**IN THE CORONER'S COURT**
**HELD AT ROTORUA**

**IN THE MATTER of the Coroners Act 2006**

**AND**

**IN THE MATTER of an Inquest into the death of:**
**MOKO SAYVIAH RANGITOHERIRI**

| **Date of Hearing:** | **3 October 2017** |
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**EVIDENCE OF JUDGE ANDREW BECROFT**

**CHILDREN'S COMMISSIONER FOR NEW ZEALAND**

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## A. Introduction

[ 1 ] Thank you for inviting me here today as an expert witness in relation to the tragic death of three year old Moko Rangitoheriri on 10 August 2015. You have specifically sought my views on the following three issues:

1. the themes/issues that emerged from the first stage of your coronial inquiry
2. the extent to which New Zealand has taken steps to provide greater protection for our most vulnerable children, since you conducted Nia Glassie's inquest eight years ago, and
3. any actions that might address the contributing factors to Moko's death

[ 2 ] I note that the extreme cruelty and deliberate relentless violence that led to Moko's death has many characteristics in common with the 'chilling' level of abuse suffered by three year old Nia Glassie, who died almost exactly eight years before Moko (in August 2007).

[ 3 ] We well know there is a "dark side" to New Zealand society. There has been a growing realisation over the past five to ten years that our relatively very high rates of family violence, drug and alcohol abuse, child abuse and neglect, bullying and youth suicide are strongly interconnected. The singular message from my first year in this role, has been that all roads lead back to genuine socio-economic disadvantage, often accompanied by marginalisation, social isolation and a sense of hopelessness.

[ 4 ] Throughout my fifteen years as Principal Youth Court Judge and over the past fifteen months since my appointment as Children's Commissioner, I have often heard policy makers and professionals refer to 'hard to reach families'. Moko and Nia's families and caregivers no doubt fall into this category and have been described in this way.

[ 5 ] We know that through chronic disadvantage and inter-generational patterns of poverty and vulnerability, these families have little resilience and have become isolated from what we might refer to as 'mainstream society'. They frequently do not trust external agencies, particularly Oranga Tamariki (previously Child, Youth and Family) or Police, often because of long histories of negative prior involvement with state agencies.

[ 6 ] Moko was killed by the adults who abused him. The responsibility for his shocking death must lie with them. This must always be the starting point in any discussion. I do not want to minimise the fact that only those who inflicted the violence in this case, could have guaranteed Moko's safety. However, on the evidence before this inquest, it is fair to say that considerable responsibility for

missing or minimising the indicators of risk for Moko must lie with the agencies who were involved with the family, especially those directly involved with Tania Shailer.

[ 7 ] As a country, we have to ensure that all our child and family focused agencies across the country, whether statutory or community, have the child-centred competencies required to engage skilfully with complex families where family violence and mental health issues are known to be serious risk factors. The competencies required include:

- engagement and trust building
- listening and skilled inquiry
- recognition of risks
- identification of needs
- the ability to hold courageous conversations
- the ability to motivate change and
- the strength to take protective action for children when required.

It also requires workers to take a whole-family view, focussing on the overall family dynamics and looking out for all children in the household, not only those who may be the specific focus of their intervention.

[ 8 ] *I have considered the question of whether mandatory reporting of suspected child abuse would have made a positive difference in Moko's case*. On reflection, in this case, I do not think it would have done.

[ 8.1 ] The main issue I have seen emerging through the pattern of evidence presented to the inquest so far, is that the range of community based professionals engaged with Tania Shailer did not recognise the importance or meaning of the risk signals that Tania and Nathalia (Moko's sister) were giving out.

[ 8.2 ] These signals indicated that there were questions to be investigated around Moko's care. Unfortunately, it has become apparent that the agency workers did not pick up on them. Given this situation, they would not have considered making a report of concern. Only one agency, the Refuge, followed its child abuse reporting policy and considered whether or not to make a report of concern to Oranga Tamariki. They decided not to report Nathalia's disclosure about Tania 'punching' Moko to Oranga Tamariki because they incorrectly judged that it was a situation of sibling rivalry.

