BEFORE THE SOCIAL WORKERS COMPLAINTS AND DISCIPLINARY TRIBUNAL

UNDER	the Social Workers Registration Act 2003 ("the Act")
IN THE MATTER	of a disciplinary charge laid against a social worker under Part 4 of the Act.
BETWEEN	**A PROFESSIONAL CONDUCT COMMITTEE** appointed under the Act **Applicant**
	AND [Ms G]of X, registered social worker **Practitioner**

DECISION – 13 December 2022

TRIBUNAL	Ms C Garvey, Chair Ms S Jarvis, Ms A McKenzie, Mrs J Pearse, Ms Fiona Wilson (Members) Ms G Fraser, Hearing Officer Ms J Kennedy, Stenographer
APPEARANCES	Ms K Kensington for the Professional Conduct Committee Mr D McGill and Ms D Beissel for [Ms G]

Introduction

1. [Ms G], now retired, was a registered social worker employed for 16 years with Child Youth and Family (now Oranga Tamariki) from 2003 to 2019. [Ms G] attained a Bachelor of Social Work in 2005. In 2013 [Ms G] was made a supervisor in the caregiving team at Oranga Tamariki's [X] site.[1] [Ms G] held this position for the period of the charge, August 2015 to February 2018.

2. On 3 December 2020 a Professional Conduct Committee (PCC) laid a disciplinary charge against [Ms G] pursuant to s72(3) of the Social Workers Registration Act 2003 (the Act). The PCC amended the charge without objection on 4 June 2021. There have been several unfortunate delays in the hearing and conclusion of the proceedings. An in-person hearing was set down for November 2021 but adjourned due to the COVID-19 pandemic and rescheduled for March 2022 when it was again adjourned. The hearing proceeded on 19-21 September 2022 in Hamilton with no time available for closing submissions and deliberation. The Tribunal proposed to reconvene by audio visual link as soon as possible for the closing submissions, however an inability to find a suitable date led us to request written submissions. We reconvened in private to deliberate on 26 October 2022.

3. On 27 October we issued a Minute indicating our finding that the charge was not proved. Counsel were invited to consider and submit any submissions as to costs and permanent non-publication orders. These submissions were received by the Tribunal on 15 November 2022.

4. This decision sets out the reasons for our findings on liability and costs, and outlines the non-publication orders we have made.

[1] The site became the [Y] site subsequently but for the purposes of the charge nothing turns on this.

The disciplinary charge

5. In August 2015 [Mr N] and [Ms H] (referred to also as the caregivers in this decision) were approved to provide home for life, transitional and/or respite care for children in the custody of Oranga Tamariki. They provided respite care to [Master G] and [Master W] in October 2015 and became long term caregivers for these two boys in April 2016. They provided respite and then full-time care for a third boy [Master L] from late 2016. The disciplinary charge originates in a complaint to Oranga Tamariki by [Mr N] and [Ms H] about the services provided to them in the context of their care for the boys and the decision to remove the boys from their care on 9 February 2018 following a period of respite.

6. The caregivers laid a formal complaint with Oranga Tamariki on 5 March 2018, leading to an internal investigation by [Ms P] Advisor Feedbacks and Complaints. Ms [P's] final report is dated 14 September 2018 and upheld much of the complaint.[2] The report made several recommendations including that a Practice Analysis be undertaken. This was done by the Regional Practice Advisor and a Senior Advisor and is dated 12 September 2018.[3] This report is also critical of the social work services provided and lack of adherence to Oranga Tamariki policy by the employees the subject of the complaint. We refer to these reports as they were included in the Agreed Bundle of Documents submitted at the hearing.

7. [Ms P's] report formed the basis of the caregivers' complaint to the Social Workers Registration Board (the Board). The Board appointed PCCs with consistent membership to separately investigate six social workers who were the

[2] AB tab 21 Oranga Tamariki Complaint Resolution Report, 14 September 2018
[3] AB tab 22 Oranga Tamariki, [Mr N] Practice Analysis, [APB & LS], 12 September 2018

subjects of the complaint.[4] The PCC laid one disciplinary charge, being the charge against [Ms G]which reads as follows:[5]

1. Between August 2015 and February 2018, [Ms G] failed to work with [Ms I] cooperatively in the best interests of social work clients, including [N] and [H], including in the following ways:

    a. [Ms G] utilized a directive and bullying approach to supervision of [Ms I].

    b. [Ms G] failed to inform [Ms I] about the case consultation of 25 January 2018 that was held to discuss the placement of the children in the care of [Mr N] and [Ms H].

    c. [Ms G] did not discuss the outcome of the case consultation on 25 January 2018 with [Ms I], and led [Ms I] to believe it was not [Ms I]'s role to provide support to [Mr N] and [Ms H] after the children were removed from their care.

2. Between August 2015 and February 2018, [Ms G] failed to make adequate records of concerns about or interactions with [Mr N] and [Ms H] including:

    a. [Ms G] had been told about concerns by other Oranga Tamariki staff about how [Mr N] and [Ms H] were treating the children and did not make any record of those concerns.

[4] Brief of Evidence Phyllis Huitema at [6]-[7]
[5] ToE 332/10: Mrs Huitema advised us that two social workers were referred for a competency review and three had no further action recommended.

b. On or about 31 May 2017, [Ms G] failed to make a record of a meeting held with [Mr N] and [Ms H] and failed to follow up on concerns raised by [Mr N] and [Ms H] during that meeting.

3. Between August 2015 and February 2018 [Ms G] failed to follow up, or ensure [Ms I] followed up, concerns [Ms G] had heard about [Mr N] and [Ms H].

4. On or about 25 January 2018 [Ms G] provided inaccurate information at a case consult held to discuss the placement of the children in the care of [Mr N] and [Ms H], by saying that "considerable work" had been done with [Mr N] and [Ms H], which was not accurate.

5. On or about 9 February 2018 [Ms G] wrote a letter to [Mr N] and [Ms H] informing them that the children in their care were to be removed, which did not adequately inform [Mr N] and [Ms H] of the reasons for that decision.

6. On or about 9 February 2018 [Ms G] signed the names of [Ms A] and [Ms E] to the letter written to [Mr N] and [Ms H] without their permission.

7. [Ms G] failed to ensure that appropriate support was provided to [Mr N] and [Ms H] after the children were removed from their care.

8. [Ms G]'s conduct breached principles 1, 4, 5, 8 and 10 of the Code of Conduct (March 2016) issued by the Social Worker's Registration Board pursuant to s 105 of the Act.

This conduct considered individually and/or cumulatively constitutes:

(a) Professional misconduct pursuant to s 82(2)(a) or 82(2)(d) of the Act; or, in the alternative

(b) Conduct that is unbecoming of a social worker and reflects adversely on her fitness to practice as a social worker pursuant to s 82(1)(b) of the Act.

Preliminary comments

8. Consistent with the internal reports, the evidence before us highlighted shortcomings in the social work services provided to the caregivers and the children in their care, including poor record keeping, lack of face-to-face contact, lack of adherence to policy and inadequate communication. We heard from six current or former Oranga Tamariki employees (all registered social workers) who attributed these shortcomings to being overworked and under resourced. There is no doubt that these factors impacted on decision making and service provision, however not all the poor practice we heard evidence of, can be excused by this. We make this point because we consider that [Ms G] was neither solely nor primarily at fault for the lack of services provided to the caregivers or the decision to remove three children from their care but has borne a disproportionate burden for this.

9. [Ms G] remained engaged in these proceedings, notwithstanding her retirement from social work practice prior to the laying of the charge. Co-operation with the Board and the disciplinary process is a matter of professional responsibility for a registered social worker set out in Principle 9 of the Code of Conduct (the Code).[6] In our view this responsibility extends to social workers appearing as witnesses and the Tribunal should not be required to explain to them the

[6] The Board must issue a Code of Conduct for social workers pursuant to s105 of the Act. References to the Code in this decision are to the version issued on 14 March 2016.

importance of these proceedings and of ensuring they are available for the time required to complete their evidence.

10. An Agreed Bundle of Documents (the bundle) is intended to be a convenient manner of compiling evidence for proceedings. The parties should adhere to the established requirements for an agreed bundle which are that each document:

    a. is what it purports to be on its face.

    b. was signed by any purported signatory shown on its face.

    c. was sent by any purported author to, and was received by, any purported addressee on its face.

    d. was produced from the custody of the party indicated in the index.

    e. is admissible evidence; and

    f. is received into evidence as soon as referred to by a witness in evidence, or by counsel in submissions, but not otherwise.

