



# Office of Hon Anne Tolley

MP for East Coast

Minister for Social Development

- 2 JUN 2016



Dear

On 17 May 2016 you emailed my office requesting, under the Official Information Act 1982, the following information:

- *Any reports or briefings received by the Minister's office in regards to Child Youth and Family interactions with the two teenage boys charged over the death of Arun Kumar.*

As you will be aware, on 10 June 2014, Mr Arun Kumar's life was taken at the hands of two individuals while working in his own business. At the point of the offending, Child, Youth and Family had open interactions with the individuals involved.

Following the outcome of the High Court trial in June 2015, I asked for an urgent investigation into Child, Youth and Family's management of the two young people. The Office of the Chief Social Worker has since completed a practice review and an operational response has been presented to the Child, Youth and Family Leadership Team.

I have enclosed the report titled '*Practice Review - young people involved in the death of Mr Kumar*', dated 13 May 2016, that provided me with the summary of the review and the proposed operational response. You will note that some information is withheld under section 9(2)(a) of the Act in order to protect the privacy of natural persons. Some information is withheld under section 9(2)(f)(iv) of the Act as it is under active consideration.

You'll also be aware that in April 2015, I commissioned an Expert Panel to provide me with independent advice on modernising Child, Youth and Family.

The Panel's first report provided me with a detailed and comprehensive analysis of the challenges facing the current system. The major issues in the current youth justice system identified by the Panel are consistent with those identified by the Chief Social Worker, and include:

- a current system that is fragmented, lacks clear accountability and is not organised around a common purpose and aligned strategy
- the system does not place children at its centre
- the current workforce lacks the capabilities and capacity to meet the increasingly complex needs of children and families

- the use of youth justice residences and custodial remand reflects an overly institutional approach to youth justice
- the youth justice system lacks integrated planning for the Young people as they transition between care and youth justice, between agencies, providers and the community.

In April 2016 I announced that the Government had agreed to major state care reforms, and the establishment of a new operating model for vulnerable children. The new system will focus on five core services, one of which is youth justice. The design of this new system is currently underway, and Cabinet will make further decisions throughout the year.

I hope you find the information in the summary of the Practice Review helpful. You have the right to seek an investigation and review of my response by the Ombudsman, whose address for contact purposes is:

The Ombudsman  
Office of the Ombudsman  
PO Box 10-152  
WELLINGTON 6143

Yours sincerely

A handwritten signature in black ink, appearing to read 'Anne Tolley', with a stylized flourish at the end.

Hon Anne Tolley  
**Minister for Social Development**



# Report

**Date:** 13 May 2016

**Security Level:** IN CONFIDENCE

**To:** Hon Anne Tolley, Minister for Social Development

## Practice Review – young people involved in the death of Mr Kumar


### Purpose of the report

- 1 This report advises you that the above practice review has been completed and was provided to me on the 11 March 2016.
- 2 The review has been presented to the Child, Youth and Family Leadership Team for their consideration and an Operational Response has been developed to address the recommendations from this review.
- 3 Please find attached a summary of the review and the Operational Response

### Recommended actions

It is recommended that you:

- |                                   |              |
|-----------------------------------|--------------|
| 1 Note the contents of the report | <b>Noted</b> |
| 2 Note the operational response   | <b>Noted</b> |

  
\_\_\_\_\_  
Paul Nixon  
Chief Social Worker  
Child Youth and Family

13-5-16  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Hon Anne Tolley  
Minister for Social Development

\_\_\_\_\_  
Date

## Background

1. On the morning of Tuesday 10 June 2014, Mr Kumar, a dairy owner in Henderson died after being stabbed repeatedly with a knife. Section 9(2)(a) Privacy of Natural Persons



2. At the time of the offending, Child Youth and Family had open interventions with both boys; a Family Group Conference plan for Young Person A and a Family/Whānau Agreement plan for Young Person B. Following the trial, the Deputy Chief Executive, commissioned a review of Child, Youth and Family's involvement with, and management of, Young Person A and Young Person B considered in the context of interagency practices and processes. It was agreed that the review findings would be provided to you in due course.
3. This review has been undertaken by the Office of the Chief Social Worker. Child, Youth and Family's involvement in the lives of both Young Person A and Young Person B began before they were born. While the review looked at historic case records it focussed its attention on the period in which the boys were most prominently featured. For Young Person A this was from August 2013 and for Young Person B the beginning of 2012, up until the death of Mr Kumar in June 2014.

