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Vulnerable Children's Bill

A submission to the Social Services Committee

Paediatric Society of New Zealand, 29 October 2013

Summary of Recommendations

The Paediatric Society of New Zealand ***recommends***

1. That the Approved Information Sharing Agreement (AISA) provisions of the amended Privacy Act be given 12 months, and then be reviewed.
2. If in the review it is found that AISAs are excessively onerous, and this has prevented their uptake, the Privacy Act should be amended to the presumption of information sharing where child protection concerns exist, as in New South Wales.
3. That Section 17 of the Child Young Persons and their Family Act be amended by this bill to require a CYF social worker to not only inform the notifier of the outcome of an investigation and the current placement of the child(ren), but where the notifier is a professional in the children's workforce as described under the Bill, to include that professional in deliberations regarding the child.
4. That the Chief Executive accountability and reporting provisions of the Bill be supported.
5. An additional clause to the Vulnerable Children's Act enabling the establishment of an Expert Advisory Group of professionals providing advice direct to the Board, the details of which would be specified in regulations.
6. That the age of children supported by the Act should be up to 18 years for all provisions, except where Government responsibility for the young person should be further extended.
7. That mandatory child protection policies are supported by a national service specification (NSS) for all children's services that requires a systems approach to change practice, as is currently in place in Health. The NSS should include management support/leadership, community agency collaboration (e.g. Memorandum of Agreement), policies/procedures, documentation processes, resources to support practice change, a workforce development plan including initial and on-going training, and quality monitoring processes and should be fully funded.
8. That the select committee considers seriously the cost-benefit of children's workforce screening and carefully considers which groups of children's workers should be screened.

   That volunteer children's organisations such as guides, scouts and services such as sports team coaches facilitating activities for children and young people be made specified organisations for the purposes of the Act.

   That children's organisations that receive funding from sources other than government or local bodies such as faith-based services that provide activities are specified organisations.
9. That the Select Committee direct the Ministry of Education to work with professional organisations to provide further guidance on which workers come under the purview of the Act.

10. That the Select Committee considers whether Clause 32 (b) should require some groups of children's workers to have complaints/incidents included within their police check.

    That employers' responsibilities be clarified to include specifically asking previous employers and any regulatory body (when appropriate) about any complaints that may have been made and or investigated.

11. That the Select Committee consider the option of shared responsibility for safety checking of the workforce. This could include specifying the relative responsibilities of the licensing/ regulatory authority for the workforce (teachers, doctors, social workers) and of the employer.

12. That the Select Committee consider requiring authorities to include complaints and incidents in their determination of whether the applicant is safe and that regulations specify the level of assessment undertaken.

13. That transfer of information between regulatory bodies be eased to identify people in whom serious concerns have led the regulatory authority to refuse to issue an Annual Practicing Certificate on child protection grounds.

14. That clause 62 be strengthened to require the relevant departments to electronically notify certain persons and organisations when a Child Harm Prevention Order has been made.

15. That those organisations informed of the Child Harm Prevention Order should be required to implement formal procedures to record the information and assess as required.

16. That Schedule 2 should be expanded to include offending related to family violence or intimate partner violence where children have been exposed to offending and that burglary, criminal damage and many other offences which under statute are 'defined as property offences' that can have a causal link to family violence be considered when determining a person's suitability to work with children.

17. That the key deliverables of the Children's Action Plan (including the comprehensive workforce development plan, Vulnerable Kids Information System and the cross-sector Children's Teams) are specified in the relevant subparts of the Vulnerable Children's Bill.

Introduction

The Paediatric Society of New Zealand thanks the Social Services Select Committee for the opportunity to provide a submission. This submission is made on behalf of the Paediatric Society of New Zealand (PSNZ).

We wish to make an oral submission to the Social Services Committee.

Background

The PSNZ is an independent society of health professionals committed in their daily work to the delivery of health care services to children and young people. The Society includes almost all practising paediatricians in New Zealand, and also includes public health physicians, paediatric surgeons, general practitioners, paediatric dentists, child health nurses, midwives, child health managers, allied health professionals (such as dietitians, physiotherapists, occupational therapists, speech language therapists, play specialists and pharmacists), child mental health professionals from several disciplines and social workers. The current membership of the Society is 512.