[ 8.3 ] Mandatory reporting requirements very probably would not have changed this outcome. However, had there been a requirement for all staff working in the vulnerable children's sector, employed by agencies approved under the Children,Young Persons and their Families Act 1989 (now revised to become the Oranga Tamariki Act 2017) to meet an agreed set of child-centred competency standards, including skills recognising risk factors for children, we may have seen a different outcome for Moko.

[ 9 ] In my role as Principal Youth Court Judge, I met many families similar to Moko's when their young people had offended and appeared before me in the Youth Court. By then, they were usually aged fourteen or older. While helpful and effective interventions with these young people and their families were still possible, I frequently reflected on the reality that much earlier supportive engagement and helpful intervention with these families would have had a far greater chance of successful impact. Particularly when their children were babies, or at least pre-primary school. And of course, early intervention would have significantly reduced the cumulative harm their young people experienced growing up in chaotic homes where family violence, alcohol and drug abuse and material disadvantage were part of daily life. It is well-established that the younger our children are, the more vulnerable they are to all forms of violence and abuse – and therefore the more potential there is for them to be seriously harmed or killed.

## B. Emerging themes from Moko's inquest so far

[ 10 ] *After considering the themes emerging from the evidence gathered in the first part of Moko's inquest, my expert social worker staff noted three core components that appear to have prevented intervention to help Moko's mother solve her housing issue or investigate what was happening for Moko in the Shailer-Haewera household:*

[ 10.1 ] The *lack of case consultation and information sharing* across agencies involved with this family and sometimes also between staff carrying out different child or adult centred roles within the same agency. Multiple agencies and professionals held pieces of information which, put together in retrospect, paint a clear and tragic picture of Moko's final months and days. Had this information been joined up, in a context where agencies were working together, the unanswered questions and associated risks to Moko would have become significantly more evident. That could, and should, have prompted protective action. The advent of the Children's Teams has addressed the information-sharing gap effectively in a few areas across the country, including Rotorua. However, there are many parts of the country, including Taupo, that do not have a Children's Team. In these latter communities, the network of agencies working with children and families,

including Oranga Tamariki, the Police, government agencies and non-government agencies, have the responsibility to establish their own local forums, sharing information and collaborating to keep children safe. An important question is whether the currently very incomplete 'roll-out' of the Children's team concept will be continued, and, if not why not?

[ 10.2 ] *An absence of the child centred competencies required for safe child protection practice across the child and family sector*. Many risk signals and triggers for action were missed. These included opportunities to:

- inquire into statements made by Tania Shailer about feeling depressed and struggling to manage the two extra children
- fully understand what lay behind Tania Shailer's comments about Moko being aggressive and her requests for help to manage Moko's behaviour
- ask about, and look closely at, the bruises on Moko's face
- inquire into the fact that at only 3 years old, Moko was spending long periods in his bedroom or the bathroom having time out and was not brought out when professionals were visiting.

Notably, none of the workers, either in Auckland or Taupo, appeared to take a whole family or whole household perspective in their work. They focused narrowly on their own area of work and on the children they regarded as their particular clients. This meant Moko did not have anyone looking out for him. All the community agencies involved knew the household was under stress and that Tania Shailer had mental health problems and a history of family violence. Sadly, none of them thought to check on Moko's wellbeing. A skilled and professional approach would have inevitably resulted in such checks, inquiries or investigations.

[ 10.3 ] *A lack of any demonstrated understanding by agencies of the impacts of poverty, hardship and deprivation on Moko's mother's resources, options and decision making around placement of her children*. Her history of extreme gang-related family violence, financial hardship and isolation, combined with a lack of whānau support, made it very difficult for her to find housing. When she was no longer able to have her children stay on the ward at Starship Hospital and could not access a place at Ronald McDonald House, she moved to her final option, which was to have Nathalia and Moko stay with Tania Shailer.

[ 11 ] ***Two examples of practice that could have delivered a different outcome for Moko:***

[ 11.1 ] *Starship Hospital and Oranga Tamariki in Auckland*

Specialist family violence agency, Shine, noted in the summary of their agency's involvement with Moko's mother:

> *'Usually when there is domestic violence and MVCOT get involved there tends to be an emphasis on the mother and what she is doing to be protective instead of looking at what can be done to support them if there are no family close to them'*

It is evident, with hindsight, that had there been coordinated case management support from Oranga Tamariki (MVCOT) and Starship Hospital to help Moko's mother find safe care with whanau or other caregivers in Auckland, life for Moko and his sister could have been very different. I recognise that both these agencies have since reviewed their practice in relation to the circumstances for Moko's mother and appreciate that they will have learned from these insights.

