On behalf of the Government, to investigate establishing an independent complaints mechanism for Child Youth and Family which could be separate from the Ministry of Social Development.

Review of Child, Youth and Family Complaints System

A report to the Minister of Social Development: June 2013

Howard Broad CNZM

Contents

PART ONE – Executive Summary

This report investigates the establishment of an independent complaints mechanism for Child Youth and Family which could be separate from the Ministry of Social Development.

The functions of CYF are to administer:

- the care and protection system;
- the youth justice system;
- the adoption system;
- the operation of the system of guardianship

These systems affect the authority for the care of a child, and decisions made within these systems are sometimes vigorously contested particularly when the state steps in to make decisions for a family. This gives rise to complaints. While complaints provide opportunities to improve organisational performance the environment and circumstances often make this an extremely difficult area to administer.

A complaint system for CYF contains broadly similar components to other sectors of social policy, and includes:

1. An organisation which embraces complaints as an opportunity to ensure good performance and to learn;
2. The legislative, policy and public interest settings that drive the performance of the system;
3. The maintenance of individual and collective professional practice (the professions) as a foundation of quality practice;
4. The oversight and review of practice and conduct to ensure that it is both effective and efficient and ensure lessons are learned.

CYF is a national service delivery division of MSD and is widely distributed. The report details an extensive history of development of care and protection and control systems against a background of philosophical tension and organisational change, sometimes amounting to considerable turmoil. Since 1989 CYF, or its predecessor organisations, have embraced public sector reform, the development of a major child protection enactment (the Children, Young Persons and Their Families Act, 1989 - CYPFA) and the signing of the international convention relating to the rights of the child (UNCROC). CYPFA enacted an internationally recognised system of family involvement in care and protection decision making which included internal checks and balances to ensure decisions were made in the interests of the child and were of the highest quality.

Two instruments in particular were fundamental – the family group conference (FGC) and the operation of the care and protection resource panel (CPRP). FGC provides an opportunity for group decision making on a child related problem, and CPRP ensures there is local professional oversight of social worker decision making. The Act also promoted community participation in the provision of services to children and young people. These systems were ultimately subject to the control of the court.

However, complaint systems remained at a basic level of provision until CYF was reintegrated back into MSD in 20007/08. At the time there was a significant challenge to social work practice, high demand for service and considerable organisational upset. The complaint system generated a significant amount of dissatisfaction. Initially actions were taken to control the effect of demand but more recently steps have been taken to professionalise and improve the complaint system. Although policies were changed in 2008 there were insufficient resources available to give them full effect. This is being remedied under a programme in which the policies have been revised. An important step in these developments was the appointment of an independent Panel of people with relevant skills to review dissatisfied complainants' cases. They have reported to the Chief Executive who has accepted all of their recommendations. There is organisational support for the complaint system.

Adjacent to the system of complaints about the present system of child protection, the Ministry has been grappling with the issue of historic complaints. It is clear that through the history of state care of children there have been instances of abuse. The victims of this abuse can be found within the prison system, in mental health facilities and care, and elsewhere through the welfare system.

CYF is not without external oversight. This includes the Ombudsman, Privacy Commissioner, the Coroner, the Courts, Child Mortality Review, the Police, and, importantly, the Children's Commissioner. There are also professional registration and support systems in place. None however, function fully effectively as the regulator of the full child protection system.

The Office of the Children's Commissioner plays a central role in oversight of CYF policies, practice and procedure. However, historically and presently it has not been resourced or fully enabled to carry out the role of a regulator of the full child protection system.

In reporting to the Minister the review has found:

1. There exists a framework of organisational, professional, and regulatory structures to support practice and performance of Child, Youth and Family;
2. The framework is operating at a very basic level of performance;
3. The four areas which if improved would impact on effectiveness are:
    a. **Feedback on Performance** - There is insufficient effort directed at obtaining feedback on CYF performance, including the identification of concerns and complaints from vulnerable children and families; a concerted strategy to return feedback to the organisation is required.
    b. **CYF Complaint System -** The CYF complaint system has recently been overhauled and is trending in a positive direction, but it is not yet proven; it requires further elaboration and oversight to ensure it operates well in the future.
    c. **Regulator** - The statutorily independent oversight mechanism for the Children, Young Persons and Their Families Act, 1989, and Child, Youth and Family – the Office of the Children's Commissioner - is inadequately resourced to perform all the functions expected

under its Act. It is not sufficiently enabled to oversee all types of complaints made against CYF. However, in my view a significant regulator is required for the system.

d. **Care and Protection Resource Panels** - The role of the Care and Protection Resource Panel as an internal monitor and facilitator under the Act has been allowed to slip in status and function: the function or something akin to it needs to be reinvigorated.

The Terms of Reference sought options that could introduce greater oversight independence. Three main options are presented, two of which can be broken into separate components:

Option	Description	Principal elements	Cost (approx.)
1	Status quo	• CE's Complaints Review – with additional support	$<200k
2A	Children's Commissioner - Complaints Review	• New Deputy Children's Commissioner with Investigation and complaints review function • Additional investigative resources • Transfer of CE Panel to Children's Commissioner • Additional support to enable the functions	$1-1.5M
2B	Children's Commissioner - Quality Improvement Process	• Additional funding to support increased practice review across child protection system • Using a 'community of practice' approach to implement change	$>900k
2C	Children's Commissioner - Complaints Advocacy	• Funding of services to support complainants in making complaints, advocacy, and special support needs	$<350k
2D	Children's Commissioner - Children in Care Monitoring	• Development and implementation of a system that improves monitoring of children in care • Appointment of monitors for every child in care	$<2.4M
2E	Children's Commissioner - Complaint process	• Audit of revised systems • Undertaken in 2015	$>250k

3A	Independent Authority - Complaints Investigation	• A separate IPCA type investigative and review Authority	$3.4-3.6M
3B	Independent Authority - Complaints Investigation	• As for 2D but reporting to Authority	$>2.4M

PART TWO - Introduction

On 12 October 2012 you appointed me to conduct an Independent Review of CYF complaints process. This is the report of my review.

Background to the Review

The Government's "The White Paper for Vulnerable Children"(2012)[1] responds to user criticisms of the Child Youth and Family (CYF) complaints process. The petition of Mr Graeme Axford to the 2009 Parliamentary Social Services Committee yielded this response: "*In our view, establishing a completely independent complaints mechanism would improve the external perception of the review process*".

The White Paper committed to "*an independent review into how the Ministry of Social Development handles complaints about actions taken under the Children, Young Persons and Their Families Act*." Further, that this review "*reflects the many submissions on the Green Paper for Vulnerable Children that felt strongly that there needed to be an independent complaints body, similar to the Independent Police Conduct Authority*".[2]

Terms of Reference

The Terms of Reference for the Review are:

> ***AN INDEPENDENT REVIEW OF COMPLAINTS PROCESSES RELATING TO CHILD YOUTH AND FAMILY***
>
> *On behalf of the Government, to investigate establishing an independent complaints mechanism for Child Youth and Family which could be separate from the Ministry of Social Development.*
>
> *In the course of this investigation, the reviewer will examine and report on the following:*
>
> - *The current arrangements for members of the public to have a complaint about Child, Youth and Family heard*
> - *Provide a view on how the current arrangements are working*
> - *Consider options for independence and report on the financial, legislative and accountability implications of these options.*

[1] The White Paper for Vulnerable Children, Vol. 1, The Minister for Social Development (2012) p. 23.

[2] Ibid.

The review will report to the Minister of Social Development by 30 June 2013. It will not re-examine any particular case investigated by the Ministry or Panel.[3]

Methodology

My methodology included:

a. An assessment of the documented policies, procedures, and reports from the Ministry of Social Development (MSD) and Child Youth and Family (CYF);
b. Interviews with the leadership of the Ministry and in particular those in significant roles within CYF;
c. Interviews with staff of CYF who are at risk of being complained about, have been complained about, have received and/or handled complaints or formed part of the process by which complaints are handled;
d. Interview with members of the Chief Executive's Review Panel;
e. Review of submissions of those responding to an invitation to submit to this review (4 received);
f. Interviews with a wide range of people who represent organisations that have a professional relationship with CYF, deliver services on behalf of CYF or under an arrangement with CYF;
g. Interviews with some people who have a special knowledge of the CYF complaint system;
h. A review of other models of professional and practice complaints and oversight models in New Zealand and overseas.

I did not interview children who are in the system but did interview representatives and advocates.

Report – Structure:

In the following part of the report (Part 3) I will firstly background Child, Youth and Family as a part of the Ministry of Social Development and describe how its primary enactment influences its services and also structures some governance features. With that background I then describe the development, structure and features of the complaint system that applies to CYF, whether internally or externally governed.

In Part 4, I go on to provide an opinion as to how well these governance arrangements work. I focus on the encouragement of feedback, bringing the voice of the children and young people into the system, the complaint process, the external oversight mechanisms and a number of system issues. Finally, in Part 5, I present a number of options that might be selected as part of a plan for change. I note in general terms what these options may cost, the accountabilities that might need to shift, and obvious legal implications.

[3] Terms of Reference, 23/10/12

PART THREE – The CYF Complaint System

The Object - Children & Families

In very general terms, the functions of CYF are to administer:

- The care and protection system
- The youth justice system
- The adoption system
- The operation of the system of guardianship

These functions relate to family structures, relationships and authority. They define relationships between CYF and a caregiver; be they parents, adoptive parents, guardians, foster carers, or a kinship carer. In each case it may raise a question about the entitlement to the care, protection or control of a child or young person.

The base position is that the biological parents of a child have the lawful authority and obligations to care for a child or young person[4] (subject to a number of qualifications by reason of the mother's circumstances at the time of the birth of the child). By agreement, not uncommonly, care may be allocated to someone else, for example a grandparent, but in these cases the lawful authority and obligations have not shifted. Others might step in as the lawful carers and adoptive parents of the child or young person when the biological parents die. Social Workers from the department might help, facilitate and mediate these cases.

Care might be vigorously contested. When a member of the family, someone providing professional service to the family, or some other believes a child needs care or protection they might make a formal notification to CYF[5]. Or the child might be apprehended by the police committing an offence raising control issues. In these cases the state (here enter CYF) might formally seek to intervene. Intervention may initiate in this way:

1. Where advice to a family might be sought and given – in most cases the wider family or some community or voluntary service provider provides what is necessary;
2. Assistance might be needed to help a difficulty in parenting that requires specific support (there might be financial assistance provided – for example: Family Start);
3. The relationship or personal issues in the family might require therapy – and provision is made for counselling, mediation or more direct medical or psychological assistance;
4. The difficulties within the family or with a child and young person might be such that a notification under the Act is made – and CYF acts upon that notification – for example following a family group conference a plan to provide for the needs of the child is implemented;

[4] Care of Children Act, 2004, s. 17.

[5] See: Children, Young Persons and Their Families Act, 1989, ss. 14, 15.

5. The difficulties are of such seriousness that the child or young person is removed from the home and placed either in the family or other foster home, or the child or young person is detained within an institution. The State then temporarily assumes the responsibility of care and protection for the child.

Interventions are always sensitive and emotional for a family. Intervention challenges the responsibility to nurture, a primary human instinct. It impacts an individual's and families' self respect. Some people complain.

Given what is at stake, challenges to the role and decisions of CYF must be expected, even encouraged. But because of the serious role and function of CYF their capacity to absorb and competence to respond ought to be first class. Complaints offer CYF:

1. An opportunity to get a decision, or procedure or process right, even if this means correcting an earlier decision, procedure or process;
2. An opportunity to develop and build an even better relationship with a family such is the likelihood that the State/Family relationship is likely to be an enduring one;
3. An opportunity to strengthen public support for the organisation;
4. An opportunity to improve the individual performance of a CYF staff member, and control misconduct;
5. An opportunity to learn from experience, good and bad, and constantly improve practice performance – the impact of policies and procedures on quality social work – and thereby improve outcomes economically[6].

Notwithstanding, this is a difficult area of administration, for several reasons:

1. Inevitably, the families affected are likely to be those without power and resources. They may struggle with authority. Entitlements might be confusing to them especially those crucial to having a say in relevant matters. It requires special efforts to compensate for these problems;
2. Dealing with some of these families and the individuals by which they are constituted may be a very challenging task. Some of those families are skilled at working the system, may be intimidating and be abusive. This takes a particularly resilient set of characteristics in a social worker to both endure this and remain effective;
3. Children are notoriously difficult to engage in these systems. They fear or avoid authority and adult processes. Some may not comprehend the process (i.e. as too young or it is bureaucratic). They might make irrational choices. They may not wish to impact a strong yet difficult relationship (i.e. with a caregiver). The difficulties in facilitating access to children and young people is an enduring challenge and an objective of any care and protection system;

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[6] See also Doolan, M., Establishing an Effective Complaints System for Child Youth and Family, Scope of Work (2005), University of Canterbury.

4. The decisions and judgments are complex and difficult and reviewing them similarly challenging.

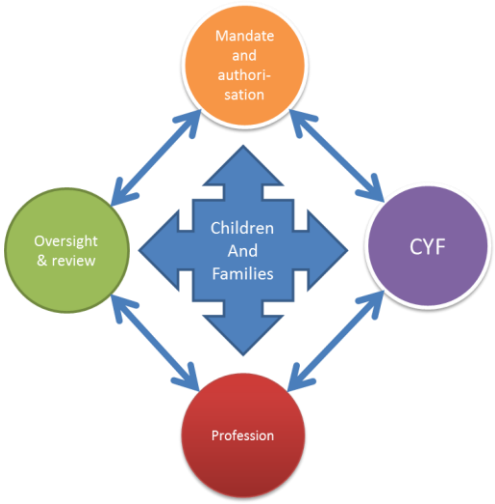
The complainants in this complaint system include:

1. Those who come under their own motivation and assistance;
2. Those who are found and encouraged to come and report;
3. Those on whose behalf a complaint is made;
4. Complaints that the system itself is expected to generate.

What are the desirable elements of a complaint system that would serve these complainants and the wider public interest? My review led me to believe that there are four interlocking parts of this complaint system.

These parts are:

1. An organisation which embraces complaints as an opportunity to ensure good performance and to learn;
2. The legislative, policy and public interest settings that drive the performance of the system;
3. The maintenance of individual and collective professional practice (the professions) as a foundation of quality practice;
4. The oversight and review of practice and conduct to ensure that it is both effective and efficient and to ensure that lessons are learned.



The Means - Child, Youth and Family

Outline

CYF is one of the service delivery clusters of the Ministry of Social Development. The Ministry is headed by the Chief Executive, presently Mr Brendan Boyle who was appointed to the role in October 2011. The role of the Chief Executive is expressed through Part 3 of the State Sector Act, 1988 and is responsible for the statutory and policy functions and duties of the department, tendering advice to the Minister(s), the general conduct of the department and the efficient, effective and economical management of its activities. The provision of a

complaints procedure is not expressly stated. A Deputy Chief Executive of the Ministry (Bernadine Mackenzie) is responsible for CYF. CYF employs social workers (under Section 5 of the State Sector Act 1988) to deliver care and protection, youth justice, adoptions and guardianship services. CYF has offices throughout New Zealand. In this respect it is one of the more widely dispersed organisations in the state sector. There are:

- Five Regions;
- 52 Site Offices from which services are delivered;
- 12 Operation Areas that manage groups of Site offices;
- Three Specialist Service units;
- Nine Residences that provide a secure environment for children and young people in youth justice or care and protection.

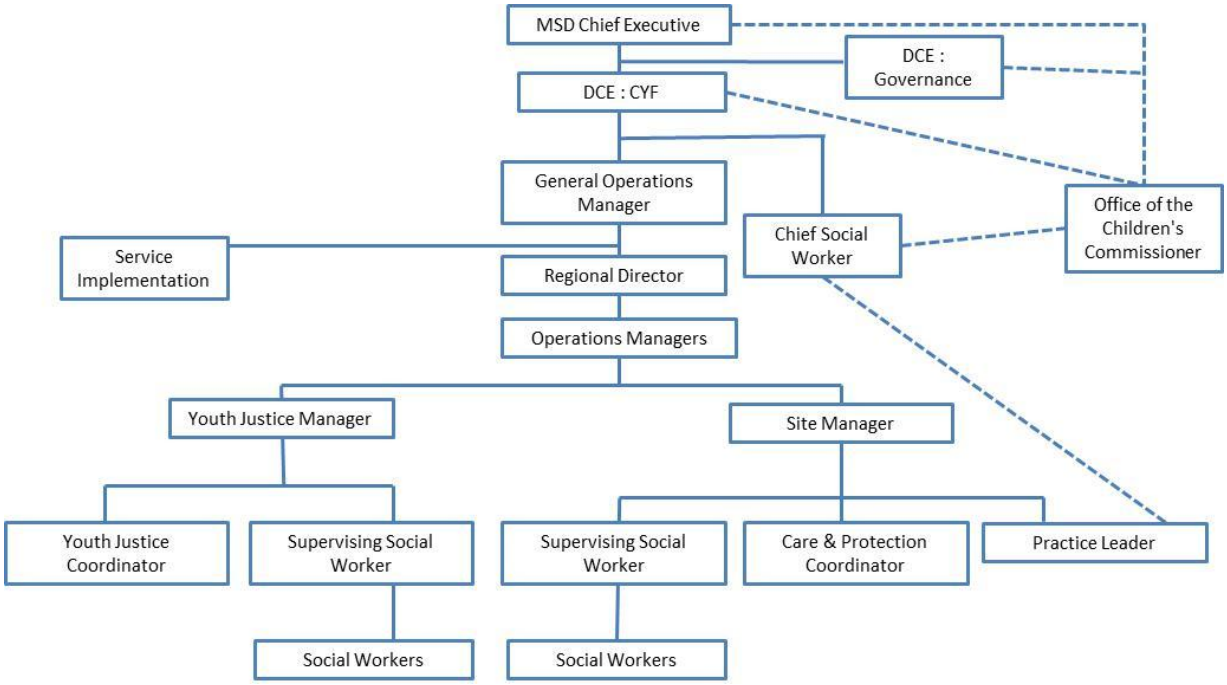
At each site social workers and senior social workers deploy in teams headed by a supervising social worker reporting to a site manager. Site managers report through Operational Managers to a Regional Director (RD) who in turn report through to the General Operations Manager. Newly appointed Service Improvement staff are deployed in regions (five) and at national office to oversee the performance of the complaint system and otherwise assure service quality. There is also a professional governance regime that exists to advise and counsel a social worker in their professional practice:

1. By supervising social workers who are registered, and selected on social work practice as well as leadership and management skills;
2. By a "practice leader" present at each site – a person selected for practice knowledge and experienced in the application of the law, policy and procedure that together comprises the practice framework and guidelines;
3. Through a "professional supervision" relationship. For social workers this is also their supervising social worker but for senior staff this relationship may occur outside the line and also the organisation.

The Chief Social Worker (CSW) oversees CYF professional practice. The CSW reports to the DCE CYF. The CSW has a practice review programme and ensures lessons learned from investigations and inquiries are incorporated into practice.

Independent oversight of social work practice guidelines and performance is invested in the office of the Children's Commissioner (OCC), a statutorily independent overseer of the interests of children (and an office I will describe in detail later in the report).

The following diagram defines the internal CYF relationships – [NB. it is not a complete organisational chart]:



The Evolution of CYF

CYF is an institution that is a product not only of the talents and ambitions of its current governance, leadership and capability but also of its background. This history describes several things:

1. The policy and structure of the CYF's guiding legislation emerged after considerable philosophical debate between professionals and the community;
2. It is not only the risks in the family setting in which children and young people are found by CYF which cause harm, but an additional risk that interventions, badly devised or implemented, can also cause harm;
3. The lack of a specific and supported complaints policy in past years has not helped maintain confidence in the otherwise difficult and complex role that CYF performs;
4. There have been recent positive changes in the CYF approach to complaints.

Tim Garlick last year published "Social Developments – An organisational history of the Ministry of Social Development and its predecessors, 1860-2011."[7] From this work, I will summarise the early origins of CYF

- In the 1920s the Department of Education held responsibilities for basic youth justice and "child welfare";
- The Great Depression led to widespread changes to the welfare system and so shifted child welfare to a new Social Security Department;

[7] Tim Garlick, "Social Developments, An Organisational History of the Ministry of Social Development and its Predecessors, 1960-2011" (2012), Ministry of Social Development, Steele Roberts Aotearoa

- The function of child welfare was primarily responsive - investigating complaints of abuse and instances where children had committed offences;
- This remained the primary operating state of the department through a "stable" period of social welfare (1940's, 1950's);
- But, in the 1960's, from within the department were emerging the elements of a preventive approach, and
- Social work practice then began building an evidence base drawing on the emerging social sciences.

The 1960's and 1970's were turbulent times for social systems. Changes to family structures increased case workloads substantially. Social workers debated the rigid case management approach against the merits of a wider 'social development' approach. The latter approach focused on "well-being in society, and preventing social breakdown and distress rather than merely curing symptoms".[8] The agency was restructured for better coordination of services (Department of Social Welfare - DSW) in 1972. Better coordination of services struggled to emerge. It seems that the broad streams of social security and child welfare largely persisted as independent operations and service and social improvements did not eventuate.

There was new child protection and youth offending legislation. This had survived academic and professional challenge. The Children and Young Persons Act 1974 "reaffirmed the underlying approach of previous decades, driving social work practice further along the path towards professionalism and the *expansion* of residential care facilities."[9] Numbers of cases and numbers in residential care continued to rise. Additionally:

- The increasing demand on social security (benefits) was an impediment to the allocation of more resources to care and protection work;
- The community continued to agitate about the model of practice – with very pointed criticisms of the "centralised, bureaucratic, social work provision [of] residential care for young people";
- But a shift towards a community development approach that "would strengthen formal and informal support systems within communities" was beginning, and a devolution of some services to community groups, including Maori was undertaken;
- Change implementation was confused and difficult.

