Strengthening independent oversight of the Oranga Tamariki system and of children's issues in New Zealand

Ko te whakakaha i te tirohanga motuhake ki te pūnaha a Oranga Tamariki me ngā take tamariki i Aotearoa

Post Consultation Report

August 2018

Sandi Beatie QSO

1. Contents

Kia tupato o tatou Tamariki. Tangohia tiaki o ta ratou rongo, kia tupato o ta ratou e kite, kia tupato o ta ratou ite. Ma te aha hoki nga Tamariki tupu, pera ka te āhua o Aotearoa

Take care of our children. Take care of what they hear, take care of what they see, take care of what they feel. For how the children grow, so will be the shape of Aotearoa.

Dame Whina Cooper

2. Introduction

Aotearoa - New Zealand has approximately 1.12 million tamariki/children and rangatahi/young people under the age of 18. A safe and secure home environment should be the experience of all children and for most that is a reality. Some, despite stable influences in their lives, do experience challenges and may need additional support either for their whānau or directly themselves to deal with things like health issues, a disability or other circumstances. And, among the 1.12 million there are also too many who may witness family violence, be bullied or subjected to physical or sexual abuse.

There is also a sizable proportion of this young population who, through no fault of their own, but through circumstance of birth and/or life events, become our most vulnerable. It is this group of children who deserve particular attention.

The facts speak for themselves: for a 12 month period ending 31 March 2018 Oranga Tamariki – the Ministry for Children had received 89,650 notifications about concerns to do with safety or wellbeing; 34,550 children and young people were assessed as requiring some form of action to be taken. There were 6,250 children and young people in the care and protection of the Chief Executive of the Ministry, and 170 young people in either youth justice custody or a combination of both types of custody.

There are also others that are not the subject of notification or in the care of Oranga Tamariki but for a range of reasons are being looked after by grandparents or other family or whānau members.

The needs of these vulnerable populations because of their circumstances can in general be higher and more complex than those of other tamariki in the wider population. In some cases they also go on to experience low educational achievement, unemployment and/or involvement in the adult corrections system.

Following a comprehensive review by an Expert Panel in 2015 that included intensive work to incorporate the voices of children and young people, a much anticipated overhaul began of how New Zealand is responding to the needs of our most at-risk

children and young people. A key aspect of these reforms was the formation of a new government department: Oranga Tamariki – the Ministry for Children.

The changes envisaged were bold and far reaching and will take time to fully implement but are supported by a strong legislative framework that spells out the breadth and seriousness of Oranga Tamariki's responsibilities and for what they will be held to account. The importance of these reforms have been further reinforced by the Government's commitment to put child wellbeing at the heart of services for children and to encourage all children to reach their potential, and to reduce the impact of child poverty.

Against this backdrop I was asked by the Ministry of Social Development (MSD) to lead a review of what might be required to strengthen current systems of independent oversight particularly in relation to the Oranga Tamariki system[1].

Keeping the system honest and ensuring that the wellness of all children can be tracked is an important part of accountability as is whether the actual experience of children and young people, whānau and carers who come into contact with Oranga Tamariki is improving.

The first phase of the review considered current settings for oversight, the gaps and overlaps, exploration of international models and the development of potential options for strengthening independent oversight arrangements. A limited amount of consultation occurred for this part of the work and was mainly confined to information gathering about how various oversight bodies exercise their functions. This work led to a Cabinet paper with MSD directed in April of this year to undertake a period of consultation with stakeholder groups. The purpose of this consultation included seeking views on the core functions required for strong oversight, critical features to success including skill and knowledge requirements, and whether and what functions best sit together and how the respective functions could be organised. The consultation also explored how a system of oversight could balance a focus on children and young people in the Oranga Tamariki system and a focus on all children.

MSD subsequently published on its website a consultation document[2] along with the Cabinet paper and sent that information directly to a wide range of interested parties including NGOs, Māori, Judges, academics, Pacific Peoples, health professionals, past Children's Commissioners, statutory bodies such as the Children's Commissioner, Chief Ombudsman and the Privacy Commissioner and chief executives of the relevant public sector agencies.

In May of this year, I was re-engaged to lead the consultation. This report has been prepared to guide any subsequent more detailed analysis that Ministers may wish the

[1] The Oranga Tamariki system includes the statutory care and protection and youth justice system in the Oranga Tamariki Act 1989. The 'system' also includes the role of other agencies e.g. the Courts, NZ Police, Corrections and those that provide services such as Health and Education.

[2] Strengthening independent oversight of Oranga Tamariki system and children's issues in New Zealand: a consultation document
Ko te whakaaha i te tirohanga motuhake ki te pūnaha a Oranga Tamariki me ngā take tamariki i Aotearoa: He pukapukua matapaki - Published by the Ministry of Social Development, May 2018

Ministry to undertake to give effect to any changes in order to strengthen the current settings for independent oversight. It includes a summary of themes arising out of 35 face to face meetings or teleconferences with groups and individual, a hui with Māori providers and 33 written submissions. The second half of my report sets out my conclusions as to what is required to build robust monitoring and accessible complaint processes that will contribute to both improved assurance for those interacting with the system and the continuous improvement of that system.

