Report of the

Investigation into the Deaths of

SALIEL JALESSA APLIN

Born 13 February 1989
Died 04 December 2001

OLYMPIA MARISA APLIN

(ALSO KNOWN AS JETSON)

Born 06 November 1990
Died 04 December 2001

Office of the Commissioner for
CHILDREN

November 2003

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Dr Cindy Kiro
Commissioner for Children

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1. EXECUTIVE SUMMARY

Saliel Aplin, aged 12, and her sister Olympia, aged 11, were killed by Bruce Howse, their stepfather, on 4 December 2001. The criminal justice system convicted Howse of their murders in December 2002. Bruce Howse's appeal against his convictions was dismissed on 7 August 2003.

This investigation was established in January 2003 to examine how the girls came to be murdered despite the fact that a variety of agencies intervened in their lives and had some awareness of risks to their safety and wellbeing, and to consider what changes are needed in the future. The terms of reference of the investigation are in Appendix 2.

The investigation highlights the complex nature of adult violence within families and the extent to which that violence is linked to the abuse of children and increased risk to their safety.

Particular emphasis has been placed on identifying the factors which contributed to and maintained the violence in Saliel and Olympia's home. It highlights how family violence can be both normalised and minimised by family, community and professionals, and the subsequent effect this has on the safety, wellbeing, and in this case, survival of children.

This investigation identifies poor practice similar to that found in the June 2000 investigation[1] into a death of a child. Policies and procedures were in place to protect these children but poor practice within and between agencies contributed to increased risks to the girls' safety.

Many opportunities for appropriate interventions were lost because no single agency had the whole picture or a complete understanding of the risks present in their lives. With the benefit of hindsight it is clear that the Police, and Child, Youth and Family, other professionals and the community, each had a partial understanding of the risks these children were facing. However, agencies did not meet to discuss their concerns and only dealt with the issues confronting their own agency at the time. No one agency triggered a mechanism such as Strengthening Families, so that all the information could be shared and acted upon in a planned and collaborative way.

No one agency or individual stepped back and asked what is going on here? Are these children safe? There was a lack of assessment of the significance of the girls' behaviours that should have raised alarm bells. There were few examples of adults talking with, listening to, or responding to what the girls were saying or not saying.

The investigation has confirmed the vital role those in the education sector play in the care and protection of children and asserts the need for schools to be significant players in interagency planning and response to children's needs.

New Zealand has a fragmented approach to the wellbeing of children and while there is not a lead agency responsible for them, their rights, interests and wellbeing will continue to be compromised.

[1] Final report on the investigation into the Death of Riri-O-Te-Rangi (James) Whakaruru, Office of the Commissioner for Children, June 2000

The investigation has found that standards for protecting children's rights in the print and electronic media require urgent development to conform with international best practice.

BACKGROUND

The Police and Child Youth and Family had extensive involvement with this family since 1989. Allegations by children in the family that they had been sexually abused were investigated but not substantiated. With the oversight of the Family Court the children had been removed from the care of their mother and her partner because of the violence between them, but were returned home two years later after the parents had attended counselling.

Up to 10 children lived with Bruce Howse and Charlene Aplin at various times. The volatile relationship between the adults erupted into physical and verbal violence regularly and on numerous occasions the children were witness to verbal and physical assault requiring the intervention of the police, neighbours and extended family members.

An allegation by Olympia in August 2001 to a friend at school, that she was being sexually abused by her stepfather, resulted in the intervention of Child, Youth and Family. Their investigation was closed after Olympia recanted her story.

This report confirms the findings of Child, Youth and Family's own review that there was a failure to investigate this allegation (notwithstanding the recantation) in accordance with policy.

Following the allegation, Howse lost his job and began drinking heavily. His relationship with the children and their mother became very strained. There were daily arguments and these verbal and physical assaults reached breaking point. Howse refused to leave. During this time of increasing family breakdown, Charlene Aplin discovered an opened letter posted to her some weeks before from a social worker asking her to contact the social worker to discuss "new information".

On 3 December 2001, Charlene Aplin confronted her partner about the "new information" which was a diary entry from Olympia detailing alleged sexual abuse by Howse. In the early hours of 4 December, Howse murdered Saliel and her sister Olympia while they were sleeping.

THE INVESTIGATION

The Commissioner for Children conducted this investigation pursuant to powers and functions given in the Children, Young Persons and their Families Act 1989 (sections 411 (1)(e) and 412). The investigation has been guided also by the United Nations Convention on the Rights of the Child, ratified by New Zealand in 1993.

Staff from the Commissioner for Children's office have interviewed a number of people in connection with this investigation. They include Charlene Aplin, the Principal and Deputy Principal of Lansdowne School, the Principal of Hiona

Intermediate, the Mayor of Masterton, Dr Susan Perry (Child, Adolescent and Family Service, Masterton) and Shirley Butler, Charlene Aplin's Counsellor.

The Court of Appeal's decision in relation to Bruce Howse's appeal has been considered. Media reports of the trial of Bruce Howse for the murders of Saliel and Olympia have been reviewed.

Further to this the Commissioner for Children requested information, and considered reports and other information from the Department of Child, Youth and Family Services and the New Zealand Police. The Commissioner for Children also met with representatives from Lansdowne School, Hiona Intermediate, the Police and the Department of Child, Youth and Family Services to allow them to comment and respond to the content of the Report. Two CYF social workers primarily involved with the children were contacted by the Office. Members of the extended family of Charlene Aplin were also contacted, as was Bruce Howse, through his legal representative.

This investigation also considers the social issues which impacted on the life and circumstances of Saliel, Olympia and their siblings leading to their tragic deaths. These issues include the role of the extended family and community response to family violence and other risk factors evident in children's lives, media reporting of children and young people who are witnesses to, or victims of violence, and the inadequacy of Government efforts to respond to family violence and the care and protection of children.

The investigation focuses on Saliel and Olympia and the circumstances of their lives and deaths so that we may better understand how best to stop this from happening to other children.

Department of Child Youth and Family Services

Child, Youth and Family had been involved with the Aplin family from 1989. The children from this family had been removed from the care of Charlene Aplin and Bruce Howse between 1994 and 1996 because of incidents of violence between the couple. Further concerns about the safety of the children arose in 2000 and culminated in the allegation by Olympia in 2001 that she was being sexually abused by Howse.

In making her decision that this allegation was untrue, a social worker failed to apply clear Departmental policy by not using a risk estimation tool or referring the disclosure to the Police. Again when the disclosure was recanted, social work practice did not conform to Departmental policy and guidelines.

Olympia remained living at home in an environment of increasing domestic violence and abuse from Howse. In December 2001 Olympia and her sister Saliel were murdered by their stepfather.

This investigation into the involvement of Child, Youth and Family in the life of these children has shown that social workers failed to recognise the risk that is posed to children who live in an environment of domestic violence. This investigation shares many conclusions with the internal investigation carried out by the Department of Child, Youth and Family. The investigations were independent of each other.

Despite extensive involvement with this family there are only five records of the social workers actually talking directly to the children. The social workers related mostly to the adults involved in this family. This relationship with the adults impacted on the social worker's ability to objectively consider the risks the children faced in an environment of ongoing domestic violence and abuse.

Despite concern expressed by the community and by social workers at the time, a decision by senior management in 2001 to restructure the Masterton office of Child, Youth and Family, may have added to the stress of the social workers working on this case. The impact of such administrative decisions has the potential to divert social workers from their professional responsibilities. A way needs to be found to ensure that possible future changes consider the likely impact on service delivery.

New Zealand Police

There is evidence from neighbours, extended family, counsellors working with the family, Child, Youth and Family and other records that the relationship between Charlene Aplin and Bruce Howse was characterised by regular verbal and physical violence sometimes requiring the intervention of the Police.

Despite this history of domestic violence, records show that the Police had only been called to the house 18 times between 1994 and the murder of Saliel and Olympia in 2001. Of those 18 visits only 12 were reportedly because of physical or verbal abuse between Charlene Aplin and Bruce Howse. 12 family violence reports (POL400) which are required to be completed by the attending Police were forwarded to the Women's Refuge. No POL400 reports were on Child, Youth and Family files because the attending Police Officer judged that there were no issues of immediate safety for the children.

The Police investigated an allegation of physical violence by Howse against Olympia in 1997. Howse had allegedly assaulted Olympia with a mop. Her mother had taken Olympia to safety, next door. Advice was given but the matter was closed without referral to Child, Youth and Family.

The pattern of repeated call outs to the Aplin/Howse residence did not generate dialogue between the Police and Child, Youth and Family because the number of calls was not viewed as extensive.

The Police did not have all of the information about the extent of violence in the house. They responded appropriately when they were called. Others in the community knew of incidents of violence that the children were witness to. There is currently only a limited avenue for agencies to review the collective knowledge that is available about families at risk.

The family and the wider community have commented very favourably on the response of the Police to the murders of the children and their sensitivity to, and support of child witnesses from the schools during the trial of Howse.

The Education Sector

Schools are a critical component of the safety and support network for children. The schools identified within this investigation attempted to respond to Saliel and Olympia's life circumstances. Saliel's behaviour was such that the school suspended her on several occasions. Her mother requested that counselling be arranged so that the reasons for the behaviour could be identified. Saliel was 12 before it was acknowledged that she had significant learning difficulties.

Olympia made allegations of sexual abuse by her stepfather to a school friend who reported it to her teacher. The school appropriately notified Child Youth and Family. School personnel were unaware that the Child, Youth and Family investigation of the allegation, and the procedures relating to the recanting of the allegation, did not conform to policy and practice guidelines. They were equally unaware that protocols in place between the Police and Child, Youth and Family to jointly investigate the alleged abuse of children were not activated.

Had the school known about this information, it might have adopted a different subsequent approach towards Olympia. Instead the school, on the information before them formed the view that Olympia was capable of "lying" about being abused.

Strong recommendations have been made within this report on the need for the education sector to be involved in interagency meetings where information relating to children's safety and wellbeing is discussed. Information about children needs to be shared so that the professionals can form the "whole picture" and develop a "whole child" response to concerning behaviour or risk presentations. These meetings would also increase mutual understandings of each agency's practice and policy context.

Bruce Howse's Response

No charges were ever laid against Bruce Howse in relation to this allegation of sexual abuse. The Commissioner also notes that the Court of Appeal expressed concerns about the veracity of this allegation in its decision, while dismissing Bruce Howse's appeal against his convictions for murder. In communications with the Commissioner through his lawyer, Bruce Howse has reiterated the points made by the Court of Appeal. He has denied that he killed or physically or sexually abused Olympia or Saliel. However, the Commissioner's focus is on the actions and response of Child, Youth and Family and the other agencies who had involvement with the family.

CONCLUSION

The investigation found that agencies and the community failed to recognise the risks that family violence places on children. Some agencies also failed to implement the policies, protocols and professional tools which would have ensured an integrated response to the risk factors clearly evident in the girls' lives. There was a lack of skilled assessment and understanding by some professionals, and the agencies involved worked without reference to each other.

Finally this investigation confirms the tragic "domino" effect when children live in violent families, when families and communities fail to recognise and respond to risks to children's safety, and when agencies fail to follow legislative, policy and practice guidelines.

New Zealand has a grim toll of abuse and violence towards children. Alarmingly high numbers of children die as a result of deliberate acts of violence against them by family members. The misery of these children's lives and deaths must result in an unequivocal commitment by all New Zealanders to the elimination of family violence. This investigation confirms the tragic link between family violence and child abuse and the factors which keep these hidden from view.

This commitment requires that families, communities and agencies recognise, report and respond to the violence impacting on children's lives. In the absence of understanding of the dynamics of family violence, and of a comprehensive, holistic and integrated response which prioritises their safety and well being, children will remain vulnerable and unprotected.

"My father is going to kill me."
Olympia Aplin, 2001

And he did

" I want more understanding about people like me and about how things should be done. My girls' lives have to mean something."
Charlene Aplin, 2003

2. INTRODUCTION

Saliel Aplin, aged 12, and her sister Olympia, aged 11, were killed by Bruce Howse, their stepfather, on 4 December 2001. The criminal justice system convicted him of their murders in December 2002. Bruce Howse's appeal against his convictions was dismissed by the Court of Appeal on 7 August 2003.

This is not the first time that the Commissioner for Children has investigated the death of a child at the hands of a family member.

The Commissioner for Children's investigation into the Death of a Child (June 2000)[2] examined the involvement of agencies with the child and his family. The focus of that investigation was the role performed by statutory and non-government agencies.

That investigation found that the children's circumstances were not responded to appropriately. The investigation highlighted poor interagency communication, and a lack of adherence to legislative, policy and practice guidelines within agencies. Further, it was found that there was a lack of skilled and professional response to matters of care and protection and family violence, combined with an absence of culturally appropriate social service delivery.

This investigation will identify the government and non government agencies who had involvement with the girls' family and examine to what extent that involvement effectively or appropriately responded to the girls' and their family's circumstances.

Saliel and Olympia both attempted to alert people to the risks in their lives by speaking and writing, by the way they acted, and the relationships they formed. This report will examine the nature of the girls' interaction with professionals and others, and comment on to what extent their voices were heard, understood, assessed and responded to.

In the absence of this information, intervention by professionals into the private lives of families, is likely to be less successful, have fewer positive outcomes for children and their families, and subsequently offer less contribution to the social health of our nation.

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[2] Final report on the investigation into the Death of Riri-O-Te-Rangi (James) Whakaruru, Office of the Commissioner for Children, June 2000

Effective social service delivery is also underpinned by skilled professional assessment and response which prioritises the best interests of a child(ren). The Children, Young Persons and their Families Act 1989 recognises the need in child protection matters for partnership between the machinery of state and the parents and family the child is part of. The Principles of this Act require children to be safe and free from harm, and for solutions to be sought through informed dialogue with the child's family.

The Education Act, 1989, emphasises that partnership between schools, children, young people, their families and their local communities is crucial to positive educational outcomes.

Te Tiriti o Waitangi affirms partnership between Maori and Tauiwi in every aspect of the nation's development. Current social policy development and Government initiatives emphasise the symbiotic nature of, and the close correlation between, benefits for families and children, and benefits to the social outcomes desired by Government and the people it serves.

