Ombudsman
Fairness for all

Case note

Unreasonable actions throughout dealings with custodial caregiver

Legislation	Ombudsmen Act 1975
Agency	Ministry for Children – Oranga Tamariki
Ombudsman	Peter Boshier
Case number(s)	511281
Date	April 2021

Use of incorrect, unverified information—failure to perform due diligence before removing mokopuna from grandmother—inadequate review of case, and inadequate response to review—failure to work with complainant in a way that met her needs as wāhine Māori

Summary

The complainant, the custodial caregiver of her mokopuna, complained to the Chief Ombudsman about Oranga Tamariki—Ministry for Children (the Ministry). The complaint concerned the Ministry's removal of te tamaiti from her care, and the Ministry's actions after reviewing her case.

The Chief Ombudsman investigated the complainant's concerns, and also investigated whether the Ministry had failed to work with her in a manner consistent with her values and needs as wāhine Māori.

The Chief Ombudsman found that the Ministry had acted unreasonably throughout its dealings with the complainant.

The Ministry's unreasonable actions included: using incorrect and unverified information about the complainant; failing to perform due diligence before removing her mokopuna; the Ministry's review of the case failing to cover the wide-ranging issues that the complainant raised; and the Ministry failing to implement the review's recommendations fairly.

The Chief Ombudsman's recommendations included that the Ministry make an adequate apology to the complainant, pay for additional counselling for her, and improve its guidance for staff on working in a trauma-informed manner. The Ministry accepted all recommendations.

Background

The complainant had been granted custody of her mokopuna five years earlier, and had been te tamaiti's full-time primary caregiver for the past year. Members of another whānau were living in her home, and the Ministry was engaged with social work for the tamariki of this whānau.

Following a social work visit concerning these tamariki, the Ministry uplifted the complainant's mokopuna under a section 39 Place of Safety Warrant. A week later, the Ministry applied for a section 78 without notice removal order, and te tamaiti was placed in the full-time care of their father.

From then on, the complainant was allowed only supervised access with her mokopuna. Another family member applied to be caregiver so they could act as supervisor. This application took more than six months to be approved and communicated to the complainant, and this delay had detrimental effects on her and her mokopuna.

On the complainant's request, the case was reviewed by the Ministry's Chief Executive's Panel (the Panel). She felt the Panel did not address all her concerns, including her request for compensation, and that the apology she received was inadequate. She then complained to the Ombudsman.

Investigation

The Chief Ombudsman investigated whether the Ministry had acted unreasonably in the following respects:

a. A lack of due diligence when seeking the Place of Safety Warrant and without notice order, and failure to acknowledge this in the apologies made after the Panel's review.

b. The scope of the Panel's review, and failure of the Panel to address the complainant's request for compensation.

c. Inadequate apologies by both the Chief Executive of Oranga Tamariki and the Regional Manager.

d. Disparity in the treatment of the complainant and the father of te tamaiti.

e. The requirement for the complainant to be supervised during access with te tamaiti, and failure to reassess this requirement in a timely manner.

f. Failure to provide for contact between the complainant and her mokopuna after te tamaiti was placed with their father.

g. Failure to address the complainant's concerns in a manner consistent with her values and preferences as a wāhine Māori.

Lack of due diligence

The Chief Ombudsman formed the opinion that there was a lack of due diligence before the Ministry applied to the Court for the Place of Safety Warrant.

The Ministry raised a wide range of concerns in its application, and stated the warrant was needed so it could investigate these concerns. They included:

- concerns about the mental health of members of the other whānau living with the complainant;
- concerns that these whānau members were displaying inappropriate sexualised behaviour and providing cannabis to the tamariki living in the home;
- that there was a 'cultish' belief system being promoted in the home;
- that the complainant's mokopuna was being prevented from attending school;
- that the local iwi service refused to work with the complainant or her whānau; and
- that at two visits to the home the adults were seen drinking alcohol.

One week later, the Ministry's application for a without notice removal order repeated these concerns. It also referred to:

- alleged erratic and violent behaviour of members of the other whānau in the home;
- isolation of te tamaiti from socialisation and education;
- te tamaiti being fed only one meal a day; and
- the refusal of the complainant to speak with Ministry staff.

