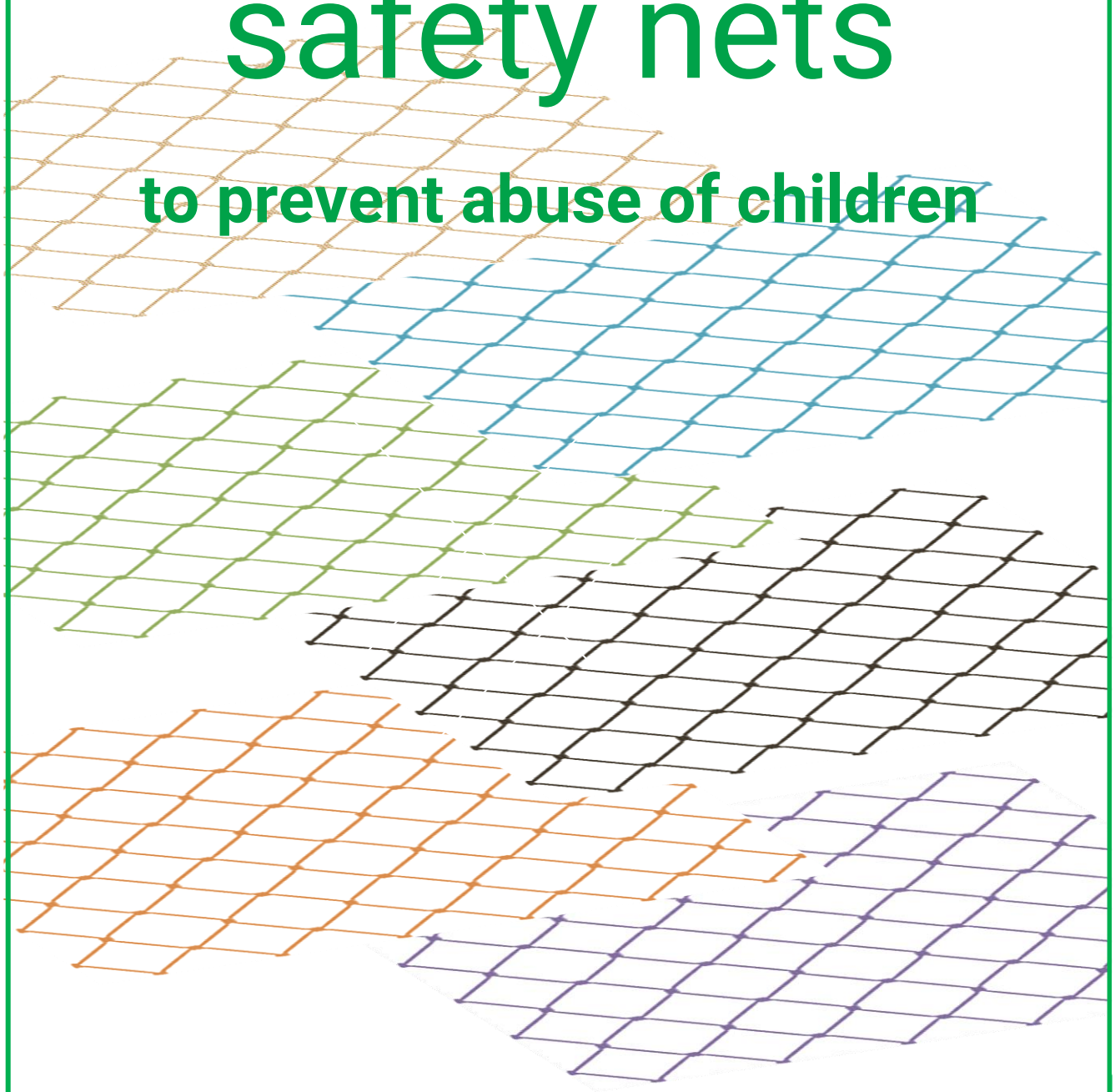
Ensuring strong and effective

safety nets

to prevent abuse of children



Report by Dame Karen Poutasi

Joint Review into the Children's Sector:

Identification and response to suspected abuse

23 November 2022

‘Ahakoa iti, he māpihi pounamu’

Even though it is small, it has its own mana, it is precious

‘Ka puta te tamaiti ki te ao,
me puta te ao ki te tamaiti’

When the child enters the world,
the community must rally around the child

I am grateful to Sir John Clarke for providing the powerful opening and closing whakataukī.

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Foreword

I express my gratitude to Malachi's mother and whānau for their generosity in sharing their raw grief and sad stories of the tragedy of Malachi's death in order that changes might occur to help prevent a future tragedy.

Malachi's death is a tragedy. For Malachi, as for so many other abused tamariki, there were individuals and agencies who had contact with him, his whānau, and his caregiver, yet no agency had the full picture of what was happening to him before it was too late.

There can be no excuses; it is time for clarity of requirements, backed by a sustained move from transactional responses to thoughtful, holistic and contextual engagement with an 'eyes wide open' approach. We must ensure a series of strong, effective, and mutually reinforcing safety nets to prevent the abuse of our tamariki. My recommendations are intended to help ensure this.

In jointly commissioning this review, I believe the chief executives of government agencies who work with tamariki and their whānau recognise the need to improve the connections in the system such that gaps are closed. My recommendations aim to ensure that overlapping safety nets exist and are hard wired. Such action will help prevent a similar tragedy to Malachi's abuse and death happening to another child for whom we all have a duty to care.

I valued the willingness of all those with whom I met to contribute to my work. Their sense of dismay was palpable.

Finally, I encourage everyone in Aotearoa to unite against appalling abuse of our tamariki. Child protection is everyone's responsibility. We simply cannot afford to look away. This is the legacy Malachi's death must leave.

Dame Karen Poutasi
November 2022

Acknowledgement
I have benefitted from the support of a committed secretariat led by Sandra Preston. Kate Riddell, Vicky Tomlinson and Sophia Walter have provided critical assistance, along with our legal advisor Sarah Jerebine.

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2. Executive Summary

Introduction

1. Five-year-old Malachi Subecz died in Starship Hospital on 12 November 2021 as a result of physical abuse by his caregiver, Michaela Barriball. She is currently serving a life sentence, with a non-parole period of 17 years, after pleading guilty to his murder.

2. Malachi was left in Ms Barriball's care by his mother after she pleaded guilty to serious charges and was remanded into custody, and therefore needed someone to look after Malachi. Ms Barriball was a workmate and friend of Malachi's mother.

3. This report has been commissioned by the six public agencies which interacted (either directly or through services provided in their sectors) with Malachi, his whānau and/or Ms Barriball in the months leading up to his death. The six agencies are: the Department of Corrections – Ara Poutama Aotearoa; New Zealand Police – Ngā Pirihimana o Aotearoa; Oranga Tamariki – Ministry for Children; the Ministry of Education – Te Tāhuhu o te Mātauranga; Manatū Hauora – Ministry of Health; and the Ministry of Social Development – Te Manatū Whakahiato Ora.[1]

4. At no time was the system able to penetrate and defeat Ms Barriball's consistent efforts to hide the repeated harm she was causing to Malachi that culminated in his murder.

5. The purpose of this report, as set out in my Terms of Reference, is to 'examine and identify ways to improve the children's sector identification of, and response to, abuse of children and young persons'.

6. The preparation of this report has been assisted by reports each of the six agencies has completed into their, or their services, individual interactions with Malachi, his whānau and Ms Barriball.

7. Each agency is responsible individually for implementing the actions identified in their report. I support and commend their efforts to take the actions they have identified, many of which I understand are underway already. I expect that agencies implementation of their own findings will continue at pace, as it is imperative they each focus on addressing the issues they have identified.

8. I have drawn on each agency's report as an input into this report. However, as in my Terms of Reference, my focus is not on individual agencies, but on the 'need to look across the whole system to see if there are improvements that can be made'.

[1] Given the role of the courts in the process for Malachi's mother and subsequent impact on Malachi, the Ministry of Justice have been kept informed on progress with, and have provided input to the Review.

Background / Context

9. We have a legislative framework in Aotearoa that requires the wellbeing and best interests of the child to be paramount [2] and this has to underpin all our considerations. There should be no 'invisible child' and yet we know 'Child abuse will be hidden'.[3] This puts considerable onus on agencies and their services to be alert to risk, and to seek and proactively share information to protect tamariki.

10. Malachi became an invisible child within the system. This is because:
    - there were those who tried to act but were not listened to;
    - there were those who were uncertain and did not act; and
    - there were those who knew and chose not to act.

11. This is not acceptable.

12. The settings for the care and protection system we have in place are still not strong enough to ensure children do not slip through the gaps. The system could have been more 'fail safe' and the settings must be addressed so that it is. The settings currently do not enable a shared focus on the needs and safety of the child above all else. My Terms of Reference ask that I assess whether agencies within the system interact effectively. My assessment in response is that they do not. While their processes allow interaction, the system is not adequately designed to support or require this interaction, with each agency established for a different, unique purpose. The system needs to be reinforced so that child protection is every agency's responsibility, not just that of Oranga Tamariki.

13. *Throughout this review, I have envisaged a children's playground climbing frame with layers of safety nets so that if a child falls through the first net they are caught by the second or third safety net. A system of mutually reinforcing, purposefully structured safety nets is essential to offering the protection and care that children like Malachi are owed*.

14. There should be a proactive duty to care for the wellbeing of children interacting with the system. A recent report of the Family Violence Death Review Committee highlights legal and societal duties of and to care. A 'duty of care' refers to legal obligations and a 'duty to care' describes 'relational obligations to each other as humans'.[4] There will be varied understandings across New Zealand society of what a societal duty to care comprises, but most New Zealanders find child abuse abhorrent and would want Aotearoa to own a duty to care.

Interactions with agencies and others

15. The series of interactions between public sector agencies and their services, Malachi's whānau, and Malachi's caregiver, Ms Barriball, in the months leading up to Malachi's murder illustrate very clearly the narrow focus of agencies, the absence of effective information sharing, and the resulting gaps in the care and protection system for children. In relation to information sharing, this observation also applies to some extent to members of the public

[2] The Care of Children Act 2004 and the Oranga Tamariki Act 1989 require that all those acting under these Acts must have the welfare/wellbeing and best interests of the child as the paramount consideration.
[3] Final Report on the Investigation into the death of James Whakaruru, Office of the Commissioner for Children, June 2000, page 5.
[4] Family Violence Death Review Committee 7th report 2019-21, page 11

and to some members of Ms Barriball's broader whānau and community with whom Ms Barriball and Malachi came into contact during the more than four months Malachi was in her care.

16. Malachi was in Ms Barriball's care because his mother had chosen Ms Barriball as his caregiver when Malachi's mother entered the prison system. There was no formal authority for this decision, nor was this needed. There is no provision for the Courts to make or oversee a decision of this kind or to make contact with an agency such as Oranga Tamariki when dependent children are affected by a custodial sentence.

17. Ms Barriball applied for a benefit, and as required by Ministry of Social Development guidelines, she provided supporting documentation to prove Malachi was in her care and to confirm his date of birth.

18. The day after Ms Barriball became Malachi's caregiver, Malachi's cousin made a Report of Concern to Oranga Tamariki. The Report of Concern was closed by Oranga Tamariki after they received assurances from Malachi's mother in prison that she held no concerns, and as the agency did not consider that a photo sourced from Facebook (provided by Malachi's cousin), which allegedly showed Malachi with bruises on his face, was compelling evidence of risk. In the Chief Social Worker's practice review, Oranga Tamariki acknowledges that it was a significant practice mistake to close the report of concern without fuller investigation.

19. A Department of Corrections probation officer contacted Oranga Tamariki to express their concerns regarding Malachi's care. The probation officer feared Malachi could be used as leverage to influence the court process. The probation officer subsequently contacted the relevant prison intelligence team with the same concerns. The intelligence team discussed internally that the probation officer should notify their concern to the Police, though the probation officer was not advised of this view.

20. In the time Malachi was in Ms Barriball's care, a representative of his whānau sought through the Family Court to have Malachi placed in the care of the whānau. Despite an expedited hearing date, there were procedural issues, coupled with Ms Barriball making herself unavailable to take part, which ultimately meant a hearing on this matter was adjourned. Malachi was murdered before it could be rescheduled.

21. Because of Ms Barriball and Malachi's housing insecurity, the Ministry of Social Development provided financial assistance for housing at the rear of Ms Barriball's father's house. Although Malachi and Ms Barriball lived in a cabin, they ate their meals and used the bathroom in the house.

22. Staff at a childcare centre attended by Malachi questioned Ms Barriball about physical injuries he had suffered. She said they were a result of a fall from his bike. Malachi said this was not the case and he thought Ms Barriball would be angry with him. Although staff at the centre took pictures of the injuries and the policy of the centre was to report such injuries, they did not.

23. At a function attended by Ms Barriball and her whānau at least one of Malachi's injuries – a burn on his forehead – was obvious to some attending. When raised with Ms Barriball, she falsely said he had already seen a doctor.

24. On 28 October 2021 Ms Barriball and her father took Malachi to a medical centre, as Ms Barriball wanted Malachi assessed for autism, to support her bid for permanent guardianship. Ms Barriball did not mention the serious burn on Malachi's abdomen, and no physical examination was deemed required, nor was undertaken.

25. During this period Ms Barriball sent text messages to her partner stating that, among other things, she hated Malachi and feared she would kill him, and to her sister and father saying she was too scared to take him to hospital or get medical attention in case she got into trouble.

Five critical gaps in the system

26. The tragedy of Malachi's abuse and death at the hands of his caregiver highlights ongoing holes in our safety nets and gaps where they need to be mutually reinforcing. These need to be addressed with urgency and determination. In undertaking this review, I conclude the sharing of information is critical to child safety as 'everyone has a piece of the jigsaw but no-one has the full picture'.[5] My report concludes there are five critical gaps in the current system of safety nets.

27. These are:

- In identifying the needs of a dependent child when charging and prosecuting sole parents through the court system.
- In the process for assessing the risk of harm to a child, which is too narrow and one dimensional.
- In agencies and their services not proactively sharing information, despite enabling provisions.
- In a lack of reporting of risk of abuse by some professionals and services.
- 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.

The first gap is in identifying the needs of a dependent child when charging and prosecuting sole parents through the court system

28. Children of incarcerated sole caregivers can be in the care of another person without formal authority for long periods, without consideration for their safety or wellbeing. For Malachi, this gap meant, from the day his mother was denied bail and incarcerated, he was with Ms Barriball informally for three months. During this time, she was able to create closeness to Malachi, preventing the risks to him being seen or acted upon. This gap must be closed.

