THIS FINDING IS SUBJECT TO PROHIBITIONS AND RESTRICTIONS ON PUBLICATION UNDER S74 OF THE CORONERS ACT 2006

CSU-2015-ROT-000302

IN THE CORONER'S COURT
HELD AT ROTORUA

IN THE MATTER of the Coroners Act 2006

AND

IN THE MATTER of an Inquest into the death of:
MOKO SAYVIAH RANGITOHERIRI

Before:	Coroner Wallace Bain
Date of Hearing:	30th and 31st August and 3rd October 2017
Appearances:	D Dowthwaite – Counsel Assisting J Munro for Karauna Rangitoheriri Snr (Moko's father) A Ngapo-Lipscombe for Nicola Dally-Paki (Moko's mother) A Lewis and Townshend for the Ministry for Vulnerable Children C Campbell for the Auckland District Health Board
Date of Findings:	11 December 2017

FINDINGS OF CORONER WALLACE BAIN

An embargo on publication of any details contained in these findings remains

In place until 6:00pm on Wednesday 13 December 2017

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HISTORY AND DECISION TO OPEN AN INQUIRY

[1] The death of Moko Sayviah Rangitoheriri, a three-year-old child born on the 15th October 2011, was reported to me last year as the Designated Coroner for the Bay of Plenty area.

[2] When this death was reported to me, because of the nature and circumstances surrounding the death, I decided to open and conduct an Inquiry into the death pursuant to the powers invested in me by the Coroners Act 2006.

(a) In deciding to open and conduct an Inquiry, I had regard to the following matters at that time (Paragraphs (a)-(m) below):

(i) A very detailed report for Coroner and associated documents provided to me by the New Zealand Police. That report lists in graphic detail a wide range of injuries that this three-year-old boy suffered. The injuries are horrific, the child has suffered considerably and eventually the child has died as a result of the injuries received.

(b) A man and a woman acting as caregivers were charged with very serious crimes for ill-treating this child including murder. They have now pleaded guilty to manslaughter and ill-treating a child. They have been remanded in custody and will appear for sentencing on June 27th 2016.

(c) Pursuant to the Coroners Act 2006, having opened the Inquiry, I am required to adjourn conducting any formal Hearing until the criminal proceedings against the people involved have been finally concluded.

(d) I have decided that this matter will proceed to a full Inquest Hearing following the conclusion of the criminal proceedings.

(e) The Inquest into the causes and circumstances of this death has as its first purpose to establish, so far as possible:

(i) A person has died; and
(ii) The person's identity; and
(iii) When and where the person died; and
(iv) The causes of the death; and
(v) The circumstances of the death.

(f) The second purpose of an inquiry is to make specified recommendations or comments that in my opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which this death has occurred. These specified recommendations or comments may be made on either or both of the following:

(i) The avoidance of circumstances similar to those in which this death has occurred;
(ii) The way in which any people should act in circumstances of that kind.

(g) A third purpose of the inquiry is to determine whether the public interest would be served by the death being investigated by other investigating authorities.

(h) There is huge public concern surrounding the circumstances of this death and, as with the Nia Glassie Inquest, the Inquest will consider the extent to which the drawing of attention to the circumstances of the death may be likely to reduce the circumstances of the occurrence of other deaths in similar circumstances.

(i) From my preliminary examination of the information made available to me so far, there are a number of questions that need to be addressed. These include:

(i) How was it that this child was left with these caregivers for a period of approximately two months?
(ii) What checks were made as to the suitability of the caregivers to look after this particular child?
(iii) What checks were made on the safety and wellbeing of this child whilst in the care of the two caregivers?
(iv) Was anyone else aware of the assaults and injuries this child was receiving whilst in the care of these caregivers?
(v) Had the parents, the child or the caregivers come to the attention of any child welfare and/or educational agencies and if so, what were the circumstances of that attention?
(vi) What agencies, if any, check on the welfare of young children so that injuries and deaths from the circumstances can be avoided in the future?
(vii) What was the suitability of these caregivers to look after this child and what checks, if any, are carried out or should be carried out before such a placement is made?

(j) The important questions addressed in the Nia Glassie[1] Inquest were these:

(i) What were the household circumstances and how were they created in which Nia Glassie suffered from violence at the hands of close family and caregivers?

(ii) What steps were taken, or could have been taken to keep Nia Glassie safe from violence by her guardian, her appointed caregivers and her whanau or her neighbouring community?

(iii) What monitoring or oversight, if any, existed or ought to have existed within the whanau, local community, or state agencies such as Health, Education and Social Welfare to keep Nia Glassie safe from death and violence? If they did exist, if monitoring or oversight did exist, why did they fail on this occasion?

(iv) What cultural socio-economic factors contributed if any to Nia Glassie's death?

(k) Sadly, it seems that ten years later we are again considering such serious and tragic consequences as a result of caregivers mistreating a child. The Coroner's Court has an Inquisitorial role, and as demonstrated in the Nia Glassie Inquest, is able to get to the truth of the matter and make specific recommendations so that these tragic circumstances are avoided in the future.

(l) The Nia Glassie Inquest highlighted the child abuse problem in New Zealand and the issue of children living in poverty. Sadly, the horrific abuse that a child such as Nia Glassie suffered appears on the face of it to have been accentuated in a worse way in the tragic death of little Moko, eight years later.

(m) There were a number of very clear and strong recommendations made in the Nia Glassie Inquest with a view to ensuring tragic deaths such as hers, and now Moko's, did not occur in the future. The Inquest into the death of Moko will also specifically look at what steps, if any, have been taken by those identified as having some responsibility in keeping children safe, and if those steps are adequate.

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[1] Nia Glassie – CSU-2008-ROT-000022

HIGH COURT FINDINGS AND FACTS – These were relied upon by the Court and adopted as evidence for the Inquest.

[3] On the 12th June 2015, Moko and his seven-year-old sister arrived in Taupo and were left with the defendants, Haerewa and Shailer.

[4] Following Moko's death, the post mortem established that he had lethal injuries causing his death which were lacerations and haemorrhage deep within his abdomen, older bruising and damage to his bowel – the combination of which caused his bowel to rupture. There was leaking of faecal matter into his abdomen causing peritonitis and septic shock.

[5] He had moderate swelling of the brain. He had significant clots and haemorrhage beneath the scalp between the brain and the covering of the brain and indicated multiple injuries inflicted over a period of days.

[6] The mechanism of death was multi-factorial. It involved the swelling of his brain, septic shock and leaking bowel contents into the abdomen – all of which were deadly.

[7] The pathologist also reported that part of his cause of death was from smothering. The pathologist noted:

> "while the mechanism of death here is complex, one fact is simple: with prompt medical attention to the signs of physical illness or mental deterioration, such as abdominal pain, nausea, vomiting, diarrhoea, loss of bowel control, fever, lethargy, or fainting, both the brain swelling and the sepsis could have been either completely prevented or reversed and Moko could still be alive today".

[8] In addition, Moko had multiple blunt force injuries all over his body and the pathologist listed them as:

- Facial/neck contusions and abrasions including periorbital haematomas;
- Patterned injury consistent with human bite mark on his left cheek, resolving;
- Patterned injury suggestive of human bite mark on right cheek, resolving;
- Lacerations to his chin, neck, ears, lower lip, mucosa including frenulum and gum;
- Abrasions to his upper lip and ears;
- Haemorrhage to both eyes;
- Contusions on multiple ribs;
- Contusion on his right testes;

- Multiple abrasions and contusions over his skin surface of his chest and abdomen;
- Patterned injuries consistent with human bite marks that were resolving, two on his left arm, one on his right forearm and one on his right shoulder;
- Additional abrasions and contusions, some of which were also suggestive of human bite marks.

[9] The other children in the house observed that Moko had been punched, kicked and slapped. They observed him being bitten multiple times on the arms and face with the degree of force so hard that it caused his skin to come off and his face to start bleeding.

[10] In the four days prior to his death, he was continually physically assaulted. These assaults included:

- Slapping Moko to his face and body with a hand and jandal;
- Kicking him to the side of his body and his legs;
- Grabbing him by the arms and throwing him onto his bed (a mattress on the floor);
- Slapped him on the face and cut his lip;
- Kicked him;
- Threw him with force onto his bed and them stomped on him on his back;
- Threw him on the floor and kicked him on the back;
- Rubbed faeces in his face after Moko had soiled himself;
- Then scrubbing Moko's body so hard in the shower that he has removed scabs on his body;
- Picking up in the bathroom, after he collapsed and letting him drop face first to the ground, adding that this occurred about 3-4 times;
- Placing his hand over Moko's mouth to stop him screaming out in pain.

[11] The main event that caused Moko's death was inflicted by stomping on his abdomen and stomach with significant force. Two of the children present witnessed this and said it was "really really hard" and that Moko was groaning and expelling bursts of air.

[12] The children also saw a hand being placed over Moko's mouth which choked him and caused him to kick and thrash his leg.

[13] It was very clear that both the defendants were well aware of what they were doing and the harm that they were causing and that he needed care. They did nothing except further assault him.

[14] By the Sunday he could barely walk, and his face was swelling significantly, he could barely open his eyes and there was bruising all over his face. He kept falling to the ground. He was defecating frequently and vomiting. Both the defendants were home together for the day and did nothing but kept him locked in his room. He repeatedly asked for water and was given it once but then was refused any more. On that Sunday, the assaults continued despite the defendants knowing how ill he was. When the faeces were rubbed in his face and washed off, it was observed that Moko was screaming in pain as scabs were removed and a hand was put over his mouth to stop the noise.

[15] By Monday, Moko was unable to communicate and kept dropping to the ground. Despite that, nothing was done to get him assistance.

[16] The High Court noted in sentencing that the major aggravating feature of the offending was that Moko was a defenceless and extremely vulnerable child. He was three years old and was utterly helpless and dependent on the caregivers for his every need. Despite that, there was a joint campaign of violence against him. That violence defies belief.

[17] The High Court also noted that the offending was extremely cruel and callous. It was inflicting appalling pain and suffering on a small child and a lot of it was in front of other children who were witnesses to this dreadful offending.

[18] The High Court concluded that the extremity of the violence, the injuries, the cruelty, the callousness, the multiple acts of violence, Moko's extreme vulnerability and the breach of trust involved in the offending, were all at the highest levels of seriousness. It concluded that all of those factors made the category of offending as "the most serious" of all manslaughter cases. There were no mitigating features in the offending.