Lack of evidence or verification

The Chief Ombudsman found that neither of the Ministry's applications to Court provided verification of concerns for te tamaiti's safety. It appeared as if the application to remove te tamaiti was based on social work for the other tamariki residing in the home, and a series of unverified allegations about the complainant.

He found that the Ministry's case consult focused on placement outside the complainant's care, despite its concerns not having been verified. There was no evidence that staff discussed what might change if the whānau they were concerned about moved out of the complainant's home.

There was no record of a conversation with the complainant to discuss the Ministry's concerns, and no record of contact with te tamaiti's school or the local iwi service about the claims made in the applications.

In its application for a removal without notice order, the Ministry stated that it '*cannot be ascertained whether [the complainant] is able to act protectively and safely in [te tamaiti's] best interests*'. The Chief Ombudsman found this statement very concerning, considering the

lack of engagement with the complainant, school, or local iwi service. A without notice removal should only occur as a last resort. The Chief Ombudsman found the rationale behind the application was insufficient.

Lack of contact with the complainant

The social worker noted that there had been a plan to call the complainant after the Place of Safety warrant was executed. However, time did not permit this, and the complainant did not contact the Ministry either. It appears the Ministry used this as a rationale to make no further attempt to contact the complainant. This was then recorded as her lack of engagement with social workers.

The only record of engagement with the complainant concerned a meeting that took place on the day the without notice removal order was granted. This record shows the complainant, a whānau member, and a social worker from the local iwi service sought a meeting with Ministry staff.

It is unclear whether anything was discussed in depth at this meeting, whether the complainant had the opportunity to respond to the concerns that had led to the application for a without notice removal order, or whether the meeting was factored into the application. On top of this, the meeting record in CYRAS (Oranga Tamariki's case management system) was backdated by four months.

Lack of contact with te tamaiti's school

Te tamaiti's school was not contacted before the Ministry applied for a Place of Safety warrant, and the case note of the social worker's eventual contact with them was also backdated by months. Concerns around te tamaiti's school attendance were not substantiated. As noted below, te tamaiti's school attendance did not alter once they were living with their father, but this appeared to be no longer a cause for concern for the Ministry.

Incorrect claims about iwi services

The Ministry stated in both applications that local iwi services refused to work with the complainant. However, the Chief Ombudsman learned that, as set out above, on the day the without notice removal order was granted, a social worker from the local iwi service was with the complainant and was seeking a meeting with Ministry staff.

Evidence of this meeting is included in CYRAS records, albeit backdated by four months. The statement that iwi services were unwilling to work with the complainant was simply not true.

Poor record keeping

The Chief Ombudsman found that the poor record keeping and backdating of case notes entered into CYRAS was unreasonable. It was unreasonable for damaging and unverified allegations to have been repeated throughout the file, to have been relied on in preparing information for court proceedings, and to have never been raised with the complainant. It appeared that simple steps could have been explored to discuss and mitigate the Ministry's concerns.

Chief Executive's Advisory Panel (the Panel)

The complainant was not satisfied with the process or outcome of the Panel's review of her case, and believed it did not fully address her complaints. The Panel's focus was on the removal of te tamaiti, and the final report stated that it did not have scope to look at her complaints about the ongoing social work for te tamaiti.

Considering the Panel is the final point of complaint handling within the Ministry, the Chief Ombudsman would expect the Panel to have looked at the complaints in their entirety, rather than focus solely on the removal.

It is understandable that the Panel cannot assess a person's entire history with the Ministry. However, the Chief Ombudsman considered that this was a missed opportunity to resolve and address the wider and continuing concerns about the social work for te tamaiti.

The complainant wrote to the Panel after its review, outlining the issues that she felt were not resolved, and noting that she felt only two of seven concerns she raised were covered. She received no response. The Chief Ombudsman found this lack of response was unreasonable.

In response to questions about the complainant's request for compensation, the Ministry stated that the complainant was *'unable to demonstrate the need for compensation'*. However, there was no record that compensation was ever explored or discussed with the complainant, and it was not addressed in the Panel's report. The Chief Ombudsman's opinion was that the lack of communication around compensation had been unreasonable.

Ministry's implementation of the Panel's recommendations

The final recommendations of the Panel included:

- Counselling be offered to the complainant and her mokopuna, paid for by the Ministry. The Panel suggested a minimum of three sessions for the complainant, in recognition of the failure to recognise her guardianship rights, which then impacted on her ability to be represented in Court and resulted in significant grief and loss issues;
- The Ministry write to the complainant and invite her to identify and correct the incorrect information held about her on CYRAS. The Panel did not have access to all CYRAS notes, so did not know the detail of all the incorrect information; and
- The complainant receive a letter of apology for the Ministry's failure to follow best practice.

