect. This safety net is important for child wellbeing, as children with a parent or parents in prison can experience a wide range of negative impacts (including long-term poor health, educational and social outcomes), and are at high risk of future imprisonment themselves.

26 However, careful thought needs to be given to the following issues:

26.1 Extending the state's role in this manner is likely to be viewed as over-reach. Particularly where a child is being cared for by a wider family member, the state would be interfering in family decision-making where there has been no concern, evidence or assessed risk of harm. This impinges on the guardianship rights of parents.

26.2 All three recommendations focus on intervening with one particular group of parents (i.e., sole parents, or co-accused parents, who are subject to arrest, remand and imprisonment). There is a risk that this may be discriminatory, and would raise human rights issues. Given the high numbers of Māori who are imprisoned, such a policy would have a disproportionate impact on Māori parents.

26.3 There are issues distinguishing between children of solo parents who go to prison, and other children who face elevated risks when their parent is no longer able to care for them. There is likely to be an equivalent risk of harm when a parent in a relationship goes to prison and leaves their child to be cared for by their de facto partner or other family members as there is for a solo parent leaving their child in the care of a friend.

26.4 The risk of harm by caregivers exists not only when the child's parent is imprisoned, but in any circumstances where the parent can no longer look after the child. There is a question of whether there is justification for the state to intervene proactively in a caregiving arrangement simply because the child belongs to a cohort where there is a statistically elevated probability of harm.

26.5 In relation to recommendation 6 (on the role of MSD), officials' initial advice suggests that expanding the role of MSD in assessing benefit eligibility when a child enters someone's care would require both policy

and legislative change.[4] Any changes that are required by this recommendation will require careful analysis, particularly in light of the risks highlighted above.

26.6 In addition, the requirement to notify could create a perverse incentive for families and whānau who may need welfare assistance but who are reluctant to have an automatic notification made to Oranga Tamariki, which may lead to those people not seeking help and putting both them and the child in a more vulnerable position than they would otherwise have been.

27 These recommendations also have significant implications for the operations of court. Increased reporting and the requirement for care arrangements or parenting orders to be in place before a sole parent is incarcerated would add significant delay in both the criminal courts and family court.

28 Independently of the report, the judiciary have formed a working group which includes representatives from Ministry of Justice, Oranga Tamariki and Corrections. The working group is considering what more can be done to support sole parents to put appropriate care arrangements in place. It is unlikely that the judiciary have had an opportunity to read the draft report or consider their view on its recommendations.

29 I will direct officials to explore whether there are other ways to address the intent behind these recommendations, and report back to Cabinet next year.

30 Dame Karen has also said if recommendation 1 is not accepted, consideration should alternatively be given to provision of legal representation for children who are facing the loss of a sole parent to incarceration when a sole parent is in the criminal courts. This will also be considered by officials.

The Independent Children's Monitor

31 Dame Karen also recommended that, in order for change to be monitored, the recommendations made in her report should be reviewed in one year's time by the Independent Children's Monitor in its new system wide role (recommendation 14). Dame Karen has advised the Executive Director of the Independent Children's Monitor of this possible recommendation.

Strengths of the child wellbeing and protection system

32 The recommendations in Dame Karen's report also reinforce the importance of the children's agencies' Oranga Tamariki Action Plan (the 'Action Plan'), to realising system change. The Action Plan is the children's agencies' collective commitment to work together ensure that children, young people, their families and whānau with the greatest needs receive the support and services they require to prevent harm and realise oranga tamariki. As Plan Minister, I

[4] For example, MSD would be required to start considering the suitability of that caregiver, which is beyond the agency's current legislative mandate.

will be continuing to hold chief executives accountable to the commitments made in the Action Plan.

33 In calling out the strengths of the child wellbeing and protection system, Dame Karen also recognises the Oranga Tamariki Future Direction Plan – with its incremental transference of the responsibilities of Oranga Tamariki to communities and organisations that are locally led and regionally enabled, while providing national support – is aligned with her recommendation for multiagency teams working in communities in partnership with iwi and NGOs, resourced and supported throughout the country to prevent and respond to harm.

Other agencies

34 Dame Karen's report has been provided to the Chief Executives of the six public sector agencies that commissioned the review,[5] and the Ministry of Justice.

35 There are other agencies implicated in the recommendations, including Te Whatu Ora – Health New Zealand, Te Aka Whai Ora – Māori Health Authority, the Independent Children's Monitor, and the Education Review Office, who have not yet seen the report, or contributed to Ministers' briefings or this Cabinet paper.

36 As these recommendations are considered and taken forward, these agencies will be involved.

Implications

37 There are no proposals for Cabinet decision in this paper. Consequently, there are no immediate implications for:

37.1 finances

37.2 legislation

37.3 regulatory impact analysis

37.4 population or

37.5 human rights.

38 I will highlight any such implications when seeking any Cabinet decisions next year, including the fiscal implications from any changes to monitoring and review practices.

[5] The six agencies are: Oranga Tamariki−Ministry for Children, NZ Police, Corrections, Ministry of Social Development, Ministry of Education, and Ministry of Health.