It is this dialogue and this partnership concept which is the crux of this report. The report identifies the distance between this family and the agencies and professionals who had involvement in their lives. Wrong perceptions and judgements about families and the safety of children within them, thrive when skilled assessment and intervention is absent from the complex relationship between "helper and helpee". Garbarino[3] stresses the need for an ecological perspective when responding to the needs of children. This perspective focuses on the needs of those in the triangle of support, the child, the parents and those who have involvement with the parents so that services, programmes and interventions can be tailored to a holistic and effective response for the child.

[3] Garbarino, James 'Children and Danger', San Francisco, 1992

3. SALIEL AND OLYMPIA

Saliel and Olympia's short lives ended with a brutal act of violence in the early hours of 4 December 2001. Their step father, Bruce Howse has been convicted of their murders.

The following describes some of the events, incidents and changes they experienced and had to respond to. This account does not refer to the circumstances of their surviving siblings except in a general sense, in order to protect their privacy. This narrative is based on CYF records, media reports of Bruce Howse's trial and interviews with the girls' extended family. Where it has been necessary to check on conflicting recollections or reports, the Commissioner has done so and has formed her own view.

Examination of the context of their childhood and the complex range of intergenerational factors affecting their well being may go some way to identifying and understanding what factors contributed to escalating risks to their safety.

What was the context of the family over time in terms of response to children's safety and children's voices being heard? What influenced their mother's life decisions about her partners, her relationship with her parents and how did her own sense of self, affect her ability to nurture her children and keep them safe?

Saliel was born on 13 February, 1989. Her older sister was three and a half and her mother nineteen. Her mother's relationship with Saliel's father ended during the pregnancy and so she was on her own with two small children. Olympia was born 20 months later, on 6 November,1990, to a different father. Their brother was born in April 1992, and another sister was born in July, 1993.

Saliel and Olympia's mother came from a large extended family. She lived for the first six years of her life with her maternal great grandfather. When he died she came to live with her parents, her three siblings and three half siblings.

Their mother reports being sexually abused during her childhood by two different men known to her family. She reports also feeling unaccepted by her family, not believed and craving attention and physical affection. She felt she was the "black sheep" of the family, a label her family still use to this day. As a teenager she remembers having poor self esteem which she hid with increasingly rebellious behaviour. At 15 she was pregnant with her first daughter. The baby's father stayed in touch but was not actively involved in her upbringing.

Her extended family gave some support and for the next two years she spent time staying with her aunt and her parents, but eventually established her own home with her child. During the course of the following year she was allegedly raped by a person known to her family and although this incident was reported to the police the prosecution was not successful.

During the next year their mother met and married a man who was to father her next three children. It is evident that Saliel and Olympia witnessed family violence from

an early age and suffered the relocations and emotional uncertainty which resulted from this violence.

Their mother applied for a non violence order during 1992 and spent some time in a women's refuge. A reconciliation occurred but at the end of 1993 after further domestic violence and court involvement their mother's marriage of about three years, characterised by violence, separations and reconciliations, was over.

When their mother was 23 she had the sole responsibility for five small children, ranging from five months to seven years old. The family moved but continued to be harassed by their mother's ex husband. As an eleven year old, Olympia recounted incidents of domestic violence from that time in her diary.

At the end of 1993, their mother contacted the Police concerned that the girls were displaying medical and behavioural symptoms associated with sexual abuse. An allegation had been made by their older sister, Saliel and Olympia were both having nightmares and bedwetting, and Saliel was described as being "overactive".

The girls were the subject of Police and CYF investigations at this time, and despite the verbal allegation by their older sister, medical and evidential investigations were inconclusive and could not proceed to Court. It was recommended at that time that Saliel, then aged four, and Olympia just three, should attend counselling.

At the beginning of 1994, Saliel and Olympia's older sister once again alleged to their mother, that she had been sexually abused. Evidential interviews occurred but once again there was no substantive evidence with which Police could proceed.

The three oldest girls continued to receive counselling.

At about this time Saliel and Olympia's mother became involved with Bruce Howse who lived in a flat at the back of their rental property in Pahiatua. They then moved as a family to Dannevirke. Saliel's mother became more concerned about the possibility that Saliel had been sexually abused as she was displaying some self harming behaviours. This concern was not focused on Bruce Howse being responsible. Saliel was taken by her mother to a doctor in Palmerston North and was examined but she did not make any verbal disclosures. The doctor did not have enough information to make a formal notification to Child, Youth and Family or the Police.

The new de facto relationship began to follow the violent patterns of her marriage. This violence was to remain a constant feature of Saliel and Olympia's family experiences for the remainder of their lives.

On 12 March 1994, their mother contacted CYF and told them that she had laid a complaint with the Police about a domestic dispute between Howse and herself. She alleged that Olympia had black eyes and marks on her arms and legs and Saliel had bruises on her arms and legs and that these injuries had been inflicted by Howse.

Counsellor Shirley Butler remembers that at this time during counselling sessions, Olympia repeatedly bashed a doll on a chair to demonstrate what she said her stepfather had done to her.

On 7 April 1994, CYF received information from a family member saying that Howse had been seen hitting the children.

Some weeks after this CYF received further information from a different member of the family that Howse had been hitting all of the children. Information was received also at that point from the children's maternal grandparents that the children were bruised when they visited them.

On 18 April 1994, a CYF report stated that the children were interviewed and disclosed physical abuse by Howse. They said that he had hit them with a jug cord, that their mother had hit the oldest daughter with an open hand, and that there had been violence between Howse and their mother.

A further constant feature of their lives began to embed itself, that is their mother on one hand alerting the authorities to the violence within the family, and on the other retracting information, and agreeing to reconciliations with Howse.

By the middle of May 1994, all of Charlene's children were removed from her and placed with their maternal grandparents. Saliel and Olympia both wanted to see their mother on a regular basis but said they didn't want to have any contact with Howse. Counselling was once again arranged for Saliel and Olympia.

By the end of 1994, the girls' mother was reporting to CYF that she was concerned that her parents were not caring for or supervising the girls adequately and that they were allowing the children to have unsupervised contact with her ex husband.

The girls at this time attended College Street Normal School, Palmerston North. A counsellor working with Olympia reported to CYF that Olympia's behaviour was concerning her, as she was approaching strangers for cuddles and affection, having nightmares and physically climbing the walls at night. Saliel had voiced her fears to the counsellor that "Bruce will kill us".

In April 1995, CYF checked the children at their grandparents after receiving information that the children had untreated headlice and sores and that they were being yelled at and physically punished by their grandparents and aunt. CYF investigated these matters and decided no further action was required. The social worker noted that the children's behaviour had improved and that they were doing well at school.

Both Howse and their mother were involved with counselling, anger management courses and parenting courses during this time and were reported to be both "punctual" and making progress. The relationship however lost none of its violent nature and their mother had to take legal steps to protect herself from Howse during this period.

Throughout the two years the children were in their grandparents' custody, there were various allegations of physical abuse by Bruce Howse against the children and counter claims of neglect and physical abuse against the grandparents documented in CYF records. Underneath these documented allegations ran rippling concern regarding the sexualized behaviour of Saliel, Olympia and their older sister.

The family patterns of adult conflict and changes in alliances, dominated the emotional environment of their childhood at that time.

On 1 August 1996 the Court ordered that Saliel, Olympia and their brother return to live with Charlene Aplin and Bruce Howse, but that their older and younger sister remain with their grandparents.

Over the next three years, Saliel and Olympia were in the middle of the continuing tension that existed between their grandparents and their mother. The tension now centred on the grandparent's opposition to having their young sister returned to their mother's care. Mediation occurred between the significant adults and caregivers in their lives. Their younger sister visited regularly but was not part of their daily life.

By November that year their older sister came back to live with them and that Christmas there were nine children (Howse's children had been placed with him) in their three bedroomed home in Kippenburger St.

Money was tight in the home, with Howse only intermittently employed and violence erupted on a regular basis particularly when he had been drinking. Their mother had to take legal steps to protect herself from Howse in April 1997 but reconciled with him after a short period. It is alleged that Howse favoured his own children over them and that they were subjected to constant verbal and physical abuse from him.

Saliel and Olympia's mother made a couple of important decisions during the next year in the midst of the violent on again off again relationship with Howse. The first, to have her tubal ligation reversed, and the second to purchase and install a sleepout at the back of the property to create more bedrooms for the children.

Saliel moved in to her new bedroom immediately but Olympia was not to join her in the sleepout until a month prior to their deaths.

On 4 October 1999 Saliel and Olympia had a new baby sister and Howse quickly established this child as his "favourite." Violence in their home was reported to the statutory authorities on many occasions. Their mother was feeling increasingly unable to cope and this culminated in her leaving Howse and taking all the children with her to her parents' home.

Olympia had her ninth birthday at her grandparents home. During this time Olympia would have regular nightmares and bang her head against the wall and scream. Her mother said Olympia could not recall in the mornings what the nightmares were about.

Howse, after an initial period back with his former wife, remained in the Kippenburger St house but began to visit the children and their mother on a regular basis sometimes staying the night.

After a six month stay with their grandparents, their mother moved the children to a new home. Howse moved to Ashurst but was a regular visitor to their new sister. They witnessed an attempt by him to take the baby away from their mother and the Police were called to intervene. A separate incident of violence between their mother and Howse also resulted in further Police intervention.

It was after these incidents that their mother moved them again, this time to Woodville to get further away from Howse.

The move to Woodville was to last only a matter of weeks as the Kippenburger St House, having been rented out, was now vacant so the family returned to Masterton.

Once again Howse became a regular visitor to the girls' home and a short time later their mother decided to reconcile with him.

During this period Howse was employed and the girls, their mother and the other children had periods of normal relaxed family life. The girls' would have eaten and be out of the way at the end of the work day to reduce opportunities for Howse to yell at them if he thought they'd done something wrong. Saliel and Olympia and their sisters and brother were the focus of his bad moods.

Visits from their grandparents and other members of the extended family were limited by Howse but family members reported later that they were aware of the tensions which existed and Howse's negative attitude towards all of the children, but particularly Saliel and Olympia, and therefore chose not to visit.

At the end of September 2000 Howse left the home for a month after a violent episode. During this month Howse returned drunk one night and took their baby sister to his brother's in Dannevirke. Their mother followed him and managed to get their sister back. Further fights occurred and another reconciliation.

Over this time Saliel's attitiude towards Bruce had worsened as had his treatment of her. Her mother noted that Saliel's behaviour had got worse since they'd returned to Masterton and that she was now getting into trouble at school. She was assigned a school social worker and at her mothers request, counselling was arranged at the local child and adolescent mental health service.

At the beginning of 2001 the girls were aware that their mum was pregnant again. She and Howse separated for a couple of weeks in February after another altercation. The pregnancy was not easy and the girls were left in the care of Howse and their oldest sister when their mother spent weeks in Masterton Hospital.

Saliel would leave school at lunchtime and spend time at the hospital with her. Late in the pregnancy more problems developed and the girls' mother was sent to Palmerston North Hospital for the weeks up to the birth of their new baby sister in July 2001.

The children stayed with their grandparents until their mother and new sister came home. They were aware that Howse was unhappy that the new baby was a girl and that he was denying that he was her father. They were aware also that Howse was stressed due to recent fights with his family and because his mother had died. He had started talking about doing a "Ratima" (the name of the person convicted for the murder of their relations some years earlier).

Shortly after, the girls mother returned to the hospital for a gall bladder operation. Again the girls were left in the care of Howse and their older sister. Saliel continued to cause concern at her school and her mother was worried as to why her behaviour was deteriorating. When her mother came home from hospital she noticed that Saliel was continually aggressive towards Howse.

On 3 August Olympia's school contacted her mother to say that Olympia had alleged that Howse had sexually abused her and her younger sister. Her mother drove immediately to the school. She was distraught and disbelieved the allegations.

School staff removed Olympia from the discussion between themselves and her mother because they felt Olympia's mother's distress and anger was such that she shouldn't be exposed to it. Olympia was taken from the school, against staff wishes, by her mother who asked staff to direct CYF to Olympia's grandparent's home.

Olympia stayed with her grandparents for the weekend and was interviewed by social workers. It is not known what other questions were asked of her by family members during the course of the weekend. The following Monday Olympia had withdrawn her allegations.

The next week a CYF social worker met with her and her teachers at school and warned Olympia against "lying" about being abused.

Upon Olympia's return home, her mother noticed that Howse's attitude towards Olympia changed and that he would deliberately exclude her or make sarcastic and racist comments to her like "nigger" and "mongrel". Olympia told her mum that Howse had told her she was a liar and a black bitch and that she was really upset with his negative and aggressive attitude towards her.

A month later changes occurred in the family. Olympia and Saliel's older sister and Howse's son moved out, their mother got a job and Olympia started sleeping in the sleepout. The relationship between their mother and Howse was deteriorating. Arguments about what they or the other kids were supposed to have done were a daily event. Saliel, and now Olympia were answering Howse back and standing up for themselves.

However their mother seemed happy with her new job and sense of independence it gave her. She was able to buy treats for them and the other children. Howse was on sick leave from work and would appear at their mother's work several times a day in addition to driving her to and from work.

On 20 November 2001, a fight erupted between Howse and their mother. Olympia was asked to run to the neighbours to call the police who arrived and took Howse to his son's address to stay the night.

All of the children witnessed this violent episode and Saliel and Olympia were too scared to go to bed in the sleepout. Their mother accompanied them to get their pyjamas and school uniforms and they all slept inside the house with the doors locked. Howse phoned their mother on numerous occasions that night to say that he was going to kill them all. He returned to the house the next day and their mother asked him to leave permanently but he said she had no legal right to keep him out of the house.

Days later Howse called Saliel a "black bitch" during an argument.

Saliel had the nickname "seal". Her mum described her as a sporty tomboy with a soft loving affectionate side "like a lamb in wolf's clothing" who spoke up if she did not like something.

Saliel could not read well and her mother believed that this was the reason she could behave badly at school. Saliel loved sports and was good at anything she played but she was particularly good at athletics.

Justice Goddard's summing up in the trial of Bruce Howse highlighted that "there was evidence from Saliel's friends, relations and other persons that Olympia and particularly Saliel were subject to Howse's antipathy and physical and verbal abuse. There was evidence that Olympia was scared of Howse: that this was contained in her own diary notes and came from her friends. There were the words she wrote in the back of her diary "my father is going to kill me" and which she repeated to a school friend and that friend's father only a week before the killings".