3. Acknowledgements

I wish to record my appreciation for the cooperation, openness and contributions throughout this review from Andrew Becroft, Children's Commissioner and his staff and Grainne Moss, Chief Executive, Oranga Tamariki and her staff.

I am also very appreciative of the willingness of the groups, agencies and individuals who took the time to respond and participate in this round of consultation and to share their views. Their help in contributing to what is needed for future arrangements was invaluable.

While I did not speak directly with children and young people I did review what they have said to the Office of the Children's Commissioner and to Oranga Tamariki as part of their respective 'voices of children' work. MSD has also engaged specialist expertise to meet with groups of children. Their views together with my report will contribute to the detailed analysis and design for strengthening independent oversight.

4. Current independent oversight arrangements

In the current settings independent oversight of children's issues has two main purposes. These are to:

• assess the Government's performance in improving the rights and position of all New Zealand children, in line with our obligations under the United Nations Convention on the Rights of the Child (UNCRoC), and advocating for change at the national level, and

• ensure the welfare and safety of children and young people in the Oranga Tamariki system.

The Children's Commissioner: under the Children's Commissioner Act 2003, the Children's Commissioner has the key role in oversight of systems and outcomes for children.

Currently the Commissioner has a broad remit, particularly in two main areas:

1. General statutory responsibilities for all children under 18, including advocating for the rights of all children. These include advancing and monitoring the application of the United Nations Convention on the Rights of the Child (UNCRoC); as a designated 'National Preventive Mechanism'. The Commissioner also examines and

monitors the treatment of children and young people detained in care and protection and youth justice residences for the purposes of the Optional Protocol to the Convention against Torture (OPCAT)[3]. The Government's focus on improving child wellbeing and reducing child poverty could also be considered by the Commissioner as part their remit. The Commissioner also has a role in receiving complaints and investigating issues that impact a wide range of children.

2. Some specific functions to provide oversight of the children and young people within the Oranga Tamariki system. These include monitoring Oranga Tamariki policies and practices, and investigating decisions, recommendations, and acts or omissions in respect of any child or young person.

The Vulnerable Children's Board: The Vulnerable Children's Board also has some oversight functions. The previous Government established the board in 2012 with Cabinet appointing its members and an independent chair. Its role is to provide cross-agency governance for implementing the modernisation of Child, Youth and Family (now called Oranga Tamariki—Ministry for Children).

VOYCE-Whakarongo Mai: The new NGO, VOYCE-Whakarongo Mai, which has a primary focus on providing independent individual and collective advocacy for children and young people in care, and it may also advocate at a systemic level.

Other oversight bodies:

There are a number of other organisations with 'independent oversight' roles that are not specific to children. These organisations can and do consider issues that affect children and young people. These include the:

- Human Rights Commissioners
- Health and Disability Commissioner
- Privacy Commissioner
- Independent Police Conduct Authority
- Ombudsman
- Education Review Office

There are also professional bodies who oversee the registration of those working with children for example, the Social Workers Registration Board.

5. Why we need stronger independent oversight

The care and protection system can be characterised as a complex interwoven set of relationships, policies, practices and legal obligations. Overlaying that with broader considerations of wellbeing for all children adds another dimension to this. Having regard to this there are several drivers for strengthening independent oversight:

[3] worldwide system of inspection of places of detention, which takes the form of an Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1984).

- A new policy agenda that puts the focus on child wellbeing.
- The Child Poverty Reduction Bill currently before Parliament and the intent of Government to develop a strategy to improve wellbeing for all children. And, its requirement for Oranga Tamariki, NZ Police and the Ministries of Health, Education, Justice and Social Development to work together on a tamariki action plan.
- The legislative changes that strengthen both the mandate and accountabilities on Oranga Tamariki to deliver improved outcomes for children and young people most at risk and who may come under their care and protection.
- New National Care Standards regulations that need to be monitored.
- The new Oranga Tamariki system designed to deliver better outcomes for children in state care today. It is important that lessons from past experience are learned where children's wellbeing and safety is concerned. Additional safeguards are essential while the system is still in build mode.

Some have raised with me the Royal Commission of Inquiry into Historical Abuse in State Care (from 1950-1999) with a particular concern that it is premature to strengthen independent oversight prior to the Commission's findings. Careful thought has been given to this. I anticipate that the circumstances and situations the Royal Commission will hear will be deeply personal and the people concerned will need the time and space to be heard. I am therefore of the view that we cannot wait three or more years until the Commission has had the time to hear from those who wish to appear before it, deliberate and craft its findings.