EVIDENCE

[19] The Court has run this Inquest in two separate phases. The first phase has been related to receiving police evidence complementary to the High Court Findings of fact... exactly what happened and didn't happen when it should have. The second phase is referred to as the "expert" phase where a number of expert witnesses have commented on what occurred and what can be done to ensure it doesn't occur in the future. The first phase has involved very detailed evidence from Detective Inspector Lewis Warner, who has provided a thorough in-depth summary of exactly what had occurred leading up to Moko's death and subsequently. He also produced to the Court the standard documents such as the post mortem report, ESR toxicology report, ID etc. It is noted that the offenders, who were convicted of Moko's manslaughter,

were each sentenced to 17 years in prison with a minimum period of imprisonment of nine years. Evidence was also read (because fog prevented witnesses arriving) from Auckland District Health Board representatives explaining the background to Moko's mother, being at Starship hospital and referring also to a number of reports of concern. The evidence from Detective Inspector Warner had also highlighted these.

[20] Moko's mother, Nicola Dally-Paki, gave detailed evidence which include the family history of domestic violence, the father's gang connections and safety concerns for the children.

[21] Moko's father is a gang member and has not been involved in these proceedings.

[22] The evidence of Detective Inspector Warner took the Court through the volatile relationship between the parents, mental health history of the offenders and the professional agencies involved with both families. He agreed in cross-examination that it was a very extensive list of individuals and organisations involved with baby Moko before his death.

[23] He also presented evidence showing that the parents, child and caregivers had come to the attention of Child Welfare and Educational agencies and Starship Hospital. The mother, Dally-Paki had identified concerns with the social worker about the violent relationship with the father. She was referred to the Shine Organisation and they provided evidence also to the Court relating to reports of concerns as to the care of the Children.

[24] Detective Inspector Warner outlined however, how CYFS had not told the police of the concerns that were expressed to them and some of these concerns did not appear to have been investigated. It was not hard for the Court to conclude that with the lack of support, whanau difficulties and financial resources the mother, Dally-Paki, really had an inability to provide a safe and stable environment for her children. That is a clear red flag from the time that they were at Starship before they were placed with the caregivers and moved to Taupo. It was missed, yet there to be seen. "Red Flag" in these Findings refers to an occasion that in hindsight was an opportunity for intervention which could have saved Moko.

[25] Whilst in Taupo there were further reports of concern from the teacher of the kindergarten and a request for "urgent attention" for the caregiver Shailer because of her depression and social needs. She already had four children aged seven, five, four and two that she was looking after before taking on Moko and his sister. She had one session of counselling and cancelled the next, which is again another red flag. Friends were saying she was struggling with depression and was admitting to having a bit of "ugly

moments". She referred to Moko in shocking terms and had complained that her mental health medication was not working.

[26] It appears in the counselling sessions that Family Works were unaware that Moko and his sister were also in the house with Shailer and the other four children. A Taupo GP had referred Shailer to a psychiatrist in Rotorua, a matter of a couple of weeks before Moko's death. It identified borderline personality disorder, self-harm tendencies, mood swings and sleep deprivation. Shailer herself went to Child, Youth and Family to lay a report of concern about the children returning to Dally-Paki on the 29th July 2015. She was also getting help from a Family Start programme from Rural Education Activities Programme (REAP), two workers visited the home ten days before Moko's death but did not see him because he was in time out in the bedroom. Again another red flag. They should have asked to see him because Shailer was again stating she was struggling to cope with his behaviour. Again, in August the Counselling session, Shailer complained that she was struggling to cope with the behaviour of Moko and his sister. It was reported that he was bruised and when speaking about him she looks stressed, tense, angry and frustrated. The counsellor arranged an urgent follow-up for August 7th, 2015 but Shailer cancelled that, Moko died on the 10th August 2015.

[27] While Maori Women's Refuge and CYFS should have been providing services, neither organisation knew that Haerewa, who had a criminal history of family violence, was living in the house. Again, a red flag. It highlighted that no one is visiting the house to actually see the children and that should have been patently clear from the reports of concern at Starship Hospital and all the other matters mentioned above. There is some disputed evidence in terms of what Maori Women's Welfare League knew about being told by Moko's sister of punching Moko, but again he was not sighted.

[28] A report of concern was officially filed on July 30th 2015 and given urgent status, and that meant that Moko and his sister should have been visited within seven days. That did not happen. It is clear from the evidence, and the post mortem report, that Moko could have been saved if he had been visited at the house within seven days of the report of concern. It was accepted that this should have happened.

[29] Moko's paternal grandmother's evidence was very compelling. She knew the background totally; she knew the mother and her son as the father. She knew of the violence and she knew of the difficulties. She said she offered to take care of Moko and his sister a month before he was killed but that was rejected by their mother. She said she wanted to pick up the children from Taupo where they were staying with Tania Shailer. She clearly had concerns. However, there were various court orders in place and in order for that to occur, Moko's mother had to give her a letter of support. Grandmother's evidence was that she

had fears for the safety of Moko and his sister in the care of Tania Shailer. She immediately had those concerns as soon as she learnt that the children were placed with her. She said she knew the background and she would not leave her grandchildren with her. She gave a plea to the Government departments and their support people involved, before the passing of her grandson Moko, that they step up when whanau like herself have concerns because it takes a lot for them to speak out. She said, "I screamed and yelled but no one heard me or helped me. My Moko screamed and yelled but no one heard him or helped him...I have no more screaming or yelling. I only have tears from within my heart and soul". She said she also approached CYFS. She rang the 0800 number and she was trying to make arrangements to take her son to see his son. She then found out the children were with Tania Shailer and she started ringing CYFS and asking questions about it. She was told there was an investigation pending on the mother. She was told the children had a lawyer and was given his number. She contacted him and he informed her that there was an investigation going on around the mother. She asked if she could do anything and was told no because it was not supported by a parent. She explained to him her concerns for Moko and his sister and that she wanted to pick them up from Taupo. She was told by the lawyer that there was nothing she could do and he would get back to her. She said those words haunted her because the next contact was a call that he did not know that her grandson was dead. She was concerned that the lawyer would not even take five minutes to meet with her and it seems he had not seen Moko or even knew where he was. She said all she basically got was that there was an investigation and her putting her hand up meant nothing. She said no one bothered to check on the children, even after a complaint was made against the mother. She made a plea that they not be defined or judged by what they are or how whanau members act. She wanted to be spoken to and understood as an individual and as a whanau.

[30] The second phase of the evidence involved hearing from people with expertise of matters relevant to the Inquest. In addition, some further evidence was added to the matrix before the Court. That was from Ms Te Tomo from Te Whare Oranga Wairoa, two statements from Mr Leshaun Perrumal from the Auckland District Health Board and a further statement from Mr Asclund, who is the lawyer for the child.

[31] Six expert witnesses later gave evidence and the final witness was the Children's Commissioner, Judge Becroft.

CONCLUSIONS FROM THE FIRST PHASE OF EVIDENCE

[32] There are numerous red flags here that have not been acted on.

[33] The reports of concerns speak for themselves and go back as far as Starship Hospital where it was clear there that an Inquiry could have been made as to the welfare of the children given the circumstances in which the mother and son were in Starship.

[34] The major concern appears to be that at no point was Moko visited by any organisation.

[35] It is clear from the pathologist's report that had Moko been seen even several hours before his death, he possibly could have been saved.

[36] As with Nia Glassie there is no register or monitoring of children under five.

[37] The recommendation in Nia Glassie No.5 was:

> "That all children from birth be compulsory registered with Government agencies and health providers and other voluntary organisations and that they be compulsory monitored through to and including the age of five. That monitoring to include scheduled and unscheduled visits to the homes where young children are living so that the monitoring will ensure that they are kept safe and then provided with the necessities of life".

[38] That has to apply with even more force today.

[39] The observation is that had this recommendation been in place for either Nia Glassie and more specifically for Moko, there was a better chance of Moko's situation being identified, leading to his removal and survival. Any organisation looking at the welfare of a child, if they had gone into the home where Moko was being "cared for", they would have found a caregiver, Shailer, in distress with depression and mental issues and assaulting Moko, another caregiver recently released from jail with a history of domestic violence and seen injuries to Moko that would have raised alarms.

EXPERT PHASE

[40] It is clear from the evidence before the Court, that substantial progress has been made since Nia Glassie. Nearly all of the recommendations were adopted, except the primary recommendation as to

the registering and monitoring of children under five, as referred to in paragraphs 46 to 49 herein. An analysis of the Nia Glassie recommendations and how they have been actioned, has been carried out by legal researchers recently within the Coronial Service Unit. Those reviews of the Recommendations Findings are:

Review of Recommendations made in Nia Glassie Finding

[1] That the government take urgent steps to ensure witnesses to any child abuse must report it immediately. Similarly that there be significant penalties for failing to so report any such abuse.

[2] Following the Nia Glassie case, legislative review was carried out by and amendments were made to the Crimes Act 1961 and the Children, Young Persons, and Their Families Act 1989 (now the Oranga Tamariki Act 1989). The amendments made it an offence for anyone who is a "member of the same household as the victim or a staff member of any hospital, institution, or residence where the victim resides",[2] to fail to take reasonable steps to protect the victim if they know the victim is at risk of death, grievous bodily harm or sexual assault.[3] The maximum sentence for this offence is ten years' imprisonment.

[3] While the amendment to the Oranga Tamariki Act 1989 applied more widely to members of the public, it does not stipulate a mandatory requirement to report. Instead, any person "may report the matter to the chief executive or constable" if the person believes that any child or young person has been or is likely to be harmed, ill-treated or abused.[4] There is to be no criminal, civil, or disciplinary liability for making such a report.[5]

This recommendation has been carried out in large part.

[4] That consideration be given to the provisions of an 0800 number with anonymity provided to caller for reporting child abuse.

[5] Subsequent to the Nia Glassie case, the Ministry for Vulnerable Children instituted a "Child Protect" line to take calls from anyone who has concerns about a child, with trained staff to listen to concerns, assess their seriousness and direct calls to the appropriate place to get help.[6] The line is free to call (0508 326 459) and it is emphasised that calls can be made anonymously and confidentiality can be kept.

