



Whanaketia

The Future

Hei ara mōu kei taku pōkai kōtuku



THROUGH PAIN AND TRAUMA, FROM DARKNESS TO LIGHT

Presented to the Governor-General by the Royal Commission of Inquiry into
Historical Abuse in State Care and in the Care of Faith-based Institutions

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Whakairihia ki te tihi o Maungārongo

He karakia

E tāmara mā, koutou te pūtake o ēnei kōwhiringa, kua horaina nei
E tohe tonu nei i te ara o te tika
E ngaki tonu ana i te mārā tipu
Anei koutou te whakairihia ki te tihi o
Maungārongo, kia tau te mauri.

Rukuhia te pū o te hinengaro
kia tāea ko te kukunitanga mai o te whakaaro nui.
Kia piere ko te ngākau mahora
kia tūwhera mai he wairua tau.

Koinei ngā pou whakairinga i te tāhuhu
o te Whare o Tū Te Mauriora.
Te āhuru mōwai o Te Pae o Rehua,
kaimuru i te hinapōuri,
kaitohu i te manawa hā ora,
kaihohou i te pai.

Nau mai e koutou kua uhia e ngā haukino
o te wā, kua pēhia e ngā whakawai a ngā tipua nei,
a te Ringatūkino rāua ko te Kanohihuna.

Koutou i whītiki i te tātua o te toa,
i kākahu i te korowai o te pono,
i whakamau i te tīpare o tō mana motuhake,
toko ake ki te pūaotanga o te āpōpō e tatari mai nei i tua o te pae,
nōu te ao e whakaata mai nei.

Kāti rā, ā te tākiritanga mai o te ata,
ā te huanga ake o te awatea,
kia tau he māramatanga,
kia ū ko te pai, kia mau ko te tika.
Koinei ko te tangi a te ngākau e Rongo,
tūturu ōwhiti whakamaua
kia tina, tina!
Hui e, tāiki e!

– *Waihoroi Paraone Hōterene*

To you upon whom this inquiry has been centered
Resolute in your pursuit of justice
Relentless in your belief for life
You have only our highest regard and respect,
may your peace of mind be assured.

Look into the deepest recesses of your being
and discover the seeds of new hope,
where the temperate heart might find solace,
and the blithe spirit might rise again.

Let these be the pillars on which the House of Self,
reconciliation can stand.
Safe haven of Rehua,
dispatcher of sorrow,
restorer of the breath of life,
purveyor of kindness.

Those of you who have faced the ill winds
of time and made to suffer,
at the hands of abusers and the hidden faces of persecutors, draw near.

You who found courage,
cloaked yourselves with your truth,
who crowned yourself with dignity,
a new tomorrow awaits beyond the horizon,
your future beckons.

And so, as dawn rises, and a new day begins,
let clarity and understanding reign,
goodness surrounds you and
justice prevails.

Rongo god of peace, this the heart desires,
we beseech you,
let it be,
it is done.

– *Waihoroi Paraone Hōterene*

Hei ara mōu kei taku pōkai kōtuku

The name of this Part comes from the waiata, and speaks to the future paths deserved of hope, aspiration and solace deserved of survivors and their whānau. The Kōtuku is the famed heron bird, and pōkai refers to the flock, or the collective of survivors.



Pānui whakatūpato

Ka nui tā mātou tiaki me te hāpai ake I te mana o ngā purapura ora I māia rawa atua nei ki te whāriki I ā rātou kōrero ki konei. Kei te mōhio mātopu ka oho pea te mauri ētahi wāhanga o ngā kōrero nei e pā ana ki te tūkino, te whakatūroro me te pāmamae, ā, tērā pea ka tākirihia ngā tauwharewarenga o te ngākau tangata I te kaha o te tumeke. Ahakoa kāore pea tēnei urupare e tau pai ki te wairua o te tangata, e pai ana te rongo I te pouri. Heoi, mehemea ka whakataumaha tēnei i ētahi o tō whānau, me whakapā atu ki tō tākuta, ki tō ratongo Hauora rānei. Whakatetia ngā kōrero a ētahi, kia tau te mauri, tiakina te wairua, ā, kia māmā te ngākau.



Distressing content warning

We honour and uphold the dignity of survivors who have so bravely shared their stories here. We acknowledge that some content contains explicit descriptions of tūkino – abuse, harm and trauma – and may evoke strong negative, emotional responses for readers. Although this response may be unpleasant and difficult to tolerate, it is also appropriate to feel upset. However, if you or someone in your close circle needs support, please contact your GP or healthcare provider. Respect others' truths, breathe deeply, take care of your spirit and be gentle with your heart.

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Kuputaka Glossary

Term	Explanation
ableism	Attitudes and behaviours society uses that privilege non-disabled people. This includes when negative assumptions are made about the skills, capacities and interests of disabled people, and when their lived experiences are denied.
disablism	Conscious, direct discrimination against people who are disabled, based on their disability.
Inquiry period	The time period of the Inquiry's investigation: 1 January 1950 to 31 December 1999.
mental distress	A mental or emotional state that causes disruption to daily life and that can vary in length of time and intensity. People experiencing mental distress includes those who are seriously upset, people who are reacting normally to a stressful situation, and people with mental illness (whether medically diagnosed or not).
MVPFAFF+	Diverse sexualities, gender expressions and roles across Pacific cultures. It stands for māhū, vakasalewalewa, palopa, fa'afafine, akava'ine, fakaleiti (leiti), fakafifine.
pastoral care	Care provided in a faith setting, such as spiritual guidance, visiting, counselling, religious counsel, Bible studies, faith activities, helping people in the church community, and more.
redress	Setting right what has been done wrong; what Aotearoa New Zealand might do to put right the profound harm that has been done to individuals, whānau and communities through abuse in care.

Term	Explanation
Takatāpui	A traditional te reo Māori word meaning 'intimate friend of the same sex'. It includes all Māori who identify with diverse sexualities, gender expressions and /or variations of sex characteristics.
tāngata kāpō Māori	A reo Māori term for a person who is blind and Māori.
tāngata Turi Māori	A reo Māori term for a person who is Māori and Deaf and may include those who are hard of hearing.
tāngata whaikaha Māori	A reo Māori term for disabled people. It reflects a definition of people who are determined to do well.
tāngata whaiora Māori	A reo Māori term for people who are seeking health. It can also be used to refer to a person receiving assessment and treatment in mental health, addiction and intellectual disability services.
Terms of Reference	The legal document setting out the Inquiry's purpose and scope as set by the government, and the matters that are out of scope.

A close-up photograph of a branch with several long, narrow, yellow-green leaves. The leaves are slightly curved and have some small dark spots. The background is a soft, out-of-focus blue sky.

"There's a photo of
me in my CYFS file from
when I was a teenager. I
wasn't very big or scary. I
was just a kid!"

MRVT
Samoan


Ūpoko | Chapter 1

He whakataki

Introduction

1. This part of the report, consistent with clauses 32(b), 32(c) and clause 32A of the Inquiry's Terms of Reference,¹ sets out the Inquiry's recommendations for changes. These changes relate to redress processes, steps to address the harm of abuse in care and changes to be made in the future to ensure that the factors that allowed abuse to occur during the Inquiry period in State care and in faith-based institutions do not persist.
2. Chapter 3 sets the scene for the Inquiry's recommendations. It describes survivors' moemoeā (dreams) for the next generation, where every child, young person and adult in Aotearoa New Zealand is loved, safe and cared for in a manner that supports their growth and development into a thriving contributor to society. Survivors' moemoeā are the foundation for the Inquiry's vision for the future – he Māra Tipu (a growing garden), and are at the heart of the Inquiry's recommendations. Chapter 3 describes he Māra Tipu – Vision for the future. Survivors see Aotearoa New Zealand's care system as broken. They want a total overhaul and fundamental change to ensure that this national catastrophe does not continue.
3. Chapter 4 sets out recommendations for the State and faith-based institutions to right the wrongs of the past. The State and faith leaders must publicly apologise and take accountability for the harm caused to survivors of abuse and neglect in their care. The puretumu torowhānui system and scheme, which the Inquiry first recommended in its December 2021 report He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, must be implemented without any further delay.
4. Chapter 5 describes the Inquiry's recommendations to make care safe for all children, young people and adults in State and faith-based care. The Inquiry recommends establishing a new care safety regulatory system, with an independent Care Safe Agency, and underpinned by a Care Safety Act. All care providers will be accredited, and staff and care workers will be fully vetted and registered. The care safety regulatory system will have consistent and comprehensive rules and standards to keep people safe, and meaningful sanctions and penalties to hold people and organisations to account. Faith-based entities and their leaders will have to abide by the same laws, rules and accountabilities as everyone else who provides care.

¹ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-Based Institutions, Terms of Reference, clauses 32(b), 32(c) and 32A.

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5. Chapter 6 sets out recommendations specific to faith-based entities, in addition to them being subject to the care safety regulatory system described in Chapter 6.
 6. Recommendations for empowering communities and entrusting them with care functions are described in Chapter 7. These recommendations will give everyone in Aotearoa New Zealand the knowledge and tools to play their part in contributing to identifying and preventing abuse and neglect. The Inquiry also wants to see a shift from State care to communities caring for each other. The Inquiry's recommendations in this chapter also require the State to uphold the rights of New Zealanders, which will contribute to preventing abuse and neglect in care.
 7. Chapter 8 focuses on how the recommendations should be implemented. The Inquiry's recommendations comprise mutually reinforcing strands woven together into a kākahu (cloak) to right the wrongs of the past and protect against abuse and neglect in care in the future. They cannot be selectively implemented.
 8. Chapter 9 sets out the Inquiry's recommended implementation timetable, including the entity or entities that the Inquiry expects will lead or co-ordinate implementation.

Ūpoko | Chapter 2

Me pehea i oti ai ngā tūtohi o te Pakirehua


How the Inquiry developed its recommendations

9. When the government finalised the Inquiry's Terms of Reference in November 2018, its scope and mandate were broad.² The Inquiry was required to investigate the abuse and neglect of children, young people and adults in care between 1 January 1950 and 31 December 1999, with two key strands of work:
 - a. **Strand 1: looking back** (establishing what happened and why) – mapping the nature and extent of abuse and neglect in care, the impacts of that abuse, and the factors that caused or contributed to that abuse.
 - b. **Strand 2: looking forward** (ensuring that what occurred cannot happen again) – reviewing current systems for preventing and responding to abuse and neglect in care, testing whether these are fit for purpose, and identifying changes that need to be made.³
10. In November 2018, the Terms of Reference mandated the Inquiry to report and make recommendations on “any gaps and areas for future changes to current frameworks to prevent and respond to abuse in State and faith-based institutions, including oversight mechanisms”.⁴

² Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018 (LI 2018/223).

³ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018 (LI 2018/223), clauses 26–26.2.

⁴ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Order 2018 (LI 2018/223), clause 32(a).

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11. In July 2021, the government changed this mandate.⁵ A new cause (clause 15D) was added to the Terms of Reference to expressly prohibit the Inquiry from examining or making any findings about care settings and current frameworks, including current legislation, policy, rules, standards and practices. The government said this change was to avoid any delays to the Inquiry's final report and because:

"Since the Royal Commission was established, there have been a number of reviews and investigations into contemporary State care issues, which have significant overlaps and risk duplication with the Royal Commission's work."⁶

12. At the same time, several other clauses were added to the Terms of Reference. Clause 32A was added to allow the Inquiry to make recommendations for future changes to ensure that the factors that allowed abuse and neglect to occur during the Inquiry period do not persist. Clauses 15A and 15B were also inserted to allow the Inquiry to consider issues and experiences after 1999 to inform any recommendations made under clause 32A. Clauses 15A and 15B allowed the Inquiry to hear from people who had been in care after 1999 or were currently in care.
13. The Inquiry's final recommendations in this part therefore cover three categories, as mandated by the updated Terms of Reference:
- a. changes to redress processes (under clause 32(b))
 - b. steps to address the harm of abuse in care (under clause 32(c))
 - c. for changes to be made in the future to ensure that the factors that allowed abuse to occur during the relevant period in State care and in faith-based institutions do not persist (clause 32A).⁷

⁵ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions Amendment Order 2021 (LI 2021/179)

⁶ Media release, Hon Jan Tinetti, Minister of Internal Affairs, Royal Commission into Historical Abuse scope adjusted to avoid timeline delay (23 April 2021), <https://www.beehive.govt.nz/release/royal-commission-historical-abuse-scope-adjusted-avoid-timeline-delay>.

⁷ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, Terms of Reference, clauses 32(b), 32(c) and 32A.

14. The Inquiry's final recommendations differ slightly from the draft recommendations submitted to the Minister of Internal Affairs, Hon Brooke van Velden, on 30 May 2024.⁸ The draft recommendations were edited for conciseness and clarity, without altering the meaning of the recommendations. The Inquiry added a small number of new recommendations and removed a small number, which were subject to ongoing natural justice consideration at the time the draft recommendations were submitted.⁹ The new recommendations are:
- a. Recommendation 20 for the government and faith-based institutions to establish a fund for projects connected to community harm arising from the cumulative impact of abuse and neglect in care
 - b. Recommendation 21 to provide for whānau harm payments to whānau of survivors of abuse and neglect in care in recognition of the collective impacts of abuse and neglect
 - c. Recommendation 88 for the government to take all practicable steps to ensure the ongoing safety of children, young people and adults in care at Gloriavale Christian Community
 - d. Recommendation 101 for faith-based entities to revise their policies to reduce high barriers to disclosing abuse and neglect in their care
 - e. Recommendation 116 supported by Commissioners Erueti and Gibson recommending that the government establish an independent commissioning agency responsible for allocating funding to collectives and /or local communities to design and deliver all care and protection, youth justice, community mental health, disability and Whānau Ora supports and services.

⁸ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, Terms of Reference, clause 32B

⁹ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, Terms of Reference, clause 39A.

Ngā mea i pā ki ngā purapura ora mai i te tau 1999 Survivors' issues and experiences after 1999

15. Neurodivergent survivor Ihorangi Reweti Peters (Ngāti Tūwharetoa, Ngāti Tahu-Ngāti Whaoa, Ngāti Kahungunu) told the Inquiry that, in 2021 when he was aged 16, he had written to the Prime Minister asking for the Inquiry's mandate not to be narrowed to exclude modern day settings. He pointed out the barriers experienced by people in care to making complaints to NZ Police, Oranga Tamariki, and the Historic Claims Unit at the Ministry of Social Development. He also said that:

"...the Royal Commission was an important pathway that young people have to share their experiences and provide recommendations to help stop this cycle of poverty, abuse and neglect."¹⁰

16. Ihorangi and other rangatahi survivors of abuse and neglect in care formed Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei after the change to the Inquiry's Terms of Reference:

"Our rōpū...are made up of tangata whenua, Tauiwī, tangata whaikaha, migrants, gender diverse, rainbow rangatahi and parents ranging in age from 17–30 years old. We have diverse experiences of the care system. Some uplifted young, some left young, some uplifted later, some abandoned by the system too early and left to fend for ourselves. Some in parts of the system where we had no say or support, and some moved from pillar to post several times. We have been unstable, invisible, silenced, and powerless in the decisions made about us, our lives, and the lives of the people we care most about. We came together as a rōpū because, whilst the Inquiry process prescribes dates, implying a beginning and an end to abuse in care, many of us exist beyond these dates, and have been called to this kaupapa because abuse in care did not just magically stop in 1999."¹¹

17. The Inquiry heard from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei and other survivors about issues and experiences that occurred after 31 December 1999. The Inquiry used these to inform the recommendations made in Chapters 5–7 under clause 32A, which are to ensure that the factors that allowed abuse to occur during the Inquiry period do not persist.

¹⁰ Witness statement of Ihorangi Reweti Peters (18 January 2022, para 60).

¹¹ Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, [Position Statement] (2024, page 1).

18. This part includes nine survivor experience profiles – of Lily, Mr RA, Ms NT, Rovin Turnbull, Tupua Ulrich, Skyler Quinn, Zion Pilgrim, Mr OB and Mr VT – to share their stories and highlight that these issues and experiences have continued since 1999 across multiple care settings. Chapters 5–7 also include quotes from survivors to illustrate the issues and experiences since 1999 that have informed the recommendations in those chapters.

Ngā ripoata me ngā arotakenga pūnaha taurima mai i te tau 1999

Reviews and reports about care settings and frameworks after 1999

19. The Inquiry was explicitly prevented by clause 15D of its Terms of Reference from examining “current care settings and current frameworks to prevent and respond to abuse in care, including current legislation, policy, rules, standards, and practices”. This meant that, although the Inquiry heard about survivors’ issues and experiences after 1999, it was constrained by the Terms of Reference from examining the context of their experiences.
20. Chapters 5–7 explain where reviews or reports have made relevant observations about current care settings and frameworks. Some of these reviews and reports are independent, and some were commissioned by the State. Many of the reviews and reports make observations or reach conclusions that echo and support what survivors told the Inquiry about their issues and experiences after 1999.
21. The following table includes some of the reviews and reports on care settings and frameworks after 1999, noting the relevant care setting or group in care. The table also includes the dates of relevant statutes. The table is not exhaustive, but does highlight the number and frequency of reviews, reports and strategies over the last 25 years. This shows that many government agencies involved in the care system have been in a state of response, reactivity and near-constant change since 1999.

Ngā ripoata me ngā arotakenga pūnaha taurima mai i te tau 1999

Reviews, reports and legislation relevant to care settings and frameworks after 1999

Name	Author	Date	Relevant care setting /s or groups
Public Health and Disability Act 2000	New Zealand Government	2000	Disability and mental health
Picking up the Pieces: Review of Special Education	Cathy Wylie	2000	Disability Education
Care and Protection is about Adult Behaviour	Ministerial Review of the Department of Child, Youth and Family Services	2000	Care and protection
Human Rights Amendment Act 2001	New Zealand Government	2001	All settings
New Zealand Disability Strategy: Making a world of difference	Ministry of Health	2001	Disability
Office of Disability Issues established	New Zealand Government	2002	Disability
Te Puāwaiwhero: Māori Mental Health National Strategy	Ministry of Health	2002	Mental health
Concluding Observations: New Zealand (Second Periodic Report)	United Nations Committee on the Rights of the Child	2003	Children and young people
To Have an Ordinary Life	Donald Beasley Institute	2003	Disability
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003	New Zealand Government	2003	Disability
Children's Commissioner Act 2003	New Zealand Government	2003	Children and young people
Pacific Models of Mental Health Service Delivery in New Zealand Project	Clinical Research and Resource Centre, Waitematā District Health Board	2004	Pacific peoples Mental health
National Office for Professional Standards established	Catholic Church in Aotearoa New Zealand	2004	Catholic
Report of the Special Rapporteur on the Situation of Human Rights and Fundamental Freedoms of Indigenous People	Rodolfo Stavenhagen, Special Rapporteur, United Nations Human Rights Council	2006	Māori
United Nations Convention on the Rights of Persons with Disabilities	United Nations General Assembly	2006 (in force 2008)	Disability and mental health Education
New Zealand Sign language becomes an official language of New Zealand through the Sign Language Act 2006	New Zealand Government	2006	All settings
United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)	United Nations	2007	Māori

Name	Author	Date	Relevant care setting/s or groups
Inquiry into the quality of care and services provision for people with disabilities	Social Services Committee, New Zealand Parliament	2008	Disability
Improving Quality of care for Pacific Peoples: A paper for the Pacific Health and Disability Action Plan Review	Ministry of Health	2008	Pacific peoples Disability and mental health
Pacific Peoples and Mental Health: A paper for the Pacific Health and Disability Action Plan Review	Ministry of Health	2008	Pacific peoples Mental health
The Health of Pacific Children and Young People in New Zealand	Ministry of Health	2008	Pacific peoples Children and young people
A Statement from the New Zealand Catholic Bishops Conference on the Declaration on the Rights of Indigenous Peoples	Catholic Church in Aotearoa New Zealand	2008	Catholic
Aotearoa New Zealand ratifies United Nations Convention on the Rights of Persons with Disabilities	New Zealand Government	2008	Disability and mental health Education
Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015	Ministry of Health	2008	Māori Mental Health
New Zealand Statement of Support for United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)	New Zealand Government	2010	Māori
O Au O Matua Fanau: Our Children are our Treasures, Child, Youth and Family Pacific Action Plan	Child, Youth and Family	2010	Care and protection and youth justice
Faiva Ora National Pasifika Disability Plan 2010–2013	Ministry of Health	2010	Disability
Including Students with High Needs	Education Review Office	2010	Disability Education
First New Zealand report on implementing the United Nations Convention on the Rights of Persons with Disabilities	New Zealand Government	2011	Disability
Enabling Good Lives (EGL) vision and principles developed	Disability community	2011	Disability
Green Paper for Vulnerable Children: Every child thrives, belongs, achieves	Expert Advisory Group	2012	Children and young people
The White Paper for Vulnerable Children	New Zealand Government	2012	Children and young people
Children's Action Plan	New Zealand Government	2012	Children and young people

