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Media Statement 1/12/2022 Dame Karen Poutasi Report: Joint Review into the Children's Sector

Report Finds Critical Gaps in Child Protection System – Interlocking Safety Nets Needed

"Following the murder of Malachi Subecz by his caregiver, Michaela Barriball, in November 2021, six public sector agencies commissioned me to complete a report on the interactions these agencies had with Malachi, his whānau and his caregiver in the months leading up to his death.

"The agencies asked me to see if the system for children as a whole could have done more to prevent harm to Malachi, identify any gaps in the system as a result of that examination, and make recommendations addressing barriers and seeking improvement to the identification, notification or response to instances of potential child abuse."

"My answers to those questions are, yes, the system as a whole could have done more to prevent harm to Malachi and, yes, there are five critical gaps across the system for children that can result in vulnerable children at risk of harm becoming invisible to those agencies."

"These gaps must be filled if the agencies are to gain and retain visibility of children at risk of harm and ensure they are protected in the future. The system has not been designed with layers of safety nets to eliminate gaps."

"Current processes and practice, including inadequate information sharing across agencies and authorities, mean some of those harming children like Malachi, have been able to hide the harm they are causing."

"One of my key recommendations is the mandatory reporting by professionals and others who work with children at high risk of harm. For mandatory reporting to be effective, I have also recommended it must be complemented by much stronger processes for information sharing across the system, much better guidelines on the risks which indicate high probability of harm, and compulsory training on how to recognise risk and how reporting should occur."

"Another recommendation is for Oranga Tamariki to vet any proposed carer when a sole parent is arrested and/or taken into custody. This will work with changes the Courts are already making to ensure the welfare of children of sole parents is considered when such a parent is arrested or sentenced. Currently, children of sole parents in custody can be in the care of another person without formal authority for long periods, with no consideration for their safety. This is not right and had terrible consequences for Malachi."

"I am aware that over the past 30 years, many of the recommendations in my report have been made by other inquiries into the tragic deaths of children. Implementation of these recommendations and embedding them into everyday practice at the local level has been inconsistent."

"That is why I am also recommending greater priority be given to increasing multi-agency, iwi and NGO partnerships in regions and communities. In my view, these collaborative teams extend and reinforce the child care and protection system and promote sharing critical information across a far

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wider range of sources. I believe these teams have been a key missing link, and inquiries of the past did not have the benefit of these new ways of working. They give me confidence that now is the time to make changes we have dismissed in the past such as mandatory reporting."

"Lastly, I want to acknowledge Malachi's mother, whose trust was abused, and his family who tried to do everything they could to alert authorities to the risks he was facing. For them, as it should have been for others, it was always about Malachi."

End

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Dame Karen Poutasi

Dame Karen Poutasi is a former Director-General of Health (1995-2006) and Chief Executive of the NZ Qualifications Authority (2006-2020). She is currently a board member of the new health agency, Te Whatu Ora, Health New Zealand, and chairs the Water Services Regulator, Taumata Arowai.