Ombudsman
Fairness for all

Case note

Treatment of disabled mother and removal of newborn child

Legislation	Ombudsmen Act 1975, ss 13, 22
Agency	Oranga Tamariki – Ministry for Children
Ombudsman	Chief Ombudsman Peter Boshier
Case number(s)	506720
Date	July 2020

Complaint about removal of newborn child—Treatment of disabled mother and generalisation of disability— Complaint handling and review inadequate—Chief Ombudsman recommends apology, ex gratia *payment and policy review.*

Background

In 2014, Child, Youth and Family, then part of the Ministry of Social Development (the Ministry)[1] removed a five-day-old child from their autistic mother, while she remained in hospital following a caesarean section delivery. This occurred without notice, after the Ministry obtained a section 78 interim custody order from the Family Court.

A section 78 interim custody order gives the Ministry immediate custody of a child, pending decisions about the child's permanent care. It is intended to be used only in the most urgent and exceptional cases, when no other option is available to ensure the child's safety. 'Without notice' means the mother wasn't aware the section 78 application was being made.

The Ministry had become involved with the mother due to concerns that she would be unable to safely parent her child. The child was placed with a caregiver and ultimately entered a Home for Life arrangement.

In 2015 the mother made a complaint to the Ministry, believing that she was being discriminated against due to disability. The Ministry did not uphold this complaint.

[1] From April 2017 this became a separate department: Oranga Tamariki – Ministry for Children

She and the child's grandmother (the Complainants) made further complaints to the Ministry. They believed that there had been no attempt to understand the mother and the nature of her disability, that Ministry staff had predetermined that the child should be permanently removed, and ultimately that there had been no opportunity for the mother to show that she could parent her child.

A complaint was made to the Ombudsman, which was initially resolved when the Ministry agreed to complete a review of the Complainants' concerns (the Review). The 2019 Review considered the Complainants' concerns about:

- the Ministry's response to the original complaint about discrimination;
- The treatment of the mother as a disabled person;
- Whether there had been an opportunity for the mother to show that she could parent;
- Whether there was a pre-determined intention to permanently remove the child;
- Whether hospital staff had been unjustly placed on 'high alert' by the Ministry;
- Comments made by the social worker to the psychologist who was preparing a report for the Court;
- Failure to identify or provide services that could mitigate some of the Ministry's concerns; and
- The way the mother's childhood history with Child, Youth and Family (CYF) was portrayed throughout the file, and in the Ministry's handling of the complaints.

The Review concluded that these concerns were not substantiated.

The Complainants subsequently made another complaint to the Ombudsman regarding the conduct of the Review and the conclusions that it had reached.

Investigation

The Chief Ombudsman notified the Ministry of his intention to investigate the complaint. The investigation considered the findings of the Review, including whether it had been undertaken properly and the conclusions were sound.

The Chief Ombudsman reviewed the file of the mother and child, including the Review and the outcomes of the earlier complaints.

Response to the 2015 complaint

The Chief Ombudsman found that the response to the 2015 complaint did not appear to take the mother's concerns seriously. The response to the complaint concluded that the Ministry had made appropriate decisions, but it did not explain why. The outcome letter said that the mother had been given the opportunity to learn skills and show that she could parent the child,

however it was not clear what these opportunities were. It also did not address the mother's concerns about how she had been treated as a disabled person.

Conduct of the 2019 Review

In considering the 2019 Review, the Chief Ombudsman considered the actions of the Ministry at the time of removal of the child. This was relevant to assessing the reasonableness of the conclusions in the 2019 Review.

The treatment of the mother as a disabled person

The Chief Ombudsman considered the Ministry did not seek to understand the mother's disability, including her strengths as a parent. No current information was sought in order to understand and plan for any possible issues. Her disability was generalised and treated only as a negative aspect of her parenting ability. She was described inappropriately throughout the file as being 'low level functioning' and 'limited'. If she disagreed with the social worker, it was described as a 'lack of insight'.

The Ministry's guidance states that disability services, support, and education are important for success, and that all individuals need to be assessed carefully and individually. The guidance also states that intellectual disability alone is a poor indicator for risk of abuse and neglect. However, the social worker did not obtain any information from the mother (or others) about her disability, so could not plan for or support the mother.

The Chief Ombudsman considered the Ministry had not met its obligations under the United Nations Convention on the Rights of Disabled Persons (the Disability Convention), in particular the rights of disabled people to create and maintain families (Article 23); the right to health care and supported decision-making (Article 25); and the right to be treated with dignity and equality (Articles 3 and 5).

Whether there had been an opportunity for the mother to show that she could parent her child

The Review stated that the mother had been given 'every opportunity at the hospital to show that she could learn parenting skills and bond with her baby'. The Chief Ombudsman determined it was not fair for the Ministry to say this. The mother spent only five days with her child, all within a hospital setting. Further, the file failed to show that the Ministry did any planning to help give the mother an opportunity to parent.

