MANATŪ HAUORA

MINISTRY OF HEALTH

Review into the death of Malachi Subecz

July 2022 – Ministry of Health

Purpose

On 1 November 2021 Malachi Subecz was taken 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 12 November 2021 Malachi's breathing tube was removed and he subsequently died from his injuries. In June 2022 his caregiver, Michaela Barriball, was sentenced to life imprisonment for his murder.

In May 2022, Oranga Tamariki sought to undertake an independent system level review (alongside internal investigations and a Practice Review) to identify what, if anything, needs to change in order to prevent similar events in the future.

The purpose of this report is to summarise the findings of a review carried out by the Ministry of Health into the points of interaction between Malachi and any health services. The review and this report are an opportunity to ascertain ways to identify and respond to abuse, and to take a preventative approach to minimise the likelihood of future similar events.

This review was carried out by Lorraine Hetaraka (Chief Nursing Officer) and Dr Timothy Jelleyman (Paediatrician and Chief Clinical Advisor – Child and Youth Health) at the Ministry.

Scope

In scope of the review were:

- clinical information regarding the interactions between Malachi and any health service
- the policies, procedures and processes of each provider in relation to the identification of child abuse and in particular how they were applied in the case of Malachi
- the relevant processes for each provider to notify and respond to potential child abuse and how these processes interact with each other across the sector
- the coordination and information sharing across agencies and health providers in cases of potential child abuse
- the training provided to staff who are involved with the identification, notification, and response to child abuse.

Information assessed

The Ministry made initial contact with Bay of Plenty DHB (DHB of domicile at the time of death) and Auckland DHB (as a result of the transfer to Starship Hospital) and requested all information regarding points of contact between Malachi and health services over the course of his life.

Through this interaction, it was identified that Malachi had attended Second Ave Health (after hours primary care clinic) in Tauranga and information on his visits were requested.

In addition, through contact with Auckland DHB it was identified that s 9(2)(a) [redacted] at Starship Hospital had

completed a Detailed Child Protection Report on 9 March 2022 for the Police[1], which included an exhaustive summary of Malachi's interactions with health services (among other things). s 9(2)(a) report was relied on heavily as part of this review.

Summary of interactions

A table of interactions between Malachi and health services can be found in Appendix One.

It is important to note that there is a relatively short period between Malachi entering Michaela's care and the time of his death (four to five months).

Review findings

The records confirm multiple points of contact between Malachi and health services in his early years. Of particular note is timely childhood vaccinations, and a reasonable number of Well Child Tamariki Ora checks.

In reviewing the available records there are examples of appropriate access to health care for the expected things that a child may present with while growing up. There are no hospitalisation episodes prior to final presentation to Starship.

The records do not indicate any particular missed flags through these years, but more reflect appropriate and proactive health service engagement. For example, on 12 December 2018 Malachi presented to Tauranga Hospital ED with a superficial burn on his hand – his mother, whom he was living with at the time of presentation had appropriately sought help, and the history aligned with what was seen in the information provided by other service providers.

At no stage has this review identified any cause for concern regarding a health professionals' practice or conduct, or concern regarding a health providers action or lack thereof to the case presented to them. The reviewers also found no evidence of deviation from services' child protection policies.

Where this review has identified areas of concern, these are primarily related to system-level issues that could not have been addressed by health professionals at the time of presentation.

Information sharing

It is noted that Malachi's weight was dropping as he grew older – his weight percentile, which had tracked normally around the 50th percentile up to age 4, is then observed to have dropped significantly to the 32nd percentile at the last available record (during which he was in the care of Michaela Barribal). The detailed Child Protection Report notes that at the time of his death, Malachi's weight was at the 11th percentile.

The Child Protection Report goes on to note that the evidence indicates that Malachi was not getting the calories he required.

[1] s 9(2)(a) 2022. "Police Child Protection Report - Malachi Subecz."

> *I would expect a 5-year-old living in a household with food, to be able easily to access all the food that he requires, and to regulate his own body weight. I am unaware that there have been any concerns about the nutritional status of any other children living on the same property as Malachi. In my view there are only two possible explanations: Malachi was too sick to eat what he needed (but there is nothing in the evidence that I have seen to suggest this) or he was not permitted to eat what he needed. In the context of all the other evidence for abuse and neglect in this child, I am concerned that his weight loss was a consequence of caloric deprivation – that is, he was being starved.*

Weight is an important global (though non-specific) indicator of wellbeing. It is unclear whether information on previous weight measurements was available during presentations to health services.

Access to joined-up medical records across providers at points of care would provide significant opportunity to identify changes in indicators such as this, providing opportunities to investigate areas of concern. In addition, the ability to access appropriate information across the health, social, and education sectors would provide more opportunities for patterns to be established and abuse recognised.

Oranga Tamariki Gateway Assessments

It is noted that there was no Gateway Assessment carried out for Malachi, and in fact no current system trigger for this robust review to have happened as he was at no point formally under the care of Oranga Tamariki.

A Gateway Assessment is an interagency process that identifies ways to address the health, education and social needs of tamariki who come into the care of Oranga Tamariki. A Gateway Assessment consists of:

- gathering health, education and wellbeing information for te tamaiti
- an assessment with a medical practitioner
- an interagency plan to follow up on identified needs.

A Gateway Assessment referral is generally made when:

- when a referral for a care and protection family group conference is made, or following it if appropriate
- within 10 working days of entering the care of Oranga Tamariki
- for tamariki already in the care of Oranga Tamariki if it would be beneficial.

The reviewers considered the benefits of a Gateway Assessment being carried out for all children who are subject to a report of concern (noting a report of concern was made by family members at the time Malachi was placed with his caregiver). From a health perspective, it would be incredibly resource intensive and impractical for a Gateway Assessment to be performed in response to all reports of concern and is unlikely to achieve the desired results. It may be appropriate from a health perspective, however, for a Gateway Assessment to be carried out for all children who are placed in care as a result of their parent(s) being imprisoned (such as Malachi), given their particular vulnerability and the limited system of checks and balances on the process of child placements in these cases.

Wider context

In carrying out this review a significant number of similar cases were identified that have resulted in the death of a child. A wider cross agency review that considers themes across several sentinel cases would be more informative for system change.

In addition, it is the view of the reviewers that a cross agency review should be systematically carried out in every case where a child dies as a result of abuse.

Recommendations

The reviewers recommend that:

1. Endeavours towards joined up medical records with appropriate point of care access continue to be supported – noting that work to implement this is underway through the HIRA programme within Te Whatu Ora. 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 which increases the risk of indicators of wellbeing being missed.
2. Consideration is given to extending Gateway Assessments to children who are placed into the care of others as result of their parent(s) being imprisoned.
3. Improvements are made to the report of concern process to incorporate multi-agency review of a report, to determine an appropriate response.
4. Ensure the findings of this multi-agency review are shared with relevant agencies to inform opportunities for inter-agency working to identify response to abuse in the future - noting there are likely opportunities to consider this through the health system reform and locality establishment, including the establishment of district hubs of expert cross agency child protection teams.
5. A cross agency review be carried out for every case where a child dies as a result of abuse, and the themes continue to be actively monitored at national leadership level.

Appendix One – Interactions between Malachi Subecz and health services

Date	Age	Contact	Description
s 9(2)(a)			

s 9(2)(a)