29. Where a sole parent is facing a custodial sentence there should be a requirement for Oranga Tamariki involvement to support the parent in the choice of a caregiver. This event is a red flag for risk and could be addressed through Police, or the relevant prosecuting agency, being required to notify Oranga Tamariki at the arrest of a sole parent or when charges are filed. This could also occur through the criminal court notifying the Department of Corrections of

[5] Final Report on the Investigation into the death of James Whakaruru, Office of the Commissioner for Children, June 2000, page 39 – this is quoting Laurie O'Reilly, the previous Commissioner for Children.

the existence of dependent children at the time a sole caregiver is incarcerated (either remanded into custody or sentenced), with Oranga Tamariki then being informed to enable an assessment of the care arrangements. I was pleased to be advised the judiciary is already giving careful thought regarding these matters, and is considering how to address this gap through the court process.

30. Children of prisoners are among our most vulnerable citizens; we have known this for some years. An incarcerated parent has very little real ability to check up on a child's care, with virtually no capacity to follow up on the caregiver's ongoing suitability or treatment of the child. If my first recommendation is not accepted, I believe 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. In this way, children would have a voice on what happens to them if their sole caregiver is indeed incarcerated. There are health, psychological, social, and economic effects on the child with the removal of a mother or primary caregiver. More needs to be done to consider how children in Malachi's position can be immediately supported. Children in this position need not just a voice but active support.[6]

The second gap is that the process for addressing the risk of harm to a child is too narrow and one dimensional

31. In its Chief Social Worker's practice review, Oranga Tamariki acknowledges that not commencing an investigation and seeking information from other agencies under its section 17 powers to investigate a Report of Concern,[7] impacted on its ability to accurately assess Malachi's safety and wellbeing.

32. At various points, the views of other agencies, as well as those of Malachi's whānau and community, should have been sought and taken into account in assessing and responding to Malachi's needs.

33. Medical records should be joined up and health sector agencies should be available to assist in assessing relevant Reports of Concern. A process to join up medical records is currently underway through various health data and digital initiatives but needs to be accorded urgency. Emergency Department and other hospital attendances need to be linked to general practice records to facilitate the opportunity to detect child abuse. Many whānau are mobile in their day-to-day lives, and health records need to be accessible to different health providers.

34. In addition, the Ministry of Health, Te Whatu Ora and Te Aka Whai Ora should be parties to the Child Protection Protocol, currently in place between Oranga Tamariki and the Police. This would enable the health sector to more readily provide key information and specialist assistance when assessing the risk of child abuse occurring. Whilst a Memorandum of

[6] See Annaliese Johnston, 'Sentencing the Silent: Children's Rights and the Dilemma of Maternal Imprisonment' (2014) 1 Public Interest Law Journal of New Zealand 97, online at http://www.nzlii.org/nz/journals/NZPubIntLawJl/2014/17.html#fn11

[7] Section 17 of the Oranga Tamariki Act 1989 states: 'If the chief executive or a constable receives a report under section 15 relating to a child or young person, they must,— (a) as soon as practicable after receiving the report, if it appears that an investigation is necessary or desirable, commence an investigation or arrange for an investigation to be commenced into the matters contained in the report to the extent that an investigation is necessary or desirable'.

Understanding is in place between District Health Boards (now Te Whatu Ora), Oranga Tamariki and Police,[8] the Child Protection Protocol presents a powerful tool. Oranga Tamariki has identified the value of including the health sector in the Child Protection Protocol themselves, and I strongly support this step being taken.

35. Monitoring of Early Childhood Education Centres' (ECEs) management of potential child abuse should be more active, and regular review of the implementation of their Child Protection Policies should be required. Malachi's childcare centre failed to follow their own policy, and there were no checks required to ensure they were implementing the policy appropriately. This is a gap that should be fixed. Young children, especially non-verbal children, are particularly vulnerable and ECEs must be particularly alert. There should be regular checks that Child Protection Policies are offering effective protection, not just that they are in place.

36. On-the-ground interagency collaborations and partnerships with iwi, whānau and relevant Non-Governmental Organisations (NGOs) will assist in getting a broader picture when hard wired protections such as the above are not sufficient to detect and act on risk. Such collaborations currently exist in different forms throughout the country but need to be expanded and resourced. This represents the direction of travel identified in the Oranga Tamariki Future Direction Plan.[9]

37. There should be no wrong door for partnered 'on-the-ground' collaborations, as this is where risk can be well assessed from a multidimensional perspective, with action taken and support arranged. Mahi tahi concepts support the effectiveness of these collaborations where trusted relationships are key to a shared view of risk.

38. There are a range of such multi-agency and partnered models sharing information and making decisions around the country. While reflecting the different needs and priorities of their communities, they share the approach of bringing the views and information of relevant agencies, iwi, kaupapa Māori organisations, NGOs and community groups to one table. This enables both a more complete picture of the risks a child and their whānau may be facing, and the development of a collective course of action.

39. Not only do these models provide for dialogue and on-the-ground wrap around support for whānau, they also enable information sharing and provide support for and accessibility to professionals. While the mix of participants at the round table may change depending on the needs of the local community, by drawing on the system and bringing the necessary information together to support effective decision making at the local level, this can be a powerful model with significant potential to change outcomes for tamariki and their whānau. Much can be learned from the on-the-ground partnerships already established. Urgency and resourcing must be afforded to rolling these out faster and wider across the country. Whilst noting that urgency is required, I am advised that such initiatives are built on relationships and trust and these do take time to build.

[8] Memorandum of Understanding between Oranga Tamariki - Ministry for Children, New Zealand Police and the District Health Boards, 7 September 2021.
[9] The Future Direction Plan was developed in response to 'Hipokingia ki te Kahu Aroha, Hipokingia ki te katoa (Te Kahu Aroha) – Report of the Oranga Tamariki Ministerial Advisory Board' July 2021 'Te Kahu Aroha' report | Oranga Tamariki – Ministry for Children

The third gap is that agencies and their services are not proactively sharing information, despite enabling provisions

40. The third critical gap is agencies and their services are not proactively sharing information or implementing their own internal requirements to do so, despite enabling provisions in the Oranga Tamariki Act 1989. The information sharing regime under the Oranga Tamariki Act 1989 allows certain agencies and persons to share information to prevent or reduce the risk of harm to a child or to assess risk, but this was not followed. Proactive sharing of interagency knowledge and insights should be hardwired where possible.

41. The Ministry of Social Development should have a system to notify Oranga Tamariki when a caregiver who has not been reviewed by Oranga Tamariki or authorised through the Family Court requests a sole parent benefit or emergency housing. This is not a suggestion to deny funding, only to make further inquiries. While not part of current procedure, it does align with legislative provisions[10] and, again, this should be a new red flag for risk, signalling the potential need for child protection.

42. This gap in sharing information must be highlighted as it impacts on, and is key to, addressing other gaps. Without effective and enhanced information sharing, the gaps will not be closed and the system strengthened. I have explored the reasons why agencies and their service providers and professionals may be reluctant to share information, and as a result have determined we need clarity and hardwired expectations. The system needs to give its people the confidence and practical training on how to use the current information sharing framework in their everyday work. The multi-agency on-the-ground partnerships will both facilitate information sharing and be enabled by it. Information is critical to the effectiveness of those partnerships.

43. There was an urgent need to consolidate a whole picture of the risks for Malachi. Each agency had part of Malachi's reality but did not register the red flags to bring it to each other in one view.

The fourth gap is that there is a lack of reporting of risk of abuse by some professionals and services

44. The fourth critical gap is the lack of reporting of the risk of abuse by some professionals and services. This gap leads me to recommend that there should be mandatory reporting of risk of abuse to Oranga Tamariki from professionals and services working in the child protection field, including across health care, welfare, education, children's services, residential services and law enforcement. These categories of frontline workers with children should be 'mandated reporters' and clearly identified in legislation. The paramountcy of the child comes to the fore in this recommendation.

45. This mandating of reporting will not be enough on its own. I have heard from those with experience in mandated reporting that it must be complemented by clear guidelines on the high risks that constitute red flags for child abuse, and should also be accompanied by certified, mandatory training to support these frontline workers. A form of training should be required to be repeated regularly as part of the practicing certificate process for frontline

[10] Section 14(1)(b) of the Oranga Tamariki Act 1989 provides a child is in need of care and protection if their parent or guardian is unable to care of them, and 'guardian' has the meaning provided in the Care of Children Act 2004.

professionals working with children. Furthermore, training should be required for employment within relevant government agencies, and for the provision of services to children.

46. I doubt whether more protocols, policies and procedures are sufficient to keep children safe. This is a view I share with the Family Violence Death Review Committee. The childcare centre attended by Malachi had a policy requiring the reporting of child abuse, but they did not follow this.

47. I heard the reporting and feedback process is not well understood and is likely under-utilised as a result. I specifically heard some agency staff may be reluctant to report risk of abuse because sometimes there is no feedback loop, so they do not know if their reporting efforts are acted on or make a difference. There is inadequate learning occurring as a result.

48. For these reasons, this has to be the time to grasp the need for mandatory reporting, together with effective and enhanced information sharing, and supported by mandatory training. How much longer must families and children wait for a system to understand and effectively use its own policies and procedures? We must create the certainty and compulsion to act now. The system settings need to be as strong as possible to protect children and to support the professionals working with them.

49. Mandatory reporting has been considered before but has not been introduced due to concerns about swamping the system with the volume of reports, and a fear this could mean inadequate investigation of reports as a result. Another reason I heard articulated was a risk that families would not seek help from professionals because they feared those professionals having to report them. I believe each of these challenges is real, but each is already in play to varying degrees and needs to be addressed regardless of whether mandatory reporting is introduced.

50. In speaking with the Victorian and New South Wales child protection agencies that have mandatory reporting in place, I have heard how these challenges can be overcome through careful definitions of what must be reported, by whom. For example, New South Wales refined their mandatory requirements down to risk of **significant harm** which has substantially reduced the number of mandatory reports, while both Victoria and New South Wales specify categories of mandatory reporters. I believe mandatory reporting, supported by mandatory training, can provide the certainty that is lacking in the system now. These must be approached together, as a package enabling change.

51. Therefore, in a similar manner to the Victorian and New South Wales approaches, I recommend developing a category of 'high risk' Reports of Concern that should be mandatorily reported by specific categories of reporters. These high-risk Reports of Concern should be focused on specific safety and protection needs. More general wellbeing concerns that do not meet a definition of high risk can meanwhile be increasingly managed in partnership with government agencies by a broader range of parties.

The fifth gap is that the system's settings enabled Malachi to be invisible

52. The final gap I must highlight is that the system settings allowed Malachi to be invisible. In my conversations I heard the comment *'Don't look away'*. This led me to consider the need for regular public awareness campaigns on abuse, what to look for, and how and when to report. This is needed to address the societal abhorrence of such child abuse as that endured by Malachi, and to provide practical information about what to do if abuse is suspected.

53. The promotion of public awareness is currently a requirement of the Oranga Tamariki Act 1989,[11] but I have not seen evidence there is specific regular promotion underway with the public, nor that there has been promotion for some time. This is despite the fact this section of the Act was introduced in 1994 precisely in lieu of mandatory reporting, as it had been a specific recommendation of the 1992 Mason Inquiry into child abuse (as well as a number of other inquiries). Aotearoa simply cannot afford to look away.

54. Malachi did not have a voice: he was not seen or focused on. We should have a child protection system that, across multiple agencies and our society, looks at and listens directly to the needs of the child themselves rather than just the adults around them. Children must be given a voice across the system that is intended to support their needs and that seeks to describe itself as child centred. We need to turn this aspiration into a reality.

55. There have been numerous reviews of previous cases of child abuse that have drawn very similar conclusions to mine. In reality, a number of the findings and recommendations of this review have largely been made before. Some recommendations have been implemented but fallen away as the spotlight moves on and the process defaults to what it knows; others have not been attempted because the environment was not seen as ready. As a society, we cannot continue to allow a cycle of abuse, review, outrage and distress – and then retreat from the difficult challenges. It is not acceptable we give up because it is too difficult. There must be sustained, determined and bold change. As difficulties arise in implementation, solutions focused on the protection of children and whānau must be found. This requires regular monitoring and accountability for change.

56. The recommendations made in this report – which are set out below and in section eight – should be reviewed against progress made in one year's time by the Independent Children's Monitor in their new system-wide role.

57. Mel Smith's words of 2011 regrettably need repeating: 'this is a heinous crime' and 'whatever needs to be done must be done'.[12] We have come some way with our efforts, and we mean well, but Malachi's sad death shows us that we must do more. We have a range of tools available to provide impetus that have either not been tried before or not maintained. There are differences in today's environment that mean it is now time to try again. There is no excuse not to proceed with implementing them now so that real change can be effected. This means identifying and fixing the gaps by securing overlapping and inter-locking safety nets so they are hardwired to identify and address risk and can enable on-the-ground

[11] At section 7(2)(ba)
[12] 'Report to Hon Paula Bennett, Minister for Social Development and Employment. Following an Inquiry into the serious abuse of a nine year old girl and other matters relating to the welfare, safety and protection of children in New Zealand'. Conducted by Mel Smith CNZM, 31 March 2011.

collaborative action that reduces harm to children. That is the core focus of my review and is the legacy Malachi's death must leave.

Recommendations

58. These are the recommendations I make to facilitate the closing of the gaps in the children's system that did not catch identifiable risks to Malachi from his carer:

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

i. **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.

ii. **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 1989, and under te Tiriti o Waitangi (and its principles).

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

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

iv. **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.

v. 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.

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

vi. **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.

vii. **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.

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

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

ix. The introduction of mandatory reporting should be supported by a **package approach that includes**:

- **A mandatory reporting guide** with a **clear definition of the red flags** that make up a high-risk Report of Concern, together with the creation of a 'High Report of Concern' category similar to the New South Wales 'Risk of Significant Harm' definition.
- **Defining mandatory reporters**, all of whom should receive regular training.
- **In addition, for professionals deemed to be mandatory reporters, there should be:**
  - **undergraduate 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.

x. 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.

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.

xi. The agencies that make up the formal Government's children's system **should be specifically defined in legislation**.

xii. 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.

xiii. **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 needs to hear the message *'don't look away'*.

xiv. 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**.

59. 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.

3. Context and Background

60. I have been commissioned by the Chief Executives of six agencies that had contact with Malachi Subecz, his mother and family, and his caregiver to look across the children's system to identify the gaps in the safety nets of care, and to provide recommendations to address them. These agencies are Oranga Tamariki – Ministry for Children; New Zealand Police – Ngā Pirihimana o Aotearoa; Ara Poutama Aotearoa – Department of Corrections; Ministry of Social Development – Te Manatū Whakahiato Ora; Ministry of Education – Te Tāhuhu o te Mātauranga; and Manatū Hauora – Ministry of Health.