One of the options that could have been initiated by either or both of these agencies was to convene a hui-a-whanau. Hui-a-whanau provide an opportunity for whānau to come together and become informed about needs, risks and worries for their Tamariki. They can then create their own plan to solve the outstanding issues, with support from the agencies involved, as needed. A hui-a-whanau could have considered Nicola Dally-Paki's housing issues and developed a safe care plan for Moko and Nathalia until adequate housing in Auckland could be found. The paternal grandmother would have been able to make her offer of care in that context, any legal matters acting as barriers could have been addressed, appropriate support and safety measures could have been put in place, and the children's care could have been monitored as necessary.

A hui-a-whanaui is not in itself a statutory intervention, that is, it is not a formal Family Group Conference. Rather, hui-a-whanau provide an informal intervention that can be set up quickly, to inform whanau, help them overcome any raruraru (conflict) and support them to work together to find their own solutions. Of course, if serious risks to children become evident during a hui-a-whanau and cannot be managed safely within the whanau, Oranga Tamariki retains the statutory obligation to intervene as necessary.

I have been encouraged to hear that Oranga Tamariki is now implementing hui-a-whanau as a national best practice approach.

[ 11.2 ] *Agencies and workers in Taupo – recognising risk for children*

Tania Shailer used a range of skilful strategies to hide what was really happening to Moko at home. However, she also 'dropped' worrying comments into her conversations with all the community agencies she was involved with. These comments would have prompted most experienced family violence and child protection practitioners to ask more questions and begin to consider initiating an assessment of Tania's stress and anger and/or an inquiry into Moko's wellbeing. I understand that these comments included telling workers about her depression getting worse, that she was feeling very stressed, that she was not managing the two extra children and that she had serious problems managing Moko's behaviour.

In the field of family violence, there is substantial evidence that people seldom disclose the detail and intensity of violence or abuse, whether in relation to themselves or others, including to children, without being directly asked by a worker who is skilled in carrying out family violence screening. They may test things out by disclosing something small and then wait to see what happens and how their worker responds. If they continue to feel safe, they may disclose more of what is happening over time.

Working safely and effectively in this arena requires workers to be fully alert to indicators of potential serious risk to children. In turn, they need to be fully supported by their agency managers and supervisors always to stay child-centred and to consult with Oranga Tamariki about any child they suspect could be at risk of harm. Under the Vulnerable Children's Act 2014, and as agencies contracted and funded by Oranga Tamariki (previously Community Investment), all agencies are required to have a child protection and reporting policy. This policy provides guidance on when to make a report of concern to Oranga Tamariki. However, such policies are only effective if workers have the experience, knowledge and skills required to assess and act on signs of risk.

## C. Strategies to improve services for vulnerable children since 2015

[ 12 ] Since Moko's death in 2015, two major pieces of child protection legislation and their associated work programmes have been established. They are now in various stages of implementation. I expect that Oranga Tamariki will provide you with detailed information on these developments.

From my perspective, the key developments have been:

1. the Oranga Tamariki (previously Child, Youth and Family) transformation programme taking place in the context of changes to the Children, Young Persons and their Families Act 1989, now the Oranga Tamariki Act 2017. See [12.1], following.
2. the Vulnerable Children's Plan, with the first plan still being developed in the context of the Vulnerable Children's Act 2014. See [12.2], following.

[ 12.1 ] *Oranga Tamariki:*

There is a substantial programme of organisational, practice and service delivery system change being designed now within Oranga Tamariki. These changes are an integral part of the major programme of service transformation which arose from the recommendations of the Expert Advisory Panel on the Modernisation of Child, Youth and Family, chaired by Dame Paula Rebstock.

It is still in the early days of implementation and the size of the change programme means it will take place over 3-5 years, not months. However, I have cautious optimism and confidence that if all aspects of the proposed changes are well-designed, fully implemented and properly resourced, Oranga Tamariki will become much better positioned to carry out its child protection mandate in timely, effective, child centred and whanau-inclusive ways.