Garlick reports in his work that by the middle of the 1980's "the Department was clearly in trouble"[10] and there was "controversy and debate over almost every aspect of policy and services and in such a large organisation with dispersed accountability and complex functions [and this] had thrown [the department] into

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[8] Ibid., p. 15.

[9] Ibid.

[10] Ibid., p. 16.

relative disarray."[11] And then, three different but powerful forces were about to meet each other at the end of the 1980's – Public Sector Reform, the United Nations Convention on the Rights of the Child (UNCROC) and the emergence of the Children, Young Persons and Their Families Act, 1989 (CYPFA) with significant ramifications for child protection.

Public Sector Reform

Public sector reforms from 1988 split policy functions and operations. It encouraged strategic management principles (in particular a drive to understand the linkages between inputs (resources) outputs (goods and services) and outcomes (impact) as a means of improving performance. There was an encouragement of business-like methods. Agencies with business like transactions fared best; but those dealing with "messy social problems" struggled.

To respond, the department restructured into the separate business units of Income Support, NZ Children and Young Persons Service and the Community Funding Agency. The latter component was introduced to emphasise contracting, accountability and service standards of outsourced (community) functions of the department. The changes did not proceed evenly, some people and processes proceeded to change at quite different rates and soon the overall coordination of the department began to experience high levels of stress. Further reviews followed.

UNCROC

At about this time also (1989) the United Nations opened for signature the UN Convention on the Rights of the Child. Michelle Egan-Bitrans[12] provides a summary of the effect of this Convention on a complaint system.

"Children have a right to express their views whenever decisions are being made that will affect their lives. They also have the right to receive relevant background information and an explanation of the reasons for such decisions. These rights are enshrined in [CYPFA] and in Articles 12 and 13 of [UNCROC]. The right to express their views becomes particularly important when children perceive that things are going wrong or they are dissatisfied with a service. This places an obligation on government to ensure that children are provided with the opportunity and mechanisms to have their views heard and given due weight and that they are able to participate in decision making. This includes mechanisms to have their complaints or concerns heard in a manner that supports their participation and well-being".

Egan-Bitrans also said "Children who are involved with Child, Youth and Family are a particularly vulnerable group of children. They often face challenges in understanding and participating in decision making processes

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[11] Ibid., p. 123.

[12] Michelle Egan-Bitran "A Review of the Child, Youth and Family Complaints Resolution Policy and Procedure", (2012), Office of the Children's Commissioner, New Zealand, p. 3.

which affect them and find it difficult to voice concerns or make a complaint because of their circumstances and the power of adults in their lives."[13] She also noted that the UN had reflected on UNCROC, and this latter point, and advised countries to ensure that there were child sensitive procedures available for children and their representatives.

According to Egan-Bitrans, a child centric approach "should be guided by natural justice principles. When seen in relation to children this means ensuring that complaints mechanisms are child sensitive, including having access for '*children and their representatives including child friendly information, advice, advocacy, - including support for self advocacy – and access to independent complaints procedures and to the Courts with the necessary and other legal assistance*.' "[14]

UNCROC is a major influence on New Zealand child protection policies and practice. The reviews and judgments on performance against UNCROC flow freely from the UN and measure our reputation in an area for which we believe we deliver high standards. The Office of the Children's Commissioner has the responsibility to monitor New Zealand's performance against the standards set in the Convention.

CYPFA

Background

At the same time as Public Sector Reform was initiated, and with the UN Convention development in the background, the philosophical criticisms of previous social work practice in New Zealand were being addressed with the ground breaking Children, Young Persons and Their Families Act, 1989 (CYPFA). Mike Doolan, who in 1988 was a senior DSW official, challenged policy makers and practitioners to develop a new approach towards young offenders. Garlick described Doolan's criticisms of then current practice[15]:

> *... past responses to offending had been firmly rooted in the "welfare tradition" which viewed it [offending] as "a cry for help, a symptom of family disorganisation or even pathology". No distinction had been made in practice, he argued, between those who offended and those in need of care protection and control. This approach had a tendency to "net-widen" by using offending behaviour as a route to tackling the wider problems of a family bringing more people into contact with the system. Yet most people ceased offending after reaching adulthood and prosecution often had harmful effects, even increasing the chances of reoffending.*

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[13] Ibid, P 6.

[14] Ibid, P 6. The quote draws upon CRC/GC/5 November 2003, para. 24.

[15] Garlick, T, (2011), supra, p. 132.

Doolan argued for the creation of a distinct youth justice service that would minimise prosecution and control the negative effects of professional intervention. He advocated what we now know as Family Group Conferences (FGC), a restorative justice approach, in which families/whanau would be more directly involved and have the power and resources to achieve a diversion from Court Prosecution. It would also become the foundation of the care and protection approach. It was to ensure that interventions to place ensured the child's placement was to people and places known to them (i.e. within a kinship relationship).

This approach to social work intercepted another approach that had been vigorously advocated, mainly by professional groups. Both approaches aspired to the same ends, but differed in method. The professionals advocated the presentation of care and protection and youth justice matters to a committee of suitably qualified people; paediatricians, social workers, police, mental health professionals and so on, for decision making in the case – in other words to substitute decision making for a family that was perceived to be failing in its role. One such model was in operation, in Dunedin during the 1980's, and perceived to be working well. However, the family approach had serious support from within the community, and in particular the Maori community. Even as the professional model was being translated into draft legislation work was suspended. The family oriented approach was substituted and carried into law. There seems now to be a settled view (at least amongst those I interviewed) that this was a good thing.

The Framework for Social Work in Child Protection

CYPFA understands and attempts to compensate for the imbalances of power between the State and families, and between adults and children and young people. The arrangement of the roles and functions established in the Act seems to me to be very important for the functioning of the CYF complaint system – the Act promotes and activates people to observe and report on the functioning of the child protection system and therefore to surface these observations – some of which ought to be raised as a complaint or a concern. Again, this is extremely important because of the nature of the client group of CYF who otherwise might not be able to raise their voice to express a complaint or concern.

CYPFA - Detail

The Act has several objects (Section 4): to assist families to discharge their responsibilities, to assist children and young people where family relationships break down, to assist and protect children and young people from coming to harm, to hold children and young people to account when they commit offences, and to build appropriate and co-operative **community capability** that can assist the wellbeing of children and young people and their families.

The Act is based on principles including:

- That a family (whanau, hapu, iwi or family group) has the primary rights and responsibilities in the care, control and protection of young people and therefore must be involved in decision making if an intervention appears warranted, s 5(a);
- That interventions should ordinarily maintain and strengthen a family grou, s 5(b);

- That decisions must consider the effect of a decision on the welfare of the child and the stability of the family group, s 5(c);
- And should take into account the wishes of the child or young person, s 5(d);
- That the manner of intervention ought to be such that gains the support of the parents or guardians of the child or young person and the child or young person themselves, s 5(e);
- And made within a timeframe that accord with the child or young person's sense of time, s 5(f).

In relation to the Care and Protection of children, the welfare and interests of the child are paramount (s 6). But for youth offending and the Youth Court respectively the public interest must be taken into account.

The Act describes a process of dealing with children and young people who are believed in need of care and protection (defined in s 14). Any person can report a risk situation to a social worker or to a police officer (s 15) for investigation. The matter can then be reported to a Care and Protection Co-ordinator (CPC) (s 18) or a Youth Justice Coordinator for the purpose of conducting a family group conference (FGC). A Court can refer directly.

Family Group Conferences (FGC)

An FGC is the place the statute intends that decisions about the care, protection and control of a child or young person ought to be firstly discussed and resolved. The FGC examines the circumstances – the issues, the options that are available from within the family or from the wider community (professional or otherwise) and the extent to which the family (in its widest possible definition) can undertake the actions necessary to ensure the interests of the child or young person are met. A critical success factor is the availability of options from which the best fit for the circumstances can be selected.

The FGC is facilitated by the Care and Protection Coordinator (CPC) appointed under section 423 because "that person is, by reason of his or her personality, training and experience, suitably qualified to exercise or perform the functions, duties and powers conferred" upon them. That is to ensure that the right people are present, that advice and support is provided, information is appropriately shared and that the decisions are properly recorded and referred. They oversee the concluding parts of an FGC such as the process of obtaining agreement to the family's decisions, recommendations or plans. A Youth Justice Coordinator does much the same work in respect of a youth justice matter. A CPC may delegate their role to a suitably experienced social worker (s 427).

Not all relevant options might be available to a FGC. The CPC has to understand and explain this to families. This occurs because an FGC does not have an open cheque book – fiscal considerations imposed by the Chief Executive have effect. Bluntly, the Chief Executive can set budgets and social work managers and their staff must observe them. However, the Act operates to ensure there is transparency over the effect of fiscal decisions on the operation of the system in any particular place.

Care and Protection Resource Panels

The local operation of FGC and the support of the CPC and social workers raised risks that were contemplated by the Act. The Care and Protection Resource Panel (CPRP) was imposed at a local level. These are committees established by the Chief Executive under s 428 and they are to (s 429):

a. Provide advice to social workers and police on the exercise or performance.... of the functions, powers and duties conferred under the Act;
b. To receive reports from the CPC on matters relating to the exercise of their functions power and duties;
c. To promote the coordination of services by the community to children and young people in need of care and protection and their families;
d. To advise the Chief Executive on the appointment of the CPC.

The CPRP is intended to provide a check on local social work practice judgments by giving advice. They also monitor (but do not advise/direct) FGC but do maintain sight on the relationship between FGC, CPC and community services. These matters ought to combine and provide an effective local oversight and guidance for reports received by CYF.

Community Sector Organisations

It had been a fight to place the community and its resources centrally in the statutory framework of child protection. The community sector is knowledge and skills rich but time and cash poor. It comprises philanthropically based organisations such as Barnardos and Youth Horizons, iwi and cultural organisations, faith based organisations such as the Salvation Army, the Catholic Social Services agency and many others. It also comprises individual professionals such as paediatricians, general practitioners, psychiatrists, psychologists, specialist therapists and counsellors.

These services are provided either through a specific contract or under the umbrella of an “approval” process provided for in the Act (sections 396-409) where the appropriateness of the organisation, its personnel and systems and its services are made subject to varying levels of scrutiny in return for funding for service delivery.

In addition to the community, other government agencies contribute. These include other parts of MSD such as Work and Income and Family and Community Services, the health system, the education network, ACC, and the Police. It is part of the scheme of the Act that coordination of services from all sectors is essential to successful child protection.

Unless the professionals involved in these other organisations are regulated (for example a registered social worker, or medical practitioner would be mandatorily regulated through the Health Professional arrangements to the Medical Council) these professionals are “regulated” only through the contracts or approvals process of CYF.

Therefore one element of these contracts is the requirement to have a complaint process. A person who wishes to complain about the service of, say, Barnardos, may do so by approaching Barnardos. But then seeking a complaint review by the Children's Commissioner is unlikely to be successful (as I will explain). CYF would regard the complaint as outside the process and there is no resort to the Ombudsman.

The larger community organisations reported to me that they have no difficulty with the requirements of a complaint system and the accountability it imposes. They are likely to be concerned about reputation and take complaints seriously, not least for the impact on funding contracts.

Community agencies are in a good position to provide comment on CYF performance. They work with CYF clients and they are knowledgeable about law, practice and process. Senior people in quite a few of these organisations advised me that if they have an issue they may raise it gently with the local CYF office and if no satisfaction is obtained they make an assessment as to whether it is worth the while to raise it through personal relationships at a higher level. None reported being asked about CYF actions or performance on a formal basis. Having said that, the present leadership of CYF were favourably described as having a good profile outside of Wellington.

All agencies are worried about the consequences of having been critical of CYF. There is evidence that in some places and at some times they have reason to worry.

This is an issue on the radar of current CYF senior staff. But it is not an easy problem to resolve. On the one hand there is a need to make use of local CYF staff knowledge about the services that are needed in any particular locality. But the staff from whom they seek opinions about need, and also supply, are also likely to have engaged with the organisations supplying services and there is a high level of risk that the opinions they hold about the quality of the services or a service provider have been formed without an adequate test. In other words, unfairly. To counter this risk, CYF are now moving to establish a further separation between funding mechanisms and local social work provision to mitigate this risk and on balance this is good thing.

There has been recent activity to develop relationships with Maori representative groups. I am surprised that given the high proportion of Maori and Pacific amongst the client families of CYF, and notwithstanding the personal interactions that exist, that stronger relationships outside of discrete service contracts has not been more visible prior to now.

The Court

I will touch briefly on the role of the Courts under the Act and the control function they have over social worker decision making. A contested or unresolved FGC goes to Court. The Court can end an intervention or steer it in different directions. The Court has to rely on the social worker to a large extent. The social worker brings objective fact to contested situations. However, this reliance can seem as unnecessarily familiar to families and therefore raise concerns that the process suffers from predetermination or bias. Further, I gather from informal conversations that the Judges would wish a greater level of consistency in social worker services. The Court can see poor practice and report it, but it does not do so frequently.

The Court may also appoint a Counsel to assist the child (s 159) or the Court (s 160) to ensure that the child has individual representation in the proceedings. The Court may also appoint a lay advocate whose role it is to bring cultural perspectives to the Court in the interests of the child. These assistants are paid by the Court, and have standing as any other advocate in the proceedings (the department, the caregivers etc.). While it is possible for the Court to extend (or replace) these appointments if it is satisfied that it is necessary or desirable in the interests of the child, this does not achieve the needs of "monitoring" a child or young person whilst in the care of the state that I will suggest later in this report.

The 1990's

I return to the chronology of events. In the 1990's after enactment, there was an earnest attempt to implement the Act. Then, in 1996, driven by further state sector restructuring, Income Support merged with the Department of Labour's Employment Service into a standalone department (WINZ,) and the residual and social work parts of the Department were combined into the New Zealand Child, Youth and Family Service (NZCYFS). The policy components of the department transferred to a new Ministry of Social Policy – intended to provide advice on the purchase of services from delivery agencies and be "strategic". Through this period there was a concerted effort to link up the community dimension of service delivery but the implementation difficulties again thwarted these intentions.

In 1999 NZCYFS was subjected to a ministerial review that identified underfunding, isolated practice and criticised it for having an undue short-term focus. The separation of funding from operations under the new public sector model was identified as distancing central government decision makers from the community and voluntary sector whilst subjecting them to increasing operational scrutiny. The community sector was struggling. There was "overwhelming anger, burnout, profound mistrust and cynicism". [16]

MSD increased efforts to coordinate the sector. More resources were invested in policy and a new Family and Community Services Service (FACS) was set up to improve relationships with community and voluntary sector agencies and to improve contracting performance.

But reports to CYF continued to climb through this period. The Police had revamped their approach to family violence reporting and began reporting all incidents at which children were affected or even present as fresh cases requiring a response. The volume of information per case also increased dramatically. Such reports doubled and then trebled in a short few years. A number of very high profile service failures relating to the abuse of young children as well as public encouragement to report abuse aggravated the demand issues. CYF systems appeared to be in deep trouble.

[16] Garlick, T, (2011), supra, p. 18.

2006-07 - Reintegration

In 2006-07 the service was consolidated into the Ministry of Social Development and a process of investment and development commenced which continues to this day.

Initially, focus was placed on gaining control of incoming workload and reporting into a central contact centre was encouraged. Assessment systems for incoming reports were introduced to channel cases for either an investigation or a "differential response" (a lower level response to reports that are escalated if the process determines a need). Breathing space was obtained. Within a few short years the performance of CYF was seen to have markedly improved. In the 2011 Performance Review (PIF) it was reported: "*MSD took responsibility for CYF in 2006. It has done an excellent job since that time at improving performance in this area. It has been widely acknowledged that MSD has been able to greatly reduce the number of unallocated cases, that it has been better at managing the risk in this highly sensitive area and that it has invested heavily in training and improved the leadership capability within CYF*."[17]

The PIF makes reference to the development of training, leadership and generally improved risk management. Another focus of development was the complaint system. The Ministry realised that the nature of the powers exercised by CYF and the levels of dissatisfaction evident amongst their client group had to have a better response and ought to inform practice better.

Complaint System - Background

The CYF complaint system inherited by CYF on integration in 2007 was basic. Everyone agrees. To make a complaint one contacted the local office, wrote to the regional representative, the chief executive, a local Member of Parliament or the Minister, called the Ombudsman or contacted the media. It required perseverance and tolerance.

At all entry points the complaint was firstly referred back for local resolution. A former Senior Social Worker neatly summarised the approach: *"Up until I left [2004] we did not have an independent complaints system. Complaints were expected to be resolved at the lowest level and if that could not be effected it was shoved up the line. At each stage the approach was to defend the CYF position".*[18] Interestingly, this same senior social worker, now working elsewhere in the network, reports that in his recent experience (past 6 months) he has had experience of the CYF complaint process: "*I have been reasonably impressed – the investigation was*

[17] Performance Improvement Framework, "Formal Review of the Ministry of Social Development (MSD)", (May 2011), State Services Commission, the Treasury. And the Department of the Prime Minister and Cabinet, p. 17.

[18] Personal Interview.

independent of the case worker, there was a thorough investigation, caregivers were interviewed, the matter was recorded, feedback was given, where there were mistakes these were admitted and acknowledged".[19]

A complaint to an MP would result most likely in a reference of the issue to the Minister who sought advice from the department. Recorded as a Ministerial, they were then handled as for a normal complaint with some subtle but important differences. Clear timelines in place gave complaints handled this way an additional level of urgency. The fact that the Minister or their staff performed oversight also tended to lend greater emphasis to the response.

This channel became a first choice channel for some. Some staff might have become irritated at this "jumping over" the system and adverse consequences for the complainant could not be ruled out.

In the old system, as now, if local resolution and any escalation procedure were not effective, the dissatisfied complainant could go to the Ombudsman. The Ombudsman requires a departmental approach first. The Ombudsman has published their approach to CYF in a Fact Sheet[20]. If dissatisfied, the complainant returned to the Ombudsman. Some did. Doubtless there were dissatisfied complainants who gave up without returning to the Ombudsman but I am unable to say how many this might be.

A person could also complain to a media organisation. The media organisation would as now make enquiries in an attempt to substantiate the complaint and then seek feedback from CYF. Notice of an impending story is usually very short, often within hours of a publishing deadline. In that time CYF must get control of the facts and organise a response. It also has to ensure that the usual "no surprises" reporting through political channels is effected. More importantly, there needs to be a rapid risk assessment for the impact of the story on other clients, on staff, and on the organisation. Questions about how and who to respond with need to be made.

For a staff member at the centre of this, and their immediate colleagues, the frenetic action of head office in the face of a media story that might be critical of practice is often contrasted with more laboured actions taken through normal risk escalation processes, say in relation to resource issues, and rather cynical comparisons made.

The media attention, despite being a very painful process for those involved, establishes three clear points. The first is that high quality practice, confidence in its content and its application, together with leadership that is skilled at advocating it's principles, is the greatest level of protection to criticisms of the organisations performance. If the leadership can defend a criticism by describing what good practice looks like, and then understand and explain what the difficulties and challenges of applying that practice might be, there will be a general acceptance that although mistakes might have been made they have been acknowledged and

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[19] Ibid.

[20] Ombudsman, "Child Youth and Family Fact Sheet", Office of the Ombudsman 6 August 2012.

understood. The system itself remains intact. That is important for the general public's confidence in a critical government system.

The second is that the likelihood of media "exposure" is less if there is a high quality and credible complaints system in operation. Additionally, that such a complaint system's credibility is tested by an effective and independent oversight system.

Thirdly, it also highlights that prevention is better than the having to take the medicine. While some relationships with families are extremely challenging, a high level of communication, relationship building and the attainment of trust is the preventive tool that protects the situation from criticism.

There is a general view that since re-integration into the Ministry there has been a greater level of ownership of organisational problems publicly, a greater defence of the difficult work of social workers in the context of performance improvement, and a much greater responsiveness to media inquiry when problems do surface.

But, the overall complaints process conducted in this manner, in the state prior to the most recent changes to the complaints policy and practice, left many complainants deeply unsatisfied. I have heard many of their stories and common themes emerged:

1. It was difficult to complain. There was an absence of information about how to complain and a demeanour and attitude from staff to whom complaints were addressed that impeded the complaint taking process. There was an absence of genuine listening involved. The complaint taking process reduced the complaint down to a core or narrow issue in which the overall importance of the complaint to the complainant was lost.
2. There was little effort made to set expectations for the complaint handling process. This often 'set up' the complainant for later disappointment when it became clear that their complaint could not overturn what they perceived as an unjust court decision. The process of investigation was not clear leading to a belief that it was unnecessarily truncated or biased in favour of the social worker.
3. A frustration that errors that appeared in the professional practice relating to matters before the court were not corrected through the oversight that the Court provided – that the Court simply received and accepted the social workers findings and that there was no realistic means of redress within the Court system for those sorts of problems.
4. A belief that the complaint would create consequences for the complainant. Given that the complainant would in most cases be in some long term relationship with CYF, particularly if they were a child, the costs of making a complaint were perceived to dramatically outweigh the benefits of doing so. Insiders to the system have acknowledged this was more than a perceived problem.
5. Children experienced difficulty in making a complaint. The complainant might be too young, with inadequate advocacy. Outside of the residences there was no special channel for children and young people to complain. Most had no idea they could, and no motivation to confront the institution. They were particularly vulnerable to fears about the consequences of a complaint on them.

