EXECUTIVE SUMMARY

RIRI-O-TE-RANGI (JAMES) WHAKARURU
Born: 13 June 1994
Died: 04 April 1999

INTRODUCTION

James Whakaruru died on 4 April 1999 from one or more physical assaults perpetrated by his mother's partner, who had been convicted of a previous assault on James in 1996. This investigation was set up to examine how James came to die in spite of the many agencies involved with James and his family, and to consider what needs to change in future.

The investigation recognises, but does not examine, the role of James' immediate and wider family in his care and protection.

The Commissioner for Children conducted this investigation pursuant to powers and functions given in the Children Young Persons and Their Families (CYPF) Act 1989 (sections 411(1)(e) and 412).

The investigation found that poor interagency communication characterised the professional work with James and his family. Agencies worked without reference to each other, and ended their involvement assuming that other parts of the system would protect James. Some workers seemed unaware of the indicators of a child at risk or did not appreciate the role they needed to play to ensure his safety and well being. There was little if any attempt to engage culturally-appropriate services, or to address the situation in the context of his wider whanau, hapu and iwi.

THE EVENTS

Infancy (June 1994–July 1996)

James' birth circumstances indicated a need for additional help and support. His mother, aged fifteen, attempted suicide ten days before his birth, citing as reasons the breakdown in her relationship with James' father and having nowhere to live.

A general practitioner (GP) and midwife assisted, but had different understandings of their respective roles. A health social worker had brief involvement, and later closed the case without assessment. The midwife was not formally told about the suicide attempt, and she in turn did not tell Plunket. Her handover information mentioned emotional and social difficulties, and (incorrect) advice that health social workers continued to be involved.

Plunket saw James and his mother three times. They ended their involvement after nine unsuccessful attempts to make contact. They did not advise the listed GP or any other agency or service.

Assault on James (18 July 1996)

James' mother, Te Rangi Whakaruru, began a relationship with Ben Haerewa when James was approximately one year old. He was seen by two GPs for facial injuries when aged 15 months (twice) and at 18 months. On 18 July 1996, when he was just over two years old, James was admitted to hospital with serious injuries from a domestic assault. This began a period of multi-agency activity.

Initial agency response

The hospital reported the assault on James to the Police on 18 July 1996, and Ben Haerewa was charged, convicted and eventually sentenced. Between hearings he was free on bail, with conditions that he not associate with Te Rangi Whakaruru nor have contact with James. The Police did not tell the Department of Child, Youth and Family Services that Ben was out on bail and that he breached bail conditions by associating with James and Te Rangi.

The Police made a formal care and protection notification to Child, Youth and Family on 19 July. Five days later a social worker visited James at his maternal grandparents where he was now staying. They advised the grandparents to seek legal custody themselves under the Guardianship Act 1968.

There is no evidence that Child, Youth and Family complied with section 17 of the CYPF Act 1989. They did not:

- gather information widely from family and other agencies, as the term "investigation" implies (s17(1))
- consult the Care and Protection Resource Panel (a statutory board of suitably qualified members of the community) as required (s17(1))
- refer James for a Family Group Conference (FGC) as required if a social worker believes that a child or young person is in need of care or protection (s17(2)).

The social worker used the relatively informal intervention of encouraging one family member to seek custody of James through civil processes. This cut across James' right under the CYPF Act, as a child in need of care and protection, to have his natural father and all his whanau involved in decisions about his future.

Holding an FGC ensures that all kin and extended family know there is a serious problem. It is followed by a period of monitoring and review. It sends a signal to family members and other agencies involved that there is official concern.

Custody proceedings (August 1996–April 1997)

During August 1996, James' mother and grandmother made applications and cross-applications to the Family Court under the Guardianship Act. These related to various configurations of the guardianship and custody of James. As part of these processes, both parties were referred for counselling, counsel for the child was appointed, and there were at least two judicial conferences with all parties present.

The custody and access process was now being used to address the care and protection issue, but the Family Court's task in this type of proceeding is to make a decision between applicants and defendants. There is scope to redirect a matter into the statutory care and protection processes in the CYPF Act if the court decides that the information available warrants this.