The fundamental shift for Oranga Tamariki is to become fully 'child-centred'. This will involve sighting children and listening to their experience. It will mean working closely with families and whanau, demonstrating a commitment to bring together extended family and wider whanau to address risks and worries and to find solutions for the challenges children and caregivers face. A new child-centred practice framework, currently under development, will be the platform from which new child-centred service approaches will be developed and implemented. Cultural approaches, including hui-a-whanau, will be integral to statutory practice going forward.

[ 12.2 ] *Vulnerable Children's Act:*

The Vulnerable Children's Act 2014 was designed to ensure services for children and families are child-centred, safe, responsive and joined-up. Achievements so far include:

- all agencies working with children are now required to have child protection policies and reporting systems in place to recognise and report child abuse and neglect
- mandatory safety checking has been introduced across the government-funded children's workforce to provide standardised pre-employment screening
- local multi-disciplinary Children's Teams have been established to work together and share responsibility to better achieve results for vulnerable children. To date, teams have been rolled out in Rotorua, Whangarei, Otaki/Horowhenua, Marlborough, Hamilton, Tairawhiti, Eastern Bay of Plenty, Whanganui, Christchurch and Clendon/Manurewa/Papakura. However, the process has stalled. There are important questions as to their future.
- an Approved Information Sharing Agreement (AISA) is in place to support better information sharing amongst the key agencies involved in the Children's Action Plan
- a draft core competency framework has been developed to support the children's workforce with a shared set of skills, values and knowledge.

[ 13 ] The aspects of this legislation that appear to me to be the most vitally important to prevent deaths such as Moko's and Nia's in the future, are the two final items on the list above:

[ 13.1 ] development of the information sharing agreement which I understand has now been completed and implemented as a key requirement for the effectiveness of the Children's Teams and

[ 13.2 ] development of a core competency framework and establishment of a shared set of skills, values and knowledge across the children's workforce. This framework has been drafted and consulted on across a wide range of social sector agencies, however regrettably it has not yet been implemented.

## D. Actions that might prevent further children dying as a result of child abuse in similar circumstances

[ 14 ] Within the context outlined under heading C. before, and given that some significant change is already underway in the vulnerable children's sector and within Oranga Tamariki, I have two suggestions to make in this section. These both address areas for development that are not currently being actioned:

[ 14.1 ] I would like to see work on the confirmation of a core competency framework (see para [ 13.2 ], before) and the establishment of a shared set of skills, values and knowledge

across the children's workforce be given high priority. A competency assessment programme must be urgently and comprehensively implemented across the vulnerable children's workforce. By way of example, see para [ 16 ], following.

[ 14.2 ] An understanding of the impacts on children, families and whanau of inequality, social isolation and child poverty, must become an integral part of this competency programme. See para [ 17 ], following.

[ 15 ] In this final section of my evidence brief, I would like to provide some addditonal information to support the two suggestions I have made above.

[ 16 ] *Progressing the implementation of a core competency framework*

[ 16.1 ] In preparing this brief of evidence, I consulted Hawke's Bay paediatrician, Dr Russell Wills, my immediate predecessor in the role of Children's Commissioner. I have asked him about the workforce competencies he believes will have the greatest impact on outcomes for vulnerable families.

[ 16.2 ] I am aware that Dr Wills was closely involved in the drafting of the competency framework during his time as Commissioner. He has been very explicit in his view: the key to effective prevention and intervention in family situations where there are serious risks of child abuse and neglect, is to ensure that that 'front line practitioners have advanced skills in engaging those families and whanau who find engaging with us difficult'.

[ 16.3 ] This is based on the premise that, typically, these adults carry high levels of trauma from their own childhoods, mental illness, addictions and current or historic family violence. A child-monitoring approach by practitioners where there is no established ongoing relationship of trust with families is not supported by the evidence as an effective intervention. On that basis, it is unlikely to lead to behaviour change or improved outcomes for children.