6. There was a lack of support in the complaint process and in particular the process lacked an independent oversight that was close to it (the Ombudsman being seen as a little too distant). The process was governed by those in the workplace that had been complained against.
7. A lack of feedback on the process. In turn this generated a feeling that the process was useless because nothing happened as a result. In particular it was perceived there was a major gap between the complaint process and the disciplinary process. Further, that if an error in the relevant record was the subject of a complaint the complaint process did not result in the error being removed – often having to be re-litigated repeatedly through all dealings later with the department.
8. The complaint handling process was perceived as flawed, with breaches of confidentiality and a lack of professionalism. The rapid turnover of staff handling the matter did not help.
9. And, tellingly, that the whole process was simply CYF looking after CYF. Whether or not elements of the process had elements of independence (e.g. the Panel) the process was not perceived as independent and therefore was unfair.

In every case, communication was a big problem. Much of the communication was delivered in an oppositional manner, expectations were not clear and consistently set, progress reporting highly variable and the final disposition of the matter often disclosed a vigorous narrowing of the complaint and a blunt defence of the system.

Complaint System Reform

The main complaints system change process was initiated with a small scoping study in 2007/08 [21]. Noting the obvious limitations to complaint processes: firstly the statutory independence of social worker practices, and secondly the independence of the Courts, the review promoted a complaints *review* process. The review dabbled with the idea of an independent statutorily based complaints review mechanism executed through an amendment to CYPFA but this was not taken further. The Chief Executive then chose to establish a second tier internal mechanism using reviewers external to CYF and MSD but reporting directly to himself as Chief Executive.

Following the review, on 21 July 2008, a new comprehensive complaints policy was promulgated. The Complaints Review mechanism commenced from that date. However, despite good intentions, the focus on demand management diverted managerial attention and resources from complaints management. There is an acceptance that the intentions of the 2008 reforms were blunted:

1. Although a need for specific staff investment into the complaints process was indicated, no additional staff were provided;

[21] Richard Bolton, "CYF Complaints Project: Issues; Initial Options, Interface with CYF Act update" – Report to the Complaints Project Steering Complaint Group, 15 February 2007.

2. The system demanded new processes and behaviours at site level but the training provided was limited;
3. The system also required new features in the information technology available and this was slow to come on stream.

It was not until 2011 that a further review of the process was undertaken that led to the modern changes that are currently being rolled out through CYF offices nationally. These changes rectify the earlier blunted rollout:

1. Staff have been provided at regional level with specific responsibilities for the complaint system;
2. Training is in the process of being conducted at a general level throughout sites (the "Wednesday Brief") and also in more detail (two day courses for those more directly involved with the complaint process;
3. The initial development of CYRAS (the CYF case recording system) has been reviewed and additional features scoped and prioritised;
4. In 2013 during the course of this review revised guidance for the policy has been released as part of the continuing process of reform. I will detail the policy and guidance further below.

Complaints From and About Children in the Care of the State

When the attempts by families to resolve the care and protection or offending issues with a young family member have failed, the state may step in to exert control. Some children and Young People are placed in the care of the Chief Executive by a Court Order. This may be:

1. When a child or young person is detained in a secure residential facility (a residence);
2. When a child is placed into a CYF family home;
3. When a child is placed into kinship care;
4. When a child is placed into foster care.

Children in care, their caregivers, and those who support and represent them, are potential complainants in a CYF complaint system. The children and young people are particularly vulnerable., As consumers and providers of and to "the system" policies ought to be in place to ensure their complaints and concerns are heard.

There is history to this question too. A legacy from the 1989 Act was the burning question about the "casualties" of the previous care system. It was clear the system replaced in 1989 had contained abusive practices and people. Harm had been caused. As the stories of those who had bad experiences while in state care accumulated, a need for an effective policy response grew. In addition to changing management practice around CYF residential care facilities, two other policy programmes were implemented. I talked with those connected to these programmes.

Confidential Listening Service

If there is any doubt about the risks of having children in the care of the state we need look no further than the experience of the Confidential Listening and Assistance Service (CLAS). This panel was established (in 2008) in order to provide an avenue for those formerly in care of the State who raised an issue about their treatment. The service, with the panel chaired by a District Court Judge (Judge Carolyn Henwood), meets with these participants, "listens" to their story and provides advice, support and assistance. The results of their work identify a clear list of the risks in state care that ought to be guarded against, and for which the system ought to actively seek out and find – in part by finding people who can report risk and then inquiring into the circumstances.

I was fortunate that the rules surrounding disclosure of the general concerns raised with the Panel had changed and I was given access to a December 2012 report[22] in which the service reported having met with (now) 702 participants (of some 1190 who have indicated a desire to meet the panel) and where their concerns were described.

It was reported that participants' "questioned the quality of care offered to them:

- The theme most loudly stated by participants was that they were taken into care (and detained some times for years) for their protection but they felt let down because they were not kept safe. Because they were not protected, their lives were ruined or greatly diminished as a result;
- Many reported that they were not monitored – the State did not effectively check on their wards. Sometimes no checks were done at all;
- The abuse of alcohol was a consistent theme running throughout the narratives – children having to live with and manage drunken adults who had responsibility for their care;
- The panel noted high levels of serious violence meted out to children;
- Participants reported a shocking level of sexual abuse – both to boys and girls;
- Most reported that the voice of the child was not sought or heard or believed;
- Neglect of physical and emotional well being and education." [23]

A particular area of concern lay in the decisions to place children in care. Participants questioned the selection of unfit and unsuitable care givers; the placement in or out of family care not being sufficiently thought through, a lack of analysis in decisions to escalate cases to institutional or psychiatric care, concerns over the cultural or religious " fit" for the child, the length of time spent in care, poor transition planning both going in

[22] Report of the Confidential Listening and Assistance Service, (2012) Chair, Judge Carolyn Henwood CNZM, Department of Internal Affairs.

[23] Ibid., p 11. *Please note these are the reports of experience of a historic nature.*

and out of care, the multiplicity of placements and the issues of mixing children in care with a particular concern over mixing care and protection and youth offender placements[24].

The service also outlined for the purposes of this review a number of the issues which appeared more frequently in their clients' submitted experience:

1. The absence of clear documented reasoning as to the decisions for the placement of a child or young person in care;
2. The tendency of social workers to change court ordered plans without referral back to the Court – these plans might then be in conflict;
3. Staff changes in the residences, disrupting a child's relationships with carers;
4. The lack of a system of monitoring of the services provided to children and young people in care outside of the residences. In this respect CLAS differentiates monitoring of "the Act", "systems and processes" and focuses on the need to monitor specific cases, and specific actions of social work practice (e.g. social workers);
5. The lack of a higher level view of a case – what this means to not only the child and young person but to the system of care.

The Service is not required to reach a finding or issue a recommendation but is more of a "truth and reconciliation" process. Clients of the service have been referred to various government agencies for further assistance. CLAS has advocated on their behalf. Action has followed. Some have laid complaints with the police, others directed to the place where legal assistance might be found, or advised how to make an approach for a particular benefit or grant, or take up various types of counselling or medical care. Developing relationships with these agencies is a principal operating method of CLAS.

CLAS takes the view that in its discharge of responsibility to children in care, "the state needs to be monitored"[25]. Further, that there ought to be a statutory standard of care for children in care that ought to underpin charters and other mechanisms that express the intended commitments to performance and against which services can be judged. That of course, might make somewhat more visible what the duty of care is to these very vulnerable people and be the standard against which to complain or assess an experience. Judge Henwood thinks that this commitment of a Government is part of a "nation building thing". I agree with this view.

CLAS is charged with hearing cases of a historic nature. It has, however, been exposed to cases of a more recent nature and wished to advise this inquiry that they fear risks are still too evident in the present age.

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[24] Ibid., p.12.

[25] Interview, Judge C Henwood.

Responses to Historic Abuse

Awareness of the social impact of institutional care was growing in the life histories of those who were presently in the prison system, amongst those experiencing mental health care and also in the wider welfare system. Dealing with the social, policy and legal issues from this legacy is clearly one of the more difficult issues confronting governments in New Zealand and elsewhere and there are few simple answers.

Up until 2007 these issues were being handled on a case by case basis and in a rather ad hoc manner.

Several issues presented:

1. While every attempt had been made to maintain the records of the era in which claims of abuse were directed, many of the records are held in archives, some are missing and all require considerable enquiry and analysis to make sense of. These records are the base upon which the organisation has to make clear and reasoned judgments on complaints which present.
2. The legal situation is complex. Many cases cannot access the Courts because they are time barred or because they are covered by the Accident Compensation system. Notwithstanding, there are some situations in which Court action is possible necessitating a rigorous examination of the facts. However, for any litigant there are additional hurdles:
    a. Can they establish grounds upon which to obtain legal aid?
    b. Can they establish causation (that the abuse as alleged caused the harm that was caused) to the standard of a civil Court. It is difficult to separate out which of these impacts are the result of the abuse suffered at the hands of state intervention or were part of the presenting condition that may have brought the individual into contact with the authorities at the time.
3. Notwithstanding these issues the moral position of the Government is vexed. The accumulating evidence is that in some places at some times serious abuse did occur and there is a question about whether current remedies are sufficiently available. The impact of any abuse has had a natural consequence that finds many of the abused now in other parts of the welfare system, in prison, under medical or psychiatric care, or in receipt of a benefit.

In addition to the establishment of CLAS, a special unit, the Care Claims and Resolution Team (CCRT) and now called the Historic Claims Unit, was established to receive and process claims dating prior to 1992. 1992 seems to be a date that is associated with the implementation of CYPFA, or was selected as part of the development of a Crown Litigation strategy, although I did not encounter anyone with the absolute evidence as to why this date was chosen.

The approach of the unit is to "be fair to everyone concerned; we are not advocates for the client, nor are we there to simply defend the Ministry's position"[26]. The unit undertakes a process of inquiry to establish the

[26] Interview G Young (2013).

facts; “if we [the Ministry or its forbears] have let the individual down, then so be it”. The focus then turns to resolution.

There are challenges in getting to a conclusion. As indicated, obtaining the official records forms part of that. This entails finding the institutional records, personal records of the individual or the family, and records of the staff who were present (or the carers). From this, generally a record of what might have happened can be established – in other words how likely the complaint is to be true. Some records are missing and in particular in 1999 there were a large number of files that were destroyed. Record keeping practices were also variable.

The unit works with the advocates or the individuals themselves personally. Over time they have closed 403 cases of which up to 20 are cases since 1992. There are 760 cases “still in the system” awaiting resolution about 90 relating to cases since 1992.

Issues that the unit are dealing with are:

1. Compensation. When the unit was set up they considered what precedents there might be to establish a figure if compensation was warranted. They drew on ACC cases, looked into the levels that the Courts were awarding in cases of exemplary damages;
2. The question of how to deal with complaints about abuse alleged to have occurred since 1992 (for example the 90 cases referred to above).

Lessons being learned from the examination of these historic cases restate the importance of a developed relationship between the social worker and the family and the need to follow the guidelines, rules, policies that are in place at the time. This stresses the critical role that practice guidelines play in the system, that these are indeed best practice. Further, experience also shows that a social worker must also ‘listen to gut instinct’ in relation to risk – and not to rest until that instinctive concern is settled.

The Residences

The residences still exist. They exist for the placement of children into secure care. Five residences remain of the network of residences that existed prior to CYPFA and fewer than 200 children are in residential care. Numbers in secure care are declining. The residences are controlled environments for the safety of the residents and the staff.

The operation of the residences is subject to the Children, Young Persons and Their Families (Residential Care) Regulations 1996. The regulations:

- Establish a set of rights for children and young people in residences (clauses 3-14);
- Establish a resident’s rights of access to a grievance procedure, and advocacy assistance to make a grievance (clause 15-16); an advocate may be a barrister or solicitor or a youth advocate (appointed under the Act) or a person nominated by the child or young person (and who is any of: a member of the family, a barrister or solicitor, a kai awhina or kai arahi, or an approved person);
- Limits the power to punish:

  - Establishing a national code of practice for management of residences;
  - Within the national code, requiring behavioural management programmes to be notified;
  - Allowing for the Chief Executive to set and limit punishments that may be imposed;
  - Prohibiting punishments to those authorised and in each case reasonable in the circumstances;
- Establish grievance panels for each residence (a panel of three appointed by the Minister which includes one from tangata whenua) who operate as a review panel of any grievance raised by a resident and to review proposed punishments. Grievance Panel's report to the Chief Executive's advisory group which includes the Principal Youth and Family Court Judges and the Children's Commissioner.

A child in a residence who wishes to complain may either speak to a staff member, raise the matter with a visitor or an advocate (such as their Court appointed solicitor) or write a complaint on a form and then post it in the facility provided at the residence.

Everyone I spoke to about the residences agreed that these are difficult places to manage. Obviously, those placed in residences are young and immature. They come from some of the most desperate backgrounds in our communities. I encountered a mix of views about the complaint systems relevant to the Residences. There is quite a view that in the context that they are places which are difficult to manage then the current system is doing quite well, and that the complaint process works satisfactorily and that the inspection system is adequate. There is an amount of resignation and pragmatism behind this view.

On the other hand, I have spoken to a number of informed commentators who aspire for better. Their criticisms of the Residences may be summarised as:

1. There is a lack of recognition of the difficulty of providing care in these difficult institutions and that we should aspire for a higher level of qualification, skill and downright passion to do the job from those who work there;
2. Notwithstanding that these are secure facilities there is a control regime that surrounds them that actively prevents better engagement between the residents and support capabilities. It is believed that this could be achieved without surrendering security interests but by taking a more therapeutic and child centred approach to the facilities' operations;
3. The residences "mix" children and young people together so that there are those with severe behavioural problems together with some who have severe mental health problems. However, they all present a risk to the community, evidenced by the scale and seriousness of their offending or their propensity to offend. The objective of having to secure these children and young people while at the same time provide for a nurturing and therapeutic environment is extremely challenging and raises the question about whether the mix ought to be tolerated;
4. In an attempt to provide for a voice for the child in the residence a cumbersome and bureaucratic complaint system has evolved. It does not follow restorative principles. Each complaint is dutifully

recorded and dealt with. But in the process the real "voice" (the point of the complaint) that is being raised might be lost, or the process might unfold in a wholly unsatisfactory manner. Three examples describe this:

a. the first is the "broken muffin" issue. A child is seeking attention, they may have had opportunities refused, they may have real unmet needs, but these have been, in their view, thwarted. So their response is to complain about a muffin that is presented in bits. A complaint is raised and thoroughly investigated. Eventually there is a file an inch thick, the complaint is upheld and someone apologises for the broken muffin. But the voice hasn't really been heard;
b. In another example, a child is pushed around in the residence by others in the residence. There might be some danger. The control of the secure space has been compromised. The investigation takes a long time as everyone's individual interests are measured and dealt with. The decision upholding the complaint is handed down on the day when the child leaves the institution. They receive the decision in writing – not face to face. They are wholly unsatisfied at having been in fear for a significant time in the residence and think the authorities simply paid their concerns lip service;
c. In a final example, a child who has mental health issues raises a complaint. And another, and another. Suddenly there are 18 complaints in the system for this child. Each, again, dutifully investigated. Someone does not step back and say – there is a profound issue here and it is not complaints.

5. While the availability of an advocate is provided for in the Residential Regulations, there is an implied pressure to opt out of that assistance. And there is the factor that everyone in a residence, and young people generally, fear the consequences of taking on the system. The complaint form includes provision to tick a box "I do not want an advocate". Advocacy for a child or young person in an institution of this nature ought to be the norm;
6. While commendable efforts to bring younger people into the Residences have occurred (for example introducing law students into relationships with residents) there are practical difficulties with this. For example, when the law student goes on University vacations the relationship is lost.

It is fortunate that the numbers in residences is much less than in previous years. To effect positive change will require the determined efforts of CYF, backed up by an independent practice review and complaints review function.

Children in Care

Those not in residences under secure care are to be found in houses, in suburbs, throughout New Zealand. A person, with good intentions and a kind heart, has taken a child or young person (from their family or otherwise) and is providing care.

There are risks including:

1. The primary care giver may cause harm;
2. While the primary care-giver may be sound, other visitors to the home may cause harm;
3. Sometimes the home has more than one child or young person in care. If this is not carefully thought through one child or young person may abuse another;
4. Sometimes a professional might unintentionally or deliberately cause harm.

Each child in care is visited by their responsible social worker on an eight week rotation. Doubts over the compliance with this CYF policy was raised with me during the course of this review. While there is a check in CYRAS to ensure a record of the visit is made, this can be circumvented. The reason given for non-compliance is the high level of caseloads of social workers and they therefore "risk assess" the work requirements of that caseload and routine visiting descends in priority. Yet this is a significant part of the defensive screen of child protection provided by the state. It seems beyond the reach of the scope of the counsel for the child to perform this role beyond the representation in the proceedings and acting on what the child might volunteer. The Children's Action Plan currently under development includes policy development that will ensure that those children and young people who require more regular contact receives it and that their interests be more actively promoted. In my view this is an activity that needs additional focus and must be regularly audited.

I also met with representatives of organisations who support care-givers. Although training is provided, allowances are paid, and additional support is provided, it is clear that it can be a very difficult journey to be a care giver. A person with considerable experience in supporting those who offer care said "People start with a caring heart but there is no support and the system grinds them down".[27] Little things such as obtaining permissions for the children under their care to do things, to get small grants or pay for small opportunities, local policies which seem to change without notice or because the CYF staff member has changed. And the selection of those sent on training courses – "some of those they have sent ought to have been the trainers!"

This interviewee's experience with the complaints process (now coming up to thirty years) were consistent with other views I received on the "old" CYF system – however his most recent experience indicated a small and positive change: "however, recently I had a really good experience, got information back, with updates on progress, it was actually good that the issue was followed up. This is last year."[28] Mostly, this commentator dealt with boys who had been abused in the care system and he believes this remains a serious risk. While on the one hand he is very supportive of the move to perform gateway examinations where every child entering care is subject to a wellness check including a medical examination. At this point information from a range of sources is collated and the analyses regularly pick up undiagnosed medical, psychological/psychiatric and education problems that need to be dealt with. But he believes there should also be an "exit interview" when

[27] Confidential interview.

[28] Confidential Interview.

a child or young person leaves care. If there are issues that for any reason have not surfaced during care this is an opportunity to try and identify them and respond to them.

In 2012 the Minister of Social Development asked "How many children were abused by Child, Youth and Family approved family/whanau caregivers while the child was in care?"; and, "How many Children are abused while in the custody of the Chief Executive?"

It required the preparation of a manual audit to provide an answer for the year 2010/11. 67 children and young people were known to be abused while in the care of the chief executive. Of those, 30 children and young people in care were abused by 26 CYF approved caregivers. In 2011/12, the most recent figures available, the figure had declined slightly (23 children and young people abused by 22 CYF caregivers, 63 children overall abused while in care). The difference between the children abused by a CYF caregiver and total abuse is due to findings against child and family support caregivers, CYF staff members, parents, and others. Most of the reported abuse was for serious physical and sexual abuse.[29]

The Professional Context

The Elements of a Profession

The ability to complain about the practice and conduct of a professional practitioner is a feature of a good complaint system within the industry in which the practitioner operates. In the health sector, for example, a complaint can be made against a registered medical practitioner that is then either investigated by the Health and Disability Commissioner (HDC) or by the conduct or competence assessment committees of the Medical Council. Professional associations (e.g. the Royal New Zealand College of General Practitioners) provide training, establish competency standards and offer support. Although the process can appear complicated it separates the investigations relating to patient health and safety from both the employer and the professional body. The interests at stake are properly separated, analysed or investigated and then resolved.

Against that standard the social work profession has the basic framework in place but the arrangements are not as fully formed. The elements are:

1. CYF has an employer related complaints process;
2. There is a system of voluntary social work registration;
3. There is a social worker (group of) professional association(s) – also voluntary;
4. There is a regulator – the Children's Commissioner (the HDC equivalent).

This section describes these professional arrangements.

[29] The figures reported here will differ from those released under the OIA to the news media as I had sought access to updated figures.

The CYF Complaint Handling Process

Introduction

Child, Youth and Family has a present complaints policy dating from 2008. The policy was reviewed in 2012. A plan has been developed to improve complaints resolution practice and it is currently being implemented. Key additional documents are:

1. **Policy:** Terms of Reference, Child Youth and Family Complaints Process, Chief Executive Advisory Panel (13 March 2008) – establishment policies for the CYF Complaints Resolution Process.
2. **Policy:** "Complaints Resolution Policy and Procedure[30]. Originally published on 21/7/08 it was revised on 21/7/10 – this is the establishing complaints resolution policy. It remains in force.
3. **Policy and Guidelines:** "Child, Youth and Family Complaints Resolution Policy and Procedures – Resource Kit for Panel Members and the Review Secretariat" (February 2009). This is policy and guidance for phases 1 and 2 of the resolution process – the internal complaints review process overseen by the Chief Executives Review Panel. This also remains in force.
4. **Communication:** "Our complaints resolution process" – a presentation for delivery to staff (undated).
5. **Guidelines:** "Key Information Complaints Resolution Families and Communities"- released March 2013.
6. **Form:** CYF Complaint Report – Template document for reporting on complaints resolution (undated form).
7. **Communication**: "Complaints Resolution" – a one-off communication for Wednesday Brief - (a weekly meeting held at every site for planning and communications purposes).

It is clear that "complaints resolution" has been the subject of significant management attention in recent years. The tempo of development and change has increased substantially over the past year. CYF is currently rolling out the change programme during the course of this review and it is incomplete.

Phase 1 – CYF Complaints Resolution

The complaints policy is based upon principles: Accessibility, Consistency, Responsiveness, Natural Justice, Accountability, and Learning.

The policy establishes that CYF views complaints as a valuable opportunity to reflect on how their services are regarded and commits to a systematic investigation that contributes to an improvement in the quality of services and the development of organisational learning. Specific actions form part of this commitment (there is a list), for example "make information about how a person may make a complaint easily accessible".

