Systems Review - Questions & Answers

1. What is the care and protection system for children?

The children's system, including the agencies with responsibilities for the care and protection of children within that, is set out in a diagram at page 57 (appendix four) of the report.

2. Why was this report commissioned?

The Chief Executives of the six agencies that had direct or indirect interactions with Malachi Subecz, his mother, his whānau or his carer and murderer, Michaela Barriball, in the months leading up to his death commissioned an independent report by Dame Karen Poutasi, a former Director-General of Health, to:

- a) Identify whether the system as a whole could or should have done more to prevent harm being done to Malachi
- b) 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.
- c) Identification of significant risk factors of child abuse including
 - i) How the relevant processes for each agency or regulated service to notify and respond to potential child abuse interact across the system
 - ii) the coordination and information sharing across agencies in cases of potential child abuse

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.

The Ombudsman issued his report into a complaint on Oranga Tamariki's handling of a Report of Concern about Malachi Subecz on 5 October 2022.

Full Terms of Reference for the review can be found from page 51 (appendix one) of the report.

3. What about the reviews that the individual agencies completed on the death of Malachi? Where do they fit in?

Each of the six commissioning agencies did a review on their interactions, direct or indirect, with Malachi Subecz, his mother, his whānau or his carer and murderer, Michaela Barriball, in the months leading up to his death. These reviews were utilised by Dame Karen in the development of her report on the wider care and protection system for children at risk of harm. The reviews will be available on each agency's website.

IN-CONFIDENCE

The <u>Ombudsman's report</u> into a complaint regarding the way in which Oranga Tamariki handled the initial Report of Concern into caregiver Michaela Barriball's treatment of Malachi Subecz also assisted the review.

4. In preparing her report did Dame Karen's team also do its own investigations or did it only rely on the agency investigations?

Yes, Dame Karen and her review team carried out their own investigations on the matters covered by the report.

5. The report mentions a number of other reports into similar incidents. Is there more detail available on them?

Key findings of the eight historical cases reviewed in the preparation of this report are set out on Appendix Three in the report. The references for each case are listed in Appendix Five.

6. Has mandatory reporting been considered before?

Yes, a number of times, in reviews following other deaths, and there have been at least two attempts to legislate mandatory reporting. Neither was successful. See pages 42-43 of the report for further details, including information from the Australian states of New South Wales and Victoria where forms of mandatory reporting has been in place since 1977 and 1993 respectively.

7. Is sharing information between agencies required by law?

If a request for information is made under section 66 of the Oranga Tamariki Act 1989, the information must be supplied to the requesting agency. In other instances, sharing is voluntary, as provided for under sections 65A to 66K.

Sections 65A to 66K of the Oranga Tamariki Act are enabling provisions to allow for information sharing between agencies. There are also information sharing protocols in force across the agencies involved in the care and protection of children. See pages 38-40 of the report for further information.