Name	Author	Date	Relevant care setting /s or groups
A Review of the Child, Youth and Family Complaints Resolution Policy and Procedure: Recommendations on how Child, Youth and Family can take a Child-Centred Approach to Complaints Resolution	Office of the Children's Commissioner	2012	Children and young people
Effective Complaint Handling	The Ombudsman	2012	All settings
Making Disability Rights Real	Independent Monitoring Mechanism of the Convention on the Rights of Persons with Disabilities	2012	Disability
The Hidden Abuse of Disabled People Residing in the Community: An exploratory study	Dr Michael Roguski	2013	Disability
Putting People First: A Review of Disability Support Services Performance and Quality Management Processes for Purchased Provider Services	K Van Eeden and Ministry of Health	2013	Disability
'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018	Ministry of Health	2014	Pacific peoples Disability and mental health
Children's Act 2014 (previously called Vulnerable Children Act)	New Zealand Government	2014	Children and young people in all settings
Te Korowai Oranga: Māori Health Strategy	Ministry of Health	2014	Māori Disability and mental health
Disability Support Services Strategic Plan 2014–2018	Ministry of Health	2014	Disability
Concluding Observations on the initial periodic report of New Zealand's progress on the Convention on the Rights of Persons with Disabilities	Committee on the Rights of Persons with Disabilities	2014	Disability
Expert Panel Final Report: Investing in New Zealand's Children and their Families	Modernising Child, Youth and Family Expert Panel	2015	Children and young people
Review of Police Custodial Management	Independent Police Conduct Authority	2015	Transitional and law enforcement
He Whakaaro Here Whakaumu Mō Aotearoa	Matike Mai Aotearoa Independent Working Group on Constitutional Transformation	2016	Māori
New Zealand Disability Strategy 2016–2025	Ministry of Health	2016	Disability
Faiva Ora National Pasifika Disability Plan 2016–2021	Ministry of Health	2016	Pacific peoples Disability
Youth Justice Secure Residences: A report on the international evidence to guide best practice and service delivery	Ian Lambie and Ministry of Social Development	2016	Youth justice

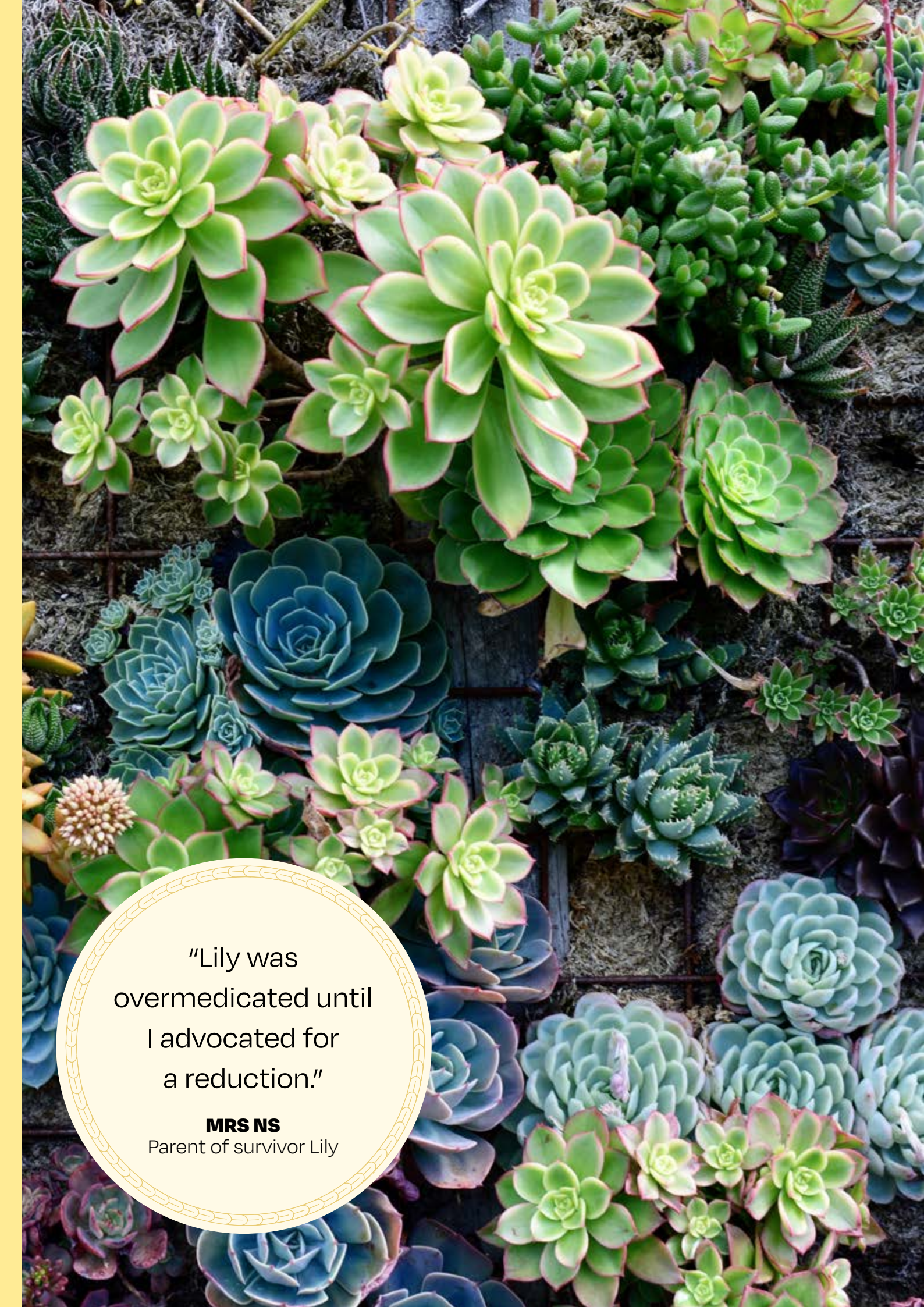
Name	Author	Date	Relevant care setting/s or groups
Concluding observations on the fifth periodic report of New Zealand	United Nations Committee on the Rights of the Child	2016	Children and young people
The Christian Church Community Trust (Gloriavale): Charities Services Investigation	Charities Services, Department of Internal Affairs	2017	Gloriavale
Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 2017	New Zealand Government	2017	Social welfare
Investigation into Ruru School seclusion complaint	The Ombudsman	2017	Disability Education
Final Report	United Kingdom Royal Commission into Institutional Responses to Child Sexual Abuse	2017	Children and young people
National Safeguarding Guidelines: Guidelines for the prevention of and response to sexual abuse in the Catholic Church in Aotearoa New Zealand	Catholic Church in Aotearoa New Zealand	2017	Catholic
Thinking outside the box? A review of seclusion and restraint practices in New Zealand	Dr Sharon Shalev and Te Kāhui Tika Tangata Human Rights Commission	2017	Disability and mental health Care and protection and youth justice Police custody
A decade of change 2007–2017: Implementing the Recommendations from the Commission of Inquiry into Police Conduct	New Zealand Police	2017	Transitional and law enforcement
Principles of the MCNZ Resolution and Redress Process for dealing with claims of abuse of children in Methodist care	The Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa	2018	Methodist
State of Care 2018: Maiea te Tūruapō – Fulfilling the Vision	Office of the Children's Commissioner	2018	Care and protection and youth justice
Feedback and Complaints Systems: A Rapid Review	Oranga Tamariki	2018	Care and protection and youth justice
He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction	Government Inquiry into Mental Health and Addiction	2018	Mental health
Mental Health Inquiry Pacific Report	Government Inquiry into Mental Health and Addiction	2018	Pacific peoples Mental health
Whāia Te Ao Mārama 2018 to 2022: The Māori Disability Action Plan	Ministry of Health	2018	Tāngata whaikaha
He Puapua: Report of the working group on a plan to realise the UN declaration on the rights of indigenous people in Aotearoa / New Zealand	Technical Working Group	2019	Māori
Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry	Waitangi Tribunal	2019	Māori Disability and mental health

Name	Author	Date	Relevant care setting/s or groups
What Makes a Good Life? Children and young people's views on wellbeing	Oranga Tamariki and Office of the Children's Commissioner	2019	Care and protection and youth justice
Te Korowai Ture ā-Whānau: The final report of the Independent Panel examining the 2014 family justice reforms	Independent Review Panel	2019	Care and protection and youth justice
Disability Action Plan 2019–2023	Office of Disability Issues	2019	Disability
New section 7AA (Duties of chief executive in relation to Treaty of Waitangi) inserted into the Oranga Tamariki Act 1989	New Zealand Government	2019	Care and protection and youth justice
Child Wellbeing Strategy	Department of the Prime Minister and Cabinet	2019	Children and young people
Zero seclusion: Safety and dignity for all	Te Tāhū Hauora Health Quality & Safety Commission	2019	Mental health
Jehovah's Witness' Scripturally Based Position on Child Protection	Jehovah's Witnesses	2020	Jehovah's Witnesses
He Take Kōhukihuki – A matter of urgency: Investigation Report into policies, practices and procedures for the removal of newborn pēpi by Oranga Tamariki, Ministry for Children	The Ombudsman	2020	Care and protection
Te Kuku O Te Manawa Moe ararā: Haumanutia ngā moemoeā a ngā tūpuna mō te oranga o ngā tamariki: A review of what needs to change to enable pēpi Māori aged 0–3 months to remain in the care of their whānau in situations where Oranga Tamariki Ministry for Children is notified of care and protection concerns	Office of the Children's Commissioner	2020	Care and protection
Education and Training Act 2020	New Zealand Government	2020	Education
Health and Disability System Review, Final Report Pūrongo Whakamutunga	Health and Disability System Review Expert Panel	2020	Disability and mental health
Optional Protocol to the Convention Against Torture (OPCAT) report on an unannounced follow up inspection of Wards 34, 35 and 36, Waikato Hospital	The Ombudsman	2020	Mental health
Seclusion and Restraint: Time for a Paradigm Shift	Dr Sharon Shalev and Te Kāhui Tika Tangata Human Rights Commission	2020	Disability and mental health Care and protection and youth justice Transitional and law enforcement
Off the Record: An investigation into the Ministry of Health's collection, use, and reporting of information about the deaths of people with intellectual disabilities	The Ombudsman	2020	Disability

Name	Author	Date	Relevant care setting/s or groups
Whakamaua: Māori Health Action Plan 2020–2025	Ministry of Health	2020	Māori Mental health
Ko Te Wā Whakawhiti, It's Time For Change: A Māori Inquiry into Oranga Tamariki – Report	Whānau Ora Commissioning Agency	2020	Māori
Changes to Title D Canons (standards for conduct)	Anglican Church in Aotearoa New Zealand and Polynesia	2020	Anglican
Hipokingia ki te Kahu Aroha Hipokingia ki te Katoa: The initial report of the Oranga Tamariki Ministerial Advisory Board	Ministerial Advisory Board	2021	Care and protection and youth justice
Te Kahu Aroha: addendum report on quality support and service outcomes for tamariki and rangatahi whaikaha, their whānau, parents and caregivers	Ministerial Advisory Board	2021	Disability Care and protection
Review of provision of care in Oranga Tamariki residences	Ministerial Advisory Board	2021	Care and protection and youth justice
Te Oranga Optional Protocol to the Convention Against Torture Monitoring Report	Office of the Children's Commissioner	2021	Care and protection
He Pā Harakeke, He Rito Whakakīkinga Whāruarua: Oranga Tamariki Urgent Inquiry (Wai 2915 report)	Waitangi Tribunal	2021	Care and protection and youth justice
Future Direction Action Plan	Oranga Tamariki	2021	Care and protection and youth justice
Optional Protocol to the Convention Against Torture (OPCAT) report on an unannounced inspection of Te Whare Ahuru Mental Health Inpatient Unit, Hutt Hospital	The Ombudsman	2021	Mental health
Supporting Aotearoa's Rainbow People: A Practical Guide for Mental Health Professionals	Inside Out	2021	Takatāpui, Rainbow and MVPFAFF+ Mental health
Just Sayin' survey: Understanding the transition needs of rainbow young people	Malatest International	2021	Takatāpui, Rainbow and MVPFAFF+ Care and protection and youth justice
Learning in residential care: they knew I wanted to learn	Education Review Office	2021	Care and protection and youth justice Education
Whakamahia te tūkino kore ināianeī, ā muri nei – Acting now for a violence and abuse free future: violence and abuse of disabled people in Aotearoa New Zealand evidence and recommendations	Te Kāhui Tika Tangata Human Rights Commission	2021	Disability
Whaikaha Ministry for Disabled People established	New Zealand Government	2022	Disability
Conversion Practices Prohibition Act 2022	New Zealand Government	2022	Takatāpui, Rainbow and MVPFAFF+

Name	Author	Date	Relevant care setting/s or groups
Nōku Te Ao: Sovereignty of the Māori Mind	Te Whatu Ora	2022	Māori Mental health
Talanoa Mai Tamaiki: The voices of Pacific children and young people	Oranga Tamariki	2022	Pacific peoples Care and protection and youth justice
Ola manuia mo alo ma fanau Pasefika	Oranga Tamariki	2022	Pacific peoples Care and protection and youth justice
Concluding observations on the combined second and third periodic reports of New Zealand	United Nations Committee on the Rights of Persons with Disabilities	2022	Disability and mental health
Pae Ora (Healthy Futures) Act 2022	New Zealand Government	2022	Disability and mental health
Epuni Residence Visit: Optional Protocol to the Convention Against Torture (OPCAT) Monitoring Report	Office of the Children's Commissioner	2022	Care and protection
Thriving at School? Education for Disabled Learners in Schools	Education Review Office	2022	Disability Education
Optional Protocol to the Convention Against Torture (OPCAT) Report on announced inspection of Pōhutakawa Forensic Intellectual Disability Unit, Mason Clinic	The Ombudsman	2022	Disability
Disability Rights: How is New Zealand doing? An update report about the state of disability rights in New Zealand	Disabled People's Organisations Coalition, the Ombudsman and Te Kāhui Tika Tangata Human Rights Commission	2022	Disability
Guidelines on deinstitutionalization, including in emergencies	United Nations Committee on the Rights of Persons with Disabilities	2022	Disability and mental health Education
Te whare Tuhua, Te Whare Matariki – Community Remand Homes Visit: Optional Protocol to the Convention Against Torture (OPCAT) Monitoring Report	Office of the Children's Commissioner	2022	Youth justice
The New Zealand Children's Commissioner's report to the United Nations Committee on the Rights of the Child	Office of the Children's Commissioner	2022	Children and young people
Highest Needs Review: What matters to stakeholders	New Zealand Council for Educational Research	2022	Disability Education
Special Review Report – Wesley College	Education Review Office	2023	Education
An Independent Inquiry into abuse at Dilworth School	Dame Silvia Cartwright	2023	Dilworth School

Name	Author	Date	Relevant care setting/s or groups
Physical restraint and de-escalation: Best international practice as applicable to secure youth justice residences – Summary report	Oranga Tamariki	2023	Youth justice
Pae Tū: Haora Māori Strategy	Ministry of Health and Te Aka Whai Ora Māori Health Authority	2023	Māori Disability and mental health
Te Mana Ola: The Pacific Health Strategy	Ministry of Health	2023	Pacific peoples Disability and mental health
Kia Manawanui Aotearoa: long term pathway to mental wellbeing	Ministry of Health	2023	Mental health
Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992	Ministry of Health	2023	Mental health
Te Puna Wai ō Tuhinapo youth justice residence visit: Optional Protocol to the Convention Against Torture (OPCAT) monitoring follow up report	Office of the Children's Commissioner	2023	Youth justice
Safety of Children in Care Annual Report July 2022 to June 2023	Oranga Tamariki	2023	Care and protection and youth justice
Final Report	Australian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability	2023	Disability
Making Ourselves Visible: The Experiences of Takatāpui and Rainbow Rangatahi in Care	Point and Associates and the Community Design Team	2023	Children and young people
Oranga Tamariki Secure Residences & A Sample of Community Homes: Independent, External Rapid Review	Debbie Francis and Paul Vlaanderen	2023	Care and protection and youth justice
Experiences of Care in Aotearoa: Agency Compliance with the National Care Standards and Related Matters Regulations 1 July 2022–30 June 2023	Independent Children's Monitor	2024	Children and young people
Without racism Aotearoa would be better	Mana Mokopuna – Children and Young People's Commission	2024	Care settings with children and young people



"Lily was
overmedicated until
I advocated for
a reduction."

MRS NS
Parent of survivor Lily

Lily

Hometown: Tāmaki Makaurau Auckland

Age when entered care: 3 years old

Year of birth: 1983

Time in care: 1986 to present

Type of care facility: Schools – Belmont Primary School in Tāmaki Makaurau Auckland, Sunnybrae Normal School in Tāmaki Makaurau Auckland, Wilson Home School in Tāmaki Makaurau Auckland; respite care – Wilson Centre Radical Respite Unit; service providers – Creative Abilities, SILC, IDEA Services, Totara Farm Trust, Taikura Trust.

Ethnicity: NZ European

Whānau background: Lily has an older sister who is involved in her care. Her parents separated when Lily was a baby.

Currently: Lily lives in Auckland and is supported by her mother, Mrs NS, and Vision West.



My daughter Lily has outlived her prognosis and is possibly the oldest person in New Zealand with Lennox Gastaut Syndrome – a severe childhood epilepsy syndrome characterised by multiple types of drug resistant seizures. She also has cognitive impairment and autistic traits.

From the 1980s until today, Lily has suffered psychological and physical abuse from education, health and support providers she should have been able to trust. Numerous attempts to correct her behaviour and make her more compliant have resulted in both physical injury and ongoing psychological harm and trauma.

As a child, Lily was overmedicated until I advocated for a reduction. When we finally got down to small doses of two drugs, this little person woke up. She later began to walk with a specially made walking frame, and she was taught to play and sign colours.

During the 1990s, Lily attended several special units in mainstream schools, but I never felt like she was part of the school, or appropriately supported. She experienced the use of aversive practices, for example, when a teacher at Belmont Primary School (Auckland) flicked water in her face and put ginger in her mouth because she had been spitting.

At Sunnybrae Normal School, they blamed lack of discipline for Lily's behaviour and used two teacher aides to force her – aged 10 years old and weighing about 26 kilograms – into a purpose-built cupboard multiple times per day. This was despite Lily's doctor explaining that she didn't understand cause and effect.

Between 1997 and 2001, Lily attended the Wilson Home School. She continued to be very unwell at times. This was often because she was in a non-convulsive status, where her brain was constantly seizing but she wasn't outwardly convulsing. At times like this, she would become increasingly comatose and unresponsive. Sadly, it seemed her teacher preferred this situation to the more highly mobile Lily, and usually failed to report it to me.

From 1998, she also attended the Radical Respite Unit at Wilson Centre. I felt one nurse took a dislike to Lily and I understand she wrote numerous incident reports about Lily's behaviour. Despite Lily's caregivers denying that many of these things had actually happened, in January 2001 I was told that they were going to potentially need to use more aversive punishments and restraints to manage Lily's behaviour. I decided to collect Lily and she never returned to the school or respite unit.

I provided full time care for Lily at home until she began attending the day programme at Creative Abilities. I was told she was having a great time doing aerobics and "other things". I ultimately found out that she wasn't really being supported at Creative Abilities. After she arrived, a caregiver would take her to their house, where she would play with their dog before being returned for transport home.

After determining there weren't any providers in Auckland with the skills to provide the support Lily needed, SILC decided to set up a service specifically for her. There was a skilled team leader who was intent on supporting Lily to live the life she chose. All Lily's staff were valued, supported and provided with excellent training.

For the first year, Lily came home so happy, and it was wonderful to see her enjoying her time there. Unfortunately, things began to go downhill after staff changes in the organisation, and towards the end of 2006, SILC announced they were pulling out of Auckland and would no longer be able to support Lily.

Taikura Trust, an NGO who were contracted as our Needs Assessment Service Coordination service by the Ministry of Health, organised for IDEA Services to take over. I withdrew Lily from IDEA Services in December 2007 after her longstanding team leader was moved to a different position while I was overseas and replaced with agency staff who had no training or introduction to Lily.

In 2008, we set up the Circle of Friends' Trust to manage the discretionary funding we received from Taikura Trust. We rented a house and had a lovely group of friends supporting Lily.

Sometime later, there were issues with a staff member obviously using Lily's money for her own gain, and when some staff resigned at the end of 2010, we couldn't replace them with people who had the necessary skills. This meant I had to provide a lot of time and input into the management of her service and, by the beginning of February 2011, I was becoming ill and exhausted.

Lily had been under the Dual Disability Team since 2009 and they had prescribed an antipsychotic drug to try to stop her desire to leap out of the car when it was travelling. I later found out this was probably due to a staff member treating her badly, and her not wanting to be in the car with them.

The psychiatrist from the Dual Disability Team suggested Lily go away for three to six months to a "calm, skilled environment where she could learn to be independent from me". Totara Farm Trust was recommended. Six months without seeing Lily wasn't an option for us, but I gratefully accepted four weeks' respite at one of their houses in Takanini.