61. As per the Terms of Reference (**Appendix One**) the purpose of the review is to:

> '1) examine and identify ways to improve the children's sector identification of, and response to, abuse of children and young persons. 2) The review will draw on the circumstances of the death of Malachi Subecz to decrease the potential for such a tragedy occurring again'.[13]

62. Malachi had just turned five when he died, after suffering prolonged and ultimately fatal abuse by Michaela Barriball. Ms Barriball was the person his mother trusted to care for Malachi when she herself was incarcerated into prison. From what I have seen, up until his mother's arrest, Malachi was a well-cared for and loved little boy.

63. Ms Barriball is currently serving a life sentence for Malachi's murder, as well as concurrent time for representative acts of harm and neglect. While Ms Barriball is the person responsible for abusing and killing Malachi, the system that is supposed to catch children from falling into harm, did not interact sufficiently well to help prevent his abuse. There were gaps at every step of the way from the arrest and charging of his mother until his death.

64. A number of government agencies and their services had some form of contact with Malachi and his whānau, and with Ms Barriball. Agencies have each conducted their own review into those interactions. The agencies' review reports have been used as an input into my review. My task, however, has been to look across the children's system as a whole, rather than focus on individual agencies, to see where improvements should be made at a system level.

65. The Chief Executives of the six agencies have asked that I look across their collective system to:
    i. Identify whether the system as a whole could or should have done more to prevent harm being done to Malachi.
    ii. Use the findings and outcomes of individual agencies' internal reviews related to this case to identify possible gaps in policy, planning, and process in the response as a system.
    iii. Identify significant risk factors of child abuse including:
        a. How the relevant processes for each agency or regulated service to notify and respond to potential child abuse interact across the system.

[13] Purpose statement 'Joint Review into the Children's Sectors: Identification and response to suspected abuse Term of Reference'.

b. The coordination and information sharing across agencies in cases of potential child abuse.

66. I have met with Malachi's mother and family. I thank them for their willingness to share their grief in the hope that what happened to Malachi should not happen to any other child.

67. I also met with a range of key stakeholders who operate within and around Aotearoa's child protection system. The list of people and organisations I have met with is included as **Appendix Two**. I have been grateful for their insights, openness, and generosity in sharing information and views.

68. I have reviewed a range of policies and protocols across government, considered previous reviews and recommendations into earlier child abuse cases (**Appendix Three**), and met with Chief Executives and senior staff from agencies. I have drawn on the Chief Ombudsman's opinion on a complaint made against Oranga Tamariki regarding the care and protection of Malachi. I visited some of the multi-agency collaborative efforts underway and heard from those on-the-ground to enable me to draw together a more cohesive view on child abuse and family harm, and opportunities to prevent and respond to this. I have also spoken to both the Victorian and New South Wales child protection agencies to understand their experiences with mandatory reporting.

69. The process has been challenging for everyone involved, as the details of what Malachi endured are hugely distressing. I acknowledge his mother, whose trust was abused, and his family who carry their sorrow and pain at the failure of the system to hear their concerns, raised repeatedly, as they tried to do everything they could to alert authorities to the risk to Malachi. The discomfort, horror and sorrow that Malachi's abuse and death have triggered for the public, as for government agencies, must be used as the catalyst for needed change.

4. Who was Malachi?

70. Malachi Rain Subecz was born on 28 September 2016 and was his mother's only child. The first four years of Malachi's life were spent in his mother's care, where he was loved and well cared for. Malachi's mother summarised this simply as 'he was my whole world'.

71. Malachi had an extended family who cared for him deeply and spent a lot of time with him and his mother. From my conversations with his mother and family, I learnt Malachi was a gentle, kind and thoughtful child, always doing what was asked of him. He looked out for others and showed empathy to both children and adults. His family also remembers his adventurous and charming side.

72. Malachi had a passion for dinosaurs - he could name them all, and tell you about their body parts and what they ate. He would be cross with you if you got this wrong. He was learning the te reo Māori names of dinosaurs.

5. What I understand happened between early 2021 and November 2021

Pre-June 2021

73. Malachi's mother was arrested and began to consider who might care for Malachi if she were incarcerated. She spoke with some of her family, who resided in Wellington, as well as her friend Ms Barriball, who resided in Tauranga. Malachi's extended Wellington whānau confirmed they were wanting to assume responsibility for the day-to-day care of Malachi.

74. In preparing to potentially receive a sentence of imprisonment, Malachi's mother decided Malachi should live with Ms Barriball. There was a non-association order between Malachi's mother and Ms Barriball's mother.

75. Malachi's mother began the process for having Ms Barriball appointed as an additional guardian through the Family Court.

June 2021

76. On 21 June 2021, Malachi's mother was remanded in custody and Malachi began to reside with Ms Barriball at his mother's request.

77. Malachi's family had been under the impression that Malachi would be placed in their care and were upset when this didn't occur. They thought Malachi should be cared for by family and had concerns about Ms Barriball's ability and motivation to care for him. In June 2021, in the days immediately following Malachi's mother's incarceration, his cousin took several steps to alert authorities to their concerns.

78. Malachi's cousin visited a Police station to ask whether legal authority existed to stop Malachi being placed in the care of a family member of an individual with whom his mother had a non-association order. Malachi's cousin was advised to seek legal advice and to contact Oranga Tamariki.

79. Malachi's cousin contacted the childcare centre where Malachi was enrolled, Abbey's Place Childcare Centre, advising them of the situation and asking them to immediately report if they had any concerns for Malachi's well-being.

80. On 22 June 2021 Malachi's cousin visited an Oranga Tamariki office to make a Report of Concern. A social worker at that Oranga Tamariki office recorded the Report of Concern and transferred it to the Tauranga West office.

81. On 23 June 2021 Malachi's cousin telephoned Oranga Tamariki. She advised that she had contacted a lawyer about making a without notice application for a parenting order to gain day-to-day care of Malachi.

82. On 23 June 2021 another member of Malachi's whānau telephoned Oranga Tamariki, expressing their concern that Malachi's mother was in prison and that Malachi may not be staying in a good environment.

83. Ms Barriball visited a Ministry of Social Development office. She applied for a Sole Parent Benefit, and as required by Ministry of Social Development guidelines, she provided supporting documentation to prove Malachi was in her care and to confirm his date of birth.

84. Throughout June, Ms Barriball also made requests for emergency housing support for herself and Malachi. Ministry of Social Development policy required confirmation from Ms Barriball that Malachi did not have family that could care for him before emergency housing could be granted. As a result of her answers and assessment of her needs, emergency housing assistance was provided.

85. On 26 June 2021 Malachi's cousin received a photo of Malachi from Ms Barriball via Facebook, and believed the photo showed bruising around his eye.

86. On 28 June 2021 Malachi's cousin spoke to an Oranga Tamariki duty social worker via telephone and was asked to email the photo to the National Contact Centre, which she did.

87. On 30 June 2021 Oranga Tamariki closed the Report of Concern made by Malachi's cousin. Oranga Tamariki recorded that they held no specific care and protection concerns and that Malachi's mother had no concerns with his care arrangements.

88. At the end of June 2021 Malachi's mother filed an application in the Family Court at Tauranga to have Ms Barriball appointed as an additional guardian.

July 2021

89. From the beginning of July 2021 Ms Barriball began to receive financial assistance from the Ministry of Social Development, to assist her in taking care of Malachi.

90. As part of the Family Court process, a 'lawyer for the child' was appointed to represent Malachi's interests.[14]

91. On 22 July 2021 the probation officer who was preparing the pre-sentence report for Malachi's mother contacted Oranga Tamariki to raise concerns regarding the care and well-being of Malachi. In the internal pre-sentencing notes, the probation officer noted they had been advised by Oranga Tamariki the file was closed as there were no concerns regarding Malachi's well-being or his care arrangements.

92. The probation officer was not satisfied with the response received from Oranga Tamariki and contacted the prison intelligence team by telephone, followed by an email on 23 July 2021. The probation officer outlined their concerns around the potential for Malachi to be used as leverage while in the care of Ms Barriball, whose mother had a non-association order with his mother, and that this might be a way for Ms Barriball's mother to contact Malachi's mother indirectly.

93. On 23 July 2021 an intelligence officer shared the probation officer's email with their supervisor, and the supervisor suggested the probation officer should contact the Police. This advice was not relayed to the probation officer.

94. On 25 July 2021 Malachi's cousin made a complaint to Oranga Tamariki about the decision to close the Report of Concern. The family continued to hold concerns about where and who Malachi was staying with.

95. On 26 July 2021 Malachi's cousin spoke with the lawyer for child and repeated her concerns about Malachi's care and protection while in the care of Ms Barriball, particularly that Ms Barriball's mother had a non-association order with Malachi's mother.

[14] The lawyer for the child is appointed by the Judge in the Family Court, to represent the child's interests and explain Court proceedings in a way that the child can understand.

96. The lawyer for the child also confirmed to Malachi's cousin she supported her participation in the Family Court proceedings.

97. At the end of July 2021 Ms Barriball approached the Ministry of Social Development again for further housing assistance, citing issues with her current housing.

98. On 30 July 2021 in response to her complaint, Malachi's cousin was advised by Oranga Tamariki that they had reviewed matters, including speaking with Malachi's mother, and decided an investigation would not be carried out.

August 2021

99. At the beginning of August 2021 Ms Barriball and Malachi met with the lawyer for the child.

100. In August 2021 the Ministry of Social Development approved payment for housing for Ms Barriball and Malachi. They moved into a cabin on Ms Barriball's father's property. The cabin had electricity but no running water. Malachi resided with Ms Barriball in the cabin from 3 September 2021 until the day he was hospitalised

September 2021

101. On 13 September 2021 Malachi's care arrangements were formalised in the Tauranga Family Court, with Ms Barriball being temporarily appointed as an Additional Guardian, pending a full hearing regarding Malachi's guardianship scheduled to be heard on 1 November 2021. In the Family Court proceeding, Ms Barriball was opposing applications made by members of Malachi's immediate family, who were themselves seeking custody and guardianship of him.

102. On 24 September 2021 Ms Barriball took Malachi to Te Puna Primary School for a pre-school visit. A staff member noticed that Malachi was slim and had bruising around his eye and on his forehead.

103. On 27 September 2021 Ms Barriball took Malachi to his childcare centre. Childcare centre staff noted Malachi's hairstyle had been changed, with his fringe covering his forehead. Malachi had 'a cluster of bruises under his chin, a scratch on his left mandible, a large swelling on his forehead (which his hair had been pulled over), and a progressively blackening left eye'.

104. Childcare centre staff contacted Ms Barriball, who advised that the bruising was caused by Malachi falling off his bike. The staff asked Malachi whether he had fallen off his bike, to which he replied no. Malachi also told childcare centre staff that Ms Barriball would not be happy with him.

105. Childcare centre staff and management took photos of Malachi's injuries and placed a note on his childcare centre file. However, they did not complete an incident form, investigate, or escalate the incident further, as required by their own Child Protection Policy.

106. On 28 September 2021 Malachi celebrated his fifth birthday at the childcare centre.

107. On 29 September 2021 Malachi attended the childcare centre for the final time.

October 2021

108. As set out in Ms Barriball's sentencing judgement,[15] between 12 and 20 October 2021, Ms Barriball sent a series of text messages to her partner. In one message she stated she hated Malachi, in another that she was scared she would kill him, and in another that she would hurt him badly. Further messages included Malachi was in too much pain and she could not take him to the hospital because they would think she abused him, that she had a lot of anger towards Malachi and could not calm herself down, that she was going to kill him if she saw him again, and she was going to take him to Wellington.

109. On 19 October 2021 Ms Barriball sent a text message to her sister saying she wanted to take Malachi to hospital but was too scared.

110. On 20 October 2021 Ms Barriball sent her father a series of text messages, advising she had not taken Malachi to hospital because her partner told her not to, because the bruises on his face would make it look bad for her, and she didn't want to get into trouble.

111. On 23 October 2021 Ms Barriball took Malachi to a family function at a restaurant in Mount Maunganui. As noted in the sentencing judgment, CCTV recordings show Malachi was in obvious pain, and Ms Barriball carried him into the restaurant. When they left the restaurant Malachi was hunched over and walking slowly. Several of Ms Barriball's family members voiced their concerns about a scabbed burn on Malachi's forehead. Ms Barriball claimed that he had accidently burnt himself in the shower and he had seen a doctor.

112. On 27 October 2021 Ms Barriball's lawyer sent an email to the lawyer for the child advising they had been told that Ms Barriball had taken Malachi to Hamilton and had remained there because her understanding was they could not return to Tauranga under the Covid-19 lockdown restrictions which were in place at the time. In reality, Ms Barriball and Malachi had not gone to Hamilton, and continued to reside in the cabin on her father's property.

113. The lawyer for the child was also advised Ms Barriball had flu-like symptoms and was awaiting the result of a Covid-19 test.

114. The lawyer for the child asked Ms Barriball to attend the hearing on 1 November 2021 via audio visual link but was told Ms Barriball did not have access to a computer. Malachi's cousin offered to deliver a laptop to Ms Barriball, but Ms Barriball declined the offer.

115. On 28 October 2021 the lawyer for the child requested the hearing not be vacated until the Covid-19 test result was known.

116. On 28 October 2021 Ms Barriball and her father took Malachi to a medical centre, as Ms Barriball wanted Malachi assessed for autism to support her bid for permanent guardianship. Ms Barriball did not mention the serious burn on Malachi's abdomen, and no physical examination was deemed required, nor was undertaken.

117. On 29 October 2021 the Family Court hearing was vacated as the Covid-19 test result was not available and because Ms Barriball claimed she had been in a region that had been locked down due to a Covid-19 outbreak. As a result, the 1 November hearing date was deferred.

[15] In the High Court of New Zealand Rotorua Registry. The Queen Vs Michaela Barriball and Sharon Barriball. Sentence of Paul Davison J, 30 June 2022.

November 2021

118. At approximately 8.30am on 1 November 2021, Ms Barriball carried Malachi from the cabin into the main house. Malachi was unconscious and suffering seizures as a result of multiple blunt force injuries to his head inflicted by Ms Barriball.

119. An ambulance was called, and Malachi was taken first to Tauranga Hospital and then Starship Children's Hospital in Auckland. Malachi had emergency surgery that same day.

120. The Department of Corrections enabled Malachi's mother to be present with Malachi in hospital.

121. The multiple injuries Malachi was subjected to by Ms Barriball proved to be un-survivable, and he passed away on 12 November 2021.