The Family Court asked Child, Youth and Family for two reports under section 29 of the Guardianship Act. In this role a social worker acts as an agent of the court reporting on the circumstances of various parties, rather than as a CYPF Act authorised child protection

agent. The social worker who dealt with the care and protection notification was not one of the social workers who completed these reports.

Between the two reports, the court asked Child, Youth and Family specifically to monitor the child and mother, but the service reported that they had been unable to do so. The first report expressed concern for James in his mother's custody, but the second stated that the department had no care or protection concerns. This was based on the mother's statement that she did not intend to cohabit with Ben Haerewa again.

Further injury to James (February 1997)

On 11 February 1997, while Ben Haerewa was in prison and future custody of James was being contested, James cut his chin in an alleged fall down steps. The hospital emergency department did not access existing hospital records regarding the previous non-accidental injury. They did not advise Child, Youth and Family of this incident.

The hospital records of this presentation show that James was probably in his mother's care, while Child, Youth and Family believed he was with his grandmother.

Ben Haerewa released from prison (3 March 1997)

Ben Haerewa was released from prison on 3 March 1997. The conditions of his release were six months supervision, with special conditions that he complete counselling, parent skills training and an anger management course. The special conditions were omitted from the information sent to the Community Probation Service.

At the time of Ben Haerewa's release, counsel for the child applied for a Temporary Protection Order for James under the Domestic Violence Act 1995. The Family Court granted the order, and also asked Child, Youth and Family for the second custody report with interim monitoring.

Ben Haerewa completed an anger management course on the second attempt. He reported only intermittently to his Probation Officer, and not at all from 23 May to 2 September 1997. The Probation Officer did not make the required home visit and employment checks, and Ben Haerewa was not brought back to court to account for the breach of the supervision requirements.

Absent from view (April 1997–May 1998)

The Family Court custody proceedings concluded on 21 April 1997 with a Memorandum of Consent placing James in the custody of his mother, with additional guardianship and access to his maternal grandmother.

No agency records show any contact with James for the next twelve months, but it seems that the family moved to a remote area.

Further injuries to James (May 1998–April 1999)

Between May 1998 and his death in April 1999, James suffered two significant injuries. Neither was reported to Child, Youth and Family or the Police.

On 9 May 1998, James came to hospital for a tear to his penis, which required emergency surgery. He attended in the care of his mother and Ben Haerewa. The hospital recorded two different explanations given by family and patient for this injury. Neither the conflicting explanations, nor the past medical history of non-accidental injury, seemed to alert any emergency or specialist staff to potential harm.

On 20 March 1999, James' mother sought help from an emergency pharmacy for a deep laceration to James' lip. She was taken to a GP who had had no previous family contact. She came to the GP again the next day, for no obvious reason, but did not return for the sutures to be removed. The GP passed information about this incident to the practice where he believed the family was known, but they said they had not seen James for "a very long time".

Death of James (4 April 1999)

James died shortly after arrival at the hospital emergency department on 4 April 1999. He had extensive internal injuries and tissue damage consistent with one - or more likely several - prolonged beatings, which caused his death.

COMMENTS

Community responsibility

The protection and nurture of children is a task shared by family and society. Society's responsibilities are expressed through macro policies which support families, and through its agents on whom it relies to identify those few children who are harmed in their families. This investigation reviewed the individual circumstances of one child, and the response of agencies who had contact with him in his community and who had an opportunity to notice and take steps to stop the harm which was occurring to him.

In the classic disaster scenario, this investigation found that there were weaknesses at every point of community contact with James.

Health sector

The health sector is a vital component of the child safety net, able both to identify children at risk and to monitor and measure ongoing safety and wellbeing.

James was seen forty times by health practitioners, four presentations at the hospital emergency department, two admissions and one outpatient clinic, three face-to-face Plunket contacts, and thirty visits to general practitioners at four practices. Collectively the health sector had available a telling picture of James' circumstances.

This picture was never put together because of poor communication between practitioners. Information was not passed on or was incomplete. Previous records within the same hospital or practice were not viewed, and where James was not known, the records suggest that social and medical histories were not sought or provided. Some individual practitioners appeared to be unaware of signs of possible risk.