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[30] "Complaints Resolution Policy and Procedure", Child, Youth and Family, Ministry of Social Development, (2008) p. 2, para. 3.

Complaints may be made in writing, or if orally presented it is to be reduced to writing, if necessary with assistance from a CYF staff member. Initial contact is facilitated by the provision of a free calling line (0508 FAMILY), a downloadable complaint form from the CYF website, by emailing CYF complaints address (complaints@cyf.govt.nz). Secondary sources of complaints are envisaged (referrals) from the Office of the Children's Commissioner, the Ombudsman, or the Privacy Commissioner – as each oversight agency requires a complainant to use the primary complaint function as a predicate to access to their procedures.

The policy also distinguishes complaint-like approaches – for example an enquiry or request for information (official or otherwise), a request for service, or a *concern* – described as "an issue that can be addressed quickly and informally at site level or where the issue was raised". The policy states, the intent of the policy is to respond to complaints about CYF *performance*.

The complaints procedure through these policy statements intends to facilitate and respond to complaints and to balance a number of legal interests such as the rights to natural justice and confidentiality.

The policy applies to all CYF employees, temporary staff, students and individual contractors. Third party providers are excluded other than their relationship with CYF (not their service delivery) because the provider is to have their own complaints process (subject to oversight and checking by the National Manager, Approvals). There is a range of other exclusions:

- complaints made by staff (staff are referred to their manager, or they are referred to Human Resources).
- matters that are more appropriate dealt with under other procedures such as:
    - allegations of abuse and neglect *[which need to follow the statutory reporting procedure];*
    - complaints about matters currently before the court;
    - complaints by a current resident of a CYF residence about matters that took place while they are in the residence. The complaints resolution process does not override the *Residence Grievance Procedures;*
    - complaints that should be managed by the Historic Claims team;
    - aspects of complaints which have resulted in the matter being treated as a disciplinary matter in relation to employees of CYF.

Guidance is given to facilitate children and young people's participation, that they are supported if desired and that the result of the complaint is communicated in person. Detailed guidance is given about handling the relationships between children, adults and CYF in respect of a complaint, particularly in cases where a complaint is made "on behalf of".

A complaint may be withdrawn at any time and guidance is given on this process.

The policy establishes a clear line of control and responsibility over complaints management processes through the Regional Director (RD), Regional Operations Manager and Operational/Site Managers. In general terms:

- The RD enables the process across the region and ensures accountability for policy compliance;

- The Regional Operations Manager has an enabling/facilitating role that supports the process and manages risk. They promote local resolution, specifically monitor progress, and maintain records of complaints (especially procedure and outcome) and reporting. They also ensures the procedure adopted is proper, that staff are trained and that the process is represented properly publicly;
- The Operations/Site Managers have "hands on" responsibility for implementing the process through the staff under their control and for ensuring complainants interests are maintained.

In 2012/13 new positions were introduced, including a Manager, Service Improvement, the (national) Advisor, Operations, and (regional) Advisors, Service Improvement. These positions have been filled. Responsibilities for these positions are clear.

The policy also recognises situations where a complaint raises several (different) issues, or is directed to several (different) recipients or is a complaint whose object extends over several regions of CYF. It directs that "in all cases it is important that the management of and response to the complaint is coordinated. The issues to be addressed and the outcomes sought by the complainant, need to be clarified at an early stage". The policy anticipates a single manager be responsible for coordination of such complaints and imposes a responsibility to coordinate the investigations as well as to ensure the complainant is kept informed of progress on all aspects through a single line of communication.

The policy establishes timeliness standards and requires that progress against these standards be recorded. For example the complaint must be registered within the database within one working day, the complaint acknowledged within five working days and so on. The IT system has alerts for these milestones. To enable the Regional Operations Manager to discharge their responsibilities collected case information has to be forwarded monthly, this is then collated and forwarded to the National Office. Updated regional information is distributed back to managers with an analysis of trends. At national level the CYF Executive are provided with monthly, quarterly and annual reports that include summary statistical information and trend analysis.

The Ministry, through its Corporate and Governance division is required to monitor and report on CYF complaints process and has a duty to report to the DCE CYF and the MSD Performance Resources and Risk Committee.

The policy provides further direction on the responsibility to maintain records of the complaint. This includes:

- The record must be "full and accurate";
- Be in a separate complaint file;
- Includes all types of information (documents, images, sound) however collected;
- Personal information collected as part of the complaint investigation is to be restricted in it's use to the purpose for which it is collected;
- Held for six months at the regional office after case is closed and then archived with the Ministry. After 25 years the record is transferred to the National Archives;
- Documents related to the complaint must be held on the file;

- Records cannot be disposed of in any circumstances without consultation without high level approval;
- The complaint is not to be linked to a staff file unless official action (warning etc.) results.

During the course of the complaint the complainant and the staff member are entitled to have access to personal information held about them – subject to the rules imposed by legislation (Privacy Act 1993, Official Information Act 1982). The complainant may request that this information be corrected, and this request must be recorded along with any decision made on the request (however there is an issue with CYRAS that locks information into the system that needs to be sorted). The name of the complainant will be provided to the specific person who has been complained about unless there is a good reason not to (e.g. the safety of an individual or the maintenance of the law - reasons founded in the Official Information Act 1982).

Since new policy was implemented in late 2012 complaints have been categorised into three levels (this part of the process has received additional guidance in the April 2013 guidance document). Triage occurs and there is good guidance provided as to how to perform this. This is basically a marshalling process ensuring that complaints enter the right process.

1. Low Intensity – (to be resolved within 10 working days) and are those that:
    - Do not require investigation;
    - May previously be dealt with as informal complaints;
    - Can be resolved with a face to face meeting or telephone call;
    - Can be resolved to both parties satisfaction within 10 working days.
2. Medium Intensity (to be resolved within 30 days) are those that:
    - Require an investigation;
    - Have the potential to escalate;
    - Have the potential to cause friction between CYF and the child, young person and their family/whanau;
    - Are about the practice and or behaviour of staff;
    - If the complainant has had a number of recent complaints registered in the complaints management system.
3. High Intensity – (require the approval of the regional director) and include those that:
    - Require national coordination;
    - Have multiple and complex issues;
    - Relate to more than one CYF site/region;
    - Have been sent to different agencies (such as MSD, the Office of the Ombudsman, or the Office of the Children's Commissioner).

These assessments may be modified through the process. Advice is given. There is also a good piece on "remedy and redress" and useful assistance in identifying and responding to complainant behaviour.

Between 7/11/11 through to 6/12/12 (one calendar year) there were 577 complaints received by CYF. 490 of these were formal and 87 were informal. Most of the complaints related to behavioural factors (being treated with respect, being treated fairly, and communication). These are matters about which the clients of CYF will have a personal view upon and which they are confident in expressing. Another significant complaint category relates to "access, care and custody" for which the importance of the issue would seem to drive the need to complain. Other important categories of complaint do not attract complaints in any quantity, in my view because a smaller proportion of CYF clients are exposed to those areas (administration, policy), know less about that part of the process and are less confident in complaining (for example the complaints about FGC is comparatively low).

With the appointment of staff to the new positions I suspect that there will be a step change in the performance of the system. There will be emphasis, continuity, accumulating experience, and an ability to focus on pressure points and trends. A critical success factor in this step change is the attitude of the top tiers of CYF, improvements will rapidly accumulate if they place priority on the process (allocate time to it) and personally and regularly review:

1. The difficult cases;
2. Cases that are taking an exceptional time to complete;
3. Analysis of trends and pressure points;
4. Staff who are regularly featuring in complaints;
5. The results of recommendations for improvement.

All of these are about "closing the loop" – spotting the issue and sticking with it until dealt with. The National Improvement Manager has a key role in helping the DCE and National Operations Manager in these habits.

Phase 2 - The Chief Executive's Advisory Panel

The history chronicles the establishment of the panel as a second tier complaints review process after an earlier attempt to develop this concept as an external, independent, and statutorily based structure had failed politically. Those dissatisfied with the CYF complaint process may ask for a Chief Executive's Review that is then conducted by the CE's Advisory Panel. The Panel is supported from within the Ministry's Corporate and Governance Group wherein also sits a secretariat to the Panel. This Group is headed by a Deputy Chief Executive distinct from the Deputy Chief Executive with responsibilities for CYF so as to maintain an internal independence. In addition to the independence from CYF (but not from the Ministry) the Panel comprises a "senior group with expertise", is a "fresh pair of eyes" over an unresolved complaint, and provides additional opportunities for improvement in organisational performance, processes and systems.

The Panel is appointed by the Chief Executive and its members are remunerated for their work. The Chair must be a person of standing in the community and be an expert or knowledgeable of statutory social work and associated social services. The other members are expected to bring one or several of the following attributes – a similar standing in social work knowledge, an ability to represent families and parents, have

expertise in children's services and child development, knowledge of relevant legislation, and familiarity with Maori/Pacific and migrant cultures.

Section 3 of the Policy sets out the role. It limits the scope to the organisational context and issues, and not "the actions of individual social workers or the actions of staff as individuals". It is resolution focused, includes issues relating to handling the Phase 1 complaint, is able to reach findings and make recommendations relating to redress and service improvements.

The panel is also guided by Principles. These include: Independence, Restoration, and Privacy.

There is a process. The Secretariat receives a request for a review, registers it (within one day) and requests the file from the National Complaints Coordinator (provided within five days). Requests that relate to complaints finalised before the advent of the policy establishing the Panel came into being are not accepted and those that were in process at that time will only be accepted after consideration on a case by case basis. If the request is otherwise outside of the jurisdiction of a CE Review the complainant will receive advice about alternatives (referral to the Ombudsman etc.) If accepted, the Secretariat handles the administration of the panel's consideration of the complaint, seeks additional information where necessary and seeks CYF comment on any new information that the request may have included. The proceedings of the Panel are recorded.

Although complaints review can be enabled through a review of the papers, the Panel can and does meet with complainants to discuss their case (they have a right to appear). The secretariat mandatorily assesses the support needs of a complainant to aid their involvement in the process and this results in the provision of interpreters, support people including legal advice, and physical support for those with disabilities. Travel costs are met when these are required for an attendance at the Panel on an "actual and reasonable" basis. Support to staff is included in the policy.

The Secretariat otherwise supports the functions of the Panel and provides or facilitates expert advice to the Panel. The operation of the Panel is also monitored. This includes case volumes, outcomes, timeliness and backlogs. This monitoring information is then provided to the Chief Executive and the Deputy CE (CYF) to enable them to carry out their governance functions.

The Chief Executive receives and considers the Panel's finding and recommendations and makes a decision on the complaint. This is communicated to the complainant through the secretariat and includes any action that is to be taken and the timeframes for these. If the complainant is a child or young person the decision must be communicated "in an appropriate way".

From the Panel's inception in July 2008 through to 6 December 2012, 129 requests were received for a review of a complaint about CYF by the Panel. Of those 40 complaints were heard by the Panel and reported to the Chief Executive. 12 complaints were upheld, 21 partly upheld and seven not upheld. Of the recommendations made by the Panel all were accepted by the Chief Executive in full. 25 complaints had been referred back to CYF as the internal process was then incomplete; 15 complaints were before the Chief Executive pending decision or within the processes of the Panel. 16 complaints were outside of its jurisdiction or were being

investigated by another body (i.e. the Police, Ombudsman or SWRB.) four complaints had been withdrawn. Six had been resolved by CYF in the meantime. Of the matters considered by the Panel three cases were taken further and complaints made to the Ombudsman who had at that time made determinations on two.

There is a general view that the Panel is working well and as planned.

CYF: Organisational Support for Complaints Management

The Complaints Policy of an organisation is one leg of the issue. The other is the extent to which the organisation supports the complaint process and learns from and uses the information that a complaint process generates. That ability to learn and use such information is part of the system that reduces the likelihood of repeat or other complaints – and thus a better service to clients.

This is a large question and so in terms of the review I focused on a number of key questions:

1. What processes support the complaints system?
    a. Selection of the right people;
    b. Training of those who implement the system.
2. What systems monitor and report on the complaints process?
    a. Reporting through to CYF leadership;
    b. Monitoring of complaints handling timelines.
3. What are the systems that review and allocate the information that is generated from the complaint process?
    a. Processes that task and coordinate the implementation of recommendations that are made when resolving complaints;
    b. The link between the complaints processes and the disciplinary process.
4. What are the systems and processes that manage the staff impact of the complaints process?

Support Processes

Initially, as I have said elsewhere, when the 2007 changes were made there was a small amount of training and exposure of the new system at the regular weekly "Wednesday briefings" that are generally conducted at each site. But that was insufficient to substantially lift the quality of complaints handling.

The changes to the complaint process of 2013 are clearly heading in the right direction. During the course of this review there has been a process to recruit the right people into the service improvement positions in each region, positions which will be critical for the development of the new system. These people have been appointed upon criteria relating to complaints and issues management. They have also been engaged in training in the new system and they are embarking on a process of implementing the system and learning from experience. Training has been extended to the senior staff in regions who are expected to have oversight of the complaints process.

The training has been a two day course. It involves exploration of the process, triage of a complaint into an appropriate channel, escalations, and contains instruction of key competencies such as communication, documentation and report writing. It is followed for a wider group of staff by a delivery at the "Wednesday Brief". The success of this training programme will have to be reviewed in due course.

These changes are important to inculcate a new attitude towards complaints at senior levels throughout the regions and thus amongst all staff. Those who process cases through to the review panel advise that the performance is very mixed indicating variability in commitment and/or skill. The evidence is, however, that performance is improving. But these are only emerging signs.

Where I think future development might be directed is in developing a more structured approach to the process of complaints handling, (see Part 4).

I did not review the process of building the practice guidelines that lie under the jurisdiction of the Chief Social Worker. But it is clear also, in keeping with other management practices that this has developed particularly under the leadership of the current CSW.

The importance of practice review is such that it ought not be left to the agency alone. In this respect, the Office of the Children's Commissioner has added value in such matters as Dr Nicola Atwool's report on Children in Care. But these reviews are occasional only.

Human Resource Support

In the wider context, and reflecting the strong connection between general social work practice and complaints handling, I considered a number of the primary development mechanisms for CYF, with the result I found:

- In general terms CYF does not have a problem recruiting social workers;
- The attrition rate (social workers leaving the service) is not abnormally high whether viewed as "all of CYF" or "field social workers" as a subset of the former (10.7/10.9%) and is presently declining;
- The average length of service of field social workers is increasing (now averaging 7.6 years);
- Personal grievances recorded in the system were not abnormal;
- Workforce registration plans are on track;
- Disciplinary processes are active, not of an unusual level, and investigation levels are declining;
- There is a structured professional development programme;
- There is a measuring tool for engagement and morale issues.

Although I did not conduct an audit of these matters, these indicator processes did not raise concerns for this review.

Employee Assistance

A complaint system must recognise and balance the interests of the complainant with those complained about. Natural justice demands this as does the duty under the State Sector Act 1988 for the Ministry to be a good employer. I was therefore careful to include in my consultation a number of CYF staff who were generous enough to talk through their experience of having been complained about. The experience of being under investigation is a stressful and challenging time, and the experience unlikely to be favourably viewed, as is clear from the impressions gleaned from these conversations:

- In one case there was a feeling that a particularly difficult individual in a family in which abuse had been admitted (by another) was trying to get back at the social worker involved – they mounted what appeared to be a deliberate campaign to get the social worker dismissed and included running their complaint through a website and other social networks and instigating a march and protest outside the CYF office. CYF had the website taken down;
- In a number of other cases the lack of good communication from the organisation left them feeling extremely isolated – after being told about the complaint there was no further information until they were called before the Review Panel. The absence of an express timeline and the absence of feedback were additional criticisms. Not being advised of actions that CYF at management level had agreed and which affected the individual social worker and which became known through their contact with the family and not directly by management were reported as particularly distressing actions;
- In another case the social worker involved found out that a complaint had been made to the Registration Board and they were advised of this on a Friday night without any pre-warning from within the organisation;
- "I felt that all the way through there was an assumption that the complainant was right";
- In other cases undertakings given by senior staff were not carried out;
- That the offer of Employee Assistance is often valueless because the social workers know the counsellors involved professionally and sometimes personally and are not motivated to use that service freely;
- The prospect of a media "outing" raises the prospect of a very horrible experience and the degree to which staff will go to "avoid that" raises a real risk that in some cases and under pressure good social work practice might suffer to the detriment of some other person;
- Some are left with the feeling that they must be cautious about what they write in notes about a case as their notes had become part of the allegation against them. "Not all social workers have natural skills at writing up their case notes, or are as good as some others at least". More training in respect of proper note taking was desired;

- In small offices complaints have a big impact. "Everyone knows everyone". Often the complainant has had contact with many or all of the social workers and the complaint can be directed against the whole office;
- From a staff members perspective it is easy to gain and hold the view that if a client complaints loudly and often they will get more attention, and result in decision changes that the social worker does not agree with.

MSD provides an Employee Assistance Programme (EAP) for when staff are experiencing difficulty. This includes an experience of a critical incident and stress management. The latter was designed to "sit alongside professional supervision, EAP and wellness programmes. There is a reasonable level of uptake of EAP although it is trending downwards in recent times[31]".

One of the inherent difficulties of the organisation in trying to resolve complaints as quickly as possible and at the same time managing affected staff, is that a very pointed conflict emerges. The conflict arises because of the need through the investigation process to believe and be seen to believe both parties to the complaint. A failure to generate confidence with the complainant undermines any attempt to obtain resolution, whereas a failure to support the staff member undermines the moral authority to lead either in a workplace or in the service generally. In both cases there may be consequences of failing to get the balance right.

I also interviewed a number of senior and supervising social workers with experience of conducting complaint investigations. Some of their comments are:

- In the past there has been an expectation that Site Managers deal with quite difficult complaints – there is a feeling that these positions were hugely overwhelmed with work expectations and load, and could not do justice to the complaint process – " things break down"[32];
- There is also a difficulty in investigating complaints in small to medium offices because of the internal relationships in existence – often staff have worked together for a long time and there has not been a lot of movement through the office;
- Nonetheless – "there is no reason why people can't act independently and professionally".
- These senior staff thought that there remained strong merit in having local offices maintaining a responsibility to resolve complaints rapidly;
- A significant issue with the complaints system is the difficulty of having local offices who get involved in the very high demand complaints. High demand in respect of the time over which dissatisfaction is (continually) being expressed, the level of intensity with which a complaint is pursued (i.e. accompanied with intimidation or compromise);

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[31] MSD presentation, comparison of third and fourth quarters 2012.

[32] CYF Managers workshop; 19 April 2013, MSD.

- Another issue is getting complaints out of some of the key processes required under the Act, such as the FGC system, which might be better enabled through a practice review method;
- There is doubt that recommendations that come out of the complaint process are actually carried out at site level in all cases;
- They also thought that it was necessary that the complaint process be properly marketed.

I have an expectation that under the improving model of complaints resolution these perceptions will change positively.

Reporting Processes

There is a system of reporting complaints through line management. At each level these reports are assessed, risks identified and dealt with and aggregated until a report is tabled at executive level (with the DCE). This system is known as the "dashboard system" and it has IT support. Timelines are monitored, more so now the IT system has been improved to provide alerts when milestones approach or over-run. The management reports include sight on recommendations that emanate from the review panel and other oversight bodies (e.g. Coroner). There is a process for managing the implementation process, ensuring that actions are taken. The Advisory Panel in the Ministry is copied into the reporting process and they report that improvements are visible. I caution, however, this is a very new set of processes (2012/13) and it is too soon to issue judgment on effect.

The 2013 guidelines identify very clearly the areas where reporting will be expected, whether on "stocks and flows" (movement of cases through the system) or trend analysis.

As the new process embeds it would be wise to have a communications plan in place that ensures that stakeholders to CYF are kept informed about where development effort is being applied, what progress is being made and what evidence there is that the changes have impacted on outcomes.

There is also attention paid to the implementation of recommendations that flow from the Review Panel. However, whether or not there is an impact of changes that have been recommended is not followed through in a rigorous manner.

Social Work Registration Board

Purpose

There is a system of registering social workers in New Zealand governed by the Social Worker's Registration Board Act, 2003. The base of this system is the existence of a Board established under the Act.

Its purpose is (s 3)

a. to protect the safety of members of the public, by prescribing or providing for mechanisms to ensure that social workers are—
    I. competent to practise; and

II. accountable for the way in which they practise; and

b. for the purposes of paragraph (a), to create a framework for the registration of social workers in New Zealand, and—

I. establish a board to register social workers, and provide for its powers; and

II. establish a tribunal to consider complaints about registered social workers; and

c. to provide for the Board to promote the benefits of registration of social workers—

I. to departments of State, other instruments of the Crown, other bodies and organisations that employ social workers, and the public; and

II. among people practising social work; and

d. to enhance the professionalism of social workers.

The elements of this approach we are concerned with are: competency, accountability, and discipline.

Competency

By s6 of the Social Workers Registration Act 2003, a person who has a recognised New Zealand qualification (see further below) is entitled to be registered if the Board is satisfied—

a. that his or her competence to practise social work has been found satisfactory under Part 3; and

b. that he or she is a fit and proper person to practise social work; and

c. that (whether because of the inclusion of an appropriate component in that qualification, or as a result of his or her satisfactory completion of a separate course or courses of training) he or she—

i. is competent to practise social work with Māori; and

ii. is competent to practise social work with different ethnic and cultural groups in New Zealand; and

d. that he or she has enough practical experience in practising social work.

An important component of registration is educational qualifications (s6). Many academic institutions now offer qualifications in social work. A "recognised New Zealand qualification" is established primarily by the completion of a qualification identified in guidelines issued by the Board. A process exists for recognition of overseas qualifications and also to recognise long standing experience of a sufficient quality that equates to a qualification.