6. How the system interacts

122. An explicit part of my terms of reference is to assess how the processes for each agency to notify and respond to child abuse interact across the system (including strengths and weaknesses), and to make recommendations. I believe the simple answer is agencies within the system do not effectively interact, and while their processes allow interaction, the system is not adequately designed to support or require this interaction, with each agency existing for a different, unique purpose.

123. I am advised the children's sector is not formally defined, but is understood to be all those agencies and partners who share responsibility for protecting and advancing the wellbeing and rights of children and young people. I am told this includes:
    - Those agencies who have particular statutory responsibilities (Children's Agencies under the Children's Act 2014).
    - Those agencies who have responsibilities under government strategies, including the Child and Youth Wellbeing Strategy, and the Oranga Tamariki Action Plan.
    - Those who share in the delivery of services to meet the needs of children, young people and their families.
    - And those who have a role in ensuring those responsibilities are performed.

124. The current view of who the children's sector includes is set out in a diagram at **Appendix Four**. I am advised this definition remains a work in progress but regardless this clearly indicates to me there is not a shared agreed definition of who and what the children's sector and system includes. I consider this lack of clarity and definition is a gap which must lead to significant potential for ambiguity and uncertainty about who bears what responsibilities in the system.

125. Identification of and response to child abuse is not always at the centre of the myriad of functions for the government sector agencies that commissioned this review. Even Oranga Tamariki, the agency at the heart of child abuse identification and response, failed to detect red flags and prioritise Malachi, as they neglected to complete the necessary checks to satisfy the agency that he was safe. The Chief Ombudsman also identified this in his report. Several agencies refer to the definition of 'child abuse' in section 2 of the Oranga Tamariki Act 1989 in their policies, and all agencies have a method for sharing child abuse definitions and guidelines for responding to suspected abuse with employees. These considerations are, however, not sufficiently embedded in day-to-day practice, and relevant training and requirements for refresher courses is not routine.

126. Malachi was not always hidden, at least not initially. There were many interactions with Malachi, his family and Ms Barriball throughout the time period he became at risk, including by multiple people and organisations. For example, in just the nine days from 21–30 June 2021, there were 14 interactions with six agencies. Some of these were on the same day.

127. Despite Malachi being present at many of the interactions and all the interactions being about him or because of him, his need to be safely cared for was not at the centre of considerations, with agencies instead defaulting to considering the needs and views of the adults around him. Agencies had opportunities to critically consider the information they

held, and proactively share this information with one another, but the system settings did not mandate or even encourage this interaction. I believe this is a significant limitation of the system. It can be reasonably assumed that had these steps been taken, Malachi would have been removed from Ms Barriball's care. However, only Malachi's mother and family had as their primary focus his wellbeing and what was happening for him, and Malachi's mother was limited by her inability to see and hold Malachi.

128. **There were those who tried to act but were not listened to.** This was particularly the case for Malachi's family, who attempted to alert authorities to their concerns for his wellbeing, and felt stonewalled at almost every juncture. Malachi's cousin contacted Police, Oranga Tamariki, and Malachi's childcare centre. Malachi's cousin worked quickly and thoughtfully to attempt to have him placed in her care through the Family Court. His family were faced with a lack of support when reporting their concerns, given no assistance to navigate the system (except from the lawyer for the child), and experienced a lack of feedback loops to know if their efforts to report were being acted on and making a difference.

129. **There were those who were uncertain and did not act.** This includes Oranga Tamariki, who did not inform itself adequately before closing the Report of Concern that required thorough investigation. It also included Malachi's childcare centre who appeared to believe Ms Barriball's version of events and did not escalate their concerns, despite having a policy that required this, and despite Malachi's cousin specifically contacting them to ask them to be particularly alert for his safety.

130. There **were those who knew and chose not to act.** As noted in the sentencing of Ms Barriball, some members of Ms Barriball's community were likely to have known he was at risk.[16]

131. A lack of sharing of information is a key gap, both from the community Malachi was residing in, and across agencies. This works at two levels; first, decisions were made without seeking adequate information that should have been considered in assessing the level of risk Malachi was facing, and secondly, there was no proactive sharing of information across agencies. Section five of my report details how each part of the system held relevant information about the care and wellbeing of Malachi, yet in order to function effectively, each part needed to identify the relevance of the information and work together with the other parts in a coordinated and mutually reinforcing manner to share and act on the information.

132. I was advised the existing information sharing framework, including how the requirements of the Privacy Act 1993 are managed, is comprehensive and enabling, but I have not seen universal evidence that frontline employees are consistently supported to understand or operationalise the information sharing framework. In fact, I heard a lot of views to suggest the opposite.

133. I have observed there is a high degree of uncertainty in the system and a lack of understanding of what information can and should be shared under the existing framework. The system relies on multiple players using a high degree of discretion, judgement and critical thinking to identify risk to the child and to act on this. This reliance on multiple

[16] In the High Court of New Zealand Rotorua Registry. The Queen Vs Michaela Barriball and Sharon Barriball. Sentence of Paul Davison J, 30 June 2022. Paragraphs 67 - 68

players to work out and do the right thing adversely impacts on the system's ability to act as an effective system of safety nets. It needs to be countered with highly effective and enhanced information sharing.

134. In some instances, agencies were not inquisitive enough to look wider than their own prescribed, albeit legally compliant, processes in the interests of the child despite risks to the child in front of them, potentially identifiable if only they had looked at him. Instead, agencies' interactions with Malachi were task-focused and insular. For example, the Ministry of Social Development assisted Ms Barriball with income and housing as requested and as is their role. From my point of view, however, I consider the fact that Malachi was newly in the care of an informal guardian who did not have income and housing, as a potential risk that the Ministry should, in future similar situations, consider and follow up on. We must create changes in the system to facilitate and improve such broader enquiry, and to address the ambiguities that exist. Only then will the system interactions be reliably effective.

135. In addition, some processes that should have connected did not. For example, if Malachi's childcare centre had notified Oranga Tamariki of his injuries, this would have provided strong evidence to support the Report of Concern made by Malachi's cousin.

136. The lack of interaction created gaps in the safety nets which allowed Malachi to fall through all too readily.

Strengths of the child wellbeing and protection system

137. As part of my review, I have also considered the strengths of the system. There is a statutory requirement under section 7AA of the Oranga Tamariki Act 1989 to give practical effect to the principles of Te Tiriti o Waitangi. The commitment of Oranga Tamariki to partnering with iwi, hapū, and kaupapa Māori organisations to find appropriate solutions for tamariki in need, as detailed in their Future Direction Plan, is a positive direction.

138. The Future Direction Plan was developed in response to the report of the Ministerial Advisory Board, 'Te Kahu Aroha'. This says 'In order to lead prevention of harm to tamariki and their whānau, collective Māori and community responsibility and authority must be strengthened and restored in a way that is fit for purpose within a modern and future context. The Crown's role is to support this kaupapa'.[17]

139. Through the Future Direction Plan, Oranga Tamariki has acknowledged there needs to be a fundamental and significant shift in its approach, operating model and practice to be truly tamariki and whānau centred.[18] The Future Direction Plan involves incremental transference of the responsibilities of Oranga Tamariki to communities and organisations that are locally led and regionally enabled, while providing national support.

140. In setting out a path to devolution, Oranga Tamariki's own Future Direction Plan is aligned with my recommendation regarding on-the-ground collaborative support initiatives by 'galvanising cross agency support for local communities, iwi, hapū, NGOs and agencies to

[17] 'Hipokingia ki te Kahu Aroha, Hipokingia ki te katoa (Te Kahu Aroha) – Report of the Oranga Tamariki Ministerial Advisory Board' July 2021, page 9
[18] Oranga Tamariki Future Direction Plan. September 2021, see New ways of working | Oranga Tamariki — Ministry for Children

take ownership of the local system that supports whānau and prevents harm to children and young people in the way they know will work for their people'.[19]

141. The Productivity Commission report, 'Together alone: a review of joined-up social services' finds that there are a range of collaborative models operating in Aotearoa that are sensitive to local requirements. It notes these models are helping to address persistent disadvantage, but are not uniformly well supported or resourced, with workforce capacity and capability constraints, and they are not yet present throughout the country.[20]

142. A further step in the right direction is the Oranga Tamariki Action Plan.[21] This brings together the children's agencies[22] in a collective commitment to work together to achieve outcomes in the Child and Youth Wellbeing Strategy and to promote the best interests and wellbeing of children and young people with the greatest needs.[23]

143. The Oranga Tamariki Action Plan is required under Part One of the Children's Act 2014. The plan was published earlier in 2022, with its purpose described as: 'to indicate how the chief executives of the children's agencies will work together to improve the well-being of the core populations of interest to the department'. The plan states 'Aotearoa should be the best place in the world for all children to live'.[24]

144. I note the plan is described as 'The Children's Agencies Joint Plan to prevent harm and promote wellbeing for the Children and young people in the populations of interest to Oranga Tamariki'. This means children with the greatest needs, and the plan is owned by all the children's agencies.

145. As I am commissioned by some of those agencies, and as my recommendations address gaps between the current safety nets and their operation, I regard this as a key action plan, with strong currency. Perhaps the document should be renamed 'the Tamariki Agencies' Action Plan' to reflect and emphasise the inter-agency commitment, collaboration and accountability needed to deliver a united children's system. This is every agency's responsibility, and the default should not be left to Oranga Tamariki alone.

146. I endorse the Plan's demand that a 'strong and passionate sense of urgency is needed by all agencies to respond immediately to the needs of children, young people and their families and whānau'.

[19] Oranga-Tamariki-Action-Plan.pdf (orangatamariki.govt.nz), page 7.
[20] Fry, J (2022) Together alone: A review of joined-up social services. www.productivity.govt.nz/inquiries/a-fair-chance-for-all Commission review of joined up social services
[21] Oranga Tamariki Action Plan is the Children's' agencies joint plan to prevent harm and promote wellbeing for the children and young people in the populations of interest to Oranga Tamariki. See Oranga Tamariki Action Plan | Oranga Tamariki — Ministry for Children
[22] New Zealand Police, Ministry of Education, Ministry of Social Development, Ministry of Health, Ministry of Justice and Oranga Tamariki—Ministry for Children.
[23] Child and Youth Wellbeing (childyouthwellbeing.govt.nz)
[24] Oranga-Tamariki-Action-Plan.pdf (orangatamariki.govt.nz) page 3

147. On a broader scale, there is a lot of goodwill and dedication evident in the system, both from frontline staff and in the policies, procedures and legislation that have evolved over time to support them, with an increasing focus on child wellbeing. Some examples include:

- The Children's Act 2014 requires that prescribed state services, boards of Health New Zealand and the Māori Health Authority, school boards and children's services must have a Child Protection Policy which contains provisions on the identification and reporting of child abuse and neglect, and that is reviewed within three years of introduction.[25]

- One of the purposes of the Public Service Act 2020 is to establish mechanisms for public service agencies to work better together, to achieve better outcomes for the public.[26] The Joint Venture for Family Violence and Sexual Violence, Te Puna Aonui, is one of the initiatives established based on the provisions of the Act. Te Puna Aonui is responsible for implementing Te Aorerekura (Action Plan for the National Strategy to Eliminate Family Violence and Sexual Violence), including by building off 'current infrastructure and learning to continue working with communities and specialist sectors'.[27] Te Puna Aonui's approach is one of a number highlighted by the Productivity Commission's recent report 'Together alone'.[28] The Act provides the foundation for more initiatives of this nature.

- The Social Wellbeing Board (SWB) and Te Puna Aonui Interdepartmental Executive Board are cross-sector groups of Chief Executives that oversee work spanning the responsibilities and interests of more than one agency.[29] One of the priority areas for the SWB is governance of the Child and Youth Wellbeing Strategy referenced above, which aims to transform the way Ministers and agencies work together to improve the wellbeing of children and young people, removing barriers to wellbeing and supporting collaboration.[30] The SWB also has an oversight role of the Oranga Tamariki Action Plan, while the Interdepartmental Executive Board oversees the implementation of Te Aorerekura.

- The Police and Oranga Tamariki have developed the Child Protection Protocol with Joint Operating Procedures to jointly consider Reports of Concern or complaints that meet a defined threshold and where there is a role for both agencies. The Child Protection Protocol exists to ensure timely, coordinated and effective action by Police and Oranga Tamariki, and to promote national consistency in responding to Reports of Concern.[31] It was renewed late last year.

- There is a useful precedent in place through the Memorandum of Understanding between former District Health Boards (now Te Whatu Ora), the Police and Oranga

[25] Children's Act 2014
[26] Public Service Act 2020.
[27] Te Aorerekura National Strategy to Eliminate Family Violence and Sexual Violence NZ Govt 2021-2023 Te-Aorerekura-National-Strategy-final.pdf (tepunaaonui.govt.nz)
[28] Fry, J (2022) Together alone: A review of joined-up social services. www.productivity.govt.nz/inquiries/a-fair-chance-for-all Commission review of joined up social services
[29] Social Wellbeing Board. Briefing to the Incoming Minister, 13 November 2020.
[30] www.childyouthwellbeing.govt.nz
[31] Child Protection Protocol: Joint Operating Procedures, between New Zealand Police and Oranga Tamariki Ministry for Children, December 2021.

Tamariki to promote information sharing and Reports of Concern to address risk for children and young people, and that could be a useful model.[32]

- The Department of Corrections has a process in place to gather information from inmates as to their childcare responsibilities at the time of incarceration. The Department is able to use information collected in this template to notify Oranga Tamariki of any risk identified. The Department of Corrections also has a pre-sentence report template that is used to identify childcare responsibilities, among other matters, with probation officers able to include this information in the 'Provision of Advice to Courts' document for the Judge to consider when determining whether or not to impose a sentence of incarceration, and the term of that sentence.[33]
- The Chief Judges of the District Court and of the High Court have recently requested the Department of Corrections ask probation officers to include information about dependent children in pre-sentence reports where the offender to be sentenced is either the primary caregiver or plays a substantial role in caregiving. And, where there is a recommended or likely sentence of imprisonment, that information is also able to be used in terms of considering what should happen for dependent children. The Chief Judges have also encouraged counsel to consider what assistance they can provide judges on this issue.[34]

148. However, the system as it stands could, and should, have done more to prevent harm being done to Malachi. The processes each agency has to identify, notify and respond to child abuse are compromised by uncertainty in understanding what can and should be done to identify and respond to risk of harm, and inadequate interaction between agencies. Uncertainty in the system must be removed, coordination between agencies must become routine, and on-the-ground partnerships secured, as it is that trust that will facilitate information sharing and action. The concept of mahi tahi is fundamental to such place-based initiatives, by which relationships for positive change can be established with whānau at the centre.[35]

Previous Reviews into Child Abuse Deaths

149. I am aware many previous reviews into child abuse and death cases in New Zealand have reached similar findings and conclusions to me as to how the system interacts.