Apology

The Chief Executive wrote to the complainant after the Panel review:

> *I apologise for the distress caused by Child, Youth and Family's[1] failure to follow best practice. This is directly related to complaint management and communications with Child, Youth and Family. I sincerely hope that the*

[1] The agency at the time was called Child, Youth and Family.

> *recommendations in the Panel's report will assist in resolving your complaint and strengthen the communication that you have with your whānau.*

A regional manager then wrote to the complainant:

> *I accept that the Chief Executives Panel has found that your experience with Child, Youth and Family was unsatisfactory for you. I understand that there were opportunities available to have provided you with more information regarding the decision making by Child Youth and Family and that the complaints process could have done more to clarify your concerns. Please accept my sincere apology that your experience was not an example of best practice.*

The Chief Ombudsman considered that these apologies were inadequate, given the complainant's experience with the Ministry. The wording of 'failure to follow best practice' did not fully address the issues the Panel identified, or the harm the complainant felt as a result of the Ministry's involvement.

The Chief Ombudsman found that what the complainant and her mokopuna experienced was considerably more than a 'failure to follow best practice', and had a lasting impact on the complainant's wellbeing. The apology minimised the experiences of both the complainant and her mokopuna, and appears to have negatively impacted the relationship between the complainant and the Ministry.

The Chief Ombudsman suggested an appropriate apology would have:

a. acknowledged the issues identified by the Panel and the harm experienced;

b. set out specific steps that would be taken to rectify the situation;

c. expressed remorse for what occurred, and the impact it has had on the complainant and te tamaiti; and

d. recognised the impact that the complainant's experience with the Ministry and the complaints process has had on her mental health and wellbeing.

The Ministry accepted that they needed to make a better apology to the complainant.

Counselling

A letter from the Ministry's Chief Executive stated that counselling would be available for six months after the letter was dated.

However, the complainant stated that communication about and approval of counselling took a significant amount of time. The Ministry contact person for the counselling had been the subject of several of her complaints, and was not someone she felt comfortable with. The complainant informed the Ministry of this, but no action was taken.

The Chief Ombudsman considered that the complainant's concerns should have been taken into account, and another staff member made the contact person for counselling.

The complainant received 11 counselling sessions before expiry of the six-month period set out in the Chief Executive's letter. The Ministry declined to fund further sessions, despite the delay in counselling starting, and despite the diagnosis the complainant received of complex post-traumatic stress disorder due to her experiences. The Ministry declined to view a letter from a medical professional that recommended the complainant continue to receive counselling to work through the trauma she had experienced.

The Chief Ombudsman formed the opinion that the length of time it took to set up counselling, the discontinuation of counselling, and that the contact person was not changed was unreasonable.

Correction of CYRAS records

One of the Panel's recommendations was that the complainant be given the chance to identify and correct the information held in CYRAS. While she was given the chance to do this by the Ministry, she advised that she felt they were unwilling or unable to continue working with her to correct the information. She was instead asked to go through the paper file herself, and attach post-it notes to the incorrect information.

The complainant indicated that this was an issue for her, as it was overwhelming and difficult for her due to the amount of information and the trauma it triggered when she went through the paperwork. There was no evidence that the Ministry worked with her assist her to correct the record, in a way that reflected her needs.

The Ombudsman was disappointed that this issue had not been dealt with by the Ministry in a way that was responsive to the complainant's mental health needs. He noted that he expects the Ministry to work with all complainants in a trauma-informed way, without assuming that they are able to review a large amount of potentially traumatic and triggering information on their own.

Disparity in treatment of complainant and birth father

The complainant felt there was a disparity in how she was treated compared to the father of te tamaiti, particularly concerning their histories of drug abuse and domestic violence, and te tamaiti's absences from school.

The complainant had been granted custody of te tamaiti by a judge who had full knowledge of her past. Despite this, the Ministry rather suddenly appeared to view the complainant's history as a serious concern to be managed following the removal of te tamaiti, and before unsupervised access could occur.