## Key messages

4. There are a number of similarities in the life experiences of the two boys. They both grew up in circumstances where drug and alcohol use, criminal activity, family violence, and anti-social behaviour were the norm. Their parents were involved in crime; including violence and drug related offences and spent time in prison.
5. Both came from large extended Māori whānau, who were prepared to step in to 'protect' the boys and their siblings from the behaviour of their parents. However, even when whānau members stepped in and decided alternative living arrangements, the boys were never totally free from these negative influences and role modelling. Both whānau were familiar with Child, Youth and Family and its processes and the wider justice and social service sectors. Both demonstrated skill in navigating these systems, managing relationships with various professionals and keeping Child, Youth and Family at a distance.
6. At no time during 2012 – 2014 were the wider (and extensive) whānau for the boys included in the responses and no cultural consultation was sought to inform our work with them.
7. Child, Youth and Family cannot do this work alone. These cases called for clear robust social work and inter-agency working, needing a well-planned and holistic assessment and strong integrated plan that was well implemented and regularly reviewed. It is evident that these core practice steps were not achieved.
8. The review highlighted the challenges faced by Child, Youth and Family in responding to the needs of children with challenging behaviours. We saw issues at the interface between youth justice and care and protection in relation to the different focus and priorities.
9. There were a number of distinct opportunities when a different approach may have seen the boys go down a different path. This included for Young Person B transfer of the case from the care and protection site to the youth justice site and for both boys particular reports of concern and FGCs where plans were not adhered to.
10. All these points required a stronger child centred, co-ordinated inter and intra agency approach; structured systematic assessment, planning, intervention and case review.

## Key findings

11. Four main themes emerged from the review:

### Planned and systematic assessment

Planned, integrated, comprehensive and well informed assessment was absent for both boys. This significantly affected the quality of subsequent decision-making, planning and intervention.

Assessment of the needs, strengths and risks for children must include those providing care of them (the kaitiaki mokopuna component of the Tuituia assessment). Section 9(2)(a) Privacy of Natural Persons

### Putting a team around the child

Agencies worked largely within their own silos – collective effort and action was missing. Consequently information was not shared in a timely or purposeful way; there was no sense of shared responsibility and no collective understanding of the lives of the two boys and what was required to bring about change.

### Providing an effective response to children with challenging behaviours

The boys' behaviour was not recognised as a risk of harm and caregiver capacity was not considered. Care or protection is about more than abuse and neglect – a willing caregiver unable to manage a child with challenging behaviours is unable to provide safe care.

There was poor communication and joint working between the care and protection and youth justice teams within Child, Youth and Family. This resulted in missed opportunities to share information, agree case direction and clarify roles and responsibilities.

### Supervision and practice leadership

Supervision that supports critical thinking and reflection; provides both support and challenge; ensures competent and accountable practice was not consistently available or provided for the social workers and supervisors working with Young Person A and Person B.

## Way forward

12. Recommendations from the review have been grouped into the four identified themes with suggested actions.

12.1 Planned and systematic assessment

- a. Review practice guidance to ensure that it is clear as to the purpose of assessment at each point in the social work process.
- b. Reiterate the importance of recording the intake decisions made at site so that needs, strengths and risks for children are clearly articulated and the rationale for the decision is accurately recorded.
- c. Review the quality assurance tools that support assessment practice to bring in a stronger multi-agency perspective.
- d. Re-invigorate the use of the group consult framework and tools to support case decision making and planning. This will involve a review of practice guidance and learning tools that supports this framework.

12.2 Putting a team around the child

- a. Review policy, guidance and learning resources to ensure that they

support the practice of working with the key agencies involved in the child's life.

12.3 Providing an effective response to children with challenging behaviours

- a. Clarify the care and protection response required for children who present with challenging behaviours; in particular the evidence that indicates that a child or young person is in need of care and protection under s14(1)(d) of the CYPF Act.
- b. Under the current review of the Child Offender Manual, strengthen the guidance available to practitioners on the practice and process of working with children who offend with a particular emphasis on: roles and responsibilities between youth justice and care and protection staff; the purpose of the pre-FGC consultation.
- c. Review current capability development and learning resources to ensure that they cover effective practice with children with challenging behaviours.

12.4 Supervision and practice leadership

- a. Develop a mandatory induction and on-going professional development programme for social work supervisors
- b. Clarify the role of the practice leader at site level in providing practice leadership across all social work practice; both care or protection and youth justice.

13. The review has been presented to the Child, Youth and Family Leadership Team for their consideration and progression. An operational response has been developed and is attached for your information.