150. I have identified at least 33 reviews and reports on the topic of child abuse and deaths, and agency capacity over the last 30 years, although there may have been more. These reviews are a mix of coronial inquests, reviews by past Children's Commissioners and reports by independent reviewers, as well as by the Family Violence Death Review Committee. Of these 33, I have detailed eight I consider particularly relevant for my review in terms of some shared circumstances and gaps in the system to those experienced for Malachi.

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[32] Memorandum of Understanding between Oranga Tamariki, the Police and District Health Boards 2011 (updated in September 2021) –Microsoft Word - FINAL MOU CYF, Police, DHBs - August 2011.doc (starship.org.nz)
[33] This refers to the pre-sentencing report prepared for anyone who is facing the possibility of a sentence of imprisonment.
[34] New Zealand Bar Association member update of 21 October 2022
35 Roguski, M., Grennell, D., Dash, S. et al. Te Pou: An Indigenous Framework to Evaluate the Inclusion of Family Voice in Family Violence Homicide Reviews. J Fam Viol (2022). https://doi.org/10.1007/s10896-022-00459-6

151. These eight reports reflect some high-profile cases of murdered children through abuse by carers, a report on a serious case of abuse, and a Ministerial review of the Department of Child, Youth and Family Services. The eight cases are:[36]

- Riri-o-te-Rangi (James) Whakaruru
- Saliel and Olympia Aplin
- Coral-Ellen Burrows
- Nia Glassie
- The 2011 report by Mel Smith
- The Brown Report
- Moko Rangitoheriri
- Leon Michael Jayet-Cole

152. I draw from these cases to reflect what Aotearoa should already have in place as a result of previous reviews similarly aimed at strengthening the system of safety nets to prevent and respond to harm to children. I also think it is important to consider past findings and recommendations in the light of the current context, as we need to be able to continuously learn from both what has, and what has not, worked previously.

153. From the eight cases I have looked at, I see the following clear themes:

- A failure of professionals to follow up when families and whānau report their concerns, or to take the views of families sufficiently seriously.
- Agencies taking a siloed approach to assess the risks facing a child when a report is investigated, considering only the piece or pieces of information before them rather than seeking a full picture of the reality for the child.
- A failure by professionals to report suspected abuse, despite multiple opportunities when they identified or were suspicious of harm caused to the child.
- A significant degree of disparity in outcomes for tamariki Māori and their whānau.
- A lack of information sharing across agencies, and assumptions that other agencies would be leading on a case, with no checks that this was the case.
- Inadequate training within agencies on what child abuse is, and what to do about it, and similarly a lack of training across relevant professions.
- A shared failure to realise or verify the reality for the child, taking only the word of the adults immediately around them at face value, despite the reality that child abuse by its nature is hidden, and that some children are groomed not to tell.
- In response to identified failings, many of the reports share calls for mandatory reporting.
- Some reports also identified the need for a locally-led response that would bring local intelligence and networks together with agencies and professionals to enable a collective assessment of risk and appropriate response.

[36] Appendix Three provides a brief summary of these reports.

154. I find it unacceptable that I need to once again make similar findings about how the system is – or is not – interacting. The majority of my recommendations are not new. Appropriate information sharing and mandatory reporting have been called for multiple times before. There have been initial responses and public condemnation of child abuse, but the system has then defaulted backward and even the changes that had been made were not all sustained. This seems to be the case with mandatory reporting in particular, as it has been strongly recommended by reviews several times in the past but has not been implemented, and then the alternatives introduced instead – for example, public campaigns on abuse – have also lost traction.

155. I believe there are important differences in today's environment that mean it is now time to try again. The difference I see today is that we have more on-the-ground partnership initiatives in place to build from, complemented by the Public Service Act 2020 supporting interaction between government agencies. In addition, I have heard that Regional Public Service Commissioners are influential in providing local leadership. Furthermore, we have a system that is already experiencing the issues that prevented some of the recommendations being implemented (for example, the school of thought that mandatory reporting would overload the system, yet the system is already stretched). What is required is a package of measures to minimise the potential problems and maximise the gain in child protection.

156. It is time to try things we have dismissed in the past, confront and address the issues, and use the breadth of the law to protect tamariki. Top-down determination and leadership must be complemented by expansion of local on-the-ground agency and community-based partnerships that are resourced and supported to share responsibility for collaborative delivery.

7. The gaps in the system of safety nets

157. My understanding of what happened and my assessment of how agencies in the system interact has led me to conclude there are five significant gaps in the system of what should be interlocking safety nets. In this context, gaps mean something that did not happen (in the implementation or delivery of the process), or something absent from the process (a design gap).

158. The five critical gaps in the system are:

- In identifying needs of a dependent child when charging and prosecuting sole parents through the court system.
- In the process for assessing risk of harm to a child, which is too narrow and one dimensional.
- In agencies and their services not proactively sharing information, despite enabling provisions.
- In a lack of reporting of the risk of abuse by some professionals and services.
- In allowing a child to be invisible. The system's settings, approach and focus enabled Malachi to be unseen at key moments when he needed to be visible.

159. There were both proactive and reactive opportunities for agencies and the system to help Malachi that were missed. These gaps, both in design and in delivery, must be closed so that we have a purposeful and powerful system of mutually reinforcing safety nets that offers children better protection.

Gap One: There is a gap in identifying the needs of a dependent child when charging and prosecuting sole parents through the court system

160. There was a brief phase of proactive opportunity to prevent Malachi going into the care of Ms Barriball. This proactive phase began from early 2021, when his mother was arrested and then charged, through to 21 June 2021 when she was remanded into custody and Malachi left the District Court informally in the care of Ms Barriball. Opportunity to then undo this placement through the court system continued through to when the Family Court was scheduled to hear applications for guardianship for Malachi on 1 November 2021. Although expedited, and despite the repeated pleas of his family for his safety to be checked, the Family Court hearing was not rescheduled in time to help Malachi.

161. My view is Malachi could have been placed with a safe caregiver when his mother was incarcerated had there been:

- A **process in place for identification, or oversight, of proposed caregiver arrangements** when a sole care parent/caregiver is charged with crimes that are likely to end in prison terms, including providing support to sole care parents and tamariki in this situation.
- A requirement in the system to **assess and approve caregiver options** for children of sole care parents who are incarcerated.

- A requirement for follow up on **how the placement is working out** for the child.
- **A focus on the views and needs of the child** – at no stage through the criminal courts phase, nor across the whole process, is it apparent that Malachi was asked his views, whether he understood what was happening or whether he was comfortable going, or then remaining, with Ms Barriball.
- **Consideration of the voice and views of whānau** about placement of a child when a sole care parent is charged and taken into custody. Malachi's mother's family believed they were to look after him, and found out only after the remand hearing (where his mother pleaded guilty and was immediately remanded into custody), that he had left the court with Ms Barriball.

162. Had these proactive requirements been in place, Malachi may not have gone into the care of Ms Barriball initially, or, if he had, may have been removed from her care early enough to prevent serious harm being done to him.

163. My assessment is 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. In particular, there is nothing at the stage when Police (or other prosecuting agency) charge a sole care parent, or in the criminal court system at the time a person is incarcerated to automatically trigger a report to Oranga Tamariki to enable a review of the safety of the caregiver placement, or to otherwise provide any support to parents and children in this situation.

164. The incarceration of a sole care parent of a dependent child is a red flag for high risk and could be addressed through Police (or other prosecuting agency) being required to notify Oranga Tamariki at arrest. Another opportunity is when charges are filed or through the criminal court notifying the Department of Corrections of the existence of dependent children at the time a sole care parent is incarcerated (either remanded into custody or sentenced). Oranga Tamariki would then be informed to enable an assessment of the care arrangements. I note the judiciary is already giving careful thought regarding these matters and how to address this gap through the court process.

165. The inadequacy of safety nets for Malachi meant there was nothing in place to support his mother in determining care for her child. Nor was there anything in place to review whether his mother's choice of caregiver was appropriate (and continued to be appropriate). Likewise, other than bringing a private application in the Family Court for guardianship and parenting orders, there was no opportunity for the family to put their view forward as to where he would be safest and happiest.

166. To close this critical gap, I am of the view several changes are required:

- Police (or other prosecuting agency) should be required to notify Oranga Tamariki when they charge a sole care parent with charges that are likely to lead to a period of incarceration. This should be a new red flag of risk.
- This would lead to Oranga Tamariki opening a Report of Concern for the dependent child/ren. This accords with the current legislative provisions which deem a child is in

need of care and protection if their parent or guardian is unable to care for them.[37] This is clearly the case when a sole care parent is incarcerated.

- The Report of Concern system should be amended, in legislation if necessary, to require that any high risk Reports of Concern – that is, those related to safety and protection concerns rather than broader wellbeing – should remain open until the caregiver and placement have been assessed, and it has been confirmed that a child is in a safe placement. The care arrangements should also be reviewed at certain points in time, as review points are necessary for Oranga Tamariki to be able to assess the ongoing suitability of the placement.
- Oranga Tamariki assessment should include a site visit of the child's new home and meeting with the child kanohi ki te kanohi. It should also include understanding who whānau are, ascertaining their view on what care arrangements should be, and discussing what their role within care could be.
- This process needs to accord with section 7AA of the Oranga Tamariki Act 1989, to ensure that the practical commitment to the principles of Te Tiriti o Waitangi, are met. This reinforces the need for discussion with whānau as to appropriate care options.
- Oranga Tamariki could issue a certificate or other form of confirmation that, while their parent is incarcerated, the child is with an authorised caregiver. This authorisation could then be referred to and sighted by other agencies on request.
- This initial review and ongoing oversight would not be determinative of any private application for guardianship or parenting orders in the Family Court, but would be complementary to any such process. The process should occur with immediate effect prior to or from the date of incarceration.

167. To reinforce this new safety layer, additional layers should also be included beyond this, for example:

- Consideration of the criminal courts (District Court and High Court) notifying Oranga Tamariki or the Family Court of each instance a sole parent or caregiver is incarcerated. They in turn could also notify whānau, so there are more 'eyes on' what is happening for the child.
- Additions to the bail and sentencing role of the criminal courts could ensure information stating, pre-bail and pre-sentence, if the defendant is a sole parent, and outlining the proposed care arrangements for children. These additions could include:
    - The lawyer for the defendant being expected, by change in practice, to seek instructions from their client as to whether they would be prepared to tell the Court their family status and whether they are a sole parent, and advising as to the status of arrangements for alternative care for dependent children.
    - Creating a requirement for Oranga Tamariki, to review proposed care arrangements for the sole-parent's children **prior** to incarceration. (If the settings outlined in paragraph 166 above are put in place in future, this step may have already happened, but I am looking for overlapping safety nets so purposefully suggest multiple layers of protection.)

[37] Oranga Tamariki Act 1989 ss 2 and 14(1)(b); guardian has the meaning prescribed under the Care of Children Act 2004

- Creating a requirement for guardianship or parenting orders (or interim orders) to be in place prior to incarceration where possible.[38]

- Requirements that interim guardians for children whose caregiver is in prison are not appointed under section 27 of Care of Children Act 2004 unless Oranga Tamariki has robustly reviewed the proposed interim placement, irrespective of whether the parties or parents consent to the placement.
- Consideration of the Lawyer for Child role being altered or enhanced in the following ways:
  - meeting with the child they have been appointed to represent on more than one occasion prior to the substantive hearing
  - visiting in the placement home to confirm living conditions and arrangements
  - speaking with the child alone, without the caregiver present
  - seeking a referral to a General Practitioner (GP) or other registered health practitioner for a general check up in temporary and interim situations where the parent is in prison (under s133(1B)(b) of the Care of Children Act 2004)
  - making a Report of Concern to Oranga Tamariki for investigation if the above is not suitable.
- Amendments to section 131A of the Care of Children Act 2004 to require Oranga Tamariki to review both the parties to parenting and guardianship applications **and** the proposed guardian, if the proposed guardian is not named as a party.
- Requirements on the Family Court to seek information on any party's criminal record from the District Court or High Court (under rule 416HB of the Family Court Rules).

168. As I have noted already, while some of these steps could become redundant should my primary recommendation be implemented for Oranga Tamariki to check potential carers of children whose sole parent is going through the criminal courts, I repeat that I am looking for overlapping safety nets. I therefore purposefully suggest multiple layers of protection at this stage of the system, as this is what Malachi needed to prevent him going to, and then staying with, the caregiver who killed him.

[38] Rule 2 of the United Nations Bangkok Rules for the Treatment of Women Prisoners states 'prior to, or on admission women with caretaking responsibilities for children shall be permitted to make arrangements for those children, including the possibility of a reasonable suspension of detention, taking into account the best interests of the children'. United Nations Rules for the Treatment of Women Prisoners and Non-custodial measures for Women Offenders (the Bangkok Rules), adopted by resolution by the General Assembly on 21 December 2010, https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf). Similarly, in some Australian jurisdictions – specifically Commonwealth law, the Australian Capital Territory, and South Australia – there are specific legislative provisions to consider the impact of imprisonment on family or dependants.

Gap Two: The process for assessing risk of harm to a child is too narrow and one dimensional

169. Once the opportunities to prevent Malachi leaving the District Court with Ms Barriball on 21 June 2021 had been missed, a series of reactive safety nets were needed to identify and react swiftly to the growing risks for Malachi.

170. Malachi's file should not have been closed without significantly more thorough investigation of risk, as required by section 17 of the Oranga Tamariki Act 1989. I observe in the Chief Social Worker's practice review that Oranga Tamariki shares this view. This includes that further steps should have been taken to determine if the Child Protection Protocol with the Police should have been triggered, with Police being notified to investigate Malachi's situation. Oranga Tamariki also believes that Health should become a party to the Child Protection Protocol.

171. I endorse this, as the addition of a health lens and medical assessment of what harm caused by abuse can look like, could have helped identify follow up action to the Report of Concern made by his family. Moreover, the Child Protection Protocol requires joint annual training between Oranga Tamariki and the Police. If Health were added, and all three parties were to regularly train together, this could help ensure a shared understanding of what the signs of abuse are and how to draw on each other's strengths in responding to Reports of Concern of abuse to children.

172. Medical records should be joined up, and whilst there are current health data and digital initiatives to do so, these should be expedited. Emergency departments, hospital, primary care and preschool Well Child Check records should be linked to facilitate the opportunity to detect child abuse and neglect. Malachi was seen at a health centre while he was carrying signs of abuse (albeit these were not visible through his clothes) and had experienced significant weight loss since his last Well Child Check.