What can be done now without compromising the Royal Commission is to establish stronger oversight to ensure circumstances such as those surrounding historic claims are less likely for children and young people in state care today. The aim of strengthening independent oversight now is to support prompt identification of concerns within the system and provide opportunities to ensure children and young people or a trusted adult can access complaint arrangements when they need to and with confidence they will be heard. Whatever is put in place now needs to be flexible enough to develop further as the Royal Commission of Inquiry progresses.

6. What was learnt from the consultation

While the consultation was focussed around gaining insights into how groups and individuals viewed the need for checks and balances in the system, the types of functions that might make up independent oversight, and the capabilities to do oversight functions well and how oversight functions might be arranged, many commented on their experiences or perceptions of Oranga Tamariki post its establishment and of the broader public system more generally. These are important perceptions and have been summarised as part of the themes below as they are relevant to decision-makers in considering how to strengthen independent oversight for the future.

The other organisation that was frequently mentioned was the Office of the Children's Commissioner (the Office). There were some who feared that this review might

somehow interfere with its independence or weaken its role while others were concerned that giving it additional responsibilities across the care and protection system could detract from its role as the authoritative voice for all children. There were strong representations from some groups not to fragment oversight functions and others who saw the 'fix' in terms of simply providing the Office with more resource. Differing levels of understanding emerged about the Children's Commissioner's powers and what the Office does in regard to monitoring and complaints. And, there were comments about the Office being seen as 'Wellington-centric' and not sufficiently connected to communities.

There were also a range of comments on matters outside the scope of this work. These have been collated by MSD for passing on to relevant agencies.

I have considered carefully all the written submissions and reviewed what people said in face to face discussions (or by phone). In order to give a flavour in this report of what came through I have divided a summary of key points into two: a set of key themes around what is required and another set representative of the spread of views about functions and form.

Key themes:

Independent oversight

- Agreement that there is a need for independent oversight and that it needs strengthening. A range of views about the how, what and where.
- The importance of independence and independent roles for holding governments to account. And, the need to address weaknesses in the mechanisms for 'holding to account' given the long standing obligations of the state in regard to child protection in previous Acts and its successors.
- The importance of whānau and whakapapa – the 'child centric' view is not the right term for what is needed, tamariki are not individuals but part of a whānau and whakapapa.
- Calls for sharper, targeted oversight that incorporates robust evidence based monitoring and evaluation of what is working and what is not and enables the tracking of pattern and trend analysis over time especially around complaints.

Rights & Interests

- Strong advocacy from NGOs in particular, around the UN Convention on the Rights of the Child - would like to see UNCRoC as the overall framework for independent oversight.
- Concerns that singling out groups of children risks stigmatising them coupled with the view that what is good for all children will be good for children in the care and protection system and they should not be treated differently. Focussing on the needs of vulnerable children may lead to a narrow view of what good outcomes mean for children.
- The advocacy role of the Children's Commissioner should include a focus on children with mental health or disabilities or special education needs.
- Institutions concerned with human rights need to combine passion and commitment with views informed by evidence derived from reliable data and

good research capability. Without this there is a risk of over reliance on personal anecdote and sweeping statements.

- Acknowledgement of the potential of VOYCE Whakarongo Mai – seen as being in formative stages but viewed as an important means of independent support for children and young people in care. Should be part of a future complaints system that is, as somewhere children and young people can go and have trust in to support them through sorting an issue or a complaint.

Care & Protection system

- Acknowledgement that the Oranga Tamariki Ministry is still in build mode and the hopes and aspirations from the work of the Expert Panel are still to be realised. Views were weighted between those seeing change begin to happen and evidence of good intentions and those critical of the pace of change and impatient for progress. The latter were forceful about wanting to see real change on the ground and improved training and support for carers. Health care professionals, social service and care providers also advocated for better ways for alleviating what was described as “administrative workloads” at Oranga Tamariki sites especially in geographic areas of highest demand and needs so that more time can be spent on social work practice and service delivery.
- Care and Protection resource panels have the potential to do a lot as a ‘check and balance’ on social worker practice to improve outcomes but do not always work effectively.
- Oranga Tamariki needs to have strong internal and credible complaint processes that are accessible, have integrity and are seen to work. While the Chief Executive’s panel is made up of independent appointees it was not seen as independent of the department.
- True Māori representation is needed in the system. There is insufficient knowledge of and focus on Te Ao Māori by agencies given the high proportion of Māori children and young people in the care and protection and youth justice systems.
- Navigating the wider system seen as being hard for individuals and those representing the interests of children – by this was meant the government departments that deal with child and whānau support related matters when these are to do with health, disability, education or housing either as a single issue such as health related or a combination of issues spanning several entities.
- Perceptions of differing policies and priorities between agencies getting in the way of seamless delivery or resolution. A lack also of consistency and coherency experienced at local levels when dealing with care and protection matters. It was suggested that there needed to be less policy and legislative compartmentalisation of children across different Ministries.