11. Some of the documents in the bundle were altered in such a way that their inclusion was not consistent with the above rules and were therefore misleading, for example the removal of email recipients and inaccurate annotations used to name a document.[7] Duplication of documents should be avoided unless there is justification for this. While not a strict requirement, having documents placed in chronological order also assists the Tribunal.

[7] AB tab 3 pp 33, 34; tab 17 p119

12. We were concerned that the CYRAS records produced were incomplete even considering the acknowledged poor record keeping.[8] For example, the bundle did not include supervision records for [Ms I] (relevant to particular 1) or any evidence of the organisation of the case consult or dissemination of its findings (particulars 1 and 2). The PCC submitted in closing that s 121 of the Evidence Act 2006, which pertains to criminal proceedings, applies. Section 121 provides that it is not necessary for the evidence on which the prosecution relies to be corroborated except with reference to specified offences. A disciplinary proceeding is not a criminal proceeding and we do not consider that s 121 is applicable in this jurisdiction. We do accept that there is a likelihood that we simply did not have all the documents that would have assisted our deliberations produced. The Tribunal's findings rely on our assessment of the witnesses and the documentary evidence that was before us.

13. Finally, where credibility was in issue due to conflicting witness evidence, we have taken into account the factors outlined by counsel for the PCC in closing submissions in reliance on *Rabih v Professional Conduct Committee of the Dental Council*.[9]

The disciplinary test

14. As above, the charge pleads that [Ms G] is guilty under s82(2)(a) of the Act of professional misconduct based on a breach of the Code), and s82(2)(d) professional misconduct being conduct that brings discredit to the profession or in the alternative s82(1)(b), is conduct unbecoming.

[8] CYRAS is an acronym for Care and Protection, Youth Justice, Residential and Adoption Services records and is an automated case management system used by Oranga Tamariki.
[9] *Rabih v Professional Conduct Committee of the Dental Council of New Zealand* [2015] NZHC 1110 at [40]. Closing submissions for the PCC at [10].

15. The PCC bears the onus of proving the charge to the civil standard, that is, on the balance of probabilities. The more serious the allegation, the stronger the evidence that may be required to prove it: *Z v Dental Complaints Assessment Committee.*[10]

16. The Tribunal adopts a two-step process to assess whether the evidence amounts to professional misconduct:

    a. the first step is to make an objective analysis of whether [Ms G]'s acts or omissions can be reasonably regarded as constituting a breach of the Code of Conduct, or as conduct which brings discredit to the social work profession.

    b. the second step is for the Tribunal to be satisfied that those acts or omissions require a disciplinary sanction for the purposes of protecting the safety of the public and/or enhancing the professionalism of social workers.

17. [Ms G]'s conduct must be assessed against the standards of "*competent, ethical and responsible practitioners*."[11] This is a key reason why the membership of the Tribunal includes three registered social workers.[12] In this case, relevant context includes the evidence of heavy caseloads beyond what was reasonably sustainable, common practice at the {Y] site insofar as the witnesses provided insight into this and the scope of [Ms G]'s professional role.[13]

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[10] *Z v Dental Complaints Assessment Committee* SC 22/2007; [2008] NZSC 55.
[11] See *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774, and *B v Medical Council* [2005] 3 NZLR 810.
[12] Section 119(1)(b) of the Act
[13] AB tab 23 Oranga Tamariki policies, Position Description for Social Work Supervisor, Child Youth and Family pp212-218

18. Not all acts or omissions in breach of the Code will reach the threshold to warrant disciplinary sanction. The PCC submits that the threshold should not be overstated given that the primary enquiry is whether there has been a breach of the Code. We observe that not every breach will warrant discipline and refer to the evidence of Phyllis Huitema to the effect that other social workers investigated by the PCC were considered to have breached the Code but did not meet the threshold for referral to the Tribunal, instead being dealt with under the PCC's power to recommend a competency review.[14]

19. Conduct unbecoming also involves a two-step approach:

    a. an objective analysis of whether [Ms G]'s acts or omissions can be reasonably regarded as conduct unbecoming of a social worker; and if so

    b. the Tribunal must then be satisfied that the acts or omissions reflect adversely on [Ms G]'s fitness to practise and require sanction for the purposes of protecting the public and/or enhancing the professionalism of social workers.

20. With that unusually extensive background, we now discuss the particulars of the charge.

Particulars 1(a) to (c)

21. Principle 8 of the 2016 Code required social workers to work openly and respectfully with colleagues. Principle 8.2 set the expectation that social workers will:

[14] ToE 335/28-336/1-4, 336/30 – 337/1. The determinations available to a PCC are set out in s71 of the Act.

> [W]ork co-operatively with colleagues when such cooperation serves the well-being and the best interests of clients.

22. We make three observations in an overview of Particular 1. First, while Ms Kensington submits that particular 1(a) relies on us finding that [Ms G] was bullying and/or directive in her behaviour towards [Ms I], this is pleaded conjunctively. Secondly, we are confined to determining the charge based on events between August 2015 and February 2018. Several witnesses referred broadly to a workplace investigation months after February 2018 but we must disregard this evidence. Thirdly, the charge refers to [Ms G]'s conduct impacting [Ms I]'s actions in relation to social work clients (plural). The PCC's case relied on services provided to [Mr N] and [Ms H] who we treat for the purposes of this charge as a singular caregiver package. We heard no evidence about other specific cases that [Ms I] was involved with.

23. [Ms G] was the supervisor for five social workers including [Ms I]. Neither party referred to the Position Description for Social Work Supervisor in the bundle.[15] This is a detailed document including essential and desirable competencies to be demonstrated by the supervisor. A supervisor must, amongst other things, ensure that Key Performance Indicators (KPIs) are met. Under the heading Team Management, a supervisor is required to "*provide direction and leadership to others*" and to hold their team members accountable for performance and consistently compare performance against standards.

24. Both [Ms G] and [Ms I] discussed the nature of their regular interactions, but with regard to formal supervision sessions there was little detail other than that

[15] Above n 13

sessions did occur on a relatively frequent basis. [Ms G] confirmed that supervision records were kept and said:[16]

> I kept those records…we had the special – you know the pads? The social work supervision pads? I always used those. So we'd start with "How are you feeling? What's been good in your week or what hasn't been so good in your week? And then we'd go into casework.

25. Without the records we are reliant on the recollection of [Ms G] and [Ms I] as to the content of their supervision sessions, and the lack of any recollection of formal supervision being sought regarding [Mr N] and [Ms H]. That there was some oversight of [Ms I]'s work with the caregivers is seen from emails and notes in the bundle.

Particular 1(a): that [Ms G] utilised a bullying and directive approach to supervision of [Ms I]

26. [Ms I]'s brief described [Ms G] as directing her to minimise telephone conversations with her caregiver clients and to focus on her [other] work. In oral evidence [Ms I] said that [Ms G]:

    a. told her on more than one occasion "*I don't want you ever to make any decision if I'm not here.*"[17]

[16] To E 479/29 - 480/1-5
[17] ToE 162/11

b. ordered her to stop removing balloons that were decorating the workplace and directed her in relation to what work she should be doing, saying "*stop doing that and do this*".[18]

27. [Ms G] denied ordering [Ms I] to do anything or that she told [Ms I] to follow her direction at all times. She equated giving direction with requiring [Ms I] to follow Oranga Tamariki policy and said being directive meant reminding her team of their KPIs "*because they were kind of doing their own thing…and I was trying to bring some sort of system into the Care Services Team.*"[19]

28. For a definition of bullying in the employment context counsel referred to the WorkSafe New Zealand "Preventing and Responding to Workplace Bullying: The Guidelines."[20] We agree that this is helpful in the absence of evidence of a relevant Oranga Tamariki policy. The Guidelines define bullying as "*repeated and unreasonable behaviour directed towards a person that can cause physical or psychological harm*." They list examples of conduct that will not be considered bullying, namely:

a. a one off or occasional instance of forgetfulness, rudeness or tactlessness.
b. setting high performance standards.
c. constructive feedback and legitimate advice or peer review.
d. a manager requiring reasonable written or verbal work instructions to be carried out.
e. a warning or disciplinary action in line with the organisation's code of conduct.

[18] ToE 171/1
[19] ToE 374/29
[20] https://worksafe.govt.nz/dmsdocument/782-preventing-and-responding-to-bullying-at-work February 2014

f. a single incident of unreasonable behaviour.

g. reasonable management actions delivered in a reasonable way.

h. differing opinions or personality clashes that do not escalate to the level of bullying, harm or violence.