The Child Protection Special Interest Group (SIG) is a sub-group of Paediatric Society members who have a special interest in the provision of services to children and young people affected by abuse and neglect. It also includes, by virtue of their appointments, all child protection and family violence co-ordinators in the 20 New Zealand District Health Boards (DHBs). Current membership of the SIG is 77 (15% of PSNZ members belong to the CPSIG) in addition to the 50 DHB Violence Intervention or Child Protection Coordinators. The Paediatric Society of New Zealand and its CPSIG therefore represents the largest national inter-disciplinary group of frontline health professionals working with children and young people, and specifically with issues of abuse and neglect.

Format of this submission

1. It is our experience as child health professionals that family violence, and in particular violence towards children, is endemic in this country and one of the major public health problems we face in child health.

2. The Society's review of the Bill considered the implications in relation to
   i. the general impact for children in relation to the care and services provided for them and
   ii. from a child health/child health services perspective.

3. The Society supports the objectives of the Bill and would like to acknowledge its commitment to children and enhancing their safety. We have presented our feedback on clauses contained in the Bill in the order presented in the document.

Subpart 1: Government priorities for vulnerable children and vulnerable children's plan –

<u>Information sharing</u>

4. Clause 4 of the bill identifies that the purpose of subpart 1 is to "ensure that children's agencies work together to improve the wellbeing of vulnerable children"[1]. One of the critical factors that is commonly experienced and negatively impacts on the ability of agencies to work collaboratively and share information is actual and perceived difficulties in sharing informatio[2].

[1] New Zealand Government. *Vulnerable Children's Bill* (2013)

[2] Smith, M. *Report to Hon Paula Bennett, Minister for Social Development and Employment: following an inquiry into the serious abuse of a nine year old girl and other matters relating to the welfare, safety and protection of children in New Zealand.* (2011).

5. The introduction of the Approved Information Sharing Agreement (AISA) regime brought about by the Privacy Amendment Act 2013[3] may address this. However it is our perception at the early stage of this legislation that the process to establish an AISA is so resource intensive (both in time and cost) that it prevents most agencies progressing with the application. We do however, understand the Government's wish to allow the legislation a fair trial.

6. That being so, we **recommend** that the AISA provisions be reviewed within 12 months of the Act being enacted (26 February 2013). If found to be too onerous, as we believe, we **recommend** that the Vulnerable Children's Bill or Privacy Act be amended to a presumption of information sharing within and between agencies where child protection concerns are present (similar to those within New South Wales[4].

7. Health professionals frequently do not get feedback from CYF about what happens to families under investigation, whose children have had a medical assessment completed as part of that investigation and, had recommendations made for their on-going care by the Paediatric Health professional – usually a Paediatrician. Therefore outcomes are not documented in the clinical (health) record and updated information such as new addresses may not be known to Health providers. This is important because it undermines the relationship between Health and CYF, making collaboration in this and future cases more difficult, and compromises outcomes for children. The Society therefore **recommends** that Section 17 of the Child Young Persons and their Family Act be amended by this bill to require CYF social worker to not only inform the notifier of the outcome of an investigation and the current placement of the child(ren), but where the notifier is a professional in the children's workforce as described under the Bill, to include that professional in deliberations regarding the child.

Chief Executive accountability

8. The Society supports the inclusion of Vulnerable Children's Plans and accountability being placed on the Chief Executive(s) of the children's agencies to develop a plan, have that plan approved by the Minister, publish the plan, implement and report on implementation. The plan must contribute to achieving the government's priorities for vulnerable children (clause 8-11) and must be reviewed three yearly (clause 12). The ministers and chief executives are accountable for delivery of the plan (clause 13).

9. The Society considers that a group of senior professionals could provide useful advice to the Vulnerable Children's Board regarding how well the intent of the Children's Action Plan is being implemented and emerging risks and opportunities in real time. We therefore **recommend** an additional clause to the Vulnerable Children's Act enabling the establishment of an Expert Advisory Group of professionals providing advice direct to the Board, the details of which would be specified in regulations. We believe a Paediatrician with expertise in child protection should be invited to sit on such a group.

[3] New Zealand Government. Privacy Amendment Act 2013 http://www.legislation.govt.nz/act/public/2013/0001/latest/DLM3941907.html?search=sw_096be8ed80c3b63f_approved+interagency+sharing+agreements_25_se&p=1&sr=0

[4] New South Wales. *Child Protection Legislation (Registrable Persons) Amendment Bill.* (2009).

10. The ministers and chief executives therefore need to ensure that funding is allocated to enable the level of response required. More funding and in particular sustainable funding will be required for Health to provide a comprehensive and safe child protection response. In the past funding has been offered for implementation of new proposals but District Health Boards have then been asked to provide funding from within existing budgets. This has not resulted in sustainable funding for child protection services in health.