This recommendation has been carried out in full.

[6] In respect of the above recommendation that wide publicity be given to these new measures.

[7] A national public awareness campaign was signalled in the Children's Action Plan to reinforce the Child Protect line but this was deferred (see also Recommendation VII). Publicity was given to these measures through media involvement in subsequent high profile child abuse

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[2] Crimes Act 1961, s 195A(2).
[3] Crimes Act 1, s 195A(1)(a).
[4] Oranga Tamariki Act 1998, s 15.
[5] Oranga Tamariki Act 1998, s 16.
[6] New Zealand Government *The white paper for vulnerable children: Volume 1* (Ministry of Social Development, October 2012) at 7, 13. https://www.mvcot.govt.nz/working-with-children/childrens-teams/

cases which has kept the issue of child abuse, and consequently the reporting of child abuse to the freephone number, in public awareness. This has however, been incidental and responsive, and not specifically directed by any organisation or agency. Messages about child abuse have also been rolled into national family violence campaigns such as the "It's not OK" campaign.

This recommendation has been carried out in part.

[8] That there be implemented urgently, a system providing appropriate monitoring and oversight of young children with government agencies providing aid and services, health providers and others.

[9] In April 2017, Child Youth and Family was reformed to become the Ministry for Vulnerable Children (Oranga Tamariki), which Social Development Minister Anne Tolley described as more child-centred, with a focus on harm and trauma prevention and early intervention rather than crisis management, is the focal point of the reformed system.[7]

[10] Previously, a Cross-Agency Care Strategy was developed between six government departments, including Police, and the Ministries of Health, Education and Justice, which have statutory duties imposed on them and which share accountability and responsibility with Oranga Tamariki.[8] Multidisciplinary Children's Teams have been, and continue to be established which support local senior specialists to indentify vulnerable children or families and tailor plans specific to that child.[9]

[11] The cooperation and coordination of services is facilitated by the newly created Vulnerable Kids Information System - a shared, password-protected web-based database with information on vulnerable children and high-risk offenders. The information can be entered by frontline workers, and different parties with interests to the data, such as social workers, case managers, and school principals, each have different levels of access to the data contained within.[10]

This recommendation has been carried out in large part.

[12] That all children from birth be compulsory registered with Government agencies and health providers and other voluntary organisations and that they be compulsory monitored through to and including the age of five. That monitoring to include scheduled and unscheduled visits to homes where young children are living so that the monitoring will ensure that they are kept safe and then provided with the necessities of life.

[13] In the Green Paper, prior to public submissions, it was suggested that the agency responsible for children would look at ways of identifying children at risk of abuse, possibly before or from birth.[11] However, this has not been implemented, neither has there been any

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[7] Anne Tolley "New Ministry for Vulnerable Children, Oranga Tamariki launched" (press release, 31 March 2017). https://www.beehive.govt.nz/release/new-ministry-vulnerable-children-oranga-tamariki-launched

[8] Vulnerable Children Act 2014, s 5.

[9] New Zealand Government *The white paper for vulnerable children: Volume 1* (Ministry of Social Development, October 2012) at 13; New Zealand Government *The white paper for vulnerable children: Progress report* (Children's Action Plan, December 2015) at 12. https://www.mvcot.govt.nz/assets/Uploads/Documents/Childrens-Action-Plan-Progress-Report-December-2015.pdf

[10] New Zealand Government *Privacy Impact Assessment* (The National Children's Director, October 2015) at [5.62-63]. https://www.mvcot.govt.nz/assets/Uploads/ViKI-Privacy-Impact-Assessment-October-2015.pdf

[11] New Zealand Government *The green paper for vulnerable children: Complete Summary of Submissions* (Ministry of Social Development, August 2012) at 126-131. https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/policy-development/green-paper-vulnerable-children/the-green-paper-for-vulnerable-children-submissions.pdf

indication that compulsory monitoring, following standard midwifery checks which end at 4-6 weeks after birth, is planned. The Well Child Tamariki Ora programme - a series of health visits and support that is free to all families for children from around 6 weeks up to 5 years of age – had existed for at least a decade before the Nia Glassie finding, but is not mandatory and requires family engagement.

This recommendation has not been carried out.

[14] That there be compulsory state intervention and the monitoring oversight of the care of children in the following circumstances:

a. A single parent family

b. A single parent who had previously come to the attention of CYFS in respect of another child

c. A single parent who was working fulltime and placed their child in the care of others

d. A single parent in receipt of a domestic purpose benefit

e. Wherever there has been domestic or child violence issues arising in a household.

This recommendation has not been carried out.

[15] That the Ministry continue with their enhanced public education campaign.

[16] The 2012 Children's Action Plan included plans for a national public awareness initiative "to explain the sorts of things that family, neighbours, and people in the community should look out for and where they can go for help".[12] This initiative was deferred, once the plan had begun to be actioned, until enough Children's Teams were established across the country to respond to the call to action the campaign would generate.[13] The public education campaign as described in the White Paper has not yet been carried out.

This recommendation has been carried out in part.

[17] That legislation be enacted to enable the compulsory sharing of information between government agencies and health providers and others. The provisions of the Privacy Act where necessary need to be overridden. The purpose of the legislation is to ensure that all professionals and other providers are able to identify children in need in a timely manner so that intervention can take place and protect them from harm

[18] The Vulnerable Kids Information System was implemented to provide a central hub and interface for sharing information accessible to a range of government agencies involved in the provision of services for vulnerable children but it was noted that privacy concerns were an issue with such a system. The Privacy Amendment Act 2013 codified the authority for information

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[12] New Zealand Government *The white paper for vulnerable children: Volume 1* (Ministry of Social Development, October 2012) at 8.

[13] New Zealand Government *The white paper for vulnerable children: Progress report* (Children's Action Plan, December 2015) at 30.

sharing between agencies. Security measures were put in place so that "only those who need to see the information will be able to do so",[14] but the Privacy Act allows exceptions for information use and sharing where the disclosure is "necessary to prevent or lessen a serious threat to public health or safety, or the life or health of the individual concerned or another individual".[15] The Privacy Commissioner earlier stated that "there is little that is more serious and imminent that the need to protect a child".[16] While the Privacy Act already allows information sharing in this circumstance, this was not always well understood and professionals did not always have the confidence to report and act on suspected abuse or neglect in cases where the parents/caregivers do not consent.[17]

This recommendation has been carried out in full.

[19] That legislation be enacted to ensure there is mandatory reporting by early childhood facilities and schools in respect of identified risk factors, absences, health and abused concerns.

[20] As part of the legislative change enacted following the White Paper, the Vulnerable Children Act 2014 made it a mandatory requirement for providers of children's services to have a child protection policy in place.[18] Such a policy must be written down and in use, say how suspected neglect and abuse will be identified and reported, be available on school websites or on request, and be reviewed every three years.[19] While the legislation is not entirely clear on the application to providers of early childhood education but the Education (Early Childhood Services) Regulations 2008 mandate that an ECE must have child protection policies in accordance with the Vulnerable Children Act.[20]

[21] Providers have discretion as to how their policies are worded and what may or may not be reported. While these policies do put measures in place encouraging the identification and reporting of potential abuse, there is no mandatory requirement to report signs or risk factors of abuse.

This recommendation has been carried out in part.

Other Information Responding to the Glassie Recommendations

[41] Since 2002, a Freephone number so that people could report concerns to the police. In 2011 it was moved to a 24/7 service. There are a number of workshops they want to look out for and how to respond vulnerable children. There was then a creation of the Ministry for Vulnerable Children, Oranga Tamariki. The Government's priority was addressing the needs of vulnerable children. There was a focus now on looking at the system players, including agencies involved. It was noted on that on 1st April 2017, the

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[14] New Zealand Government *The white paper for vulnerable children: Volume 1* (Ministry of Social Development, October 2012) at 10.
[15] Privacy Act 1993 s6, principles 10 and 11.
[16] Privacy Commissioner, Privacy Commissioner statement on Nia Glassie case, (media release, August 25 2011). https://www.privacy.org.nz/news-and-publications/statements-media-releases/privacy-commissioner-statement-on-nia-glassie-case/
[17] New Zealand Government *The white paper for vulnerable children: Progress report* (Children's Action Plan, December 2015) at 30.
[18] Vulnerable Children Act 2014, ss 16-18.
[19] Vulnerable Children Act, ss 12, 19
[20] Education (Early Childhood Services) Regulations 2008, Health and Safety Practices Criterion 28.

Ministry took over from Child, Youth and Family and began the four to five-year process of transforming the way New Zealand protects and improves the lives of vulnerable children and young people.

[42] The Court notes here that these changes will take some time to come into force and this is commented upon by subsequent experts in the evidence before the inquest. Prevention and early intervention is what is now focused on. There is to be more individualised, intensive and specialised care and this new approach is in addition to the range of substantial changes to social work practice. It was noted there was a local initiative by the Bay of Plenty Impact Governance Group. That involved a wide range of agencies as listed earlier. It is cheered by the Bay of Plenty District Commander for the New Zealand Police. They meet regularly and share information in a collaborative way with a view to preventing harm to children. There was an emphasis clearly on working with Maori and looking at cultural issues.

Tayelva Petley

[43] The changes that have been made since Nia Glassie were further averted to in the evidence of Tayelva Petley, who conducted an in-depth review and is the regional manager in Bay of Plenty for the Ministry of Vulnerable Children. She has worked for the organisation for 27 years and is very well qualified. She also outlines the significant Law changes since the Nia Glassie Coronial Findings which include:

- Approved information sharing added to the Privacy Act
- Criminal Legislation amended to require parents to take reasonable steps to protect children
- The sweeping steps introduced in the Vulnerable Children's Act 2014
- The Act required DHB's and School Boards to have child protection policies in place
- Far greater oversight from the Family Court

[44] She also outlined the increase into agency collaboration and other steps taken to respond to the Nia Glassie recommendations.