Two significant events occurred during those four weeks. First, Lily managed to leave the property in the middle of the night while two staff members were asleep in the house and despite the doors being locked. She wandered down the road before the staff noticed she was missing. Some people she approached called the police, who transported her to Middlemore Hospital. When staff called the police and found out where she was, they collected her from the hospital.

Second, when Lily was picked up, she had significant bruising on her upper thighs, chest and neck. A staff member employed by the Circle of Friends' Trust explained that a few days earlier it had been suggested to Lily's staff to use physical restraint for behaviour management. When it didn't work, they contacted the Totara Farm manager who sent two male staff members to take over.

The men took Lily to her bedroom and advised her staff to go the office. They were encouraged to stay there for about an hour. Over this time, they saw Lily leave the room continually and, on each occasion, be taken back by the men. They thought the men's treatment of Lily was "very rough and scary" and felt that the Totara Farm staff appeared to be "fed up with Lily's attitude".

After this, Lily was afraid of men. She had always enjoyed the company of our male friends and to see her shy away from people she had been comfortable with was incredibly sad.

When we told the Dual Disability Team psychiatrist how appalled we were at what had happened, she became very defensive saying a number of her clients experienced bruising. We received a letter shortly after discharging Lily from the Dual Disability service.

Repeated texts, emails and phone calls requesting copies of the incident reports from Totara Farm failed to elicit any response. When a meeting was finally arranged by Taikura Trust seven weeks later, we were told their staff were well trained in restraint and the bruising had nothing to do with them. The Totara Farm manager delivered this information while leaning across the table and shaking her finger at us. This appeared to be totally acceptable to Taikura Trust. The meeting was incredibly stressful and I felt very unsupported and unsafe.

I reported the incident to the police but was told they wouldn't be laying charges. An officer told me that Lily was an "unreliable witness" and couldn't give evidence.

I also reported it to the Ministry of Health and the Health and Disability Commissioner, but they declined to investigate any further as the police had already determined there was insufficient evidence to show who caused the injuries. I've always been very upset that they thought this traumatic event for Lily wasn't worth investigating further.

Since 2012, we have had seven failed providers. A clear pattern has emerged where providers believe they can provide the necessary support, but when they can't meet their contractual requirements, I feel like we can't continue with the service or they provide a totally unacceptable ultimatum.

After another period of supporting Lily ourselves, her seizures continued to worsen and, with very little support, I was exhausted. In 2018, I decided that Lily needed to be hospitalised. Due to my exhausted state, it was recommended I call an ambulance to transport Lily to Auckland City Hospital and go to bed.

My daughter and a friend travelled to the hospital and were told that they had to have eight security guards sitting on Lily to restrain her, and that she hadn't received any of her medication since her arrival. They phoned me at 4am and told me I needed to come immediately, or they felt she would die.

The total lack of understanding or training to support someone in a very stressful situation who is cognitively impaired and non-verbal was appalling, and Lily was extremely traumatised by what happened. Between April and September, I stayed with her 24/7 so she wouldn't end up with more security guards restraining her.


Vision West became Lily's provider in 2020 and we became concerned early on when new staff were busy vacuuming and dusting but seemed anxious about interacting with Lily. We later found out that staff had responded to an ad for a home support worker. The manager seemed unable to understand the difference between supporting someone like Lily to live a meaningful life and doing a few hours housekeeping.

Since the beginning of 2022, Lily's service has had serious gaps in the roster. All current staff are exhausted and burnt out. I am too, after 40 years of caring and advocating for Lily.

When I seriously considered finding another provider, I could see that history would only repeat itself – so I have also asked Vision West to accept an investigation into why it appears to be so incredibly difficult to support Lily successfully.

All disabled people must be able to enjoy the same human rights as every other citizen of Aotearoa. Abuse of these most vulnerable citizens must not be allowed to continue.¹²

¹² Witness statement of Mrs NS (mother of Lily) (27 April 2023).



"I remember
having no food growing
up...my mum was a good
mum, she just needed support
and I think I would've had
a better life if she got the
support she needed."

JAMIE HENDERSON
Survivor

Ūpoko | Chapter 3

He Māra Tipu – He tohu whakatipu


He Māra Tipu – Vision for the future

22. Over more than five years, the Inquiry heard about survivors' moemoeā (dreams) for the future. Survivors, their whānau and support networks told the Inquiry that they want to see an Aotearoa New Zealand where every child, young person and adult is loved, safe and cared for in a manner that supports their growth and development into a thriving contributor to society. Survivors' moemoeā are summarised below.

He moemoeā ā ngā purapura ora mo tuawhakarere

Survivors' dreams for the future

- Aotearoa New Zealand's care system is broken. Survivors want to see a total overhaul and fundamental change to ensure that this national catastrophe does not continue.
- Survivors told the Inquiry that the care systems need to fundamentally change. This would see the State handing over power, funding and control of preventative supports and care services to local communities and communities of interest.
- Survivors want every whānau supported so they can provide loving care themselves. That means they must receive the supports they need, when they need these and for as long as needed, to realise their full potential and flourish. Additional daily care support may be required to avoid out-of-whānau care. Faith-based institutions would exit the business of care and in their pastoral care adopt national standards and transparent complaint processes.

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- From time to time, out-of-whānau care will be required. When out-of-whānau care is required, it must be short-term. It must be delivered by the community, hapū or collective and the individual and their whānau have control of decisions on care. Out-of-whānau care should only be used to give the wider whānau time to receive holistic support, for example for healing or resetting, so they can be brought back together. Everyone in the community works to return that child home. Out-of-whānau care will be in plain sight, with children safeguarded in multiple ways and wider whānau / family connections maintained at all times.
 - Local schools are welcoming and inclusive of all students and all students have their diverse needs met and achieve to their potential. Children, young people and adults receive the disability or mental health supports they need.
 - The Crown must cede authority and live up to the promise of te Tiriti o Waitangi. Whānau, hapū and iwi must be able to exercise their right to tino rangatiratanga over kāinga and are empowered to care for their tamariki, rangatahi, pakeke and wider whānau according to their tikanga and mātauranga. The mana of all individuals, communities and whānau must be restored.
 - Human rights are respected, made real, and embedded into law to support people to avoid out-of-whānau care and give greater protection to people who may require care of their choice in the community.
 - In faith-based institutions, leaders providing pastoral care reflect the diversity of their communities and expression of that diversity is welcomed. Respect for te Tiriti o Waitangi, human rights for all people and freedom of belief simultaneously flourish. Faith community members are free to choose partners, seek appropriate health care and have no fear of being shunned.
 - Communities, hapū and iwi must be enabled and empowered to design, implement, innovate and control how the care systems operate for their community. The Government should invest in communities that have levels of social deprivation, support communities to identify those in need, understand the evidence of what works to prevent the need for a care intervention, take an early investment approach and measure long-term outcomes in communities.

- Survivors spoke in detail about local communities defining the preventative work, support services and out-of-whānau care. Survivors and whānau took the Inquiry to examples in the community where this is happening – where hapū provide a full preventative service to whānau.
- Survivors acknowledge that devolving power, funding and control from the State into local hands will take time. It will require several stepping stones to get there. Some local communities or communities of interest will be ready now, so these steps can be taken immediately. Others will need extra support and investment before they can take on new or expanded roles in providing services and supports.
- Most significantly, survivors want the State to radically change its attitude and practices relating to care decision-making and investment, which are characterised by low trust and a focus on risk aversion and crisis response rather than empowering whānau and local communities to look after their own.

23. Survivors' moemoeā set the foundation for the Inquiry's own vision for the future – he Māra Tipu (a growing garden). The concept of he Māra Tipu was introduced in the Inquiry's 2021 report *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui*. The name of the report drew on the whakataukī "he purapura ora, he māra tipu", which reflects the idea that a seedling, despite being trampled upon and losing part of itself, still has infinite potential to grow and regenerate.¹³
24. The Inquiry also considered the large body of evidence from survivors, their whānau and support networks; from hapū, iwi, Māori, and Pacific Peoples; from disability communities; from advocacy groups, and experts; from former and current staff of care settings; and from religious leaders and religious communities. These witnesses described their experiences both during the Inquiry period and after 1999. The evidence the Inquiry has heard, including about survivors' issues and experiences after 1999, has clearly demonstrated that the current care system is not fit for purpose.
25. Due to the constraints of the Terms of Reference, the Inquiry cannot set out the full pathway to reach he Māra Tipu. It can, however, recommend the first steps that survivors, local communities, the State and faith-based entities should take on the journey towards he Māra Tipu. The recommendations in Chapters 4–8 do just that. The full description of the Inquiry's vision for the future – he Māra Tipu – is set out in below.

¹³ Royal Commission of Inquiry into Abuse in Care, *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui*, Volume 1 (2021, pages 6 and 56).

Ngā haukerekere a ngā mahi tūkino

Abuse and neglect in care was widespread and systemic

26. The care system in Aotearoa New Zealand was a fully funded failure that enabled pervasive abuse and neglect. The State and faith-based institutions took on responsibility for caring for over half a million babies, children, young people and adults between 1950 and 1999, but did not keep them all safe.
27. In the Inquiry period, families, whānau, kāinga and communities needed support to care for their children, young people and adults in care in their homes and communities. Many faced significant challenges, including poverty, impacts of colonisation, and family violence, or had unmet needs due to disability or experience of mental distress. The State removed children, young people and adults from their whānau and support networks and placed them into care settings, many of which were harmful and abusive. Societal attitudes reflecting racism, ableism and sexism and punitive attitudes towards children and young people made some people more likely to be placed in care and more likely to experience abuse there.
28. Children, young people and adults were abused and neglected in the care of the State and in the care of faith-based institutions. They were in social welfare residences and institutions, foster care, disability and psychiatric care, schools, orphanages, faith communities, unmarried mothers' homes, health camps, and the care of NZ Police. This Inquiry was the first opportunity we have had in Aotearoa New Zealand to examine the care system as a whole. No inquiry locally or overseas has had such a wide mandate. The Inquiry found pervasive abuse and neglect everywhere it looked.
29. Survivors described many kinds of physical, sexual, psychological and emotional abuse and neglect while they were in care. Some groups experienced targeted abuse and neglect that was specific to who they were – including Māori, Pacific Peoples, Deaf and disabled people, people who experience mental distress, Takatāpui, Rainbow, and MVPFAFF+, and women and girls. Some survivors were subjected to solitary confinement and forced labour.
30. The harm and trauma suffered by children, young people and adults in State and faith-based care has affected every part of their lives. Almost every survivor who came forward to share their experience with the Inquiry has endured irreparable damage to the quality of their lives.

31. For too long society in Aotearoa New Zealand has been unwilling to accept that abuse and neglect in State and faith-based care was widespread and systemic. It did not occur solely due to the actions of a few 'bad apples' but was deeply rooted and enabled across all levels of the systems responsible for providing care. Nor was it a small failure that solely affected survivors. It was pervasive throughout the Inquiry period with devastating, multigenerational effects for survivors, their whānau and society as a whole.
32. The abuse and neglect experienced by survivors has contributed to an intergenerational transfer of inequities, including poorer physical health, mental health, education and employment outcomes, family and intimate partner violence, substance misuse and abuse, and fewer opportunities for many. One of the greatest costs is the loss of generations of adults who might otherwise have positively contributed to their whānau and community. Abuse and neglect in care contributed to, and in many ways created, the 'care to custody' pipeline and the formation and entrenchment of gangs in Aotearoa New Zealand, costing society both in terms of victimisation and the direct costs of policing and imprisonment.

33. The Inquiry has found that around 200,000 people were abused in care between 1950 and 1999. However, the true number of survivors could be much higher. The estimated total economic cost of this abuse and neglect is around \$200 billion.¹⁴ This amount is:
- a. over three times what the New Zealand government spent on war and rehabilitation during World War Two (£615 million in 1946, which, adjusted for inflation, is \$63.2 billion in 2023)¹⁵
 - b. over three times the cost of the government's COVID-19 Response and Recovery Fund (\$61.6 billion in 2022, or \$67.9 billion in 2023 adjusted for inflation)¹⁶
 - c. almost four times the cost of the 2010–2011 Canterbury earthquakes response and recovery (\$57 billion, adjusted for inflation for 2023), based on:
 - i. total estimated insurance claim costs, including private insurers and the Earthquake Commission (\$38 billion in 2021, or \$44.8 billion in 2023 adjusted for inflation)¹⁷
 - ii. core Crown Canterbury Earthquake Recovery costs, excluding the Earthquake Commission (\$7.6 billion in 2014, or \$9.8 billion in 2023, adjusted for inflation)¹⁸
 - iii. Christchurch City Council earthquake costs to date (\$1.9 billion as at 2017, or \$2.4 billion in 2023, adjusted for inflation)¹⁹
 - d. 100 times the cost of the 2023 Auckland Anniversary Day floods and Cyclone Gabrielle response and recovery (\$2.021 billion).²⁰
34. In fact, the estimated cost of abuse and neglect in care is more than the total of all of the above events combined.

14 Based on \$857,000 estimated lifetime individual economic costs per survivor, adjusted for inflation to \$1.05 million in 2023. See MartinJenkins, *Economic cost of abuse in care (2020)*; Reserve Bank of New Zealand website, *Inflation calculator* (accessed 20 March 2024), <https://www.rbnz.govt.nz/monetary-policy/about-monetary-policy/inflation-calculator>.

15 An Encyclopaedia of New Zealand, *Second World War*, AH McLintock (ed) (1966); Baker, JVT, *War Economy*, in *Official History of NZ in the Second World War 1939–45* (Department of Internal Affairs, 1965, pages 256–258).

16 The Treasury website, *Overview of the COVID-19 Response and Recovery Fund (CRRF)*, accessed 20 March 2024, <https://www.treasury.govt.nz/information-and-services/nz-economy/covid-19-economic-response/overview-covid-19-response-and-recovery-fund-crrf>.

17 Cole, R, *Finding and reserving Canterbury earthquake insurance claims* (Reserve Bank of New Zealand, February 2021), <https://www.rbnz.govt.nz/-/media/project/sites/rbnz/files/publications/analytical-notes/2021/an2021-2.pdf>.

18 The Treasury, *Report to the Minister of Finance: Canterbury Earthquake Fiscal Update May 2014* (26 May 2014), <https://www.treasury.govt.nz/sites/default/files/2018-02/b14-2913046.pdf>.

19 Deloitte, *Christchurch City Council: Cost of the Earthquake to Council* (13 December 2017), <https://www.ccc.govt.nz/assets/Documents/The-Council/Plans-Strategies-Policies-Bylaws/Strategies/Global-Settlement/Cost-of-the-earthquakes-Deloitte-Report-Final.pdf>.

20 The Treasury website, *North Island Weather Events Response and Recovery Funding* (accessed 21 March 2024), <https://www.treasury.govt.nz/information-and-services/nz-economy/climate-change/north-island-weather-events-response-and-recovery-funding>.

He karonga te eke noa An avoidable failure

35. Survivors, their whānau and communities, and our whole society have paid the price for this avoidable failure. Although a significant amount of resourcing has gone into providing care, for many people in care the money spent has not translated to better outcomes. At the same time, faith-based institutions continue to receive the financial benefits of tax-exempt status, despite the significant abuse and neglect that was perpetrated in their care.
36. Decision-makers have been told multiple times over the last 40 years about the deficiencies with our country's care systems but their responses have not matched the magnitude of the issues. The Puao-te-Ata-Tū report pointed this out in 1988:
- “We need the co-ordinated approach that has been used to deal with civil emergencies because we are under no illusions that New Zealand is facing a major social crisis. The solutions to social problems lie in a co-ordinated attack on the problems, involving the resources of the private sector as well as the public and particularly of the people themselves.”²¹*
37. The State continues to make incremental and disconnected attempts to improve care systems despite the increasing calls for urgent radical change. Continuing to tweak the status quo will not answer those calls. For the last 70 years, the State has taken responsibility for children, young people and adults who need care, but decisions about that care have largely been made by people with little connection to those going into care and their communities. This State-led model of care cannot be described as anything less than a dismal failure. Peter Whitcombe, Chief Social Worker, told the Inquiry that Oranga Tamariki staff sometimes refer to their residential care facility model as a “fully funded failure model”.²²
38. Aotearoa New Zealand's systems of care – in social welfare, disability, mental health, education and transitional settings – need a total overhaul and fundamental change. The ultimate outcome the Inquiry wants to see is a country where no child, young person or adult experiences abuse or neglect, and where every whānau who needs support is safe, is loved, and receives the supports it needs, when it needs them and for as long as it needs them, so that whānau members can realise their full potential and rights and live a good life as they define it. All the Inquiry's recommendations must be fully implemented to improve the lives of survivors and of all New Zealanders.

²¹ Department of Social Welfare, Māori Perspective Advisory Committee. Puao-te-Ata-tu (Day Break): The Report of the Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare(1988, page 44).

²² Transcript of evidence of Chief Social Worker Peter Whitcombe for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (24 August 2022, page 876).



Ko te mahi tūkinō i ngā pūnaha taurima, e pā ana ki a tātou katoa

Abuse and neglect in care affects everyone

39. Aotearoa New Zealand has a reputation for being a safe place to grow up, raise a family, and grow old, but there is a dark side to our society that we must confront and address – the abuse and neglect that around 200,000 people experienced while in State and faith-based care during the Inquiry period.
40. Many of the factors that contributed to abuse and neglect during the Inquiry period are not confined to the past. They are present today and continue to put people at risk of harm. Settings outside the Inquiry's scope, such as rest homes or aged care facilities, sports clubs, community organisations and youth groups, have been the subject of international investigations and inquiries into abuse and neglect. It is highly likely that people in these settings in Aotearoa New Zealand have experienced abuse and /or neglect.
41. In Part 4, the Inquiry found that the 1970s had the highest rates and incidents of abuse and neglect, followed by the 1960s and then the 1980s.²³ The two generations born between 1946 and 1976 are therefore likely to know someone who was abused or neglected in care or to have experienced it themselves. The oldest of these generations are now increasingly requiring care and supports as they age. By 2028, over 1 million New Zealanders will be aged over 65.²⁴
42. Internationally, Aotearoa New Zealand is often seen as a beacon of human rights and liberal progress. New Zealanders are proud of our country's worldwide reputation for fairness, justice, and the protection of individual freedoms. However, this image contrasts starkly with our domestic reality, where we have a terrible track record of abuse and neglect in care settings. The Inquiry urges New Zealanders to consider its findings and recommendations and apply them more broadly than the scope of its investigation allowed.


²³ DOT loves data consulting, Final report - Quantitative Analysis of Abuse in Care (Royal Commission of Inquiry into Abuse in Care, September 2023 p 74).

²⁴ <https://www.stats.govt.nz/>.

He papa whāinga e hua ai ko te Māra Tipu

A fundamental shift is needed to reach he Māra Tipu

43. The Inquiry's vision for the future includes one of the most fundamental changes to systems of care this country has ever seen. It would see the State handing over power, funding and control of supports and services to individuals, groups and organisations chosen by collectives and / or local communities. Current systems of care will never truly serve or meet people's needs until people and communities are enabled and empowered to design, innovate, implement and control how the care systems operate. The Inquiry sees collectives and local communities defining themselves and grouping together to design and deliver supports and services according to shared values, goals, experiences, needs, location, interests, ancestry, whakapapa, ethnicity, religion and / or culture. This is consistent with international practice, which has seen a shift towards the use of community-based services where possible, and consideration being given to how to best address the needs of and improve outcomes for whānau and communities more broadly.
44. Devolving power, funding and control from the State will take time. It will require several stepping stones along the pathway to get there. The Inquiry envisages that the first steps will include the care settings within the Inquiry's scope – social welfare, disability, mental health, education and transitional settings – but that, over time, other social services could be devolved to communities. At the same time, the Inquiry pictures significant downsizing and / or disestablishment of government agencies currently designing and delivering care. The Inquiry does not foresee Oranga Tamariki as part of he Māra Tipu. The Inquiry would expect to see other agencies involved in the care system, such as the Ministry of Health, Whaikaha and the Ministry of Education, reducing in size and shifting focus to supporting collectives and local communities.
45. Some collectives and / or local communities will be ready for the State to devolve power, funding and control now, so the first steps towards he Māra Tipu can be taken immediately. Others will need extra support and investment before they can take on new or expanded roles in providing services and supports. Most significantly, the State will need to radically change its attitude and practices relating to care decision-making and investment, which are characterised by low trust and a focus on value for money rather than empowering collectives and / or local communities to look after their own.