Her mother told the Court that Olympia, called Olly by the family, had a loving, and caring nature and that she was a great singer. She described Olympia as being an avid reader and singer who was in the school choir and kapa haka group.

Olly was "very affectionate and lovable" and would make her mother cards saying, "I love you Mum". She usually slept cuddled up with a teddy bear. Olympia's older sister said that Olympia was scared of the dark and of spiders, and that she thought a ghost lived in the sleep out. Her oldest sister described her as being sensitive with a kind heart.

Two nights before they died the girls were at their older sister's house and Olympia wanted to take one of the neighbour's puppies home. Saliel had an argument with Howse. When he told Saliel to stop smoking a cigarette, Saliel responded quietly to Howse that she was "going to nark on him".

The girls' mother told the Court that during this time, her children told her that Howse was hitting them and that she heard him calling them names like "nigger".

The day before their deaths, Saliel and Olympia went to school as usual and that evening had dinner and watched television before going to bed at about 9 pm. She made sure her mum filled out two forms to take to school the next day, one giving permission to compete in an inter school athletics competition.

Olympia and Saliel both kissed their mother before going to bed in the sleepout that night.

On the night of the 3 December 2001, Saliel and Olympia were each both killed by a single knife wound and bled to death. The Crown prosecutor told the jury that they "were terrible vicious blows against which the girls had no hope of defending themselves".

Police found Saliel in bed, lying on her back. There was a large amount of blood around her and on the bed. It is believed that Saliel would have lost consciousness within a minute and died within ten minutes.

Olympia was found leaning over her bed in "prayer position". Her bedclothes were covered in blood. Medical experts told the Court that Olympia died from blood loss but that it took from 30 minutes to two hours for her to die. There were signs that she had moved around the sleep out during this time.

In their short lives Saliel and Olympia;

- Lived in ten homes.
- Attended six different schools.
- Lived in eight different towns or cities.
- Lived with their grandparents for two years after being removed from their mother's care.
- Lived apart from their younger sister for five years.
- Lived with their mother and two different partners both of whom were violent.
- Lived in a house with up to ten children intermittently for four years.
- Were exposed to 12 recorded incidents of violence and at least 35 violent incidents not reported.
- Alleged abuse on at least five occasions.
- Attended counselling intermittently since they were three and four years old.
- Were psychologically assessed by court order on at least two occasions.
- Were monitored by CYF nearly all of their lives.

4. THE INVESTIGATION

The statutory authority for the Commissioner's investigation has been described in the Executive Summary section of the report, as has the scope and process of the investigation.

The purpose of the investigation was to determine whether increased understanding of the family's circumstances could have generated a different and more effective response from the agencies and professionals involved. Saliel and Olympia's lives were affected by a combination of violence, multiple and intergenerational experiences of neglect and abuse, poverty, and prolonged exposure to trauma and chaos from an early age.

It is important to explain at this point what this report does and does not seek to investigate and report on. The Commissioner's focus is on the actions and response of the relevant agencies. Those are the terms of reference.

It is not the purpose of this investigation to revisit the trial or appeal or the scope of the trial or appeal of Bruce Howse.

No charges were ever laid against Bruce Howse in relation to the allegations of sexual abuse. The Commissioner also notes that the Court of Appeal expressed concerns about the veracity of these allegations in its decision dismissing Bruce Howse's appeal against his convictions for murder.

In accordance with the Commissioner's duty under section 414 of the Act, the Commissioner sent relevant extracts from the draft report to Bruce Howse, as the draft report contained adverse comments about him. In communications with the Commissioner, Bruce Howse has reiterated the points made by the Court of Appeal. He has denied that he killed or abused Olympia or Saliel.

Bruce Howse's legal representative has further advised that:

The allegations [of sexual abuse] have been found to be dubious and unreliable [by the Court of Appeal]. They should not therefore be relied upon by you and any such allegations should be left out of your final report altogether."

Mr Howse has instructed his legal representative to consider an appeal to the Privy Council because of the nature of the Court of Appeal's decision. His legal representative has advised that :

Accordingly, we consider that this matter is not at an end judicially. An appeal to the Privy Council is a distinct possibility and having regard to the findings made by the Court of Appeal in favour of Mr Howse, such an appeal must be regarded as having a good prospect of success.

It is stated that it is consequently inappropriate for Mr Howse to comment in detail on the draft report.

Mr Howse's legal representative also advises that:

On legal advice therefore, Mr Howse is not prepared to make any comment in respect of your draft report other than to say he strongly denies that he killed or ever abused his step daughters.

The Commissioner relies on the fact that Bruce Howse was convicted of murdering Saliel and Olympia. The Commissioner also accepts that Bruce Howse was neither charged nor convicted of sexually abusing them. Notwithstanding this, it is clear that allegations of sexual abuse were made. That is highly relevant in assessing the response of the various agencies. The Commissioner does not consider that there is any material or responses, including those submitted by Bruce Howse's legal representative, which change the need for this assessment.

5. AGENCY INVOLVEMENT

The murder of these children was horrific. The Court of Appeal described the crimes as "appalling". Bruce Howse was sentenced for their deaths and punished by the judicial system. The length of his sentence (reduced to a 25 year minimum period of imprisonment on appeal) has been widely accepted as an appropriate reflection of community abhorrence about his actions.

No one predicted that Howse would murder Saliel and Olympia. The Police, who knew him well, expressed surprise that Howse committed these murders. Social workers who knew this family very well, judged the children to be safe in his care. Many agencies were aware of the volatile and chaotic environment in which Saliel and Olympia lived.

5.1 Department of Child, Youth and Family Services

A report on the involvement of Child, Youth and Family social workers undertaken by independent reviewers, and the subsequent findings of the Chief Social Worker provide, with the benefit of hindsight, some understanding of the decisions taken by social workers over time.

They found that some of the decisions reached by one social worker and her supervisor failed to follow Departmental policy and lacked sound professional judgement.

It is usual practice for the office of the Commissioner for Children to review the deaths of children who have been known to the Department of Child, Youth and Family Services.

Staff from the Office undertook a close analysis of the actions of Child Youth and Family. In carrying out this review they had access to and considered: the Department's initial report to the Commissioner for Children; the entire paper and computer files on this family, which included the Department's internal Five Day Report; the completed case review commissioned by the Chief Social Worker; and her report to the Chief Executive Officer of the Department of Child, Youth and Family Services.

The Department commissioned an independent review of this case because it had an extensive historical as well as current involvement with the family at the time of the girls' deaths.

The terms of reference of the review were to:

1. Construct a chronology of the case as known to the Department.

2. Identify any significant casework issues arising from the Department's management of the case, considering issues of practice and service delivery.

3. Analyse these practice and service delivery issues with reference to the relevant legislation and to the Department of Child, Youth and Family Services policies

and procedures. Any policy and procedural change that may be required or that needs to be reinforced will be made clear in the review report.

The review considered both policy and legislative imperatives required of the staff and the impact of administrative and structural changes on the social work staff managing Saliel and Olympia's case when they were murdered.

Chronology

As identified in an internal CYF review, the Department interacted with the family in three distinct phases. The first phase, from 1989 to 1993, concerned the Department's investigation of an allegation regarding the sexual abuse of the Aplin children.

The second phase started in 1994 and continued through 1999, when Charlene Aplin was developing a relationship with Howse. At this time Olympia and Saliel and their siblings were in the custody and additional guardianship of the Director General before being returned to their mother, Charlene Aplin and Bruce Howse's care in September 1996.

The third phase began in April 2000, with notifications and interventions relating to, or arising out of changes in the relationship between Charlene Aplin and Bruce Howse, as well as a concern for the safety of the children. A notification regarding an allegation on 3 August 2001 of suspected sexual abuse of Olympia is considered in this third phase, as is the additional information contained in Olympia's diary, raising concerns which had not been investigated at the time of Olympia's death.

Social work intervention

Saliel and Olympia had a number of social workers involved with their family, not a particularly large number of workers compared to other children who are in the care of the Department for a long period of time. The quality of the social work largely depended on the skill and experience of the social worker managing the case at the time. One social worker had extensive contact with this family. Her supervisor also knew this family well and worked with them for many years.

The difficulties identified in the social work practice in the third phase leading up to the death of the children, relate to the practice of the social worker and the quality of her supervision. Generally it appeared that there was an emphasis on recording as opposed to effective social work practice being underpinned by a clear and broad plan to identify the care and protection needs and the safety of the children.

The management of this case was characterised by the failure of the social worker and supervisor to comprehend the significance of the allegations and counter-allegations of abuse that were rife in this family. The social workers failed to use the tools provided by the Department to assist them in determining the level of risk the children faced. They failed to consult appropriately at critical periods with the Police and the Care and Protection Resource Panel and with their own Practice Manager.

By way of explanation the supervisor detailed a number of significant management decisions which impacted on the quality of the social work practice at this time. A Roopu team of social workers under his leadership were managing a large number of complex cases (36% more cases than the other team in the office). This Roopu team

was created with the support and advocacy of a site manager whose position was disestablished shortly before the Aplin girls were murdered. The supervisor raised his concerns about removal of the management position with the Chief Executive without success. Because of his seniority the supervisor believes he became a 'de facto' manager and assumed considerable management responsibility in the Masterton office. His desire to improve performance in the office generally prevented his close supervision of the Aplin case. It was in this context that the letter to Charlene Aplin regarding the "new information" was sent.

The social worker involved has pointed out Charlene, by her own admission, would sometimes lie and cover up what was happening within the household. This indicated the difficulties the social workers faced in finding the truth in any situation. The social worker has also highlighted the complexities of working with both Charlene Aplin's children and the five children of Bruce Howse.

The social worker told the Commissioner's staff that during her thirteen years as a social worker, she followed the policies and procedures set down by the Department, and duly implemented appropriate protocol when confronted with instances of disclosure of alleged sexual abuse.

Familiarity

Phase three, part two, begins from 3 August 2001 when Lansdowne School notified the Department that Olympia had made an allegation to another student that she had been sexually abused by Howse.

The social workers responded relatively quickly to the notification to ensure the safety of the child. The child was sighted by the social workers and deemed to be safe with her grandparents.

The information reached the Masterton office by way of a "critical" notification from the National Call Centre. The supervisor in the Masterton Office noted on CYRAS (the Department's computerised case work management system) that, "two social workers visited the school and the home of grandmother following consultation with school and assessed that Olympia was safe in consultation with grandmother and mother". The CYRAS note prompts, "What is this assessment based on?" The supervisor states, " social worker has worked with this whanau before, **knows them better than they know themselves** and is confident that grandmother will keep Olympia safe"(my emphasis).

The Supervisor's statement that the social worker, "knows them better than they know themselves" is an example of the failure of those working with this family to objectively consider information coming to the Department about the family and risks to the children within it. An analysis of the records in this case confirms that social workers had a focus on adult relationships and were concerned primarily about adult behaviour and relationships, failing to give due weight to the significance of the statements being made by the children.

The poor judgement of the supervisor is further compounded by his failure to challenge the social worker's lack of professional analysis or assessment of the way in which the Aplin/Howse family operated, and the risks this created for the children's care and protection.

Retraction

In September 2001, Olympia retracted her allegations against her stepfather.

The Commissioner has considered the Court of Appeal's comments in relation to Olympia's retraction of her allegations not just to adults but also to one of her siblings. This led the Court of Appeal to express doubt about the veracity of the allegations when deciding whether or not the trial judge should have allowed the jury to hear the allegations, or should have provided further context for the jury.

The Commissioner's focus is on whether Olympia and Saliel were listened to by the relevant agencies, particularly Child, Youth and Family.

It is also noted that it is not uncommon for children to retract their statements when they realise the likely impact of their statement on family relationships or when they are accused of fabrication. Because of this phenomenon, clear practice guidelines are provided in the Care and Protection Handbook (herein after referred to as the Handbook) to guide social workers when they are faced with this situation.

The decision by the social worker and supervisor to close the case following Olympia's retraction, without reference to the Handbook was both premature and contrary to practice guidelines. The Handbook describes exactly what should have happened in the management of this case. There was no referral to the Police under the SAT protocol nor was any risk estimation undertaken. The Handbook clearly describes steps that social workers should take when a child recants.

A decision by the supervisor that the case would be closed "subsequent to referral to the CPRP and its endorsement of that conclusion" indicates that the supervisor was using the referral to the Panel to justify decisions that had already been reached, without proper reference to policy and good social work practice.

By this time, on the 3 September 2001, the school had forwarded notes from Olympia's diary to the Department. This new information was subsumed into the referral to the Panel and not investigated separately.

SAT Protocol

Details of the allegation made by Olympia to her friend at school were not conveyed by Child, Youth and Family to the Police. Such sharing of information is required under a protocol agreed between the Department and the Police. The protocol is described in the Handbook and it is the expected that staff apply the protocol in responding to notifications of alleged sexual abuse.

Clearly there was a serious breach of the formal protocols and practice guidelines that are in place between the Police and the Department when children allege sexual abuse.

Risk assessment

The application of the risk estimation tool should have been carried out at particular points in time throughout the life of this case. Failure to do this clearly signifies a breach of the Department's policies and procedures, and represents a violation of the

children's right to care and protection provided for in the Children, Young Persons and their Families Act.

Communication

A decision to send a letter to the home in which Howse resided referring to "new information" was, in hindsight, unwise. There was a strong likelihood that Howse could intercept the letter. This had the potential to place the children at serious risk.

Office Management

The Department's independent review concluded that "the administrative changes, the nature and volume of work which was required to be undertaken in the Masterton office, and the difficulty in coping with the aftermath of two child murders, imposed additional stressors beyond that generally described by social workers".

The Department has yet to identify a mechanism which will enable it to respond to such stressors. The Department was aware of the particular resourcing difficulties facing Masterton and had taken steps to fill three vacancies. Decisions taken at a National Office level to remove the local site manager created considerable community unease and unease amongst staff. The failure of the decision-makers in Wellington to respond adequately and promptly, to the unique situation developing in Masterton (until after the murder of Saliel and Olympia) would indicate a need for improved communication between the field staff and National Office.

5.1.1 Findings

The extensive review undertaken by the Office of the Commissioner has found that:

1. There was a failure to investigate an allegation of sexual abuse in accordance with sound professional practice clearly described in the Department's own practice guidelines. It is acknowledged that judicial doubt has been expressed about the allegation. However, there was a clearly defined practice which should have been followed.