29. [Ms I] said in her brief of evidence:[21]

My relationship with [Ms G] was very challenging. In my opinion, [Ms G] micromanaged me. I felt bullied by her.

30. [Ms I] said that she spoke to the Site Manager [Ms A] about her experience with [Ms G] and that [Ms A] was supportive but there was no change. However, [Ms A] stated that no complaint of bullying was made at the relevant time.[22]

31. When asked for specific examples of [Ms G]'s allegedly bullying behaviour [Ms I] said that [Ms G] told her she was "*not performing.*"[23] She referred to an incident where she was admonished in front of others for returning late from lunch. [Ms I] said she was concerned about [Ms G]'s demeanour towards her, saying "*what I'm trying to explain is the demeanour of the conversation, day in / day out, that it is bullying*."[24]

32. [Ms G] denied telling [Ms I] that she was not performing or that she micro-managed [Ms I].[25]

33. In closing submissions counsel for [Ms G] characterised the supervisory relationship as one in which [Ms G] was trying to elevate an underperforming

[21] Brief of Evidence [I], 5 May 2021 at [32]
[22] ToE 195/19
[23] ToE 165/31
[24] ToE 176/28
[25] ToE 386/15

member of her team and that [Ms I] failed to do what was reasonably expected of someone of her experience and skill level.[26] That a high level of support and direction was required for [Ms I] to perform her role, was affirmed by Site Manager [Ms A] and [Ms R], now a Senior Advisor with Oranga Tamariki and who also was supervised by [Ms G] between March 2017 and February 2018. [Ms A] expressed confidence in [Ms G] as a supervisor and described her as "*supportive and frustrated*"[27] with [Ms I], who she said found it difficult to comply with expectations that she complete work "*the right way and the best way.*"[28]

34. [Ms R] (who appeared as a witness for [Ms G]) said in her brief that:

> [5] [G] was professional, approachable and always available for informal and formal supervision. She was clear about organisational objective and expectations. [G] was caring, easy to engage and had a lovely sense of humour.
>
> …
>
> [7] The Caregiving team had performance issues. [G]'s management style reflected this by her having to monitor staff more to meet team and organisational objectives.

35. [Ms R] said that she observed positive interactions between [Ms G] and [Ms I] and that *"[a] supervisor has to give direction if things aren't being done, but I wouldn't have seen that in an impatient way*."[29]

[26] At [87]
[27] TOE 193/28
[28] TOE 195/1-6
[29] TOE 504/23

36. We accept that [Ms I], although a senior practitioner, required support, direction and oversight and felt under pressure to complete her duties with a large caseload of 50-60 caregivers.[30] She did not provide services to [Mr N] and [Ms H] in accordance with Oranga Tamariki's Caregiver Support policy.[31] This policy required a caregiver social worker to visit caregivers once a week for the first four weeks of a placement and then a minimum of every eight weeks thereafter. A two-yearly review of the status of caregivers is also required under the Caregiver Review policy.[32] [Ms I] visited [Mr N] and [Ms H] twice, first in August 2015 to assess their suitability to be appointed caregivers and the second time on 9 January 2018 to carry out the required two-yearly review, which was overdue from August 2017. [Ms I] did also speak to them by telephone and sent and received emails to do with their caregiving role.

37. [Ms I] said she had no concerns about the caregivers[33] and she did not raise issues about them in supervision sessions with [Ms G].[34] It seems likely that [Ms I]'s inaction in relation to [Mr N] and [Ms H] was not a consequence of bullying and directive behaviour from [Ms G] but of her high workload and not giving priority to two caregivers who she considered capable.

38. The Tribunal is not satisfied that [Ms G] was bullying in her approach to [Ms I]. We accept that [Ms I] felt upset by the level of direction being given but in reference to the WorkSafe Guidelines, we find that this was [Ms G] outlining reasonable expectations to meet KPIs, as her position required of her. A supervisor being directive does not in and of itself warrant criticism. This might be so if the directions given are consistently unreasonable or outside the scope

[30] Above n 21 at [23]
[31] Above n 13 Caregiver Support Policy p 182
[32] Above n 13 Caregiver review Policy p 189
[33] ToE 145/24
[34] ToE 164/28

of the tasks reasonably expected of a supervisee, but we were not satisfied that this was the case here. We are not satisfied that [Ms G] was bullying or was directive in a way that warrants an adverse finding. Accordingly, we find particular 1(a) is not proved.

Particular 1(b): that [Ms G] failed to inform [Ms I] of the case consult of 25 January 2021

39. The PCC must establish that it was [Ms G]'s responsibility to ensure that [Ms I] was informed of and present at the case consult on 25 January 2018. It is not enough that it was desirable that [Ms I] attend. The Tribunal heard, and accepts, that consults are often called at short notice and attended by those who are immediately available and involved with the relevant case. The primary consideration is the wellbeing of the children under discussion, which means representation from the Care and Protection team is paramount. We were told that at the relevant time it was not uncommon for a caregiver social worker or supervisor to not be present at a consult.[35]

40. Oranga Tamariki's Child and Family Consult policy and the related case consult tool inform the proper conduct of a consult.[36] The case consult tool was not used, and close adherence to the policy is not apparent from the Practice Leader's record of the meeting. According to the policy, a case consult must be used when removal of tamariki from their home is considered. The policy does not stipulate who must attend, which reflects the myriad uses of a consult, including for discussions with whānau, individual consideration by a social worker, in supervision and in a group consult process.[37]

[35] ToE 487/1-4, 491/2-16 [Ms S]
[36] Above n 13 Child and Family Consult p193
[37] Above n 13 p194

41. The Practice Leader [Ms E] called the case consult on 25 January 2018 to discuss the ongoing placement of the three children with the caregivers. It was [Ms E]' responsibility to use the policy and to decide whether to record the discussion and outcome using the tool. In the weeks prior to the case consult [Ms E] discussed concerns about the youngest boy [Master L] with [Ms T], his care and protection social worker, and documented her decision that [Master L] would not return to the caregivers from respite care. [Ms E] also documented her intention to consult with the care and protection social worker for the two older boys so their care could be aligned.[38] We do not know whether this occurred before the case consult.

42. As to inviting the participants to the case consult, [Ms E] believed that she used email calendar invites sent by administrative staff on her behalf but was unable to produce evidence of this. [Ms E] said it would be "*highly unusual*" to call a consult orally.[39] In contrast, [Ms G] recalled that the consult was arranged orally on the day with those on the floor and that [Ms I] was not present.[40] [Ms I] confirmed that she was not invited but could not say whether she was present in the office or not.[41]

43. Whatever the mode of invitation, [Ms I] was not invited to attend the consult by [Ms E], and no comment was made by [Ms E] as to her absence. Despite this, under cross-examination [Ms E] accepted that "*it would have been pretty remiss [of me] not to invite her*."[42]

[38] Above n 7 pp18-19
[39] ToE 279/34
[40] ToE 365/24
[41] ToE 149/7
[42] ToE 283/1

44. We do not need to determine how the consult was convened because the PCC has not established the fundamental element of this particular, namely that it was [Ms G]'s responsibility to ensure that [Ms I] was present. Nor has the PCC established that [Ms I] was even available in the Oranga Tamariki premises at the time the case consult was held, or that [Ms G] instructed her not to attend. Accordingly, we find particular 1(b) is not proved.

Particular 1(c): that [Ms G] did not discuss the outcome of the case consultation with [Ms I] and led [Ms I] to believe it was not her role to provide support to the caregivers after the children were removed

45. We are critical of the way in which the outcome of the case consult was communicated among staff and with the caregivers. The decision to remove the children had far reaching implications for them, including multiple short-term placements after a long period of stability, as well as for [Mr N] and [Ms H].[43] Communication with the children was the role of the care and protection team, but it was essential that [Ms I] and/or [Ms G] communicated promptly with [Mr N] and [Ms H] about the end of the placement and their ongoing status as caregivers. In our view this ought to have involved recognition and acknowledgment of the impact of the decision on the caregivers, an explanation of any support Oranga Tamariki could provide and details about how to access support from Fostering Kids. The Tribunal considers that [Ms G] had a responsibility as the caregiver representative at the case consult and as [Ms I]'s supervisor to ensure that appropriate follow up was undertaken.

46. The case consult note records a decision that the caregivers would not be notified of the removal of the children until they had been taken to respite

[43] Above n 3 at p 164 noting that since their removal in February 2018 the two older boys had lived with six different caregivers at the time the report was written in September 2018.

care.[44] It was unclear when [Ms I] read this note, or whether the decision to put off discussion about the decision with the caregivers was communicated to her. [Ms G] does not dispute that she failed to discuss the consult with [Ms I] and the first element of particular 1(c) is made out.