Children’s Commissioner

- The role of Children’s Commissioner is seen as a strong advocate for all children and their rights, particularly supportive of the role as an independent voice and influencer. Would like to see some continuity of focus between

Children's Commissioners around areas of focus in order to track progress for children and young people over time.
- Te Tiriti should be incorporated into the Children's Commissioner's Act for the purposes of enduring commitment to Te Ao Māori.
- The Children's Commissioner should focus on the volume of children and young people who come to the attention of Oranga Tamariki.
- The Office of the Children's Commissioner should be a symbol of hope with a broad focus on all children rather than what could be seen as a deficit focus.

Previous reports
- A sense of frustration that previous reports have not been sufficiently acted upon – those mentioned were: Puao-Te-Ata-Tu (1988); Review of Child Youth and Family Complaints System 2013 (commonly referred to as the Broad Report); and Confidential Listening and Assistance Service Final Report 2015.

7. Views on functions and form

The consultation document set out four possible options for independent oversight. In summary these were:

1) Keep all four independent oversight functions together as they are now, but strengthen aspects of the oversight model by providing additional investment into the Office of Children's Commissioner.
2) Keep all four independent oversight functions together as they are now, but make changes to the Children's Commissioner Act to enhance the structure capability and powers of the Office.
3) Separate functions to ensure clear focus on particular functions, with some remaining with the Children's Commissioner such as systemic advocacy and monitoring and other functions (complaints review and investigations) established elsewhere.
4) Separate the functions to ensure clear focus on particular functions, with systemic advocacy remaining within the Office of the Children's Commissioner and a new or existing body focussing on monitoring, complaints view and investigations.

I reinforced during the consultation that these options were not givens and that other ideas or combinations could be put forward.

There was, in general, consensus around independent oversight needing to incorporate the functions of systemic advocacy, monitoring, complaints and investigation. Although as acknowledged earlier there were a range of views on what the focus of each of the functions should be, how they should be organised and who was best to deliver them.

Those that stated a specific preference lent more toward options 1 or 2 and some were in favour of 3 or 4. Those not stating a particular preference did emphasise the need for a more robust monitoring or audit system and/or identified the need for an independent complaints and investigations body for care and protection. Spanning

this spectrum of views were suggestions for what was needed to achieve the functions and how they might be organised. These are summarised as follows:

- Locate all the independent oversight functions together within the Office of the Children's Commissioner because of the synergies between them. The four functions were seen as complimentary to each other with the work of each strengthening the independent voice for children. Suggested changes to the Act to give more teeth to the Children's Commissioner's recommendations and provide the Office with more resource dollars and people.
- Strengthen systemic advocacy and monitoring focussed on the interests of all children through greater investment in the Office of the Children's Commissioner.
- Introduce inspection and monitoring of public services that impact children. And, establish independent visitors for all children in the Oranga Tamariki system.
- Separate the management and potentially the funding of systemic advocacy for all children from independent oversight monitoring and that monitoring from complaint and investigation functions if all housed together. If, for example, the decision was to place them all within the Office of the Children's Commissioner then utilise a Deputy Commissioner model over monitoring and another over complaints and investigations. Separate management was seen as a means of avoiding any perceptions of potential conflict between functions, providing for greater specialist capability and avoiding competition between functions for focus and resource.
- Increase the size of the Office and reconfigure the team structure in the rights and advice area.
- Consider the appointment of a Māori Commissioner to bring focus to the 66% of Māori children and young people in care.
- Make the Children's Commissioner an Officer of Parliament as a means of embedding greater authority[4].
- Create a "watchdog" or regulator for the Oranga Tamariki system that covers a broader spectrum of care and protection situations for example, s396 providers[5] and periodic sample monitoring of whānau and foster care situations.
- The National Care Standards regulations should form the foundation for a regular programme of assessment. Provide for periodic 'deep dives' of selected components for example, of entry into care, the safety and wellbeing of children and young people, quality of care and transition from care.
- Independent monitoring should be evidence based i.e. what's working and what's not, examples of good practice, analysis of patterns and trends and identification of areas for system improvement.
- Establish a separate complaints and investigations body for the care and protection system that is accessible to children, young people and adults and operates along restorative principles.

[4] https://www.parliament.nz/en/visit-and-learn/how-parliament-works/parliamentary-practice-in-new-zealand/chapter-7-officers-of-parliament-and-other-officers-and-bodies-associated-with-parliament/

[5] Oranga Tamariki Act 1989, section 396: providers contracted to provide services

The purpose of this round of consultation was not to obtain agreement to one path or another but to test the proposition that there is a need to strengthen independent oversight of the Oranga Tamariki system and children's issues, seek responses to potential pathways for doing so and, to elicit additional views and suggestions. First and foremost a consensus emerged around something needing to be done to support the evolution of the care and protection system through the monitoring and evaluation of its practices and the experiences of those who either come in contact with it, or are placed in its care, or who work within it. And, an accompanying need for safe and trusted avenues for complaint and investigation and, for making suggestions for improvement.