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OFFICIAL INFORMATION

**Child Youth and Family Operational Response to the Practice Review – young people involved in the death of Mr Kumar**

	Recommendation	Suggested Action (s)	Lead	Status	Timescale	Outcome	How will we measure success?
<b>1</b>	<b>Planned and Systematic Assessment</b>						
<b>(a)</b>	Revisit existing practice guidance to ensure key messages are clear as to the purpose of assessment in the social work process	This will be progressed and further informed by the Assessment Triage pilot	OCSW	Designing pilot and quality assurance	31 July 2016	As a result of the pilot there will be clearer and more robust and timely responses in decision making and assessment.	
<b>(b)</b>	Recording intake decisions made at site so that needs, strengths and risks for children are clearly articulated and the rationale for the decision is accurately recorded	Whilst this will be considered in the above pilot an interim measure will be a communication to sites around effective recording of decision making rationale.	Operations		30 June 2016	Clear account of rationale for decisions taken at consistency/pathway discussions.	Sample audit
<b>(c)</b>	Review the quality assurance tools that support assessment practice to bring in a stronger multi-agency perspective	It is anticipated that this will be part of the Transformation programme	Transformation programme				
<b>(d)</b>	Re-invigorate the use of the group consult framework and tools to support case decision making and planning. This will involve a review of practice guidance and learning tools that supports this framework.	This will be progressed and further informed by the Assessment Triage pilot	OCSW	Designing pilot and quality assurance.	31 August 2016	As a result of the pilot there will be clearer and more robust and timely responses in decision making, assessment and planning	

Recommendation	Suggested Action (s)	Lead	Status	Timescale	Outcome	How will we measure success?
<b>2 Putting a team around the child - getting good outcomes for children requires that professionals work together, sharing information and staying connected</b>						
<b>(a)</b> Revisit existing policy, guidance and learning resources to ensure that they support the practice of working with the key agencies involved in the child's life.	It is anticipated that this will be part of the Transformation programme	Transformation programme				
<b>3 Providing an effective response to children with challenging behaviours</b>						
<b>(a)</b> Clarify the care and protection response required for children who present with challenging behaviours; in particular the evidence that indicates that a child or young person is in need of care and protection under s14(1)(d) of the CYPF Act	This will be progressed and further informed by the Assessment Triage pilot.	OCSW	Designing pilot and quality assurance	31 July 2016	As a result of the pilot there will be clearer and more robust and timely responses in decision making, assessment and planning	



Recommendation	Suggested Action (s)	Lead	Status	Timescale	Outcome	How will we measure success?
<b>(b)</b>	Under the current review of the Child Offender Manual, strengthen the guidance available to practitioners on the practice and process of working with children who offend with a particular emphasis on: roles and responsibilities between youth justice and care and protection staff; the purpose of the pre-FGC consultation	Youth Justice Support	Waitakeri YJ and Police are currently trialling a new approach to working with children who offend. Workshops focused on children who offend are to be held in Auckland to further support this work The information from the trial and workshops will inform the update of the manual as required with a view to implement nationally	s 9(2)(f)(iv) Active considerations	Children who currently are involved in Youth Justice system will have their care and protection needs addressed.	Sample audit of FGC plans
<b>(c)</b>	Resource identifying successful and evidence based intervention strategies for young people	OCSW	Research currently underway in the pathways to resilience in conjunction with the OCSW and Massey university	30 September 2016	Staff are equipped to work with young people with challenging behaviours.	Guidance for staff will be on CYF Practice Centre Sample practice
<b>(4) Supervision and Practice Leadership</b>						
<b>(a)</b>	Develop a mandatory induction and on going professional development programme for social work supervisors	OCSW (Learning and Capability Development)	Resources allocation planning currently occurring. Commencement is dependent on the completion of the review of purpose and function, standards and expectations of the role and the review of key	December 2016	Implementation of a newly designed development framework for supervisors Improvement in the quality of supervision and leadership of practice	

Recommendation	Suggested Action (s)	Lead	Status	Timescale	Outcome	How will we measure success?
	<p>Re-design an induction and on-going programme of development including supervisors.</p> <p>Design performance support resources and mechanisms to support supervisor development and performance.</p> <p>Develop evaluation measures that support continuous quality improvement and bespoke on-going professional development opportunities – including qualification.</p>		<p>policies resources and tools associated with supervision.</p> <p>Current Practice Leadership Curriculum and Leading Practice programmes will be available to all supervisors in the interim.</p>			
<b>(b)</b>	<p>Clarify the role of the practice leader at site level in providing practice leadership across all social work practice; both care or protection and youth justice.</p>	<p>Operations and OCSW</p>	<p>Ongoing discussions currently to inform the paper.</p>	<p>30 June 2016</p>	<p>To be determined once paper is completed</p>	

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