Memo

Update on the review of the identification of and response to suspected abuse (the Malachi Subecz review)

Date:	10 October 2022
To:	Dr Diana Sarfati – Director-General of Health
Copy to:	Maree Roberts – Deputy Director-General, Strategy, Policy and Legislation
From:	Steve Barnes – Group Manager, Family and Community Health Policy
For your:	Information

Purpose of report

1. This report provides an update on the *Joint Review into the Children's Sector: Identification of and response to suspected abuse (the independent review)*.
2. It also provides further context for and initial advice on ways to progress recommendations from the health system's *Review into the death of Malachi Subecz (the health system review)*, which is informing but separate from the cross-agency independent review.
3. We recommend that you share this memo with the Chief Executives of Te Whatu Ora and Te Aka Whai Ora.

Background and context

4. On 12 November 2021, 5-year-old Malachi Subecz passed away from injuries inflicted by his caregiver Michaela Barriball, who subsequently pled guilty to murder, injuring with intent and ill treatment of a child. His mother was in prison on unrelated matters when his injuries were sustained.
5. A number of agencies had some form of contact with Malachi, his caregiver, and/or his whānau during his short life, which agencies are conducting their own reviews into. Chief Executives of the six agencies[1] that provided services (or regulated the provision of services) also agreed to appoint an Independent Reviewer to draw on this case to identify ways to improve the system's identification of and response to abuse of children and young people. Dame Karen Poutasi was then appointed, who you met with to discuss this work on 9 August 2022.
6. The scope of the review is to:

    - identify whether the system as a whole could or should have done more to prevent harm to Malachi

[1] Oranga Tamariki, New Zealand Police, Ara Poutama Aotearoa - Department of Corrections, Te Manatū Whakahiato Ora - Ministry of Social Development, Te Tāhuhu o te Mātauranga - Ministry of Education, Manatū Hauora - Ministry of Health.

- use the findings and outcomes of internal agency reviews to identify gaps in policy, planning and process in the response as a system
- identify significant risk factors of child abuse, including:
    - how agency or service processes that notify and respond to potential abuse interact across the system
    - the coordination and sharing of information across agencies in cases of potential child abuse.

Update on the independent cross-agency review

7. I am the Ministry representative on the Interagency Coordination Group that was established to support the independent review. The following themes are emerging:

    - a lack of a formal process for what happens when a single parent is remanded in custody
    - a lack of awareness among service providers about when reporting to authorities such as Police or Oranga Tamariki should occur
    - poor on the ground connectivity and wrap-around supports
    - different agency interpretations about what constitutes child abuse and what is considered a 'red flag'
    - the need for improved processes for monitoring child protection policies.

8. To inform these conversations and the independent review itself, agencies are providing further information on these and other topics. The Ministry is currently building a picture of the existing ways in which potential child abuse is defined, identified, processed and notified within the health sector, and when and how it may be shared with other agencies. This is an especially delicate topic in the health sector, which privileges privacy and relies on confidentiality to ensure people are comfortable seeking health care for them and their whānau.

Progressing the health system review into the death of Malachi Subecz

9. To inform the independent review and identify possible areas of improvement, in July 2022 the Ministry undertook a review into the points of contact Malachi Subecz had with health services. The review was led by the Office of the Chief Clinical Officers, authored by Lorraine Hetaraka (Chief Nursing Officer) and Dr Timothy Jelleyman (Paediatrician and Chief Clinical Advisor). It looked at clinical information from health system interactions, processes for identifying and responding to child abuse, coordination across providers and agencies, and relevant staff training.

10. The report found that the multiple points of contact Malachi had with the health system were typical of a young child. The records do not indicate any missed flags, cause for concern regarding a health professional's practice, nor deviation from child protection policies.

11. The reviewers did identify several system-level issues that could not have been addressed by individual health professionals at the time of presentation. The report identifies five recommendations, some of which involve systems and processes that interact with the wider children's sector, and should therefore be considered alongside the system-level independent review.