2. There was a failure to adhere to the SAT protocol, which would have resulted in a joint investigation between the Police and CYF.

3. There was a failure to consider the need for a formal risk assessment.

4. There was a failure to consult with the Practice Manager.

5. The safety of the children was not able to be assured because social workers consistently minimised information gathered from the children and failed to recognise that their own relationships with the adults involved with this case were preventing an objective analysis not just of the nature/truth of the allegations, but also why they were being made.

6. Proper adherence to policy and the application of protocols and risk assessment tools would have provided this objective analysis but both were not utilised.

7. The decision by the social worker to send a letter, worded as it was, to Charlene Aplin, referring to new information that she needed to investigate, was unwise.

8. Familiarity of social work staff with the Howse/Aplin family prevented objective informed decision making in this case and compromised the care and protection services afforded Olympia and Saliel.

The findings reached by the office of the Commissioner for Children largely concur with the findings of the Chief Social Worker, after she had considered the report of the independent reviewers.

However there are a number of further matters the Commissioner for Children has raised with the Chief Executive of Child, Youth and Family for her consideration and response.

5.1.2 Further matters arising from the investigation

Listening to Social Workers

CYF have undertaken a significant number of structural reviews with the laudable intention of improving service delivery and cutting administrative costs. The impact of these changes has been commented on in many reviews of the Department.

Sadly, the views of field staff about the impact of these changes have not been given due regard by the decision-makers in National Office. The decision to remove the local site manager and change reporting lines from Palmerston North to Wellington office was greeted sceptically by the Masterton staff and community alike at the time of the changes.

Despite protests, the decision was implemented and the reviewers have acknowledged that this impacted on staff morale and their ability to manage high caseloads. CYF have responded to the crisis after the deaths of the children, by placing an acting manager on site and channelling extra supervisory support to the site to stabilise service delivery and rebuild community confidence.

The Baseline Review released on 23 October 2003, reiterated that the Department needs to seriously consider the impact of any structural changes it proposes making. At present only the Chief Social Worker and the Principal Advisor (Capability Development) represent the social work profession at a senior management level. The Department could benefit by reviewing how its service delivery function is represented when such important decisions are to be made, to strengthen the voice of its social workers so that their views are properly considered.

Relationships

The Department's New Directions initiative encourages the closer collaboration and cooperation of the Department with its community. It is apparent in talking to the Principals of the schools which Saliel and Olympia attended, that their relationship with the Department could, at best be described as "distant". Both Principals described the difficulties they had experienced in contacting CYF, their reluctance to make referrals and their concern over the lack of information provided to them by social workers who place children in their schools, or who are working with the families of children in their schools.

The supervisor at Child, Youth and Family has stated to the Commissioner that in his view, relationships between the schools and the Department had broken down with the Departmental decision to handle all intake calls through a call centre in Auckland. Intake social workers at the Masterton site had previously maintained established links with key people in schools and other agencies regarding notifications and other concerns about children, young people and their families in the local area. These relationships and sharing of information were markedly reduced with the establishment of the national call centre. However the Commissioner recognises that there may be other advantages to having a dedicated Call Centre.

The tragic outcome of Olympia alleging abuse at school has only served to heighten the school's anxiety about reporting abuse to CYF. In addition, it was reported to staff from the Commissioner's office that it is the feeling of teachers that children will be less likely to disclose abuse given what had happened to Olympia and Saliel.

A CYF community liaison social worker based in Wellington, visiting Masterton schools irregularly, is not sufficient to build close links and collegial support at a local level. Consideration should be given to increasing the number of Community Liaison Social Workers or to adopting a model where social workers are allocated a "geographical patch" for which they are responsible. As part of this responsibility, social workers should be encouraged to develop close relationships with school Principals in order to build trusting and cooperative relationships.

Workload Assessment

The Chief Social Worker acknowledges in her report on the deaths of Saliel and Olympia, that staff of the Masterton Office felt under-resourced. The supervisor of the case closed a notification in September 2000 "due to the nature of this notification, *limited resources and the pressure of more serious notifications that are not being activated"*.

CYF is funded by Government and the allocation of that funding is determined administratively. The amount of resource made available to a site is determined by a formula which considers, along with other factors, the number and nature of the notifications each site has to manage.

It is difficult to determine if the Masterton site was under-resourced. The social work staff claim that they lacked resources and were overworked. However, without an effective tool to measure caseloads, any claim that the office required more social workers is subjective, and must be treated with caution.

Until the Department puts in place an effective workload management tool, it will be difficult to ascertain the level of resources required to meet demand.

The community has some sympathy for social workers who are required to meet an uncapped demand for services within a capped budget. However, while there is no effective measure of workload, claims of under-resourcing and overwork have the potential to be used as a way of disguising poor practice. The supervisor's decision to close a notification partly because of the "lack of resources and the demands of other cases" is, in the absence of an effective workload measure of these cases, difficult to support.

The failure of the social worker and the supervisor to use the risk estimation tool or consult with the Police or the CPRP before closing the case adds to the perception that the claim of a "lack of resources" was used to disguise poor practice.

This investigation identifies the need for the Department to develop and implement an effective workload management tool, which will assist in the measurement of demand and in the allocation of resources.

Care and Protection Resource Panels

The decision by the supervisor to close this case "subject to referral to the Care and Protection Resource Panel for their endorsement" raises concern.

The Care and Protection Resource Panels are an essential care and protection tool to act as a check and a balance on social work decision making. Panels are reliant on the supervisor providing them with accurate and timely information, in order to be effective.

The information provided to the Care and Protection Resource Panel in Masterton in respect of the notification concerning Olympia and her sister was not of a sufficient quality for their role to be effective.

Care and Protection Resource Panels could benefit from the learnings in this case. Reference to this case could be included in the training of social workers and of Care and Protection Resource Panel members.

Roopu Teams

The Masterton office has a Roopu team which deals with cases involving Maori families. This team was established to provide a culturally appropriate response to its clients. The office of the Commissioner for Children is not aware of a review into the effectiveness of this approach to service delivery.

There are an increasing number of CYF offices which have Roopu teams. Anecdotal information would suggest that these teams are very effective in working with Maori clients. There are also reports however, that social workers working in these teams often work under extreme pressure. Maori staff may not have the guidance of Maori Practice Managers for example. The Masterton Team was reportedly understaffed and had to manage highly complex cases.

A review of the effectiveness of the Roopu Team concept would be useful. The review should consider the resourcing, training and professional support of social workers working in Roopu Teams.

Listening to Children

The social workers in this case had been involved closely with this family for several years. Comments on the files indicate that most of their involvement centred on the adult members of the family, the police, the teachers, the counsellors, the judiciary and other community support agencies working with the Aplin/Howse family.

The safety of the children was not able to be assured because social workers had consistently minimised information gathered from the children and failed to recognise that their own relationships with the adults involved with this case were preventing an objective analysis, not just of the nature/truth of the allegations, but also why they were being made.

The chronology of this case, as recorded on the electronic file, details 180 file notes. Of these, only five file notes provide evidence that a social worker spoke with a child. The supervisor suggested that social work visiting books might record further contact with the children. However, if these records exist, they were not made available to the Office of the Commissioner for Children. There is a need identified in this and other cases that come to the attention of this office, for social workers to engage more with children.

The United Nations Convention on the Rights of the Child to which New Zealand is a signatory, calls on all New Zealanders to give children the opportunity to be heard in all matters that affect them. In the social work setting this must require an effective and regular dialogue between social workers and their clients (children) to ensure that decisions being taken on their behalf adequately reflects their best interests and views.

Reviewing Casework

The Department's terms of reference required the reviewers to analyse practice and service delivery issues with reference to the relevant legislation and to policies and procedures. In reaching their conclusions the reviewers have confined their enquiry to interviewing Departmental staff and reviewing Departmental material. The Commissioner believes that the best way of gaining an accurate picture of all of the service delivery issues is to talk to the recipients of the service provided by the social workers.

The Department should consider expanding their terms of reference in future casework reviews, to ensure that practice improvements consider the views of the clients they serve.

5.2 New Zealand Police

Staff from the office of the Commissioner for Children visited Masterton Police to investigate the extent and nature of the involvement of the Police with Charlene Aplin and Bruce Howse. Interviews were held and files relating to the investigation were reviewed.

In interviews with Charlene Aplin, and in reviewing the CYF files, in considering the statements made by Charlene Aplin's counsellor, neighbours, and in comments from the school, it is apparent that Charlene had extensive contact with the Police. On at least 18 occasions between 25th December 1994 and the murder of Saliel and Olympia in 2001 the police responded to incidents at the request of either Charlene Aplin or Bruce Howse.

Not all of these call outs were as a result of domestic violence between the two adults. However there is no doubt that a level of domestic violence existed in the relationship between the adults which most New Zealanders would find difficult to comprehend.

For example Charlene described an incident in 1997, when she alleged that Bruce got Saliel, then aged 8 years old, drunk to the point where Saliel could not stand up and was vomiting. The resulting confrontation between Charlene and Bruce was typical of similar incidents of violence that characterised the relationship. Bruce began by verbally abusing Charlene and then the children. He then smashed treasured items and smashed holes in the wall before turning his attention to physically assaulting the children. In response, Charlene attacked Bruce with a baseball bat and managed to escape with the children in tow. The Police, and Child Youth and Family were not made aware of this and numerous other incidents of violence.

The Police record their attendance at family violence incidents by completing a family violence report (P0L400). These family violence reports record details of the incident including the number of people (and their ages) residing in the home. It is expected that these reports of family violence are referred to Child Youth and Family when the immediate safety of children is considered to be at risk. There are no family violence reports on the CYF files which were made available to the office of the Commissioner for Children. From this, one could assume that none of the incidents of domestic violence attended by the Police raised issues of immediate safety for the children.

However, the office of the Commissioner for Children has been assured that the 12 Family Violence Reports that were required to be completed in response to the recorded incidents at the Aplin/Howse residence, were referred to the Masterton Women's Refuge. In New Zealand, the Police forward POL400s to the nearest Women's Refuge where refuge personnel screen each of these reports and alert other agencies if a further intervention in the family is deemed necessary.

The Police files record an incident on the 20 June, 1997. The Police were called to the home of Charlene Aplin and Bruce Howse at 2 o'clock in the afternoon by Charlene Aplin. Charlene Aplin had taken her seven year old daughter to the home next door after Howse had assaulted her daughter with a mop.

The file records "Both parties spoken to. Nil problems. Advice given." The file was closed.

It is noted that Bruce Howse denies that he ever abused (sexually or otherwise) the Aplin children.

Child Youth and Family have acknowledged in their review of their management of the Aplin/Jetson case, that the social worker and supervisor seriously breached policy by failing to report the allegation of abuse made by Olympia (3 August, 2001), to the Police, so that consultation regarding an appropriate investigation could occur.

The joint CAT/SAT protocol, agreed by the Police and Child, Youth and Family acknowledges that "an interagency approach to the investigation and management of child abuse cases will enhance the protection of the child, accountability of any offender and partial or full reintegration of the child into the family". Both the Police and CYF agree that CYF should be notified where allegations of child abuse are made to the Police and that the Police should be notified where any allegation of abuse is made to CYF.

It can only be assumed that the Police attending the incident on 20 June 1997, concluded that the assault on Olympia could not be classed as serious physical harm, as no notification was made to Child, Youth and Family.

What is known is that the number of 'call outs' to the Aplin/Howse residence, did not at that time generate dialogue between the Police and Child, Youth and Family, about the children caught up in this abusive environment. The Police advise that the number of calls would not be considered extensive or significant, in comparison with other parts of the country. They report that this view is consistent with graded response models which define 'high risk repeat victimisation' as those cases where three or more calls have been made to the same address in the same year.

It is significant, that we now know, with the benefit of hindsight, that a large number of individuals within the community, neighbours, social workers, friends, family, and counsellors were aware of the violence in the household. Many would only have a small part of the picture of that abusive environment. The Police could only respond to part of the picture also. They responded appropriately, when called on, within the policy and guidelines available to them.

However, the question remains, where does the responsibility lie to take a step back, to review the collective knowledge that was available about this family?

Research helps us understand the link between partner abuse and child abuse. Studies suggest that in up to 53% of all families where women are being beaten, their children are also victims of abuse by the same perpetrators.[4] The risk to children where their mothers have suffered severe abuse should not be underestimated. The Domestic Violence Act, 1995, acknowledges that a child witnessing family violence is being subjected to abuse (Sect 3 (3)(a)).

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[4] Edelson. J, 1995 "Mothers and Children: Understanding the Links between Women Battering and Child Abuse". Presented at the Strategic Planning Workshop on Violence Against Women. National Institute of Justice, Washington, D.C. March 31, 1995.

The Masterton Police responded to the calls from both Charlene Aplin and Bruce Howse, both of whom alleged verbal and physical violence. The Police administration advise that the Masterton District has a progressive and thorough response to incidents of reported domestic violence. All POL 400s are reviewed by their Family Violence coordinator. "Intell" staff are actively involved in reviewing all reports to identify trends and isolate potential risk. The Area Controller also acts as a check to ensure that where necessary, referrals are made to other appropriate agencies. The Police are actively involved in the Violence Free Wairarapa Campaign instigated by the Mayor following the murder of these two girls and other violent child murders in the region

Increased public awareness about the need to report domestic violence as a result of this campaign will hopefully result in increased Police involvement, which will allow in future, the early identification of children who are at serious risk.

Interviews with school personnel, family members and community leaders held during this investigation, revealed very positive comments about how the Police responded at the time of the girls' deaths and during the time of Bruce Howse's trial for their murder. People spoke highly of the sensitive and supportive assistance provided by the Police over this difficult time in their community.

School personnel noted how supportive the Police were to children who had to travel to Wellington to give evidence at the trial. Some of these children were not accompanied by their family, and it was observed that the Police went to great lengths to ensure the children were comfortable, well fed and not traumatised by their involvement in the trial.

5.2.1 Findings

1. Police in Masterton were called out to the home of Charlene Aplin and her partner Bruce Howse and responded to numerous incidents of family violence over a period of 6 years.

2. Masterton Police files contain 12 Family Violence reports (POL 400).

3. The Police referred the POL400's to the Women's Refuge. None of the Police attending the calls to the Aplin/Howse home considered the children to be at risk of serious physical harm.