According to Ministry records, both the father and his partner had a history of violence in their relationships. The complainant raised that the father was charged with an offence shortly after the removal of te tamaiti from her care.

Unverified allegations of the complainant's drug use

One note on CYRAS from a Child and Family consult raised the possibility that the complainant was using intravenous drugs. No further investigation into this issue appears to have occurred.

Recommendations were made for the complainant to attend alcohol and drug counselling, as well as 'remain abstinent' from drugs. The complainant was at times spoken about in notes as if she was currently using intravenous drugs, despite the lack of recorded evidence for this. Social workers did not contact her counsellor, or allow a drug test to be organised.

It was clear from the file that the father also had a history of drug use, yet he was given the opportunity to complete drug screening tests early in the process of deciding to place te tamaiti with him.

It was concerning, if a history of drug use for both parties was a factor in decisions around placement and contact, that the complainant was not given the opportunity by the Ministry to complete testing. The Chief Ombudsman formed the opinion that this was unreasonable.

Alleged isolation of te tamaiti from school

Another of the concerns leading to the removal was alleged isolation of te tamaiti from school. While te tamaiti was in their father's care, they missed a similar amount of school as when they were in the complainant's care. If this was not a concern for the Ministry, the perceived differences in the situations should have been clearly explained to the complainant.

Considering the lack of evidence gathering or recording of evidence in relation to the concerns about the complainant, the Chief Ombudsman noted that he could see why the complainant believed that the Ministry treated the parties differently.

While the Chief Ombudsman did not comment on the appropriateness of the decisions around placement, or the Ministry's interaction with te tamaiti's father, he noted that the complainant perceived a significant discrepancy between her treatment and the father's. These perceptions may not have arisen if the initial concerns about the complainant had been properly investigated. More could have been done to improve the relationship between the complainant and the Ministry, and the omissions in this respect were unreasonable.

The Ministry agreed that more could have been done to access information about the complainant's drug and alcohol counselling, and to undertake drug testing.

Final transition of te tamaiti and contact post-transition

Lack of contact during transition

One of the complainant's concerns was around the lack of contact during the transition to te tamaiti's father's care, and the fact that she had limited contact despite having been the primary caregiver.

There was involvement by other professionals at the time of transition, including a professional with the appropriate knowledge and expertise to inform contact arrangements, and the social worker should have had regard to this.

An email from a psychologist involved in the case recommended a slow transition to the father's home, including school holiday visits, and overnights. While this email was unsolicited, it was sent in the psychologist's professional capacity, and was their professional opinion. This email appeared to have been disregarded by the social worker, who stated in an email to the

complainant that it was her professional opinion that te tamaiti was fine to be transitioned more immediately.

The Ministry disagreed that there were issues with the transition, and referred to two case notes as indicative of planning. These two notes were not evidence that there was ongoing consultation between the social worker and psychologist. One noted that a voicemail was left for the psychologist, and the second related to arranging a new venue for counselling.

The Chief Ombudsman did not form an opinion on whether the social worker made the right decision. However, it was his opinion that CYRAS records should have shown clearly why the social worker disagreed with the psychologist's recommendations for a slow transition.

Access and supervision

One of the complainant's concerns was the length of time it took for a whānau member to be assessed as a caregiver for supervised access, and the time it then took the Ministry inform the complainant of approval.

A request for a caregiver assessment was completed in the month after te tamaiti's removal. The assessment was completed several months later, but was not recorded in CYRAS, and neither the complainant nor her social worker were informed. Overall, the referral, the assessment, and communication of approval to the complainant took six months.

Lack of clarity or consistency about need for supervision

There is considerable lack of clarity in the records about why access had to be supervised, and for how long. In the initial plan, contact was to be supervised for '*as long as the social worker considers necessary*.' An updated section 186 social work report then outlined that contact was important and should continue, but needed to remain supervised until the complainant could provide evidence that she had continued counselling and mental health support, and was abstinent from substances. At that point, the social worker would consider allowing additional or unsupervised contact.

A month later, it was decided that the complainant would have 12 months of supervised access before reassessment. Records show that the complainant then requested a conversation about what she needed to do to work towards unsupervised access, but there was no evidence that this occurred. There are no clear records on what was required of the complainant beyond continued abstinence and ongoing counselling, and while the case notes mention the possibility of a hui-a-whānau to discuss holiday access, there is no record of this occurring.