Consultation

39 This paper was prepared by Oranga Tamariki. The six agencies who commissioned Dame Karen's report and the Ministry of Justice were consulted.

Communications

40 The current proposal is that the report will be released by Dame Karen at a press conference. Chief Executives propose to release a joint media statement in response to Dame Karen's report, acknowledging and welcoming it. Individual agency reviews or review summaries will also be publicly released on individual agency websites on the same day.

Proactive Release

41 I propose to proactively release this Cabinet paper within 30 business days of Cabinet's consideration.

Recommendations

The Minister for Children recommends that Cabinet:

1 **note** that Dame Karen Poutasi has submitted her review of the children's sector response to child abuse, drawing on the events leading up to the death of 5-year-old Malachi Subecz;

2 **note** that Dame Karen has made 14 recommendations;

3 **note** that officials have advised that—

3.1 five recommendations are operational in nature or otherwise within the authority of Chief Executives to support and progress, with two of these already being implemented;

3.2 three recommendations would require Ministerial and Cabinet approval and subsequent legislative amendments;

3.3 five recommendations should be the subject of further consideration because of the significant consequences that could arise from implementation and would also require legislative change if introduced; and

3.4 the last recommendation is that the Independent Children's Monitor review Dame Karen's recommendations in one year's time;

4 **note** the report will be published at a press conference later this week; and

5 **invite** the Minister for Children or other relevant Ministers to report back to Cabinet in the new year on the recommendations that require Cabinet approval.

Authorised for lodgement

Hon Kelvin Davis
Minister for Children

Appendix 1: Dame Karen's Recommendations

In identifying needs of a dependent child when charging and prosecuting sole parents through the court system

1 Oranga Tamariki should be engaged in vetting a carer when a sole parent of a child is arrested and/or taken into custody. Police (or other prosecuting agency) in the first instance, and the Court in the second, will need to build into their processes time for this to occur.

Further advice will be provided

2 Oranga Tamariki should be engaged in regular follow up checks and support for such an approved carer while the sole parent remains in custody. Resourcing must be addressed to enable this to occur.

- I note that all Oranga Tamariki actions must be taken in accordance with its duties under s 7AA of the Oranga Tamariki Act, and under te Tiriti o Waitangi (and its principles).

Further advice will be provided

In the process for assessing risk of harm to a child, which is too narrow and one dimensional

3 Multiagency teams working in communities in partnership with iwi and NGOs, resourced and supported throughout the country to prevent and respond to harm. There are examples of this happening already across the country. Implementation in all localities must be a priority so that locally relevant teams can help assess, respond to the risk to a child and provide support.

Already being worked on

4 Medical Records held in different parts of the health sector should be linked to enable health professionals to view a complete picture of a child's medical history.

Already being worked on

5 The health sector should be added as a partner to the Child Protection Protocol between Police and Oranga Tamariki to enable access to health professionals experienced in the identification of child abuse, and to facilitate regular joint training.

Officials support in-principle

In agencies and their services not proactively sharing information, despite enabling provisions

6 The Ministry of Social Development should notify Oranga Tamariki when a caregiver who is not a lawful guardian, and who has not been reviewed by Oranga Tamariki or authorised through the Family Court, requests a sole parent benefit or other assistance from the agency for a child whose caregiver is in prison.

Further advice will be provided

7 The enhancement of understanding of the information sharing regime in the Oranga Tamariki Act 1989, to educate and encourage child welfare and protection agencies

and individuals in the sector to share information with other child welfare and protection agencies, on an ongoing basis.

Officials support in-principle

In a lack of reporting of risk of abuse by some professionals and services

8 Professionals and services who work with children should be mandated to report suspected abuse to Oranga Tamariki. I recommend this be legislated by defining the professionals who are to be classed as ‘mandatory reporters’, to remove any uncertainty amongst professionals around their obligations to report.

Further advice will be provided

9 The introduction of mandatory reporting should be supported by a package approach that includes:

- A mandatory reporting guide with a clear definition of what the red flags are that make up a high-risk Report of Concern, together with the creation of a ‘High Report of Concern’ category similar to the NSW ‘Risk of Significant Harm’ definition.
- Defining mandatory reporters, all of whom should receive regular training.
- In addition, for professionals deemed to be mandatory reporters, there should be:
    - Undergraduate professional courses teaching risks and signs of child abuse.
    - Mandatory regular updated training regarding their responsibilities and the detection of child abuse, with practising certificates conditional on training and refreshers.

Further advice will be provided

10 There should be active monitoring of the implementation by early childhood education services of their required child protection policies to ensure they are providing effective protection for children. Therefore, the Ministry of Education and the Education Review Office should jointly design and administer a monitoring and review cycle for the implementation of Child Protection Policies in Early Learning Services

Further advice will be provided

In allowing a child to be invisible – the system’s settings enabled Malachi to be unseen at key moments when he needed to be visible

11 The agencies that make up the formal Government’s children’s system should be specifically defined in legislation.

Further advice will be provided

12 These agencies should have a specific responsibility included in their founding legislation to make clear that they share responsibility for checking the safety of children.