47. The second part of this particular is not made out however. [Ms I] was aware of the decision reasonably soon after it was made and told the Tribunal:[45]

> At that time of the Case Consult, there was no clarity whether this is on hold, or it's going to be an investigation, so therefore I did not make phone conversation to [the caregivers] to see how they are because they'd have – if these children are removed from the caregivers, they have questions, they want to know why, what happened, why are they not coming back, and I had no answers to any of these questions.

48. From this evidence we infer that [Ms I] was quite promptly aware of the decision to remove the children. This is consistent with what is reported in the [P] report, attributing [Ms I]'s lack of follow up to the fact that there was no formal investigation of abuse or neglect. [Ms I] is reported as advising that she was told the concerns did not warrant an investigation so she did not consider the need to provide support around the removal of the children. We agree with the report's findings that the limitations of the Complaints Against Caregivers policy does not excuse the failure to communicate and offer support to the caregivers.[46]

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[44] Above n 7 p 28
[45] ToE 150/26
[46] Above n 2 p153. [Ms P] wrote "*Staff informed me that support was not offered to the caregivers because this matter was dealt with as a complaint rather than an investigation of allegations. I found this response disingenuous*."

49. The PCC rely upon [Ms I]'s evidence of a conversation with [Ms G] on 10 January 2018, the day following the caregiver review. [Ms I]'s brief of evidence states:

> [15] [Ms G] told me that she had other information coming through and expressed to me she had concerns about [Mr N] and [Ms H]. She did not specify what these concerns were.
>
> [16] [Ms G] told me she was planning to hold a meeting and said I should not take any further steps relating to them.[47]

50. The PCC submit that this conversation led [Ms I] to believe it was not her role to provide support and as a result she did not do so.

51. The Tribunal accepts that there was a conversation on 10 January regarding the visit to the caregivers, which [Ms I] explained was because it was outside working hours and she needed to claim TOIL, time off in lieu of extra hours worked.[48] However, we find that [Ms I]'s description of it is not entirely accurate for the reasons following:

    a. there is no evidence that as at 10 January 2018 [Ms G] was aware of specific and current concerns about the care of the three children, either from [Ms G] or from any witness other than [Ms I]. There is no apparent basis for [Ms G] to have held such concerns at that time.

    b. there is no evidence that [Ms G] was planning to hold a meeting, and it was the Practice Leader who initiated the case consult.

[47] Above n 21
[48] ToE 160/14-22.

c. [Ms E] discussed concerns with [Ms T] about [Master L]'s placement in supervision in December 2017 and January 2018 but only documented the discussions on 11 and 18 January 2018. There was no evidence before the Tribunal that [Ms E] or [Ms T] discussed the placement with [Ms G] in the weeks before the case consult.

d. [Ms E] called the case consult of her own volition and without prior discussion with [Ms G].

52. The internal investigation records the sequence of events around the caregiver review as follows:

> On 9 January 2018 [Ms I] visited the couple to complete the "two yearly review" that had been overdue since 21 August 2017. She opened a CYRAS record on 23 January 2018 but did not enter any information on that date. [Ms I] was not invited to the Case Consultation held on 25 January 2018. Her supervisor informed her later, that the children were being removed from the caregivers and that their caregiver status would be placed "on hold." [Ms I] felt her notes about the "two yearly review" were no longer required so she left the record empty.[49]

53. Nothing is reported in the internal investigation about a conversation with [Ms G] on 10 January, or [Ms G] leading [Ms I] to believe at the time that it was not her role to provide support. While this is not determinative it appears to us a more plausible explanation that [Ms I] did not offer support because of the lack of formal investigation which would have given her policy direction to follow, and her concern that the discussion would be a difficult one given she was not present at the case consult and not party to the decision making.

[49] Above n 2 p 154

54. We find that [Ms G] did not discuss the case consultation with [Ms I] and provide instruction on providing support as she ought to have done, but the evidence does not establish that [Ms G] led her to believe it was not [Ms I]'s role to provide support. We do not consider the finding to the extent it has been made reaches the threshold for discipline.

Particular 2: that [Ms G] failed to make adequate records of concerns about or her interactions with the caregivers

55. The Oranga Tamariki Recording Policy outlines the importance of up to date, accurate and relevant reporting.[50] The policy expects that case records should be child centered, succinct and accurate, timely, relevant and differentiate opinion from fact.[51]

56. On the evidence before the Tribunal, the case file for [Mr N] and [Ms H] appeared to have documents missing and entries were frequently not made in a timely manner. This is consistent with [P's] finding that there was "*a pattern of poor case note recording that breaches the Ministry's Recording Policy*."[52] CYRAS automatically populates the record with the date the record is opened and the date the record is created (that is, when an entry is made. On occasion a record may be opened but nothing written). The author can manually change the date the record relates to in order to provide accurate information and the bundle contains many records where the subject event or interaction occurred one or two or more weeks prior, including retrospective entries made by very senior staff. The examples span 2016 to 2018 indicating that such delays were tolerated

[50] Above n 13 Recording Policy p 202
[51] Above n 13 at 203
[52] Above n 2 at 151

and even considered acceptable over a long period of time.[53] The policy expectation of "timely" recording suggests to us the same day or shortly after, but a timeframe is not specified. The most obvious risk in delayed record keeping is that important information is not available to those using the case file, such as with [Ms I]'s two-yearly caregiver review on 9 January 2018 which was not documented until sometime after the case consultation on 25 January 2018.[54] Delay also gives rise to a risk of inaccurate or incomplete recollection and recording.

Particular 2(a): [Ms G] did not document concerns about the caregivers that she was told by other Oranga Tamariki staff

57. In closing submissions relating to this particular the PCC relies on two occasions where [Ms G] was aware of concerns raised by or about the caregivers and did not make a record in CYRAS. The first relates to a complaint on 21 December 2016 about the caregivers' methods of discipline. An anonymous caller to Oranga Tamariki reported that the older two boys were disciplined with extensive time out, being made to sit on a wooden floor for two hours at a time, and that [Mr N] had told them "Christmas is cancelled" and not allowing the boys to eat purchased food as a punishment when the whanau were out for a meal. The informant denied any physical abuse of the children. A case note was made by the call-taker and reminded to the boys' case worker, the case worker's supervisor and the National Call Centre supervisor. [Ms G] was not initially a recipient of this information.[55]

[53] Above n 7 pp 8, 9, 14, 15, 18, 19, 25, 27, 42, 120.
[54] Above n 47 at [13]; n 2 at p154
[55] Above n7 p 6

58. The caregivers were spoken to individually by telephone and text messages were exchanged between [Mr N] and the care and protection social worker. The same social worker arranged to attend the boys at their holiday programme, which she did on 23 December. A partial print out of the text messages is included in the bundle but does not include the content written by the social worker. The messages attributed to [Mr N] indicate there was substance to the allegations in that he acknowledges banning sweets, making the boys sit on the floor for extended periods and a suggestion of withholding Christmas presents until after Christmas (we accept the caregivers' evidence that Christmas was celebrated).[56]

59. [Ms G] was advised of the above by the Practice Leader [Ms E] on 22 December 2017.[57] [Ms E]' note of this conversation records their agreement that the conduct did not meet the threshold for an investigation, and that because the caregiver social worker was on leave [Ms G] would contact the caregivers to discuss this with them. [Ms G] spoke first to [Mr N] on 23 December and later that day to [Ms H] and she made a record of these discussions.[58]

60. On 23 December [Ms O] spoke to the older two boys and documented their version of events and the fact they both felt safe with the caregivers. The progress plan – such as it is – does not refer to [Ms G].[59]

61. The PCC submits that it was for [Ms G] to elicit the full details surrounding the anonymous complaint and [Mr N]'s methods of discipline, and to document this and that because she did not do so: "*none of the context appeared in the case note, which he* [[Mr N] *considered problematic when that was later relied upon to remove the children."*

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[56] p 7
[57] p8
[58] p9
[59] Above n 7 at p11: [Ms O']s plan is "[Master G] and [Master W] will remain in the care of [N] and [H] or with an alternative service caregiver."