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46. The Inquiry's vision is for Māori to exercise tino rangatiratanga over kāinga and to care for their mokopuna, uri and whānau in line with te Tiriti o Waitangi. Alongside the transformation in the provision of care, there is a need for a mature and fair conversation and process about New Zealand's constitutional arrangements and how to give effect to the vision in te Tiriti o Waitangi of a true partnership between two peoples.
47. The Inquiry's vision for the future includes human rights being fully realised for all. This would include the rights guaranteed to women, children, Māori (as an indigenous people under the United Nations Declaration on the rights of Indigenous Peoples), Deaf and disabled people and people who experience mental distress.
48. As the Inquiry noted in Part 1, in Aotearoa New Zealand our te Tiriti o Waitangi and human rights protections, including those contained in the United Nations Declaration on the Rights of Indigenous Peoples, are set out in a variety of statutes and the common (court-made) law.²⁵ This means they are not all in one place and not all rights have been incorporated into our domestic law. In the future, the Inquiry envisages the rights guaranteed by te Tiriti o Waitangi and economic, social and cultural rights being enshrined in legislation alongside civil and political rights. These new statutory rights should be subject to a supermajority of 75 percent of all members of Parliament being necessary to change or repeal it. This will protect the legislation from the influence of our comparatively short Parliamentary terms and help maintain their long-term integrity. These changes will also form part of the constitutional conversation that Aotearoa New Zealand needs to have.
49. Again, these ideas are not new. For example, more than 35 years ago the Pūao-te-Ata-Tū report called for government to "harness the initiatives of the Māori people and the community at large to help address the [social] problems" and "...promote and sustain community responses".²⁶ Other jurisdictions, including the United States and Australia, made significant shifts towards devolving child protection decision-making to indigenous communities in the 1970s and 1980s.²⁷ Australia also made a transformational shift in the provision of disability services and supports in 2013 using a person-centred insurance model under the National Disability Insurance Scheme, enabling disabled people to choose and control who provides their support. In 2019, Canada passed legislation affirming the right of indigenous peoples to self-determination, including jurisdiction in relation to child and family services.²⁸

25 Glazebrook, S, Baird, N & Holden, S, New Zealand: Country Report on Human Rights, Victoria University of Wellington Law Review, Volume 40 (2009, page 58).

26 Department of Social Welfare, Māori Perspective Advisory Committee. Puao-te-Ata-tu (Day Break): The Report of the Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare (1988, pages 44–45).

27 Indian Child Welfare Act, PL 95–608, Approved November 8, 1978 (92 Stat. 3069); Secretariat of National Aboriginal and Islander Child Care, Aboriginal and Torres Strait Islander Child Placement Principle: Aims and Core Elements (June 2013, page 2).

28 An Act respecting First Nations, Inuit and Métis children, youth and families (S.C. 2019, c. 24), Assented to 2019–06–21.

50. The Inquiry sees a future where there is minimal, if any, need for any child, young person or adult who needs support to be placed in out-of-whānau care. Individuals and whānau will have everything they need to flourish and their mana will be enhanced. In he Māra Tipu, survivors will have the supports and tools they need to heal and thrive and live a fulfilling and productive life. In he Māra Tipu, Māori and the Crown will be genuinely partnering to realise the promise of te Tiriti o Waitangi. Whānau, hapū and iwi will exercise tino rangatiratanga over their kāinga and be empowered to care for their tamariki, rangatahi, pakeke Māori and whānau according to their tikanga and mātauranga.
51. The Inquiry cannot map the full extent of the pathway to achieve its vision of he Māra Tipu. The Inquiry can provide navigation lights based on its findings and observations. Once its recommendations have been implemented, survivors, people receiving supports and services, whānau, collectives and local communities, the State and faith-based entities should review how far they have come, how much progress has been made, and together, map out the steps they need to take to achieve the vision.

He Māra Tipu – He pūnaha taurima mo tuawhakarere He Māra Tipu – what will the future care system look like?

52. In this Part, the Inquiry uses “faith-based entities” to refer to organisations with a faith-based interest involved in providing care supports and services. The Inquiry does this to distinguish between the “faith-based institutions” as defined in its Inquiry’s Terms of Reference, which were the subject of its investigations into abuse and neglect of people in their care between 1950 and 1999. The Inquiry envisages that a broader range of denominations and religious groups may be involved in providing care in the future.

Ngā mahi ā ngā momo hinonga o te pūnaha taurima Functions of different entities in future care system

Individuals and whānau

- Access supports and services from care providers and other providers

Care providers

(including individuals, rōpū, NGOs, faith-based entities, organisations, hapū, iwi)

- Provide supports and services tailored to meet community needs (including care and protection, youth justice, disability, community mental health) (\$ via Commissioning Agency)
- Comply with National Care Safety Strategy and statutory rules, standards and guidelines
- Investigate and report on complaints
- Care providers are accredited
- Staff and care workers are registered
- Prospective staff are screened and vetted
- Staff and care workers are trained
- Collect and keep full and accurate records

Independent entities

Puretumu Torowhānui Agency

- Implements puretumu torowhānui system and scheme

Care Safe Agency

- Whole of system leadership on preventing and responding to abuse in care
- Develops National Care Safety Strategy and action plan
- Sets, monitors and enforces statutory care safety rules and standards
- Investigates and reports on complaints
- Keeps national register of substantiated complaints
- Accredits care providers and other providers
- Registers staff and care workers
- Leads public awareness, education and prevention initiatives
- Develops training and education for staff and care workers
- Undertakes research, data analysis and horizon scanning
- Provides advice to Government on prevention and responding to abuse

Core Public Service

Care System Office (later to become the Ministry for Care System)

Departmental agency with Chief Executive and Advisory Board

- Implements Inquiry recommendations and reports on progress
- Coordinates all government care services funding to Commissioning Agency (funding amounts decided by Ministers/Cabinet)
- Facilitates public participation/collaboration on implementing recommendations
- Facilitates and coordinates with other departments involved in providing care services and supports
- Monitors performance of Care Safety Agency, Commissioning Agency and Puretumu Torowhānui Agency
- Provides policy advice to Ministers on care system as a whole
- Administers Care Safety Act (and makes law changes)

Ministry of Health

- Provides policy and funding advice on mental health matters to Ministers
- Administers relevant legislation (eg, Mental Health (Compulsory Assessment and Treatment) Act, Pae Ora Act)

Collectives and/or local communities

(including individuals, rūpū, NGOs, faith-based entities, organisations, hapū, iwi)

- Allocated \$ from Commissioning Agency
- Procure supports and services (including care and protection and youth justice, disability, community mental health) from care providers
- Invest in communities' and care providers' capacity and capability building

Other providers (schools and hospitals)

- Contracted by, Commissioning Agencies
- Provide inpatient mental health and education supports and services (contracted via Commissioning Agency)
- Comply with National Care Safety Strategy and statutory rules, standards and guidelines
- Investigate and report on complaints
- Providers are accredited
- Staff and care workers are registered
- Prospective staff are screened and vetted
- Staff and care workers are trained
- Collect and keep full and accurate records

Commissioning Agency

Independent Crown Entity with Board

- Allocates funding to collectives and/or local communities for supports and services (including care and protection and youth justice, disability, community mental health) and for capacity and capability building
- Contracts delivery of in patient mental health and education supports and services from hospitals and schools

Independent oversight bodies

- Investigate and report on complaints brought by users of supports and services
- Proactively inspect care providers and other providers

Whaikaha

- Provides policy and funding advice on disability matters to Ministers
- Administers relevant legislation (eg, NZSL Act)

Ministry of Social Development

- Provides policy and funding advice on care and protection and youth justice matters to Ministers
- Administers relevant legislation (eg, OT Act)

Ministry of Education

- Provides policy and funding advice on education matters to Ministers
- Administers relevant legislation (eg, Education and Training Act)



53. The diagram above describes the functions of the different entities in the care system:
- a. **Individuals and whānau** who need support can:
 - i. access the supports and services they need from care providers and /or other providers (such as hospitals and schools) in their local communities
 - ii. raise concerns (about the individual's wellbeing or care providers' practice) or make complaints directly to care providers or other providers, to the Care Safe Agency, and /or to Independent Oversight Bodies.
 - b. **Collectives and /or local communities:** will be allocated funding by the Commissioning Agency to procure supports and services tailored to meet community needs from care providers, and to invest in community and care provider capacity and capability building. Collectives could include individuals, rōpū, NGOs, faith-based entities, organisations, hapū, iwi, etc.
 - c. **Care providers:** collectives and /or local communities will procure supports and services from care providers. Care providers could include individuals, rōpū, NGOs, faith-based entities, organisations, hapū, iwi, etc. They will be responsible for:
 - i. providing preventative and holistic supports and services tailored to meet community needs (including care and protection, youth justice, disability and community mental health services)
 - ii. complying with the National Care Safety Strategy and the rules, standards and guidelines set by the Care Safe Agency, including implementing safeguarding policies and procedure, being accredited entities, having staff who are registered, screened, vetted and trained, collecting full and accurate records, investigating and reporting on complaints received by users of supports and services, and undertaking mandatory reporting.
 - d. **Other providers:** schools and hospitals will be responsible for:
 - i. providing inpatient mental health and education supports and services
 - ii. complying with the National Care Safety Strategy and the rules, standards and guidelines set by the Care Safe Agency, including implementing safeguarding policies and procedure, being accredited entities, having staff who are registered, screened, vetted and trained, collecting full and accurate records, investigating and reporting on complaints received by users of supports and services, and undertaking mandatory reporting.

e. **Independent Entities:**

- i. **Puretumu Torowhānui Agency:** an independent Crown entity with a board, responsible for implementing the puretumu torowhānui system and scheme
- ii. **Care Safe Agency:** an independent Crown entity with a board, the primary regulatory agency for the new national care safety regulatory system, with responsibility for:
 - > whole of system leadership on preventing and responding to abuse in care
 - > developing the National Care Safety Strategy and its supporting action plan to prevent and respond to abuse and neglect in care
 - > setting, monitoring and reporting on care safety rules and standards
 - > investigating breaches of rules and standards and enforcing a range of sanctions and penalties against care providers, staff and care workers
 - > investigating and reporting on complaints received directly from users of supports and services
 - > collating and keeping a national register of complaints and the outcomes of investigations from State and faith-based care providers, other providers of supports and services, professional registration bodies and Independent Oversight Bodies
 - > accrediting care providers and other providers of supports and services
 - > registering staff and care workers who are not already covered by existing professional registration regimes
 - > setting training and education standards and developing curriculums for staff and care workers
 - > workforce development and career pathways for staff and care workers
 - > leading public awareness, education and prevention initiatives
 - > undertaking research, data analysis and horizon-scanning
 - > advising government on prevention and responding to abuse and neglect in care, including where systemic deficiencies are identified.
- iii. **Commissioning Agency:** an independent Crown entity with a board, responsible for:
 - > allocating funding to collectives and / or local communities so they can procure supports and services from care providers
 - > allocating funding to collectives and / or local communities to invest in capability and capacity building
 - > contracting delivery of inpatient mental health and education supports and services from hospitals and schools.

iv. **Independent Oversight Bodies** (the Ombudsman, Te Kāhui Tika Tangata Human Rights Commission, Health and Disability Commissioner, Mana Mokopuna): work collaboratively to proactively investigate care providers, hospitals and schools, and investigate and report on complaints brought by users of supports and services.

f. **Departments of State:**

- i. **Care System Office:** a departmental agency with its own chief executive and advisory board, responsible for implementing the Inquiry's recommendations. It will: facilitate effective participation of Māori in accordance with te Tiriti o Waitangi and public engagement and co-design to implement the Inquiry's recommendations; report publicly on implementation progress, coordinate advice to Ministers on the total amount of funding for the Commissioning Agency; monitor the organisational performance of the Care Safe Agency, Commissioning Agency and Puretumu Torowhānui Redress Agency; provide policy advice to Ministers on the care system as a whole; and administer the Care Safety Act.
- ii. **Other government departments:** would continue to provide policy and funding advice to Ministers responsible for the care system and administer relevant legislation (other than the Care Safety Act).

54. In he Māra Tipu, the State's role in the care system will be focused on:
- a. providing sufficient and sustainable investment in the care system, including investment in capacity and capability building, and design and delivery of care and support services, to realise he Māra Tipu
 - b. reporting to government, Parliament and the public on the use of public monies to invest in the care system
 - c. administration of legislation relevant to the care system, including legislation that upholds the rights of children, Deaf and disabled people, and people experiencing mental distress
 - d. collaborating with people in care, survivors, whānau and communities on new legislation or amendments to existing legislation relevant to the care system.
55. In he Māra Tipu, power, investment and decision-making about care services have been devolved from the State to collectives and local communities. The new arrangements for procuring preventative supports and services (through the Commissioning Agency and collectives and /or local communities) will drive strong, evidence-based investment approaches that will:
- a. meet the aspirations and needs of people and whānau in need
 - b. achieve the best possible outcomes for people in need
 - c. achieve fair outcomes for all people in need
 - d. enable early investment to prevent, reduce and delay the need for out-of-whānau care.

Ngā hua Māra Tipu

He Māra Tipu outcomes

56. The Inquiry's vision for the future – he Māra Tipu – will be realised when the following outcomes are in place:
- a. survivors of abuse and /or neglect in care have the supports and tools they need to heal, thrive and live a fulfilling and productive life
 - b. the mana and mauri of every child, young person or adult in care is recognised, upheld and enhanced
 - c. no child, young person or adult experiences abuse or neglect
 - d. all individuals and whānau have everything they need to flourish
 - e. any individuals or whānau who need support are safe, are loved, receive the supports they need, when they need them and for as long as they need them, to realise their full potential and live a good life as they define it
 - f. te Tiriti o Waitangi rights and human rights protections, including those in the United Nations Declaration on the Rights of Indigenous Peoples, and economic, cultural and social rights, are given effect through incorporation into domestic law that is subject to a supermajority to change or repeal it
 - g. whānau, hapū and iwi can exercise tino rangatiratanga over their kāinga and to care for their mokopuna, uri and whānau
 - h. the human rights of Deaf and disabled people, and people who experience mental distress, are fully realised through standalone legislation that protects and strengthens these rights, including through giving effect to the United Nations Convention on the Rights of Persons with Disabilities
 - i. few, if any, children, young people or adults need out-of-whānau care
 - j. collectives and local communities have the investment, capability and capacity to proactively prevent and reduce harm in their communities, and are empowered to design, implement and deliver locally led supports and services for people who need them
 - k. entities and people providing supports and services are safe, highly trained, skilled and well paid, and representative of those in care.

Te parau Māra Tipu

The pathway to he Māra Tipu

57. The Inquiry foresees at least three phases of work on the pathway to realising he Māra Tipu between now and 2040:
- a. **Phase 1** (2024–2030): Implementing the Inquiry's recommendations and consolidating change
 - b. **Phase 2** (2031): Review Phase 1 and implement next steps towards he Māra Tipu
 - c. **Phase 3** (2032–2040): Review Phase 2 and implement final next steps towards he Māra Tipu
58. There is a significant programme of work involved in implementing the Inquiry's recommendations and realising he Māra Tipu. This will involve many stakeholders and parties working together to achieve this shared vision. Government, faith-based entities, hapū, iwi, communities and organisations each have a critical role.
59. Embarking on the pathway to he Māra Tipu includes a significant shift in how government and faith-based institutions work with communities. It is critical that all voices are heard and have opportunities to participate, make shared decisions and have ownership over the changes that will occur.
60. The process for implementing recommendations must give effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples and enable Māori-led approaches. There must also be a process of co-design with affected communities, including children, young people and adults in care, survivors, Māori, Pacific peoples, culturally and linguistically diverse communities, Deaf and disabled people, people who experience mental distress, and Takatāpui, Rainbow and MVPFAFF+. This is discussed further in Recommendations 131–132.
61. The Inquiry envisages that community participation in the implementation of recommendations and the care system generally will shift over time. The Inquiry has identified three key phases, using the IAP2 Spectrum of Public Participation.²⁹

²⁹ International Association for Public Participation, IAP2 Spectrum of Public Participation (2018), <https://iap2.org.au/resources/spectrum/>. Involve means “to work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered”, collaborate means “to partner with the public in each aspect of the decision including the development of alternatives and the identification of a preferred solution” and empower means “to place final decision making in the hands of the public”.

Whāinga 1 (2024–2030): Te whakatinana i ngā whakatau o te Pakirehua me te whakatoka i ngā mea ka hua
Phase 1 (2024–2030): Implementing the Inquiry’s recommendations and consolidating change

62. The work during this phase would be initially led by the State and faith-based entities, increasingly involving people in care, survivors, whānau and communities in design and implementation.
63. The Inquiry envisages public participation in the design and implementation of these recommendations operating at the “collaborate / co-design” level on the IAP2 Spectrum of Public Participation. This means that the State and faith-based entities would partner with communities in every aspect of decision-making, including determining the issue / problem, developing solutions, assessing options and making choices.

Whāinga 2 (2031): Te arotake me te whakarite ahunga ki he Māra Tipu
Phase 2 (2031): Reviewing and deciding on next steps towards he Māra Tipu


64. The State, Māori, faith-based entities, people in care, whānau and communities jointly consider the outcome of the independent review into the implementation of the Inquiry’s recommendations (Recommendation 136) and identify the next steps needed to continue towards he Māra Tipu.
65. During this stage, there will be some activities that are occurring at the “collaborate / co-design” level on the IAP2 Spectrum of Public Participation, as discussed above. However, a key component of the review will be to identify the remaining steps to reach he Māra Tipu, where communities are empowered to make key decisions to minimise the need for out-of-whānau care (Recommendations 111–115) and in relation to provision of services for whānau in need of additional support. This would reflect the “empower” level of the IAP2 Spectrum of Public Participation.
66. For transparency and accountability, the State and faith-based entities would formally respond to the independent review by 31 December 2031, including on the next steps and the timelines for implementation of these (Recommendation 138).



Whāinga 3 (2032–2040): Te whakatinana i te ara whāinga ki he Māra Tipu

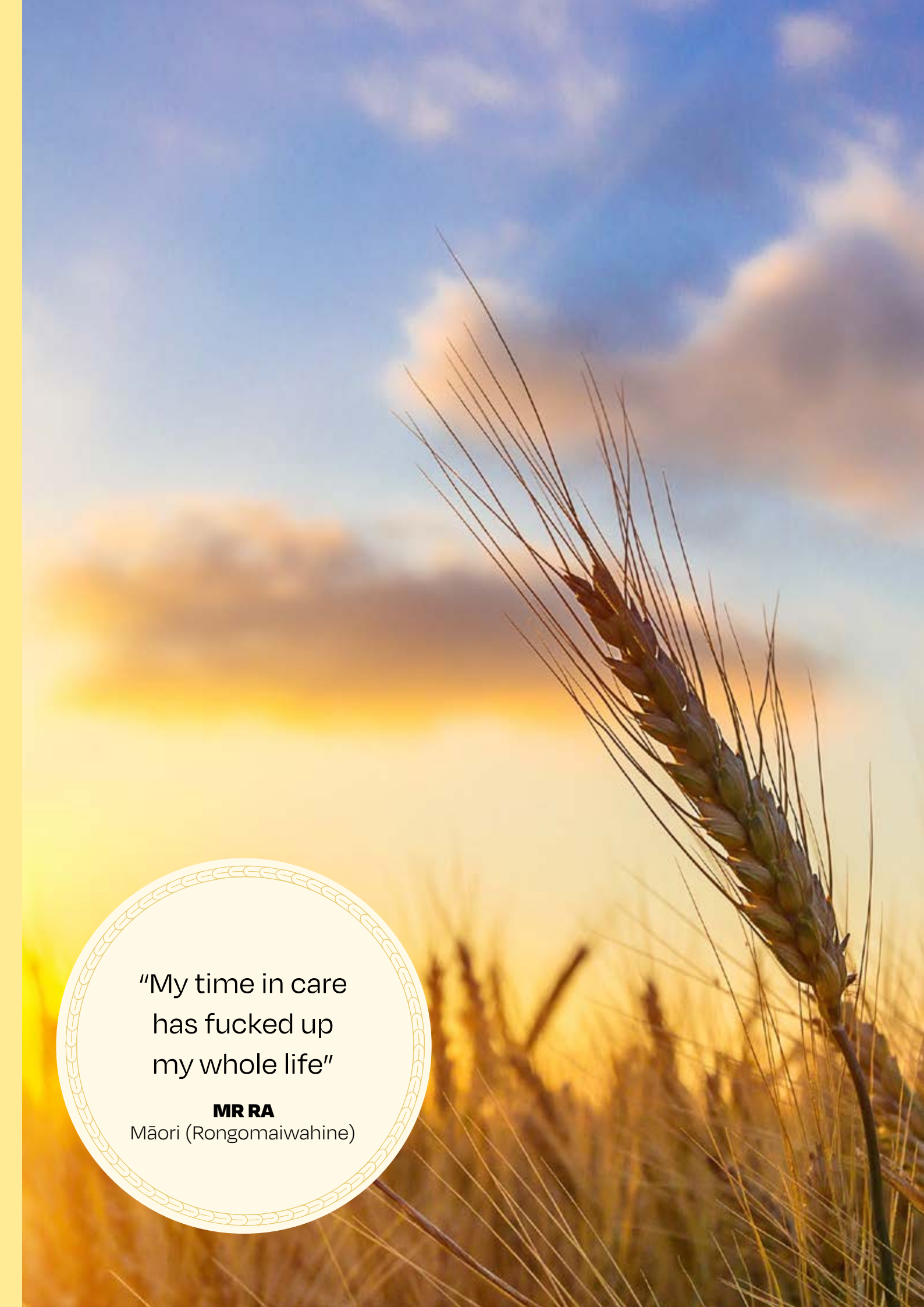
Phase 3 (2032–2040): Implement the next steps towards he Māra Tipu

67. The State, faith-based entities, people in care, whānau and communities partner to implement the next steps they have collaboratively identified following the independent review. By 2040, the care system reflects the vision – he Māra Tipu. In he Māra Tipu, power, investment and decision-making about care services have been devolved from the State to collectives and local communities.