[45] There was some rigorous cross-examination as to the failures that had occurred and what confidence could be held for the future and that was answered by the certain steps that had been taken and put in place to try and avoid that happening in the future. One significant factor was the mandatory registration of social workers and it was put to Ms Petley there was substantial evidence that people seldom disclose the detail and intensity of violence and abuse and that the worker may not have had the skill to carry out family violence screening. The observation was also "working safely and effectively in this area requires workers to be alert to indicators of potential serious risk to children". She was asked if

she was comfortable with that observation and she agreed with it absolutely stating that they had to find pathways and opportunities as to where whanau feel safe and able to share what is happening. It was referred to her in the Tanya Shailer case there were things said or noted that may have been picked up and led to someone going to the home to see Moko and that was agreed upon. She absolutely agreed with the Children's Commissioner observation that there needed to be an agreed set of child centre competency standards and upskilling of those involved at the coal face. This applied to social workers, not only in Oranga Tamariki, but in other Government organisations contracted. It was agreed there were too many social workers dealing with Tanya Shailer and the training wasn't sufficient for them to identify what was going on. She agreed that it was difficult to get families to engage and staff had to be upskilled in that area. It was put to her that Dr Morreau, in one of his recommendations, suggested that babies should have a permanent attachment figure by six month of age and was suggesting that as the first professional that is engaged with a child is the midwife,they engage with the mother while she is pregnant and she agreed. She supported the concept that midwives could play a significant role of the Oranga Tamariki and identify children that might be vulnerable. She agreed with questioning from the Court that nearly all the recommendations from Nia Glassie Inquest have been implemented. It was put to her that the primary recommendation was that there was no process in New Zealand to register every child under five. In that case if a family chose to, a child would not be registered and no one would know it exists in order to provide services or even know where the child was. The comment was that whanau and family know the child exists. It was put to her that years ago Plunket as an organisation visited the child on a compulsory basis and that this was a wonderful service, with which she agreed. It was also put to her that if Plunket or another organisation had the authority they needed to have the ability to compulsory visit putting aside safety concerns and that was agreed to. The Court put to her that from the Nia Glassie Inquest, that had the home been visited and Nia Glassie was found to be in the care of 17 year olds, marijuana and alcohol and or had Moko been interviewed they would still both be alive and she agreed with that.

[46] The significant change made was the introduction of the Section 18a – 18d of the Oranga Tamariki Act 1989. They provided for greater oversight from the Family Court to help ensure children's safety and wellbeing and parents that had previous children apparently removed due to abuse or neglect.

Inspector Mark Loper

[47] Inspector Loper manages all aspects of criminal investigations and ensures high quality investigations. He has managed and has strategic oversight of multiple homicide investigations including approximately eight child homicides. He was the officer in charge of the Nia Glassie investigation 2007. He had the strategic oversight of operation CORSA which was the investigation into the death of Moko.

[48] He accepted that the police had a role in apprehending and prosecuting perpetrators of family violence but also that they had an additional and comprehensive role in contributing toward prevention. He said it was at the forefront of what the police want to do. The police in Rotorua are also involved with the Ministry group, being the Bay of Plenty Collective Impact Governance Group. One of the themes was about upskilling those involved with addressing issues of family violence. He was very clear that the police in dealing with family violence issues, was an intention to have greater skills in identifying the possibility of future family violence. This was particularly so around child abuse. Mark Loper, whilst

[49] There were a number of very clear and strong recommendations made in the Nia Glassie Inquest with a view to ensuring tragic deaths such as hers, and now Moko's, did not occur in the future. The Inquest into the death of Moko will also specifically look at what steps, if any, have been taken by those identified as having some responsibility in keeping children safe, and if those steps are adequate.

[50] Alarmingly, he said "there have been 94 child homicides involving children aged between 0-14 years, in New Zealand from 2007 – 2015".

[51] The Court comments this is a shocking indictment on child abuse in New Zealand.

[52] He said that since Nia Glassie, the New Zealand Police have conducted a number of reviews into the management and investigation of child abuse. There have been significant changes being made as to processes and procedures. He listed nine separate changes that had been made, which included dedicated child protection team supervisors, protocols for working between the police and Oranga Tamariki, the introduction of child quality assurance programmes and the introduction of extensive training programmes for investigations around the child protection protocol.

[53] He said the New Zealand Police had recognised that child abuse is a significant aspect of family violence within homes in New Zealand. Alarmingly, he said that most offenders are from within a family and it is not unusual to find other family members also have knowledge that offending is occurring.

[54] That certainly is the Court's observation from the evidence in the Nia Glassie Inquest and now in Moko's Inquest. Many of these, it seems are preventable and, in the Courts view, focus should be on identifying and assisting in this area.

[55] He commented that police have been broadening their response to family harm and there has been a cultural shift so that staff are more victim focused.

[56] He noted that family harm encapsulates a broader more holistic view of issues occurring within families and the detrimental effects. It is not concentrated solely on violence, but considers some factors that he listed as:

- Alcohol and drug abuse
- Unemployment
- Deprivation/poverty
- Lack of parenting/life skills and,
- Coercive and controlling behaviour.

[57] He noted the development of a family harm project team in Rotorua. Those teams is a collective response involving the number of the statutory agencies which include Police, Department of Corrections, Oranga Tamariki, Department of Health, Women's Refuge, Ministry of Education, ACC and MSD. There is an enhancing flow of information within the group. The focus now is in identifying the underlying causes of family harm so that interventions can take place.

[58] He noted the development of a family harm project team in Rotorua. Those teams is a collective response involving the number of the statutory agencies which include Police, Department of Corrections, Oranga Tamariki, Department of Health, Women's Refuge, Ministry of Education, ACC and MSD. There is an enhancing flow of information within the group. The focus now is in identifying the underlying causes of family harm so that interventions can take place.

[59] He concluded by saying that the police had made positive improvements in tackling child abuse and family harm and recognise there is significant progress to be made in making our communities and families safe.

[60] The Court comments that it is indeed heartening to see the wide and extensive range of initiatives that the New Zealand Police have taken along with other organisations. Inspector Mark Loper is probably the most experienced police officer in New Zealand dealing with child abuse and family violence and what he says should be listened to very very carefully indeed. The statistics about the 94 child homicides in New Zealand since Nia Glassie are chilling and we simply have to do better as a community and country.

Michael Bryant

Michael Bryant

[61] Michael Bryant gave evidence and is the Social Development Regional Commissioner in the Bay of Plenty. He has very high qualifications in this area. He wanted to explain the role of the Ministry of Social Development and outlined the changes that had been made.

[62] Separate to Mr Bryant's evidence, the Court also noted that prior to the introduction of these Sections the safety of a child was only assessed when abusive parents were brought to the attention of the Ministry. The Ministry would then have to prove to the Family Court that a child was unsafe. The changes have reversed to burden of proof and the parent will have to prove that the child is safe in their care. It was also noted that the Children, Young Persons and the Families Act 1989 was amended in 2016, raising the age of care and protection to a young person's 18th birthday. It was further amended in 2017 and strengthening that provisions allowing information sharing.

[63] The inter-agency collaboration was noted and what was now happening in terms of the change. There were significant children's teams introduced.

Merepeka Raukawa-Tait

[64] The evidence of Merepeka Raukawa-Tait was very impressive and she outlined the steps, that in her view, needed to be taken in addition to those that have already been taken. Whilst she commends those, she was very strong in her evidence, especially with Maori families, that there needed to be a family wide approach and in addition it was important to ensure there was appropriate family support available as soon as possible. She felt there should be Maori providers for Maori families and she did not hold back in her views as to why.

[65] The Court comments these matters are often hard to say, but she is of Maori origin herself and currently does hold a number of senior positions. It is not to be forgotten she was a former CEO of Women's Refuge.

[66] She gave evidence in the Nia Glassie Inquest and is prominent in community affairs in the Rotorua area. She has wide experience and knowledge in working in the area of abuse to women and children. She has been a member of the Maori Reference Group for prevention of family violence for many years. She is a former CEO of Women's Refuge and currently Chair of the North Island Whanau Ora Commissioning Agency. She demonstrated in her evidence that she is not afraid to speak out when that may help prevent the impact on safety for women and children.

[67] She understood that the recommendations of Nia Glassie had been implemented but she noted that the establishment of the Ministry of Vulnerable Children giving themselves five years to embed significant changes, suggests that there needs to be more work done. She referred to the number of children that continue to be harmed and killed in New Zealand as supporting the renewed endeavours.

[68] She focused on, where she believes, improvements could be made to early intervention and it included:

1. Emphasis family strengths
All public awareness raising campaigns to keep children safe should show families as strong, safe and thriving. And with a clear sense of cultural identity. Families should not be portrayed as mad, bad, or sad. This perception influences the willingness of family members, friends, and the general public to intervene and take action if necessary.

2. Take a family wide approach to keeping children safe
When children are identified as being at risk, work must start immediately with the family. Experienced providers work with the family to plan for a better future including a safe and violence free home. At risk children live in at rick homes.

3. Ensure appropriate family support is available as early as possible
Wherever possible engage with Whanau Ora social service providers to support and help families identified at risk. They understand one programme and one provider cannot cover all areas of support and care needed. Whanau Ora providers belong to a local collective in their communities and take a family wide approach to the support they provide.

4. Reframe Public Awareness campaigns to express messages that are meaningful
Campaigns all year round should focus on factors that strengthen and protect families. Communicate what they are, celebrate them and build on them:

- Family stability – healthy loving families
- Social support – being supported by family and friends in good times and bad
- Social capital – being part of the community
- Parents' knowledge about their child's development – growing healthy, happy children
- Family values and practices – close-knit families who talk to each other and know they belong
- Cultural identity – feeling confident and proud of who they are; strong culture / strong family
- "Think Big" for families

5. Fund preventative and early intervention services to be successful

6. Share data between agencies and providers
The Privacy Act is often used to prevent families getting the support and help they need. One Provider One Plan. Do away with "6 cars up the drive".

7. Measure the success of agency and provider support and help
Funding, when outcomes are consistently poor, should be discontinued.

8. Maori providers for Maori families
Maori families respond better to offers of support and help when providers are seen to be non judgemental and having knowledge of Maori culture and values.

9. Government agencies and service providers continue to build capability for working with Maori families
- whole of whanau approaches
- incorporating tikanga
- accountability for results
- working collaboratively with others

10. Support at the front end
Time, resources and adequate funding should be applied upfront. Remedial and corrective costs far outweigh investment upfront.