11. The age of children supported by the Act should be up to 18 years for all provisions, except where Government responsibility for the young person should be further extended.

12. It is noted that in clause 5 of this subpart the age of child means under the age of 18 and not married or in civil Union. This definition aligns with the United Nations Convention on the Rights of the Child (UNCROC)[5]. We note that this is not consistent with Subpart 2.

13. The age range for child within clause 15 relates to the Children Young Persons and their Families Act which is up to the age of 17[6]. The Society would **recommend** that to be consistent with UNCROC[5] and the Bill that the Children, Young Persons and their Families Act 1989 age definition is amended to up to 18 to meet New Zealand's obligations under UNCROC.

Subpart 2: Child protection policies

14. The Society supports the requirement that designated services (and those to whom they may contract with) are required to have child protection policies, for example state services, DHBs, Schools. This has implications for the primary care setting, independent midwives and private practitioners.

15. The policy states that they must include "the provisions on the identification and reporting of child abuse and neglect" (clause 14). We note this stops short of introducing mandatory reporting.

16. We note that Chief Executives are required to report on the establishment and implementation of child protection policies, that the policy must be available on the internet and that it be reviewed very three years.

17. The Society notes that the inclusion criteria is only for government funded organisations, organisations that receive no funding from government for example, those receiving philanthropic funding are excluded. In effect this creates a two-tier system in relation to regulations for services provided to children.

18. The Bill also contains mixed messages in regard to these definitions. Although 'child' and 'young person' are defined as being included in the Bill, the Bill talks about 'child' protection policies and 'child' harm prevention. This is confusing. The Society **recommends** that the bill includes a statement to the effect that although the word 'child' is used, the requirements pertain to both children and young persons.

[5] United Nations Treaty Collection. *United Nations Convention on the Rights of a Child.* (1989).
[6] New Zealand Government. *Child Young Persons and their Families Act* (1989).

19. However, child protection policies alone are not enough to change practice. There is clear evidence and national experience that, to change practice, policies must be supported by regulations in national service specifications requiring a systems approach.

20. All DHBs have child protection policies. They are required within the service specification of the DHB Violence Intervention Programme contract with the Ministry of Health (MOH)[7]. The service specification structure recognises that policy alone will not change practice and that a systems process is required[8,9]. The Service Specification includes the requirement to have and report on:
    - Management support for the policy
    - Community agency collaboration, e.g., via Memorandum of Agreement
    - Policies/procedures
    - Standardised documentation processes
    - Staff resources to support practice change,
    - Training/work force development, initial and on-going
    - Quality and monitoring processes.

21. The society therefore **recommends** an addition to clause 19 be made to read as
    (c) A national service specification for all children's services that requires a systems approach including management support/leadership, community agency collaboration (e.g. Memorandum of Agreement), policies/procedures, documentation processes, resources, work force development plan including initial and on-going training, and quality monitoring processes.

    This requires further targeted funding for DHBs to be able to support child protection services in this manner.

Subpart 3: Children's worker safety checking

22. The Society supports the inclusion of safety checks as one action to support the achievement of the objective that is to ensure children are safe with those who work with them. It does recognise that this should not be seen as a "catch-all" and the issues within this safety checking are complex.

23. Specified organisations should include volunteer and or non-government/local government funded organisations.

24. For children generally, while the Act as it is proposed specifies almost all paid positions, the Act does not include volunteer children's organisations and services, such as guides, scouts, St John Ambulance cadets and sports team coaches nor agencies that are funded philanthropically (receiving no government or local government funding) e.g. services funded by religious organisations or private trusts.

[7] http://www.health.govt.nz/our-work/preventative-health-wellness/family-violence
[8] Wills, R. et al, Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach, *Journal of Paediatrics and Child Health* (2008), 44: 92-98
[9] http://www.niphmhr.aut.ac.nz/research-centres/interdisciplinary-trauma-research-unit/family-violence/family-violence-project-evaluation

Such groups are included in relevant Australian legislation without an excessive or onerous burden on the organisations involved. The Society therefore **recommends** that within clause 33, an additional point is made that is:

(d) declaring that volunteer children's organisations such as guides, scouts and services such as sports team coaches that provide activities are specified organisations.

(e) declaring that children's organisations that receive funding from sources other than government or local bodies such faith-based services that provide activities are specified organisations.