"I remember that staff members would sometimes make jokes about Samoans, and that other staff members did not even know I was Samoan and would assume I was Māori."

MR GU
Samoan



"My time in care
has fucked up
my whole life"

MR RA

Māori (Rongomaiwahine)

Mr RA

Hometown: Kirikiriroa Hamilton

Age when entered care: 12 years old

Year of birth: 1988

Type of care facility: Foster homes; family homes – Melville Family Home, Silverdale Family Home, Fairfield Family Home; specialist schools – Amber Centre Classroom; residential specialist schools – Waimokoia Residential School in Tāmaki Makaurau Auckland; residential care – Weymouth in Te Tonga o Tāmaki Makaurau South Auck; trust programmes – Piako Whānau Trust programme, Te Whakapakari Youth Trust Programme on Aotea Great Barrier Island.

Ethnicity: Māori (Rongomaiwahine)

Whānau background: Mr RA has two younger siblings with the same parents, two half-sisters from his mother, and one half-brother and four half-sisters from his father. His parents separated when he was young but lived together in the same house a lot of the time.

Currently: Mr RA has spent time in prison. His children, whom he loves, were going to be taken into State care, but Mr RA opposed that, so they remained with whānau. Nevertheless, he feels he's passed on intergenerational trauma. He doesn't believe Oranga Tamariki can keep his kids safe, so he's always made sure they stay with whānau while in care.



When I was young, I was neglected at home and exposed to gang culture. My mother was verbally abusive and rough on me, and often violent to my dad. When I was 5 years old, there were concerns about violence and neglect at home and Child, Youth and Family Services (CYFS) got involved for a few months.

When I was 9 years old, my principal referred me to Special Education Services (SES) because I was playing up at school and getting aggressive. I worked with a psychologist who believed my behaviour at school was learned from home. She told CYFS she was worried I was being beaten at home or not being looked after properly. CYFS did nothing.

I was sexually abused by a teacher aide when I was 9 or 10 years old. At first, I felt he was genuine and looked up to him. He would praise me, encourage me with my schoolwork and buy me lunch. My mum trusted him too and let me go to his place for the weekend, where we played Nintendo and smoked fish. I slept on a mattress in his lounge. When I woke in the morning, he had his hand on my penis and was masturbating me. I automatically knew it was wrong and told him I wanted to go home.

I couldn't tell my mum what had happened, and I had to deal with that man over the next seven years as he went on to work in Youth Justice.

In late 1998 I went to the Amber Centre Classroom at SES – it was mostly good but staff would restrain me and I'd get into arguments with other kids. Staff and my psychologist were worried about my wellbeing at home because I would beg not to go back there. CYFS didn't do much to look out for me, but my psychologist referred me to Waimokoia, and I went there for a year. But the staff there sometimes restrained me because I'd been aggressive or abusive, or fighting with other kids. They'd twist my arms and pull my wrist back so it touched the back of my head. I was assaulted there by a staff member and I would get into fights with other kids. I'd often end up in the Time Out room.

After Waimokoia, my psychologist continued to monitor my schooling. I was still acting out and was suspended a few times. Then I met with a psychiatrist for an assessment. They thought I was constantly in stressed mode, needed therapeutic input and whānau involvement in therapy. But my mum didn't engage with mental health services on my behalf so nothing happened.

Over the next few years, I came to police notice for offending and not showing up for school. I was 12 years old and getting into serious crime. I didn't show up to a family group conference because I had run away. My parents said they had no control over me, couldn't stop me offending and didn't want me back home. When police found me, I was placed in CYFS custody and sent to the Melville Family Home. I took off within nine minutes of getting there. Each time I went back there I'd run away again.

Between the ages of 12 to 14 years old, when I ran away I would often stay at a halfway house run by two women in their late teens / early twenties. While I was there I'd do sexual favours for them. There were no other adults supervising or caring for me, and I didn't go to school. I supported myself by dealing cannabis and stealing. I was in CYFS custody a lot of that time – they knew I went back on the streets and to the halfway house but didn't do enough to keep me safe.

Once, after being sent back to the Melville Family Home, I told a social worker that some family friends were keen to look after me. I was formally placed with this family, and I'm still close to them now. My foster mother told CYFS the women at the halfway house had forced me to burgle houses to earn my keep, got me stoned and forced me to have sex with them. My social worker told her to keep me safe and tell me it wasn't my fault. But CYFS never spoke to me about it and I was never offered any counselling.

One weekend, I went to stay with my parents, and they wouldn't let me go back to my foster family. Being back with my parents meant I didn't go to school much and got into trouble with police a few times – I ended up being referred to Youth Justice. Over the next few months, I was placed in different family homes and ran away each time. At one, I was appointed trackers and security guards from CYFS. I fought with other boys at that home. The foster parents there would preach tikanga Māori to us and try to incorporate Māori values. But at the same time, they'd allow all this violence between us.

In mid-June 2002, when I was 13 years old, I ran away for a month. When I was found, I said I wouldn't run away again – but within two hours of being placed in a home, I took off. When I was found a week later, CYFS had nowhere to place me so took me to my father's house. My social worker didn't try to contact me until I was picked up by police in late August. I was placed in a family home and I took off again.

Later that year, my social worker did a wellbeing assessment that noted I'd committed 80 offences since I was 11 years old, hadn't attended any education activity for some time, and most of my friends were engaged in criminal activity. I was 14 years old and my parents didn't know how to deal with me. A month later I was arrested again and taken to Weymouth.

At Weymouth I was assaulted by staff members and excessively restrained – arm locks, wrist locks, neck locks. I was always fighting with the other kids and staff didn't do anything to stop it. I got sent to Secure a lot, where you'd be locked down for 23 hours a day. I was also strip-searched by male staff. I had to take off all my clothes and hold a towel around myself until they told me to show my arse. They had a metal detector and if it picked up a lighter, I'd be made to squat or show my arse. I know a lot of these searches didn't follow proper procedure.

In mid-2003, when I was 14 years old, I went to Whakapakari Youth Trust on Great Barrier Island. The brochure said it was all about Māori integrity and connecting back to your culture. One of my mates warned me not to go, and I wish I'd listened. We had to do adult slave labour there – fishing, digging longdrops and woodcutting, which was dangerous. We used chainsaws to cut giant trees. There was also a lot of violence between the boys.

We'd get punished for fighting, smoking or not working as hard as everyone else. Punishment meant carting bags filled with rocks for a kilometre. It got to the point where I was getting 50 bags at a time.

Every night we'd do over an hour of kapa haka, which was hard after a day of labour. If we didn't do something right, we'd get whacked with a long stick. If you showed weakness after being hit, we'd have to stay longer and that frustrated everyone.

Once I found a stash of cannabis and took some – but a staff member worked out I'd found it, tied me to a tree for two days and told me to think about what I'd done. When I was untied, I had to go and see another staff member, a big guy. He told me to lie about finding the cannabis. When I said I wouldn't, he punched me in the face and threatened me with more time on the island. Then he stood behind me and put his hand on my penis, over my pants. I pushed away from him, then he told me to stick his cock in my mouth. I said no, but he threatened to keep me on the island for another six months. I was so scared and just about to do it when I spewed on the floor, so he punched me in the side of the head.

When I left Whakapakari in September 2003, I went to my aunt's place in Hastings. It was cool living with her, although she was strict. However, I didn't end up seeing a social worker until October 2004, when I was 16 years old, and by that time I was getting restless living with my aunt. She really tried with me but eventually she'd had enough and I was removed from her care.

I ended up back at my dad's place – but mostly I was on the streets. Around this time, the man who had sexually abused me was allocated as my Youth Justice co-ordinator. He didn't do anything to me but it brought up all those old memories and I hated seeing him again.

I had a few charges going through the Youth Court around then, and I was getting into more trouble and getting arrested again. I ended up in Lower North Youth Justice Residential Centre. There were lots of fights at Lower North. Once some of the other kids tried to drown me. I smashed one in the face and had to go to Secure, which seemed really unfair. I was strip-searched every time I went in there. I'd hold a towel around me but then had to drop it down my legs to show them my butt and penis. I had to squat too. It was always male staff who did the strip searches.

I was at Lower North until June 2005, when I was sent to Youth Justice North for a few months. Some of the staff there were physically and verbally abusive. I ended up in Secure about four times. In September, I ran away while being taken to court. I was missing for a few weeks before I got picked up by police. I was convicted of aggravated robbery and sentenced to two years' imprisonment – and CYFS officially closed my case in November 2005. I was 17 years old.

My time in care has fucked up my whole life. I never understood its impact until I met a counsellor who helped me identify why I act and think the way I do and how that goes back to childhood trauma.


I have flashbacks and sleepless nights. I disassociate myself from the memories. Sometimes I have internal rage and other times numbness. For years, I wasn't able to connect with my Māoritanga because of a lot of the people who abused me were Māori. But the biggest thing for me is the impact it's had on my kids. I was in prison a lot of the time when they were growing up and, just like me, they've been taken into State care.

In 2022, my lawyers sent my claim to the education and social development ministries – it's not clear which part of the State is responsible for the abuse. My lawyers tried to get information from Oranga Tamariki to help sort it out but they refused to hand anything over because it was too hard to gather.

I don't trust the State or the care system. That started when I trusted someone who abused me. I let my defences down and he betrayed me. I put my walls up and haven't let them down since. I still get flashbacks about what he did to me, and yuck feelings. I feel I am owed more than an apology but what can they provide? What's the price of childhood?

I've done some serious offending and spent a lot of time in prison, and I don't want evil to ruin me. Bringing my legal claim and seeking counselling is part of my quest for closure, because I need to focus on moving forward.³⁰

³⁰ Witness statement of Mr RA, WITN0712001 (Royal Commission of Inquiry into Abuse in Care, 15 August 2022).



"Priests,
teachers and the
school nurse knew
about the abuse
but did nothing."

MS NT
Pākeha

Ms NT

Hometown: Aorangi Feilding

Year of birth: 1974

Type of care facility: Psychiatric hospital – Te Whare Ahuru Mental Health Ward in Te Awa Kairangi ki Tai Lower Hutt

Ethnicity: Pākeha

Whānau background: Ms NT has two younger siblings. Growing up, her family attended church regularly and she was an altar boy.

Currently: Ms NT has a partner and they have a good relationship. However, her biological family can't accept her for who she is. Ms NT has a child from a previous relationship



When I was a child, there were times I thought I was a woman, but I didn't really know what transgender was.

I don't remember much from my childhood, although I remember attending church twice a week. I made friends with another boy at primary school, and sometime between the ages of 8 and 11 years old, we went camping with another friend. My friend threatened me with violence and they made me give them blowjobs. The sexual activity, including rape, continued for a number of years and my friend used intimidation, financial control and physical assault to control me.

Because of this, I became sexualised at an early age and thought this kind of activity was normal.

I went to a Catholic boarding school when I was teenager. I think I may have been seen as an effeminate child – I was skinny and vulnerable and got bullied. I was beaten up by other boys many times, and I was often caned until I bled. Priests and teachers, and the school nurse knew about the abuse, but no action was taken. At 14 years old, I was caught sniffing glue so I ran away and got expelled.

I ended up at a local high school and the same 'friend' started sexually abusing me again. It was horrible and became quite violent – he was stronger and bigger than me. One day I just walked away – I hadn't known I could do that before then. I had never told anyone I was being raped and abused and it was only later I realised it wasn't normal behaviour.

I blocked out the trauma with solvent use and cannabis, which reduced the pain.

I was expelled in sixth form, due to my low attendance and drug use. After that, my parents asked me to move out. I had an older girlfriend by then, so I moved in with her and we had a child. After a couple of years, I moved, got a polytech qualification, broke up with my girlfriend and started to view myself as bisexual. But although I was working and had started studying for a degree, things weren't going well for me and I attempted suicide. I was then diagnosed as having an adjustment disorder.

I finished my degree in 2000 and over the next few years, I travelled overseas, then moved to Wellington and started work there. About this time, I started to confirm in my mind that I was a woman.

I stopped using solvents when I was 28 years old but started using cannabis to cope with my anxiety. At work, I was sexually harassed so I left. That, plus being diagnosed with a brain tumour, led to my breakdown. Following that, I told my partner about my childhood abuse. She was the first person I ever told. She listened, she understood, and she was supportive.

I still have the brain tumour, it's slow growing and I am on a 'watch and wait' programme and may require surgery. I have hearing loss in one ear because of it.

Having a breakdown really affected me financially. I made a claim with ACC regarding weekly compensation – this claim had nothing to do with my childhood abuse.

Chasing my claim was extremely difficult and I went through five case managers. To start, they wanted a medical certificate from 2000 – by the time I finally got one, I had a new case manager and instead of using the medical certificate, I had to have a psychological review and they decided instead to cover me using the 1996 medical report that diagnosed me with an adjustment disorder.

For the next five years, I had psychosis and hallucinations – I couldn't leave home. Around 2006 or 2007, I tried to kill myself again and was admitted to hospital as a voluntary mental health patient. I returned home after six weeks but when I couldn't sleep, I took a double dose of medication. My partner thought I'd tried to attempt suicide again so she called the police. They asked her if I had a firearm and when she said she didn't know, the Armed Offenders Squad came. Embarrassed and naked, I ran away in shock and they stopped me with a taser and pepper spray. I was readmitted to the mental health ward under the Mental Health Act and after six weeks I was allowed to return home on the condition I take my medication.

By this time, I had started to transition from being a man to a woman with hormones and testosterone blockers. When I was readmitted, all of my hormone treatment was stopped and I found this distressing. This was a time when gender identity and transgender people were not so common and there was a stigma attached to people like me.

I remained under the Mental Health Act for two years. During that time, I started part-time work and made a gradual recovery. Once I came out from the compulsory treatment order in 2010, I went back into the gender reassignment programme. I started a new job, but after a few years I became unwell and got bullied. I ended up having psychotherapy for five years. It was challenging but, along with gently changing my medications, I began to improve.

In 2016 I had gender reassignment surgery in the United Kingdom and in 2019, I began training to be a nurse. After graduating, I started working in mental health.

In August 2020, ACC declined me the weekly compensation and considered if I could have an independence allowance – I was assessed as being impaired to a level of 25 percent. I asked for the decision to be reviewed but it was upheld. In the review, ACC said I have no clear recollections of the abuse as a child – however, this isn't true. It also said I agreed with the 1996 date ACC had used for my claim, however I did not. Also, my claim had been for my breakdown, not my childhood abuse. I realise now I needed an independent advocate but I felt too much shame to try and get one. I couldn't afford a lawyer.

I would like things to change.

Transgender people face stigma, exclusion and marginalisation. I have experienced all of these things, especially from my biological family. They still can't accept me for who I am – that hurts most. I understand that at least 40 percent of transgender people attempt suicide at least once and most of them don't have the support of family or friends. I place myself in that category.

Although attitudes towards transgender people have gradually improved over the last 20 years, I still run into problems. I have been treated badly by medical practitioners, who have refused to use my chosen name or pronouns in their report and when speaking to me. I also found it hard to get my brain tumour diagnosed – when I first presented with deafness, my psychiatrist said it was psychological. Because of this, finding the tumours was delayed.

I would like ACC to be nice. Sensitive claims are hard to file and case managers change so often, it's hard to start from scratch with a new person who has to know the things I feel most whakamā (embarrassed) about in life. I would have preferred fewer people to know my story and to have only one point of contact for the whole process.

I would like better mental health support for adolescents, and I would like every child to have the opportunity to speak to someone confidentially, away from their home and parents.

If I had been given the chance to talk to a school nurse who was trained in mental health then I might have disclosed my abuse and received treatment for my issues. My life might have been quite different.³¹

³¹ Witness statement of Ms NT (20 January 2022).

Ūpoko | Chapter 4

Te whakatika i ngā hē o ngā ra ō mua

Righting the wrongs of the past

68. The Inquiry's December 2021 report He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui included 95 recommendations that, if implemented, would:

"...establish what will eventually be a new scheme to provide puretumu torowhānui, or holistic redress for survivors of abuse in the care of State agencies, agencies providing care on the State's behalf (which we refer to as indirect State care), and faith-based institutions. This puretumu torowhānui scheme will aim to restore the power, dignity and standing of those affected by abuse in care, without them having to go to court, as well as take effective steps to prevent abuse. It will fit within what we refer to as the "puretumu torowhānui system", which is the wider system of services, organisations (including the courts), laws and policies that have a role in providing different types of puretumu torowhānui and preventing or responding to tūkinō in care."³²


³² Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 264).

Ngā tūtohi popoto o He Purapura Ora, he Māra Tipu: Ki tua i ngā puretumu torowhānui

Summary of recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui

69. The key recommendations made in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui must be urgently implemented. To distinguish from recommendations in this final report, recommendations originally set out in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui are called “Holistic Redress Recommendations.”
70. In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry recommended that the Crown should establish a puretumu torowhānui system to respond to abuse in State care, indirect State care and faith-based care (Holistic Redress Recommendation 1). Those designing it and operating it should give effect to te Tiriti o Waitangi and its principles (Holistic Redress Recommendation 2) and it should be consistent with the commitments Aotearoa New Zealand has under international human rights law (Holistic Redress Recommendation 3).
71. The Inquiry recommended that the Crown should:
- a. establish and invest in a well-resourced independent Māori Collective made up of Māori to lead the design of the puretumu torowhānui scheme (Holistic Redress Recommendation 5)
 - b. establish an independent Purapura Ora Collective that includes people with relevant expertise and lived experience of disability to ensure the puretumu torowhānui system and scheme are designed from the perspective of survivors (Holistic Redress Recommendation 6)
 - c. consult with survivors, experts and other interested people (Holistic Redress Recommendation 7)
 - d. consult faith-based institutions, indirect State care providers, other interested parties and the public (Holistic Redress Recommendation 8), and
 - e. take an all-of-system approach to responding to abuse in care (Holistic Redress Recommendation 9).

72. The Inquiry recommended that the Crown should set up a fair, effective, accessible and independent puretumu torowhānui scheme (Holistic Redress Recommendation 12), underpinned by the principles, values, concepts, te Tiriti o Waitangi obligations and international law commitments that will guide the design of the system (Holistic Redress Recommendation 13) and governed by a body that gives effect to te Tiriti o Waitangi and reflects the diversity of survivors, including disabled survivors, as well as including people with relevant expertise (Holistic Redress Recommendation 14).
73. The puretumu torowhānui scheme should provide a safe, supportive environment for survivors to talk about their abuse, consider survivors' accounts and make decisions on puretumu torowhānui, disseminate information about the scheme, and report and make recommendations on systemic issues relevant to abuse in care (Holistic Redress Recommendation 16).
74. The puretumu torowhānui scheme should operate independently of the institutions where the tūkino, or abuse, harm and trauma took place and should have no interactions with these institutions or the people within them, except where necessary to carry out its functions (Holistic Redress Recommendation 17).
75. The Inquiry recommended that the puretumu torowhānui scheme should be open to all survivors, enable whānau to continue a claim made by a survivor if the survivor dies, or make a claim on a survivor's behalf and prioritise claims from elderly or seriously ill survivors (Holistic Redress Recommendation 18). It should cover physical, sexual, emotional, psychological, racial and cultural abuse in care, along with neglect, which may include medical, spiritual and educational neglect and historical, contemporary and future claims of abuse in care (Holistic Redress Recommendation 19).
76. The puretumu torowhānui scheme should, regardless of whether an institution still exists or has funds, cover abuse in any State agency that assumed responsibility, either directly or indirectly, for the care of an individual when they were abused and any faith-based institution that assumed responsibility for the care of an individual when they were abused (Holistic Redress Recommendation 20).
77. The puretumu torowhānui scheme should extensively and proactively publicise its work (Holistic Redress Recommendation 22). It should be trauma-informed and flexible, minimise any barriers to obtaining redress, be timely, allow survivors to be flexible, be respectful and responsive to the cultures of all survivors, support survivors to make their own informed decisions throughout the claims process, and have enough suitably trained staff so that the number of times survivors must recount the tūkino or abuse, harm and trauma suffered is minimised (Holistic Redress Recommendation 23).