12. The health system review also indicates improvements that can be progressed from within the health system, and in relation to broader work being undertaken as part of the Oranga Tamariki Action Plan and the health system reforms. With input from the authors of the

health system review, we have identified some initial ways these five recommendations could be approached:

1) Work towards joined up medical records with appropriate point of care access

13. Children involved with Oranga Tamariki may often move between different services, locations, and sometimes caregivers, which increases the chance that wellbeing indicators are missed. As there are currently multiple different information systems used by different health practitioners, they do not always have a comprehensive picture of a child's previous medical history and interactions. This lack of integration between systems creates risks, including:

- an increased likelihood that potential indicators of concern are not identified or tracked
- continuity of care is lost as a child may not receive ongoing treatment for certain issues, or particular support needs are not understood when they access different health services.

14. There is a need to both improve access to health records from different parts of the health system, and promote access to information from across various services and sectors that may support children in these circumstances. The Hira programme currently underway within Te Whatu Ora is working to address these needs, and is capable of addressing this recommendation over the medium to long term.

15. Hira is an ecosystem of digital services seeking to empower New Zealanders with better control of their health information. Tranche one is focused on enabling the exchange of health information between existing systems for a range of authorised users to access, view and edit. Where appropriate, officials are already engaging with other agencies about the potential for the exchange of health information across agencies and services beyond the health system. It is also envisioned that an event or change of information (such as a drop in weight) could trigger a notification to all relevant parties.

16. We understand that tranche one of this work is expected to be delivered by mid-2024. Ministry officials will continue to work with Te Whatu Ora colleagues and relevant children's agencies to ensure the limitations identified in the health system review are appropriately addressed through this work, or by other means if necessary and/or in the meantime.

2) Consider extending Gateway Assessments to children who are placed in the care of others because of their parent(s) being imprisoned

17. Gateway Assessments are an interagency process that gather health, education and wellbeing information, involve assessments by a range of professionals (including health practitioners), and culminate in a plan to follow up on any identified needs. These assessments are usually though not exclusively triggered when children first come into the care of Oranga Tamariki.

18. The review noted that there was no Gateway Assessment carried out for Malachi, and that there is no current system trigger for such an assessment to occur, given he was never formally under the care of Oranga Tamariki and only a report of concern was made. As there were 77,500 reports of concern from 1 April 2020 to 31 March 2021, it would be highly resource intensive and likely undesirable for every report of concern to automatically trigger a Gateway Assessment. The review notes this, though indicates it may be appropriate for a Gateway Assessment to occur when a child is placed with a new caregiver due to their parent(s) being imprisoned. Children in this situation are likely to be particularly vulnerable,

and there is greater risk given the limited system of checks and balances on the process of child placements in such cases.

19. One opportunity to consider trigger points for the use of Gateway Assessments is through a planned review of the Gateway programme, which was a commitment in the recent Oranga Tamariki Action Plan (OTAP). This will be led by Oranga Tamariki with a scope for this review to be determined by the end of 2022. As part of this review and any redesign that may follow, we can work with Oranga Tamariki and Ministry of Education colleagues to ensure the review considers the triggers for a Gateway Assessment to occur, including where a parent is in prison, or perhaps more broadly when different forms of new caregiver arrangements are made.

20. Gateway Assessments are usually a one-off assessment, limiting their ability to monitor wellbeing indicators over time and to respond to potential child abuse concerns as they arise. This recommendation must therefore also be considered among the broader landscape of assessments and ongoing monitoring that exist across the children's sector, which often include but may not be led by health agencies or providers.

21. This is particularly relevant to the recent commitment made by health agencies in the OTAP Implementation Plan to assess, plan for and meet the health needs of children in care and youth justice through an integrated service model across agencies. This model is likely to include a focus on promoting a continuous health journey for children involved with Oranga Tamariki that goes beyond point-in-time mechanisms such as Gateway Assessments. This work programme is currently being established, with the delivery model set to be developed by the end of 2023.

22. We could also consider whether another form of assessment or process could be implemented that would enable more effective monitoring of the ongoing wellbeing of children in similar situations. This would likely involve interagency work with Oranga Tamariki, Ara Poutama Aotearoa - Department of Corrections, and New Zealand Police.