One of the functions of the SWRB is to ensure that the curriculum and teaching standards remain relevant and to the right level of quality. The SWRB has a process of recognising and re-recognising the qualifications offered by tertiary institutions. The Board establishes criteria involving competencies, a graduate profile and curriculum standards that are assessed by Board representatives. Cultural assessors are involved. Site visits are made. The Board establishes relationships with other quality control mechanisms such as NZQA. The Board recovers the costs of certification from the institutions involved.

The Performance Improvement Framework for CYF (a central agencies overseen process of reviewing a government agencies fitness for purpose) determined that given the dependence of CYF (and therefore the

wider industry) on the quality of social work education to train new social workers who can undertake statutory social work roles, and given the belief that there is a consistency problem, MSD ought to do more to help improve the quality of this education and to shape the market for social workers. This is a view that could equally be applied to other organisations and bodies who have a stake in the quality of care and protection and youth justice in New Zealand.

"Competence" and "practice experience" is determined by a process of assessment and proof of application of the educational learning. This assessment, generally, has to be undertaken every five years. Various organisations are recognised as capable of undertaking these assessments. The requirements that they be a fit and proper person includes provision of evidence of identity, the provision of confidential references and a police check for relevant convictions. Cultural qualification ensures that a social worker has the knowledge to work satisfactorily within different cultural settings relevant to New Zealand.

A registered social worker must have a practising certificate to work as a social worker. An annual practising certificate ensures that there is a check that they have maintained quality standards, remain a fit and proper person, have undertaken prescribed levels of professional development and are not subject to disciplinary procedures.

Although the Social Workers Registration Act 2003 does not specify professional supervision as a requirement for achievement of competency the Board may under section 29(1) and (2) adopt conditions for practicing certificates that may include supervision and in fact do so. It publishes its requirements for supervision to form part of the certification process that includes principles and specific expectations.[33] This includes that professional supervision be conducted by a registered social worker. There is training and support for this role.

There are a number of definitions of "supervision" in this context but a good descriptive definition is: "an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person".[34] The benefit of therapeutic (practice) competence is intended to impact positively on the quality of the service provided to the clients of the practice.

In the USA there are statutory definitions of supervision, for example, from Minnesota: " 'Supervision' means a professional relationship between a supervisor and a social worker in which the supervisor provides evaluation and direction of the services provided by the social worker to promote competent and ethical services to

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[33] Social Workers Registration Board, Supervision Expectations for Registered Social Workers – Policy Statement, (2009, reviewed May 2011).

[34] Loganbill, C, Hardy, E. and Delworth, U. (1982) Supervision, a Conceptual Model. *The Counselling Psychologist,* 10(1): 3-42, referenced in Hawkins, P. Hohet, R., Supervision in the Helping Professions, 2nd Ed. (2005) Open University Press, p.50.

clients through the continuing development of the social workers knowledge and application of accepted professional social work knowledge skills and values"[35].

I explored this issue for the purpose of determining whether external supervision might form part of the balancing of the role and function of social workers under CYPFA. In Minnesota, USA, legislation requires that supervision be external to the employer. The social worker can then freely discuss ethical conflicts, impacts of organisational policy, and workload issues that might otherwise be judged in the employment setting. In contrast CYF require social workers undertake professional supervision. This is provided through direct line management. The approach is defended as a standard practice by CYF.

Accountability

A registered social worker is subject to "The Code of Conduct for Social Work Practice in Aotearoa New Zealand". The code covers standards of personal conduct and integrity, provision of services at a competent level of professional practice, and respect for civil, legal and human rights of their clients.

Discipline

Part 4 of the Act describes the process of investigation and discipline. The elements of the disciplinary arrangements are:

1. A Tribunal receives and deals with complaints about registered social workers to which anyone can complain. A complaint may also be made to the HDC if health services are involved – there a requirement to coordinate HDC and SWRB actions in such a case – but the HDC has priority (see s. 61, 64). A Court before which a social worker is convicted has a responsibility to inform the Board (s 63);
2. The Tribunal refers complaints to a knowledgeable complaints assessment committee (CAC); and the Social Worker concerned is notified and supplied particulars of the complaint (s 65) and the process (e.g. see s 70);
3. The CAC regulates its own process;
4. An investigation follows, or, the CAC may adopt another investigation (e.g. the proceedings of a Court, or an organisation like CYF). Due process must be followed – s. 71;
5. The CAC then makes a determination (s 71(1)) that:
    - The complaint or conviction should be referred to the Board to review the competence or fitness of the registered social worker to practice;
    - The complaint should be conciliated;
    - The complaint or conviction should be submitted to the Tribunal;
    - No further steps are required to be taken.

[35] Minnesota Statutes, Section 148D.010, subdivision 16.

6. The Act provides for a process to bring the complaint or conviction to the Board on a question of fitness, to the Tribunal for hearing of a charge and for a process of conciliation (which where not successful can revert back to the Tribunal);
7. The Tribunal can impose penalties if it is satisfied that a social worker is guilty of :
    - professional misconduct (which includes a breach of the SW code of conduct or makes a false claim of registration);
    - conduct unbecoming a social worker, or
    - conduct which reflects badly on the social worker's fitness to practice as a social worker, or
    - an offence for which they have been convicted that is punishable by 3 months imprisonment or longer, or
    - a failure to comply with restrictions on his or her registration;
8. These include: censure, fines, being required to undergo remedial training, pay costs or expenses, or finally be de-registered (the Tribunal can cancel a registration if the finding relates to gross or severe professional misconduct). It can also suspend registration for a period of up to 12 months; or restrict the social worker's practice for a period of up to three years. A social worker can also request to be removed from the register;
9. The Tribunal may also fix a date from which a cancelled registration may be re-applied for, or impose conditions precedent to a new registration application.

There are several impacts of the disciplinary process. A prospective employer of a social worker in a role in which registration is required (by the organisation's policy) or otherwise desired can check the registered status of the applicant. They can see if the applicant has been struck off, or have unsatisfied requirements to complete before full registration will apply.

The Board has a responsibility (section 3(c) and (d)) to promote the benefits of registration and social work professionalism. As part of this role it examines cases where there "has been a negative outcome for someone receiving social work services ... and has found that in most cases the individual identified as a social worker [at the centre of the case]

- Did not meet the Board's minimum criteria and never held social work qualifications or social work practice experience;
- Was not registered;
- Was not supervised by a registered competent social worker;
- Was never held to account by an authorised disciplinary tribunal;
- Is able to continue to work in the social service sector without being held to account"[36].

[36] Chair: Social Workers Registration Board, Opening Statement to the Social Services Committee (Notes) 2012.

I understand that the Government has considered at several points the question of making social workers mandatorily registered. It remains an objective of the Board. The largest employers of social workers, in CYF and the Health sector, have policies aiming for full registration in the immediate future. I understand that CYF requires registration for social work services provided under CYPFA although I have not audited these contracts and cannot confirm that this is the case in all contracts. As each contract is audited, reviewed or rolled over the requirement to specify social work services and to ensure registration of those social workers ought to be applied.

Social Work Professional Associations.

There are a number of social worker associations. A primary example is the Aotearoa New Zealand Association of Social Workers. It has a history extending back to 1964 and its functions include the following:

- Offering professional development in the practice of social work;
- Networking, collegial support and international links;
- Research;
- The provision of competency assessment services;
- Publishing articles and newsletters;
- A complaint system.

Two of these functions are particularly relevant for this review.

1. In order that its members are able to continue to practice, ANZASW offers process of establishing a standard of competency which is a basis for full membership of the Association. This intends to be, and it is, recognised as meeting the competency basis for registration;
2. Because membership of the Association is standards based there is also a complaints process whereby the professional practice and conduct of its members are subject to scrutiny. The process activates when the complaint cannot be investigated by another body (for example by the SWRB because the member is not registered with that body) or the other body that might have jurisdiction to investigate has declined to investigate.

The Tangata Whenua Social Workers Association provides also professional development, supervision, education, practice standards and competency assessment for Maori practitioners. The Association builds its ethical framework, competencies, practice standards, and professional development within an overarching Maori philosophy.

Neither of these organisations operates as a ”union” in the sense that they bargain on pay and conditions for their members. There is a limited amount of professional advocacy. There are other social worker organisations including international networks.

The Regulator – The Children's Commissioner

The Children's Commissioner is an independent public official established under the Children's Commissioner Act 2003. The Commissioner is the primary "regulator" of child protection in New Zealand. The Act contemplates that the individual appointed may be a Judge, s 7(5).

Under the Act the Commissioner has several forms of function that must be discharged independently – s 12(2):

1. **Investigation** of
    a. decisions or acts and omissions made in respect of a child in their personal capacity – s 12(1)a) and specifically those made under CYPFA , 13(1)(a)
    b. to inquire generally into, and report on, any matter, including any enactment of law, or any practice or procedure, that relates to the welfare of children, s 12(1)(l)
2. **Advocacy –** in respect of
    a. Complaint mechanisms, s 12(1)(b)
    b. Children's interests, rights and welfare s 12(1)(c) and (f), and specifically with CYF, 13(1)(c)
    c. The Convention (UNCROC), s 12 (1)(d)
    d. Raising public awareness on matters that relates to the welfare of children, s 12(1)(i)
    e. Promoting the participation of children in decision making, s 12(1)(j)
3. **Research –**
    a. Into any matter that relates to the welfare of children, s 12(1)(e)
    b. Receive public submissions on the welfare of children, s 12(1)(h)
4. **Report -** in particular
    a. To a Court (by invitation) on any matter that affects the Convention, or Children's interests, rights and welfare
    b. To the Prime Minister on matters affecting the rights of children, s 12(1)(k)
    c. In relation to an investigation, s 12(1)(l)
    d. On any matter relating to CYPFA or its regulations, s 13(1)(d)
5. **Monitor** – (only in relation to CYPFA)
    a. The policies and practices of MSD/CYF, s 13(1)(b)(i)
    b. The policies and practices of any person or organisation exercising a function, duty or power under the Act, s 13(1)(b)(ii)
    c. The workings of CYPFA, s 13(1)(e)

The Commissioner has a statutory responsibility to develop means of consulting with children (Section 14) to ensure their views are represented in the discharge of their functions (except for the investigative power previously mentioned) but must in conducting an investigation nevertheless "have regard to the question of whether the rights or the welfare and interests of one or more children have been prejudiced".

Either before or during an investigation the Commissioner may consider that the subject matter of the case lies more properly within the scope of the functions of the Human Rights Commissioner, the CE MSD, the Commissioner of Police, the Health and Disability Commissioner, the Chief Ombudsman, the Independent Police Conduct Authority or the Privacy Commissioner, (s 19). Upon a determination that the matter does so it is to be referred there without delay.

The Commissioner's function to investigate may not be unlimited.

- "Investigations" must relate to any decision made, or act done or omitted in respect of any child in that child's personal capacity (and whether under CYPFA (s 13) or elsewhere (s 12).) On one view, this may cover all cases dealt with by CYF and would extend to allow investigation of complaints by caregivers and others (for example about their treatment by a CYF social worker) because CYF's involvement is determined by a notification about a child or young person and their personal situation. But a narrow definition of "the child's personal capacity" may exclude investigations of some aspects of caregivers relationships with CYF that might mitigate the full discharge of a complaints investigation and review function that might be envisaged (i.e. as an option presented in this report).
- The "monitor/assess" (the word "investigate" is absent) function under s 13(1)(b) relates to "(i) the policies and practices of the department or (ii) the policies and practices of any other person, body or organisation that relate to the performance or exercise by the person body or organisation of a function, duty or power under that Act or Regulations made under the Act". This does not allow the use of the Commissioner's special powers to acquire information for monitoring and assessment. This may need to change to give full effect to the Commissioner's role in an extended complaints investigation and review function that may, as I have said, be envisaged.

Where the Commissioner investigates, the Commissioner may require a person to provide information if the Commissioner believes on reasonable grounds it is necessary to enable them to carry out an investigation (s. 20). The power can only be initiated in relation to an investigation, and where that person has failed to respond to a request for that information and it is not reasonably practicable to obtain the information from another source or it is required to verify or refute information from another source. This power does not apply to information that would be privileged in a court. The Commissioner has authority to seek information by inspection of a record held by a Court.

The Commissioner and staff must maintain secrecy; this is subject to certain limitations (s 22). The limitations impose a restriction on disclosure of information obtained under s 20 so that it cannot, for example, be reported to the likes of the Chief Executive or the Social Workers Registration Board. However, there is an authority to consult in specified circumstances (s 23).

The Commissioner's power lies in the ability to report publicly. Before doing so, the Commissioner must not make adverse comment on a matter that affects any person before giving that person an opportunity to be heard. (s 25). The Commissioner ought to be able to make recommendations, to require a response and then

to report to the Minister on any response. The Act would already allow for the Commissioner to make follow up inquiries to provide recommended change had occurred or was embedded in practice as appropriate.

In respect of monitoring it:

- Monitors Youth Justice and Care & Protection Residences by making a mix of announced and unannounced visits (5 residences, five visits specified in the Output Agreement) - (it also discharges responsibilities as a National Protective Mechanism under OPCAT – Optional Protocol to the UN Convention against Cruel, Inhuman or Degrading Treatment or Punishment) – and reports on these inspections.
- Carries out CYF Site and Youth Justice monitoring in accordance with the Monitoring Plan agreed with CYF (10 sites visits expected under the Output Plan).
- Produces thematic reviews (such as the OPCAT joint review of detention of Children and Young People in Police Cells) and then monitors the implementation of recommendations. It intends to produce one thematic review this year.
- Monitors recommendations made by CC re Children in State Care/child neglect.
- Is extending monitoring to agencies approved under s 396 (Iwi/cultural/C&F Support service) which deliver services under the Act (this will not be conducted in this year).

Its specific advocacy intentions are focused mainly in the health, child poverty, and education areas. There is little that is included in the individual and system advocacy that derives from a constant review of social work practice in New Zealand.

There is an intention to improve the collaboration with the Families Commission as it specifically repositions as a policy agency focused on family issues. Both agencies recognise there is room to collaborate.

The Children's Commissioner is funded by appropriation through Vote: Social Development. The extent of that funding is negotiated through the development of an Output Agreement. The Commissioner performs the role in conjunction with another medical role, thus the function is a part time commitment. It is hard not to describe the Commissioner's office other than as a small boutique unit. It spends a little over $2.1 M per year (c.f. Queensland where the office with a similar mandate but considerably extended services has a budget of $A 47 M). The ambitions, governed primarily by the small size of the agency and its limited funding base, are less than what I had expected to find.

Other Independent Oversight of CYF

The Police

The police receive complaints and deal with criminal matters. There are a number of situations where the police might have occasion to become connected to a CYF complaint process. Examples are:

1. There is a mandatory requirement that the Police be advised of a death in a CYF residence (s 395, CYPFA);
2. In the event that a CYF staff member commits a criminal offence against the Ministry for example by stealing departmental property or falsifying expense claims;
3. A CYF contract manager could be investigated and prosecuted for accepting bribes to favour a particular tender in the process of allocating contracts for service to the Ministry;
4. Where a CYF staff member commits an offence of personal violence (including sexual violence) against any person but particularly a child or young person in state care;
5. Where a grossly negligent action of an employee of the Ministry causes the death of a Child or Young Person both the individual and the Ministry could be investigated under criminal provisions.

The Ministry has clear standards of conduct and efficient processes for handling staff that are investigated, prosecuted and convicted of criminal actions.

Privacy Commissioner

A breach of privacy by CYF or a member of CYF staff falls within the jurisdiction of the Privacy Commissioner.

The Privacy Act 1993 establishes a set of Information Privacy Principles (s 6) of general application (see definition of agency at s 2) that maintain a set of standards for those who would collect and use personal information about any person. The Principles at s 6 are enforceable against a public sector agency (s 11).

The Privacy Commissioner has a general obligation to "inquire generally into any matter, including any enactment or law, or any practice, or procedure, whether governmental or non-governmental, or any technical development, if it appears to the Commissioner that the privacy of the individual is being, or may be, infringed thereby" (s 13(m)). An individual person may complain if any action is or appears to be an interference with their privacy; s 67(1) the complaint may be made either to the Privacy Commissioner or the Ombudsman s 67(s) and if the latter they are to forward the complaint to the Privacy Commissioner as soon as possible s 67(3). The Privacy Commissioner is to give assistance to make a complaint and it is to be reduced to writing as soon as practicable, s 63.

The Privacy Commissioner may investigate, conciliate, or take any action as contemplated by the Act, s 69. They can take no action: s 70, 71. The Act steers the Privacy Commissioner towards settlement of complaints including the holding of a compulsory conference to gain agreement (s 76). If this is not possible the Privacy Commissioner may refer the matter to the Director of Human Rights Proceedings for the exercise of their discretion to bring proceedings under the Act (s 77 and 82) after giving the respondent to the complaint an opportunity to be heard. The Director, an independent official, may decide to take the matter to the Human Rights Tribunal.

The Tribunal may make a declaration that there has been an interference with privacy, make a restraining order against continuation or repetition of the breach, award damages or require actions to be taken that

remedy the interference or redress loss or damage or order any other remedy that fits, s 85. Costs may be ordered.

The Privacy Commissioner has powers to require information to be supplied and may examine witnesses on oath.

The Privacy Commissioner is active in relation to a key MSD risk relating to the retention and disclosure of personal information.

Complaint to an Ombudsman

The Ombudsman oversees all aspects of Government administration and this includes CYF activities (excluding the decisions of Courts in respect of CYF cases.) Complaints are open to any person (s 16, Ombudsman's Act 1975), and the scope "to investigate any decision or recommendation made, or any act done or omitted, … relating to a matter of administration and affecting any person or body of persons in his or its personal capacity." The Ombudsman may decline to investigate a matter for which there appears to be another avenue to seek remedy that is reasonable. It is in this respect that the Ombudsman, as a matter of practice, defers any investigation of a complaint within its jurisdiction unless and until the matter has been referred to the appropriate department for response in the first instance. The Ombudsman's office maintains secrecy over their investigations other than disclosures required for the purposes of their investigations and reporting (s21).

The Ombudsman cannot investigate decisions to take children into care when a Court order has been made that the child is in need of care and protection; or decisions relating to custody and access of children. This is because these decisions are made by the Family Court. In their publication concerning Child Youth and Family[37] - the Ombudsman makes it clear that it can investigate CYF actions which are not related to custody or access decisions and cite for example:

- The manner in which CYF acted in uplifting a child;
- The standard of service provided by social workers;
- Delays in responding to correspondence;
- Failure to respond to telephone calls;
- Failure to comply with policies and procedures;
- The way in which CYF has investigated a concern about the care and protection of a child.

I am led to understand that there have been only two instances where the Ombudsman has been called upon to investigate an unresolved complaint that has proceeded through both steps in the CYF complaint process.

[37] Fact Sheet: Child Youth and Family, Office of the Ombudsman, 6 August 2012

Child Mortality Review

The Child and Youth Mortality Review Committee (CYMRC) is a group appointed under the New Zealand Public Health & Disability Amendment Act 2010 by the Health Safety & Quality Commission to review the lives and deaths of children and young people who die aged between 28 days and 25 years of life. The purpose of the inquiry is to understand the circumstances of the death, to learn from it, and to make recommendations and changes that might help prevent future deaths.

There is a local CYMRC working in every District Health Board. It does not operate on an individualised complaint basis, instead it reviews practice from every perspective and forms views by an assessment of that practice against principle. Although the Committee produces information for publicity by the Commission all individual information is protected and kept confidential.

The significance of the Committee is that in its reports it may offer direct or implied criticism of a particular practice or system (or lack of them) which is then for organisations (e.g. CYF) to act upon. The relationship between CYF and the Committee is therefore an important one.

The Courts

The Courts, Generally

The Courts supervise the decisions of the social worker who take action under their relevant enactments. The social worker may have, for example, received a report that a child is in need of care and protection under s 15 of the Act, investigated the matter (s 17) to the point where they suspect the report is correct and now wish to obtain a warrant to search for the child and take him or her into the custody of the department. They apply to the Court for a Place of Safety Warrant (s 39) and take the child into custody. Thereafter the Act contemplates a wide range of situations where there will be an interaction between the Court, the social worker, the child (who will be represented separately) and the other parties (e.g. the parents).

The question is which part of the process and decision making lies within the unique jurisdiction of the Court and which is amenable to an administrative complaint process such as that operated by CYF.

The Ombudsman has issued a guideline[38] which sets out clearly that most of the process involved is subject to a complaint process. That is, if anyone is aggrieved about the process of investigation and the compilation of the factual record upon which a Court may later rely, or the conduct of the social worker who interacts with the child, parents, counsel, or any other person, they may complain. Just as a person who thinks a lawyer has behaved badly could take a matter to the Law Practitioners Disciplinary process.

Two aspects of this situation which are were raised with me during my review:

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[38] Office of the Ombudsman, Fact Sheet: Child Youth and Family, (6 August 2012) p. 1-2.

1. It relates to the difficulty of making a complaint during the process (i.e. before judicial decision making). On the one hand there is a tendency to cast the net protecting judicial independence wide because of the principle's importance, and because there is a concern that litigants might use a parallel complaint process to delay or subvert the Court process. On the other hand if the complaint process is not undertaken pre-court there is a danger that Court decision making might be compromised by a flawed process that has not been corrected. This is a difficult tension.
2. The second issue relates to the ability of the Court to take action if a matter warranting complaint comes to light through the Court process. There is limited ability for the Court to punish the state's case in order to signal dissatisfaction with behaviour as the victim of that action could ultimately be the child. The Court can describe the misconduct in a judgment and ask the Registrar to refer the matter to the Chief Executive, or could do so verbally to the Chief Executive's representative in Court. The Court could also refer the judgment to the Chief Executive under cover note for them to take action as they see fit. The main action the Court can take is to work through the social worker to have the deficiencies rectified.