173. A high degree of suspicion is warranted from such signs, and would have been assisted if health records were better linked. For example, had his Well Child or medical centre notes from his younger years been sighted, it would have been apparent he had slid rapidly down the weight percentile comparison, and this observation alone could have triggered further investigation. The Ministry of Health review of what happened for Malachi recommends that 'Endeavours toward joined up medical records with appropriate point of care access [should] continue to be supported ….. Priority should be given to joining up the medical records of children, particularly those in vulnerable situations, given they often move between different services and geographical locations.'[39]

174. Potentially the most robust safety net needed is that the agencies which may hold information relevant to child protection – led by Oranga Tamariki but also requiring the commitment of the Ministries of Education, Health, Social Development, Police, and drawing on the input of the Department of Corrections, working together with agencies' services and with iwi and NGOs – have a dedicated forum 'on-the-ground' to bring their collective local intelligence, leadership and knowledge together so that a full view of the risk to a child is available. Such place-based collaborations are where whānau, community and government

[39] Review into the Death of Malachi Subecz, Ministry of Health, July 2022, page 4

agencies can bring the pieces of a jigsaw puzzle together. *I am reminded 'everyone has part of the jigsaw but no one has the full picture'.*[40] This has to be remedied.

175. The intelligence and knowledge of the whānau and community is a critical lens that is necessary to enable a thorough assessment of the reality of the risks facing a child. Malachi's family tried multiple times and through multiple avenues to bring their view to the table.

176. There was no ability to bring a shared view of the risk that Malachi was facing in place. This was a significant gap. It meant there was insufficient information recorded in Malachi's Report of Concern file to enable a thorough and balanced assessment, with Oranga Tamariki only having one narrow lens of information as to what was happening for Malachi registered in their system. Oranga Tamariki also acknowledges this in its practice review, stating 'A consistent system for localised, cross-agency, information sharing that also prioritises responding to identified needs when there are safety and wellbeing concerns' should have been a feature of assessment'.[41]

177. The intended layers of safety nets each failed Malachi, by not supporting inquiry into his reality, rather focusing on individual agency procedures and portfolio requirements. This misfocus let the gaps in the existing safety nets align for Malachi to slip through unnoticed. The information sharing system did not work proactively to identify Malachi and his needs in any holistic way. The process for assessing harm remained one dimensional.

178. To address this gap, I am of the view these changes are required:

- Oranga Tamariki should not close any Reports of Concern that indicate a high risk to the child (including care of a child of an incarcerated sole caregiver, as well as allegations of physical harm) without first obtaining information from relevant agencies, as well as those of family and of the community the child is residing within, so that there is adequate information to make a thorough assessment.
- Multi-agency teams in place for each region will expedite this process. Effective and enhanced information sharing will assist such groups to fulfil their potential to prevent or respond more fully to risks of abuse.
- This is the direction of Oranga Tamariki's Future Direction Plan, with its focus on devolution through a locally-led, regionally-enabled and nationally-supported model. This direction is also reinforced by the collectively agreed Oranga Tamariki Action Plan.
- Until there has been confirmation the child is safely cared for, based on consolidated information, Report of Concern files should remain open with a watching brief by Oranga Tamariki.
- The Oranga Tamariki assessment process should include actively seeking the views of whānau alongside the views or choices of the legal caregiver, and should recognise that a sole parent in prison has limited opportunity to monitor the care of their child.

[40] Final Report on the Investigation into the death of James Whakaruru, Office of the Commissioner for Children, June 2000. page 39 – this is quoting Laurie O'Reilly, the previous Commissioner for Children.
[41] Ko te huarahi pono, ka wātea, kia whakamarama, kia whakatika – a review of the practice in relation to Malachi Subecz and his whānau' November 2022, page 67.

179. In addition to the failure to thoroughly review the Report of Concern, it is accepted in Oranga Tamariki's Practice Review that Malachi had unmet wellbeing needs that should have been supported regardless of follow up to the care and protection Report of Concern outcome. Had there been partnerships through on-the-ground arrangements in place, Malachi's broader needs could have been addressed. Again, I see this as another layer of safety, as addressing any other of Malachi's needs would have ensured that there were eyes on him that could have identified the risks to safety he was facing.

Gap Three: Agencies and their services are not proactively sharing information, despite enabling provisions

180. A further breach of the layers of reactive safety nets that should have worked for Malachi, was the lack of use by some agencies of their own information sharing requirements both internally and with Oranga Tamariki. There are information sharing protocols in place across the agencies designed specifically to identify risks to children and to alert Oranga Tamariki to these, but there were not all used in Malachi's case. Sections 65A-66K of the Oranga Tamariki Act 1989 rely on the paramountcy principle[42] whereby the interests of the child take precedence over privacy, yet information was not shared sufficiently to protect Malachi.

181. The need to bring an enhanced information sharing regime into effect is clear to me from a number of events that impacted for Malachi. These include:

- The numerous contacts Ms Barriball had with the Ministry of Social Development. This included receiving a benefit and financial support for housing for herself and Malachi, when she had him in her care informally. This is not a suggestion that assistance was granted inappropriately, or contrary to legal requirements. However, I consider it has exposed a gap in the system that needs to be addressed. Under different settings, this could constitute a new red flag of risk and invoke a report to Oranga Tamariki.
- The implications of Ms Barriball's request from Ministry of Social Development for financial support and housing while she had Malachi in her care, at least when viewed together if not individually, could have triggered a new Report of Concern to Oranga Tamariki on growing risks for a child. There is no current requirement that these types of steps should be reported to Oranga Tamariki but I believe that there should be, so that they can form another layer of the necessary safety nets.
- The Department of Corrections raised concerns as to the placement of Malachi with Ms Barriball, with Malachi's mother's probation officer calling the Oranga Tamariki intake social worker to discuss. The social worker informed the probation officer the Report of Concern had been closed. Unconvinced that this was the right outcome, the probation officer emailed their concerns to a prison intelligence team within the Department of Corrections. The view formed in response was the probation officer should contact Police to raise these concerns. This advice was not conveyed to the probation officer and Police were therefore not advised of the probation officer's concerns.

[42] Section 4A of the Oranga Tamariki Act states: 'all matters relating to the administration or application of this Act … the well-being and best interests of the child or young person are the first and paramount consideration'; Section 65A states that 'Persons carrying out functions under sections 66 to 66Q must have regard to the principle that (because the well-being and best interests of a child or young person are the first and paramount consideration) the well-being and best interests of any child or young person, in general, take precedence over any duty of confidentiality owed by any person…'

182. The above tells me there was no ability to bring together a shared understanding across agencies of the risk of abuse Malachi was facing. I have already stated in the sections above the need for multi-agency teams to be in place for each region, each partnered with local iwi, community and NGOs. Such collaborations not only serve to broaden agencies' perspectives but also to support up-to-date intelligence and insights being shared in real time.

183. In addition to the work underway to devolve responsibilities to a regional model under the Oranga Tamariki Future Direction Plan and the agency collaboration being driven through the Oranga Tamariki Action Plan, other initiatives exist for agencies to connect to. I have visited and heard from several interagency/NGO community collaborations focussed on wrap-around local services to support actions to reduce family harm and child abuse, focussed on the needs of the child and whānau. Furthermore the Health localities required by the Pae Ora (Healthy Futures) 2022 Act will 'consult social sector agencies and other entities that contribute to relevant population outcomes within the locality' (s55(3)(c)) and work closely with their iwi and Māori Partnership Boards for their area. This provides a further avenue for strengthening on-the-ground collaboration and building the essential local trust through mahi tahi. This will contribute to multi-agency connectivity and effectiveness, and support the proactive sharing of information when children are at risk of abuse.

184. The tools are becoming available to support and nurture a partnered, collaborative direction of travel. I recommend urgent and deliberative action to foster such collaborations where they exist and to commence them where they are currently absent. Interagency/iwi/NGO and community collaborations will vary according to local needs and must be 'owned' locally and able to share information enabled by my recommendation regarding strengthened information sharing so that it is both effective and enhanced.

185. There is no wrong door into the partnered collaborations, and no wrong approach as long as they meet local need and can share accountability for assessing the risk to a child and providing appropriate follow up. This could be through a statutory response from Oranga Tamariki for a high risk Report of Concern, or, where a Report of Concern does not reach the threshold for statutory Oranga Tamariki or Police action, through a more general community response of support or tailored services.

Information sharing must be effective

186. As referenced above, information was not shared, sought or consolidated to allow a thorough view of what was happening for Malachi. In its practice review, Oranga Tamariki acknowledges that not considering the report of concern further and not seeking information from other agencies impacted on its ability to assess Malachi's safety and wellbeing. Similarly, agencies did not proactively share information with Oranga Tamariki. This is despite the framework for information sharing, including privacy implications under the Privacy Act 1993 and principles, being permissive about sharing information when a child is at risk. Principle 11 of the Privacy Act 1993 enables disclosure when necessary to prevent or lessen a serious threat to someone's life or health, and a broad ability for interagency sharing of information when a child is at risk under section 66C of the Oranga Tamariki Act 1989.

187. However, notwithstanding these principles and the enabling legislative framework for information sharing, what I saw was a gap between the framework and practice. Information can and should be shared under the framework, but it seems the framework is not well

understood by frontline workers. It may be that policies and practice describing information sharing and privacy requirements for the frontline are overcomplicated and not reflective of their everyday workloads and realities, or it may be there is simply a lack of awareness amongst frontline staff. I have also been advised that reticence to share information may arise from a misplaced sense of obligation to the caregiver. Whatever the reason, there is a significant lack of ownership for proactively sharing information across the system at multiple opportunities.

188. I accept, under current settings, agencies may have been following their own procedures correctly, but the lack of proactive or inquisitive and contextual thinking meant a whole view of the realities and risks of Malachi's situation was not put together by agencies. The settings need to change to address this. Uncertainty has created a 'hit and miss' potential, with severe repercussions for a child at risk. This says to me we need to do more to help agency staff and their services understand that sharing relevant information is key to enabling action on child abuse. Professionals and agencies' uncertainties must be addressed. There can be no excuses.

189. The current information sharing provisions are voluntary. A September 2021 evaluation of their impact found voluntary provisions were slowly being implemented, but some changes should be considered to strengthen the system; these included provision of more guidance and training, and greater consistency in utilisation of the provisions across the agencies (as the evaluation found some were utilising the provisions more than others). The evaluation specifically identified that 'There is still a group in the sector who are unaware of the provisions and others who are aware but not yet confident using them'.[43]

190. I agree there should be ongoing education to make information sharing provisions clearer, as well as regular training on the detection of child abuse. In addition, considering the gaps in information sharing that I have seen, I believe there is a pressing need to reduce confusion and empower information sharing that will support both management of Reports of Concern and community /on-the-ground initiatives. This means enhanced and effective proactive information sharing mechanisms need to be developed to address the uncertainty that exists across the system as to what can be shared and when. The system needs to take ownership for sharing information proactively.

191. This will require making explicit in shared training, that observations to be shared do not have to meet a 'test' of proven harm, but rather are about encouraging and enabling a wider view of possible risk and concern and supporting a duty to care about the wellbeing of a child. This is to help ensure that the child is front and centre of interactions and not ignored in the background with a focus only on the adults accompanying them.

[43] 'Evaluating the voluntary information sharing provisions of the Oranga Tamariki Act 1989'. Synergia Evaluation, September 2021, page 31

Gap Four: Lack of reporting of risk of abuse by some professionals and services

192. There were several opportunities for professionals to help Malachi that were missed and would have formed a further safety net to identify risks to his safety. These included:

- His early childcare centre, Abbey's Place, where childcare workers saw evidence of harm, but which the centre did not report. Instead they asked Ms Barriball about the bruises, contusions, and scabs they had observed and photographed. This was contrary to their own Child Protection Policy, which should have triggered a Report of Concern to Oranga Tamariki straight away. Ms Barriball denied any concerns, claiming that Malachi had fallen off his bike. The centre then asked Malachi if this was the case; he said he had not fallen off a bike, and that Ms Barriball would be mad with him. Still they did not report this, and despite Malachi's cousin having specifically asked them to be particularly alert to risk to Malachi.
- All services working with children are required under the Children's Act 2014 to have a Child Protection Policy. I am advised that Abbey's Place Childcare Centre had a Child Protection Policy in place. Clearly it was not implemented. The Ministry of Education subsequently investigated the situation and removed the centre's licence to operate.
- I have been advised there are currently no requirements for independent review of implementation of child protection policies by early childcare centres in place. I am further been advised that there could be value in standardising a template for Child Protection Policies, so that each service does not need to invent their own. Nor is there any training required on the implementation of these policies. While some childcare centres do offer regular training for their staff, this is by voluntary arrangement by individual centres. This means that there is potential for early childcare centres to have child protection policies in place that are not understood by staff and not implemented appropriately. This is a critical gap that must be addressed

It is time to move to mandatory reporting where there is high risk of abuse

193. I have learnt through my review 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. This extends to significant gaps or inaction by agencies and professionals reporting concerns of abuse to Oranga Tamariki for investigation. In my view, it is time to move to mandatory reporting by designated 'mandatory reporters' to address these uncertainties and gaps, and ensure the breadth of the law in Aotearoa can be applied to protect children from harm.

194. Mandatory reporting has been recommended numerous times by previous reviews into child abuse cases. In response, there have been two attempts to change the legislation to make reporting mandatory, both of which were ultimately unsuccessful. Instead of introducing mandatory reporting, it was considered that nation-wide publicity campaigns would be as effective in ensuring society had a clear understanding of what child abuse is and when to report it. As a result, the duties of the Chief Executive of (the then) Child, Youth and Family were extended to include responsibility for developing child abuse reporting protocols and public education campaigns. An example of these campaigns includes the 'Never Shake a baby' campaign of 2009. Such steps are likely to have been useful, but – aside from the

reality that no campaigns have been undertaken in recent years – they have not proven adequate on their own in addressing the challenge of child abuse.

195. I have discussed mandatory reporting with the relevant Australian agencies of both the states of New South Wales and Victoria. New South Wales has had mandatory reporting in place since 1977 (strengthened in 1987 and again in 1998), while Victoria has had it in place since 1993. There is much to learn from their experiences, but the key lesson to me is essentially that tight and clear definitions supported their implementation of mandatory reporting, together with a strong set of Mandatory Reporting Guidelines. This includes New South Wales specifying that mandatory reporting is required for **significant** harm, having added the 'significant' to address the risk from a rise in reporting of concerns that were not specifically related to child protection, while Victoria has focused its mandatory reporter requirements on sexual and physical abuse. Both states also moved to specify professionals and services deemed to be mandatory classes of reporters.