[69] She was very strong in her view that there needed to be a significant culture change. What we are presently looking at is the aftermath and what needs to happen is, what can be done prior to that. She was adamant that there needed to be a culture change in the Ministry for Vulnerable Children and the Court notes that they have given themselves five years in which to achieve that. The Court strongly recommends that they have regard to all of the evidence that she has given in this Inquest and that will be made available to the Ministry.

[70] She highlights however, the causes and pressure points. She referred to families living in inadequate housing. Little or no income. The father in jail. Serious health issues. Truancy etc. and pointing to the fact that there was no hope for that family. They are in struggle street, she said, every day and it wears them down. They have become tired, tempers get frayed, there is a bit of biff and the boot comes in and then we end up with tragedies such as Nia Glassie and Moko. She clearly points to poverty as being a driver. Her evidence is set out very clearly in these Findings, and in particular the Court draws attention to her evidence about families putting their hand up and taking a significant role.

[71] There was a wide range of cross-examination. She told the Court she could write a book about family violence and as she said in the Nia Glassie Inquest, there has to be a major revamp of our establishments. She said there needed to be a significant culture change so that we eventually see changes in the outcomes that we all want.

[72] It is the whole family approach that is need she said. She said that she believed that the Ministry of Vulnerable Children was attempting to make the necessary changes. She commented that there had been fourteen reports over the last twelve years and, at some stage they must get it right. She felt meeting the people within the organisation had been there too long and it was time to move on and a culture change was required.

[73] She felt that we should be looking at how Maori respond. Maori whanau respond to someone who they believe understands their values, understands their background, will be non-judgemental, will look past exactly what is – will look past and see what's actually the story behind and so it's getting in early. That was very important, she said. The Ministry of Vulnerable children came after the event. Millions of dollars and thousands of hours were going into that side of the work but she felt there should be more in the front end. We should be getting to families as soon as possible. She felt that perhaps the Ministry of Vulnerable Children will make valuable efforts, it's like the ambulance at the bottom of the cliff. She said Maori families respond differently and mostly they are not going to pick up an 0800 number and ring. They will talk to someone they believe can and will support them but the Ministry she said definitely comes after the event.

[74] She felt there also we should be being put up front and investing in families. She didn't see that as a cost. Poverty is there and people are living with it and it is hard for the agencies charged with helping them. And if you understood in Moko's case, the Maori Women's Refuge was trying to help but no longer held the contract. We need to sit down with the families at first instance. You may find there is overcrowding in the house, no money and people barely surviving and you end up with a situation as we had to baby Moko. She said it was not any wonder that this happens but it is not right. She agreed with a suggestion from Judge Becroft about having a whanau hui and having a hui prior to the Ministry being involved and that should be encouraged and supported. The whanau who we should be --exactly that. They set the agenda and take control from the start. That would be a safe environment and any agency would play minor role at that point. Maybe a simple thing like providing the family petrol to get to the hui and kai when they get there and other things they need. But she said if whanau will get to the hui if they believe it is going to help them. That is the forum at the start, that they should be attending and encouraged to attend.

[75] Iwi should be concerned when a child is harmed. She noticed that iwi leaders were now trying to come up to speed but they have been conspicuous by their absence in the past. She said they should have been sending a message loud and clear that you do not harm our Maori women and our Maori children. They have been very quiet over the years but she felt that they were now trying very hard now and there were some good iwi leaders coming through.

[76] She felt there was a link between Nia Glassie and Moko because it was the same issue of placing children ultimately with people who didn't keep them safe. She felt the care of children and safety of a child is paramount.

[77] In answer to questions from the Court, she said there were some wonderful moves now being put in place. She referred to the expert evidence before the Court in the morning and Judge Becroft's analysis. Looking back, she was asked to comment. But her summary was that we have to get to our families and, if they are vulnerable and at risk that's where we have to get the support. She said it is the family responsibility and, if we are Maori then it's the whanau, hapu and iwi. She agreed there were a number of red flags from the start with the mother being in Starship and not picked up from Shailer with her own four children and then the difficulties with the further two and no one going in to see the house or interview the children and like Nia Glassie, no one going into that home. She said that what she would like to see one day is that families put their hand up first and they don't have to wait for an agency to see a red flag. Families should be able to say "I'll put my hand up and say I'm not coping". There should be no shame "I'm not coping". The shame lies, she said, in actually not doing anything about it. It is the families that they must go to. They need to be able to go to someone in the family and say they are not coping and they are getting to a dangerous situation in the family. She agreed there didn't appear to be anyone that Shailer could go to but she said in every family there is usually someone that you can trust, even if it is not a family member who is close.

[78] Alarmingly, she said that research shows that for every child that is abused, there are six adults that know what's going on. In that case, then there must be somebody, she said, who could say I suspect or I know. She agreed that portraying families who are doing well and how they put their hand up and how they cope would be a good thing. She also thought there should be focus on getting help for our men so they know too that they are not useless and they are not hopeless and they're not a hopeless cause and they should be got to early.

[79] At the conclusion of her evidence, she agreed with the Court putting to her as follows:

> "And I think the thrust of what you are telling me is something along, if you always do what you always did, you will always get what you always got, isn't that what you are telling me? Answer – Yes your Honour."

[80] She agreed there were some wonderful moves being put in place now and, in particular, she felt what Judge Becroft was outlining had to be particularly listened to. In essence she is saying the support should go to the families at first instance to try and prevent having to involve the Ministry and others and putting children at risk. She was very clear in her statement "It is the family responsibility and if we are Maori, then it's whanau, hapu and iwi."

[81] The court commends her for her evidence and thanks her for her honesty, directness and identifying pressure points, as she has, particularly within Maori.

Doctor Johan Morreau

[82] The evidence of Dr Johan Morreau was very helpful to the Court. As mentioned by him, his address can be seen on YouTube under "Ted Talks, The First 1000 Days, Dr Morreau" series, relating to vulnerable children and abuse, and is very informative.

[83] Doctor Morreau had been a paediatrician at Lakes DHB for the last 35 years. He was involved in the Nia Glassie Inquest and he has been able to review in detail Moko's case. He has also been able to observe the changing patterns in morbidity and mortality in New Zealand health services. He has discussed it widely with colleagues. He had also reviewed the evidence given in the first day of the Inquest and said he was seriously disturbed with the level of violence Moko suffered. In all of his career he has never seen a more serious case. He felt it was symptomatic of a country undervaluing our children and felt clearly that New Zealand had to address this aspect and the societal issues associated with Moko's death.

[84] He reviewed a report to the Ministry of Health about the best start in life. He felt the development of new children's ministry Oranga Tamariki was a positive development and gave the opportunity for them with other services to work inextricably together and develop a system that had the potential to improve health of the wellbeing of children and young people.

(i) Reduce the frequency of serious harm to children
(ii) Reduce youth suicide.

[85] He felt there needed to be wider focus on the issues, to acknowledge that children matter.

[86] He referred to the expert's forum on child abuse in 2009 and noted that the recommendations from the report had been partially implemented.

[87] He reflected on the last twenty years of pathology and the medical issues facing New Zealand children. He noticed it cost around $100,00 annually to look after a low security prisoner but a dollar invested in a child would save $17 of a later government spend.

[88] He felt Moko's case was symptomatic of society's approach at present and the frequency of the abuse to children, youth suicide won't change without a whole of government plan for children and young people. An important part of the solution was planning and to facilitate the engagement of social working (or equivalent) support early in pregnancy and "for as long as it takes".

[89] He referred to the formation of the child at conception. Good nutrition and a healthy mother free of negative brain damaging effects of alcohol and drugs was critical. Equally important is the attachment bond for children to learn respect and empathy. He noted in the first 1,000 days there was a window of opportunity for the child to receive the care and attention they need. If they don't receive it, or are abused or neglected, neuro developmental behaviour and mental health issues result.

[90] The Court notes this is a very important observation. Whilst most New Zealand children grow up in a very good environment there remains a significant proportion for whom it is seriously not the case. He noted for Moko's case:

(i) The only health professional every mother meets is a midwife. Support systems that engage with mother and their families need to be developed around this role.
(ii) At least 20% of Lakes DHB pregnancies have high level of serious health and social needs, therefore they need a systems wide approach.
(iii) That young mothers and fathers are the population in society, most amenable to change and growth.
(iv) There were wider societal issues such as poverty and equity that needed to be addressed.
(v) The health system in providing mental health care has to have the time and resources to provide the support needed to both adults and their children.
(vi) For a range of complex reasons, the support systems failed the family.

[91] His recommendations were:

(i) There needs to be first 1,000 days' target for all New Zealand children for health and welfare services.
(ii) There needs to be a combined Oranga Tamariki Health approach with the mother being linked to a midwife very early on and where needed linked to relevant social working support. This should include mandatory engagement where this is needed.
(iii) All babies have permanent attachment figure by six months of age as a target for Oranga Tamariki.

(iv) Wider societal issues be addressed to reduce inequity, poverty, focus on child and youth and ongoing factors to reduce family violence. This may involve a reduction in access to alcohol and drugs, focusing on men's health, valuing Maori culture and active investment in welfare, housing, health services.

(v) Refine the cultures by which the government system works. Dispense with the word vulnerable – in this context it is noted that that has occurred with the new government.

(vi) Re-visit and implement the public health advisory committee, advice to the Minister of Health in 2010. He felt now there was a new window of opportunity to make a difference and if we don't, children will continue to be damaged and die.

[92] He noted that many of his reflections and recommendations are similar and almost identical to what he had to say in the Nia Glassie Inquest

[93] He was asked about assessment in Lakes DHB in pregnancy and that those needing to be valued mothers would providing support identify 300 annually babies that are perhaps in that 20% needing wraparound support. In some populations, it could be 30% and would make a significant difference to child outcomes.

[94] The Court agrees with his recommendations and, in particular, his reference to the first 1,000 days' window. The window of opportunity for the child to receive the care and attention they need. He refers to the need to support the midwife and provide social working supports to the family at this time "for as long as it takes". As mentioned in Glassie, this seems to be a matter of funding, but the midwife and/or Plunket involvement with young children up to five years of age should be compulsory. He says in his recommendations "that all babies have their permanent attachment figure by six months of age and that this be legislated for and become a "target" for our welfare services. Again, he is supporting the need that all children up to five years of age need to be identified, recorded, visited and checked on regularly. If they are not recorded anywhere, how does anyone know that they even exist and therefore whether there is any abuse?