Further advice will be provided

13 Regular public awareness campaigns should be undertaken so the public is attuned to the signs and red flags that can signal abuse and are confident in knowing how to report this so children can be helped. Aotearoa society needs to hear the message “don’t look away”.

Officials support in-principle

14 In order that change can be monitored, the recommendations made in this report should be reviewed in one year’s time by the Independent Children’s Monitor in its new system wide role.

Further advice will be provided

I note all agencies have responsibilities to design and deliver their services and actions in accordance with Te Tiriti o Waitangi, and my recommendations must be addressed with consideration of Te Tiriti in front of mind.

Appendix 2: Timeline of events[6]

Date	Agency	Description
21 June 2021	District Court	Malachi's mother remanded in custody, Malachi left court with Ms Barriball to live with her
22 June 2021	Police	Malachi's cousin visited a Police station to raise concerns about Malachi and his care arrangements
22 June 2021	Childcare centre	Malachi's cousin contacted the childcare centre and informed them of the situation and to report concerns
22 June 2021	Oranga Tamariki	Malachi's cousin visited an Oranga Tamariki office to make a Report of Concern
23 June 2021	Oranga Tamariki	Malachi's cousin phoned Oranga Tamariki
23 June 2021	Oranga Tamariki	Another member of Malachi's family phoned Oranga Tamariki
June 2021	Ministry of Social Development	Ms Barriball applied for a Sole Parent Benefit
June 2021	Ministry of Social Development	Ms Barriball applied for emergency housing
26 June 2021		Malachi's cousin received a photo of Malachi
28 June 2021	Oranga Tamariki	Malachi's cousin spoke to Oranga Tamariki and provided the photo
30 June 2021	Oranga Tamariki	Closed the report of concern
30 June 2021	Family Court	Malachi's mother filed an application at the Tauranga Family Court to have Ms Barriball appointed as an additional guardian
From 1 July 2021	Ministry of Social Development	Ms Barriball started receiving financial assistance
July 2021	Family Court	A 'lawyer for child' was appointed to represent Malachi's interests
22 July 2022	Oranga Tamariki/Corrections	A Probation Officer contacted Oranga Tamariki to raise concerns about the care of Malachi
23 July 2021	Corrections	Probation Officer contacted the Corrections intelligence team outlining the concerns
23 July 2021	Corrections	Corrections intelligence officer reviewed and supervisor suggested that Police should be contacted
25 July 2021	Oranga Tamariki	Malachi's cousin made a complaint to Oranga Tamariki about closing the Report of Concern
26 July 2021	Family Court	Malachi's cousin spoke with the lawyer for child expressing her concerns
End July 2021	Ministry of Social Development	Ms Barriball seeks further housing assistance
30 July 2021	Oranga Tamariki	Malachi's cousin advised by Oranga Tamariki that they had reviewed matters and confirmed an investigation would not be completed
Early August 2021	Family Court	Ms Barriball and Malachi met with the lawyer for child
August 2021	Ministry of Social Development	Ms Barriball was approved payment for housing
13 September 2021	Family Court	Malachi's care arrangements formalised in court and Ms Barriball temporarily appointed as an additional guardian pending a full hearing

[6] There were additional agency interactions which have not been further detailed in Dame Karen Poutasi's report due to privacy considerations

Date	Agency	Description
		scheduled for 1 November. Ms Barriball opposed applications made by members of Malachi's immediate family, who were also seeking custody.
24 September 2021	Te Puna Primary School	Ms Barriball took Malachi for a pre-school visit where a staff member noticed Malachi was slim and had bruising around his eye
27 September 2021	Childcare Centre	Malachi was taken to his childcare centre where staff noticed his hair style had changed and he had bruises and some apparent injuries
27 September 2021	Childcare Centre	Staff at the Childcare centre contacted Ms Barriball who advised Malachi's bruising was the result of falling off a bike
27 September 2021	Childcare Centre	Staff at the childcare centre took photos of Malachi's injuries and placed on his file
29 September 2021	Childcare Centre	Malachi attended the childcare centre for the final time
27 October 2021	Family Court	Ms Barriball's lawyer sent an email to the lawyer for child advising Ms Barriball and Malachi had travelled to Hamilton (however this was not true). Ms Barriball was asked by the lawyer for child to attend the hearing on 1 November via video link. Ms Barriball was also awaiting a Covid-19 test result
28 October 2021	Family Court	Lawyer for child requested hearing not be vacated until Covid-19 test result was known
28 October 2021	Medical Centre	Ms Barriball and her father took Malachi to a medical centre to be assessed for autism – no physical examination was completed
29 October 2021	Family Court	The hearing was vacated as the Covid-19 test result was not available. The 1 November hearing date was deferred
1 November 2021	Hospital	An ambulance was called for Malachi as he was unconscious and suffering seizures. Malachi was taken to Tauranga hospital and subsequently transferred to Starship Children's hospital in Auckland
12 November 2021	Hospital	Malachi passed away