196. I believe that we need to make similar clarifications here in Aotearoa. There should be a category of indicators of abuse that are classified as high risk and that require a 'High' Report of Concern response. It is these that should require mandatory reporting by professionals and service providers who work with children. It is also these High Reports of Concern that should not be closed (refer to paragraph 166) until Oranga Tamariki has ensured that they or one of their partners on the ground has had eyes on the child.

197. I consider it significant in Victoria that, once a report of sexual and/or physical harm is made to their Department of Families, Fairness and Housing, the majority (70%) are then moved to co-located interagency and community hubs to follow up. These are termed the 'Orange Door', and there is a network of these hubs across the state.[44] This is similar to my recommendation for multi-agency, partnered teams on-the-ground to assess Reports of Concern and what follow-up is required, both statutory and for general referrals for support.

198. This also reinforces my view that there can be no wrong door for reports to be followed up through. Whether multi-agency teams have come about because of concerns of family violence, through Oranga Tamariki, the health sector or from iwi or the community, the need is to coordinate and bring the information together in one place amongst those who can make a difference through both a statutory child protection response, and/or support for more general needs. These on-the-ground initiatives ultimately provide a mechanism for addressing the determinants of health and wellbeing, Pae Ora, with its components of mauri ora, whānau ora and pae ora.

199. I acknowledge there are potential challenges that need to be planned for introducing mandatory reporting. From the experiences of both New South Wales and Victoria, I know one impact can be a significant rise in the volume of reporting which can risk overwhelming the system. This can impact on confidence the system is able to be effective at protecting children.

[44] The Victorian Child Protection Policy Directorate within the Department of Families, Fairness and Housing generously shared their time in a conversation on 26 October 2021; they also shared links to some of their supporting material eg https://providers.dffh.vic.gov.au/mandatory-reporting and When to report to child protection 2019.pptx (live.com). Add in NSW refs also

200. I also heard, however, these challenges can be addressed through careful planning and by clearly defining what constitutes a significant risk of harm that must be reported, and by whom. I have heard it is also important to clarify whose role it is to respond to different levels of concern for a child, including where the concern is for general wellbeing rather than for specific safety and protection needs. I believe this is where multi-agency partnered teams can complement mandatory reporting of significant risk of harm in Aotearoa.

201. I am told the reasons that mandatory reporting was not introduced in New Zealand following strong recommendations to do so in previous reviews were due to similar fears about the system being overloaded and trust being eroded. This included a fear that some families would not seek help from professionals, for example health professionals, because they feared being reported to the state. While acknowledging these are real concerns, I believe that each of these risks is manageable if policy and processes for mandatory reporting of high risks of abuse are appropriately designed and supported with tailored guidance, supported by regular training.

202. That is the view of both New South Wales and Victoria in their experience of the impact of mandatory reporting. This means that mandatory reporting should be introduced as part of a package that includes mandatory training, effective and enhanced information sharing, clear and agreed definitions of what indicators of abuse that require reporting are (what the 'red flags' are), and expansion of locally-led partnerships of agencies together with iwi, kaupapa Māori organisations, Pacific providers, NGOs and community groups. Public health and primary care may also be involved.

203. These groups are all needed at the table, so that there are pathways to strong statutory protection when it is needed, to relevant and accessible community support regardless, and to provide support and follow up when needs are identified but they do not reach a threshold of safety and protection concerns as a 'High' Report of Concern.

204. I believe that introducing mandatory reporting will force these issues to finally be addressed. Moreover, the context of Aotearoa today is different from even a decade ago, when mandatory reporting was last considered. There are now cross-agency collaborations, drivers and systems in place at both the national and local on-the-ground levels that can help mandatory reporting be applied without it being an overly blunt tool. Introducing mandatory reporting as part of a package of change will provide the certainty and legal authority to report concerns that some professionals and services have otherwise struggled with to date.

A process for introducing mandatory reporting for children at high risk of abuse needs to be undertaken

205. I recommend a comprehensive process is undertaken to design how mandatory reporting of at risk children will work. Considerations within this process must include articulating all the relevant red flags that together indicate high risk of harm to a child. Considerations should include who is required to be a 'mandatory reporter'.

206. In developing our own criteria for who is covered by mandatory reporting requirements, there could be value in reviewing the scope of existing international precedents. For example, I note under section 27 of the New South Wales Children and Young Persons (Care and Protection) Act 1998 No 157, mandatory reporting requirements apply to:

(a) person who, in the course of his or her professional work or other paid employment delivers health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children, and
(b) a person who holds a management position in an organisation the duties of which include direct responsibility for, or direct supervision of, the provision of health care, welfare, education, children's services, residential services, or law enforcement, wholly or partly, to children, and
(c) a person in religious ministry, or a person providing religion-based activities to children, and
(d) a registered psychologist providing a professional service as a psychologist.' [45]

207. Other steps that need to accompany bringing mandatory reporting into the legislation, include ensuring:

- A clear definition of what abuse is and what the red flags of abuse can include, including what should constitute a 'High' risk to require such a Report of Concern.
- Agreement with local on-the-ground partnership arrangements as to how Oranga Tamariki works with partners throughout the process of assessing and responding to High Reports of Concern. Noting there are place based initiatives currently that will provide valuable models. Reports that do not fit with a 'High' classification can still have children and whānau supported locally.
- Effective monitoring of reporting. The implementation of Child Protection Policies by all Education providers needs to be monitored regularly through a dedicated monitoring function.
- Mandatory training for all children's workers and providers of children's services, in line with the definitions of 'children's workers' and 'children's services' set out in the Children's Act 2014. Training is vital to ensuring workers can identify risk of abuse and can implement their responsibilities. It also aids collaboration between professions and agencies.
- Effective and enhanced information sharing as set out in the section above.
- In addition, and again following the New South Wales experience, to support those deemed to be mandatory reporters, a guide should be developed to help mandatory reporters decide when and what to report, as part of setting an agreed definition of what the red flags are that indicate need for a High Report of Concern response. This could build on and extend from the definition of serious harm in section 14AA of the Oranga Tamariki Act 1989.
- There needs to be adequate resourcing of Oranga Tamariki to enable effective response to mandatory reporting. Whilst numbers of Reports of Concern are currently relatively numerous (on a national comparator scale) and the workload is currently heavy, the new system both central and devolved will require additional establishment resources. Once bedded in, this can be reviewed.

208. As a corollary to mandatory reporting, there should be clear feedback loops to professionals and services who notify Oranga Tamariki as to the outcome of their report. Despite a requirement in the Oranga Tamariki Act 1989 for Oranga Tamariki to inform notifiers as to

[45] Children and Young Persons (Care and Protection) Act 1998 No 157 - NSW Legislation

the outcome of a Report of Concern, I have heard numerous times during this Review, including from other government agencies, that this does not always happen. The data I have seen indicates that there is no consistent measure of how often feedback and notification of outcomes takes place. This lack of feedback, I am told, risks frustration and mistrust, and can disincentivise future reporting and collaboration. This also misses opportunities for learning from the feedback.

209. While I believe that mandatory reporting is necessary for professionals working with children and for providers of children's services, I do not recommend mandatory reporting by the general public, as I do not think this is a practical recommendation because of the training and compliance measures that would be required. I recognise and applaud those volunteer and community organisations who do choose to train their teams in recognising and responding appropriately to suspected abuse. There is significant value in outcomes for children through community groups taking these steps. In addition, I consider there must be regular campaigns – as required in the legislation already anyway – to build community understanding of what abuse is, how children can be harmed, and how whānau and community can intervene safely through reporting their concerns, as well as what training is available in the community for them to draw on.

210. I know that community ties can make some people fearful of reporting, so there needs to be trusted avenues to report through in communities. This complements my recommendation for multi-agency and partnered teams to be established, as I expect there will be people within the iwi, NGOs and community groups who participate in local on-the-ground initiatives who would be trusted to hear concerns. This is one of the advantages of a partnered approach at the ground level, as it gives rise to more potential for children at high risk of abuse being detected and 'seen' – and therefore getting the help they need sooner.

Gap Five: The system's settings enabled Malachi to be invisible

211. At the centre of everything in this review sits Malachi. It is a tragedy he has only become the centre of attention because he was killed. He should have been noticed and his needs should have been front and centre throughout, but instead, even when he was sitting in front of adults, he was not properly seen.

212. Agencies and professionals each seem to have defaulted to a focus on the adults around him and whether their immediate needs were met, assuming this would be the same as meeting his needs. What I have seen is a transactional focus on moving requests through, or indeed closing reports rather than a 'duty to care' to look closely at the safety of children. This duty to care applies to all of us, and, alongside whānau, applies most particularly across those agencies and providers who make decisions and provide services that affect children. I have been advised that the critical message is '*Don't look away*'.

213. It is a significant and material gap in the design of the system that the views of Malachi were not actively sought or seriously considered at virtually any point from the arrest of his mother through to the morning of 1 November 2021 when he suffered his fatal injuries. We know children of prisoners are some of our most at risk citizens. We also know that, by its very nature, abuse will be hidden and, when they are in the presence of their abuser, children will be unable to explain or alert other adults to the risk they are in. For these reasons, there regardless needs to be a safety layer to ensure eyes on and active listening for the views of

the child, as well as channels for health, educational, welfare, and other support to be directed towards a child facing the very difficult sudden loss of their mother to a prison.[46]

214. Malachi needed eyes specifically on him at numerous points throughout the time he was with Ms Barriball, as she was too easily able to hide or explain away his suffering when she presented for meetings and appointments.

215. Malachi was visible only through Ms Barriball, who was perpetuating the harm and manipulating the system to keep it hidden. Despite it being a feature of abuse for perpetrators to hide the harm they are inflicting, Malachi's own views and experience were not sought. The system did not adequately require consideration of Malachi in his own right. Agencies exist with vertical accountabilities, when we need horizontal responsibility, especially for children at risk of harm. I see significant value in ensuring children are actively and directly focussed on by the agencies and service providers that make up the children's system. The system needs to be knitted together, with children as the focus.

216. My terms of reference ask me to assess interactions across the children's system and make recommendations in response. I believe the simple answer is that the agencies within the system do not effectively interact for a child at risk. The system has not been designed to do so, with each agency comprising the children's system existing for unique purposes. I recommend a specific responsibility is needed to categorically unite an effective children's system that makes it explicit that each agency, preferably in their founding legislation, shares responsibility for focusing on, and checking the safety of, children.

217. In jointly commissioning this review, I believe the Chief Executives of the six agencies recognise the need to improve the system such that overlapping safety nets are hard wired into it. Such action will help prevent the tragedy of Malachi's death happening to another child for whom we all have the duty to care.

[46] For a discussion of some of the needs of children in this position, see Annaliese Johnston, 'Sentencing the Silent: Children's Rights and the Dilemma of Maternal Imprisonment' (2014) 1 Public Interest Law Journal of New Zealand 97, online at http://www.nzlii.org/nz/journals/NZPubIntLawJl/2014/17.html#fn11.

8. Recommendations

218. The death of Malachi was a heinous crime committed by Michaela Barriball. She has been imprisoned for life, but that cannot be the end of the response to Malachi's tragic murder. I have been tasked to examine and identify ways to improve the children's sector identification of, notification, and response to suspected abuse of children and young persons.

219. The following are the recommendations I make to facilitate the closing of the gaps in the children's system that did not catch identifiable risks to Malachi from his carer. The recommendations are grouped under the gaps identified

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

i. **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.

ii. **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 1989, and under te Tiriti o Waitangi (and its principles).

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

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

iv. **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.

v. 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.

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

vi. **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, including emergency housing support, from the agency for a child whose caregiver is in prison.

vii. **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.

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

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

ix. The introduction of mandatory reporting should be supported by a **package approach that includes**:

- **A mandatory reporting guide** with a **clear definition of the red flags** that make up a high-risk Report of Concern, together with the creation of a 'High Report of Concern' category similar to the New South Wales 'Risk of Significant Harm' definition.
- **Defining mandatory reporters**, all of whom should receive regular training.
- **In addition, for professionals deemed to be mandatory reporters, there should be:**
  - **Undergraduate 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.

x. 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.

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

xi. The agencies that make up the formal Government's children's system **should be specifically defined in legislation**.

xii. 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.

xiii. **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'*.

xiv. So change can be monitored, **the recommendations made in this report should be reviewed in one year's time by the Independent Children's Monitor in its new system-wide role**.

220. 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.

221. I make these recommendations because the lack of action for Malachi meant he became an invisible child and his abuse was hidden. There were:
    - those who knew and chose not to act
    - those who tried to act but were not listened to
    - those who were uncertain and did nothing.

222. Our children deserve better protection from us all. But the system's current settings are neither adequate nor sufficiently clear to ensure action and shared responsibility. There are gaps in the safety nets where there should be overlaps secured by hard wiring. Settings need to be addressed so that the system does not default to any one agency to deliver the change needed. It is everyone's responsibility to address potential child abuse. *Do not look away*.

‘Mā o mokopuna koe e mōhiotia’

You will be known on the welfare and achievements of your descendants

I am grateful to Sir John Clarke for providing the powerful opening and closing whakataukī.

Appendix One: Terms of Reference

Joint Review into the Children's Sector: Identification and response to suspected abuse Terms of Reference

Purpose

1. The purpose of this review is to examine and identify ways to improve the children's sector identification of, and response to, abuse of children and young persons.
2. The review will draw on the circumstances of the death of Malachi Subecz to decrease the potential for such a tragedy occurring again.

Background

3. On 1 November 2021 five–year–old Malachi Subecz was admitted to hospital with a significant head injury and multiple bruises present around his face, forehead and limbs. He was intubated and flown to Starship Hospital for emergency neurosurgery. On 10 November 2021 his breathing tube was removed and on 12 November 2021 he died from his injuries.
4. At the time, his mother was in prison on unrelated matters. His caregiver, Michaela Barriball, was charged with murder, injuring with intent and two charges of ill treatment of a child. She pled guilty to the charges on 27 April 2022.
5. A number of agencies had some form of contact with Malachi, his caregiver, and whānau. While agencies are each conducting their own reviews or investigations into their interactions, there is a need to look across the whole system to see if there are improvements that can be made.

Participating Agencies

6. Participating Agencies are:
    - 6.1 Oranga Tamariki—Ministry for Children
    - 6.2 New Zealand Police
    - 6.3 Department of Corrections
    - 6.4 Ministry of Social Development
    - 6.5 Ministry of Education
    - 6.6 Ministry of Health.[47]
7. The Chief Executives of the Participating Agencies have agreed to appoint an independent reviewer to look across the system to identify gaps and opportunities to improve the system response into matters of child abuse.
8. Once the report is finalised, the Ministers responsible for the Participating Agencies (the Responsible Ministers) will direct officials to consider the findings of the review and report back on how they will address any issues and inadequacies the review brings to light and provide Responsible Ministers and the whānau with a plan for doing so.