There was also a strong body of opinion around the continuing need for strong systemic advocacy to highlight and represent the rights and interests of all children and young people with the Government's initiatives around poverty reduction and wellbeing seen as positive directional enhancements to this.

However, how to balance and address the need for independent oversight of a particular system (care and protection) with systemic advocacy of the rights and interests of all children and young people more generally wasn't so clear cut. It is this conundrum that the next part of my report attempts to clarify.

In order to examine this question further I found it useful to break down the component parts to illustrate what functions of oversight are needed both generally in regard to all children and what is needed in addition for the care and protection system.

8. What is needed to protect the rights and interests of all children

My assumptions in developing the following table are that as a country we:

- Care about children and young people
- Recognise our obligations by being a signatory to the UN Convention on the Rights of the Child
- Value the importance of whānau and family in children's lives
- Want all our children and young people to grow and thrive
- Support the promotion and protection of their interests.

Function	Purpose	Role
Systemic Advocacy for all children	To focus on the rights of children & to ensure voice is given to what matters to them	***Promote*** the rights & welfare of children. ***Promote*** and educate on UNCRoC. ***Listen*** to the voices of children & young people about what's important to them. ***Facilitate*** the voices of children into agencies developing policies or processes that affect

		children's lives. ***Represent*** children's interests to decision-makers. ***Raise*** public awareness & breakdown stereotypes around particular groups. ***Promote*** the participation of children & young people in decision-making. **Bring** a whole of system perspective.
Function	**Purpose**	**Role**
Systemic Monitoring	Authoritative source of advice to government & the public on the health & wellbeing of children & young people.	***Collect & synthesise*** data including research on child development & children's experiences. ***Evaluate & comment*** on the rights, interests & welfare of children. ***Investigate*** specific issues of disadvantage affecting children's lives. ***Evaluate*** the application of UNCRoC by the state & instruments of the Crown.
Function	**Purpose**	**Role**
Complaints Support	To ensure accessible advice on & help with complaint pathways.	**Contact** point for children or those acting on their behalf wishing to make a complaint. ***Provide*** an advisory and referral service to other independent complaint bodies. ***Act as navigator*** for those wishing to pursue a complaint to find the right door. **Help navigate** complex cross boundary issues. **Work with** agencies to develop child friendly accessible complaints processes.

9. What is needed to protect the safety and wellbeing of children and young people in care and protection

While all of the functions in the first table are applicable to all children including those in the care of Oranga Tamariki system there are some additional considerations specific to them. The children who come to the attention of Oranga Tamariki or who may be placed in its care are among our most vulnerable. The exercise of intrusive and coercive powers are not to be taken lightly and can have a significant impact on parents, whānau and these children and young people.

My working assumption is that the *independent* oversight of our care and protection system should be no less than that which applies to other parts of the state where coercive and intrusive powers can be exercised.

Function	Purpose	Role
General advocacy for children in care & protection	Trusted source of information, communication & advice	***Provide guidance*** on rights in care and where to go for help. **Provide guidance** on how to raise a complaint and what will happen to it. ***Promote*** the participation of children & young, their whānau, carers, providers in decision-making. ***Facilitate*** the voices of children & young people to be heard. ***Provide*** an avenue for whānau, providers & carers to make suggestions for improving the system. ***Represent*** the interests & concerns of children and young people into the Oranga Tamariki system.

Function	Purpose	Role
Monitoring of care & protection system	To build trust & confidence in systematic monitoring of the care & protection eco-system.	***Regular*** reviews under OPCAT of Oranga Tamariki secure residences & youth justice facilities. ***Planned*** programme of assessment of the application of the National Care Standards & outcomes for children & young people. ***Targeted*** 'deep dive' reviews of specific elements of care & protection e.g. assess complaints system, transitions in & out of care. ***Public reporting*** of findings & agreed follow-up actions. ***Sharing of insights*** i.e. good and/or innovative practice across the system. ***Foster learning system & continuous improvement*** through reporting on trends & patterns over time.
Function	**Purpose**	**Role**
Complaints Review	Independent accessible and safe avenue for complaints**.**	***Provide*** system of triage to avoid duplication with agency internal processes. ***Provide*** 'step up' avenue from internal Oranga Tamariki complaints mechanism. ***Review*** of a decisions where there is dissatisfaction with the outcome of internal complaints process. ***Determine*** what remedy should apply. Work with Oranga Tamariki and/or other agencies to seek resolution.

Function	Purpose	Role
Investigation	To provide a transparent system for inquiry and for determining an outcome	***Inquire*** into a complaint deemed to be a breach in standard of care or an aspect of the safety & well-being of a child or young person. ***Inquire*** into a complaint where rights or fairness of practice, procedure or a decision are at issue. ***Undertake*** 'own initiative' investigations where systematic breaches of standards of care have been identified. ***Determine*** remedy or sanction. ***Publicly*** report on findings and actions to be taken by Oranga Tamariki and/or other agencies.