Further clarification about Children's Workers

25. The Society notes the details contained within the safety checks processes and the interpretation and specified organisations defined in clauses 23 and 24. We note that the interpretation of who is a children's worker within section 23 is complex. For example, a midwife could be deemed a children's worker due to their role within antenatal and postnatal care of a woman and her baby, however the multiple clauses within this section mean that a midwife in relation to providing care to the newborn baby (child) may not meet the criteria because in almost all situations they would not be providing such care without the parent or guardian being present (clause 23 (1), (b)). However, if the midwife provides care to any young, unmarried mothers (aged under 17 years) then they would require safety checks within the definition of child (clause 15).

26. We **recommend** that the Select Committee direct the Ministry of Education to work further with professional organisations to provide further guidance on which workers come under the purview of the Act.

27. The Society supports the proposed legislation regarding the requirement that safety checks should be conducted for both current and new employees and the requirement for on-going, periodic checking every three years (clauses 25-27). The Society also endorses the requirements of a safety check, including the need to confirm the identity of the person, and undertake a risk assessment as per the regulations (as specified in clause 31 and 32). Clarification regarding Clause 31 (3) in relation to Criminal Records (Clean Slate) Act that means any conviction will be shown for any core worker (children's worker working alone with children).

Responsibility of employers and regulatory authorities

28. The Society notes the complexity of the issue of safety checking, for example in DHBs the following need to be considered in relation to the workforce such as, are they;

- An employee or contracted provider e.g. cleaning services, volunteer
- A member of professional body or not e.g. not all Social Workers are registered
- A student on placements for nursing, medical training, social work, dieticians
- An employee on a rotational training programme through multiple organisations, e.g. Junior Medical Officers who rotate through DHBs, in one DHB they may not provide care to children but on their next placement this may be core role or role undertaken when on-call across a range of services
- Employed within a mainstream core service but their role may require some service delivery in children's services e.g. maintenance staff, orderlies
- An independent provider who has an access agreement with the organisation (e.g., lead maternity caregiver, GP in a rural hospital).

29. In addition, the Society notes that the risk assessment (to be developed) and associated safety checking based on purely an assessment of the judicial system cannot provide a complete risk assessment. When completing a risk assessment it would be reasonable to consider information available from other sources such as the regulatory body (if they are registered) and previous employers. When considering the possible information available there appears to be a hierarchy of information (in relation to substantiation) as defined in the table below.

Table 1: Hierarchy of information related to safety checks

Employer	Regulatory Body	Judicial System
Complaint	Complaint	Complaint or incident
Investigation (upheld or not)	Investigation (upheld or not)	Investigation (upheld or not)
	Charge/ Breech of Code of conduct	Charge/Arrest
Review panel/ Management review/ Finding	Review panel: conviction	Court; Conviction Criminal Records (Clean Slate) Act
Response e.g. disciplinary action	Sanction	Sentence

30. The challenge with implementation of any system such as safety checking is to balance the safety of children against the privacy of affected adults and determine the appropriate threshold, e.g., allegation (or a pattern of allegations) versus substantiation. In relation to police checks, a pattern of incidents (even those that do not progress to an arrest) may be relevant, such as any family violence related (POL 1310) incidents.

31. The Society therefore **recommends** that the Select Committee considers whether Clause 32 (b) should require some groups of children's workers to have complaints/incidents included within their police check.

32. We also **recommend** that employers' responsibilities be clarified to include specifically asking previous employers and any regulatory body (when appropriate) about any complaints that may have been made and or investigated.

Resourcing safety checking

33. Another challenge is consideration of the cost-benefit ratio of this particular form of child abuse prevention strategy given the number in the workforce to be checked and the cost and time involved.

34. While privacy and risk needs to be considered, so too is the issue of resource. The process has to be manageable both in time and cost for the size of the workforce, for example, the current estimated health workforce is between 20475 to 27634 core workers and 49,622 to 58392 wider workforce workers (total 70,097 to 86, 026 staff)[10].

35. To ensure all workers are assessed to the required standard will require a standardisation process and infrastructure that ensures it is manageable and not cost prohibitive for both initial and on-going testing for small and large organisations alike. For example, in 2012 the police asked for feedback regarding a submission to recover

[10] O'Meara, B. *Regulatory Impact Statement, Safeguarding the children's workforce through standard safety checks.*

costs and it was proposed that a charge of between $5-7 would be implemented for standard checking with $10-14 for urgent checks[11]. These costs are not likely to cover the actual cost for this process. Both cost and capacity of organisations to conduct checks and the judicial system to respond to the increased demand need to be considered.