Children's Commissioner, Judge Becroft

[95] The Court was indeed fortunate to have the Children's Commissioner; Judge Andrew Becroft appear before it. He is a very experienced lawyer and formerly spent many years as the Principal Youth Court Judge.

[96] He had provided a comprehensive 17-page brief of evidence but before the Court he provided a 10-point summary of his evidence, and spoke to those point

> "Point one. I don't hold personal professional expertise in child abuse or neglect in respect of babies or young children but my office does with very skilled and expert staff and I thank them for the details in my evidence. What I can say is that all I saw as Principal Youth Court Judge for 15 years emphasised the importance as a country of doing the work with nought to five year olds as well as we could to provide stable, safe, loving environments. Because the overwhelming majority of young offenders are those who have been abused, neglected and damaged themselves. They may abuse and damage others but at least 75% of them have an existing or past Child, Youth and Family history. So, nothing is more important than doing this work well.
>
> Point two. After 15 months in this role I'm often asked what is the state of our children in New Zealand. I think it could be summarised in this way, in a three-part breakdown. Seventy percent do well, some do well leading well, culturally, academically and sportingly. Twenty percent, however, do badly and struggle and 10% do very badly, probably as bad if not worse than most Western world counterparts. That breakdown holds in almost all the areas of New Zealand life. Inevitably in my role I have been pulled in to that 10% and as I say in paragraph 3 of my brief of evidence we well know that there is a "dark side" to New Zealand society. There has been a growing realisation over the past 5 to 10 years that our relatively very high rates of family violence, drug and alcohol abuse, child abuse and neglect in this case, bullying and youth suicide are strongly inter-connected. The singular message from my first year in this role has been that all roads lead back to genuine socio-economic disadvantage, often accompanied by marginalisation, social isolation and a sense of hopelessness. These are the families without resilience to cope under pressure. They are clearly these sorts of factors, a significant risk factor, for adverse life outcomes. They are not determinative because thankfully most children are provided with stable loving environments by their caregivers. But in that 10% of extreme hardship there are significant risk factors.
>
> Point three. It would be wrong to say that nothing has happened, Sir, since the Nia Glassie inquest. In fact, your own research shows there's been some significant progress and that should be acknowledged.
>
> Point four. The starting point in my view must be that responsibility for Moko's tragic if not abhorrent death lies with the adults who have been convicted of his manslaughter. They must bear personal responsibility for it. As I say in paragraph 6 of my brief, Moko was killed by the adults

who abused him. The responsibility for his shocking death must lie with them. This must be the starting point in any discussion. I do not want to minimise the fact that only those who inflicted the violence in this case could have guaranteed Moko's safety and it is important in this exercise that we don't shift the primary blame from those two people.

Point five. That said it is fair to say that Government agencies, Oranga Tamariki and Starship Hospital, at least three NGOs and a number of friends either missed or minimised or misinterpreted signals or evidence or what might be called red flags that should have prompted further investigation and collaborative intervention. As I say in 21.1 of my evidence there were sufficient eyes and ears into Moko's circumstances and care at various stages, yet the eyes did not properly see and the ears did not clearly hear and nor did they trigger proper investigation about his real condition and risks. I am not attributing blame or making personal criticism when I say this but it does seem fair to say that if Oranga Tamariki and/or Starship Hospital – and I know it's easy to be wise in retrospect – if they had taken a different and more proactive approach to the issue of finding and ensuring safe care for Moko and his sister in Auckland when they were effectively boarding with their mother in Starship Hospital, the situation for Moko could have been very different. As I say in paragraph 11.1 30 there was an opportunity for proactive and collaborative approach holding for instance a hui o whānau to look at all the options for the care of Moko and his sister when they were in Starship Hospital especially given there were concerns being raised regarding possible medical neglect by Moko's mother in respect of another child at the hospital. Similarly, in Taupō at least three organisations, which I understand from the evidence to be the Māori Women's Refuge, REAP, which held the Family Start contract and Family Works, either missed or misinterpreted or minimised warning signals or what might be called red flags which could have prompted further investigation and I set that out in paragraph 8.2 and in paragraph 11.2. I also understand from the evidence that Oranga Tamariki in Taupō failed to comply with its own seven-day timeframe for a home visit following the filing of a report of concern on the 30th of July 2015. My point is all workers were no doubt 10 skilled in their particular area but apparently, they did not take a child-centred and child-focussed approach.

Point number 6. There is a need for a core competency framework for dealing with children allegedly abused and neglected or in risky circumstances to be rolled out nationally. This I think is an important point. There must be a development of a core competency framework, an establishment of a shared set of skills, values and knowledge across the children's workforce. The framework has been drafted and consulted on across a wide range of social sector agencies. It was part of what was anticipated in the Vulnerable Childrens Act. However, regrettably and somewhat

inexplicably, it has not yet been implemented. It is crucial that this core competency framework be rolled out nationally as soon as possible. As I say in paragraph 21.3, "Children do not have a voice themselves to identify or expose their abuse. All those working with children need appropriate training and professional development to recognise risks, potential warning signs and the need for a skilled interaction with adult caregivers, otherwise we will not be acting in child centred or child focused ways." I accept child focused practices it does work, it can be easily misunderstood but the starting point is because children don't have their own voice, adults need to be very skilled and trained especially working with adults and especially those adults who have the most to lose by telling the truth. There are real skills needed to understand dynamics of family of stressed adult caregivers and to put themselves the experts into the role and voice of children, to understand what is happening for them, to investigate and dig much deeper, rather than take at face value what has been told by adults. In fact, the previous children's commissioner, Dr Russell Wills was closely involved in the drafting of the competency framework during his time as commissioner. He has been very explicit in his view. The key to effective prevention and intervention in family situations where there are serious risks of abuse and neglect, is to ensure that front line practitioners have advanced child focused skills in engaging those families and whānau who find engaging with us the most difficult. I hope that one of the recommendations from this inquiry can be to ask what is happening to the core competency framework. Why is it not now mandatory for any frontline worker in any NGO to have received certified training in this child competency framework. That in fact was point 6 and 7.

Point 8 & 9: I will read from paragraph 21.4. "An important part of that child focused training is to ensure collaboration between organisations working with children in risky environments. In the film Spotlight that won the academy award regarding child abuse in the Catholic Church in Boston, there was one line that struck a chord. It was said, 'If it takes a village to raise a child, it takes a village to abuse a child.' In one sense and in this case, if there had been information sharing and collective collaborative endeavour, if all those who had been working with Moko's caregiver and his mother had worked together to share and pool information, we may have had a significantly different result and if a child focused approach means anything, it must include all those working with children, sharing their information especially when there are clear risks and signals regarding the safety of a child."

Point 10: There have been repeated calls for what might be called a national register of every child born in New Zealand, would provide a basis for monitoring. Not least of which from yourself Sir and that was a recommendation that arose from the Nia Glassie inquest. It seems that there has

been no traction generated for this idea and there has been little national debate. Clearly, one factor that would count against such a register is that 70% or so of children which is confirmed by Dr Morreau's evidence, would probably not need that sort of state monitoring or intervention but it would be a question for you as to whether that is recommended again. Two things can be said. There are in fact existing mechanisms that in theory at least ought to have provided that monitoring of the most risky or if its expanded by 20%, 30% of children who perhaps most need to be carefully monitored and checked. One is the children's team initiative. That was developed as a means of providing local identification of children who most needed 10 support and assistance. As I understand it, about 20,000 children were considered nationally to come eventually within the children's team concept. In fact, to date, about 2000 children only are covered by the limited number of children's teams that have been rolled out. For reasons, I'm not exactly sure of, and which seems all too typical of New Zealand's approach, a pilot such as this seems to have stalled, probably because of the expert advisory groups' work and the creation of Oranga Tamariki but make no mistake, that was an initiative, that was designed to provide concentrated assistance and support and where necessary, intervention for families who were most at risk of having children removed. I hope that this inquest provides an opportunity to ask, what has happened to the children's team's initiative. Dr Morreau talked about one such children's team in Rotorua. Clearly, there are questions to ask as to what lessons have been learnt, how can the idea be better implemented. Dr Morreau himself said there were times when families had been identified and the children's team had agreed on what steps needed to be taken but there seems to be either a shortage of resources or direction but given the optimism that was connected to the roll out of children's teams, we need to ask, if that has stopped and if that pilot won't be continued, what is going to replace it? In terms of a national mechanism that would be akin to the monitoring that you and others have previously suggested, the Well Child Tamariki Ora programme is the successor of Plunket. As I understand it, eight visits are guaranteed from birth through to just before school."

[97] Judge Becroft said, "that programmes reach only covers 91% or 92% of New Zealand's children. The big question is, who has been missed and to what extent is the group that has been missed, to what extent does that constitute the 10% that Dr Morreau was talking about and I've talked about? I think this inquest could well ask what is the state of the Well Child Tamariki Ora programme. Why does it not cover 100% and I know there will be some conscious objectors in that group who won't be part of it but there are also some families in deep need who are being missed and maybe there is an opportunity to deepen and widen that assessment so it is more than just specific health needs but the opportunities taken to look at family needs as a whole."

[98] "Plunket nurses of the past did exactly that. So, my point is there are two existing mechanisms if resourced and supported could meet the very concern that you have regarding the lack of a national register or monitoring programme. The infrastructure is there but only partially. And also, I would say there are a number of local initiatives around the country that are targeted for at that group of birth babies in the 10 percent who seem to need the most help. One for instance is the 1000 Days Trust in Invercargill, the line taken from Dr Morreau's Ted talk. Another one is the Family Help Trust in Christchurch which I was patron, who are actively targeting those babies born in situations where there is likely to be the most risk, so there is much going on in New Zealand locally and much that could be done nationally if it were properly supported to meet the very need that you identified and made recommendations about in the Glassie case."

[99] "And you ask would having a national register have made a difference in this case. You know, probably not because unless there is skilled intervention from child-focussed competent practitioners, even given regular monitoring, unless those skills are there it could have been missed, as it was missed here. And it's easy with the wisdom of hindsight, I know, to say there were warning signals but there is unmistakably clear it seems to our office, that skilled and competent frontline social workers trained in a child-focussed approach, at least some of them would not have missed those- what have been called red flags."