In separating out what is needed for all children and what are the particular requirements of those who come into contact with or are actually being cared for within the care and protection system helped to identify points of intersection and difference. Before traversing my views on potential form it has been useful to consider how some other jurisdictions are approaching this.

10. Reflections on overseas models

A mix of different models for independent oversight for children and young people were examined as part of this review. Principally, the models in place in England, Scotland, Wales, Canada and Australia.

While there are some notable features of the independent oversight models in these countries, there does not seem to be a definitive one 'best practice model'. There also appears to be little compelling evidence to suggest which approaches to covering the various functions are most effective.

There are significant variations in the role, scope and functions of these oversight bodies. For example, key elements of child care and protection systems are often devolved to some extent for example, to a state or province level (i.e. Australia and Canada) or local government level (e.g. England) which contribute to variations in how oversight arrangements are structured.

The main independent oversight functions – advocacy, monitoring, complaints and investigations are typically separated-out to some degree:

- Almost all these countries/jurisdictions have a Children's Commissioner (or an equivalent entity) in place at the federal or state or province level. Their principal focus is typically the promotion and protection of the rights of children including oversight of UNCRoC obligations and often monitoring government policies at a high-level. They tend to have a broad remit that covers all children, and give priority to the most vulnerable or disadvantaged. In some cases their roles extend to investigating individual complaints and /or incidents for example, in Wales, Scotland and the Northern Territory in Australia. However, the exercise of these functions is often in practice limited by resource constraints. Most countries/jurisdictions have a sole Commissioner/Advocate, but a few for example, Queensland and Victoria have a multi-Commissioner model.

- In a number of jurisdictions, the functions of operational-level monitoring and oversight of complaints and investigations are carried out by separate entities, in some cases with an Ombudsman being assigned a role for example, in England and New South Wales.

- There are also significant variations in the scope of the role of key oversight bodies, with some inspection and monitoring agencies covering solely care and protection services for children, and others covering a wider range of services including education, and health and disability services and/or wider target groups such as families.

- Scotland, England and the state of Queensland in Australia make use to varying degrees of individual-level advocates for children called 'guardians' or 'independent visitors' which tend to be positively viewed in independent evaluations.

The funding of oversight in some of the more comparable jurisdictions to New Zealand for example, Queensland and Victoria appear to be significantly higher per child than for the equivalent functions in New Zealand.

An overall conclusion was that most of the countries looked at have continued over the years to review and refine how they respond to the representation of children's issues and the need for particular independent oversight of those in state care.

11. What is best for Aotearoa New Zealand

My task was to hear from a range of voices about their views on what is required for independent oversight of the Oranga Tamariki system and of children's issues. This report provides the flavour of those views (in summarised form) and from that I have made a preliminary analysis of what is needed. I wish to reinforce that my

conclusions do not come at the end of detailed analysis that is for the next stage of this work. My preliminary views are set out to inform and act as a guide for the analysis and policy development needed for detailed design.

I am not convinced that combining all the functions as summarised in the two charts above into one organisation is as simple an exercise as some might believe or will necessarily lead to the best outcome. There is the need for strong advocacy around the rights and interests of all children, for children's voices to be heard by decision-makers and for there to be avenues for them, parents, whānau, carers and trusted others acting on their behalf, to raise issues of concern or complaint and to receive help around how to get these addressed. There is also the need for monitoring of the system and using the insights gained from that to influence public understanding and government policy. There is also the need for an authoritative voice of inquiry and influence to represent issues of most significance to child wellbeing whether that be for example, around health, disability, education or housing and to be able to put the voices of children before the institutions of government. The most obvious role for these responsibilities is that of a Children's Commissioner.

The Commissioner currently has a general mandate under the Children's Commissioner Act 2003 to investigate, monitor and assess practices and provision of services under the Oranga Tamariki Act 1989. In practice, while the Commissioner is able to provide a certain degree of oversight, the Commissioner does not routinely provide systematic monitoring of legislative compliance or of the quality of services, including in relation to children in care[6].

The Office of the Children's Commissioner conducts visits Oranga Tamariki sites to look at practice issues and can undertake thematic reviews which are incorporated into development reports. A multidimensional framework has acted as the reference point for these monitoring activities. This framework includes components for assessing the quality of site leadership and management and the quality of social work practice including care plans.

The Commissioner also has a designation under the United Nations Optional Protocol to the Convention against Torture (OPCAT) for systematic monitoring of secure residences and specialist youth facilities. This monitoring equated as at 31 March 2018 to approximately 2.7% of children and young people in the care of the chief executive of Oranga Tamariki. The Office conducts a regular programme of announced and unannounced visits with a team of 3 to 4 assessors undertaking each visit. The framework for these assessments is based on six standard OPCAT domains:

- treatment e.g. relationship with staff, physical safety
- protection system e.g. knowledge of rights, access to complaint avenues
- material conditions e.g. standard of facility & external environment
- activities and contact with others e.g. programmes and access to whānau, and
- medical and therapeutic services i.e. quality of these services.