Whether there was a pre-determined intention to permanently remove the child

A document when the child was two weeks old referred to a permanency goal of 'home for life', that is a permanent placement not with the birth parents. The Complainants had raised this with the Ministry many times, as it seemed to be a very early decision to remove the child permanently.

The Chief Ombudsman considered the Ministry had failed to address these concerns. Although the document did exist, the Ministry had not spoken to the Complainants to seek clarity on the source of their concern, and instead continued to deny that such an early intention had been formed.

Whether hospital staff were unjustly placed on 'high alert' by the Ministry

The Complainants were concerned that hospital had been warned in advance of concerns about the mother, and were therefore hyper-vigilant in their observations and criticisms of her.

The Chief Ombudsman considered the Ministry had informed hospital staff of their concerns about the mother in a way that focussed only on the risks associated with her disability. It did not include any information about ways that hospital staff could have assisted her. More specific and useful information should have been provided to the hospital.

Comments made by the social worker to the psychologist

During proceedings, the Family Court had asked for a psychologist's report under section 178 of the Oranga Tamariki Act 1989. This was completed, and the Complainants raised concerns about its content, including comments made to the psychologist by the social worker.

The Chief Ombudsman explained that he was unable to consider the psychologist's report, and what they chose to include in it, as the psychologist was a private professional not subject to an Ombudsman's jurisdiction. The social worker's comments, focussing only on negative aspects of her behaviour, were however considered by the Chief Ombudsman in terms of the treatment of the mother as a disabled person (as discussed above).

Failure to identify or provide services to the mother

The psychologist's report referred to a lack of support services in the region, and the mother's need for 'intensive supports.' The Chief Ombudsman found the Ministry relied on this statement, without properly investigating whether there were services available to help the mother. The Complainants had reported a number of options available, including supported living and specific disability support.

Focus on the mother's childhood

The mother had been involved with Child, Youth and Family (CYF) as a young person. The Complainants were concerned about how heavily this history featured in the Ministry's reports, including when they were assessing and responding to the complaints.

The Chief Ombudsman considered that there had been an unreasonable focus on the mother's childhood history, without explaining what had taken place in the years following the mother leaving CYF care. While some of the background may have been relevant, it was not balanced by an accurate reflection of the circumstances as they were at the time of the child's birth.

However, the Chief Ombudsman did note that when the Ministry was considering whether there were care and protection concerns for the child, the mother's history did not seem to have been given undue weight.

Outcome of the 2019 Review

Because of the above conclusions, the Chief Ombudsman considered that the 2019 Review had been carried out unreasonably. In addition to disagreeing with its conclusions, the Chief Ombudsman noted that the reviewer should have met with the Complainants. The level of engagement between the reviewer and the Complainants appeared to be inadequate, given that a number of concerns had not been clarified or fully addressed.

Outcome

The Chief Ombudsman formed the opinion the Ministry had acted unreasonably in its treatment of the child's mother. This included the lack of action during and after pregnancy to identify available supports, communication with hospital staff, failure to understand the mother's strengths as a disabled person and the nature of her disability, and the early decision for a permanent 'home for life' placement.

The Chief Ombudsman also formed the opinion the Ministry had unreasonably failed to address the concerns of the Complainants, which had been raised as early as 2014.

Changes that had occurred since the child's removal

Since the time of the child's removal, practice at the Ministry has changed, particularly following the Hawke's Bay Practice Review. These changes include:

- An expectation that all section 78 custody applications are to be made 'on notice' unless there is a clear need for action in order to protect a child from immediate and imminent danger. If a 'without notice' section 78 application is to be made, that application must have additional checks completed by a Regional Legal Manager, Site Manager, and Practice Leader.
- Practice Leaders at each site review all reports of concern for unborn and new-born babies.
- A new Service Broker role has been established to improve services across the regions. More Regional Disability Advisors have also been employed. When working with disabled parents, sites are encouraged to:
    - Contact their Regional Disability Advisor;
    - Engage with the wider sector, including the Needs Assessment and Service Coordination Services; and
    - Engage with the site lawyer if a court process is going to involve disabled parents.

Recommendations

Taking these changes and the circumstances of the Complainants into account, the Chief Ombudsman recommended the Ministry:

- Scope a review of its practices and policies around involvement with disabled parents, to then be agreed upon with the Chief Ombudsman. The review is to be conducted with the involvement of disabled people-led organisations, in accordance with the Disability Convention;
- Apologise to the Complainants;
- Make an ex gratia payment to the Complainants, noting that it is now impossible to be certain that the mother was unable to parent the child, and that the passage of time and subsequent Court decisions meant that there is no prospect of return of the child.

The Ministry accepted these recommendations, and following the Chief Ombudsman's report, made contact with his staff to begin implementing the recommendations.

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