[100] In questioning he commented that he knew that Oranga Tamariki was rolling out a national child focused training programme for all front line social workers. This is in answer to a question about core competencies of social workers which he felt had led to a number of red flags being missed. He is adamant that the government will have to provide the training of the core competency framework. That he said was a non-negotiable. He said it was not a job for well-meaning untrained amateurs. They have got to provide expert child focused training. He noted the Vulnerable Children's Act talked about exactly that with core competencies and so the legislation package had to be taken as a whole. He was supportive of mandatory registration of social workers. He commented on the name Vulnerable Children but it's noted by the Court that this has now been changed. He said he noticed that there was going to be a change in approach and it was now to be child focused and that gave a sense of encouragement. He felt there was a once in a lifetime opportunity in Aotearoa New Zealand to build a world leading care and protection and youth justice system. He said "we will never get this chance again." He went on to say..." this is it. It's been delivered to us. We are told it is a three to five-year building plan. The architect's plans are on the whiteboard. Dr Morreau said he is optimistic. He is an expert in the field. I'm optimistic, that for instance, there's going to be a new professional conference framework delivered by the end of the year".

[101] "So, in summary, that is my 10-point set of observations and I am happy to expand further if required but I think it better to put it in that way than repeat all 17 pages.

Judge Becroft said, "All roads lead back to genuine socio-economic disadvantage."

[102] And then said, "In addition, criminal legislation was amended to require parents to comply."

[103] He accepted that the police had a role in apprehending and prosecuting perpetrators of family violence but also that they had an additional and comprehensive role in contributing toward prevention. He said it was at the forefront of what the police want to do. The police in Rotorua are also involved with the Ministry group, being the Bay of Plenty Collective Impact Governance Group. One of the themes was about upskilling those involved with addressing issues of family violence. He was very clear that the police in dealing with family violence issues, was an intention to have greater skills in identifying the possibility of future family violence. This was particularly so around child abuse.

[104] The Court noted there were a number of very clear and strong recommendations made in the Nia Glassie Inquest with a view to ensuring tragic deaths such as hers, and now Moko's, did not occur in the future. The Inquest into the death of Moko specifically looked at what steps, if any, have been taken by those identified as having some responsibility in keeping children safe, and if those steps are adequate.

[105] In essence he highlighted the lack of training and ability of care workers to identify the red flags that were clearly there. In this case with Moko, there were a number of red flags and they should have been picked up, but they were missed. As he said "there was sufficient eyes and ears to Moko's circumstances and care at various stages, yet their eyes did not properly see and the ears did not clearly hear and nor did that trigger proper investigation about his real condition and risk." As the Court determines and made clear by Inspector Warner, this was abundantly clear right from the time that Moko's mother was at Starship Hospital.

[106] The Court also notes it had the chilling evidence of Moko's grandmother as she seemed by the system to be excluded of providing the care and was appalled that Moko was with Shailer and her partner. A question arises also about the lawyer appointed by the Court and as to why that lawyer did not visit Moko in his residential circumstances.

[107] Judge Becroft also notes from the evidence of Oranga Tamariki that Taupo failed to comply with its own seven-day timeframe and provide a follow-up home visit. But as he said whilst the workers are skilled in their particular area, they did not take a child centred and child focused approach. He calls very pointedly for the need for a core competency frame work in dealing with children allegedly abused and

neglected or in risky circumstances and that this should be rolled out nationally. He said the framework had been drafted and consulted on across a wide of range of social sector agencies. He said it was what was anticipated in the Vulnerable Children's Act and then he went on to say:

"however, regrettably in somewhat inexplicably, it has not yet been implemented. It is crucial that this core competency framework be rolled out nationally as soon as possible".

[108] He went on to say that this is because children did not have a voice for themselves to expose the abuse they receive.

[109] He also referred to the repeated calls for a national register of every child born in New Zealand and it will provide a basis for monitoring. He clearly was disappointed that no attraction had been generated for that and very little national debate. Whilst it may be the 70% of children he said would not need that sort of state monitoring, it would certainly stop the Nia Glassie and Moko situation. He referred to existing mechanisms but clearly, unless you have a compulsory registration of all children under five and they are regularly checked, then some are going to fall through the cracks just as Nia Glassie did and now Moko has. But he went on to say that when you have the National Register, there needs to be intervention from child focus confident practitioners and if that didn't occur, then they would slip through the cracks again.

[110] Under cross-examination, he elaborated on the whole change and the approach taken to monitoring children so that they are to be more child focused. The Court finds the most chilling part of his evidence was this:

"Make no mistake. We have a once in a life-time opportunity in Aotearoa New Zealand to build a world leading care and protection in the Youth Justice system. We will never get this chance again. This is it. It's been delivered to us. We are told it is a three to five-year building plan. The architect's plans are on the whiteboard. Doctor Morreau said he was optimistic. He's an expert in the field. I'm optimistic that, for instance, there's going to be a new professional competency framework delivered by the end of the year. But as a country, we have got to hold Oranga Tamariki to the fire and say that three to five-year building plan has got to take place and we can't scrimp or save on the architectural plans. They have got to be delivered in full. And that's one of the roles that I have."

[111] We can as a country, I think, be very relieved and encouraged when we hear a person of the stature of the Children's Commissioner, speaking in the way it is outlined above. The Court has every confidence that he will monitor this closely and hopefully we will see a big difference and a huge reduction in child abuse.

[112] Significant tranches of the Experts evidence has been included in these Findings so that the full context of what they are saying can be fully appreciated.

PURPOSE OF AN INQUIRY

[113] The purpose of an inquiry is set out under Part 3 of the Coroners Act 2006 (Act). Section 57 of the Act defines the purpose of inquiries as follows;

(a) A coroner opens and conducts an inquiry (including any related Inquest) for the 3 purposes, and not to determine civil, criminal, or disciplinary liability.

(b) The first purpose is to establish, so far as is possible-

i. That a person has died; and

ii. The person's identity;

iii. When and where the person died; and

iv. The causes of the death; and

v. The circumstances of the death.

(c) The second purpose is to make specified recommendations or comments that, in the coroner's opinion, may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred.

(d) The third purpose is to determine whether the public interest would be served by the death being investigated by other investigating authorities in the performance or exercise of their functions, powers, or duties, and to refer the death to them if satisfied that the public interest would be served by their investigating it in the performance or exercise of their functions, powers, or duties.

FINDINGS

[114] I find that **Moko Sayviah Rangitoheriri**, who died at Taupo on 10 August 2015, his cause of death being multiple blunt force injuries, battered child syndrome as a result of a malicious homicide where two humans killed this defenceless three-year-old boy with vicious assaults over a period of time, which was extremely cruel and callous and inflicted appalling pain and suffering on a small child - as found by the High Court.

COMMENTS AND RECOMMENDATIONS

(a) It remains to be considered whether any recommendations or comments should be made in terms of Section 57(3) In so doing the Court refers to the consideration given to this section

by Heron J in Matthews v Hunter [1993] 2NZLR 683. Any recommendations or comments, in terms of the Section are to be for the avoidance of circumstances similar to those in which the death occurred. Section 51(7) of the Coroner's Act 1988 provides:

"A Coroner holds an inquest for the purpose of:

(b) Making any recommendations or comments on the avoidance of circumstances similar to those in which the death occurred, or on the manner in which any persons should act in such circumstances, that, in the opinion of the Coroner, may if drawn to public attention reduce the chances of the occurrence of other deaths in such circumstances."

(b) In R v. South London Coroner ex p Thompson (1982) 126 SJ 625 Lord Lane CJ said of Coroner's inquests (emphasising the important distinction that exists between accusatorial and inquisitorial processes):

"Once again it should not be forgotten that an inquest is a fact-finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest, it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the Judge holding the balance of the ring, which ever metaphor one chooses to use."

(c) The Brodrick Committee (Report of the Committee on Death Certification and Coroners, dated September 22, 1971, CMND. 4810, chaired by Mr (later Judge) Norman Brodrick QC) exhaustively considered the role of the Coroner's inquest in modern society and identified the following grounds of public interest which it believed a Coroner's inquiry should serve:

"(i) To determine the medical cause of death;

(ii) To allay rumours or suspicion;

(iii) To draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;

(iv) To advance medical knowledge;

(v) To preserve the legal interests of the deceased person's family, heirs or other interested parties."

(d) Furthermore, case law amplifies how a Coroner should act and in the case of **Luow v McLean** C.P. 445/87 Hardie boys J, cited with approval excerpts from the following case which sets out the Coroners roles: -

In the case of Ex Parte Minister of Justice re **Malcolm** [1965] NSWR 1598 at 1602

"they can, and should, afford a quick and cheap method of drawing public circumstances attaching to a death, even though there is no suggestion of murder of manslaughter, are one example. Thus, the relatives of a deceased person may feel that the deceased died owing to the negligence or inefficiency of medical authorities: there have been, for instance, several recent cases connected with the admission of patients to mental or other hospitals. If there has been any dereliction for

> duty, the facts are brought out into the open for all to judge; equally if the suspicions are unjustified, this also can be exposed and the persons cleared of unjustified suspicion. A properly conducted inquest has advantages in speed and cheapness over alternative judicial proceedings."

COMMENT

[115] The Court has set out in considerable detail, evidence that was before it in the Inquest. To recap, the Inquest was carried out in two phases. The first one was to determine the facts relating to the shocking death of Moko. The Court was then adjourned and several experts were called at a second sitting of the Inquest. Two of those experts namely Doctor Johan Morreau and Children's Commissioner, Judge Becroft, had made available to them, the evidence that had been given. At the second sitting of the Inquest, these experts gave their evidence and focus of it was to identify what had occurred, changes that had been made and needed to be made so that hopefully this will not occur in the future.

[116] The child abuse figures in New Zealand are appalling. For a country of nearly 4.5 million its rate of child abuse in death within families from child abuse is one of the worst in the developed world.

[117] In his evidence, Inspector Loper stated "according to our records, there have been 94 child homicides involving children aged between 0-14 years, in New Zealand from 2007 to 2015". In other words, since Nia Glassie.

[118] On average, one child is killed every five weeks in New Zealand and most of those are under five years old. In addition, 90% of those child deaths are perpetrated by someone the child knew. A child is admitted to a New Zealand hospital every second day with injuries arising from either assault, neglect or mal-treatment – according to research. Nearly half of them are under five years old.