[ 16.4 ] However, there is a growing evidence base on 'what works' with such families. Trauma-informed practice includes de-escalation and rapport building skills and can be formally taught, or learned in the field. The Meihana (hui) Model is part of the curriculum for

medical students at Otago University and has been shown to improve the ability of non-Māori students to communicate effectively with Māori whānau. The Family Partnerships Model developed by Hilton Davis has also been shown in large trials across different disciplines to improve clinical outcomes for patients with chronic illness. This model was brought to New Zealand by Plunket, who have extensive experience of its application through their Tamariki Ora programme delivered across a range of New Zealand communities.

[ 16.5 ] Experienced social work, nursing, medicine, education, allied health, family violence prevention and family support practitioners working with vulnerable families commonly report needing additional skills they did not learn during their professional study. This includes how to work effectively with Māori (for non-Māori), assessment of mental health, addictions, child abuse and family violence, clarity on the law on information sharing when children are at risk and assessment of children exposed to adversity.

[ 16.6 ] In Hawke's Bay, the District Health Board's Ngatahi Programme has begun mapping these skills with four hundred and fifty practitioners in health, education and social services across the region. This is happening in the context of an agreed version of the Vulnerable Children's draft core competency framework. Dr Wills is responsible for this project and reports that they expect to complete mapping of the identified development needs of these staff by the end of September and to have an analysis of findings completed by early November. He anticipates sharing these results with professional registration bodies and undergraduate training institutions late in the year. The next step in this plan is to develop a cross-sector training programme based on the identified training needs of the Hawke's Bay children's workforce, for delivery in 2018 and 2019.

The programme will be independently evaluated by experienced researchers and will be published. Dr Wills would be happy to provide further information on this project for the Coroner if requested.

[ 16.7 ] I believe that we must substantially improve knowledge and skills across the whole Vulnerable Children's workforce. We must ensure there is effective engagement with all families and whānau and that key indicators or clues relevant to children's safety are not missed. A deliberate and sufficiently resourced initiative such as that currently being implemented in Hawke's Bay should be implemented on a national basis. This was what was originally envisaged in the Children's Action Plan in 2014.

[ 16.8 ] The Expert Advisory Panel on the Modernisation of Child, Youth and Family, in Recommendation 36 of their Final Report published in December 2015, recommended that there be:

> 'an explicit focus on early identification of those families with children most at risk of poor life outcomes and the mitigation of early risk factors contributing to child vulnerability, such as family violence. The panel suggested that this would include:
>
> - Supporting adults to get the help they need to be able to provide safe and loving care for their child/ren
> - A workforce that is equipped to understand the dynamics of, and effective responses to, family violence.

*[ 17 ] Understanding the impacts of inequality, social isolation and child poverty*

My considered view is that to prevent other children dying at the hands of their caregivers in the way Moko and Nia died, it is necessary for the agencies and workers who make up the Vulnerable Children's Workforce to better understand the complex situation of disadvantage which shapes the lives of our most chaotic and isolated families.

[ 17.1 ] To reach out to families and whanau successfully, workers need to take the time to understand the world-view of those they work with, including their histories, worries, daily realities, cultural perspectives, fears and hopes. Only by gathering these insights and working alongside hapu and iwi, neighbourhoods and communities to ensure these insights inform and shape service delivery and professional practice, are we likely to make the kinds of lasting break-throughs that are needed to deliver safe effective services for disadvantaged families and whanau and their children.

[ 17.2 ] To quote Rotorua paediatrician, Dr Johann Morreau, in his Ted Talk in Tauranga in August 2016:

> 'There's an elephant in the room… Financial poverty, poverty of parenting and poverty of spirit and hope, all have lifelong implications for the wellbeing of children'.

[ 17.3 ] New Zealand has 1,123,000 children. That is 23% of the population. Looking generally at our New Zealand children overall:

- 70% of New Zealand children (the majority) are doing well. They are living healthy, productive lives and achieving good outcomes.
- 20% (the next group) face one or more challenges and are struggling. They need additional supports to enable them to have better outcomes.
- 10% are children and young people facing multiple and complex challenges. No one intervention will be adequate, and they will likely need significant support for themselves and their family over a period of time. From everything we understand about Moko and Nia's whanau, they would have fallen into this group. This cohort of 10% of children are the same group that Dr Morreau is most worried about. They do as badly, if not worse, than the same group in most western world countries.