[6] Treasury Regulatory Impact Statement: Oranga Tamariki (National Care Standards) Regulations 2018

Recently, the Office added its own further dimension referred to as Mana Mokopuna. This has been described as an indigenous approach for monitoring the experiences of the resident children and young people and is aligned to “mana tamaiti” (intrinsic value, inherent dignity, wellbeing) in the Oranga Tamariki legislation. Reports now record, in anonymous form, quotes from children and young people.

Proposed recommendations arising from these assessments are discussed with Oranga Tamariki prior to finalising a report. Oranga Tamariki also provides a separate written response.

For the past three years the Children’s Commissioner has published a State of Care report which brings together perspectives from the monitoring it undertakes.

I understand there is some consideration being given to extending the number of OPCAT designations held by the Children’s Commissioner to cover other situations such as youth mental health and youth forensic facilities. It would, in my view, be prudent to consider this from a system wide perspective including the extent of OPCAT designations required, where these are best located for monitoring purposes and the implications for the proposed designee organisation in terms of capacity to do the work.

The Office of the Children’s Commissioner comprises 23.18 full-time equivalent staff (FTEs) including the Commissioner[7]. Of the total number there are 4.7FTEs covering corporate and communication functions and 7.3 FTES funded on fixed terms until June 2018. From both a resource and capacity perspective the Office isn’t equipped currently to extend its OPCAT designations nor is it well positioned to adequately carry out systematic monitoring across the breadth of the care and protection system.

If government and the public are to be assured that the reforms being rolled out are leading to better experiences and outcomes for children in care then independent oversight needs to extend to where the majority of children and young people in care are living and being cared for. There are a number of organisations and people that play a very important role in our care, protection and youth justice systems. These include non-government organisations contracted by Oranga Tamariki to provide services to children and young people under section 396 of the Act, and kin or foster carers.

Independent oversight of this broader set of care arrangements should be based around the National Care Standards and include both the quality of care and service provision and the quality of support available to carers. Care will need to be taken in the detailed design of these monitoring arrangements to ensure the focus is targeted on what matters and avoids providers becoming burdened with duplicative means of oversight.

Any independent system of oversight needs to work with Oranga Tamariki and the broader system. There are a number of checks and balances on Oranga Tamariki as a public service department including oversight by Parliament and the Ombudsman and there are significant responsibilities on its Chief Executive as set out in law. Oranga Tamariki has a number of internal mechanisms in place including a Chief

[7] Children’s Commissioner: Briefing to Incoming Government 2017

Social Worker who oversees professional practice and quality assurance; grievance panels within residences and youth justice facilities comprising external members; and a number of advisory bodies or committees with external people serving on them. It has also been trialling internal feedback and complaint systems and there is a 'Chief Executive's Panel' to which unresolved complaints can be referred. The panel is made up of external members appointed by the Chief Executive.

I accept the concerns that emerged from the consultation around the size of New Zealand's population and the need to avoid fragmentation or in establishing new bodies causing more confusion about who does what and what's the right door in to them. And, while I respect the view of those who would prefer the status quo I don't believe no change is an option if independent oversight is to be strengthened to match the needs of the new environment for care and protection services. I am of the view that new more focussed functions of monitoring, complaints review and investigation need to be established. There is the need to maintain the OPCAT associated monitoring of secure residences and facilities but also broader systematic monitoring of the care and protection system as a whole.

One response could be to separate independent oversight functions for all children from those that are needed specifically for the Oranga Tamariki system by having the former located as they are now within the role of a Children's Commissioner with it continuing to have responsibility for UNCRoC and the OPCAT monitoring. And, establish a new body to undertake the broader oversight functions for the Oranga Tamariki system. However, I am persuaded largely by economies of scale and potential time lags in getting new bodies established and functioning effectively toward the argument that there is sense in at least the broader monitoring being housed in an existing body such as the Office of the Children's Commissioner but with changes to its legislation and structure. This would mean reshaping the organisation from what it is today and building in new functions.

Monitoring of the National Care Standards would represent a significant shift in scale and is more regulatory in nature than what the Office of the Children's Commissioner undertakes now. While the OPCAT monitoring of secure residences should remain an important part of oversight functions, there will need to be investment in an appropriate level of design expertise to develop a framework and its implementation for monitoring of the National Care Standards and for undertaking periodic targeted 'deep dives' from time to time of particular aspects of the care and protection system.

Depth of knowledge and credible senior level experience in care and protection will be essential along with other capabilities such as child or youth development expertise, data analysis and interpersonal knowhow and good judgement. Not all of this expertise should need to reside in-house. There would be value in augmenting in- house personnel with a small number of independent external expert assessors (by way of either secondment or contract) to provide depth of senior professional expertise as part of the monitoring programme.