4. Masterton Police did adhere to Police policy when responding to domestic violence calls to the Aplin/Howse home.

5. No one agency has a responsibility to determine the extent of and response to the impact of domestic violence on children. Social workers, the Police, teachers and other community agencies may have part of the picture, but currently have limited requirement to consult or discuss these concerns with each other.

5.3 The Education Sector

At the time of their deaths, Saliel was attending Hiona Intermediate, and Olympia was a pupil at Lansdowne School. Both schools had become closely involved with the girls' circumstances and attempted to meet their varied needs through referral to appropriate agencies and support from within the school.

Saliel had been stood down and suspended from Hiona Intermediate on three occasions in the year of her death because of her "unacceptable" behaviour. It was during this process that it was discovered that she had significant learning problems and was three years behind her classmates in reading and mathematics. Saliel loved sports and excelled in athletics and soccer. Some months before her death Saliel had been referred to the school social worker.

Four months before her death Olympia alleged abuse within her family to a school friend who disclosed it to staff at Lansdowne School. School records evidence a high level of concern for Olympia before and after this allegation was made and this concern was communicated to her family and CYF. Olympia was active in school activities and was a member of the school kapa haka group and enjoyed singing in events organised by the school.

Hiona Intermediate

The Principal of Hiona Intermediate, Mr Peter Debney, reports that he had extensive knowledge of Saliel's living situation. He knew Bruce Howse before Saliel's enrolment, due to the fact that Bruce Howse's son had been a pupil at the school some years before. He also had visited Saliel's home on about three occasions in the two years she had been a pupil at Hiona Intermediate.

Saliel had been stood down and suspended from the school on four occasions in the two years she was a pupil at Hiona Intermediate. The suspension in June 2001, lasted a full month and the reason for this was said to be so that referrals could be made to the Child, Adolescent and Family Service at Masterton Hospital and to the school social worker. Saliel's mother had asked during the Board of Trustee's disciplinary meeting that Saliel be referred for counselling.

Saliel's mother reports that it was only during this suspension process that Saliel's learning problems were identified (three years behind her chronological age in reading and mathematics). She attributes some of Saliel's anger at school, to her frustration with not being able to function well in the school environment.

The Principal was concerned that Saliel was developing a smoking addiction and that her parents were condoning her smoking by offering cigarettes as a reward for good behaviour.

Saliel was suspended again in September 2001, some few weeks after her previous suspension.

The media reports of Bruce Howse's trial indicate that the Principal of Hiona Intermediate, told the Court that although he had some suspicions that Saliel had

experienced physical and sexual abuse, he had no evidence with which to notify authorities.

After the referral to CAMHS, discussions were held between the school and that agency regarding Saliel and the possible reasons or factors which may have been causing or contributing to her behaviour at school. Saliel did form a good relationship with the school social worker, who did not receive any information from Saliel which indicated that she felt unsafe at home.

Lansdowne School

On 23 April 2001, the school recorded that Olympia became very upset and was reluctant to go home. She told staff that there had been arguments between her home and the neighbours, which had involved shouting and physical abuse.

Staff took Olympia home and informed Olympia's mother, Charlene, about what Olympia has said. It was recorded that her mother showed no surprise at the facts and told staff that the Police had been involved on several occasions. Staff advised Charlene that they would keep a record of this event and that they informed Olympia that she must tell her mother if she was hurt again.

On the morning of 3 August 2001, Olympia made an allegation of sexual abuse at school to her friend, who reported it to a teacher's aide, that her "father," Bruce Howse, was sexually abusing her and her younger sister. The teacher aide immediately passed on this information to the Deputy Principal who then spoke with Olympia.

The Principal was away from school that day and the Deputy Principal activated the school's "Physical and Sexual Abuse of Children Policy" and made an immediate notification to Child, Youth and Family.

Records indicate telephone calls between a CYF supervisor and the school during late morning. Olympia told staff at 2.50pm that she was happy to go home. However at 3pm Olympia said she was no longer comfortable going home. It was agreed that a staff member would take her to her grandparent's home in River Road.

The school records show that the staff member passed Bruce Howse's car (identified by Olympia) and that he then followed the staff member and Olympia some distance to the grandparent's house. The staff member at that point decided to return to the school with Olympia for "safety."

Charlene Aplin states that she was made aware of the situation at school initially by Bruce Howse. He reported that "a teacher had taken Olympia somewhere in her car", and that he had followed the car and that Olympia was "laughing".

Charlene was in the middle of feeding the baby, so rang the school to find out what was happening. Charlene then decided to go to the school and took her oldest daughter with her.

School records state that on arrival;

Mrs A and daughter arrived and when told about the disclosure, were angry with Olympia. Olympia removed to photocopy room out of earshot.

Mrs A calmed a little and said they were going to River Rd-tell them (CYF) to meet us there and I'm taking Olympia. The DP advised her not to -Mrs A shoved her on the chest forcefully. The DP advised her that this was assault. Another staff member followed her out to the car, cautioning her against taking her and being so angry towards Olympia. Mrs A cautioned her daughter not to say anything more and went off. 15 minutes later Mrs A rang, sounding calmer and asked where CYF were and said that she had sent all the other kids home.

How CYF responded to this notification has been reported elsewhere in this report.

School records show that they were involved in a meeting on Monday 6 August with Charlene Aplin and her mother. The abuse allegation and Olympia's retraction and investigation by CYF were discussed.

Charlene agreed to apologise in writing to the Deputy Principal for pushing her on the previous Friday.

A further meeting occurred on 13 August. The school requested that the CYF social worker come to the school so that she and school staff could communicate to Olympia the dangers and consequences of false allegations. Olympia's mother was not invited to this meeting.

On 16 August the Principal records that;

RE: Olympia Aplin/ Diary
-Copy of pages of Olympia's diary (photocopies) to me from BOT member and mother of Olympia's friend - Olympia left diary after staying overnight.
NB
(i) Diary (copy) referred to social worker- 3/9/01 social worker read in my office-noted similarity to previous verbal allegations against stepfather.

(ii)) Allegation re Friday 3 August-this was the day the allegations were made to teachers at school-CYF notification made.
-Mother informed of allegation (note reaction-came to school and abused teachers).
-Grandparents informed by phone.
-Older sister informed.

(iii) On 3/08 - Olympia left school with mother -was taken to grandmother's-mother phoned we're here (11 River Rd) where are CYF?
-Social workers met O/mother at home.

(iv) Diary-virtually same allegations as before.
-Diary communicated to CYF social worker, not mother (note above reaction).
-CYF had already satisfied the allegations were false and withdrawn.
-Olympia's credibility was nil!

(v)) School's role in notifying CYF had been met!

The school passed the copy of Olympia's diary to CYF, who recorded that this was received by them on 3 September 2001.

On 24 August 2001 the school recorded that Olympia told staff that her stepfather had hit her with a broom handle when he found that she had left her jacket at a friends. Records of this event include a drawing of the mark on Olympia's leg and comments.

Red welt-4"-appearing on left leg (thigh)-bruise about 4"by 4"-kind of scraped.

There is no record that the school notified CYF or the Police that Olympia had alleged that Bruce Howse had physically abused her.

Interviews with school personnel during the course of this investigation revealed the deep impact that the girls' deaths had on pupils at both schools, on the staff and on the school community. Staff and pupils of both schools gave evidence to the Court during the trial of Bruce Howse which concluded one year after the girls' deaths.

5.3.1 Findings

1. Lansdowne School made an appropriate notification to the Department of Child, Youth and Family Services on 3 August 2001, when Olympia Aplin alleged sexual abuse.

2. Lansdowne School informed Olympia's mother of the detail of Olympia's allegations against Bruce Howse. Ideally this information should have been communicated to the family by statutory social workers.

3. Staff from Lansdowne School attempted to protect Olympia from her mother and sister's anger at the information within Olympia's disclosure.

4. Staff appropriately advised Mrs Aplin not to take her daughter from the school on the afternoon of 3 August.

5. Lansdowne School were informed by CYF on 6 August that the investigation into Olympia's allegations were completed and no further action was to be taken by the Department. The school had no reason to suspect that the CYF investigation was flawed.

6. Lansdowne School were unaware that CYF had not applied proper process to the fact that Olympia had withdrawn (recanted) her allegation. They were not informed by the social worker of the correct policy and practice, which should follow when a child recants an abuse allegation.

7. On the basis of CYF information Lansdowne School believed that Olympia had lied about Bruce Howse abusing her. The school requested that a CYF social worker talk to Olympia to impress on her the dangers of "lying" about abuse.

8. Lansdowne School did not notify Child, Youth and Family or the Police on 24 August when Olympia alleged physical abuse by Bruce Howse.

9. Hiona Intermediate suspended Saliel on two occasions in 2001, the first for a period of one month.

10. Hiona Intermediate, at Ms Aplin's request, made a referral to CAFS and to the school social worker because there was concern about Saliel's behaviour.

11. Hiona Intermediate, in Saliel's second year of enrolment, assessed that she had learning difficulties and was three years behind her chronological age for reading and mathematics.

6. MEDIA REPORTING OF CHILDREN AND YOUNG PEOPLE WHO ARE WITNESSES OR VICTIMS OF VIOLENCE

The facts of Saliel and Olympia's deaths were reported widely in print and electronic media. Media coverage included interviews with family members and comments from community members and professionals, as well as the facts relating to the criminal processes.

It has been reported to the Commissioner that the media approached the surviving children and young people in Saliel and Olympia's family, and their friends, on several occasions near their schools and homes. Saliel and Olympia's older sister was pursued by a television crew in the streets of Masterton, days after their deaths. She was at that time 16 years of age. She sought shelter in a shop where a friend of her mothers worked and was driven home.

For the children and young people within the family the impact of their sisters' violent death was at that time, and still is, profound. It is difficult to imagine how children in the family were able to understand the facts of their deaths let alone process their shock and multiple and intertwined feelings of grief, anger, fear and loss.

Children outside of the family, their friends and school mates, were said to be numbed, sad and fearful that someone "just like them" could be killed so violently in their own home.

It is difficult to understand why the media at that time felt it was important to pursue the surviving siblings to gather comments for their coverage of the events.

Even if this could be justified in terms of the "public interest" one would expect that an ethical journalist would have some appreciation of the impact of these violent child deaths on the children in the family and their friends and respect their privacy at that time by not approaching them for interviews.

The fact that Bruce Howse's trial was not concluded until one year later, meant that the children and young people (family and friends) who were to give evidence in the Court, were in an emotional limbo. Their own timeframe of grieving or acceptance was affected by the timing of the criminal and court processes.

Media reports of the trial were extensive and the children of the Masterton community, and Olympia and Saliel's surviving siblings, were likely to have watched television coverage or read newspaper reports which identified every fact of the trial.

It is accepted that Howse's legal counsel had a right to pursue lines of questioning in the defence of his client. However it is difficult to accept that the media reports of this questioning needed to be as insensitive as they were.

The media reported in detail how Saliel had been suspended, was a smoker, was verbally and physically violent and that she was a sad and troubled child. The reporting of this detail seemed to infer that somehow Saliel was at fault and that this was a possible reason that she was murdered.

These media reports highlighted for many that even in death Saliel was a victim, and that she and her sister's rights to respect, privacy and dignity were violated.

The following headlines evidence further disrespect for the murdered children and the circumstances their surviving siblings found themselves in.

Stabbed girl a troubled child
The Dominion 8/4/02

Howse threatened to kill, says girls'sister
The Dominion Post 22/11/02

Dad I hate you-girl's note
The Press 26/11/02

Stabbed girls may have been asleep
Dominion Post 21/11/02

Death family's dark past
Waikato Times 6/12/01s

Policeman hit as mother tried to see bodies
The Evening Post 9/4/02

One of dead Masterton girls was "in position of prayer"
The Dominion 3/4/02

Children and young people have a right to protection from media reporting of events in their lives.

The New Zealand Press Council articulates the standards expected in relation to children and young people. The Council assert that Editors should have particular care and consideration for reporting on and about children and young people.

The Press Council emphasises the need for journalists to respect people's (no specific reference to children) rights to privacy of person, space and personal information. The Council nevertheless asserts that the right to privacy should not interfere with publication of matters of public record, or of significant public interest.

Journalists are expected to exhibit careful consideration and attention in their approaches and enquiries to people suffering from trauma or grief. Once again children are not referred to specifically by the Press Council in this regard.

The Council however does assert that publications should exercise care and discretion before identifying relatives of persons convicted or accused of crime where the reference to them is not directly relevant to the matter reported.

The Free to Air Television Code of Broadcasting Practice (effective from 1 January 2002) determines that broadcasters should take particular care when dealing with distressing situations, and with grief and bereavement, and that discretion and sensitivity are expected. The Code also states that broadcasters should recognise the

rights of individuals, particularly children and young people, not to be exploited, humiliated or unnecessarily identified.

The Code (Standard 9) makes specific reference to children's interests by stating that during children's normally accepted viewing times, broadcasters are required, in the preparation and presentation of programmes, to consider the interests of child viewers. Specific reference is made of the need to handle scenes or themes, dealing with disturbing social or domestic friction, in which people, especially children, may be humiliated or badly treated, should be handled with care and sensitivity.

The Code's privacy principles (Appendix 2, vii) recognise that children's vulnerability must be of prime concern to broadcasters.

Children's rights and the media have been the subject of international deliberation and action. The first international consultative conference on journalism and child rights was held in Recife, Brazil, on May 2nd 1998. There were 104 signatories (New Zealand was not amongst the signatories) to a statement of guidelines and principles for reporting on issues involving children.

The conference emphasised that journalistic activity which touches on the lives and welfare of children should always be carried out with appreciation of the vulnerable situation of children and the profession's commitment to strive for standards of excellence in terms of accuracy and sensitivity when reporting on issues involving children.

Saliel and Olympia's siblings have to live with the constant comment of other children and adults about what occurred in their family and to some extent their identity is shaped by what happened. This continues to the present time.

Recently their brother, on the way to the dairy, heard boys on their bikes call out "look - that's the brother of those girls who were murdered".

Clearly there is no way to know how a community will respond to cases of children who have suffered tragedy in their lives. However the media can play a part in this, by ensuring the most ethical and careful consideration of what is reported, and what possible effect this may have on the surviving children and young people in Saliel and Olympia's family.

6.1 FINDINGS

1. News media, by approaching and making inquiries of children in the family and community in the days after Olympia and Saliel's deaths, showed little consideration of the grief and trauma the children were experiencing.