- 
78. The Inquiry recommended that the puretumu torowhānui scheme should have processes in place so that survivors and their whānau who interact with it receive manaakitia kia tipu (Holistic Redress Recommendation 24). The scheme should provide support services that are free, flexible, culturally appropriate and tailored to individual needs, to help survivors, and where appropriate whānau, understand the puretumu torowhānui scheme and make a claim (Holistic Redress Recommendation 25).
79. The puretumu torowhānui scheme should offer a listening service to survivors so they can talk about their experiences of tūkino, or abuse, harm and trauma, in a private and non-judgemental setting (Holistic Redress Recommendation 26) and should, if survivors wish, use information disclosed to the listening service in support of their claim for puretumu torowhānui (Holistic Redress Recommendation 27).
80. The Inquiry also recommended that the Crown offer faith-based institutions and indirect State care providers a window of opportunity to voluntarily join the puretumu torowhānui scheme before considering any necessary measures to ensure their participation, including terminating or not renewing contracts. Faith-based institutions and indirect State care providers should contribute to the scheme and the Crown or the scheme should have a process for collecting any payments awarded against these entities.

Te whakatinana ō ngā tūtohi ō He Purapura Ora, he Māra Tipu Implementation of recommendations in He Purapura Ora, he Māra Tipu


81. The Inquiry prioritised delivering its He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui report and its recommendations for a puretumu torowhānui system and scheme because the Inquiry recognised that survivors had been waiting for a long time for recognition and remedies of the abuse and neglect they suffered. The Inquiry also identified areas for urgent interim action to be taken until the new system and scheme was in place, such as making interim payments for elderly or seriously ill survivors, where appropriate.³³

³³ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 281).

82. In December 2021, the government announced that it intended to introduce a new independent redress scheme, with a collaborative design process to begin in mid-2022 and final decisions to be made around mid-2023.³⁴ The government noted at that time that it was:
- “... moving on this now ... because we want to minimise delays for survivors who are waiting for their claims to be resolved. We are conscious of the age and ill-health of many of the survivors who suffered abuse at a time when care was heavily institutionalised!”*³⁵
83. In the more than two years since the He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui report was delivered, the government has made very little clear progress in implementing its Holistic Redress Recommendations. The government has failed to meet the timeframes the Inquiry set in the report, and it has failed to meet the timeframes it set itself. The steps the government has taken to date are inconsistent in important respects with the Holistic Redress Recommendations.
84. The Inquiry is frustrated and disappointed about these delays. Survivors have died waiting for the puretumu torowhānui system and scheme to be established. As the Inquiry has set out in Part 8, it is not clear whether survivors who have accepted a settlement in the meantime will have access to a new scheme, as the government has not yet made final decisions on the scope of any new scheme. This situation is unacceptable.
85. The Inquiry remains of the view that full implementation is required to provide survivors with access to effective and fair holistic redress – puretumu torowhānui. In 2023 the government set up a design group to provide advice on the implementation of the recommendations. The government should give effect to the design group's work, alongside the Inquiry's recommendations.

³⁴ Media release, New Zealand Government, Survivors of abuse in state and faith-based care will have access to new independent redress process (15 December 2021), <https://www.beehive.govt.nz/release/survivors-abuse-state-and-faith-based-care-will-have-access-new-independent-redress-process>.

³⁵ Media release, New Zealand Government, Survivors of abuse in state and faith-based care will have access to new independent redress process (15 December 2021), <https://www.beehive.govt.nz/release/survivors-abuse-state-and-faith-based-care-will-have-access-new-independent-redress-process>.



He hautū i te pūnaha puretumu torowhānui hei kaupapa matua, ināia tonu nei


Implement the new puretumu torowhānui system and scheme as an immediate priority

86. The problems with existing redress processes are well-documented. The solution, in the Inquiry's view, is establishing a new puretumu torowhānui system and scheme that is open to all survivors of abuse in State and faith-based care, including indirect State care, and is independent of the State, indirect State care providers and faith-based institutions. In line with the Inquiry's Holistic Redress Recommendations 12–14, the puretumu torowhānui system and scheme, once established, should be run by an independent statutory Crown entity with a board, at 'arm's length' from government.
87. This puretumu torowhānui scheme would help ensure there is consistency and equity in the outcomes for survivors. Properly designed, it would be survivor-focused, trauma-informed and accessible to all survivors. This requires ensuring there is survivor representation in the leadership, governance, and operations of the new scheme.
88. Properly resourced, it would become an efficient way of providing puretumu torowhānui, and in particular would develop specific skills and work proficiently with Māori, Pacific Peoples, Deaf and disabled people, and people experiencing mental distress. This requires leadership and staffing of the new scheme to prioritise diversity and lived experience.
89. Properly independent, it would avoid the need for survivors to approach the organisations they did not trust, an interaction many found distressing or traumatising. It would also eliminate the inherent conflict of interest these organisations face in investigating themselves.
90. Such a scheme, being governed by legislation, would have defined rules and transparent outcomes. Further, having a single scheme that covers all State, indirect State care and faith-based institutions would mean that survivors who were abused in several institutions would not need to seek redress from each.

91. The Inquiry is deeply concerned that survivors still do not have access to puretumu torowhānui or redress for the abuse and neglect they suffered. Since the He Purapura Ora, he Māra Tipu report, more survivors have passed without seeing any redress for the tūkino they experienced. In the Inquiry's view the government response to the He Purapura Ora, he Māra Tipu report has not been adequately communicated to survivors and stakeholders. We cannot afford to stall progress any longer. The government needs to move with urgency to implement the recommendations in the Inquiry's interim report on redress, as well as the recommendations in this chapter. This should include swift publication of a roadmap for implementation of the puretumu torowhānui system and scheme to ensure transparency and openness about the path forward.
92. Recommendation 1 responds to clause 32(c) of the Inquiry's Terms of Reference, which relates to other appropriate steps the State and faith-based institutions should take to address the harm caused by abuse in care.
93. Some of the recommendations in this final report expand on, or replace, one or more of the 95 Holistic Redress Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui. This is explained when the relevant recommendations in this report are discussed. Where any of the recommendations in this final report may appear to contradict any of the Holistic Redress Recommendations and this is not clearly explained, the Inquiry intends for the recommendations in this report to take precedence.

Tūtohi | Recommendation 1

As an immediate priority, the government and faith-based institutions should implement the 95 Holistic Redress Recommendations in the Inquiry's interim report on redress, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, together with the recommendations of the design group, subject to any further recommendations made in this report.



He whakapahā me te tohu ki ngā pārure o ngā mahi tūkinō i ngā pūnaha taurima

Apologies and acknowledgements of the harm caused by abuse and neglect in care

94. Recommendations 2–7 respond to clause 32(c) of the Inquiry's Terms of Reference, which relates to other appropriate steps the State and faith-based institutions should take to address the harm caused by abuse in care.

Kia puta he tohu me te reo whakapahā tūmatawhānui i ngā kaitaki matua

Key leaders to make public acknowledgements and apologies

95. The Inquiry considers that public acknowledgements and apologies are appropriate steps to address the harm caused.³⁶ The Inquiry notes the Crown Response and a small group of survivors have begun working on a national apology.
96. In the Inquiry's view, an authentic apology must include acknowledgement of the harm and trauma caused, acceptance of responsibility for the harm and an expression of regret or remorse, must be made by a person at an appropriate level of authority, and must come directly from the institution concerned (Holistic Redress Recommendation 33). It should include a commitment to redressing harm financially and providing supports to ensure the restoration of wellbeing and mana. In addition, as emphasised by the vast majority of survivors who spoke to us, a genuine apology must entail a commitment to do everything possible to stop abuse and neglect in care from happening again.

³⁶ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-Based Institutions, Terms of Reference, clause 30.

97. The Inquiry's interim report *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui* made 95 Holistic Redress Recommendations, including that the Crown and relevant faith-based institutions and indirect State care providers should take accountability by publicly acknowledging and apologising for the tūkino inflicted and suffered at an individual, community and national level (Holistic Redress Recommendations 10 and 11).³⁷ The Inquiry added that apologies from "heads of relevant faith-based institutions and indirect State care providers, would be a symbolic counterweight to the years of denial of any systemic problem in care institutions".³⁸
98. All apologies should be trauma-informed and survivor-centric. To ensure this, the Inquiry considers that its recommendations on public apologies and acknowledgements should be expanded and made more specific. The Inquiry expects all acknowledgements and apologies to include strong engagement with affected communities in accordance with implementation Recommendations 126–127.

Kia puta he reo whakapahā ā-motu i te Pāremata National apology in Parliament

99. The Inquiry acknowledges the work undertaken to date by the Crown Response Design and Advisory Groups on a national apology. This is a new recommendation, which should be considered alongside the Holistic Redress Recommendations in *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui* on public acknowledgements and apologies (Holistic Redress Recommendations 10 and 11).
100. Ahead of the apology, the Inquiry recommends that the Prime Minister, relevant ministers and other government officials privately meet with a group of survivor leaders to acknowledge their tireless efforts in support of this Inquiry and the resulting apology. This will also provide an opportunity for engagement and reflection about the apology and for the Prime Minister and government to hear from survivors about their reflections on the Inquiry process and the important work that is to follow.

³⁷ Royal Commission of Inquiry into Abuse in Care, *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui*, Volume 1 (2021, page 275).

³⁸ Royal Commission of Inquiry into Abuse in Care, *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui*, Volume 1 (2021, page 275).

Tūtohi | Recommendation 2

The Prime Minister should make a national apology for historical abuse and neglect in the care of the State (both direct and indirectly provided) in the House of Representatives. The national apology should:

- a. be developed and agreed with a representative group of survivors
- b. be consistent with the puretumu torowhānui system and scheme and the Holistic Redress Recommendations from the Inquiry's interim report on redress, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui
- c. apologise to all survivors of abuse and neglect in State-based care (both direct and indirect care), and include specific apologies to:
 - i. the many who suffered abuse and neglect who have died and are no longer able to share their experiences and acknowledge them and their whānau, hapū, iwi, communities and support networks
 - ii. Māori survivors, their whānau, hapū, iwi, communities and support networks
 - iii. Pacific survivors, their kainga, communities and support networks
 - iv. Deaf survivors, their whānau, hapū, iwi, communities and support networks
 - v. disabled survivors, their whānau, hapū, iwi, communities and support networks
 - vi. Pākehā / NZ European survivors, their family, communities and support networks
 - vii. survivors who experienced mental distress, their whānau, hapū, iwi, communities and support networks
 - viii. Takatāpui, Rainbow, MVPFAFF+ survivors, their whānau, hapū, iwi, communities and support networks
- d. as outlined in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, make a specific apology to groups, who were harmed, including Māori, where appropriate.

Kia puta te he tohu me te reo whakapahā tūmatawhānui mai te Pope

Public acknowledgement and apology from the Pope

101. An apology from the Pope is a necessary step towards true reconciliation and acknowledgment of the harm suffered by survivors of abuse and neglect in the care of the Catholic Church in Aotearoa New Zealand.
102. Internationally, some inquiries have recommended a papal apology. In March 2010, Pope Benedict XVI wrote a pastoral letter of apology for the abuse that had been carried out by Catholic clergy in Ireland.³⁹ In Australia, a papal apology was not recommended; however, Pope Francis responded to the work of the Inquiry by saying that the findings of Australia's Royal Commission into Institutional Responses to Child Abuse "deserves to be studied in depth".⁴⁰
103. Apologies have been offered by Te Rōpū Tautoko and the St John of God Order for the abuse and neglect suffered by survivors who were cared for by the Hospitaller Order of the Brothers of St John of God at Marylands School and Hebron Trust. Although the apologies have conveyed empathy, these did not address the responsibility for the harm done.
104. In its closing statement at the Marylands School public hearing (February 2022), the Catholic Church accepted that the abuse and neglect that occurred at Marylands and Hebron Trust was "the darkest chapter in the history of the Catholic Church in New Zealand."⁴¹
105. Other orders of the Catholic Church caused immeasurable harm to children and young people who were in their pastoral care, attending Catholic schools, orphanages, hospitals, or placed into Catholic foster care.
106. The Pope must make the public apologies and acknowledge and accept responsibility for the abuse and neglect of survivors in the care of dioceses and religious congregations of the Catholic Church in Aotearoa New Zealand. The Inquiry notes that the Pope is scheduled to make an Apostolic Journey to Indonesia, Papua New Guinea, Timor-Leste, and Singapore in September 2024 and considers it would be appropriate for him to also visit Aotearoa New Zealand to apologise in person to survivors of abuse in care within the Catholic Church.

³⁹ Pastoral letter of the Holy Father Pope Benedict XVI to the Catholics of Ireland (2010).

⁴⁰ Vatican News, Catholic leaders respond to final report of Australian Royal Commission (16 December 2017), <https://www.vaticannews.va/en/vatican-city/news/2017-12/vatican-responds-to-final-report-of-australian-royal-commission.html>.

⁴¹ Transcript of evidence of the closing statement of Sally McKechnie on behalf of the Bishops and Congregational leaders of the Catholic Church in Aotearoa New Zealand at the Inquiry's Marylands School Hearing (Royal Commission of Inquiry into Abuse in Care, 17 February 2022, page 619).

Kia puta he tohu me te reo whakapahā tūmatawhānui mai i ngā kaitiaki matua ā-whakapono

Public acknowledgements and apologies from other faith leaders

107. The most senior international leaders of faith-based institutions must make public apologies and acknowledge and accept responsibility for the abuse and neglect of survivors in the care of those institutions in Aotearoa New Zealand.
108. The Inquiry acknowledges that Gloriavale Christian Community does not have an international leader, so the Inquiry has directed this Recommendation to their most senior leader in Aotearoa New Zealand. Similarly, the Methodist and Presbyterian Churches exist internationally but their governance structure is such that the churches in Aotearoa New Zealand are not officially linked to any international body.
109. This is a new Recommendation, which should be considered alongside the Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui on public acknowledgements and apologies (Holistic Redress Recommendations 10 and 11).

He reo whakapahā mai i ngā kaiarataki kaupapa tūmatawhānui Public acknowledgements and apologies by public sector and professional body leaders

110. The Inquiry found that leaders and decision-makers across the public sector, professional bodies, and both direct and indirect care providers have not taken accountability for decisions, policies and practices their organisations implemented that contributed to children, young people and adults in State care experiencing abuse and neglect. Jonathan Mosen (Pākehā, Blind), a survivor who attended Homai School in Tāmaki Makaurau Auckland in the 1980s, told the Inquiry that:

*"In 2002 I became the Chair of the Board of the Blind Foundation. One of my aspirations in that role was to have the organisation come to terms with a past that has been very empowering for a lot of blind kids but also has serious dark sides...I had people on the Board that said you cannot impose today's values on what happened then."*⁴²
111. Public sector agencies and professional bodies must take concerted action to demonstrate that their apologies are sincere and genuine and recognise that there is significant work to do to if they wish to rebuild any trust with survivors, due to the horrific abuse perpetrated in their care and in many cases the years of denial that followed.
112. This is a new Recommendation, which should be considered alongside the Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui on public acknowledgements and apologies (Holistic Redress Recommendations 10 and 11).

⁴² Witness statement of Jonathan Mosen (18 November 2021, para 5.2).

Tūtohi | Recommendation 3

Public acknowledgments and apologies for historical abuse and neglect in the care of the State (both direct and indirectly provided care) and faith-based institutions should be made to survivors, their whānau and support networks by:

- a. the most senior leaders of all faith-based institutions, and in particular and without limitation:
 - i. the Pope should make a public apology and acknowledgement for the abuse and neglect in the care of the Catholic Church in Aotearoa New Zealand
 - ii. the Archbishop of Canterbury should make a public apology and acknowledgement for the abuse and neglect in the care of the Anglican Church in Aotearoa New Zealand and Polynesia
 - iii. the President Elect should make a public apology and acknowledgement for the abuse and neglect in the care of the Methodist Church of New Zealand
 - iv. the Moderator of the Presbyterian Church of Aotearoa New Zealand should make a public apology and acknowledgement for the abuse and neglect in the care of the Presbyterian Church of Aotearoa New Zealand
 - v. the Chief Executive Officer (or equivalent) of each individual Presbyterian Support Organisation should make public apologies and acknowledgements for abuse and neglect in the care of their respective Presbyterian Support organisation
 - vi. the General of The Salvation Army should make a public apology and acknowledgement for the abuse and neglect in the care of The Salvation Army of New Zealand, Fiji, Tonga and Samoa Territory
 - vii. the Overseeing Shepherd should make a public apology and acknowledgement for the abuse and neglect in the care of Gloriavale Christian Community
 - viii. the Governing Body of Jehovah's Witnesses should make a public apology and acknowledgement for the abuse and neglect in the care of Jehovah's Witnesses in New Zealand
- b. public sector leaders, including the Public Service Commissioner, the Solicitor-General, the Commissioner of NZ Police and the Chief Executives of Oranga Tamariki, the Ministry of Social Development, the Ministry of Health and the Ministry of Education

- c. the leaders of relevant professional bodies, including the Royal Australian and New Zealand College of Psychiatrists, the Medical Council of New Zealand, the Aotearoa New Zealand Association of Social Workers, the New Zealand Nurses Association and the Teaching Council of Aotearoa New Zealand
- d. the leaders of all direct and indirect care providers, including Blind Low Vision NZ and IHC.

Each public apology should be:

- a. developed and agreed with a representative group of survivors
- b. be consistent with the puretumu torowhānui system and scheme and the Holistic Redress Recommendations from the Inquiry's interim report, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui.

St John of God Order ki Pāpua Niu Kini

St John of God Order in Papua New Guinea

113. Some brothers who were at Marylands School were transferred from Aotearoa New Zealand to minister in Australia and Papua New Guinea.⁴³ The Hospitaller Order of the Brothers of St John of God confirmed that of the 25 brothers in the Oceania branch as at September 2021, eight brothers are currently ministering in Papua New Guinea.⁴⁴ Included in this group were:
- a. Brother Roger Moloney, who was convicted of sexually abusing children at Marylands. Brother Roger Moloney faced 30 charges at trial relating to 11 complainants and was convicted of seven charges of doing and inducing indecent acts on five complainants⁴⁵
 - b. Brothers Raymond Garchow and Thaddeus (William Lebler), who were charged with numerous accounts of sexual abuse but due to their ill health never went to trial. Brother Raymond Garchow faced 16 charges in relation to two complainants. A stay of proceedings was issued in relation to the charges. One complainant was in ill health, and the charges in relation to the remaining complainant were dismissed, as the judge found that the complainant was open to suggestibility and his evidence could not be relied upon. In addition, Brother Garchow himself was in poor health.⁴⁶

⁴³ Witness statement of Brother Timothy Graham (28 September 2021, para 37).

⁴⁴ Witness statement of Brother Timothy Graham, WITN0837001, EXT0018177 (28 September 2021, para 40).

⁴⁵ Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Chapter 5, para 77).

⁴⁶ Royal Commission of Inquiry into Abuse in Care, Stolen lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Chapter 5, paras 80–84).

114. Authorities in Aotearoa New Zealand and Australia have investigated the abuse and neglect that occurred in facilities operated by the Order or have investigated and prosecuted abusive brothers themselves, as circumstances allowed. But to the Inquiry's knowledge, no such investigations have occurred in Papua New Guinea and the Inquiry holds grave concerns for children, young people and adults who were placed in the care of the Order and its brothers.
115. This is a new puretumu torowhānui (holistic redress) Recommendation, which should be considered alongside the Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui on public acknowledgements and apologies (Holistic Redress Recommendations 10 and 11).

Tūtohi | Recommendation 4

The Catholic Church's principal representative in Aotearoa New Zealand, the Archbishop of Wellington and eighth ordinary of the see, should write to the Pope and the Congregation for the Institutes of Consecrated Life and Societies of Apostolic Life:

- a. expressing concern that brothers in the Hospitaller Order of the Brothers of St John of God who have been accused or convicted of sexual abuse and neglect in Australia and Aotearoa New Zealand have also been sent to Papua New Guinea, and little is known about the nature and extent of abuse and neglect there or the needs of potential survivors
- b. seeking an Apostolic visitation into the nature and extent of abuse and neglect by the Order in Papua New Guinea and the systemic factors leading to abuse and neglect by the Order in the Oceania province.

The letter should be developed and agreed with a representative group of survivors. The letter and report from the Pope and the Congregation for the Institutes of Consecrated Life and Societies of Apostolic Life should be made public.

**Kia tirohia anō te tika o te whakahua ingoa huarahi,
kaupapa tūmatawhānui rānei, kua tohia mo tētahi
kaitūkino kua kitea i te hē**

**Review the appropriateness of street names,
public amenities named after a proven perpetrator**



Renaming ceremony in Christchurch of Marylands Place and Marylands Reserve to Validation Place and Validation Reserve, June 2024.

116. Many survivors have called for the removal of any honours awarded to, or memorials to, perpetrators of abuse and neglect in care.⁴⁷ In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry recommended that the Crown, indirect State care providers and faith-based institutions “should consider...removing memorials to perpetrators” (Holistic Redress Recommendation 71).⁴⁸

⁴⁷ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 329).