62. In his evidence to the Tribunal [Mr N] did insist that [Ms G] failed to make inquiries about why the boys were disciplined, and he disputed the allegations of extensive time out. We consider that the care and protection social worker was the appropriate person to follow this up and did so. [Mr N] had ample opportunity to explain events from his perspective at the time and did this and to his mind, the matter was resolved. Ultimately Oranga Tamariki's concern was with the disciplinary methods employed regardless of context, and even had the records included more background information we do not consider this would have had any bearing on the outcome of the case consult in January 2018.

63. We accept [Ms G]'s position that if her colleagues had concerns about the caregivers and the safety and wellbeing of the children, it was for those social workers to ensure that this was documented in CYRAS. [Ms G] stated that the information she had was "*third hand to start with. Nobody had actually made a complaint in writing and put those concerns down*."[60] [Ms A] said it would be unlikely for a caregiver supervisor to record concerns unless they were the first person to know of these.[61] [Ms A] also said she was aware of concerns but attributed this knowledge to information obtained from the care and protection social workers.[62]

64. The second event that the PCC rely on to assert a failure by [Ms G] to record concerns told to her, is the meeting that she and [Ms A] attended with the caregivers on 31 May 2017 in response to a complaint by [Mr N]. [Mr N] requested this meeting to discuss his concerns about the social workers and the level of support the caregivers were receiving for [Master L]. Insofar as there were contemporaneous concerns about the caregivers this was separately

[60] ToE 392/11
[61] ToE 255/16
[62] ToE 255/8

discussed at a consult called by [Ms E] in March 2017 and attended by several staff including [Ms G] and members of the care and protection team.[63] There was a further Professionals Consult called by then-Practice Leader [Ms S] on 17 May 2017, which [Ms G] also attended alongside counsel for the child, a second Practice Leader and a care and protection social worker and her supervisor.[64]

65. We find no evidence that [Ms G] held concerns that were not shared by or known to her Oranga Tamariki social work colleagues and that she had the responsibility to record those concerns.

Particular 2(b): that [Ms G] failed to make any record of the meeting on or about 31 May 2017

66. In May 2017 [Mr N] contacted Oranga Tamariki including to seek assistance for [Master L] and raising concern about contact with his mother. On 17 May [Mr N] emailed [Ms A] and said:

> On a separate but related issue, [H] and I would like to meet with you as site manager [out] of business hours, and lodge a complaint regarding your departments care for [Master L]. It has been below standard.[65]

67. The email went on to outline the caregivers' concerns with a perceived lack of engagement and support from Oranga Tamariki. [Mr N] concludes with a request for action, writing:[66]

[63] Above n 7 p14 Case note record dated 27 March 2017 [Ms E] for consult held 22 March 2017
[64] Above n 7 p15 Professionals consult record by [Ms S] dated 29 May 2017 for consult held 17 May 2017
[65] AB tab 17 p119; document 4
[66] Above n 15 p131

> One thing I will say: We have attended several meetings so far and nothing comes out of them. If you want to discuss this again, it needs to be properly organised and followed up. So far, the parties have been great at calling meetings and talking however, there is very little follow up.

68. It fell to [Ms G] to organise the meeting and attend at the caregivers' home with [Ms A].[67] No contemporaneous record of the meeting was made. [Ms G] was not instructed to record the meeting by [Ms A] and she considered that it was [Ms A]'s responsibility to do this as the meeting was to discuss the complaints of [Mr N] that he had raised with [Ms A] directly. It is the Tribunal's view that the first responsibility to document the meeting lay with [Ms A] for this reason and in her more senior role as Site Manager.

69. We note our concern that an adapted version of [Mr N]'s email was included in the bundle with the header "*Email to [G] (Caregiver Supervisor) from [N] 17 May 2017*."[68] The email was addressed and sent to [Ms A].

70. While [Ms A] was reluctant to accept that the meeting was requested with her ("*I'll accept that [Ms G] arranged the meeting at my request and that we both attended*")[69] she agreed that when dealing with a complaint as Site Manager it was her responsibility to record an outcome and respond.[70] This did not happen, and [Ms A]'s annotated records confirm that "[t]*here are no further records of any discussions or actions that followed from this meeting*". [Ms A] did however action [Mr N]'s request to have a different social worker liaise with the caregivers in place of the allocated social worker for the two older boys, as they did not get along. [71]

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[67] AB tab 14 p92
[68] Above n 65
[69] TOE 201/12
[70] TOE 207/17
[71] AB tab 18

71. [Ms A] made an undated note regarding the meeting some months later, saying she did so under "*considerable pressure by the organisation.*"[72] It reads:[73]

> There were no minutes or notes taken at this meeting. The outcome was some shared clarity around the management of [Master L]'s behavior, the importance of contact with his mother, the roles of social workers and caregivers, communication with the social worker and other agencies and follow up to see if a co-worker could be appointed to have direct contact with [N] and [H] other than [Ms D] who would remain as key worker.
>
> [N] and [H] appeared to remain convinced that their management of food for [Master L] was as it should be and anyone else involved in the care of [Master L] should follow the management plan put in place by [N] and [H]. [N] and [H] appeared to remain unconvinced that regular contact for [Master L] with his mother as per the psychologist recommendations was the best thing for [Master L] and requested that they not have any direct contact with social worker Pam Wood who they requested should be removed from the case.

72. The caregivers disputed the accuracy of this record but [Ms G] did not. Insofar as it outlines [Ms A]'s recollection of the meeting, it is noted that there was no further action required by [Ms G].

73. For the reasons above we find that particulars 2(a) and (b) have not been proved. [Ms G] documented her interactions with the caregivers in December 2016. She did not make a record of the meeting in May 2017 but neither did [Ms

[72] ToE 250/31
[73] above n 7

A], who we consider had the primary responsibility for doing so. We also find that the focus of the meeting was the caregivers' complaints to [Ms A] about inadequate communication and engagement by the care and protection team with the caregivers and various other professionals, these being matters which were outside [Ms G]'s remit to follow up.

Particular 3: that [Ms G] failed to follow up or ensure [Ms I] followed up concerns she had heard about the caregivers

74. Particular 3 relies on the same evidence as particular 2, with the additional requirement that [Ms G] ought to have and did not ensure that [Ms I] followed up concerns that [Ms G] had heard about the caregivers. In the absence of evidence that [Ms G] had heard concerns other than those already discussed, we find that particular 3 is not proved.

75. We also observe that the caregivers themselves were in direct communication with [Ms I] by email and by phone.[74] [Ms I] characterised her role as being "*assessment, review, everyday communication with the caregivers and report writing and all that*" and accepted that she was the first point of contact for the caregivers.[75]

Particular 4: that [Ms G] provided inaccurate information to the case consult, inaccurately saying "considerable work" had been done with the caregivers

76. On 2 February 2018 [Ms E] made a detailed record of the case consult that had taken place on 25 January 2018, the bulk of which outlines information

[74] Eg above n 67 pp 56-67, 70-72, 82, 84
[75] ToE 148/8, 21

attributed to the care and protection social workers.[76] The consult was attended by [Ms E], care and protection social workers [Ms Y], [Ms T] and [Ms D], a care and protection social work supervisor [Ms K], and [Ms G]. [Ms E] (Practice Leader) and [Ms K] were the senior staff present with the evidence being that [Ms K] filled in as Site Manager for [Ms A] when she was on leave, which she was at the time.[77]

77. The purpose of the consult is stated as being to discuss "*the various reports of worry regarding [N] and [H]'s care of the children in their home*." [Ms E] goes on to write:

> [G] acknowledged that there has been considerable work done with [N] & [H] to try and modify their regimented attitude to caring for children. There does not seem to have been any change and there continues to be concerns.