[ 17.4 ] It is clear from the evidence on child poverty in New Zealand and from international data on the impacts of economic and social inequality (Wilkinson and Pickett, The Spirit Level, 2009) that the economic, health and social challenges faced by this most disadvantaged group of children and their families impacts them by, for example:

- Infant mortality
- Homicides
- Imprisonment
- Mental illness
- Suicide
- Hospitalisation of children from abuse and neglect

[ 17.5 ] As professionals, organisations and communities, we have a clear responsibility to reach out to this group of children, their families and whānau, to offer our help and support in ways that enable them to engage positively with us. But New Zealand also has a national responsibility at governmental level, to address the structural and systemic factors that are producing this serious inequality. I have been heartened during the recent election campaign to hear political leaders voicing their commitment to addressing the levels of inequality that create child poverty.

[17.6] As we consider the critical impacts of material deprivation, inequality and social isolation in escalating risk for the safety, health and wellbeing of children and families, it is important to understand the heightened impact for tamariki Māori and whānau. This has particular significance here, given that both Moko and Nia are tamariki Māori. Fundamental to any real systemic change is addressing the current significant disproportionality of adverse outcomes for Māori children.

[ 17.7 ] I was a member of the New Zealand delegation that went to Geneva in 2016 to present New Zealand's submission to the United Nations' Committee on the Rights of the Child.

A key message in our submission was that:

> 'Targeting the root causes of inequity and improving outcomes for Māori children across the board will transform the New Zealand landscape for children and come closer to achieving the full implementation of the United Nations Convention on the Rights of the Child'

[ 17.8 ] The following figures make this picture stark. When we compare New Zealand data on the comparative health and living standards of tamariki Māori and New Zealand European children, the figures become even more worrying. For example:

| Measure | Māori | NZ European |
|---|---|---|
| Sudden Unexpected Death in Infants (SUDI) (per 1,000 deaths. 2010-2012) | 1.8 | 0.4 |
| Meningococcal infection (per 100,000. 2013) | <1 year: 32.3<br>1-4 years: 15.7 | <1 year: 18.4<br>1-4 years: 5.2 |
| Child poverty (0-17years, below 60% median household income, after housing costs, 2014) | 33% | 16% |
| Child material hardship (0-17years , 2014) | 24% | 8% |
| Children in crowded housing (2014) | 25% | 5% |
| Youth justice: (number and percentage of children aged 10-16 charged in court, 2014/15) | 1,152<br>(59%) | 489<br>(24%) |

* Appendix 1:
Comparison of selected measures of wellbeing between Māori and New Zealand European (full table).

## E. Mandatory Assessment of every child born in New Zealand?

[ 18 ] The question of mandatory assessment of every child born in New Zealand raises significant issues. One of these issues is the expense involved with the majority of children who will be found not to be at risk. Previous Children's Commissioners, each in different ways, have all proposed that there should be a programme of assessment and monitoring for at least the most vulnerable of our children. For example, in 2006, Cindy Kiro (Children's Commissioner from

2003 to 2008) proposed an integrated framework for children and families, including a centralised information hub where information from child assessments would be stored in one system. This was known as Te Ara Tukutuku Whanaungatanga o nga Tamariki – Weaving Pathways to Wellbeing Framework.

[ 19 ] There are, however, a number of existing mechanisms that ought to assist in achieving this same end. One would be extending the geographical coverage of Children's Teams. As I understand it, the Children's Team initiative is only rolled out to cover 2,000 children, out of the predicted population of 20,000 significantly at risk children. This initiative now appears to have stalled. Another is the Well Child Tamariki Ora programme. Our opportunity with Well Child is to extend the programme's reach by 8% - from 92% to 100% of our children - and to deepen the assessment beyond health to address social needs.

[ 20 ] There are also a number of local initiatives specifically designed to reach the 8% of children and families that are not yet receiving Well Child Tamariki Ora oversight and support. These include Family Help Trust in Christchurch and the 'One Thousand Days Trust' in Invercargill.

## F. Conclusion

[ 21 ] Moko's abhorrent death was preventable. Obvious questions arise from the circumstances of his death, and some clear lessons should be learnt.