⁴⁸ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 330).

117. The Inquiry also considers there should be a review of the names of any street, public place (e.g. a reserve), public amenity (e.g. town hall, public reserve), or institution (e.g. a church or school) named after a proven perpetrator of abuse and neglect in care, or that otherwise has a clear association with a perpetrator or institution where proven abuse and neglect took place. The same applies to any memorials that otherwise depict, recognise or celebrate a proven perpetrator of abuse and neglect in care. The review should consider whether any such names should be changed and if any other steps should be taken to address harm caused to survivors by the memorialisation of the perpetrators of abuse and neglect against them and the places where it happened.
118. This is a new Recommendation, which should be considered alongside the Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui on public acknowledgements and apologies (Holistic Redress Recommendations 10 and 11).

Tūtohi | Recommendation 5

All entities that provide care, or have provided care, directly or indirectly on behalf of the State and faith-based entities, local authorities and any other relevant entities should:

- a. review the appropriateness of any streets, public amenities, public honours or memorials named after, depicting, recognising or celebrating a proven perpetrator of abuse and neglect in care and / or an institution where proven abuse and neglect took place
- b. consider what steps may be taken to change the names and what else should be done to address the harm caused to survivors by the memorialisation of proven perpetrators and institutions where abuse and neglect took place.

He whakatau kawengā-ā-hara mo tētahi i ngā mahi tūkinō, parahako, patu tāngata rānei

Take steps to determine liability for torture, or cruel, inhuman or degrading treatment or punishment

119. The Inquiry does not have the power to determine whether any person or institution is legally responsible (i.e. liable under civil or criminal law, or in a disciplinary sense) including for acts such as torture. However, it can recommend that further steps be taken to determine liability.
120. During the Inquiry period, there was evidence in many care settings indicating acts of abuse and neglect that may have elements of torture, or cruel, inhuman, or degrading treatment or punishment. The use of electric shocks and paraldehyde as punishment at the Lake Alice Child and Adolescent Unit met the definition of torture as stated by the Solicitor-General. The Inquiry's findings in relation to Te Whakapakari Youth Programme, Marylands School and Hebron Trust, Hokio Beach School and Kohitere Boys' Training Centre, Kimberley Centre, Van Asch and Kelston Deaf Schools give rise to concerns about these matters too.
121. The United Nations Convention against Torture requires Aotearoa New Zealand to carry out a prompt and impartial investigation wherever there are reasonable grounds to believe that torture or cruel, inhuman or degrading treatment or punishment has occurred in places under its jurisdiction.⁴⁹ As referred to in the Inquiry's report *Stolen Lives, Marked Souls*, the United Nations Committee Against Torture has concluded that international legal obligations to investigate alleged torture may apply regardless of whether the alleged acts of torture occurred before or after the State ratified the applicable human rights treaty.⁵⁰
122. Aotearoa New Zealand has recognised the international legal right to be free from torture and cruel, inhuman or degrading treatment or punishment since 1978 when it ratified the International Covenant on Civil and Political Rights. Those subjected to breaches of their right to be free from torture and cruel, inhuman or degrading treatment or punishment have a right to effective redress for those breaches.⁵¹

49 United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, articles 12 and 16.

50 Royal Commission of Inquiry into Abuse in Care, *Stolen Lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (2023, page 303); *In the matter of an application by Rosaleen Dalton for Judicial Review (Northern Ireland)* [2023] UKSC 36.

51 United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, articles 12 and 16.

123. Acts of abuse and neglect of this nature may constitute breaches of Aotearoa New Zealand's criminal and civil law. Investigating these acts (including the systemic factors that contributed to these occurring), holding those responsible to account, and providing redress to survivors is the right thing to do.
124. Allegations of abuse and neglect must be considered from a human rights perspective. Serious abuse and neglect, including but not limited to sexual abuse and neglect, may well amount to torture or cruel, inhuman or degrading treatment or punishment. Allegations of serious abuse and neglect need to be investigated and otherwise addressed based on that understanding.
125. NZ Police must work proactively to ensure that survivors, their whānau and support networks know about investigations into possible torture or cruel, inhuman or degrading treatment or punishment in State or faith-based care. This should include communication and advertising that is culturally appropriate and tailored to survivor needs to take account of barriers that may prevent people from contacting NZ Police.

Tūtohi | Recommendation 6

Where there are reasonable grounds to believe that torture, or cruel, inhuman or degrading treatment or punishment have occurred in care directly or indirectly on behalf of the State or faith-based entities, and the relevant allegations have not been investigated by NZ Police or credible new information has arisen since the allegations were investigated, NZ Police should:

- a. open or re-open independent and transparent criminal investigations into possible criminal offending
- b. proactively and widely advertise the intent to investigate and ongoing investigations
- c. provide appropriate assistance and support to survivors, their whānau and support networks who contact them in relation to the investigations.

Tūtohi | Recommendation 7

Where there are reasonable grounds to believe that torture, or cruel, inhuman or degrading treatment or punishment have occurred in care, the State, faith-based institutions and indirect care providers should:

- a. provide reasonable assistance to any NZ Police investigation
- b. take all reasonable steps to ensure an impartial and independent investigation is carried out by an appropriate investigator
- c. if there is credible evidence of breaches of the law (including breaches of human rights), ensure that appropriate redress is provided to the survivors, consistent with applicable domestic and /or international obligations
- d. use best endeavours to have the liability of every relevant institution in relation to such acts determined. This may include:
 - i. seeking opinions from King's Counsel, which are then shared with relevant survivors, on the nature of the conduct and the liability of relevant institutions, including as applicable under the New Zealand Bill of Rights Act 1990. Consideration may also be given to seeking declaratory judgments from the courts. Survivors should be fully supported to take part in these initiatives, including with funding for legal and other expenses
 - ii. not pleading limitation defences in cases brought by survivors, for as long as limitation defences remain available.

He whakapai ake i ngā kaupapa tiaki purapura ora i pākia i ngā mahi tūkinō i ngā pūnaha taurima Improving redress processes for survivors of abuse and neglect in care

126. The Recommendations set out below build on the Recommendations in the Inquiry's interim report He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, and should be read alongside those Recommendations. The Inquiry notes that if the government were to decide to implement an alternative redress system and scheme, the Recommendations below would apply to it also.
127. Recommendations 8–21 respond to clause 32(b) of the Inquiry's Terms of Reference, which relates to changes to redress processes for individuals who have been abused in State or faith-based care.

He tohe tonu i ngā kaitiaki kaupapa-ā-whakapono me te hunga kaitiaki kei waho i ngā kaupapa kāwanatanga kia uru ki raro i te kaupapa pūnaha puretumu

Ensure faith-based institutions and indirect State care providers join the puretumu torowhānui system and scheme

128. In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry recommended that the new redress scheme should be open to all survivors of abuse and neglect in care, regardless of whether the abuse and neglect occurred in a State, indirect state, or faith-based institution.⁵² The reasons for this included ensuring consistency and fairness, and ensuring that survivors abused or neglected in more than one institution do not have to make multiple redress claims (reducing traumatisation).
129. The Inquiry referred to some institutions taking a long time to join the Australian National Redress Scheme and the steps taken in response to that.⁵³ The Inquiry recommended that faith-based institutions and indirect State care providers be given a reasonable opportunity (for example, four to six months) to join the scheme (Holistic Redress Recommendation 21). The Inquiry also recommended that, following that period and if necessary, the Crown should consider options to encourage or compel participation.⁵⁴
130. The Inquiry remains of the view that it is critical for the puretumu torowhānui system and scheme to be universal to ensure that all institutions where people have suffered abuse and neglect are held accountable for the harm that has occurred. The Inquiry no longer considers it appropriate for participation in the system and scheme to be voluntary.
131. All faith-based institutions and indirect care providers must work proactively to ensure that survivors, their whānau and support networks know about the puretumu torowhānui system and scheme, know how to seek redress, and know about the support options available to them.

⁵² Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 284).

⁵³ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 285).

⁵⁴ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 285).



Tūtohi | Recommendation 8

The government should take all practicable steps, including incentives and, if necessary, compulsion, to ensure that faith-based institutions and indirect care providers immediately join the puretumu torowhānui system and scheme once it is established.

Tūtohi | Recommendation 9

Representatives of faith-based institutions and indirect care providers should meet with relevant State representatives and agree on what steps they can take, whether separately or together, to ensure that survivors, their whānau and support networks are made aware of the puretumu torowhānui system and scheme and the support options available to them.

He whakahoki i te mana o te kaupapa pūnaha puretumu torowhānui mai i te Tīhema 2021 Backdate eligibility for the puretumu torowhānui system and scheme to December 2021

132. The Inquiry is concerned that survivors have died waiting for the urgent interim payments that were recommended in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, and that the government is continuing to take a liability limitation approach before the puretumu torowhānui system and scheme is set up.
133. To account for this, eligibility for the scheme should be retrospective to include the whānau of survivors who were alive at the date on which Inquiry's He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui report was delivered (1 December 2021) but have since died.
134. The Inquiry reiterates the previous Recommendation in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui (Holistic Redress Recommendation 18) that the scheme must be open to all survivors, including those who have been through previous redress processes (including processes / settlements finalised at any time before the puretumu torowhānui system and scheme is established).

Tūtohi | Recommendation 10

The government and faith-based institutions should ensure that once the puretumu torowhānui system and scheme is established:

- a. the effective start date for the system and scheme is 1 December 2021, to enable the whānau of survivors who have died since that date to be eligible for redress claims and the full range of support services available through the system and scheme
- b. it is open to all survivors, including those who have been through all redress processes (including those that have been completed since 1 December 2021), whether or not any signed settlement agreement was full and final.

Me whakatau he utu ki ngā purapura ora i pākia e ngā mahi tūkinō i roto i ngā pūnaha taurima **Compensate survivors of abuse and neglect in care**

135. The Inquiry has recorded its concerns about survivors not having access to an effective remedy for abuse and neglect in care, including compensation.

Me hāngai te ōha utu ki te āhua o te mahi tūkinō **Payments should provide meaningful recognition of abuse and neglect**

136. In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry found that existing payments in State and faith-based claims processes for abuse and neglect in care did not provide meaningful redress and were plainly insufficient.⁵⁵ State payments lacked a principled basis and were comparatively low, ranging from \$6,000 to \$20,000 per survivor, especially compared with overseas schemes.⁵⁶ Faith-based institutions offered slightly higher averages than State payments, around \$30,000, but still fell short of meaningful redress.⁵⁷

⁵⁵ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, pages 305–6).

⁵⁶ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, pages 160 and 305).

⁵⁷ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 306).

137. The Inquiry reiterates its previous Recommendation that financial payments by the puretumu torowhānui system and scheme should provide meaningful recognition of the abuse and neglect suffered, and its impact, but not compensation for harm or loss (Holistic Redress Recommendation 40). Although it did not set out specific payment amounts, the Inquiry stated that achieving this would require substantially higher payments than had been paid by the State and faith-based institutions before He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui was released in December 2021.⁵⁸
138. In Part 8, the Inquiry set out its concerns that the indicative cost scenarios included in the 1 December 2022 Cabinet paper on parameters for a new government redress scheme were based on domestic and international comparators at the lowest end of the range.
139. The Inquiry reiterates its previous Recommendation setting out the matters that should be considered in determining the size of payments, including that they should compare favourably with overseas schemes (Holistic Redress Recommendation 41).⁵⁹ It will also be important to factor in matters such as inflation since the maximum amounts available in overseas schemes were set. Another relevant comparison will be the Dilworth Redress Programme established in 2022 and payments made under that scheme, which is discussed in Part 8.

Ngā whakatau hei panoni ture tikanga ā-iwi

Alternative to civil litigation reform recommendations

140. In Part 8, the Inquiry set out its concerns that the civil litigation reforms the Inquiry recommended in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui (Holistic Redress Recommendations 75 and 78) have not been implemented. These were:
- a. establishing a statutory right to be free from abuse and neglect in care and a related duty to protect that right
 - b. an exception to the accident compensation (ACC) bar so that survivors of abuse and neglect in care can seek compensation in the courts by taking civil cases
 - c. removing statutory limitation periods for abuse and neglect in care cases.⁶⁰

⁵⁸ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, pages 304–306).

⁵⁹ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 308).

⁶⁰ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, pages 330–334 and 338).

141. The Inquiry included alternative Recommendations (Holistic Redress Recommendation 76) if the government decided not to proceed with its civil litigation reform Recommendations. One of these was that the Crown should consider empowering the new puretumu torowhānui system and scheme to award compensation. The other was that the Crown consider reforming the accident compensation (ACC) scheme so that it covers the same abuse and neglect as the new scheme and provides fair compensation and other appropriate remedies for that abuse and neglect.⁶¹ The Inquiry is also not aware of any steps being taken on its alternative Recommendations.
142. Survivors must have access to an effective remedy. In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry explained why it did not consider that either of the alternative Recommendations was the best option. The Inquiry remains of that view. The Inquiry also said that the required reform to the accident compensation (ACC) scheme would be considerable.⁶² That remains the case. However, if the government does not implement its civil litigation reform Recommendations, then the Inquiry recommends accident compensation (ACC) reform.
143. The Recommendation below expands on, and replaces, Holistic Redress Recommendation 76 in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui.

Tūtohi | Recommendation 11

If the government does not progress the Inquiry's recommended civil litigation reforms (Holistic Redress Recommendations 75 and 78 from the Inquiry's interim report, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui):

- a. the government should reform the accident compensation (ACC) scheme to provide tailored compensation for survivors of abuse and neglect in care and other appropriate remedies
- b. survivors should be fairly and meaningfully compensated for all direct and indirect losses that flow from the abuse and neglect they experienced in care and that are covered by the new puretumu torowhānui system and scheme
- c. the application process should be survivor-focused, trauma-informed and delivered in a culturally and linguistically appropriate manner.

⁶¹ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 333).

⁶² Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 333).

Whakatau motuhake mō te Order of the Brothers of St John of God

Order of the Brothers of St John of God

specific actions

He āwhina i ngā purapura ora o St John of God mai te kura o Marylands me ngā kaitiaki o Hebron ki te toro i ngā whakahaere puretumu

Assisting St John of God survivors from Marylands School and Hebron Trust with the redress process

144. The Inquiry found that the Order's redress to survivors through its pastoral process had the potential to transform the lives of those traumatised by their abuse and neglect but that the retraction of the pastoral process in 2004 caused further harm.⁶³
145. The Inquiry's Stolen Lives, Marked Souls report included evidence from Cooper Legal, the law firm acting for many Marylands and Hebron Trust survivors. Cooper Legal set out its experience with the Order's redress process in 2022, stating that the Order's lawyers raised technical legal issues relating to the Limitation Act, accident compensation, and proof issues, especially in relation to Hebron Trust-related claims.⁶⁴
146. Cooper Legal also stated that settlement documentation in 2022 required survivors to warrant that all material and /or relevant acts, facts and circumstances including "all abuse suffered by [the survivor] at any time has been disclosed and forms part of the claim". This approach does not acknowledge that survivors often incrementally disclose the abuse they suffered. In addition, the settlement deeds include confidentiality clauses, which the Order has previously said would not be required.⁶⁵
147. The Inquiry also found that the Bishop of Christchurch failed to ensure the Order responded adequately to reports of abuse and claims for redress from 1993 and appeared to be mostly concerned with minimising any harm to the Catholic Church's reputation.

63 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Chapter 5, para 331(h)).

64 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Chapter 5, para 268).

65 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Chapter 5, para 269).

148. The Inquiry acknowledges the steps taken by Te Rōpū Tautoko to improve its redress processes, including the establishment of the Tautoko Roadmap.⁶⁶ The Inquiry also acknowledges, as part of the Tautoko Roadmap, the ten commitments made to abuse and neglect survivors issued on 10 January 2023 by the Bishops and Congregational Leaders of the Catholic Church in Aotearoa New Zealand.⁶⁷ These developments do not impact the Order's current redress process.
149. The Inquiry's Marylands School (St John of God) Hearing in February 2022 and the release of *Stolen Lives, Marked Souls* in July 2023 will likely be a catalyst for new claims or requests to reopen or reassess claims of those alleging abuse and neglect while in the care of the Order.
150. The Inquiry does not have confidence in the Order's current redress process. Although progress is being made through the development and implementation of the Tautoko Roadmap, without an independent oversight function, interim steps should be taken to respond to new claims or requests to reopen or reassess claims of those alleging abuse and neglect while in the care of the Order.

Tūtohi | Recommendation 12

The Bishop of the Diocese of Christchurch should write to the Provincial of the Oceania Province of the St John of God Brothers seeking:

- a. regular notifications of all new reports of abuse and neglect in Aotearoa New Zealand received by the Order of the Brothers of St John of God (subject to complainants' consent)
- b. regular notifications of all requests to reopen or reassess claims involving Aotearoa New Zealand survivors
- c. the Order's response to all such reports and requests.

All correspondence should be made public, together with an explanation of the steps taken in response as soon as possible.

⁶⁶ Te Rōpū Tautoko, *Tautoko Roadmap: Responding to the Recommendations and themes arising from the Royal Commission (2022)*.

⁶⁷ Media release, Congregational Leaders' Conference Aotearoa New Zealand and New Zealand Catholic Bishops Conference, *Statement of Catholic Church Leaders on looking forward from the work of the Royal Commission on Abuse in Care (10 January 2023)*.

**Ngā mahi tautoko puretumu a ngā kaitiaki o te Hāhi Kātorika,
te Order me te Kāwanatanga, i ngā purapura ora**
**Survivor supports provided by the Catholic Church, the Order and
State representatives about the redress and support available**

151. The Inquiry's Stolen Lives, Marked Souls report noted that there are limitations to the Catholic Church's abuse data and that the data cannot give a complete picture as it only includes reported abuse.⁶⁸ As stated in Stolen Lives, Marked Souls, much abuse goes unreported, because of the significant barriers to survivors reporting abuse while in the care of faith-based institutions, including the Catholic Church. The level of disability of some of the boys at Marylands and the isolation from whānau and peers for children and young people associated with Hebron Trust was likely to be a further barrier to reporting.⁶⁹ At times, when a report was made, it may not have been recorded. The Report treated the abuse data as indicative, likely revealing only the tip of the iceberg of the number of children and young people at Marylands and Hebron Trust who were actually abused or the true amount of abuse and neglect that was inflicted on them.⁷⁰
152. The report also found the Order has never proactively sought out survivors who attended Hebron Trust facilities and offered help or puretumu torowhānui (holistic redress). Neither has the Catholic Church, the Order, any successive bishop or Catholic Church entity.⁷¹
153. Given the known barriers to reporting abuse and neglect and the amount of abuse and neglect that has likely gone unreported, there is a need for guidance and consistent messaging by the Catholic Church, the Order and State representatives about the redress and support available to all survivors of Marylands, Hebron Trust and St Joseph's Orphanage.
154. There are different avenues available to survivors who experienced abuse and neglect while in the care of the Order. Some survivors may be entitled to seek redress from either the Catholic Church, the Order, the Sisters of Nazareth and the Ministry of Social Development or one or more of these institutions and agencies, depending on the circumstances of placement and the types of abuse and neglect suffered.
155. Many of those at Marylands were disabled and a high number of tamariki and rangatahi Māori were in the care of the Hebron Trust. The messaging regarding the redress and support available needs to be culturally appropriate and tailored to survivor needs to take account of barriers that may prevent people from seeking redress.

68 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Chapter 4, para 87).

69 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Chapter 4, para 87).

70 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Chapter 4, para 89).

71 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, Executive Summary, para 51).

Tūtohi | Recommendation 13

The Bishop of Christchurch, the Provincial of the Oceania Province of the St John of God Brothers and relevant State representatives should meet and agree on what steps they can take, whether separately or together, to ensure all survivors of Marylands School, St Joseph's Orphanage and Hebron Trust in Ōtautahi Christchurch and their whānau or support networks are made aware of the new puretumu torowhānui system and scheme and the support options available to them.

He whakamana i te Tiriti o Waitangi ki roto i te kaupapa pūnaha puretumu torowhānui

Give effect to te Tiriti o Waitangi in the puretumu torowhānui system and scheme

156. As discussed in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, for many Māori, restoration of tino rangatiratanga over whānau, hapū, iwi and kāinga is seen as a critical step towards any effective redress for abuse and neglect in care. Since the Inquiry period, incremental changes have been made by the State to recognise te Tiriti o Waitangi and its principles, particularly through incorporating them into law and policy. In the Inquiry's view, a significantly greater focus on the rights guaranteed under te Tiriti o Waitangi and its principles is required.
157. In its interim report He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry recommended that the puretumu torowhānui system and scheme, and those designing and operating it, should give effect to te Tiriti o Waitangi, in particular the right to tino rangatiratanga (Holistic Redress Recommendation 2).



Tūtohi | Recommendation 14

The government should ensure that the puretumu torowhānui system and scheme is designed and operated in a manner that gives effect to te Tiriti o Waitangi and its principles.