Department of Child, Youth and Family Services

Social workers in Child, Youth and Family are authorised under the CYPF Act to investigate, assess and intervene when a child is suspected of harm within a family. They are required to secure the child's protection in ways which, as far as possible, support and sustain the child's enduring connection with his family.

Legal and policy requirements help find the appropriate balance in each case, but these were not followed for James. Information held by other agencies was not sought, the investigation was not planned and managed jointly with Police, the Care and Protection Resource Panel (CPRP) was not consulted, and there was no Family Group Conference. The chosen intervention (resolution of safety and care through family-initiated legal action) did not match the actual and potential degree of harm.

The department decided unilaterally to encourage one grandmother to seek custody, in direct contravention of CYPF Act principles. James was entitled to have all his family involved in decisions about his safety and wellbeing.

Child, Youth and Family was also asked, in their role under the Guardianship Act, to report to the Family Court on the custody dispute between mother and grandmother. The two reports reached diametrically opposed conclusions about James' safety with his mother, and were not based on any extensive enquiries or observation of the situation.

Police/Child, Youth and Family Child Abuse Protocol

Police are the primary law enforcement agents. They also have powers and responsibilities under the care and protection provisions of the CYPF Act, and these are further specified in a formal protocol with Child, Youth and Family. In cases of child sexual abuse and serious physical abuse, Police and Child, Youth and Family are required to jointly plan and manage the child protection and criminal justice aspects.

The Police made a formal child abuse notification on 19 July 1996, but then dealt independently with Ben Haerewa's offending. They did not advise Child, Youth and Family when Ben Haerewa was found with James and his mother at her home, in breach of his bail conditions. Nor did they push the department to act.

Criminal Justice system

When Ben Haerewa was released from prison, Child, Youth and Family were not notified. There was no legal or procedural requirement for the prison service to do so.

Community Probation Service

Ben Haerewa was under supervision by the Department of Corrections Community Probation Service from 3 May to 2 September 1998. This supervision provided potential oversight of Ben Haerewa's contact and involvement with James, but there were no home or employment visits and reporting was allowed to lapse. The supervision order was imposed for a serious assault on a child, but the service did not apparently communicate with Child, Youth and Family.

The special conditions attached to the supervision order focused on behavioural change in areas, which would arguably have enhanced James' safety. However, these were omitted from the information forwarded from the Department for Courts.

The Family Court granted a Temporary Protection Order for James against Ben Haerewa shortly after his release from prison. The Department for Courts did not formally advise the Community Probation Service, who were responsible for supervising Ben Haerewa, although there is evidence to suggest that they knew informally.

CONCLUSION

It is an indictment on our society that James was known to so many, yet he died. Child abuse will be hidden, so those whose work involves them with children need to be well informed, and alert to the small signs of risk.

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, and this case shows the effect of cumulative errors and omissions.

Agencies employing staff to work closely with children and families also have a responsibility to employ enough staff, and to train, support and monitor them. This investigation did not examine the organisational context of this case. There is strong anecdotal evidence of inadequate resources in services, and this could be a factor in so many workers simply failing to carry out expected tasks.

This investigation shows that bringing together the pieces held by each agency and worker gives a clearer picture of what is occurring for a child. Coordinated work takes time, money and effort. The fragmentation of services and narrow focus on single agency outputs in the last fifteen years has worked to the detriment of child protection. Government needs to recognise the importance of intersectoral communication, planning and review. It needs to be in each department's outputs, and funded.

Government also has a commitment to honour the Treaty of Waitangi, which is fundamental to the relationship between Maori and the State. James' safety and wellbeing was intrinsically linked to the health and well being of his whanau, hapu and iwi. Problems within his whanau were extensive and well known, but each was addressed in isolation using an individualistic approach. A community based organisation providing culturally appropriate services may have been more successful in developing an enduring relationship with the whanau, and understanding and addressing the underlying issues affecting them.

In the end there is a child. The story of this one small damaged child should stir each worker and each agency to examine their practice and the purpose of their activities. It is incumbent upon all to honour the relationship between professional and client/patient in abiding by regulations, best practice and the moral imperatives of their profession.