Later the following year, the whānau member who was approved to supervise access asked the Ministry to change arrangements and allow the complainant to spend time with her mokopuna without supervision. This was arranged, and a contract signed; there was no evidence of any issues, and notes suggested that unsupervised access could possibly be extended.

Despite this, it is repeated throughout planning documents that there is '*still a concern that the complainant will undermine their mokopuna's placement with their father'*. Later in the file, another plan seemed to indicate that there was no chance of the complainant having unsupervised access, stating that this would put te tamaiti at risk of being exposed to drug

taking, social isolation, physical and verbal abuse, grooming, and submission to group leaders. This plan referred again to the unproven allegations against the complainant, including some concerns that appeared entirely without basis.

No opportunity for complainant to demonstrate abstinence

Although abstinence was a requirement for unsupervised access, the Ministry failed to undertake drug testing, preventing the complainant from demonstrating that she was not abusing substances. She reported attending ongoing counselling, and attending alcohol and drug groups. Ministry staff did not follow up on this information, nor make any attempt to speak to the complainant's counsellor, until 18 months after the initial removal.

It was unclear why the complainant remained on supervised access for a lengthy period of time. It was noted in a final report that the complainant had addressed the concerns around her substance use and was attending counselling. However, this appeared to have been the case the entire time. This calls into question the reasoning behind the need for supervised access at all.

The Chief Ombudsman formed the opinion that it was unreasonable that the complainant was kept on supervised access without clear communication with them or their wider whānau, without the complainant being given the opportunity to show via a drug test that she was abstinent, and without taking into consideration te tamaiti's view that they wanted one on one time with their grandparent.

Cultural consideration of complaint handling

The complainant had requested a hui kanohi ki te kanohi with those involved at a site level to discuss what had occurred. This was raised with the Ministry on two occasions as a means of resolving this complaint. The Ministry would not participate, and queried the usefulness of such an approach. When the complainant raised that an in person meeting would be their preference, she received this response:

> *'You received a letter of apology from the Chief Executive regarding the issues you raised about the failure of staff to follow best practice. As this has already been acknowledged and addressed I will not involve any remaining staff in a meeting with you'.*

It was explained in the response to the Chief Ombudsman's provisional opinion that this was due to key staff no longer working for the Ministry. However, it could have been an important step in resolving the complaint and the Chief Ombudsman found it was unreasonable that Ministry staff were unwilling to meet with the complainant.

When asked what cultural considerations were undertaken when working with the complainant, the response received stated it was an 'ongoing issue' for the complainant. The Chief Ombudsman emphasised that it was not an 'ongoing issue' for the complainant, but an issue for the Ministry to address.

Outcome

It was the Chief Ombudsman's opinion that the Ministry acted unreasonably, in:

a. The lack of due diligence in seeking the section 39 Place of Safety warrant, and subsequent section 78 without notice removal order, including reliance on unproven information, reference to incorrect information, and the provision of this information to the court;

b. The lack of record-keeping and back-dated recording of meetings and conversations;

c. Failure of the Panel to respond to the request for compensation;

d. Handling of the Panel's recommendation of counselling;

e. The adequacy of the apologies made to the complainant;

f. The apparent discrepancy in treatment of different parties, and failure to explain differences in approach to the complainant;

g. The transition of te tamaiti and access arrangements after this; and

h. Failure to address complaints in a culturally appropriate manner.

Recommendations

The Chief Ombudsman recommended:

i. The Ministry arrange and fund further counselling sessions for the complainant, taking into consideration the professional judgement of her counsellor for the length of these sessions;

j. The Ministry reconsiders the request for compensation, noting that there appear to be a range of practice failures throughout this file;

k. A copy of my final opinion is placed on the complainants file, in addition to providing more time for them to complete the correction letter;

l. The Ministry develop guidance for staff around working with individuals who are correcting errors in their CYRAS records, in a trauma-informed manner. This need not be lengthy or exhaustive, but should prompt consideration of the potential trauma in reviewing CYRAS records, and examples of options that could best support the individual. This should be provided to me for review; and

m. An appropriate apology is made to the complainant, provided to me for advance review.

These recommendations were accepted by the Ministry.

This case note is published under the authority of the Ombudsmen Rules 1989. It sets out an Ombudsman's view on the facts of a particular case. It should not be taken as establishing any legal precedent that would bind an Ombudsman in future.