[47] While the Ministries of Education and Health may not hold any information themselves, they regulate services who may do so.

Scope

9. The scope of the review is to:

    9.1 Identify whether the system as a whole could or should have done more to prevent harm being done to Malachi

    9.2 Use the findings and outcomes of individual agencies internal reviews related to this case to identify possible gaps in policy, planning, process in the response as a system.

    9.3 Identification of significant risk factors of child abuse including

        (a) How the relevant processes for each agency or regulated service to notify and respond to potential child abuse interact across the system

        (b) the coordination and information sharing across agencies in cases of potential child abuse

Role of Reviewer

10. The reviewer will conduct a procedurally fair review, gather information, and report it in a manner which enables Chief Executives of Responsible Agencies to consider and direct appropriate next steps.

11. The reviewer's role is to investigate, form views, draw conclusions and make recommendations in the context of the review.

How the review will be conducted

12. This review will be conducted in accordance with the principles of natural justice and will be conducted in a fair, impartial and timely way.

13. The reviews or investigations referred to in paragraph 5 will be provided to the reviewer. The reviewer must coordinate with the people conducting those reviews and as far as possible avoid duplicating their work.

    13.1 Note some aspects of agency internal reviews may need to be withheld, i.e., if there are operational sensitivities or because it cuts across the role of the Coroner

14. Interviews may be conducted in person, by video conference, or over the phone.

15. The secretariat will:

    15.1 collate and coordinate information from Participating Agencies

    15.2 organise dates, times and locations of interviews with relevant parties

    15.3 brief interviewees on the purpose of the review

    15.4 remind each interviewee that they must keep the content of the interview confidential.

16. The reviewer will prepare a draft report once they have gathered all of the information, they believe is relevant. The report will:

    16.1 provide a description of the matters within scope of the review

    16.2 provide an assessment of how these processes interact with each other across the children's system, including strengths and weaknesses

    16.3 identify any barriers to effective identification, notification or response to instances of potential child abuse

    16.4 make recommendations to improve the identification, notification or response to

instances of potential child abuse across the system.

17. The draft report will be provided for consultation with the Participating Agencies who may also consult with their Ministers. Feedback on the draft report may be provided. The reviewer must consider any feedback and may amend the report.

18. The final report will be sent to Chappie Te Kani, Chief Executive, Oranga Tamariki. Chief Executives of Responsible Agencies will decide how and when the final report is to be communicated publicly.

19. Chief Executives of Responsible Agencies will decide what next steps, if any, are appropriate.

Confidentiality and Privacy

20. Given the potential sensitivities inherent in reviews, it is important that everybody involved in this process respects confidentiality and acts with discretion. The reviewer will remind any staff and their representatives/support involved and/or interviewed, that they also need to respect the confidentiality of the review. This will help to maintain the integrity of the review and to protect the privacy of all parties involved in this review process.

Process for concerns or issues raised with the Reviewer

21. During the review and any engagements people may raise specific complaints with the reviewer relating to agencies.

22. The Reviewer through the Secretariat Lead will:

    22.1 acknowledge and thank people for their willingness to raise their concerns

    22.2 explain that the reviewer cannot intervene in operational decisions for individuals, specific cases or investigate specific complaints

    22.3 refer any complainants to the responsible agency representative identified.

Timeframe

23. The review is expected to commence once the participating agencies have concluded their reviews or investigations and should be completed as quickly as practicable, ideally within 90 working days. It is acknowledged that there may be a large amount of information to consider, a number of people who may need to be interviewed, and the reviewer's other commitments will need to be accommodated.

24. The reasons for any delays, and actions to mitigate the impact of those delays, should be clearly recorded.

Appendix Two: People and Organisations I met with

To assist me in gathering information for this review, I met with the following people/organisations:

Title/Organisation/Relationship to Malachi Subecz
Mother of Malachi Subecz
Family members of Malachi Subecz
Associate Professor, University of Otago – Te Whare Wānanga o Ōtākou
Chair, Social Workers Registration Board – Kāhui Whakamana Tauwhiro
Chair, and Member, Family Violence Death Review Committee
Chief Executive, Department of Corrections – Ara Poutama Aotearoa
Chief Executive, Manatū Hauora – Ministry of Health
Chief Executive, Ministry of Education – Te Tāhuhu o te Mātauranga
Chief Executive, Ministry of Justice – Te Tāhū o te Ture
Chief Executive, Ministry of Social Development – Te Manatū Whakahiato Ora
Chief Executive, Oranga Tamariki – Ministry for Children
Chief Executive, Te Puna Aonui
Chief Ombudsman, Office of the Ombudsman – Tari o te Kaitiaki Mana Tangata
Chief Social Worker, Oranga Tamariki – Ministry for Children
Child Matters New Zealand
Children's Commissioner – Manaakitia Ā Tātou Tamariki
Commissioner of Police, New Zealand Police – Ngā Pirihimana o Aotearoa
Department Representative, Department of Communities and Justice, New South Wales, Australia
Department Representative, Department of Families, Fairness and Housing, Victoria, Australia
Deputy Chief Executive, Ministry of Social Development – Te Manatū Whakahiato Ora
Executive Director and Chief Monitor, Independent Children's Monitor – Te Mana Whakamaru Tamariki Motuhake
General Manager, Oranga Tamariki – Ministry for Children
Lawyer for Malachi Subecz
Multi-agency Centre, Te Pou Herenga Waka
Paediatrician (Child Protection, Shaken Baby Prevention and Family Violence Intervention), Starship Hospital and Honorary Associate Professor, Department of Paediatrics, University of Auckland
Principal Youth Court Judge
Privacy Commissioner and Deputy Privacy Commissioner – Te Mana Mātāpono Matatapu
Regional Manager, Oranga Tamariki – Ministry for Children
Regional Manager and Site Manager, Oranga Tamariki – Ministry for Children
The South Auckland Social Wellbeing Board

Appendix Three: Past Reports

The eight cases and reports I have looked at are:

- **Riri-o-te-Rangi (James) Whakaruru.** James was murdered by his stepfather on 4 April 1999. The Commissioner for Children review found poor communication between agencies, stating 'agencies worked without reference to each other, and ended their involvement assuming that other parts of the system would protect James'. The Children's Commissioner found 'all the professionals and agencies in James' life could and should have done better by him'.

- **The 2000 Brown Report,** commissioned by the then Minister of Social Services and Employment**,** highlighted the pressure that the Department of Child Youth and Family were under at the time, and found that a culture change was needed. The recommendations included more interagency work was needed, as well as working more closely with communities in both consultation and partnership.

- **Saliel and Olympia Aplin.** Saliel and Olympia were murdered by their stepfather on 4 December 2001. The Commissioner for Children's review identified poor practice within and between agencies, with no single agency having 'the whole picture or a complete understanding of the risks present in their lives.

- **Coral-Ellen Burrows**. Similar to Malachi's family's efforts to alert agencies to the risk Malachi was in, in 2003 Coral-Ellen's father contacted the then Department of Child Youth and Family to express his fears for the safety of Coral-Ellen and her brother, who were living with their mother and her partner. The call was neither recorded nor investigated. Coral-Ellen was murdered by her stepfather later that year, on 9 September 2003. In her review of the case Ailsa Duffy QC concluded the error in recording and lack of investigation was made due to a lack of training, heavy workloads and limited supervision. She further stated unless these failings were addressed, 'there is nothing to stop this event occurring again'.

- **Nia Glassie.** Nia was murdered at the age of three by her mother's partner and his brother on 3 August 2007. Three other adults were also charged in connection to the abuse inflicted on Nia. There were several people – including professionals – who had some knowledge of the abuse Nia was suffering. Coroner Bain recommended legislation should 'be enacted to enable the compulsory sharing of information between government agencies and health providers and others' and 'that legislation be enacted to ensure there is mandatory reporting by early childhood facilities and schools in respect of identified risk factors, absences, health and abuse concerns'. He also recommended that any witnesses to any child abuse must report it immediately.

- **The 2011 report by Mel Smith** into the serious sexual abuse of a nine year old girl also identified the need for agencies to work closely together and recommended 'a legislative requirement for mandatory reporting should be examined again with urgency'.

- **Moko Rangitoheriri.** Moko died in 2015 at the age of three, while in the care of his mother's friend and her partner who subjected him to daily assaults over a period of months. Within his recommendations, Coroner Bain - who also was the Corner for the Nia Glassie case - called for significant culture change within Child Youth and Family Services (CYFS). He

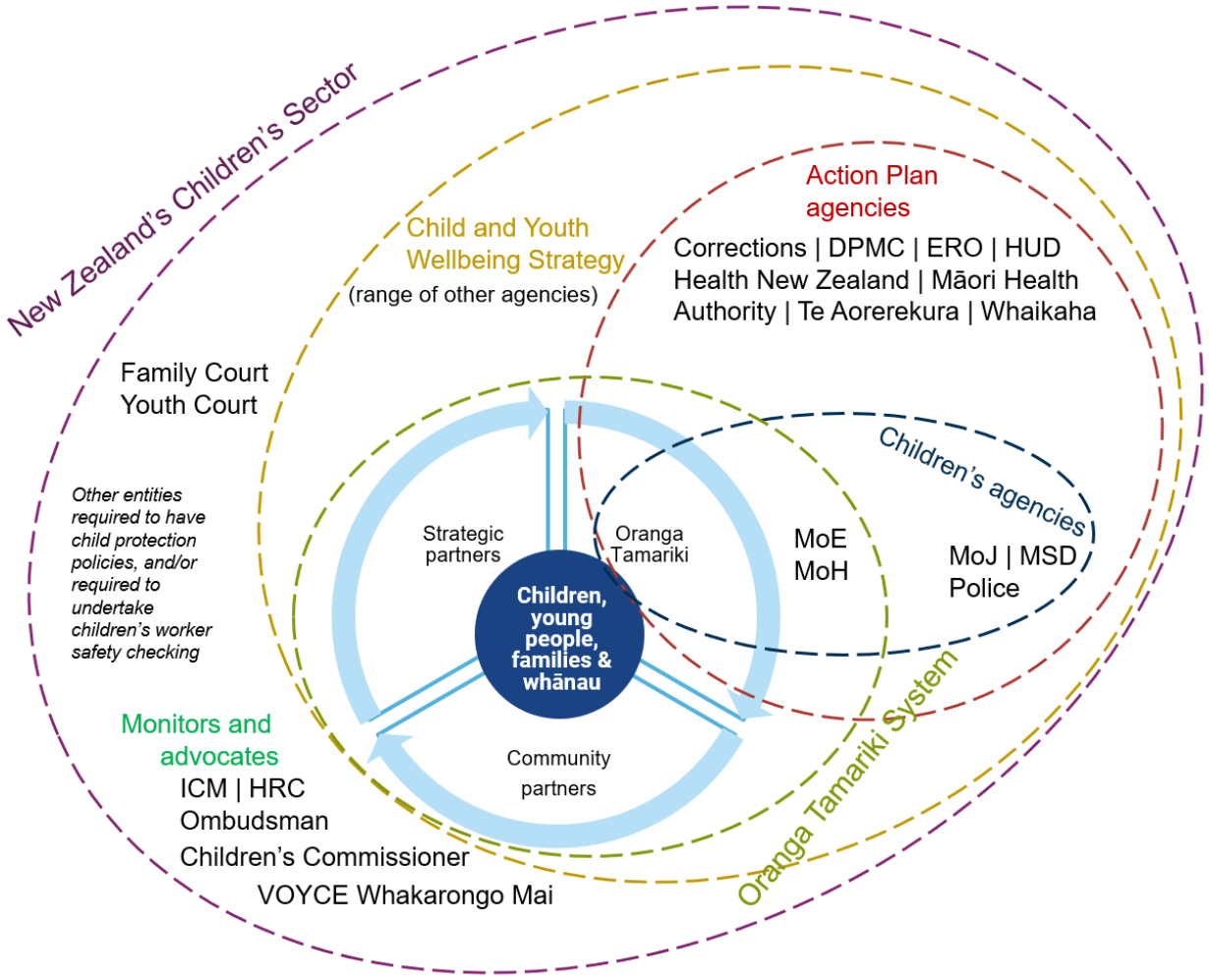
noted the pressure points that were risking child abuse, including increasing poverty, and the need for a family wide approach and the necessity for family support to be available.

- **Leon Michael Jayet-Cole.** Leon died on 29 May 2015 as a result of an assault perpetrated by his stepfather two days earlier. Coroner Windley found Leon was exposed to an escalating risk of violence prior to his death, that Police, CYFS and the Canterbury District Health Board should have collectively identified, but did not, and that the systems and processes that 'existed at the relevant time within each agency, and as between the CDHB, CYFS and Police, for identifying and responding to child safety concerns were broadly adequate but were not utilised or optimised as they should have been'.

While not a local case, I also found the 2003 Victoria Climbie Inquiry in the United Kingdom of relevance, as it shares some of the failings that have become familiar during my review of the New Zealand child abuse and death cases. Victoria Climbie was an eight year old girl murdered following months of abuse at the hand of her temporary guardians. The recommendations that stood out to me from this review included:

- the need for improvements to information sharing across agencies;
- the need for social services to make an assessment of suitability of accommodation whenever it places a child in temporary accommodation;
- the need for a common language to be established for use across all agencies to help those agencies identify who they are concerned about, why they are concerned, who is best placed to respond to those concerns, and what outcome is being sought from any planned response;
- that Chief Executives and lead members of local authorities with social service responsibilities must ensure that children's services are explicitly included in their authority's list of priorities and operational plans; and
- recommending all GPs, general practice staff and all those working in primary healthcare should receive training in the recognition of deliberate harm to children.

Appendix Four: The Children's Sector as it has been described to me



Note: Description/diagram provided by Oranga Tamariki, November 2022.

Appendix Five: References / sources

Agency reports

1. Police Family Violence Death Review (PFVDR) – Malachi Rain SUBECZ. 18 November 2021
2. Fact-finding review into Corrections' management of Malachi's Mother. Office of the Inspectorate, Ara Poutama Aotearoa. November 2022.
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About Dame Karen Poutasi

Dame Karen Poutasi has a wide background in the public service, including as Director General of Health, Chief Executive of the New Zealand Qualifications Authority and Commissioner for Waikato District Health Board.

She is currently on the Board of Te Whatu Ora, and is Chair of Taumata Arowai and of Kāpuhipuhi Wellington Uni-Professional.

Her professional grounding is as a public health medicine specialist.

About the cover page

The cover of this report is designed to reflect the layers of safety nets across the system that should be hard wired to protect children in future. Each net represents a different part of the system, each of which should overlap, be mutually reinforcing and strengthen the system as a whole. Our tamariki are owed this.