2. News media violated these children's rights to privacy, respect and dignity.

3. Media reports of Bruce Howse's trial were not balanced in the interests of the children with due respect for Saliel and Olympia's privacy and dignity or appreciation of the circumstances of their lives and deaths.

7. DISCUSSION

7.1 Current Government policy on the care and protection of children

The care and protection of children and efforts to eliminate family violence has been the subject of focused government and non-government activity and attention in the last two to three years.

As stated in the Commissioner for Children's report into the death of a child (June 2000).

The Department of Child, Youth and Family Services has, over time, been the focus of public and professional anger and criticism about children who are killed or harmed by abuse and neglect.

Whilst it is true that this agency has the statutory responsibility to administer the Children, Young Persons and their Families Act, it is recognised by many that the agency is only one part of the wider care and protection system which should respond to children who are abused and neglected.

A strong care and protection system is evidenced by three main factors:

1. *There ought to be strong working relationships between all agencies involved with children, both government and non-government so that crucial information is shared.*

2. *There ought to be high levels of community and professional knowledge about care and protection, so that child abuse and neglect is recognised and reported appropriately.*

3. *There ought to be fundamental and operational adherence to the care and protection legislation and clear, strong links between the policies and practices of other jurisdictions, so that in all matters the best interests of the child are of paramount concern (p.25)*

That investigation resulted in 59 recommendations being made to government, government agencies and heath providers. The interagency working party established by the then Minister of Social Services, the Hon Steve Maharey and led by Dame Margaret Bazely, to monitor the adoption of those recommendations, has reported to the Commissioner for Children.

The report indicated that good progress had been made in actioning all recommendations.

It is concerning to note that this investigation identifies poor intra and interagency practice similar to that found in the June 2000 investigation.

The Brown Report

Also in 2000, the Minister directed that a review of the Department of Child, Youth and Family Services be completed. This review[5] was carried out by retired Judge

[5] Care and Protection is about adult behaviour, The Ministerial Review of the Department of Child Youth and Family Services, December 2000

Mick Brown, a former Principal Youth Court Judge, and his report was released in December 2000.

This review made a total of 57 recommendations for change within the Department in the areas of operations, management, accountability, outcomes, the quality of social work, referral and notification processes, placement and the care of children, services for and by Maori, interagency work, and child and adolescent mental health.

New Directions

In their response to the Brown report, the Department of Child, Youth and Family Services established the New Directions[6] policy. The overall goal of the New Directions programme is to build an organisation that advances the well being of families and the well being of children and young people as members of families, whanau, hapu, iwi and family groups. "Children and young people who are in need of care or protection, or who offend against the law are the focus of our services." (New Directions Programme Charter, 25 June 01).

As a result of this policy, 24 projects are highlighted as major contributors to addressing the needs of those who require their services. These projects cover a range of issues such as;

1. Development and implementation of a strengths-based outcome focussed approach to social work.

2. Development of a comprehensive social work workforce planning strategy.

3. Development and implementation of a Learning and Development strategy to ensure focus on frontline professional development needs.

4. Development of local services mapping for Child and Family Social Services.

5. Design a joined up regionally focussed agency.

6. Development and implementation of a Maori Strategy.

A number of these projects have already been completed.

A central concern expressed by Mick Brown was that "the Care and Protection Sector does not have an agreed vision, nor an agreed strategy as to how the vision can become a reality. We need a clearly defined blueprint for the future, and one which the Government will commit itself to fully resource".

The government has responded to this concern by developing The Care and Protection Blueprint 2003 which is a strategy for enhancing the services provided to children and young people who are at risk of, or who have suffered from abuse and neglect. "It has been developed for the whole care and protection community and is aimed at improving the way government and community agencies work together to respond to child abuse and neglect."

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[6] New Directions Programme Charter, 2001 (unpublished)

The Blueprint

The Blueprint[7] is consistent with other cross sector strategies such as Te Rito, New Zealand Family Violence and Prevention Strategy, the Youth Offending Strategy and New Zealand's Agenda for Children.

The Blueprint has ten actions areas, which aim to establish strategies or mechanisms over the next eighteen months. The Blueprint goals are being managed by the Ministry of Social Development with the involvement of other relevant Government departments.

Attention is focused within the Blueprint on developing Maori leadership of, and involvement in, the care and protection community. This will also involve engaging Pacific and other ethnic communities in the planning and provision of care and protection services, and incorporating the views of children, young people and their families into the planning and provision of services.

The Blueprint also involves the development of outcome measures for the care and protection community, and of enhanced evaluation of care and protection services.

Further the Blueprint plans to improve interagency collaboration, develop a government investment strategy for care and protection, address workforce issues, identify and promote good practice and to review the role of Care and Protection Resource Panels.

The Department of Child, Youth and Family Services in their briefing to the incoming Minister (August 2002) has expressed concern that they have been identified to lead nine of the eighteen action areas of Te Rito and that this has meant a large commitment of already scarce resources. Clearly the Department's workplan directed by the action areas of the Blueprint will involve a further stretching of those already scarce resources.

Baseline Review of CYF

The Department was recently the subject of a joint Treasury, Ministry of Social Development and State Services Commission review of their baseline services, which focussed on the Department's role, strategies and services and how those services are delivered. The review aimed to assess the appropriate level of resources needed by the Department. It's findings were released on 23 October 2003 by Minister Dyson.

Saliel and Olympia died in December 2001. It remains to be seen whether children and young people who live in similar circumstances will benefit from the planned improvements to the care and protection sector outlined above.

All children have a right to care and protection and these rights are provided for within domestic legislation and international conventions. Accountability on the part of government and society to ensure that their legal rights are upheld is vital to their survival and wellbeing.

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[7] New Directions Programme Charter, 2001 (unpublished)

The current analysis and review of the Department's role, and the work planned by the Ministry of Social Development in respect of the Blueprint action areas, needs to ensure that the rights of children and young people provided for in the Children, Young Persons and their Families Act are not in any way compromised or infringed.

7.2 Current Government policy on Family Violence

Violence between adults in families has been increasingly acknowledged within New Zealand society. During the last two years family violence has been the subject of focused action on the part of government and communities.

Although there has been increased reporting of and arrest rates for family violence and increased availability of programmes provided for under the Domestic Violence Act, 1995, there has been concern expressed as to how children affected by family violence can be better identified and more effectively responded to.

Research[8] shows that partner abuse and child abuse are closely linked. As stated earlier, Edelson[9] suggests that up to 53% of all families where women are being beaten, their children are also victims of abuse by the same perpetrator. Research also suggests that children who witness domestic violence may suffer social and mental health problems such as childhood conduct disorders, personality disorders, and a propensity to later violent behaviour.

Growing up in a violent family is a form of emotional abuse and neglect for children. This abuse and neglect can result in those children exhibiting socially unresponsive behaviours, being emotionally blunted and being passive, apathetic and inattentive.

Research by Bruce Perry (1997) indicates that brains of babies and small children who are exposed to violence, abuse or trauma are profoundly affected, and that as a result of this exposure, their neurophysiological development can be markedly reduced. This can impact on a child's ability to learn, and their emotional, cognitive and psychological well being.

The risks to children when violence is occurring within their home should not be underestimated.

Until recently there has been a fragmented approach to family violence in terms of how it is understood, and also in terms of the services offered to families where violence between the adults is present. Edelson suggests that often treatment or intervention is offered to different members of the family with little attention to providing a holistic approach. Further he suggests that focus on a single approach to violence in the home will have limited success.

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[8] Hamilton C & Browne D, "Recurrent abuse during childhood: A survey of referrals to Police child protection units in England" Unpublished report

[9] Edelson J (1999) "The overlap between child abuse and woman battering" in Violence Against Women 5 (2)

Te Rito

Te Rito[10], the New Zealand Family Violence Prevention Strategy (February 2002), implements the Government prevention plan of action to eliminate family violence. The fact that family violence is a significant social issue in New Zealand has created the need for a focused strategy which approaches family violence in a more comprehensive and coordinated way and places emphasis on prevention and early intervention strategies.

Research related to the intertwining experiences of adults who have experienced abuse as children, and who are the victims of violence in their adult relationships, and the subsequent ability to keep their children safe, is rare.

Until recently there has been little national and international research which provides an holistic view and understanding of family and the factors which contribute to and heal violence and abuse within them.

New Zealand Research on Family Violence

The excellent research[11], "Free from Abuse What Women Say and What Can be Done", provides new understandings of family violence and abuse and contains powerful suggestions for action.

The research was completed in three strands, Maori, General and Pacific, but the report is presented as one document for the purpose of "safe guarding the overall focus on women and the service and policy recommendations." (p.2).

It was found that the first efforts by women communicating about being abused were usually to relatives and friends and the responses of those people had the effect of either leading women to seek further assistance, or of keeping them trapped for further abuse.

It was found also that financial considerations played a key part in decision making and that abusive relationships led to transience. The stories of the women refer to economic hardship, to support given sometimes by family and friends in practical and enduring ways, and sometimes to services where they received assistance.

The interviews which formed the basis of this research revealed women who were tenacious in finding work, extremely resourceful about saving and managing money, women who were adamant about bringing their children up in safe, stable and optimum home conditions.

Extensive descriptions of abuse in domestic relationships were given, "One of the effects of abuse is that women can be rendered incapable of acting on their own behalf and getting to safety" (p.56).

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[10] Te Rito New Zealand Family Violence Prevention Strategy, Ministry of Social Development, 2002

[11] Free From Abuse: What Women Say And What Can Be Done. Hand.J, Elizabeth.V, Martin.B, Rauwhero. H,H, Burton.M, Selby.S, Falanitule,L, Public Health Promotion, Auckland

Some women spoke of the division which occurred in their families when as children they were sexually abused by family members and of the intergenerational nature of that type of abuse.

One woman spoke of her family's rejection of her and the stigma attached to being pregnant at 15 and having to leave school. Many women spoke of their love for their own fathers and their fathers' attempts to protect and support them over time.

The women's stories revealed varied use of services, from sustained use of a wide range of services to little knowledge of services and perceptions that services were not supportive to Maori. (p.62)

Some women spoke of how helpful the police were in terms of giving information and support, while others spoke of how ineffective protection orders were because "he just tore them up".

Hine Rauwhero (Tainui, Raukawa ki te Kaokaoroa), researcher of the Maori strand of the research, found that whanau support is of primary significance to abused women and that interventions are often mediated through whanau, parents and grandparents.

However she states that in some instances whanau may be unable to respond adequately. Her view is that abuse appears across generations, but it is not the only factor of abuse. A further finding is that many women may choose to "manage" violence rather than separate from their abusive partners because of economic and social reasons.

Te Rito[12] recognises that "first contact" people working with children and families (such as teachers and health professionals) are in a prime position to identify children affected by family violence. Appropriate guidelines, procedures and training are required by these professionals. They are then in a better position to identify the indicators of family violence, know what to do, how best to respond and who to refer families to.

Education on family violence for people working with children and families is promoted within the strategy as is the inclusion of this education in all tertiary and private provider establishments (particularly teachers and health professionals) for those intending to work with children and families.

Relevance to this investigation

Saliel and Olympia lived with family violence all of their lives, in terms of witnessing violence perpetrated on their mother, or being victims of physical and verbal and sexual violence by especially the male adults in their home.

Many professionals were aware that family violence existed in their home and some judged that regardless of this, they and their siblings, were not at risk of physical abuse.

Assessments completed by a variety of professionals over a nine year period, reviewed for the purposes of this investigation, are silent on whether Saliel and

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[12] Te Rito New Zealand Family Violence Prevention Strategy, Ministry of Social Development, 2002

Olympia's behavioural, cognitive and or emotional responses may have been linked to this violence.

It is also clear that there was a fragmented response to the violence in their home. Responses to individual adult family members did not comprehensively identify or respond to Olympia, Saliel or their siblings' needs.

Interviews with both the girls' schools did not reveal any suspicions from staff about the possibility of family violence within their home.

7.3 Counselling and Mental Health Services for Children

At the time of her death, Saliel was a client of the Masterton Child and Adolescent Mental Health Services and attended sessions with her mother on occasions, and with Howse on other occasions.

Saliel and Olympia had received counselling from a variety of counsellors since they were very young because of their allegations of sexual abuse.

They did not however, have access to the children's programmes provided for in the Domestic Violence Act,1995 because of a failure of the statutory agencies to report and respond to their circumstances.

Currently children can access free counselling if they meet the criteria determined by a variety of counselling providers. Sexual abuse counselling is funded by ACC. CYF or the Family Court fund counselling if Court hearings or interventions under the CYPF or Guardianship Acts identify a need, either as an intervention, or as a way for increased information about a child to be put before the Court.

Currently there is concern amongst families, counsellors and other professionals that unless a child has physical evidence of abuse having occurred, there is little provision for funded counselling. Many children who are troubled or unhappy for a variety of as yet undetected reasons, cannot receive counselling if their parents cannot afford it or if their presenting symptoms are not deemed to be in the most serious 3% of the child and adolescent mental health population.

There is a further concern that there is currently no central database which records whether a child has accessed funded counselling through Health, ACC, or through the provisions of the Domestic Violence Act. Consequently, any involvement on the part of statutory agencies, Health, Education or counselling agencies can and does happen without any sharing of information of concern.

The fact that a child's counselling, therapeutic and or rehabilitative needs must be compartmentalised in terms of their needs relating to sexual abuse, domestic violence and or mental health is of strong concern to this office. It appears that a lack of a "whole child" approach is mirrored and intensified in terms of the counselling or lack of it that is currently provided for children.

On a more general theme, the New Zealand Paediatric Society[13] has developed some voluntary standards in relation to health services for children and adolescents. These standards have been developed in recognition of the fact that children and adolescents are vulnerable and fragile in both physiological and psychological terms and that they are not just "little adults". They have needs that are distinctly different from adults and that these special needs must be provided for during every step of health service delivery.

7.4 The Education Sector

Schools have a critical role to play in the care and protection of children and young people. The circumstances of children's lives are generally well known by their teachers and school management and governance policies and practices should ensure that their learning, behavioural and emotional needs are responded to.

Tomorrow's Schools (Education Act,1989) emphasises the critical relationship between schools, parents and communities in order that positive student outcomes are created. The Act (sections 77(a) and (b)) require that parents are reported to regularly on their child's progress at school and that they are informed of matters which may be impeding their progress. Schools are also required to offer guidance or counselling to students where appropriate.