36. The Society believes the responsibility for determining if the check is a fail should rest with the organisation that conducts the safety check and they should report this back to the employee. In the event that the check undertaken by a regulatory body is a fail, then they should also advise the employer.

37. The Society therefore **recommends** that the Select Committee consider the option of shared responsibility for safety checking of the workforce.

38. The Act could require that those who are registered with a regulatory body such as the Teacher's Council, Medical Council or Nursing Council be assessed within their annual practicing certification (APC) process. For example, junior medical staff who rotate through multiple hospitals are managed by the New Zealand Medical Council APC process.

39. While the employer would still hold responsibility for ensuring they have an APC, the process of checking if there are any issues known within the regulatory body and or judiciary that impact on their ability to be a children's worker would rest with the regulatory body. The APC should specify the level of approval (system would need to be revised to include this designation).

40. Table 2 outlines how such a process could be managed within a DHB. It would be reliant on the DHB maintaining a database of those employees who are registered and for those that are not, the responsibility would remain with the employer. For the non-regulated workforce, these responsibilities would fall on employers, as per Table 2.

Table 2: Roles and responsibility for employer and regulatory body

Authority	Regulated workforce	Non-regulated workforce
Employer	Identity check Reference check (including previous complaints) Check APC annually on recruitment	Identity check Reference check (complaints) Risk assessment Police check specify level of assessment, (e.g. children's worker)
Regulatory Body	Police check, annual Complaints review (specify level of assessment, e.g. children's worker)	

[11] http://www.police.govt.nz/sites/default/files/publications/cost-recovery-dec-11-2012.pdf

41. The Society **recommends** that the Select Committee support clause 32 (d) that allows for licencing bodies of specified professions to be able to complete the safety checks.

42. We further **recommend** that that requirement should include complaints and incidents.

43. We also **recommend** that regulations specify the level of assessment undertaken for the major groups in the children's workforce, e.g. an APC for a New Zealand Registered Nurse working in paediatric ward or as a Public Health Nurse should specify that they been assessed and met the criteria required for a children's worker.

Information sharing between regulatory authorities

44. The Society notes that perpetrators with malicious intent who become aware of concerns from a regulatory body may move to working in a non-regulated position, e.g., give up social worker registration; change from teacher to teacher aide or volunteer organisation. We therefore **recommend** that transfer of information between bodies be actively facilitated to identify such behaviour in people for whom serious concerns have led the regulatory authority to refuse to issue an APC on child protection grounds. This would require a moderating process to ensure a similar standard applies across all regulatory authorities, such as common lay appointments across several bodies.

45. Most contracted employees are not registered (cleaners, kitchen staff, orderlies) and so the matter of contracted staff would need to be addressed within contractual documents.

Part 2: Child Harm Prevention Orders

Subpart 1 imposition and review of child harm prevention orders

46. The Society recognises that the implementation of Child Harm Prevention Orders aims to enhance the safety of children by imposing restrictions on people who pose a high risk of causing serious harm. We note that there are criteria regarding the application of such orders including the level of risk assessment and review required (clause 48-70).

47. Government departments should bear responsibility for sharing critical information, rather than the individual concerned.

48. The Society **recommends** that clause 62 is strengthened to require the relevant departments (e.g., Police) to electronically notify certain persons and organisations (e.g., Ministry of Health) of
    a) the terms and conditions of the orders, and
    b) the name and address of the person subject to the order
    c) Information that should be included and updated as required would be the name, date of birth and address for any child(ren) that may pertain to the order.

49. The Society **recommends** that those organisations informed should be required to implement formal procedures to record the information and assess as required.

50. In addition, families move and this information should be available across organisations (e.g., all DHBs).

51. While the information technology system proposed in the Vulnerable Children's Action Plan may address this issue, the timing of implementing orders and establishing systems need to be considered.

Sharing of information about parents on children's health records

52. Currently, legislation allows health professionals to collect information related to the care provision of the index patient. To conduct a thorough assessment of children and young person's health needs, including risk assessment in relation to child protection concerns, information regarding the parents' and or care givers' ability to provide that care and protection should be considered.

53. At present, unless the adult(s) providing care volunteer their health-related information and consents to its access, the health professional cannot access health-related information regarding a primary caregiver.