78. The PCC allege that the words "*considerable work*" is a direct quote from [Ms G]'s comments at the consult. The harm of this statement is said to be that it was an inaccurate reflection of the support provided to the caregivers to assist them in parenting children with high needs and was influential in the decision not to return the children home. [Ms G] has given several conflicting responses as to whether she used those words, and what was meant by them:

    a. By letter dated 19 November 2018 [Ms G]'s counsel advised the Board that "*[Ms G] said that there had been considerable work done with the complainants to try and modify their regimented attitude to caring for the*

[76] Above n 7 pp 27-28
[77] ToE 252/31-34, 253/1-11

children and there did not appear to be any changes. [Ms G] stands by this comment…"[78]

b. [Ms G] was interviewed by the PCC in November and December 2019. When asked whether she recalled saying "*considerable work*" she replied "*No, I sat and listened to a lot of the stuff that was being said*" and it was "*not accurate recording*."[79]

c. By letter dated 2 February 2021 [Ms G]'s counsel wrote that "*[Ms G] says that the comment "considerable work" has been taken out of context" and was meant to refer to her own workplace stress and demands*;[80]

d. In evidence before the Tribunal [Ms G] was asked "*Well do you accept that what you said gave rise to the understanding that considerable work had been done*?" and replied "*No, I didn't use the word considerable*."

e. Mr McGill opened with an emphatic denial that [Ms G] said "*considerable work*" and in closing submitted that notwithstanding her previous statements [Ms G] was clear before the Tribunal that "*she did not use these words*."[81]

79. In her brief of evidence [Ms E] said she invited [Ms G] to the consult to represent the views of the caregivers, and that she took notes while others spoke. [Ms E] does not refer to the contentious phrase, but says:[82]

[78] AB tab 27 Duncan Cotterill letter to the Board at [24], p 244
[79] AB tab 30 Transcript of PCC interview with [G] 11 November 2019 (Part 1) and 12 December 2019 (Part 2) pp282 and 284
[80] AB tab 32 at [4.6.1]
[81] Submissions on Liability at [142]
[82] Brief of Evidence of [Ms E], 27 May 2021 at [22]

> [Ms G] was very clear that she felt there was nothing that could be done to help [Mr N] and [Ms H] improve their caregiving practice. She said there had been many attempts to help [Mr N] and [Ms H] and there was nothing more that could be done.

80. [Ms E] was questioned about this and did not answer directly, instead observing that if [Ms G] had opposed the content of the note she could have asked for it to be amended. [Ms E] describes the consult note as a summary of what was said and that no one objected to its content.[83]

81. Having considered [Ms G]'s vacillating responses and [Ms E]' equivocal ones, we find that the case consult is a summary by [Ms E] of the discussion that occurred. We are not convinced that [Ms G] used the phrase "*considerable work*" to assert that she had made such efforts to assist the caregivers to adjust what the consult note describes as their regimented approach to parenting, but that [Ms E] has captured the tenor of the discussion at the consult around interactions with the caregivers. It is unfortunate that such emphasis has been placed on the words "*considerable work*" to the point that the internal investigation recommended that it be retracted from the case consult note[84] and their subsequent inclusion in the disciplinary charge. It is perhaps telling that [Mr N] assumed [Ms G] was "*the driving force*" behind the decision to remove the children, because he had no contact from the Site Manager, it was [Ms G] who requested to meet with the caregivers to discuss concerns and who wrote the letter advising of the decision to remove the children, and because of the comments attributed to her in the case consult record.[85]

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[83] ToE 290, 291
[84] Above n 2 p150; and see above n7 p29 Correction to previous Case note
[85] ToE 86/31 and ToE 87/1

82. The views of the care and protection social workers are set out at length in the same record and are critical of the caregivers. [Ms D] is reported as being removed as key worker because she found the caregivers impossible to work with and insistent on total control, impacting the youngest child's contact with his mother. Ongoing concerns about discipline are reflected in comments attributed to [Ms T], describing the youngest child as living from one punishment to the next. She is also reported as saying there was no evidence of love shown by the caregivers, with examples of unpleasant comments made by [Ms H] about [Master L]. [Ms Y], social worker for the two older boys is reported as advising that the caregivers would not work as a team, refused to go out of their way in the slightest and that their care was not child focused.

83. The overall impression we gain from the consult record is of a shared view that [Mr N] and [Ms H] were not seen as suitable for parenting [Master L] and that disagreement with their approach to parenting was not new. What is clear is that it was a care and protection team decision not to return the boys to [Mr N] and [Ms H]'s care, and that from [Ms E's] evidence she and the care and protection social workers had made up their mind what was going to happen with [Master L] and that following discussion, it was decided that the other two boys would also be removed.

84. [Ms G] told the Tribunal that she had many telephone calls with the caregivers and that these conversations were "*hard*".[86] There is evidence that [Ms G] was often required to assist the caregivers when her colleagues were unavailable or non-responsive. The Tribunal considers it likely that [Ms G] felt she had made considerable effort and was aware that other staff found the caregivers difficult to deal with and so [Ms G] stepped in.

[86] ToE 361/15

85. We agree with Ms [P's] observation that:[87]

> [In] the absence of any record that staff disputed [Ms G]'s summation, it can be assumed that all staff present believed that the concerns discussed at this consultation had already been addressed with the caregivers who had not made any changes.

86. We note also that the internal investigation records that training was offered but not taken up by the caregivers.[88]

87. We do not consider that [Ms G]'s input at the consult was deliberately misleading or inaccurate or ultimately determinative of the mutual decision to remove the three children from the care of [Mr N] and [Ms H]. The decision to remove [Master L] had already been made and the decision to remove the other boys was a collective one. We are not satisfied to the requisite standard that [Ms G] used "*considerable work*" in the context described and as such we do not find this particular proved.

Particular 5: that [Ms G]'s letter did not adequately inform the caregivers of the reasons for the decision to remove the children from their care

88. The case consult note records agreement that the caregivers would not be told of the decision to remove the boys until after they had left for respite care, which had been arranged to start on 2 February 2018. It states that [Ms G] would work with [Ms A] to inform the caregivers.[89] [Ms G] discussed the decision with [Ms A] on 30 January 2018 and telephoned [Mr N] that day to request a meeting

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[87] Above n2 p 144

[88] above n 3 p155: "[*Ms I], [Mr N] and [Ms H] agree that the caregivers were invited to enrol in training provided by Fostering Kids but as they both worked fulltime, and [Mr[N] worked shifts (police) they were unable to attend at the times and dates scheduled*."

[89] Above n 7 p28

on 1 February.[90] [Mr N] spoke to [Ms H], then emailed [Ms G] on 31 January declining to meet until Oranga Tamariki had provided disclosure of the concerns to be discussed.[91]

89. [Ms G] then consulted with [Ms A] and eventually prepared a letter outlining the decision to remove the children, which she emailed to [Mr N] on 9 February 2018. Particular 5 relies on this letter, and asserts that it does not adequately inform [Mr N] and [Ms H] of the reasons for the decision.[92]

90. The letter starts by referring to the prior request for a meeting, and goes on to state:

A number of concerns have been highlighted by social workers.

- The lack of team work – you are very clear about your own ideas for the children.
- Your inability for reasonable face to face communication with all Oranga Tamariki staff.
- Your regimented attitude to providing care for children in our custody who have experienced trauma in their lives.
- Your apparent lack of understanding about whanau remaining in the children's lives.
- Your apparent lack of love and affection towards the children in your care.

[90] p30
[91] p31
[92] p32

> A case consult has been held with our Practice Leader [Ms E] and the decision was made at that consult that all three children would not be returning to your care.
>
> We are happy to organise a meeting on your return from holiday to discuss these concerns and our decision that the children will not return to your care.

91. The content of the letter was undoubtedly a shock to the caregivers. In our view it was not an acceptable way to communicate the decision not to return the three children to the caregivers, when there had been no consultation and in the absence of allegations of abuse or neglect.

92. [Ms G] said she felt at a loss about how to write this letter as she had never had to do this before.[93] [Ms E] was on leave so was not available for advice. [Ms G] has consistently maintained that she made a draft of the letter which she discussed with [Ms A], who made changes to it. Under cross-examination [Ms G] said:[94]

> No it's not my letter, it is a joint letter between [Ms A] and myself. You've got to remember, that was the first kind of letter I had written of that type, I'd never had that situation in my professional career so that's why I turned to my superior, [Ms A], to proof-read it, and she made the amendments, and she sent it back.

93. [Ms G] said she did not refer to the case consult note when she drafted the letter. When cross examined on the wording used in the letter she said "*I didn't get those reasons, that was amended by [A]*."[95]

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[93] Above n 79 p 274; ToE 445/10
[94] ToE 432/19-35
[95] ToE 446/22

94. [Ms G] was adamant that she emailed the letter in draft to [Ms A] who made changes. Unfortunately, the emails between [Ms A] and [Ms G] were not produced. [Ms A] did not deny seeing a draft of the letter or requesting and making some changes. She did not see the final version before it was sent, but equally did not make clear that she required this.