The Court could if petitioned on a matter of fact, examine witnesses or ask for more information from CYF. Otherwise opening up the procedural issues pre-court to independent inquiry seems fraught with risk.

I should also add that there are obviously a number of people who at the conclusion of a Court case simply are left in disagreement with the decision of the Court. The decision to remove a child from the custody of the parent(s) for example will be resisted as it expressly or impliedly criticises that basic human function of nurturing. The process of complaint against these decisions is through the appeal processes of the Court, difficult as they may be, and are outside the scope of this review.

The Coroner

The main connection between the Coroner and CYF is when the actions of the statutory care and protection system are a factor in the lead up to a death[39]. The Coroners Act 2006 describes the role of the Coroner. At section 4 it outlines that the Coroner receives reports of a death, oversees the forensic and other aspects of an investigation into the death, if necessary holds an inquiry and then makes findings about who died and the circumstances of the death. The Coroner can publish their opinions and comments (through a Judgment) if they think such publication would reduce the likelihood of a similar occurrence, and they can refer a matter to any other investigating authorities should they think that would serve the wider public interest.

Coroners' reports, which often contain recommendations, are received by CYF and implemented through its internal processes. In the opinion of the Chief Coroner the attention and responsiveness to Coroner's findings and recommendations has not always been good. In his opinion Coroners have felt that at times they have

[39] Judge Neil MacLean, Chief Coroner, Interview 25/3/13".

been "fobbed off" and that there was no follow through in making changes. Coroners' findings are not, however, binding.

There has been a marked changed in recent times, with a conscious effort by senior CYF staff to engage proactively with the Coroner's office. It has also been helpful that recommendations and findings are now published on the Coroner's website, as is the response of an agency to those matters. If the response is inadequate "it is there for all to see[40].

Judicial Review

For completeness, there is also the potential of a dissatisfied complainant to challenge an administrative decision by means of a judicial review. This is more likely in decisions over contracts for service or the grant of approved status but could also operate in any other decision such as a decision not to call a family group conference. It is a rare procedure.

Comparing Models – The IPCA and the Health and Disability Commissioner

In order to lead into the options part of this report (Part 5) I think it useful to compare a number of other oversight models. The TOR suggest the Independent Police Conduct Authority (IPCA), there is the Health and Disability Commissioner (relevant as a model that operates within a directly comparable framework) and the Transport Accident Investigation Commission (that is an example of an agency focused on investigation and reporting). I will compare with the Children's Commissioner.

I use as the basic points of comparison the following:

- Purpose (establishment of standards, systems improvement, enforcement of accountability, resolution of a complaint etc.);
- Scope (complaints, standards, systems);
- Membership;
- Methods (investigation, monitoring, review);
- Powers (to access, protect or disclose information);
- Protections (from prosecution or civil suit, against having to give evidence);
- Impact (by publishing, referring, taking proceedings).

Purpose

Children's Commissioner	IPCA	HDC	TAIC
• Promotes the welfare of children, and the UN Convention • Investigation of complaints relating to children	• Oversight of police conduct • Investigates complaints of misconduct/neglect of duty and associated policies and practices	• Oversight of health practice • Establish a Code and investigate breaches of the Code	• Prevention of transport accidents • Investigates accidents and incidents

[40] Judge MacLean, Ibid.

Membership

Children's Commissioner	IPCA	HDC	TAIC
• Commissioner: A statutorily Independent Public Official (may be a Judge) • Acts independently	• An Authority comprising up to five members; Chair must be a Judge • Acts Independently	• Commissioner: A statutorily Independent Public Official • Acts independently	• Commission, three members, one is appointed Chair • Acts independently

Scope

Children's Commissioner	IPCA	HDC	TAIC
• The welfare of children • Complaints that relate to a child or young person "in their personal capacity"	• Limited to complaints made against the Police or serious incidents mandatorily reported to the Authority by Police and policies and practices that are related to the complaint	• Complaints that concern the Code and 'own motion' investigations of breaches of the Code	• Investigation of accidents and incidents in rail, air and marine modes of transport

Methods

Children's Commissioner	IPCA	HDC	TAIC
• Investigate • Monitor • Research & Evaluate • Advocate • Refer to other agencies • Report	• Investigate • Monitor investigations • Report	• Draft code (standards) • Investigate • Monitor • Report • Issue proceedings (Director of Proceedings) • Refer (to Tribunals)	• Investigate • Report

Powers

Children's Commissioner	IPCA	HDC	TAIC
• Require production of documents • Prohibited from disclosing material obtained coercively	• Full commission of Inquiry powers • Maintains secrecy except for reporting	• Commission of Inquiry – like powers	• Commission of Inquiry powers • Access to certain specific information

Protections

Children's Commissioner	IPCA	HDC	TAIC
• Protected from civil and criminal proceedings unless acting in bad faith • Cannot be called to give evidence	• Protected from criminal and civil liability unless acting in bad faith • Cannot be called to give evidence	• Proceedings privileged, subject to certain qualifications • Cannot be called to give evidence (also subject to qualification)	• Evidence obtained by TAIC not admissible in Court • Report only evidence in Coroners hearings

Impact/Effect Change

Children's Commissioner	IPCA	HDC	TAIC
• Make findings and issue Report	• Make findings and Report • Seek response • If unsatisfied, table report with Minister or in Parliament	• Establish a Code and investigate breaches • Make findings and issue reports • Issue proceedings to enforce accountability	• Investigate accidents and incidents and make findings • Report safety recommendations

The IPCA

The Terms of Reference specifically question whether an independent system of oversight for CYF should be along the lines of the IPCA (Independent Police Conduct Authority). I therefore set out here in somewhat more detail how the IPCA works.

This is a statutorily based complaints system for the Police. It was established initially as the Police Complaints Authority in 1988 after concerns about manner in which complaints against the Police made during and after the Springbok Tour in 1981 had been dealt with by the Police.

One difference between Police and CYF is that there is no independent registration system for Police officers. All matters to do with practice quality, competence, discipline and employment are within the domain of a Commissioner of Police appointed under the Policing Act 2008 (formerly the Police Act, 1958).

The governing legislation is the Independent Police Conduct Authority Act 1988. By section 4 the Authority is established, to comprise up to five members. One must be a Judge or retired Judge who is also appointed as Chair (s5A). It must act independently (s 4AB).

The functions of the IPCA are (S 12):

a. to receive complaints—
  i. alleging any misconduct or neglect of duty by any Police employee; or
  ii. concerning any practice, policy, or procedure of the Police affecting the person or body of persons making the complaint in a personal capacity;
b. to investigate of its own motion, where it is satisfied that there are reasonable grounds to carry out an investigation in the public interest, any incident involving death or serious bodily harm notified to the Authority by the Commissioner under section 13:
c. to take such action in respect of complaints, incidents, and other matters as is contemplated by this Act.

The workings of the Authority are linked to complaints.

By s 12(2) the Authority: "In the course of taking action in respect of any complaint the Authority may investigate any apparent misconduct or neglect of duty by a Police employee, or any Police practice, policy, or procedure, which appears to the Authority to relate to the complaint, notwithstanding that the complaint itself does not refer to that misconduct, neglect, practice, policy, or procedure". This provision extends the power to investigate a complaint to any matter associated with it, but the initiation is the receipt of a complaint and there must be a reasonable nexus between the complaint and the extent of the inquiry.

The Authority does not have a monitoring role, nor an ability to commence an "own motion" review on risks or matters of concern. The section 13 "own motion" provision relates only to the circumstances where a death or serious injury has or appears to have been caused by a member of Police and is not commenced by a complaint as such, but by a mandatory notification to the Authority by the Commissioner of Police.

Otherwise complaints made about the police that fit the criteria in s 12(1)(a) that are made to the Police must be reported to the IPCA by the Police within five working days. Complaints that are made to the Authority must be reported to the Police.

The Authority has a number of options by which it must deal with complaints (s17).

(1) On receiving or being notified of a complaint under this Act, the Authority may do all or any of the following:

- (a) investigate the complaint itself, whether or not the Police have commenced a Police investigation;
- (ab) refer the complaint to the Police for investigation by the Police;
- (b) defer action until the receipt of a report from the Commissioner on a Police investigation of the complaint undertaken on behalf of the Authority;
- (c) oversee a Police investigation of the complaint;
- (ca) defer action until the receipt of a report from the Commissioner following a criminal investigation or a disciplinary investigation, or both, initiated and undertaken by the Police;
- (d) decide, in accordance with section 18, to take no action on the complaint.

This approach provides the Authority with a great deal of flexibility without giving up control of the complaint process. Like the Chief Executive's Advisory Panel (MSD) and in respect of control over social workers, the IPCA cannot change a statutory decision of a police officer. The IPCA can review all aspects of a criminal investigation which might be complained of as misconduct or neglect of duty, but it has no power to correct a bad decision directly. For example, it has no power to cancel an arrest or to withdraw a prosecution. The IPCA jurisdiction is in respect of a complaint of misconduct or neglect of a police employee and not the offence to which that misconduct or neglect might be connected.

The Police are required to report on any complaint investigation that they conduct (s 20), and must also comply with requests for information sought by the Authority (s 21).

The Authority has the same powers to inquire into a matter as a Commission of Inquiry, and can call and receive evidence in a hearing. It can require attendance at the hearing and compel the evidence. A witness may not claim a privilege in respect of the evidence they can give but the evidence provided is not admissible in a court. The Authority has used this power in the past.

The Authority conducts its affairs in private subject to necessary disclosures to enable the Authority to carry out its functions, and for reporting as envisaged under the Act. The proceedings of the Authority are also privileged, that is the Authority is protected from criminal or civil proceedings and neither they or any person

holding office under the Authority can be called to give evidence in a Court. This protection lies at the heart of the model – encouraging those with information to impart on the subjects of the inquiries of the Authority to give that information freely and without fear that it may be used against their personal interest.

The IPCA has no authority to bring proceedings against the Police or any of its members. Partly this might be a reflection on the existence of other responsibilities in other agencies (for example the Police are the agency that brings criminal proceedings against police staff) and because of the additional capabilities that would be required to support such a function. Such a change has been contemplated.

The strongest weapon in the IPCA's toolkit is the impact on confidence in the Commissioner their reports deliver. A vital part of the confidence in a Commissioner is the demonstration of appropriate responsiveness to the reports, recommendations and other influences that derive from the Independent Authority's work. And confidence is the factor which underpins the Commissioner's tenure in office.

PART FOUR – The Effectiveness of the System

You have asked for my view of how the arrangements which I have described in the previous Part of this report are working. One of the benefits of describing the current arrangements in considerable detail is that it enables the issues to be addressed to be dealt with in rather more short order.

General Observations

The people that I spoke to during this review consistently emphasised some common themes:

- That Child Youth and Family have an extraordinarily difficult function to perform. Working in and amongst some of our most vulnerable families, encountering the plight in which those families live and the state in which children and young people can be left in – this must require a great deal of resilience and strength of character;
- There are people of extraordinary talent, passion and commitment who work in CYF and have done so over the years. The people who on a daily basis execute the practice of social work, confront difficult and complex issues and rise above the bureaucracy that a large organisation operating in a critical system imposes, perform some of the country's most valuable service;
- Yes, also, the challenge of the work, the urgency, the timeframes, the difficult nature of some of the client base, the competition for resources – all combine to create personal and organisational pressures through which the weaknesses of human endeavour (mistakes, errors, misconduct and deliberate malpractice) can occur;
- Interviewees frequently vented at "the system" as something different from the people who are engaged in it. There is an understanding that the history, culture, systems, embedded practice and resource base drives current attitudes and performance. And there was widespread criticism of "the system";
- It is also clear that people have difficulty separating CYF from the issues of its client base; they are held accountable for the human conditions for which they must provide a counter or support, the decisions of other agencies such as the Courts, the Police and providers. They are held responsible for doing things, and for not doing things depending on what has happened;
- There was a difficulty in separating CYF's perceived performance in handling complaints through the processes from the work of CYF generally. The perceived weaknesses of the one infected the other. This demonstrated to me the clear relationship between general social work practice and the performance of the complaint system. They are mutually supporting concepts and will move progressively in the same direction. So the work of the Chief Social Worker in improving social worker practice, or the performance of the human resources functions of training, professional development, appraisal and discipline will also impact on complaint process outcomes.

Findings - Summary

In summary, it is my opinion that:

4. There exists a framework of organisational, professional, and regulatory structures to support practice and performance of Child, Youth and Family;
5. The framework is operating at a very basic level of performance;
6. The four areas which if improved would impact on effectiveness are:
    a. **Feedback on Performance** - There is insufficient effort directed at obtaining feedback on CYF performance, and including the identification of concerns and complaints from vulnerable children and families; a concerted strategy to return feedback to the organisation is required.
    b. **CYF Complaint System -** The CYF complaint system has recently been overhauled and is trending in a positive direction, but it is not yet proven; it requires further elaboration and oversight to ensure it operates well in the future.
    c. **Regulator** - The statutorily independent oversight mechanism for the Children, Young Persons and Their Families Act, 1989, and Child, Youth and Family, the Office of the Children's Commissioner, is inadequately resourced to perform all the functions expected under its Act. It is not sufficiently enabled to oversee all types of complaints made against CYF. However, in my view a significant regulator is required for the system.
    d. **Care and Protection Resource Panels** - The role of the Care and Protection Resource Panel as an internal monitor and facilitator under the Act has been allowed to slip in status and function: the function or something akin to it needs to be reinvigorated.

I was fortunate to have several prime resources with which to assess the complaints handling process. These have been:

1. From the Office of the Ombudsman, "Effective Complaint Handling"[41];
2. Mike Doolan's: "Establishing an Effective Complaints System for Child Youth and Family, Scope of Work"[42];
3. And, Michelle Egan-Bitran's: "A Review of the Child, Youth and Family Complaints Resolution Policy and Procedure"[43].

[41] Office of the Ombudsman, Occasional Paper. (2012).

[42] Doolan, M., (2005).

[43] Egan-Bitran, M., (2012).

Issue 1 – Encouraging Feedback

One of the reasons I laboured the background of CYF was to explain an organisation that had been subject of many reviews, had been involved in many public cases in which the social worker bore the brunt of public responsibility for the system, and in which there had been a lengthy battle over the philosophies and methodologies of child care, protection and control.

It might be said that there was not a dearth of feedback to CYF. Some of it would have been very unpleasant. Why ask for more of that? This may explain why it is that CYF does not have an integrated feedback system that is valuable for informing all the purposes of strategic management. A holistic strategy to build client and community feedback in which the complaints system forms part would be a valuable part of strategic management. There are two main parts to this. Firstly, the expansion of general and specific feedback systems. And secondly, increasing the targeting the voice of the child as a key instrument in the system.

Visibility and Use of the Complaint System

More could be done to increase the volume and targeting of feedback. In respect of the complaints' system this means:

1. Making it clear when CYF is establishing a client relationship that feedback, including complaints, is both acceptable and normal.
    a. The ability to provide feedback or to complain or raise a concern needs to be built into and embedded into the client management approach. When entering into a relationship and at significant points throughout the relationship there needs to be a formal request for feedback.
    b. This needs to include opportunities to provide positive feedback (what has been good about the experience) as well as being able to signal that there is a concern or that they have a complaint. Rather than viewing this as an opportunity for the client to "get back" at the social worker, this should be seen as an opportunity to allay concerns and get things right without a complaint developing into a pitched battle.
    c. I think that the profile of the complaints component of the CYF website could be improved, more advertising of the process offered at CYF offices, and complaints pamphlets and other material could be included in regular communications to clients.
2. Developing and implementing a strategy to market the complaints system amongst the wider group of people who interact with CYF on a regular basis. These stakeholders include professionals, community and iwi agencies, and client advocacy groups. This strategy ought to be led in the community by the local CYF Site Manager, and undertaken as far as is practicable through personal meetings, or organised briefing sessions. These sessions need not be confined to the complaint system. While there might be a reluctance to talk about the child protection system too widely because of the risks of imparting or commenting on personal information, the public need to know

about the system we operate, its strengths and weaknesses, its methods and performance. There is also a need to market the work and (with some reservation) the people in CYF and the social work profession.

3. Develop specific and regular relationship meetings between CYF regional and site leadership and local Maori (in other than a business setting). In these meetings I would encourage CYF to (a) obtain the views of Maori about the relationship, (b) provide information about current trends, services, issues and opportunities, and (c) seek information about service pressures and opportunities. This must be done face-to face and not in the middle of a crisis. In some areas, specific relationship development into the Pacific community and the representative groups for those of Asian ethnicity, migrant and refugee communities should also be encouraged.
4. There is an absence of more general feedback mechanisms. This point has been acknowledged and is an "intention" of CYF. There are a number of opportunities that occur to me:
    a. A measure of public trust and confidence ought to be established. Correlating this measure with the number and nature of complaints will provide useful information for service delivery. The series of interview I have conducted was regarded by many in the network as a "novelty" and yet could easily be repeated by CYF on a regular basis.
    b. Although not without difficulty, there is also a normal 'client satisfaction' instrument that could and should be developed. Even those who are mightily aggrieved at the result of state action in relation to their family and who might be very challenging and difficult to listen to ought to have the opportunity for structured feedback and will, in sum, produce useful information for service delivery and practitioner performance. A time series based on this measure would therefore be useful and I would suggest a baseline be established as soon as practicable.
5. Another opportunity that could be usefully pursued, perhaps for a set period of time, is the provision of support to complainants as they proceed through the process. It was repeated to me that complainants who are already in a vulnerable state, and confronting the State, and dealing with issues of sensitivity and complexity, ought to have support in the form of advocacy. There are examples available in the health sector where some agencies are specifically funded to provide such advocacy service. There is a parallel benefit to these services as they will explain the system and thus set realistic expectations as to what might be obtained from a complaint. In some cases an early explanation from a neutral advisor might indicate a complaint ought to be directed elsewhere such as to the Police, an appeal through the Courts, or a complaint through processes of other agencies.

The following point appears trite, but is important. Something has to be done to change the perception that CYF staff do not answer the telephone nor acknowledge written correspondence. There was seldom an interview that I conducted that did not include the criticism that CYF is incredibly hard to make contact with outside of the call centre. The messaging from client groups and stakeholders as well as professions was

deafening. If the strategy is call centred based then messages left through the centre need to be answered promptly. I encourage CYF to develop a specific strategy around "client service".

Bringing the Voice of the Child into the Complaint System

Without a doubt the most troubling recurring theme encountered in this review was the absence of the voice of the child into the complaint system. Notwithstanding that both the Children's Commissioner and CYF have programmes that seek out feedback from children and young people; the record system discloses that there have only been two complaints by children in the post-2008 system outside of the Residence Grievance Procedure. The system primarily deals with complaints by adults about their experience of the CYF systems, processes and people (which may be as a parent, carer or advocate or in some cases about their experience of the system of some time ago as a child) and the complaints process does not achieve any effective platform for children to complain.

There are plenty of impediments to the raising of a child or young person's voice into the system. These impediments include:

- In some cases the child is too young to understand the nature of the process in which they are placed;
- There is a natural power imbalance and children and young people often simply assume there is no place for complaints against the powerful from them;
- Children and young people fear the consequences of a complaint;
- Their connection with the adults that present as the system to them is a long term relationship – and they fear the potential for adverse decisions about them to be "stored up" and used against them;
- Children and Young People may have to make an impossible choice and select what they perceive as the "least worst option" that they perceive – for example if they have formed an attachment with one carer but the partner of that carer is abusive to them, they may choose to absorb the abuse for fear of losing the relationship with the carer to whom they have become attached;
- There are examples of being intimidated and threatened directly about complaining to a social worker or other person who could take action on a complaint;
- The perception amongst a variety of advocate organisations that a complaint to CYF would not result in any meaningful action – and this perception is transferred to the child or young person with whom they deal;
- Children and young people appreciate that there is potential for complaint but don't know how and fear the unknowns about the process itself – what they might be asked to do, the loss of personal information, the fear of being exposed as "a nark" to their peers and so on.

Notwithstanding these difficulties, the work being undertaken in this area should be prioritised.

Research

This is an area in which the need for constant research and evaluation is necessary. Partly this is the responsibility of MSD/CYF and it also falls within the responsibility of the Children's Commissioner. Many of my interviewees spoke about the need to be better informed, and bemoaned the fact that the Office of the Children's Commissioner had not been fully enabled to discharge its role.

If enabled better, what could the Office of the Children's Commissioner do to help inform the quality of practice (and thus reduce complaints)? In 2002 a specific piece of work was completed that attempted to answer this question[44]. The analysis "provides a comprehensive exploration of research within the area of State Care of Children, and a research framework from within which central research and evaluation questions may be addressed". It defined a wide range of intended research into the theory and practice of care from which practical applications may be made (such as amending the practice guidelines of social workers). 21 separate pieces of work were described.

The targets for research and evaluation were grouped under four titles (but integrated):

- The context of care – projects involving literature and document reviewed, promotion of research by others, the maintenance of a knowledge database and a care database;
- The Chronology of Care – including studies of the experiences of both adults and children in the system, studies in the transitions people make in the system, and a longitudinal study (following specified children through care and recording and evaluating the experience);
- The Resources for Care – a suite of projects evaluating the availability and application of resources;
- The Development of Care – in which the Care approach is interrogated.

I believe that the expectations placed upon the Children's Commissioner in the Ministerial agreement should be raised and the resources provided to meet the higher level of expectation.

Dr Nicola Atwool's Report on Children in Care

This report from 2009/10 was a specific review to supplement monitoring activities was undertaken by the Children's Commissioner[45]. Dr. Atwool was appointed to lead the project. She reviewed legislation, undertook a literature review, analysed case and call information and interviewed children and young people in care and caregivers. She also interviewed social workers and a number of lawyers for children.