The importance of the quality of systematic monitoring can't be understated – it must provide credible evidence based assessments, be a respected source of independent advice and add value to Oranga Tamariki as well as contributing to a learning system of improvement in practice and service delivery. It must also be a

trusted source of independent reporting that provides assurance to Ministers, Parliament and to the public. To successfully carry out this monitoring will require full access to information and data that the monitor deems necessary. I have in mind a system that develops over time into a model of 'best practice' similar to that of the rigour brought to the evaluation of our school and early childhood sectors through the Education Review Office.

To that end I recommend consideration be given to moving away from a Commissioner sole model to the creation of a Commission with two full-time statutory Commissioners: a Children's Commissioner and a Commissioner, Care & Protection with each having separate roles and statutory responsibilies. It is envisaged that both roles would be publicly notified in a manner to attract suitably qualified individuals to apply with appointments made on the recommendation of the Prime Minister to the Governor General.

The Children's Commissioner would by statute provide the leadership for the role in regard to the rights and interests of all children and would be the guardian for New Zealand's responsibilities in relation to UNCRoC.

The Commissioner, Care & Protection would have statutory responsibilities for monitoring the Oranga Tamariki system and reporting to government and the public on how that system is tracking in terms of improvements to quality of care and the outcomes for children and young people.

I suggest that a Board be appointed by government to support the Commissioners. A credible well-functioning Board would provide the benefits of:

- Augmenting educational and vocational backgrounds and diversity of experience
- Supporting the independent oversight functions by bringing a strategic / non-operational perspective
- Contributing to the organisations strategy, outcomes and the performance of the chief executive
- Acting as a sounding board for the Commissioners to enable them to test ideas and potential decisions
- Reinforcing the leadership and management role of the chief executive.

I envisage the two Commissioners being ex officio executive members of the Board together with between 5-6 independent non-executive appointees. Rangatahi/young people should be among those considered for appointment. The make-up of the knowledge and skills of a Board will be critical to its credibility with a blend of experience and brainpower. In that regard consideration should be given to including knowledge of child and/or youth development and perspectives and skills in tikanga Māori, Pacific custom and practice, and governance expertise.

I further suggest that this refashioned organisation is led and managed by a chief executive who is also the employer of the staff supporting the work of the two Commissioners. The Board would appoint the chief executive and oversee their performance.

Complaints review and investigation relating to the Oranga Tamariki system could potentially be incorporated under the Commissioner, Care and Protection role however, there is a need for the functions to be perceived as independent from other functions. Also, a very different skill set is required for complaints review and investigation with those functions needing to be accessible to a range of people including children, young people and adults i.e. parents, whānau/family and carers.

The key messages from those with experience of the care and protection system is that independent complaint avenues separate from Oranga Tamariki are needed for children, young people and adults. They need to be accessible, trusted, fair and safe. True independence, timeliness in dealing with complaints and credible leadership and ease of process were also seen as essential. To that end an alternative choice is to either establish a separate body for complaints review and investigations or incorporate those functions into an existing body such as the Ombudsman. The latter would have some apparent advantages given the status as an Officer of Parliament but also because there is established experience in complaint and investigation processes and procedures and offices outside of Wellington. If the latter was preferred then further analysis would be required to explore what legislative changes would be needed to establish an independent complaints review and investigation pathway for the care and protection system. There will also need to be further work on the capabilities that would have to be built into an existing organisation to ensure a child friendly gateway as well as ease of access for whānau, family members or others wishing to seek a complaint review.

The changes I have proposed are not insignificant, there would need to be changes to legislation and new provisions added there would also be the need to establish new roles and a structure to support them. However, if strengthening of independent oversight is to be achieved and be ‘fit for purpose’ for now and the future then it should be done properly. It can be achievable with the right level of leadership, change and capacity building expertise and adequate funding to support the transition and future operation.

12. Concluding comments

I believe the time is right for considering strengthening the independent oversight of the Oranga Tamariki system and particularly so now that for the first time New Zealand has a set of overarching standards for the quality of care embodied in regulation. We know that there is a body of support for this to happen.

There are no easy answers as to what is the right course in terms of balancing the interests of all children with those of our most vulnerable. New Zealand is not alone in this, other countries have tried different approaches and this continues to be an evolving landscape. Nevertheless, our relative small size and our track record in being seen to lead innovative reform of our institutions suggests there is opportunity here to take a lead in strengthening the value of the rights and interests of all children. And, to also specifically back-up the changes happening within the Oranga Tamariki system by ensuring ongoing learning and improvement through a better more comprehensive approach to independent oversight.

It has been a genuine privilege to have undertaken this round of consultation and to have talked with and heard from so many committed and passionate people. While this report provides, at a high level, what came out of the consultation there is a wealth of information still to be drawn from it that will contribute to further work to follow. I have come to some conclusions about what is needed and how that should be progressed however, it is for Ministers to decide what they wish to take forward which will inform the more detailed work.