Education professionals, as a result of training and experience, routinely identify children who require specialist support, in terms of their learning, behaviour or social needs. Some of this assistance will be provided from within the school in terms of specialist programmes, the provision of extra in class support or from staff with particular expertise.

External assistance can be provided by the school accessing other specialists, such as psychologists, resource teachers of learning and behaviour, behaviour specialists, speech therapists, and hearing and vision specialists. Schools also have access to health professionals such as Public Health Nurses. Some schools also have school social workers or truancy officers who attempt to maintain links between the school and the child's family.

The decision to trigger extra assistance for a child is usually at the Principal or teacher's recommendation and advice to, and agreement with, parents.

Schools can respond to the behaviour of a student by invoking disciplinary procedures outlined in the Education Act, 1989. A school may decide that a student's behaviour is such that s(he) should be stood down, suspended, expelled or excluded. The disciplinary processes should involve a focus on a particular child's circumstances[14] and have minimal disruption to a child's learning. The processes can also be a means by which other assistance required by the child and his or her family is identified and provided. Thus it is of importance that a child's behaviour is responded to, but of more importance is the analysis of what is the basis or reasons for that behaviour. In the absence of this type of assessment, school discipline

[13] New Zealand Standards for the Wellbeing of Children and Adolescents Receiving Healthcare, Paediatric Society of New Zealand, May 2002

[14] M and R v S and Board of Trustees Palmerston North Boys High School (1990) HC: Palmerston North, CP 302 and 305 5/12/90, McGechan, J.

systems could rightly be perceived as punitive, unhelpful and failing to respond to a child's overall circumstances.

The allegation by a child or young person of abuse or neglect within a school can create a crisis for the staff in terms of how to respond to both the information within the allegation and to the child. Current policy and practice relating to how schools should respond to this situation, has been shaped by both legislation (CYPF Act, 1989, Education Act, 1989) and intersectoral protocols and agreements.

Although New Zealand does not have a policy of mandatory reporting of child abuse and neglect (where teachers and other people working with children and young people are legally bound to report all allegations by children and young people of abuse), school policy, procedure and professional training in the area of abuse and family violence, should routinely result in schools notifying the statutory agencies, (Police or CYF) of all matters contained within any allegation.

The CYPF Act allows for statutory social workers to interview children and young people at school without the permission or knowledge of the parents. The reasons for this, are that to inform the parents prior to an interview or investigation taking place may in fact put the child at increased risk, or adversely affect the child's ability to make a full disclosure. Social workers are required to notify the parents or caregivers as soon as is possible after the interview.

It is of absolute importance that schools are able to trust that notifications regarding child abuse and neglect to statutory agencies will be professionally responded to.

Education professionals are not care and protection, or family violence specialists, although they have knowledge about the factors which may impact on a child's learning, wellbeing and development. Knowledge regarding the recognition of indicators of child abuse and neglect and family violence is central to a school's ability to respond to the welfare of children. Once they have identified and notified a concern to statutory agencies schools rely on the judgement, skill and professionalism of those specialists. There is a valid assumption that social workers will complete investigations in a way which is consistent with legislative, policy and practice guidelines. Also that the outcomes of that investigation will be not only accurate but any decisions made will be in the "best interests of the child".

CYF statistics relating to notifications made to the Department, indicate that schools represent one of the lowest groups of professionals who inform them of incidents of child abuse and neglect. Whether this statistic relates to a lack of ability to recognise and thus report indicators of possible child abuse or family violence, or whether it reflects a lack of confidence in the ability of the Department to respond to concerns about children should be the subject of further study. CYF Community Liaison Social Workers have an important role to play in assisting schools to understand factors adversely affecting the welfare of children and to recognise those indicators.

Strengthening Families and other interagency processes are significant opportunities for sharing and acting on information which identify children at risk or in need, and are thus critical helping structures for children, young people and their families.

Community Child Protection Teams, made up of health, education, welfare and police personnel, have in the past (1980's), provided a structure whereby those working with children, young people and their families, could regularly share

information, discuss children or families causing concern, or discuss the current social issues impacting on the community and decide on any interagency response required.

Clearly it is of fundamental importance that schools are able to discuss their concerns about individual children with statutory and other agencies who may be able to assist by responding to a child's circumstances in a planned and collaborative way.

7.5 Extended Family and Community response to violence towards children

Media reports of the Howse murder trial reveal that;

- Neighbours heard screaming the night Saliel and Olympia died but that it was not unusual and they ignored it.

- Charlene's sister told the Court of an incident where she hit Howse in the face after she thought he was going to hit one of the children. Howse laughed at her.

- Howse's son, said that on the night of 20 November 2001 Howse said he "was going to kill them at 52 Kippenburger St." He said it was not the first time Howse said he would kill them.

- Mrs Aplin, the girls' maternal grandmother, told the Court that she did not visit their home often because of the tension there. Her husband said that he had seen Howse "pick on the kids for no reason, both physically and verbally." Mr Aplin said he stopped visiting the house because he did not like the way Howse treated the children.

- A neighbour told the Court that she had seen Howse hit the children, including with a broomstick on some occasions. She heard Howse threaten to send the children away and twice she heard Howse threaten to kill them. She said that yelling and fighting between the adults in the Howse/Aplin household was almost a daily occurrence.

- The girls' older sister told the Court that she remembered a night where Howse was brought to her grandparent's home after a violent incident. "He said he was going to kill my family," she said. The threat was made in the months before the girls died. She said that he seemed serious and had made that threat before. She also said that if Howse had been drinking he became violent and would hit.

- A school friend of Olympia's told the Court that Olympia came to school with injuries she said were caused by Howse. She said that about a week before she died, Olympia told her that Howse had threatened to kill her and Saliel but she had not believed her. Olympia told her that her stepfather hit her, hurt her and was cruel to her.

Extended family, neighbours, friends and community members are crucial monitors of children's safety and wellbeing, in that they are in a position to notice and respond to factors or circumstances which may result in a child being caused harm.

Many people feel reluctance or unwillingness to interfere or intrude into the private lives of families. Even when family violence or child abuse is noticed or suspected, it

appears that it is difficult, if not impossible, for many individuals to act on or report information, belief or suspicion.

On the other hand the public continues to express shock, anger and outrage over the numbers of child abuse cases and deaths.

The Brown report (2000) pointed to the need for a fresh look at public attitudes towards violence in families and communities and the abuse and neglect of children. Judge Mick Brown called for public education initiatives, which could succeed in shifting public attitudes of acceptance and collusion, to an obligation among individuals and communities to address child welfare issues and violence.

Child, Youth and Family have responded to this suggestion by introducing the programme "Everyday Communities" the goal of which is to ensure that, "All New Zealanders are aware of their responsibility to act to keep children and young people safe."

This programme complements other CYF education campaigns over the last five years: The "Breaking the Cycle" and the "Neglect Prevention" programmes.

The CYF briefing to the incoming Minister (August 2002), reports that the initial results of the "Everyday Communities" are very encouraging. CYF note within this briefing that only one per cent of their overall funding can currently be spent on prevention programmes.

In view of this investment it is unlikely that the programme's aim "to build on and strengthen the cultural and societal beliefs and practices that underpin child safety and well being by fostering and supporting a whole of community response to child protection and well being" will be realised.

Clearly there is a need for increased awareness, commitment and responsibility to keep children safe, underpinned by increased recognition of the factors which may indicate a threat to safety.

7.6 Response by Professionals

Dr Susan Perry, psychiatrist with CAFS, told the Court during Howse's trial that she felt actively blocked by Howse who would dominate conversations during Saliel's counselling. After several appointments attended by Howse she was increasingly concerned they were not solving Saliel's problems.

"I felt we were not being told the full story... I felt Saliel's behaviour was a sign of the distress she was experiencing somewhere, probably at home". She also said it was apparent that when she tried to follow things up that no one else knew the full story either. She said Saliel appeared to have a good relationship with her mother. However, when Saliel came for an interview with Howse she was different. Dr Perry said she was dissatisfied with the way Howse was dealing with Saliel's problems which was one of the reasons she was concerned.

Counsellor Shirley Butler reported to the Court (the family was first referred to her in 1994), that she felt Howse was always angry, especially when challenged or thwarted. She told the Court that Howse often used the expression that he would kill

someone. Ms Butler said that Charlene was the more moderate parent and the children were not afraid of her.

A CYF social worker who was involved in the CYPF Act and Guardianship Act applications to the Family Court and social work interventions between Bruce Howse and his ex partner, asked to be removed from the case because she was scared of Bruce Howse.

A staff member of Lansdowne School, after taking Olympia to her grandparents on the day of her allegation, returned to school with Olympia, after she noticed Howse following them, "for safety."

For most adults, professionals included, the thought that an adult could commit violent acts on other adults or children is an absolute anathema. The Principal of Lansdowne School has said to this office that he still, almost two years later, feels a sense of shock and disbelief that these children were killed so violently by Howse. He said that no one could have expected that the girls would die as they did.

Child abuse and violence within families is difficult to identify and sometimes even more difficult to respond to.

As stated in The Commissioner's report into the Death of a Child (June 2000);

Child abuse is complicated, both in its presentation and in the difficult decisions which have to be made. Anyone concerned about a child has to work with partial information, and the anxiety not to do more harm than good. These dilemmas face everyone, family members, neighbours and agency workers.

Professionals whose work involves children have particular responsibilities, but are guided and protected by legal and policy requirements and by accepted standards of best practice in their profession. Society expects scrupulous adherence from those in trusted positions. (p.5)

As in the June 2000 investigation this report identifies the effect of sequential or cumulative errors and omissions on the part of professionals. Once again this investigation has shown the need for bringing together the pieces of information held by each agency and worker is of fundamental importance in being able to determine a clear picture of what is happening for a child, or as in this case, children.

Clearly Government needs to be reminded again to recognise the importance of intersectoral communication, planning and review and that this recognition requires specific focus in terms of departmental outputs and funding.

7.7 Child Protection Teams

With the introduction of the Children, Young Persons and their Families Act in 1989 the model of interagency communication in place at that time, the Child Protection Team, was disbanded.

The Children, Young Persons and their Families Act enabled the increased participation of the family in decision making. The Family Group Conference was created to enable families to have a greater say in decisions affecting their children.

Professional decision making had to provide greater recognition and give increased weight to the needs and wishes of the wider family.

In her excellent and challenging article[15] Anne Caton describes the arguments for the Child Protection Team model.

Children and young persons in need of care and protection are commonly known to several agencies and helping services; it makes sense to work together.

It is often hard to know if a child or young person is in need of care or protection and usually each agency or group has only part of the picture; it is clearer if the bits of the picture are put together.

It is inefficient to have lots of workers involved who are duplicating or contradicting what others are doing; it is more efficient to plan together.

When a child dies or is seriously injured, it is commonly found that they were known to many agencies and groups but they "fell through the cracks"; it is safer if those involved consciously built a safety net around the child or young persons which is appropriate to the particular situation.

For a variety of reasons, not the least of which was the huge philosophical and ideological shift brought about by the introduction of the CYPF Act, the interagency case conference supported by the Child Protection Team structure, was discarded.

Kinley and Doolan in their assessment of the deaths of children known to Child, Youth and Family, "Patterns and Reflections" (1997), identified that a common weakness in social work practice was inadequate social work investigation and assessment of child protection notifications. Anne Caton argues that in New Zealand, particularly because of the requirements of our child protection legislation, there may be a risk during the investigation and assessment of a case, that social workers place too much emphasis on forming and maintaining a relationship with the family at the "expense of comprehensive information gathering and careful consideration of all facets of the child's situation".

She argues that child protection social workers owe it to the child and to society to be thorough. Arranging for interagency groups to come together during the investigation and assessment of the case to share information and assess risk could ensure that "more pieces of the jigsaw are available for a picture of what is happening for this child".

Checks and balances on social work decision making are essential. Social workers and their supervisors have tools available to them to assist in their decision making.

They have a Care and Protection Resource Panel made up of community representatives available to challenge assumptions and suggest alternatives to social worker decision making. They have a Family Group Conference process which ensures that family views are considered. Ultimately they have the Family Court where decisions can be reviewed and challenged.

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[15] Caton, Anne "The interagency approach to child protection: what is possible today", Social Work Now, December 2000

Sadly the Aplin case vividly demonstrates the effect of professionals working in isolation from each other, the normal checks and balances that should have been applied in the management of this case were not adequately or appropriately actioned. The agencies involved and individual counsellors each had a part of this jigsaw. All of them were well motivated and wanted the best for the Aplin children. It could be argued that the sum of the knowledge of what was happening in this family, only revealed now with the benefit of hindsight, could have produced a different outcome for Saliel and Olympia.

The creation of a local Child Protection Team where professionals meet to discuss their knowledge of, and describe their involvement in at risk families, could well be the vehicle for an improved interagency child protection response.

Anne Caton identified that one of the major strengths of the Child Protection Team Model was that each case conference had one or two members who were involved in every case conference. "With experience, team members became very knowledgable and helpful to case workers. The team members, free of any relationship with the family, could look at a case more objectively and this distance provided a useful balance to the natural involvement and anxiety of the frontline workers".

The deaths of Olympia and Saliel have highlighted and reconfirmed the fact that many agencies can be involved with a family and know part of the picture. These parts need to be brought together.

The Child Protection Team can exist alongside the Family Group Conference, and other whanau decision making processes. None is exclusive of the other. It may be time for Government to look again to legislate for the creation of Child Protection Teams and to provide appropriate resources for their effective coordination.

8. RECOMMENDATIONS

8.1 The Minister of Social Development

1. Report on the need for a national plan for social services for children and young people which not only responds to care and protection and youth justice issues, but also incorporates the, education and health sectors.

2. Report on whether the current intersectoral collaboration initiatives responding to family violence and the welfare of children would benefit from a clear overarching child policy and a detailed national plan.

3. Report on the implementation of the objectives of Te Rito to promote and increase child advocacy services. This report to include information on funding for this promotion, and to which organisations this funding is to be directed and according to what criteria.

4. Report on the current number of children's programmes provided for within the Domestic Violence Act, and their effectiveness. This report to include identification of the barriers to increased services to children who are affected by family violence.

5. Report on the establishment of local child protection teams, made up of all agencies that work with children, young people and their families.