54. The implications of this in relation to orders are considerable. For example, if a child is presented to services accompanied by an adult who may have a Child Harm Prevention Order, as the child is the index patient, unless legislation changes and systems are established to link children's and parent/care-giver information systems, the health professionals providing care for this child may not be aware that such an order exists.

55. Another example is the pregnant woman (whose new partner has an order) accessing maternity services who does not or cannot share this information with her midwife. The woman is very unlikely to volunteer the information and current systems would not allow access.

56. Therefore, the society **recommends** that changes need to be made that reflect the child centred principles and allow appropriate information sharing so that health professionals can have this information readily available and or at least provide a process to seek this information.

57. We recognise that the information needs to be current and as such processes that hold/flag the information need to be responsive to the current status, such as terms, timeframes (3-10 years), reviews and any updates to the orders.

58. The society **recommends** that more detail is required in relation to the qualifications of the psychologist providing a report and we **recommend** that the report includes the following two aspects:
    a) A forensic psychology or psychiatric report that has a mental health basis
    b) An assessment regarding previous parenting that may involve reports from Health and Child Youth and Family (where known).

Part 3 Amendments to Acts;

Subpart 1—Amendments to Children, Young Persons, and Their Families Act 1989

59. The Society endorses the amendments to the Children, Young Persons, and Their Families Act 1989 that requires the adoption of a holistic approach (clause 102) and the requirement to adopt as the first and paramount consideration the welfare and interests of the child (clause 103).

60. The Society supports the amendment made within the definition of child or young person in need of care and protection (clause 104). This amendment places onus on the parent (who has as defined in clause 104, either a specified conviction or has previously had a child removed from their care and there is no likelihood that the child will be returned to their care) to demonstrate that s/he are unlikely to abuse a subsequent child.

61. While such amendments can be made as specified above, the issue that requires further consideration is how such actions can be made effective through implementation of interagency information sharing and infrastructure so that this information is shared with those who will be providing care, e.g. Lead Maternity Career, Maternity services in DHBs.

62. The society proposes an additional amendment to the Children, Young Persons, and their Families Act 1989 that increases the age to less than 18 years in alignment with UNCROC.

63. The Society commends the Bill for amending the Children, Young Persons, and their Families Act 1989 in regard to Family Group Conference to include in Section 23 'information and advice relating to the health and education needs of every child or young person in respect of whom the conference is convened' (Clause 109).

64. The Society believes that health input into Family Group Conferences (FGC) can be very important and we **recommend** that guidelines should specify that sufficient notice should be given for health workers involved with the child and or young person so they can attend the conference FGCs to explain the medical findings.

65. The Society commends the amendment that means permanent caregivers must get financial assistance in a range of circumstances (clause 132).

66. The Society commends the inclusion in the Bill that allows a permanent caregiver to apply for a review if the decision regarding financial assistance is to decline the application (clause 133).

67. The Society commends the inclusion of specified offences (such as sexual offending and offences in the Crimes Act relating to homicide and grievous/serious assaults) in Schedule 2. The Society **recommends** the listing should be expanded to include offending related to family violence or intimate partner violence where children have been exposed to offending. For example, there is no mention of kidnapping (not the same as abduction), assaults on a child's mother (witnessed by the child) or breaches of protection orders (both carrying a term of imprisonment of two years). Burglary, criminal damage and many other offences which under statute are 'defined as property offences' can have a causal link to family violence. All such offences should be considered in determining a person's suitability to work with children.

68. The Society notes that the comprehensive workforce development plan, Vulnerable Kids Information System and the cross-sector Children's Teams are not identified in Bill; these are three of the key deliverables within the Children's Action Plan. It is also noted that these items have direct correlation to one or more of the subparts of the Bill, e.g. information sharing, child protection policies and Child Harm Prevention Orders.

    The Society **recommends** that the key deliverables of the Children's Action Plan (including the comprehensive workforce development plan, Vulnerable Kids Information System and the cross-sector Children's Teams) are specified in the relevant subparts of the Vulnerable Children's Bill.

Conclusion

Child maltreatment causes profound harm to children and young people; the Vulnerable Children's Bill is a fundamental part of the Children's Action Plan that aims to identify, support and protect vulnerable children (and young people). The Society considers the Bill has the potential to make a lasting difference; we offer some recommendations that we believe will strengthen the legislation further. From the health perspective there is a considerable shortfall in the funding available to provide optimal child protection services within DHBs. This will need to be addressed if the aims of this Bill are to be fully realised. We welcome the opportunity to discuss the matter further via an oral submission.

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