95. We find that the PCC has not proved particular 5. The letter captures the reasons for the decision to remove the children as documented in the case consult record. [Ms E] was on leave and did not see the letter before it was sent by email. Under cross-examination [Ms E] was asked whether its contents reflected the discussion at the case consult. After confirming that she did not see the letter before it was sent, she said that if she had read it "*I wouldn't have thought oh my gosh, no that's not right because it is.*"[96] When she was questioned by the Tribunal about the letter she said in the same vein "*If I did read it, I wouldn't have thought, oh no*. *Yep*"[97]

96. We consider that the failure to implement the Case Consult policy and tool contributed to the unsatisfactory way the decision was made and communicated. The Tribunal, in the absence of an allegation of abuse or neglect or anything warranting a report of concern or formal investigation, did not see evidence of the need for urgency in the decision to remove the children. It cannot go unremarked that there was a disturbing lack of consideration given to the views of the children who were not consulted, despite their legal right to be and the disruptive impact of the decision on their lives.[98] There was also a lack of respect shown to the caregivers by the decision not to consult them in the

[96] ToE 304/23-32
[97] ToE 312/15
[98] Oranga Tamariki Act 1989 section 11

circumstances and the Case Consult Policy provides guidance on what this consultation should entail.[99] There was also a lack of consultation with others who were invested in the wellbeing of the children such as the youngest boy's parents, schools, counsel for the child or any others with knowledge of their current circumstances. In our view these shortcomings impacted on the robustness of the decision and led to an undue emphasis on [Ms G] as the person tasked with communicating the decision.

Particular 6: that [Ms G] signed the names of her Site Manager and Practice leader without permission

97. Beneath her own name [Ms G] typed the names and titles of [Ms A] and [Ms E] at the end of the letter. All three names were typed, as opposed to a formal digital e-signature or a printed, signed and scanned version of the letter. For the purposes of the charge we do not think this is material as the critical fact is that [Ms G] was responsible for entering all three names and the critical question is whether she had permission to do so. We agree with the PCC's submission that the use of a name attributes authorship, ownership and responsibility, so the need for consent is very important.

98. [Ms G] has consistently said that she had permission from [Ms A] to use her name, and that of [Ms E]. There is no dispute that [Ms E] was not aware in advance that her name would be included.

99. In [Ms G]'s initial response to the Board she does not discuss the signing of the letter but this reflects that the complaint to the Board relied on Ms [P's] investigation report which did not note this as a concern. It is notable that the matter of the signatures was not raised during the internal investigation, given

[99] Above n 13 at p195

the strong denials subsequently by [Ms A] and [Ms E] that they were agreeable to their name being included.

100. In her interview with the PCC in December 2019 [Ms G] said:

> Because, when I wrote that letter on [E] and [A]'s behalf, but I said to [A] at the time that I was not putting my name solely to it, because I didn't readily understand why the children were coming out, because there was no details provided in that case consult.
>
> ….Because I was not going to be a scapegoat for other practitioners.
>
> Q. Were they aware that their names were going to put on that letter?
>
> I spoke to [A]. She read the letter and then made some changes to it. I said to her about [E]. I can't remember her exact words. But she was in agreement that our three names would be put on it. For me, when I came out and was directed to write that letter, I was at a loss because it was very hard to write; because I didn't have all the details of why the C & P practice leader made the decision to take those children out."[100]

101. [Ms G] states in her brief that [Ms A] gave her permission to use [Ms E] name. When giving evidence to the Tribunal about the content of the letter and her discussions with [Ms A], [Ms G] said:

> Absolutely. She amended that letter. That is why I find it really hard to accept that she sat here yesterday and said she did not ask-she didn't approve of her name going on that letter. She told me to put it on and she told me to put on [E]'s…

[100] Above n 79 p274

…

She did [make significant amendments], and that's where we really need the evidence from the email trail at Oranga Tamariki."[101]

102. In her brief of evidence [Ms A] denied seeing the final version of the letter and said she did not allow the allow anyone to add her name to emails or letters without express permission. [Ms A] told the Tribunal "*I'm not denying I had influence in the content. What I'm saying is I did not expect to see my name on the end of it*."[102]

103. Both [Ms A] and [Ms E] were copied in on the original email to [Mr N] and neither raised an objection at the time about their names being included.

104. We find on the balance of probabilities that [Ms G] did discuss the names to be put on the letter and believed that she had [Ms A]'s permission, in her capacity as Site Manager and in the knowledge that [Ms E] had led the case consult and decision making, to do so.

Particular 7: that [Ms G] failed to ensure that appropriate support was provided to the caregivers after the children were removed from their care

105. We heard little detail of what follow up occurred with the caregivers after the children were removed. We have no doubt, and [Ms G] accepts, that she did not provide appropriate support herself or to take steps to ensure that this was offered by [Ms I]. An offer to meet the caregivers is contained in the letter of 9 February but there was no follow up of this offer, which would have been appropriate notwithstanding [Mr N]'s response on the same date outlining his

[101] ToE 44/6 24 – 447/1-5
[102] ToE 229/33

intention to take his concerns to someone other than [Ms G] or [Ms A], having "*little faith*" in them.[103]

106. We consider that the letter ought to have set out available support from Oranga Tamariki and to provide information about the services that Fostering Kids offer, but this was not done. In our view, the fact that the caregivers did enlist the support of Fostering Kids does not absolve [Ms G] and [Ms I] of responsibility to offer support around the removal of the children, and to ensure that the caregivers were informed of their caregiver status.

107. We accept [Ms G]'s evidence that independent of any instruction from her, [Ms I] had responsibility as the caregiver social worker to provide support and did not do so. We also consider that the Site Manager had a role to play in this regard, also being a recipient of [Mr N]'s response to the 9 February letter. [Ms A] made no reply until subsequently required by her employer to address [Mr N]'s formal complaint dated 5 March 2018.

108. The bundle contains some information regarding the involvement of Fostering Kids, with correspondence dated 23 February 2018 alluding to a telephone conversation between Robert Surtees of that organisation and [Ms G], on 19 February. Mr Surtees requested a meeting with Oranga Tamariki. His email begins "*Hi all*" and refers to [Ms G] in the third person ("*I had a conversation with [G] on the 19th of February…*"). While it is [Ms G] who has uploaded the letter into CYRAS it is not clear who all the recipients were, but we infer this was not solely [Ms G].[104]

[103] above n 7 p33
[104] Above n 7 pp34-5

109. We find that [Ms G] did fail to ensure that appropriate support was provided to [Mr N] and [Ms H] after the children were removed from their care. However, we find this falls short of the threshold warranting discipline. [Ms G] was not alone in the obligation to do more and to not simply accept [Mr N]'s immediate and naturally upset response, as a reason for not ensuring that support was offered. This failure constitutes a breach of principle 5 of the Code, as to the need to protect the rights and promote the interests of clients. Principle 5.2 sets out the expectation that social workers will facilitate access to services, resources and other professionals where appropriate.

110. As we observed at the outset not all breaches of the Code will warrant disciplinary sanction and to punish [Ms G] for this breach would amount to a disproportionate response based on the evidence before us.

Costs

111. When the Tribunal makes a finding against a social worker under s82 of the Act, the Tribunal may then make one or more of the orders set out in s83 under the heading Penalties. Section 83(1)(e)(i)-(iv) allows us to order that a social worker pay part or all of the costs and expenses incidental to PCC inquiries and the prosecution of a charge by the PCC or Director of Proceedings (DP) and hearing of any charge. The Board may apply costs paid under s83(1) to reimburse itself: s86(1)(b).

112. The Act is silent as to costs in favour of a social worker who is wholly or partly successful in defending a disciplinary charge. We sought submissions from counsel on this matter, given [Ms G]'s successful defence of the charge and because the question of costs in favour of a social worker has not to our knowledge been considered in the context of the Act.

113. In brief, the PCC submit that costs should not be awarded in favour of [Ms G] because:

    a. in contrast to some other professional disciplinary regimes the Tribunal lacks jurisdiction to make such an order.

    b. an order for costs is limited to where a disciplinary ground has been made out under s82.

    c. it is the Board and the profession who will bear the brunt of a costs order in favour of [Ms G].

114. The PCC submit that if the Tribunal considers it does have jurisdiction then there are well established principles which confine the circumstances in which such order will be justified, and we should not adopt the approach that costs follow the event. In line with the principles set out in *Baxendale-Walker v Law Society* relevant considerations would include whether the charge was misconceived, without foundation or some improper motive[105]. Counsel submitted that a success is only one factor to be weighed and in itself not sufficient to justify costs. Counsel also noted that two particulars of the charge were established, albeit not reaching the threshold for a disciplinary sanction.