[119] The Court is reminded of the quote: -

> "those who cannot remember the past, are condemned to repeat it" – George Santayana

[120] Far too many children are living below the poverty line. It is indeed encouraging to see that the new Prime Minister has given herself a Ministerial role to deal with reducing child poverty and, in the Court's view, if an inroad is to be made into child abuse figures.

[121] Add to that, the suicide figures in New Zealand, and in particular the horrendous youth suicide figures, one would conclude that New Zealand is indeed a very dangerous country. Male youth suicide figures are the highest in the OECD and despite significant recent publicity and major publications

running a series of articles concerning suicide, the alarming statistics seem to show that if anything, suicide has increased this year.

[122] New Zealand is a beautiful country. Some see it as isolated with many fjords, mountains and landscapes. As the press has recorded, another form of isolation tragically is depression and suicide. A new report by Unicef contains the shocking statistic – New Zealand has by far the highest youth suicide rate in the developed world. The youth suicide rate for teenagers between 15 to 19 is the highest of a long list of 41 OECD and EU countries. Clearly, higher suicide rates are linked to factors such as child poverty and the factors causing that. As Merepeka Raukawa-Tait says, there is a "toxic mix and you get very high rates of family violence, child abuse and child poverty.

[123] Added to this, we see in the recently released suicide figures, that the national suicide numbers have risen three years in a row. It is the highest on record. Yet this despite a great deal of further discussion about suicide, many media articles and many steps being taken to try and change things.

[124] The evidence before this Court, demonstrates unequivocally that major steps need to be taken and with urgency. The Court does have confidence from the evidence it has heard that there is a "plan" in the wider sense with the steps that are being taken. The active involvement of the Children's Commissioner is a huge factor of hope that he will monitor the steps being taken and will be given the powers and the resources to ensure this occurs. As he very clearly and chillingly said in his evidence "we have a once in a lifetime opportunity in Aotearoa New Zealand to build a world leading care and protection...we will never get this chance again". The Court hoped this would happen and child abuse figures would be drastically reduced following the Nia Glassie Inquest and Recommendations. Sadly, that has not occurred and as evident in the evidence before this Court in the Moko Inquest, significantly more needs to be done. That seems to have been identified and the Court makes the recommendations below in order to try and ensure that child abuse and deaths occurring and the circumstances suffered by little Moko, do not occur again.

[125] The Court hoped that in the last few days a UN report has been released by a committee monitoring the rights of children that is damming for New Zealand, saying we are failing our children in several areas. It notes our high rates of violence to children, and that we are world leaders in Youth Suicide. Maori children in care are 60% yet Maori children are only 25% of the population. We have higher rates of poverty than comparable OECD countries. The monitoring group is led by the Children's Commissioner. He points to the lack of a coordinated approach as one area that needs addressing. He says it has to be sustained.....it is beyond politics and will stand the shifts of political power.

ADVERSE COMMENT

[126] There is a requirement under the Coroners Act to ensure that the Coroner does not comment adversely on a dead person or a living person, without ensuring there is notification and there is a chance to respond.

[127] These Findings, in the Court's view, do not invoke the section relating to adverse comment. If it did, then the Court is of the view that more than adequate notice has been given to all people and organisations involved and they have had more than adequate opportunities to raise any concerns they have with the Court and had the opportunity to appear at the Inquest. In addition, opportunity was given to make submissions and none were received.

[128] As a matter of fairness, Provisional Findings were released to parties who may be subject to adverse comment and recommendations, with opportunities to respond. This is a requirement of the Coroners Act. Some further submissions have been made and considered carefully by the Court. Where considered necessary, adjustments have been made which also include adjustments in respect of comments and recommendations.

[129] The Court has made some other minor adjustments.

RECOMMENDATIONS

[130] A number of detailed recommendations could be made, but the Court is of the view that most of these are already encompassed in the steps that have been taken, as outlined in the evidence of those experts from the Ministry and, in particular, the Children's Commissioner, Judge Becroft.

[131] The Court remains however, of the view that the singular and most important primary recommendation to be followed, is that which was outlined in the Nia Glassie recommendations and referred to in paragraph 49-51 above. This recommendation is directed to the Government generally and not at any specific Ministry. That recommendation is repeated:

> " that all children from birth be compulsory registered with Government agencies and health providers and other voluntary organisations and that they be compulsory monitored through to and including the age of five. That monitoring to include scheduled and unscheduled visits to

the homes where young children are living so that the monitoring will ensure that they are kept safe and then provided with the necessities of life".

[132] Had that recommendation been in place, and for example midwives and Plunket were empowered to check on children and enter homes (subject to safety considerations) and properly funded to do so, Nia Glassie and Moko would probably still be alive today. The Court asks one simple question. If there is no record of the existence of a child under five, then how can all children under five be properly checked to be safe in their environments?

[133] The court also **strongly recommends** that:

(1) The Government and the Ministry for Vulnerable Children Oranga Tamariki work with the Children's Commissioner to have an acceptable registration and checking process implemented.

(2) That the Government and the Ministry for Vulnerable Children Oranga Tamariki consider very closely the evidence of Merepeka Raukawa-Tait, and in particular, her highlighting the necessity for a significant culture change, the pressure points that are arising and causing abuse, the poverty factors and the need, particularly with Maori families, for a family wide approach and the necessity for family support to be available.

(3) That the Children's Commissioner's view set out in paragraph 120 above that Aotearoa New Zealand has a one-off opportunity to build a leading care protection youth justice system be implemented and at the first stage of that, is set a competency framework for dealing with children allegedly abused and neglected or in risky circumstances be rolled out nationally. That the Government work with the Children's Commissioner to ensure that this core competency framework be rolled out nationally as soon as possible.

(4) It is directed that a copy of these Findings be sent to:

(a) Prime Minister as the Minister for Child Poverty Reduction.

(b) Minister and Ministry for Social Development

(c) Minister for Children

(d) Ministry of Vulnerable Children Oranga Tamariki

CONCLUDING COMMENT

When I completed the Nia Glassie Inquest, I said in para 66:

The facts associated with this horrific child abuse of little Nia Glassie are chilling. In my 19 years of conducting Inquests as a Judge of the Coroner's Court, I have never had to endure such horrendous evidence which lead to the death of this little girl in horrific circumstances. My earnest wish is that no one ever has to experience that again.

It is now 10 yrs on from Nia's horrific death on 3rd August 2007. This Court has had to go through this again. But the horrific circumstances surrounding Nia's death have been surpassed beyond belief with the violence perpetrated on Moko:

"The High Court concluded that the extremity of the violence, the injuries, the cruelty, the callousness, the multiple acts of violence, Moko's extreme vulnerability and the breach of trust involved in the offending, were all at the highest levels of seriousness. It concluded that all of those factors made the category of offending as "the most serious" of all manslaughter cases. There were no mitigating features in the offending"

Whatever it takes, whatever it costs, we cannot allow this child abuse to continue.

"On average, one child is killed every five weeks in New Zealand and most of those are under five years old. In addition, 90% of those child deaths are perpetrated by someone the child knew. A child is admitted to a New Zealand hospital every second day with injuries arising from either assault, neglect or mal-treatment – according to research. Nearly half of them are under five years old."

In his evidence, Inspector Loper stated "according to our records, there have been 94 child homicides involving children aged between 0-14 years, in New Zealand from 2007 to 2015". In other words, since Nia Glassie

New Zealand is very fortunate to have a Children's Commissioner, who is devoted to decreasing child poverty and prepared to closely oversee changes to ensure child abuse is drastically reduced. The Court has total confidence in his ability to do this, having regard to the evidence before this Inquest and the way the various Ministries and organisations have responded and the changes that are being made.

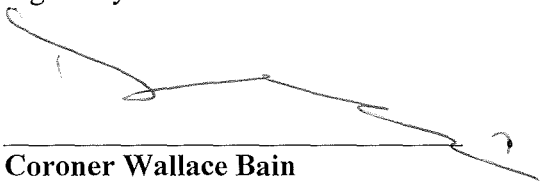
Let's take up the call from the Children's Commissioner, Judge Becroft—

"We have a once in a lifetime opportunity in Aotearoa New Zealand to build a world leading care and protection...we will never get this chance again".

As the colloquialism says -"Let's do this".

As a country, we must. This shameful abuse against our children has to stop.

Signed by the Coroner at Rotorua on this 11th day of December 2017.



Coroner Wallace Bain
Regional Coroner - Bay of Plenty

CERTIFICATE OF FINDINGS

Section 94, Coroners Act 2006

IN THE MATTER of **Moko Sayviah RANGITOHERIRI**

The Secretary, Ministry of Justice, Wellington

As the Coroner conducting the inquiry into the death of the deceased, after considering all the evidence admitted to date for its purposes, and in the light of the purposes stated in section 57 of the Coroners Act 2006, I make the following findings:

Full Name of deceased:	Moko Sayviah RANGITOHERIRI
Late of:	49 Marshall Avenue Richmond Heights Taupo
Occupation:	Child
Sex:	Male
Date of Birth:	14 October 2011
Place of Death:	Taupo Hospital 32 Kotare Street Taupo New Zealand
Date of Death:	10 August 2015
Cause(s) of Death	
(a). Direct cause:	Multiple blunt force injuries
(b). Antecedent cause (if known):	Battered child syndrome
(c). Underlying condition (if known):	
(d). Other significant conditions contributing to death, but not related to disease or condition causing it (if known):	

Circumstances of death: I find that **Moko Sayviah Rangitoheriri**, who died at Taupo on 10 August 2015, his cause of death being multiple blunt force injuries, battered child syndrome as a result of a malicious homicide where two humans killed this defenceless three-year-old boy with vicious assaults over a period of time, which was extremely cruel and callous and inflicted appalling pain and suffering on a small child - as found by the High Court.

I have, under section 74 of the Coroners Act 2006, prohibited the making public of the following:

i) The photographs forming part of the evidence
ii) The addresses, telephone numbers, e-mail addresses (where applicable) of persons who have provided signed statements in evidence.

Those findings, and my reasons for making them, are also set out in my written findings dated

Signed at Rotorua on 11th day of December 2017.

Coroner Wallace Bain