3) Make improvements to the report of concern process to incorporate multi-agency review of, and responses to, a report

23. Reports of concerns can be made to Oranga Tamariki or Police by anyone who is worried about a child or young person. These are then assessed by Oranga Tamariki, who ascertain the risk and/or connect whānau with supports where appropriate. At present this is a centralised, single-agency process predominantly focused on immediate risk.

24. Increasing the ability for reports of concern infrastructure to coordinate and involve a wider range of services (including health services) may add an additional level of oversight, while also facilitating earlier access to a range of supports for children and whānau.

25. Given the cross-sectoral nature of this recommendation, it is likely best considered in the context of the wider independent review, and progressed through a commitment already made in the OTAP. Led by Oranga Tamariki, this commits relevant children's agencies to support a coordinated, locally-led approach to prevention with community partners, with an initial focus on locally co-ordinated reports of concern.

26. This recommendation will also be informed by the information agencies are gathering on current policies that define how potential child abuse is identified and responded to within and across different sectors.

4) ***Ensure the findings of the independent review are shared with relevant agencies to inform opportunities for interagency working to identify and respond to abuse in the future***

27. The draft report will be circulated for agency comment in mid-November, with the final report being sent to the Chief Executive of Oranga Tamariki. Once finalised, Ministers responsible for the participating agencies will then direct officials to consider its findings and report back on how they will address the issues raised.

28. This process will allow for a cross-agency and system-level response to any issues and opportunities identified by the independent review, which will very likely cover interagency processes for identifying and responding to abuse. Ministry officials will also work with relevant Te Whatu Ora and Te Aka Whai Ora colleagues to ensure recommendations are considered in the context of the health and disability reforms. The locality networks being established, which will include district hubs of expert cross-agency child protection teams, will also be relevant to this work.

5) Carry out a cross agency review of each case where a child dies as a result of abuse, and actively monitor themes at a national leadership level

29. The case of Malachi Subecz is unfortunately not an isolated incident, with an average of one New Zealand child dying as a result of abuse every five weeks – one of the highest rates in the OECD[2]. Such tragedies likely indicate failings of the system to prevent the most severe outcomes, as well as better ways of preventing and appropriately responding to a spectrum of abuse experienced by children and young people in New Zealand. Ensuring continued cross-agency oversight of and responses to such instances is therefore likely to improve the system and the checks and balances within it.

30. We expect something of this nature will be considered as part of the independent review. In partnership with other relevant agencies, we will work through this process to determine how such an oversight mechanism should be designed, and where it should sit.

Next steps

31. We will continue to update you on how the issues raised through the health system review are being addressed, while we continue to inform and contribute to the independent review. We will notify you of any further recommendations or areas of focus we believe should be considered. The Minister of Health will be informed of this work through an item in the next Weekly Report (17th to 21st October), and kept up to date as appropriate.

32. Interviews and information gathered for the independent review is expected to be completed by the end of October. We understand the draft report will be circulated for agency comment in mid-November, before being delivered to the Chief Executive of Oranga Tamariki on behalf of the commissioning Chief Executives before 14 December 2022.

33. Once finalised, responsible Ministers will then direct officials to consider the findings of the report and report back on how they will address issues it raises. The current intention is for individual agency reviews (including the health system review) to be publicly released at the same time as the independent review.

34. We have engaged with Te Whatu Ora officials as part of the information gathering process, and will increasingly be working with Te Whatu Ora and Te Aka Whai Ora as this work

[2] H, Nobilo, *Why should we care – The abuse and neglect of children in New Zealand.* 2018

develops, noting the sensitive nature of this case. We recommend you share this memo with the Chief Executives of Te Whatu Ora and Te Aka Whai Ora to inform them of this work.

Recommendations

It is recommended that you:

2.	**Share**	this briefing with Fepulea'i Margie Apa (CEO Te Whatu Ora) and Riana Manuel (CEO Te Aka Whai Ora)	**Yes**
3.	**Note**	officials will continue to update you on both the health system review and the independent review as this work develops	**Yes**

Signature  Date: 10/10/2022

Steve Barnes

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Signature  Date: 11/10/2022

Dr Diana Sarfati

Director-General of Health