115. On behalf of [Ms G] it was submitted that costs ought to be awarded on the basis that the charge was not proved and that costs should follow the event. Alternatively, counsel submitted that there are good reasons for an order for costs, namely:

[105] *Baxendale-Walker v Law Society* [2007] EWCA Civ 233; [2008] 1 WLR 426

a. the prosecution of the charge on the basis of professional misconduct was misconceived.

b. the PCC refused to accept an offer of compromise from [Ms G] which would have rendered a hearing unnecessary, this being an offer to admit the facts constituting particular 2(b) and 3. That is, that she did not make a note of the meeting on 31 May 2017 and she did not follow up and failed to ensure [I] followed up with the caregivers to provide support following the decision to remove the children.

116. The starting point is the Act and the express provisions relating to costs in proceedings heard by this Tribunal. As above, the Act provides under the heading Penalties that where a finding is made under s82, an order for costs against the social worker may be made under s83(1)(e). Where an order under s83(1)(e) has been made in previous matters the Tribunal has taken guidance from the approach to costs in disciplinary proceedings against health practitioners as determined by the HPDT and the appellate courts because the HPCA Act has an identical provision for an order of costs against a health practitioner against whom an adverse disciplinary finding is made: s101(1)(f).

117. Section 86 of the Act provides that the Board is responsible for the funding of all costs of the Tribunal, the PCC, as well as all costs of and incidental to any hearing before the Tribunal: s86(1)(a)(iii). Section 94 refers to costs on appeal to the District Court being available to any party, but confines this to the costs incurred in respect of the appeal. This means that if a social worker brought an appeal against a decision of this Tribunal, they would in the usual course be able to apply to the appellate court for costs. The principles on which such an award might be made is a matter for that court.

118. The Second Schedule to the Act further describes the functions and powers of the Tribunal and makes no express reference to costs. As counsel for the PCC observes, the Schedule allows the Tribunal to make rules of procedure, but these must be published, and of course this power is subject to the jurisdiction of the Tribunal that is conferred by Part 4 of the Act and any relevant regulations.

119. We have considered whether the costs of a successful respondent could be covered by the Board's responsibility to meet all costs of and incidental to the proceedings in s86(1)(a)(iii). While there is no similar catch-all provision in the HPCA Act, there was in the predecessor legislation on which the HPCA is modeled. Pursuant to s 113(c) of the Medical Practitioners Act 1995 the Medical Council was responsible for all costs of and incidental to the Medical Practitioners Disciplinary Tribunal (MPDT), the Complaints Assessment Committee and any proceedings before the MPDT. When the HPCA Act amalgamated responsibility for disciplinary proceedings against health practitioners registered with any of the Responsible Authorities (RAs) to the HPDT, specific provisions were introduced for funding of investigations, tribunal proceedings and general administrative costs by the various RAs: HPCA Act s103A. Section 103A(b) defines "general administrative costs" as all expenses payable by or on behalf of the HPDT in connection with the administration of the Tribunal that are not payable in respect of any proceeding under s 104(1)(a) or (b). This supports the position that the earlier reference to costs of and incidental to proceedings under the Medical Practitioners Act did not extend to the costs incurred by a successful defendant, but only to administrative costs of the MPDT and the statutorily prescribed functions of the MPDT and CAC.

120. Further, in proceedings where a medical practitioner successfully defended a disciplinary charge before the MPDT the decisions show that the question of costs simply did not arise. Without discussion or apparent reference to

submissions, the decisions invariably conclude that as the charge was dismissed there were no issues as to penalty or costs.[106]

121. The HPDT has followed the same approach. The PCC refers in submissions on costs to an unsuccessful application for costs by Dr N when the charge against him was not proved. While the HPDT expressed sympathy for the practitioner's application they determined that the HPCA Act did not confer jurisdiction to make an order: *Re Dr N* [HPDT] 913/Med16/375P. This reflected what the HPDT acknowledged were obiter findings of the High Court and Court of Appeal in *Roberts v Professional Conduct Committee of the Nursing Council of New Zealand* [2014] NZCA 141. In those appeals the courts found that costs are available to a successful appellant in relation to the appeal but not to a practitioner in the first instance before the HPDT.

122. Like health practitioners, funding for PCCs and disciplinary proceedings prosecuted by a PCC is by the profession and able to be recouped through a disciplinary levy on members of the profession registered with the Board.[107] The same is true of real estate agents and the legal profession. However, unlike the SWR Act and the HPCA Act, the Real Estate Agents Act 2008 and the Lawyers and Conveyancers Act 2006 provide their respective disciplinary tribunals a discretion to order costs in favour of any party to proceedings.[108]

123. Similarly, teachers are subject to a disciplinary levy payable to the Teaching Council and under the Education and Training Act 2020 the Teachers Disciplinary

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[106] Eg E [1997] NZMPDT 5; Harrild [2004] NZMPDT;

[107] The Director of Proceedings appointed under the Health and Disability Commissioner Act 1994 may prosecute a charge before the SWCDT. The DP is independent of but funded by the Commissioner. The HDC Act provides that the DP may be liable for any costs order made by any tribunal, court or other body for proceedings in which the DP was a party but this is subject to the ability of such tribunal, court or other body to make an order in the first instance. The DP is funded by the Crown, not a profession.

[108] Real Estate Agents Act 2008 s 110A; Lawyers and Conveyancers Act 2006 s249. Levies including for discipline are recoverable under s22 and s74 respectively.

Tribunal may order any party to a proceeding to pay costs to another party: s500(1)(h) and (i). A Practice Note outlining the basis on which such an order will be considered in favour of a teacher states this will require "good reasons" and this means something more than a successful defence.[109]

124. As submitted on behalf of [Ms G], the general principle in civil proceedings is that costs follow the event. Quantum is determined by a set scale such as under Part 14 of the High Court Rules, or by reference to established principles. We must draw a distinction between civil and disciplinary proceedings. In disciplinary proceedings before this Tribunal, funding comes from the profession and the PCC is discharging an important regulatory function, ultimately in the interest of the profession and the public. The purpose of discipline is to set and maintain professional standards and to protect the public by providing a mechanism for dealing with practitioners who do not meet those standards.

125. We have sympathy for a social worker in [Ms G]'s position who has been the subject of a long investigation and disciplinary proceedings which she has successfully defended. We also have sympathy for the submission made on [Ms G]'s behalf that given the PCC's broad investigative powers and wide range of recommended actions, an immunity from costs may present a lack of incentive not to bring a charge.

126. However, we conclude for the reasons set out above that in the absence of an express statutory provision empowering the Tribunal to order costs in favour of a social worker, we do not have jurisdiction to do so.

[109] Practice Note 1: Costs. Refers for principles for exercise of discretion to *Baxendale-Walker v Law Society*

Non-publication of name and identifying particulars

127. The Tribunal may make orders for non-publication of the name or particulars of any person under s79 of the Act, whether on the application of the prosecuting body or social worker, complainant or a witness or of its own motion. The Tribunal is required to have regard to the interests of any person including the complainant, and the public interest, and may make an order if it is satisfied that it is desirable to do so.

128. Interim orders were made on 2 March 2021 prohibiting publication of the name and identifying details of [Ms G] and the caregivers. These orders were made on application of both parties.

129. The Tribunal is satisfied that permanent orders are desirable in the interests of [Ms G], the caregiver complainants [N] and [H] and the children for whom they were providing care for the period covered by the charge. Due to the risk of identifying those listed, the interim orders prohibiting publication of the names of witnesses [I], [A] and [E] and their specific place of employment (at the relevant time, Oranga Tamariki's [Y] site) is continued. We also extend this order to the other witnesses who appeared before the Tribunal ([Ms R], [Ms S], [Ms C]) for the same reason. The name of the Convenor of the PCC, Ms Huitema may be published.

130. We consider that there can be adequate publication of this charge to convey the Tribunal's findings with these non-publication orders in place, even though they are necessarily extensive. Both parties support such orders being made.

Orders

131. Accordingly the Tribunal finds as follows:

a. the charge against [G] is dismissed.

b. the names of [Ms G], [Mr N], [Ms H], [Ms I], [Ms R], [Ms S], [Ms E], [Ms A], [Master L], [Master G] and [Master W] are not to be published in relation to this matter.

c. the identifying particulars that are prohibited from publication are the name of the [Y] site and the names of employees within this decision who were identified by witnesses and/or in materials in the bundle during the course of this hearing.

132. For the reasons set out above no order for costs is made.

133. Subject to the non-publication orders above, the Tribunal directs the Hearing Officer to request the Board Registrar to publish this decision on the Board's website and to publish a summary of the Tribunal's decision in the Board's professional publication to members of the social work profession.

DATED this 13th day of December 2022

Catherine Garvey
Deputy Chairperson
Social Workers Complaints and Disciplinary Tribunal