6. Ensure that the decisions of the baseline review of the Department of Child, Youth and Family Services are accompanied by an analysis of the impact of those decisions on children and young people's rights defined by the CYPF legislation and international convention (UNCROC).

7. Commission research on the impact on children of family violence within the New Zealand context.

8.2 The Chief Executive of the Department of Child, Youth and Family Services

1. Direct Practice and Site Managers to meet with Area Controllers from the Police to review their application of the CAT/SAT protocol.

2. Restate to social work staff Departmental policy and procedures relating to the investigation and assessment of child protection notifications, with particular emphasis on Risk Estimation Tools, SAT/CAT protocol and referrals to the Care and Protection Resource Panels.

3. Include compliance with policy as a performance measure in individual social worker performance objectives.

4. Ensure that Departmental social work staff receive ongoing training in family violence and methods of intervening to protect children.

5. Ensure social work staff receive training which enables them to interview, listen and respond to children and young people.

6. Review how the Department's delivery function is represented at senior management level to ensure that the experience of practitioners is appropriately considered.

7. Consider an increase in the numbers of Community Liaison Social Work positions or the adoption of a model where social workers have responsibility for a geographical area.

8. Develop and implement an effective workload management tool.

9. Review the effectiveness of Roopu teams and the resourcing, training and professional support for these teams.

10. Direct that case reviews in future consider the views of clients (including the views of children) to assess the effectiveness of Departmental intervention.

11. Discuss the extension of the Social Workers in Schools Programme with the Secretary of Education.

8.3 The Commissioner for Police

1. Direct Area Controllers (and any other appropriate staff) to meet with Child, Youth and Family Practice and Site Managers to review their application of the CAT/SAT protocol.

2. Restate the policy and procedures relating to the application of the CAT/SAT protocol to all staff.

3. Consider the desirability of instructing all staff who complete Family Violence Reports (POL400) to record an assessment of the risk to children who witness family violence.

4. Ensure that all staff are aware of local agencies and supports for children who are victims or witnesses of family violence.

8.4 The Director-General of Health

1. Implement the United Nations Convention on the Rights of the Child, by ensuring that the voluntary standards for the wellbeing of children and adolescents receiving healthcare, developed by the Paediatric Society, are made compulsory for all providers of healthcare services to children and adolescents.

2. Report to the Commissioner for Children on the progress of this implementation by December 2003.

3. Ensure that Child and Adolescent Mental Health Services have assessment tools to identify and support children who may be experiencing family violence.

4. Ensure that Child and Adolescent Mental Health Services take part in regular interagency child protection meetings.

5. Develop a national Child Health Information strategy which ensures that all health professionals are able to access and record information about health and counselling services provided to a child on a common database.

8.5 The Secretary of Education

1. Recognise the central role schools play in the welfare of children by providing guidelines to schools so that schools are increasingly involved in interagency processes, which can assess and respond to a child's whole circumstances.

2. Review the current stand-down, suspension, expulsion and exclusion guidelines, to ensure that schools refer children and young people to appropriate statutory or community agencies during disciplinary processes, and that this referral is monitored by schools in terms of shared case management and review with those agencies.

3. Monitor the degree to which schools refer to specialist agencies and whether that referral results in collaborative and planned intervention in the best interests of the child.

4. Provide information to schools which clarifies the policy and procedures of statutory investigations relating to disclosures by children about abuse, neglect and family violence.

5. Develop a protocol with the Department of Child, Youth and Family Services which ensures that schools receive regular training and support from Departmental Community Liaison Social Workers, or from Departmental Social Workers and, or Managers.

6. Discuss with the Department of Child, Youth and Family Services, the expansion of the Social Workers in Schools programme and report to the Commissioner for Children on the results of those discussions.

7. Provide information and training to members of Boards of Trustees on child abuse, neglect and family violence, so that discipline procedures respond to a child's whole circumstances and any factors which might be contributing to their behaviour.

8. Provide members of Boards of Trustees with training and information on child advocacy and the legislation, policy and practice which impacts on children's interests, wellbeing and development.

8.6 Media

8.6.1 Minister of Broadcasting

1. Note the recommendations to Editors of print and electronic media.

2. Note the recommendations made regarding the need to research and publish information on children's rights and the media.

8.6.2 Editors of Electronic and Print media

1. Ensure that children and young people's rights to privacy and dignity are upheld when reporting on or about them.

2. Ensure that the vulnerability of children and young people is recognised, and that care, consideration and sensitivity is demonstrated when reporting on or about children and young people in distressing situations, or who are victims of violent crime.

3. Recommend to journalist training organisations that knowledge of children's rights and the media are included in curricula of those organisations and institutions.

8.6.3 The New Zealand Press Council

1. Amend their guidelines to include specific reference to the vulnerability of children in terms of their rights to privacy being upheld. This amendment to specify what "care and consideration" means in connection to reporting on and about children and young people.

2. Become a signatory to international guidelines involving children's rights and the media.

8.6.4 The New Zealand Broadcasting Standards Authority

1. Publish a report to accompany the Authority's Code of Practice which describes and defines children's rights and the media, and which provides guidelines and information on how broadcasters can and should take "particular care" with children and their rights. This should include particular reference to children who are in distressing situations, or who are the victims of violent crime.

2. Become a signatory to international guidelines involving children's rights and the media.

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APPENDIX 1

Glossary of Terms

CYF	Department of Child, Youth and Family Services
CAT/SAT	Child Abuse Team/Serious Abuse Team Protocol established between Police and Social Workers for the joint working of cases of child/serious abuse.
FGC	Family Group Conference
RES	Risk Estimation System - social work tool for identifying vulnerability of child, likelihood of further harm and the potential level of severity of that harm
CYPF ACT	Children, Young Persons and Their Families Act, 1989
UNCROC	United Nations Convention on the Rights of the Child
OCC	Office of the Commissioner for Children
CYRAS	Child, Youth, Residential and Adoption System – the Department of Child, Youth and Family Service's computerised case work management system
CPRP	Care and Protection Resource Panel (aka the Panel) Consultative body consisting of members of local communities who work in the care and protection sector.
POL 400	Police Family Violence Report
DV ACT	Domestic Violence Act, 1995
CAFS	Child, Adolescent and Family Services funded by District Health Boards
CAMHS	Child and Adolescent Mental Health Services funded by District Health Boards
DP	Deputy Principal
BOT	Board of Trustees

APPENDIX 2

Terms of Reference for the investigation of the office of the Commissioner for Children into the deaths of Saliel and Olympia Aplin – established January 2003

Objective

To determine whether the agencies and schools who had involvement with Saliel Aplin and Olympia Aplin (aka Jetson) responded appropriately to their circumstances.

The review will include:

1. An analysis of the Department of Child, Youth and Family Service's involvement.

2. An analysis of the response of the Department of Child, Youth and Family Service to the deaths of the children. This will review of the strategies or plans put in place by the Department of Child, Youth and Family Services management to ensure safe practice at the Masterton site.

3. An analysis of schools response to risk factors.

4. An analysis of any other agency/professional involvement with the girls and their family.

5. An analysis of the dynamics within the family relationships which contributed to a lack of safety for the children and the extent to which the Department of Child, Youth and Family Service's social worker and other professionals were aware of and responded to these dynamics.

APPENDIX 3

Information from a Protocol between the New Zealand Police and the Department of Child Youth and Family Services

Part three : children as secondary victims through witnessing violence or other crime
Policy and procedures to deal appropriately with this area of child abuse are being developed.
Refer to Domestic Violence Act 1996.

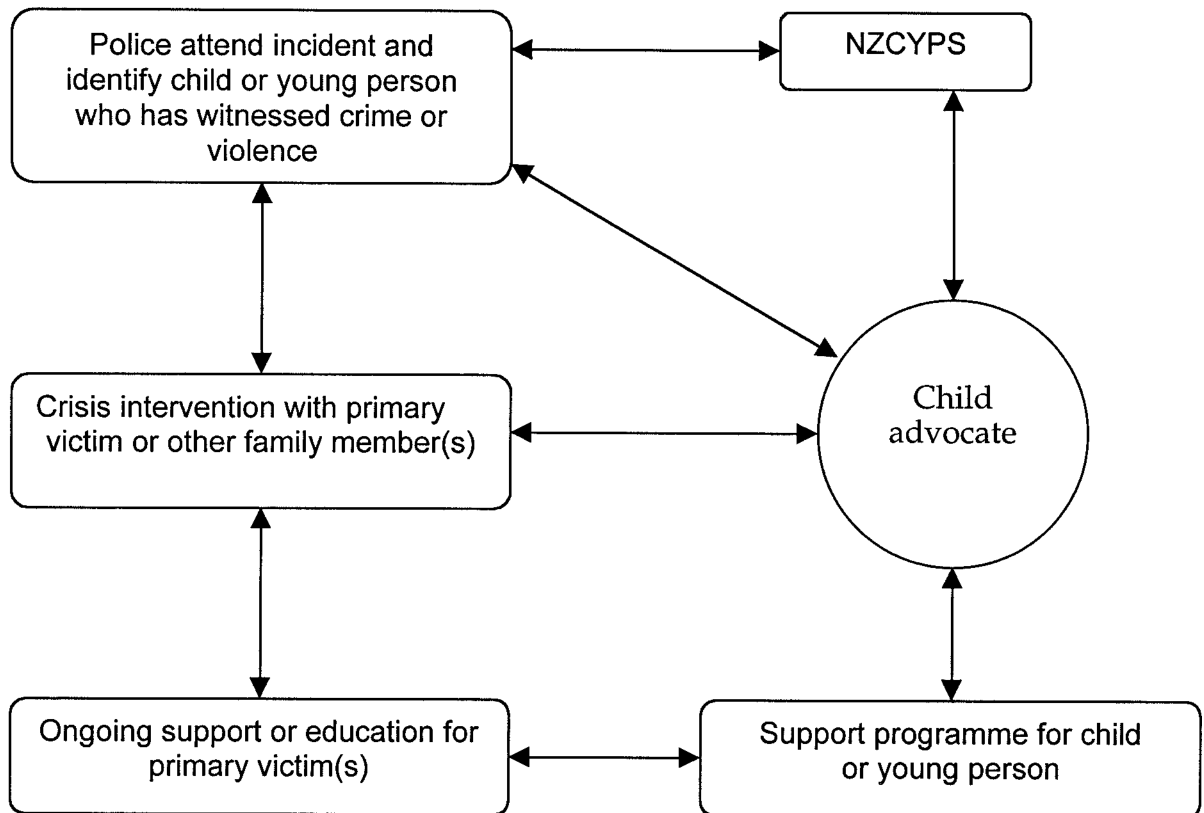
Research suggests that in about 70% of reported family violence cases, children or young persons have been present or have witnessed the incident. Children and young persons are often victims of family violence-related assaults, or can suffer trauma from witnessing family violence.
When attending incidents of family violence or any other situations when a child and young person is likely to have witnessed violence between their parents or caregivers, officers will be required to ascertain the safety of the child or young person. In these instances, violence would include any:

- physical
- sexual
- emotional, or
- psychological violence, including threats of such violence and intimidation.

As a matter of best practice, attending police officers must ascertain whether children are involved as victims or have witnessed the incident under investigation. In the interests of child safety, it may be necessary to speak to the children directly.
When support agencies receive requests for crisis intervention from attending police officers, they must fully recognise the need for the safety and protection of any children present.
In most instances, the interests of the children are best met by a child advocacy service or agency. Such service or agency, as a matter of good practice, is required to liaise with the police, NZCYPS, and other family violence service providers.
The child advocacy service is responsible for ensuring full consideration of the child's interests and that appropriate interventions are established to afford maximum protection. Such considerations must reflect the principles of CYP&F Act 1989.
When the immediate safety of the child is considered to be at risk, attending police should liaise directly with NZCYPS for appropriate action to be undertaken in accordance with existing child abuse protocols.

If required, details of the child's involvement should be made available to NZCYPS, support agencies or child advocates, as agreed by local protocols. Such considerations must reflect the principles of section 6 of the CYP&F Act, which states that the child's welfare should be considered paramount.

Secondary victims or witnesses flowchart



1. Child advocate position currently being developed. The success of services to those involved in family violence will depend on the strength of networking and communication between the key agencies.
2. Notification to NZCYPS would be appropriate if the child/children are at risk of physical or emotional harm.

APPENDIX 4

United Nations Convention on the Rights of the Child
(Articles relevant to this Investigation)

New Zealand ratified this Convention in March, 1993.

Laurie O'Reilly, Commissioner for Children 1996 - 1998 said that' 'the Convention ... provides a tool for developing awareness about children's rights. It is also a tool for determining what are children's rightful entitlements, often largely synonymous with their needs.

Article 42 states that, 'State parties undertake to make the principles and provisions of the Convention widely known, by appropriate and accurate means, to adults and children alike.'

The Convention is best read as a whole, however the following articles have particular relevance in relation to Saliel and Olympia.

From the Preamble

Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community,

Recognizing that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

From the Convention

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 6

1. States Parties recognize that every child has the inherent right to life.

2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 16

1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.

2. The child has the right to the protection of the law against such interference or attacks.

Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health. To this end, States Parties shall:

(a) Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of article 29;

(b) Encourage international co-operation in the production, exchange and dissemination of such information and material from a diversity of cultural, national and international sources;

(c) Encourage the production and dissemination of children's books;

(d) Encourage the mass media to have particular regard to the linguistic needs of the child who belongs to a minority group or who is indigenous;

(e) Encourage the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being, bearing in mind the provisions of articles 13 and 18.

Article 18

1. States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

2. For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

3. States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 28

1. States Parties recognize the right of the child to education and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

(a) Make primary education compulsory and available free to all;

(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

(c) Make higher education accessible to all on the basis of capacity by every appropriate means;

(d) Make educational and vocational information and guidance available and accessible to all children;

(e) Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

2. States Parties shall take all appropriate measures to ensure that school discipline is administered in a manner consistent with the child's human dignity and in conformity with the present Convention.

3. States Parties shall promote and encourage international cooperation in matters relating to education, in particular with a view to contributing to the elimination of ignorance and illiteracy throughout the world and facilitating access to scientific and technical knowledge and modern teaching methods. In this regard, particular account shall be taken of the needs of developing countries.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

(a) The inducement or coercion of a child to engage in any unlawful sexual activity;

(b) The exploitative use of children in prostitution or other unlawful sexual practices;

(c) The exploitative use of children in pornographic performances and materials.