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[44] Connolly, M., Doolan, M., van Heugten, K., Anglem, J, Crighton-Hill, Y., and Woollon, R (2002) *Children in Statutory Care: Experiences and Outcomes – A Research and evaluation framework to test the effectiveness of the State as a provider of care.* Report prepared for the Department of Child, Youth and Family, Wellington, Ministry of Social Development.

[45] Atwool, Dr. Nicola, *Children in Care, A report into the quality of services provided to children in care.* Office of the Children's Commissioner, (2010).

The results comprise a succinct list of the determinants of quality service by social workers to their client group. Not surprisingly the children and young people reported the importance of maintaining links with the birth family, the challenges of having many placements – particularly if moved to another district, of maintaining and having more contact with their social worker, of having an opportunity to participate in decision making and for their plan to be individualised. Caregivers reported on the absence of support from social workers and the lack of involvement in case planning and decision making. These are familiar themes. Interestingly, the responses from social workers mirrored their clients. And the lawyers critically raised the issues of CYF's emphasis on permanent placements and also raised concerns about the particular [unmet] needs of very young children in care.

Dr Atwool made a number of recommendations some of which have been picked up by CYF (for example there is now a full assessment of needs when a child enters state care). Other relevant recommendations were to emphasise the importance of the social worker programmed visits (which she too had reported as not occurring in many places), the need for more training, the need for more involvement of children and young people in case planning and decision making. Many of the recommendations would be met in the event the processes under the Act (FGC etc.) were carried out consistently well.

If you were seeking to increase the level of feedback and were looking to design instruments that covered key risks and concerns, this research is a good place to start. And I would imagine a search for this form of feedback would result in a conversion of some of the feedback into a complaint. This is because some of the feedback is of such a nature that it is insufficient to simply fix the matter; there needs to be a step further and the cause of the problem identified and properly fixed. Often that requires an inquiry of some kind.

Egan-Bitran Report on CYF Complaints (2012)

Michelle Egan-Bitran from the Office of the Children's Commissioner's Office reviewed the Child, Youth and Family Complaints Resolution Policy and Procedure and made recommendations on "how Child, Youth and Family can take a Child-Centred Approach to Complaints Resolution" (2012).

Her report establishes (p 12) what being "child centred to complaints resolution means" (I summarise):

- Treating all children with dignity and respect;
- Acknowledging that children have rights and knowing what rights a child has in connection with a given-issue;
- Including children in decision-making processes that affect them, listening to and considering what children have to say within a process accessible to and useable by children, excluding only in exceptional circumstances;
- Viewing every decision according to its impact on an individual child, ensuring that the best interests of the child are central to decision making;
- Recognising that giving acknowledgement and due consideration to a child's view is part of determining their best interests;

- Ensuring children get what they need and that they understand that they might not always get everything that they want.

Further (p. 12) "Two elements underpin a child-centred complaints review:

- Hearing the views, opinions and concerns of the child, and
- Holding the child's best interests primary in all decisions.

She believed there was a need to improve children and young people's awareness of the complaint system, and then to activate that awareness by enabling a relationship between the child or young person and an independent advocate that focuses on their views and wishes rather than applying a judgment about what is in their best interest (which view is supported by other elements of the system, e.g. the CYF case based social worker). Children have a different view about timeliness than adults and there is a need to increase the level of communication about the progress of the complaint. The process of resolving the complaint should be problem solving in nature, and is an opportunity to reconcile differences in understanding with the goal of making the best decision in the interests of the child.

This review (p. 16) also noted in the literature that there be a point of access to the complaints process that is independent of the department, that the complaints when investigated have independent oversight including presence at all key decisions. The need to collect and analyse information about complaints was also referenced. And that the complaint system should be regularly audited both to ensure that the system is generating information relevant to policy and practice change but also to ensure standards are maintained.

Ms Egan-Bittan's work went beyond literature reviews and involved seeking the views of children and community organisations.

This work provides a sound basis for developing and implementing a strategy that results in a greater voice of the child in the system.

Monitoring/Advocacy

Children in care require close monitoring of their care plans and a robust review of how those plans are achieving real outcomes for them. The outcomes for children in care must focus on their health, education, safety, belonging and participation and economic well being. These outcomes are set out in the Interagency care forum and are likely to be part of the governments new Children's Bill. Regular FGC are an appropriate way to bring both families and agencies together to monitor and oversee plans and outcomes for children. The FGC must hold everyone to account for their contribution and this is already respected and embedded in New Zealand law and practice and is culturally responsive particularly as half the children in care are Maori.

CYF policy requires that a child in care be visited at least every eight weeks. I believe that this must be rigorously audited to ensure that it happens. A child in care must also be represented by a Court ordered "Counsel for the Child" or "lay advocate".

Is that enough? Is some other form of monitoring necessary? Is there another way to ensure that a child has such a beneficial relationship with the social worker and CYF, and is there another way to ensure that if the child wished to report that they were unsafe (and thus that the State is failing to protect them) they could do so?

In addition to the visits of the social worker, and the other actions of the FGC, an independent child's guardian or advocate either drawn from the family group conference or independently appointed could be given legal (and independent) authority to monitor and report on outcomes and results for these children. This needs to be someone who understands the child and their needs and be close to their experiences of care, also being able to listen to their wishes and feelings.

The principles underpinning any such advocacy, guardianship or monitoring arrangement must be: the ability of that person to keep in close touch with the child, excellent at listening to the child and having a child centred attitude and practice. A good knowledge in child development and care systems that operate around them would be advantageous. The ability to focus on cross agency mechanisms and accountabilities and thus draw these elements to the service of the child and the care plan would also be important. It has been suggested that a suitable family member, teacher, social/youth worker or a similar friend could perform the role – the important point is that there is someone suitable be specifically assigned to the role – and that the role extends beyond that which is assigned formally within proceedings to the counsel for the child or lay advocate.

There is a system operating in Queensland. A branch of the Office of Children's Commissioner and Child Guardian (QLD) operates a substantial advocacy service for the 8000 plus children in care in the state. The advocates are selected on the basis that they have experience of working with children (for example: social workers, teachers, childcare workers, or police). They must hold a "Blue Card" obtained from another branch of the Children's Commissioner's office which operates a mandatory system of in depth vetting of all those working in protected occupations, those with access to children. They are paid a fee for a monthly visit to a child to build and maintain a relationship and raise individual and systemic issues (about 20,000 issues are raised annually with about 1000 found worthy of a further response). The Queensland Children's Commissioner's office believes that this approach is behind a substantial reduction of abuse in care in the past seven years.

Others are not so sure. There have been major changes in the child protection system in Queensland (such as in the Department who also operate a two tiered complaint system), and there are other factors such as the "Blue Card" and the substantial practice review function that the Children's Commissioner also operates. A social work view from New Zealand fears such a system would set up the social worker against the advocate, particularly if the wrong people were selected. Still another view, this time from Australia, thought that the Queensland model was gold plated and not yet proven. I note that it is presently under review.

The New South Wales Ombudsman's office believes that better value for money is obtained in their system of mandatory reporting of "reportable conduct" involving child carers. "Reportable conduct" includes sexual

offences or misconduct, assault, ill treatment or neglect, or behaviour that causes psychological harm but does not include reasonable discipline or trivial use of force. Any allegations of a reportable incident by an employee or volunteer with a government or non-government agency must be reported to the Ombudsman. The Ombudsman may investigate, conciliate and direct that action be taken[46]. Specific information sharing protocols exist. The point of the reporting procedure is to be proactive against those who abuse the position of trust they have with children, and to ensure they do not work in places where they could be a risk.

There is another example to consider. In New Zealand the Ministry of Health run a system of inspection:

> *District Inspectors are established by statutory authority under the Act. Their role is to ensure that people subject to compulsory assessment and treatment are advised of their rights, complaints of breaches of their rights are investigated, and services are improved if required in order for their rights to be upheld*[47].

They are lawyers but :

> *District Inspectors are independent from health and disability services. They are not to act as patient advocates or as legal advisors to the mental health or disability service, or any health provider. District Inspectors are not health care providers. District Inspectors are required at all times to be detached from the clinical decision-making processes that affect individual patients*[48].

Inspectors balance the imposition of compulsory treatment. The numbers under compulsory treatment are about the same as those in care under CYPFA (and therefore the costs might be assumed to be reasonably comparable.)

This questions whether the complaints system would be advantaged by investments in monitoring and advocacy in order to surface issues that ought to be investigated as a complaint against the system or its participants. Monitoring and advocacy systems are not inexpensive (the Mental Health Example in New Zealand consumes just over $2M), and may prove to be difficult to implement effectively but do satisfy the call for the "state to be monitored" and be a further step to ensure the safety and well-being of children.

White Paper on Care

I must also acknowledge a parallel piece of work to my own. In the Children's Action Plan under the White Paper for Vulnerable Children is a Children's Care Strategy. This strategy, with elaboration and implementation, currently under formulation includes:

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[46] Ombudsman Act 1974, No 68, ss. 25A-25J (NSW).

[47] Guidelines for the Function and Role of District Inspectors Appointed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (2012), Ministry of Health, Wellington.

[48] Ibid.

a. Establishing clear outcomes and targets for children needing care and protection;
b. Stronger multi-agency governance arrangements;
c. Greater responsiveness to Maori;
d. Stronger assessments, integrated planning, and monitoring and review;
e. Reinvigorated family group conference process (stronger representation of family/whanau and other sectors);
f. Better services for high and complex needs children and young people;
g. Better data;
h. Better selection and support to caregivers;
i. Greater range and choice of placement types;
j. Ensuring children's voices are heard;
k. Better transitions from care returning to a parent, to a Home for Life or to independent living;
l. Improved outcome reporting.

I reiterate that these approaches are in formulation only.

Feedback Strategy

In my view, therefore a number of specific actions could be undertaken to encourage feedback:

1. Consideration should be given to the establishment of a statutorily based set of rights for children in care (and not just for those in a residence) so that a clearer basis exists on which services can be assessed (and thus give an impetus for feedback to be provided);
2. CYF staff ought to take more time, and care, in explaining processes that are relevant to a child or young person, when a relationship with the family is established and when the issue relates to the child or young person;
3. Given the importance of the time a social worker spends with a child or young person in care, more attention needs to be paid to this service. There needs to be specific auditing of the timeliness, quality, and frequency of the communications to children in care by social workers;
4. In every case involving a child in care, an independent and confidential advocate for the child should be appointed and supported: -
    a. Ideally, this ought to be a natural and in-place advocate such as a non-conflicted family member, the children's advocate appointed under the Act, or an existing "friend" such as a school teacher, doctor, or youth worker;
    b. The role for these advocates could be defined and if necessary arrangements made for them to carry out their function. The role is to maintain a relationship, understand their viewpoint (focus on their views and wishes), and represent it without "gloss" to the system.
5. There is a specific need to conduct "exit interviews" as children and young people leave care (or within a short period after they have left);

6. The Office of the Children's Commissioner ought to compile statistics on complaints in the system (CYF and elsewhere), periodically review the statistical base and report specifically to the Minister on an annual basis on:
    a. The number and nature of complaints by a child to CYF;
    b. The timeliness and means of resolving these complaints;
    c. The nature and status of the recommendations resulting from investigations into child and young people's complaints.

Issue 2 - The CYF Complaint Handling Process

Local complaint resolution in a timely manner is the appropriate first step. I am also of the view that the policy and guidelines that have been developed (and are still being developed – one of the main Guidelines was presented after this report had been drafted) provide a good basis for change. There is a plan, accountabilities have been assigned, and action is proceeding broadly in line with the plan. I have some advice:

1. The policy components of the new arrangements need to be compiled into a single document under "roadmap" that show how the components of the system fit together. To gain a full picture of the policy and process one has to read a number of documents including policies and guidelines. The 2008 document ought to be updated to reflect the more sophisticated process that is being implemented presently.
2. The responsibility for supervision of a complaint investigation needs to be expanded – and I would encourage the policy to insist on a documented appointment process (of the lead investigator). There needs to be a sign-off at the right level that the investigator is free of conflict, has been appropriately trained, has the time and resources to conduct the inquiry, and there has been an opportunity for the complainant to lodge an objection.
3. In addition, there is a need to identify, in writing, who is the investigator of any case. Further the same should occur to identify the investigator and investigation supervisor (who checks the investigators process, analysis, decision making and communications). These are simple but effective reinforcements of the accountabilities in the process. These accountabilities must not be unclear or confused.
4. Further policy and guidance on the "expectations" part in the initiation of the complaint's resolution process needs to be given to cover –
    a. The person responsible for the investigation;
    b. Timelines and in particular expectations about progress reports and feedback;
    c. The nature of the process, how it will unfold;
    d. The identification of the supervisor of the process;
    e. The other options that are also available;
    f. The rights involved.

5. I would also encourage the expansion of the policy and guidelines in respect of the "lifecycle" of the inquiry. Every complaints resolution process, while uniquely different in terms of subject matter and personalities, follows a natural process. These include:
    a. Initial contact;
    b. Complaint reception and recording;
    c. Planning (establishing objectives and process – including a communications plan);
    d. The process of investigating and resolving (a process of interviews, inspection of records; systems, mediating etc.) There is room to deal with issues such as undertaking an inspection of CYRAS records and other commonly difficult components of an investigation of the type CYF performs;
    e. Analysis;
    f. Decision making;
    g. Reflection and Supervision.

    While the guidelines do attend to these issues in part, I think a more structured and deliberate attention to the process of investigation would yield benefits, not least in the ability of a subsequent review to trace the process. It also offers up opportunities to provide and index checklists, memory aids, case studies, legal issues (and thus a whole investigative knowledge base) of assistance to the investigator.

6. Following on from this theme, I would also encourage the development of a more sophisticated final report template. If there is clear guidance given on what is expected as the "deliverable" of the complaint's resolution process it will be a simpler process for the investigator.
7. The policy must establish as a requirement the need to make, document and provide reasons for decisions – this is a fundamental underpinning of natural justice.
8. Guidance could also be given on the issue about the factual base to be acquired and how. In the investigations with which I am familiar the party that has the best grasp of the facts has an advantage. In a resolution oriented process simply the process of acquiring facts or challenging them, can be an impediment to resolution (it might for example call into question someone's honesty). However one might wish to resolve a matter there is also the potential that the process might change track and enter a legal or employment process in which issues such as how information (evidence) was obtained could be a factor. Some expansion of this issue is warranted.
9. In respect of the counting rules for complaints, I would also encourage the reduction of complaints to their component allegations. The collection of statistics should not only by complainant (there are x number of complainants) but also by complaint type (there are y number of complaints). The value is to not only count those aggrieved and the number of investigations, but also the number of complaints. A single complainant may have a number of issues and specific problem areas can be quantified.

10. The training packages that have been provided to me cover the policy and guidelines and doubtless during the training session there is discussion and the transfer of knowledge from the presenter to the students. I am used to training materials being arranged in a more formal format with clear expressions of the learning objectives, a learning method that is explicit, and training resources that are included or referenced. Therefore, I suggest that the total training requirements for complaints resolution be reviewed by an organisational learning professional.
11. While the policy and flow charts that support it focus on the steps to be taken to respond to a complaint and bring it to resolution the policy finishes too soon. The value of the process is both to resolve problems from the client's perspective, and to inform part of the organisational learning cycle. It would be useful therefore to map out what happens to complaints' recommendations after they are delivered, and flow through the organisation into policy, training, information systems, and leadership domains.
12. Although there is guidance on the issue of employee support, there is a need to make explicit what the organisation's commitments are to the staff who are subject of an investigation. The staff members may feel completely isolated from the department and that the offers of assistance are simply paying lip service to the employer's responsibilities. More guidance on this point is required.
13. Taking complaints in relation to a matter that is before, or has been before the Court requires an unpicking of what the jurisdiction of the Court is or has been, and what is properly a matter of administrative complaint. It is too easy to say "its before the Court, we can't do anything". Therefore a carefully researched piece of advice in the guidelines that goes beyond just identifying the areas which can be subject of complaint might be very useful.

Issue 3 - Independence in the Oversight of CYF Complaints

The Chief Executive's Advisory Panel

The Chief Executive's Panel has been in operation since 2009 and at the time I drew statistics it had considered 129 cases. The panel upholds a significant number of complaints and there are few who take the option of complaining further which indicates that there is a degree of satisfaction from those who access its services.

The members of the panel are independent of MSD. One said to me that they would be most indignant if they or the panel were described in any other way. They have assured me that they have had no direction or interference from the Ministry and all of the recommendations that they have made to the Chief Executive have been accepted. I accept these points, but there is more to independence than that.

For there to be independence, and as importantly the perception of independence, the following needs to be present:

1. The appointment of the Panel members through an independent process. This would be satisfied if the membership was appointed by the Minister, the Ombudsman, the Children's Commissioner or some other person independent of the Ministry.
2. An opportunity for an independent approach to the Panel. Currently the Panel is a "Review" panel of matters that are channelled through the first phase of the CYF complaints resolution process. The value of an independent approach is that a complainant can be satisfied there is neither censorship nor narrowing of their complaint. It is vitally important to allow this mechanism, even if subsequent steps are then carried out in the CYF process.
3. The resources available to the Panel ought not to be questioned on the basis of presumed partiality. Resources affect the amount of time that can be spent on a review, who and where relevant people may be spoken to, the amount of preparation that can be provided. The number of Panel members affects the timeliness of cases.
4. The ability to act is also an incident of independence. Who the Panel reports to, what they are allowed to say and to whom, are all part of the freedoms to express an opinion without perceived qualification.
5. The protections that are available over process are also an incident of independence. Can they take information through confidential sources that can be protected? Can their work be stymied through fear of retribution against an expression of opinion (e.g. the threat of defamation)?. Often independent authorities are required to observe confidentiality over their work and are protected from undue attack.
6. The level of independence ought to be commensurate with the significance of the issue under discussion. The issue of the integrity of the child protection system seems to me to be an area where significant level of independent oversight is warranted.

In these respects the Panel is not independent.

While each of the recommendations they have made has proceeded to implementation there is some doubt as to whether implementation was completed in all cases and in particular whether the intended changes to practice have occurred (that is whether the change has been effective). There is a case for an independent view to be taken not only over the implementation of recommendations but the establishment of proof that effective change has resulted.

Notwithstanding that the Advisory Panel has been generally well received, there are criticisms reported about it and how it operates. Some of these derive from a misunderstanding of the control that CYF has over all decisions made under the Act. Relevant criticisms are:

1. It takes a long time to proceed through the process. This is in part a product of how long it takes to bring the complaint together in a way that the panel can consider it. If the complaint has been "narrowed" in the CYF part of the process then work, sometimes of a considerable nature, has to be undertaken by the secretariat to open the issues back up again, gain an understanding of what the full

extent of the issues are and then document them. The work of the secretariat has been invaluable in the operation of the panel. I am advised that the Chief Executive is looking to increase the number of panel members to spread the load and improve throughput of cases in a timely manner and also the support available to the Panel (administrative and legal).

2. Coordinating the Panel has been a challenge. The members are people of standing in their own right and busy elsewhere in their professional lives. This contributes to the delay in completing through the process. Other aspects of coordination problems were identified. An example was that the secretariat arranged for one complainant to travel from a provincial city to Wellington to attend the Panel, and CYF arranged for the staff member complained about to attend. By coincidence they were seated next to each other on the plane to Wellington which was an uncomfortable experience for both.
3. Some commentators thought that the Panel could be usefully added to by having a "non-insider" as a member– that is someone who has not immersed in the area such as a social work professional or a wellington public servant. I am sure that this is code for a level of mistrust in the system and a belief that some of the problems can be "cut through" with an objective and "common sense" approach. While I am not sure the Panel is the proper place to reconcile the philosophic challenges in child protection (and I note particularly that some of the point of the criticism might be directed against either the Court or the evidence base). Tthere is a need to ensure that any oversight mechanism is respected amongst as wider set of stakeholders as possible.
4. There is also a view that the role of the Panel has been unnecessarily circumscribed. It is organisationally and not personally oriented – and thus unable to make findings in respect of individual practice or behaviour. I sense that the reason for this is to avoid the panel's workings, restorative as they are in nature, from becoming embroiled in employment or legal disputes and there may be an issue in supplying the Panel with some information held by CYF.
5. Finally, there is a level of frustration from panel members that I spoke to that they do not see an issue "through" from complaint to embedded change. While they are pleased that in their short history the Chief Executive has accepted every one of their recommendations they do not have a report back on what has happened to their recommendations and thus to "close the loop". I note that the Chief Executive has recently increased the level of reporting back on implementation to himself.

The Office of the Children's Commissioner

CYPFA (and later the Act for the office split out from CYPFA) establishes the Office of the Children's Commissioner as an oversight regime but with a primary emphasis as the children's advocate. In its focus on the child it was given an extremely broad spread of functions, monitoring all that is anticipated in the Convention and thus exercising oversight across all areas of Government and the community "in the interests of the child".

The Children's Commissioner's powers to investigate decisions affecting children (under s 12(1)(a) of their Act) or decisions made under CYPFA (under s 13(1)(a)) must relate to a child in that child's personal capacity. This probably limits in some degree the power to investigate complaints made by adults against their treatment during decisions or actions that are taken under the Act.

With its limited budget, and also the limitation of the power to investigate, it is not surprising that it has not performed the role of the regulator of CYPFA and CYF as we might now expect it to do. To further explain, in the 2012/13 financial year its Output Agreement with the Minister included:

1. Visits to nine Residences (out of nine Residences and one CYF home);
2. 10 CYF site visits (out of 60);
3. One visit to a Community provider (s 396 CYPFA) – resources have not been allocated to this;
4. No investigations.

