

Treatment of disabled mother and uplift of newborn pēpi

| | |
|-----------------------|---|
| 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 uplift of newborn child—treatment of disabled mother and generalisation of disability—complaint-handling and review inadequate—Chief Ombudsman recommended apology, ex gratia payment and policy review.

Background

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

A section 78 interim custody order gives the Ministry immediate custody 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 her disability. The Ministry did not uphold this complaint.

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

She and another relative made further complaints to the Ministry. They believed 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 Ministry's review, in 2019, 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 she could parent;
- whether there was a predetermined 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 on the matter; and
- failure to identify or provide services that could mitigate some of the Ministry's concerns.

The review concluded that these concerns were not substantiated. The complainants then complained 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 Ministry's review, including whether it had been undertaken properly and whether the conclusions were sound.

The 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 Ombudsman found 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 Ministry's 2019 review

In considering the 2019 review, the 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 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.

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 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 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 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 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 predetermined 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 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.

Failure to identify or provide services to the mother

A report referred to a lack of support services in the area and the mother’s need for ‘intensive supports’. The Ombudsman found the Ministry relied on this statement without properly investigating whether there were services available to help the mother.

Outcome of the 2019 review

Overall, the Ombudsman considered that the 2019 review had been carried out unreasonably. In addition to disagreeing with its conclusions, the Ombudsman noted 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 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 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 newborn 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 Ombudsman recommended the Ministry:

- Scope a review of its practices and policies around involvement with disabled parents, to be agreed with the Chief Ombudsman. The review was 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 decisions mean that there is no prospect of return of the child.

The Ministry accepted these recommendations.

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.