[ 21.1 ] There were sufficient "eyes" and "ears" into Moko's circumstances and care at various stages. Yet the "eyes" did not see, and the "ears" did not hear, nor did they trigger proper investigation about his real condition and risks. I do not intend to attribute blame or make any personal criticisms. However, it seems fair to say that if Oranga Tamariki and/or Starship Hospital had taken a different and more proactive approach to the issue of finding safe care for Moko and his sister in Auckland, the situation for Moko could have been very different – see para [ 11.1 ], before.
Similarly, in Taupo, at least three organisations – which I understand from the evidence to be The Māori Women's Refuge, REAP which held the Family Start contract, and Family Works – either missed, misinterpreted, or minimised warning signals, or what might be called "red flags", which should have prompted further investigation. See paras [ 8.2 ] and [ 11.2 ], before.
I also understand from the evidence that Oranga Tamariki in Taupo failed to comply with

its own seven day timeframe for a home visit following the filing of a Report of Concern on 30th July 2015.

[ 21.2 ] All those involved in working with children and family need to have appropriate skills and professional expertise to ensure that warning signs are not missed, minimised or misinterpreted.

[ 21.3 ] Children do not have a voice themselves to identify or expose their abuse. All those working with children need appropriate training and professional development to recognise risks, potential warning signs and the need for skilled interaction with adult care givers, otherwise we will not be acting in child centred or child focused ways.

[ 21.4 ] An important part of training is to ensure collaboration between organisations working with children in risky environments.

[ 21.5 ] A national register of every child born in New Zealand, including a centralised information hub. has been suggested many times in recent years. The idea appears to have gained no traction and has generated little national debate. Existing initiatives and programmes, if better resourced and developed, might achieve the same result.

[ 22 ] In closing, I hope this evidence brief adds value to your deliberations. I look forward to appearing at the inquest in person on Tuesday 3rd October at 2:15pm and welcome this opportunity to discuss opportunities and solutions for keeping our most vulnerable children safe.

Nga mihi

Judge Andrew Becroft
Children's Commissioner

Date: 3 October 2017

**Appendix 1**

## Comparison of selected measures of wellbeing between Māori and New Zealand European

Targeting the root causes of inequity and improving outcomes for Māori children across the board will transform the New Zealand landscape for children and come closer to achieving the full implementation of the United Nations Convention on the Rights of the Child.

| Measure | Māori | NZ European (unless specified as non-Māori or total NZ population) |
|---|---|---|
| **EDUCATION** | | |
| 18 year olds with NCEA L2 or above (2014) | 67.1% | 85.1% |
| Children in State care with National Certificate of Education Achievement Level2 or above | 15% | 25% |
| Early Childhood Education participation | 92.3% | 98.2% |
| **HEALTH** | | |
| Current smokers (aged 15 above, 2013-2014) | 40.6% | 15.2% |
| Life expectancy at birth | Women: 77.1 years<br>Men: 73 years | Women: 83.9 years<br>Men: 80.3 years |
| Youth suicide (15-24 years) | 48.0 per 100,000 | 17.3 per 100,000 (non-Māori) |
| Meningococcal infection (per 100,000. 2013) | All ages: 3.4<br><1 year: 32.3<br>1-4 years: 15.7 | All ages: 1.5 (total NZ pop.)<br><1 year: 18.4<br>1-4 years: 5.2 |
| Rheumatic fever (all ages, per 100,000. 2012-2014) | 13.3 | 4.2 (non-Māori) |
| Sudden Unexpected Death in Infants (SUDI) (per 1,000 deaths. 2010-2012) | 1.8 | 0.4 (non-Māori) |
| **LIVING STANDARDS** | | |
| Child poverty (0-17years, below 60% median household income, after housing costs, 2014) | 33% | 16% |
| Child material hardship (0-17years , 2014) | 24% | 8% |
| Children in crowded housing (2014) | 25% | 5% |
| Unemployment (all ages, 2014) | 12.1% | 4.4% |
| Not in Education, Employment or training (NEET) rate (15-24 years, 2015) | 20.9% | 9.4% |
| Youth justice: (number and percentage of children aged 10-16 charged in court, 2014/15) | 1,152 (59%) | 489 (24%) |