The Output Agreement is largely constructed by the Ministry and it is funded from within the Ministry baseline appropriation.

A total of 2.8 staff members in the Office are dedicated to work on care and protection and youth justice matters.

In addition, the Office undertakes research into children's issues, and has significant commitments responding to new policy and intended legislation to provide opinions on compliance with the Convention and to raise the interests of the child as a voice in the process. A menu of potential research and evaluation was developed in 2002; "Children in Statutory Care: Experiences and Outcomes; Research and Evaluation Strategy".

There is no doubt that the Office performs good work. But it is not achieving the role of a full "regulator" of care and protection and youth justice services. I am minded of the view of Judge Henwood and the CLAS experience, "the State needs to be monitored" and agree that a full regulator level of oversight is required.

I find that there are structural gaps in the oversight of CYF and CYPFA:

1. The absence of a meaningful independent access point for complaints across the care and protection system (dedicated to the purpose). Some complainants about CYF might wish to raise an objection to having their case investigated by CYF. Notwithstanding recent changes it is important for the integrity of the system that there is a fully independent access point through which the overseers can ensure that a complaint is fully heard. That way a proper decision about the best means of resolving it can be made. Therefore, an ability to see some complainants face to face and receive and document their concerns or complaints is an important part of the independent role.
2. The low risk to the child protection network of an investigation for the purpose of establishing and reinforcing accountabilities. This year the Output Review anticipates no investigations. That is unacceptable.
3. An insufficient number of practice reviews. While the CSW performs practice reviews for CYF, as is proper, the important reviews ought to be chaired by the independent regulator, and such practice

reviews as are conducted could be usefully added to by having oversight over their terms of reference and results.

4. There is a significant need for more practice reviews that cut across organisational boundaries. This is particularly so given that practice guidance suggests multi-agency responses are best, and because Government policy is catching up with this guidance in the form of "Better Public Services" and the sharing of responsibility for outcomes. A good example is the review of children in police cells under OPCAT.
5. While there is system monitoring undertaken by the Office, the extent and depth of this monitoring needs to be increased in order to provide the level of assurance that the public interest requires (see below).
6. Completing the picture of gaps is the absence of the accumulation of "risk based intelligence". I mean an independent view of risk as other than a high level system view. For effective change in the assurance around individual clients of CYF, and partly informed by the complaint, investigation and monitoring systems, the independent regulator needs to identify in more detail the risks of and to people in the system , the places where they are, and the events and actions that comprise the risk.

Issue 4: System Issues

In the previous part I described the delicate balancing of roles and responsibilities that were arranged around the social worker in a case in order that the interests of the child or young person be kept in view. There is a structural separation between the social worker in a case and the CPC who calls, facilitates and concludes a family group conference. There is a further structural separation between the social worker and the CPRP who bring community oversight to cases. I believe that the drafters of the Act thought that by creating these separations they were increasing the protections around the process by increasing the number of people who must view and review a case. The people in these roles can and should be raising concerns about the process. Further, there should be clear guidance that they must raise a complaint if they see clearly unlawful or dangerous behaviour.

As far as the CPC are concerned I can understand why this position reports to the Site Manager. The operation of FGC are a key part of the Site Manager's accountabilities, there are balancing considerations between operational and fiscal performance and the CPC needs good employment related and professional oversight

With the CPRP I think the issues are different. I did detect that there was a view amongst social workers that the CPRP was a bureaucratic system that just had to be "jumped through". Over time, the professionals have drifted away from the panels and while there is community membership they may not reflect the high powered local oversight that was intended. I would doubt that all cases that ought to be heard by Panels are in fact heard, and there is limited feedback to the Panel on cases. Although they report annually to the Chief Executive their visibility in the system is muted. I gather there is a view amongst some that it is a concept whose time is passed.

I think there remains a need for a strong local oversight of the child protection system. The need to have a professional check on cases proceeding into the system remains and there is an issue about the options that are locally available to be coordinated. The operation of CPRP, or if their time has truly come then some other form of local should be in the clear monitoring sights of the regulator.

CPRP ought to have the following features:

1. Their membership must be of sufficient breadth and depth to be able to offer both the professional advice but also the contacts and connections that is the purpose of the Panel. There ought to be representation across professionals as well as agencies (specifically including health and education) and the community sector.
2. The Panel needs to be independently supported, i.e. a local secretary, through which the requirements and needs of the Panel can be communicated. In particular, this support must ensure that there is transparency about the CYF case system to the Panel that all cases that are to go to the Panel are in fact considered. This would also cover issues that might require urgent consideration between the regular panel meetings.
3. The Panel ought to have national oversight and this ought to report outside of the CYF reporting line to the Chief Executive. A specifically appointed person should be tasked with communicating and coordinating, ensuring that appropriate training and support materials exist and remain current and that opportunities for moderation between Panels occurs that then ensures national consistency while retaining local perspectives.
4. The Budget for Panels ought to be removed from local Site management and placed with the national coordinator.
5. The Chief Executive must report on an annual basis to the Children's Commissioner on the functioning of the CPRP.

PART FIVE – Options for Change

Introductions - Options

In this Part I will report the options to provide a greater level of independence in the investigations and complaints review function.

The options are:

1. The status quo. In this Option the Chief Executive's Panel is retained in its present state (or with minor enhancements).
2. An enhanced complaints and complaints review function is established within the Children's Commissioner's office comprising any or all of the following elements:
    a. An investigations group;
    b. An enhanced collaborative quality improvement process (practice monitoring and review function);
    c. A complaints advocacy service;
    d. A 'children in care' monitoring and advocacy service;
    e. A one-off audit of the CYF complaints process in 2014/15.
3. An Independent Child Protection Authority
    a. An Independent Child Protection Authority;
    b. An Independent Child Protection Authority and Child Guardian.

1 The Status Quo

This option would require an acceptance that the current review panel not only reviews complaints in a satisfactory manner (which it does) but in its continued operation would be capable of removing the perception that it is not independent (which I think would be difficult).

The minor enhancements that could be implemented are:

1. Increasing the number of Panel members in order to be able to run several panels at once;
2. Increasing the level of support to the Panel secretariat to enable a faster accumulation of information necessary for the panel to complete its deliberation, and inquire into aspects of the matter independently of the CYF investigating officer.

Authority	Accountability	Resources
• No change	• No change	• Budget change <$200k

Benefits	Risks
• Improved timelines will improve perceptions of responsiveness • Unlikely to shift the over perception of a lack of independence.	• Will not shift perceptions

2 Children's Commissioner Option

In this option the Children's Commissioner will be handed a more specific regulatory oversight role of complaints, not only from and for children, but generally under the CYFPA landscape.

There are five parts to this option which can be selected individually, or in any combination. This option will require a significant increase in the funding of the Office of the Children's Commissioner.

2a Investigations Service

A new Investigations Group would be established in the OCC. A Deputy Commissioner (Complaints and Investigations) would be appointed by the Minister (on advice) to administer the complaints and investigations function of the Office of the Children's Commissioner. It should be recognised that if the Deputy Commissioner holds judicial rank they continue with the privileges of their judicial appointment. A judicial appointment ought to be considered seriously. They would be required separately to act independently to avoid any conflict with other parts of the Children's Commissioner's functions. The functions of the Children's Commissioner under their Act would be amended to ensure full authority to investigate all complaints made in respect of decision and actions taken (or not) under the CYPFA falls within the Commissioner's jurisdiction.

This option assumes that the Chief Executive's Panel would continue largely in its current role (complaints review and resolution) but making findings on cases to the Deputy Children's Commissioner. The group would undertake several functions:

1. It would take complaints directly from complainants, arrange for the complaints to be reduced to writing, make an assessment and determine where the complaint should be referred for action. In most cases this will be to refer to CYF for local resolution.
2. It will receive reports of complaints received and recorded by CYF, make an assessment of the complaint and determine where the complaint should be referred for action. Again, this will result in most cases being directed into the CYF complaint process.
3. In serious cases, (which will need to be defined) or at the election of the Deputy Children's Commissioner, the group would investigate. The investigation would follow with a report to the Children's Commissioner. The group would be delegated the Commissioner's powers to seek

information and be bound by the attendant secrecy provisions. There would be a statutory obligation to keep the complainant informed.

4. Where there is a sequence of similar cases or where there is a concern of a serious systemic issue, the Children's Commissioner may refer the issue to the Deputy Children's Commissioner for an investigation into the system. On such a referral the powers to investigate will also apply.
5. The Deputy Commissioner could also elect to:
    a. Take no action;
    b. Take action to oversee a CYF complaints resolution process.
6. The Deputy Children's Commissioner will receive referrals of dissatisfied complainants from the CYF complaint process (and from complaint processes elsewhere that relate to the operation of CYPFA) and determine whether to review them. A reviewer would undertake a review of all or part of the investigation and report to the Deputy Children's Commissioner.
7. The Deputy Children's Commissioner may then refer an investigation report, or dissatisfied complainant to the Panel for consideration of the matter, preparation of findings and recommendations. The Panel would consider the case, meet with the complainant if necessary, direct any further investigation if required, and provide findings and recommendations. The Panel by falling under the Children's Commissioner's legislation would also be under an obligation to act independently in arriving at its findings and recommendations.
8. The Deputy Children's Commissioner would receive the Panel's report and then may:
    a. Issue the report with findings and recommendations to the Chief Executive (the IPCA approach for this part of the function I consider a suitable model), with a view that the Chief Executive would accept or not accept the findings and recommendations.
    b. Refer the report to any other agency for their consideration and action. This may include:
        i. The Police
        ii. The Human Rights Commission
        iii. The Privacy Commissioner
        iv. The Social Workers Registration Board
        v. The Health & Disability Commissioner
    c. Publish a report.
9. The Children's Commissioner would monitor the implementation of any accepted recommendations until satisfied effective change had occurred. It would have specific authority to make inquiries or assessments to enable it to form a view that the change had occurred. In the event implementation is unsatisfactory the Children's Commissioner may report to the Minister and report publicly.
10. The Group would establish a database of complaints (including CYF complaints), relevant complaint information, and be able to analyse this information for risks and other trends. A summary of indications from this source would be included in the Children's Commissioner's Annual Report to the Minister.

Authority	Accountability	Resources
• Authority to conduct investigations and authority to require information from third party providers (complaints information) would be extended to ensure full ability to investigate is enabled.	• Delegations within Children's Commissioner's office required?	• 10 staff including new Deputy Commissioner ($1-1.5M) • Includes Secretarial support, complainant support, risk information officer • Includes Accommodation & overheads

Benefits	Risks
• Improved perception of independent investigation and oversight • Improved system wide knowledge of complaints	• Case volumes; mitigated by empowering the OCC to select cases to investigate and review. • Perceived risk of conflict between the children's advocacy role of OCC and the investigative role

2b Collaborative Quality Improvement Process

The monitoring function within the Office of the Children's Commissioner is a critical underpinning of service quality (and thus the CYF complaints system). It could be enhanced by the establishment of a Collaborative Quality Improvement Process. This would be a non-judging, continuous improvement oriented, and evidence based approach to social work practice. Key functions would be to:

1. Establishment of communities of practice (stakeholders) to the quality improvement system;
2. Agree the priorities for practice improvement with CYF and the sector;
3. Identification of best practice (with a process to inform this determination);
4. Monitoring programme designed to clarify and confirm best practice, identifying practice leaders;
5. An information sharing process (documenting and communicating best practice);
6. Reporting change to the community of practitioners.

Authority	Accountability	Resources
• Authorities as exist sufficient	• No changes to accountabilities	• Increase in Monitoring resources at Office of Children's Commissioner • Monitoring team leader, with two principal advisors, three advisors and two additional support staff = (<$900k) • Includes Accommodation and Operating expenditure

Benefits	Risks
• Consistent and collaborative approach to practice quality under CYPFA • Would support necessary culture change in social work practice; • Organisations and social workers would want to 'opt in' to these processes rather than take a defensive and protective stance to an imposed practice review; • An exposure of key risks affecting the care and protection of children and young people and their families and means of dealing with them.	• Obtaining momentum and traction quickly enough to deliver visible benefits to children, young people and families • Managing the volume of opportunity within resources

2c Complaints Advocacy Service

There is a need to provide support to those who find it difficult to complain about CYF. While the current policy provides advice on this point the responsibility to oversee complainant support ought to be independent of the organisation.

In this model, the Children's Commissioner will offer a service of complaint advocacy support to complainants who are assessed as requiring specific and additional support. Criteria would need to be established based on:

- The age, circumstances and location of the complainant;
- The availability of other support;
- The nature and complexity of the case;
- Other special factors.

The services provided could include:

1. Assistance in making the complaint (including the explanation of the process, likely outcomes, and other options);
2. Reduction of the complaint to writing (i.e. the time and empathy to work through the issues to a recognisable complaint);
3. Advocacy in respect of services otherwise available (for example: legal, counselling);
4. Personal support in respect of interview, and/or presentations to a Panel;
5. Special support needs (for example: interpreters).

The process would be moderated from the Children's Commissioners office where one staff member would oversee the programme. The programme would be budget controlled with developing experience about needs and priorities.

Authority	Accountability	Resources
• Authorities as exist sufficient	• No changes to accountabilities	• One staff member • Resources to provide assistance to complainants ($<350k p.a.)

Benefits	Risks
• Vulnerable or intimidated complainants assisted to have a voice in the system	• Increased case volumes • Additional cost of complaint handling

2d Children in Care Monitoring Service

The review believes there is a need to monitor the State's actions in respect of children in care. Although there is recognition of an advocacy service in respect of children and young people in residences there is a bias against this. A neutral advocate ought to be identified and supported for every child or young person in the care of the state.

Such a system would take more than this review to design. But its features are:

1. An independent (of the state) capable guardian of the child or young person's viewpoint (as opposed to a judgement about their best interest).
2. An ability to have access on sufficient occasions and places to form a relationship and presence at key opportunities for the child or young person's voice to be heard. This will include at planning or decision making points or when there are risks and opportunities to report.
3. The relationship will generate "issues" that need to be reported and followed up.

Authority	Accountability	Resources
• Changes to CYPFA/CC Act would probably be required in order to get access to the child, share key information, to be informed about events and decisions, and to establish rights to be heard] • Protection would be necessary for disclosure of information by the advocate	• Is consistent with the other responsibilities of the Office of the Children's Commissioner	• Estimate $2-2.4M

Benefits	Risks
• Supplements CYF formal processes for introducing the voice of the child into the system • Increase the level of concerns and complaints heard from children and young people • Reduce the risk of harm to children and young people in care	• Potential conflict between the advocate and the statutory social worker • The child or young person may still not overcome natural impediments to disclosures • There would be a small increase in administrative costs including one off change management costs associated with an expansion of the role and function of the Children's Commissioner.

2e Complaints System Audit

There should be a one-off audit of the functioning of the complaints process being implemented presently by CYF. I suggest this occur in FY 2014/15. The audit should cover:

1. Systems that improve accessibility to the system, including marketing;
2. Investigations practice, including consistency and quality;
3. Case disposition timeliness (adherence to policy);
4. Matters relating to investigations allocation and supervision (including conflicts);
5. Implementation of findings and recommendations;
6. Complainant satisfaction;
7. Sector trust and confidence.

The Commissioner should report the result of this audit publicly.

Authority	Accountability	Resources
• Within current authority	• No changes required	• Approx. <$250,000

Benefits	Risks
• Assurance that the CYF process is functioning as intended • Assurance that recommended improvements have been considered and where appropriate implemented	• Cost

3 An Independent Child Protection Authority

3a An Independent Child Protection Authority

This option overcomes the issues relating to potential and perceived conflicts between the Children's advocacy role in the OCC and the role and functions to investigate and monitor.

In this model

1. An individual would be appointed by the Minister as the Children and Young Person's Authority to head a statutorily based Authority responsible for:
    a. Complaint receipt and assessment;
    b. Investigations of complaints;
    c. System monitoring (investigation of systemic problems);
    d. System intelligence (identification of risk);
    e. Reporting.
2. The Authority would hold the position and rank of at least a District Court Judge (as is contemplated could be the case with the Children's Commissioner under the Act). A number of other suitable people would be appointed as additional members of the Authority. They would be selected for their knowledge, experience and integrity.
3. The investigations component of the Authority would operate as for the Children's Commissioner option with these differences:
    a. The "Panel" concept would still operate but through the appointments as additional members of the Authority;
    b. There would be authority to hold hearings, call evidence, require witnesses to attend (attach Commission of Inquiry powers and responsibilities).
4. The Monitoring component of the Model would operate as an "own motion" authority to commence an investigation into a systemic issue. Similar powers including to the case investigation function would also attach to this component.
5. The Authority's power to act would be limited to those suggested for the Children's Commissioner. The ability to publish and to follow up on findings and recommendations is sufficient.

6. The Authority would be established as a new Crown Entity, statutorily independent for its operations, but required to carry out the responsibilities under the Crown Entities Act, 2004. The Authority would be established as the Board for the purposes of the Act. The Authority would need to report to a Minister other than the Minister of Social Development.

Authority	Accountability	Resources
• A significant and new piece of legislation • New appropriation	• Removal of functions from Children's Commissioner	• $3 – 3.75 M
Benefits	**Risks**	
• Development of a clear standard for investigation for complaints under CYPFA • Would be a more interrogative approach to complaints with a focus on enforcement of accountabilities	• Costs – most expensive of the options • Time – lead establishment time • Regulatory – requires a substantial piece of legislation that might be contested (thus delay)	

3b An Independent Child Protection Authority (with Guardian role)

This option adds the children in care monitoring role to the Independent Authority (see 2D above).

Authority	Accountability	Resources
• Would require additional legislation	• Reporting to Authority	• $<2.4M
Benefits	**Risks**	
• As for 2D	• As for 2D	

Transmission

I submit my report in accordance with the Terms of Engagement:

Howard Broad *CNZM*

Appendix: Consultation

A list of those consulted in the development of this report. I apologise for any interviewee who feels they are not represented in this list or has been omitted.

1. Angus, Dr. John, Chair - MSD CE's Complaints Review Panel
2. Axford, Graham, Complainant advocate
3. Barber, Audrey, Office of the Children's Commissioner
4. Barnados
5. Bazley, Dame Margaret, former CE Department of Social Welfare
6. Beattie, Sandi, Deputy Commissioner, State Services Commission
7. Becroft, Judge Andrew – Chief Youth Court Judge
8. Bell, Stephen, CE Lifeline
9. Bond, Mr Michael, Queensland Department of Families
10. Boshier, Judge Peter, former Chief Family Court Judge and presently Law Commissioner
11. Boyle, Brendan, CE MSD
12. Carruthers, Sir David – Chair, Independent Police Conduct Authority
13. Catholic Social Services Wellington
14. Chair: Care and Protection Resource Panel (1)
15. Clark, Phil, Queensland Ombudsman
16. Clarke, Dr Kenneth, Mid Central Health
17. Cooper, Sonia – Barrister and Solicitor
18. Crawshaw, Dr John, Director of Mental Health and Chief Advisor, Ministry of Health
19. Davies, Dr Emma, Rowe Davies Research
20. Dodds, Andrew, HR - CYF
21. Doolan, Michael, retired Chief Social Worker CYF
22. Edwards, Marama, National Operations Manager : CYF – MSD
23. Glavish, Naida, Auckland District Health Board, Ngati Whatua.
24. Gorman, Doug – AEGIS Project - MSD
25. Grady, Philip, CE Odyssey House
26. Graveson, Chris, Retired Inspector (Police Youth Services)
27. Griffiths, Toni – Complaints Project CYF
28. Hassall, Dr Ian, Paediatrician and former Children's Commissioner
29. Henaghan, Professor Mark, Dean of Otago Law School, Otago University
30. Henwood, Judge Carolyn – Confidential Listening and Assistance Service
31. Hill, Anthony – Health and Disability Commissioner
32. Hoquard, Toni, Social Work Registration Board
33. Hughes, Peter, formerly CE MSD
34. Individual written public submissions from previous complainants (4) and one personal interview of a complainant
35. Kairo, Dr. Cindy, former Children's Commissioner
36. Kelly, Dr Patrick, Paediatrician, Starship Hospital
37. Kinmond, Steve, Office of the Ombudsman, New South Wales
38. Lifeline Aotearoa
39. Mackenzie, Bernadine, Deputy Chief Executive, CYF - MSD
40. MacLean, Judge Neil, Chief Coroner
41. Max, Dame Lesley – CE Great Potentials
42. McDonald, Alison, MacGregor, Andrew and McCaul Barry – from Corporate Governance Group, MSD
43. Men's Advocate (of former residents of Boys Homes)
44. Ngapuhi Iwi Social Services Limited, Kaikohe
45. Nixon, Paul, Chief Social Worker CYF - MSD
46. Otangarei Trust, Whangarei
47. Raukawa Iwi Social Services
48. Renouf, Jacqui – former Member, MSD CE's Complaints Review Panel
49. Rutherford, David Chief Commissioner, The Human Rights Commission
50. Salmon, Barry, Queensland Office of the Children's Commissioner and Child Guardian
51. Smith, Mel, former Ombudsman and Member, MSD CE's Complaints Review Panel
52. Smith, Ray CE Department of Corrections and formerly DCE CYF - MSD

53. Social Workers who had been complained against (3)
54. Social workers who had undertaken or reviewed investigations (4)
55. Stoop, Graham – CE Education Review Office
56. Wakem, Dame Beverley – Chief Ombudsman
57. Wills, Dr. Russell – Children's Commissioner
58. Wilson, Dr Janice and Shelley Hanifin – Health Quality and Safety Commission
59. Wintringham, Michael, Member - MSD CE's Complaints Review Panel
60. Young, Garth, MSD – Historic Complaints Team
61. Youth Horizons

Appendix – Acknowledgements

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