He whakatō i ngā mōtikl tangata ki roto i te kaupapa pūnaha puretumu torowhānui

Embed human rights into the puretumu torowhānui system and scheme

158. Aotearoa New Zealand's international human rights obligations are relevant to care, including the status of those receiving care as rights-holders. These rights and obligations extend to survivors of abuse and neglect in State and faith-based care, their whānau and support networks. The following Recommendations should be read together and form a basis to ensure that the design and operation of the puretumu torowhānui system and scheme is underpinned by human rights principles.
159. The human rights of survivors, their whānau and support networks, and the corresponding obligations under the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the United Nations Declaration on the Rights of Indigenous Peoples and the Convention on the Elimination of All Forms of Discrimination against Women should underpin the design and operation of the puretumu torowhānui system and scheme.
160. Part of realising these rights includes addressing any barriers that may impact on people's ability to communicate their needs and participate fully in decisions that affect them. For Deaf and disabled people, and people experiencing mental distress, communication assistance could include augmentative and alternative communication devices, alternate formats, and supported decision-making. Māori, Pacific peoples and others from linguistically or culturally diverse backgrounds may face additional barriers. Communication assistance could include, for example, te reo Māori sign language interpreters, and support people with appropriate cultural and language competency.

Tūtohi | Recommendation 15

The government should ensure that the puretumu torowhānui system and scheme is designed and operated in a manner consistent with:

- a. upholding the rights of Māori as indigenous peoples of Aotearoa New Zealand in accordance with United Nations Declaration on the Rights of Indigenous Peoples
- b. upholding the rights of Māori, Pacific peoples, and people from other linguistically or culturally diverse backgrounds, in accordance with the Convention on the Elimination of All Forms of Racial Discrimination
- c. upholding the rights of girls and women, in accordance with the Convention on the Elimination of All Forms of Discrimination against Women
- d. upholding the rights of Deaf and disabled people, and people who experience mental distress in accordance with the Convention on the Rights of Persons with Disabilities and the Enabling Good Lives principles, including:
 - i. recognition that Deaf and disabled people and people who experience mental distress in care have:
 - > the same rights as others to make decisions that affect them, including adults having decision-making supports as appropriate
 - > the right to access and use supports (including communication assistance) in making and participating in decisions that affect them, communicating their will and preferences, and developing their decision-making ability
 - > access and use advocacy services in making and participating in decisions, and communicating their will and preferences
 - ii. recognition that tāngata Turi, tāngata whaikaha and tāngata whaiora Māori and Pacific survivors who are Deaf, disabled or experience mental distress, survivors from other culturally or linguistically diverse backgrounds, and Takatāpui, Rainbow and MVPFAFF+ survivors may experience barriers to engaging with the system and scheme due to cultural, language and other differences, and that these barriers need to be addressed
- e. upholding the rights of children, and ensuring that all parties involved in the design and operation of the system and scheme:
 - i. act with the best interests of the child as a primary consideration, consistent with the United Nations Convention on the Rights of the Child
 - ii. recognise the rights of iwi, hapū and whānau Māori to retain shared responsibility for the wellbeing of tamariki and rangatahi Māori, consistent with the United Nations Declaration on the Rights of Indigenous Peoples.

He waihangl tohu tika ā-tangata i roto i ngā pūnaha puretumu torowhānui

Establishing human rights indicators for the puretumu torowhānui system and scheme

161. In the Inquiry's view government should establish performance indicators to measure human rights performance for the puretumu torowhānui system and scheme, assist in identifying gaps and other issues, promote human rights consistent decision-making and conduct in care, and increase the visibility of human rights in care.
162. Indicators are used to assess and monitor human rights realisation in care. The Office of the United Nations High Commissioner for Human Rights has issued guidance on human rights indicators.⁷² Indicators could include, for example, the number of complaints reported to care providers during an annual reporting period alleging breach of the right to security of the person and the number of those complaints that were resolved within a year of being made. Further indicators could include the number of those complaints that were upheld and the number of complainants with upheld complaints who received effective redress.⁷³
163. The process of choosing indicators involves considering which human rights are relevant to the puretumu torowhānui system and scheme, how those human rights apply in practice to care settings, and the information required in Aotearoa New Zealand to measure over time whether applicable human rights obligations are being met or not. They should also give effect to te Tiriti o Waitangi principles and provide a measure for how the Crown's te Tiriti o Waitangi obligations are being met. Te Kāhui Tika Tangata Human Rights Commission's indicators for the right to adequate housing in New Zealand, including the process it followed to choose relevant indicators, provide a useful example of how this work could be done.⁷⁴
164. This will require government, other entities involved in care, survivors and other interested groups to analyse and make transparent decisions on how broad human rights standards and te Tiriti o Waitangi principles apply to care in this country, and to revise those decisions periodically. It will also result in the establishment of an Aotearoa New Zealand-specific human rights framework for care, which the Inquiry found was lacking during the Inquiry period. It will also support Aotearoa New Zealand's international reputation as a champion of human rights.
165. Once established, the government should publish these indicators and provide regular public reporting against their progress.

72 United Nations Office of the High Commissioner for Human Rights, *Human Rights Indicators: a Guide to Measurement and Implementation* (Geneva, 2012, page 16).

73 See United Nations Office of the High Commissioner for Human Rights, *Human Rights Indicators: a Guide to Measurement and Implementation* (Geneva, 2012, page 151).

74 Te Kāhui Tika Tangata Human Rights Commission website, *Right to a decent home: Measuring progress*, (accessed 28 February 2024), <https://housing.hrc.co.nz/measuring-progress>.



Tūtohi | Recommendation 16

The government should establish performance indicators for the puretumu torowhānui system and scheme, based on New Zealand's domestic and international obligations including te Tiriti o Waitangi and taking into account guidance from the Office of the United Nations High Commissioner for Human Rights.



Tūtohi | Recommendation 17

The government should regularly assess the puretumu torowhānui system and scheme against the performance indicators and publish annual reports on progress against the indicators.

Tirohia anō mehemea kei te ōrite ngā whakatau mō Lake Alice

Review Lake Alice settlements for parity

166. The Inquiry's interim report Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit referred to the differing amounts received by survivors in the first round and second round of Crown settlement processes. Claimants who settled as part of the first round had a percentage deducted for legal fees while those who settled during the second round did not.⁷⁵ Relevant to this was a 2002 judgment by the District Court, which found that a claimant who settled during the second round was entitled to receive a sum that did not include a deduction for legal fees.⁷⁶
167. The Solicitor-General said to this Inquiry that "although the Government attempted to achieve equity between the two rounds, this was poorly executed".⁷⁷ This has left most claimants who settled during the first round with an ongoing sense of grievance.⁷⁸ The inequity needs to be addressed. The Inquiry thinks that a specific, independent review is required. The review should be empowered to make recommendations on steps to achieve parity between first and second round claimants. This should include matters such as whether any further payments should be made to claimants who settled during the first round and whether interest should be added to any such payments. Claimants who have not yet received redress should receive payments on a par with the second round claimants.
168. All claimants (whether they have previously settled or not) and survivors who have not submitted claims in respect of their treatment at Lake Alice will be eligible for the new puretumu torowhānui system and scheme and the redress available through that scheme (Recommendation 1).

75 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, pages 284–288).

76 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, page 287).

77 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, page 290).

78 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, page 290).

Tūtohi | Recommendation 18

The government should:


- a. appoint an independent person to promptly review all Lake Alice settlements and advise whether any further payments to claimants who have previously settled are necessary to ensure parity in light of the District Court decision in 2002 regarding the deduction of money from second round claimants for legal costs
- b. ensure that any payments to claimants who have not yet settled are, as a minimum, equitable in light of the review.

Whakatūria he arotakenga motuhake mō ngā poka ingoā kore me ngā urupā Establish an independent investigation of unmarked graves and urupā

169. The Inquiry heard from many people who could not find the graves of whānau members who had died in care. The Inquiry also noted that calls had been made for an investigation of potential unmarked graves and urupā at psychiatric hospitals and psychopaedic sites.⁷⁹
170. In He Purapura Ora, he Māra Tipu, the Inquiry recommended the government consider resourcing a national project to carry out this investigation and to connect whānau of those found to be buried in these sites (Holistic Redress Recommendation 72). This included a Recommendation that Government support tāngata whenua who wish to heal or whakawātea the whenua where this occurred.⁸⁰ As set out in Part 8, the Inquiry is not aware of any steps taken to implement this Recommendation. It is therefore necessary to move from recommending that the government consider this action, to directing the government to act urgently.

⁷⁹ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 329).

⁸⁰ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 330).

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171. The Inquiry envisages that the independent body will develop culturally appropriate policies and procedures for the search for unmarked graves and urupā, and the repatriation of remains if requested by whānau. These must be jointly developed by government and Māori in accordance with te Tiriti o Waitangi, as well as co-designed with communities in line with implementation Recommendations 126–127. The United Nations Declaration on the Rights of Indigenous Peoples provides guidance on search, recovery, access, repatriation and commemoration in relation to remains and burial sites.⁸¹ Funding for the independent body must include funding for culturally appropriate repatriation, if requested by whānau.



Tūtohi | Recommendation 19

The government should appoint and fund an independent advisory group to investigate potential unmarked graves and urupā at the sites of former psychiatric and psychopaedic hospitals, social welfare institutions or other relevant sites.

⁸¹ United Nations Declaration on the Rights of Indigenous Peoples, article 12.

Whakatū tahua pūtea i ngā kaupapa e hāngai ana ki ngā parurengi i hua ake i ngā mahi tūkino katoa i pā ki te hunga i roto i ngā pūnaha taurima

Establish a fund for projects connected to community harm arising from the cumulative impact of abuse and neglect in care


172. He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui noted that further recommendations would be made on the extent to which whānau of survivors could independently apply to the puretumu torowhānui system and scheme, and on how the puretumu torowhānui system and scheme could facilitate other forms of collective redress.⁸²
173. The Inquiry considers that collectives could be seen in a number of ways, including, but not limited to:
- a. whānau, hapū and iwi
 - b. other Māori collectives (e.g. urban Māori authorities)
 - c. Pacific collectives (for example communities, that identify with a particular Pacific nation), church communities, and school communities
 - d. disabled and mental health communities
 - e. the Deaf community
 - f. survivors who attended a particular State or faith-based facility
 - g. communities where State or faith-based care facilities were located
 - h. survivors from faith communities (e.g. Gloriavale)
 - i. Takatāpui, Rainbow or MVPFAFF+ communities.

⁸² Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 281).

174. The impacts of being placed into and abused or neglected in State and faith-based care are not only felt by individual survivors, but also collectively and intergenerationally by their whānau and communities. This has also created collective mamae (hurt) and whakamā (shame). It has led to many Māori survivors having limited knowledge of their whakapapa and being disconnected from their culture and identity because of what they experienced. It has led to tamariki, partners, whānau, hapū, iwi and hāpori (communities) being exposed to mental and physical health issues, drug and alcohol abuse, violence, relationship difficulties and family breakdown. The collective harm suffered can be understood as the harm caused to the relevant collective identity or the collective itself by abuse and neglect in care. This could include:
- a. loss of connection to whakapapa or other kinship connections
 - b. loss of language and / or culture
 - c. loss of relationships
 - d. stigmatisation due to association with particular institution(s)
 - e. impact on whenua with which the collective has a relationship
 - f. collective whakamā, shame, humiliation, embarrassment or hurt caused by or arising from the abuse of members of the collective, or the impact on the mana of that collective
 - g. intergenerational trauma
 - h. impact on the collective's ability to care for itself, where abuse of its members has been large scale and has therefore affected their ability to care for themselves and their whānau
 - i. loss of collective cohesiveness
 - j. loss of leaders or loss of potential for the collective.

He kāpuinga Māori Māori collectives

175. The Inquiry considered how any collective Holistic Redress Recommendations would apply to Māori collectives, and in particular how any collective redress initiatives would be distinct from the historical Treaty settlement framework.
176. Since the 1990s, over 80 settlements have been completed with iwi and collectives, covering most of Aotearoa New Zealand. Claims are settled for specified ancestral lines and are final. This means that in exchange for the settlement redress, the settlement legislation removes the ability of the courts, the Waitangi Tribunal or any other judicial body or tribunal from reopening and reconsidering the historical claims.

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177. The Treaty settlement framework is complex both in how claimant groups are defined and how redress is constructed. The Inquiry does not want any recommendations to cut across this landscape, including the full and final nature of settlements and the fairness between settlements. The Inquiry thinks that recommendations to offer collective redress based on whakapapa would be difficult to implement in practice and would disadvantage Māori who do not have knowledge of their whakapapa. It would also open the question of who would administer any collective redress, whether this would necessitate a change to current governance entities, rūnanga and other Māori governance arrangements, and what form the redress would take. These administrative questions arise for other potential collectives as well.
178. Instead, the Inquiry considers that the most practical way to provide collective redress to all groups is through a model like those used in Canada and Australia to provide affected communities with funding to use on projects related to healing the trauma of abuse in care. Both the Australian and Canadian funds were established with government funding following Royal Commissions of Inquiry in each country.
179. The Canadian Aboriginal Healing Foundation was established in 1998 by the Government of Canada. It aimed to support healing for Aboriginal communities and individuals affected by the legacy of residential schools. Between 1998 and 2014, when its mandate expired, the Foundation supported initiatives focusing on mental health, cultural revitalisation, and reconciliation and emphasised the importance of community-driven projects tailored to local needs.
180. The Australian Healing Foundation, also known as The Healing Foundation, is a national organisation established to address the ongoing trauma experienced by Aboriginal and Torres Strait Islander peoples as a result of colonisation and systemic injustices. The Foundation funds and supports various healing programmes, including trauma-informed care, cultural revitalisation projects and community-driven initiatives. It has noted that “healing is a holistic process, which addresses mental, physical, emotional and spiritual needs and involves connections to culture, family and land. Healing works best when solutions are culturally strong, developed and driven at the local level”.⁸³

⁸³ <https://healingfoundation.org.au/community-healing/>.

181. The Healing Foundations in both countries are independent from the State. They both grant funding based on defined criteria and are governed by Boards who are representative of the communities the funding is intended for. Funding amounts are robust relative to the size of the eligible populations. The Canadian fund provided \$350 million in 1998 for a First Nations population of 799,910. Australia has committed \$26.4 million per year for four years from 2019 for a combined population of 983,700.
182. The Inquiry considers a similar model is appropriate for providing collective redress to communities.

Tūtohi | Recommendation 20

The government and faith-based institutions should jointly establish a fund to provide contestable funding for projects that promote effective community healing from the collective impacts of abuse and neglect in care, similar to those established in Canada and Australia. The entity holding and distributing the funding should be independent from State and faith-based entities.

He utua ā whānau ki ngā whānau purapura ora Whānau payments for whānau of survivors of abuse and neglect in care

183. The Inquiry received accounts from many who suffered harm as a result of their whānau member's experiences of abuse and / or neglect in care. The Inquiry recommends addressing the impacts on those living with survivors who are suffering the effects of tūkino from abuse and neglect in care. In determining which whānau members should be eligible, the Inquiry recognises that whānau are extensive and include diverse kinship ties.
184. The Inquiry reviewed international precedents where whānau members could make independent claims for redress. For example, Tasmania's Stolen Generation programme, starting in 2006, paid biological children of survivors a flat rate of AUD\$5,000, up to AUD\$20,000 per family. In some cases, whānau inclusion requires the survivor to forfeit their claim. In Canada, the Indian Residential Schools Settlement Agreement's Personal Credits programme allowed survivors to transfer credits worth CAD\$3,000 to children and grandchildren. The Scottish Redress Scheme permits survivors to assign their claim to a beneficiary.

185. The Inquiry evaluated the Tasmanian model, which sets a maximum value per whānau, necessitating the distribution of funds among members, potentially causing issues. Additionally, a maximum cap could be unfair to differently sized whānau. Since each whānau member's claim is based on the harm they experienced, their claims should be independent. Limiting compensation to biological children does not reflect the diverse make-up of many whānau in Aotearoa New Zealand.
186. Affected whānau members should be able to make claims without relying on the direct survivor's involvement, subject to privacy considerations. Eligible whānau could include the survivor's children or other members cared for by the survivor. Those who are both impacted whānau and direct survivors would be eligible for either a whānau harm payment or direct survivor redress, reflecting the different bases for each payment. Standard claims acknowledge tūkino experienced in care, while whānau harm payments recognise intergenerational impacts. However, an affected whānau member would only receive one harm payment regardless of how many survivors cared for them.
187. The Inquiry also considered the potential for using capital investment earnings to fund scholarships or other benefits for whānau, which could be explored in the programme's future development.

Tūtohi | Recommendation 21

Recognising the intergenerational damage caused by abuse in care, the Inquiry recommends that a whānau harm payment be provided for members of whānau who have been cared for by survivors and thereby potentially impacted by their tūkino, to help prevent further intergenerational harm. The Inquiry recommends this is set at \$10,000.

Ngā panonitanga o te wāhanga ā-ture Justice sector reforms

188. The Inquiry heard from some survivors (who attempted to seek justice, accountability and /or redress for the abuse and /or neglect they suffered) that their interactions with the justice system resulted in additional harm or trauma. These Recommendations are directed to making the justice system in Aotearoa New Zealand safer and more accessible for survivors of abuse and /or neglect in care, their whānau and support networks.
189. The following Recommendations 22–38 respond to clause 32(c) of the Inquiry’s Terms of Reference, which relate to recommendations for other appropriate steps the State and faith-based institutions should take to address the harm caused by abuse in care.

Panonihia ngā tikanga whakawhiu-ā-ture Amend prosecution guidelines

190. The Inquiry reported in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui that survivors consider that holding perpetrators and organisations to account was a crucial part of moving on with their lives.⁸⁴ The conviction of a survivor’s perpetrator provides a measure of accountability and justice for the survivor and can also be an important step of the road to healing. The Inquiry found however that very few perpetrators of abuse and neglect of people in care have ever stood before a court to answer for all their actions.⁸⁵ During the Inquiry period, survivors who complained to NZ Police and were witnesses in criminal proceedings often had negative and harmful experiences.

⁸⁴ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 242).

⁸⁵ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 242).

191. In the Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit report, the Inquiry found that there were grave investigation failures in three investigations conducted by NZ Police between 1977 and 2021.⁸⁶ These included that NZ Police failed to contact and interview complainants, failed to investigate serious sexual offending, accepted at face value the perpetrator's account,⁸⁷ and did not obtain an expert psychiatric opinion from someone unconnected to Lake Alice.⁸⁸ The Inquiry has heard many other accounts from survivors of abuse in care that they were simply not believed by NZ Police if they did complain.
192. The Solicitor-General's suite of prosecution guidelines apply to all public prosecutions, including those conducted by Crown Prosecutors and NZ Police.⁸⁹ The Inquiry considers that the guidelines require review and amendment to ensure that there is better oversight and consistency of investigations, charging decisions, and how charges are prosecuted.

Me whai wāhi ngā ture o te ao whānui hei taki wherawhera me te whakatau whiu

International instruments must be considered in investigations and in prosecution decisions

193. In December 2019, the United Nations Committee Against Torture found that Aotearoa New Zealand was in breach of the Convention against Torture for failing to ensure a prompt and impartial investigation into Lake Alice.⁹⁰ The Inquiry concluded that the use of electric shocks and paraldehyde to punish children and young people at Lake Alice met the definition of torture. The Inquiry also found that the Crown failed to consider whether the abuse and neglect at Lake Alice could amount to torture.⁹¹
194. As the Inquiry reported in *Stolen Lives, Marked Souls*,⁹² there are other international obligations, including the need to ensure that no child is subjected to cruel, inhuman or degrading treatment or punishment.⁹³

86 Royal Commission of Inquiry into Abuse in Care, *Beautiful children: Inquiry into the Lake Alice child and adolescent unit* (2022, pages 267–270, pages 304–315).

87 Royal Commission of Inquiry into Abuse in Care, *Beautiful children: Inquiry into the Lake Alice child and adolescent unit* (2022, para 768).

88 Royal Commission of Inquiry into Abuse in Care, *Beautiful children: Inquiry into the Lake Alice child and adolescent unit* (2022, page 271).

89 Crown Law, *Solicitor-General's Prosecution Guidelines* as at 1 July 2013, clause 2.1.

90 Royal Commission of Inquiry into Abuse in Care, *Beautiful children: Inquiry into the Lake Alice child and adolescent unit* (2022, pages 316 and 333).

91 Royal Commission of Inquiry into Abuse in Care, *Beautiful children: Inquiry into the Lake Alice child and adolescent unit* (2022, page 327).

92 Royal Commission of Inquiry into Abuse in Care, *Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (2023, page 327).

93 International Covenant on Civil and Political Rights, article 7; United Nation Convention on the Rights of the Child, article 37.

195. All international obligations adopted by Aotearoa New Zealand should be considered during criminal investigations, and when decisions are made about whether to charge a person, and other prosecution decisions. These obligations should be considered at every step of the prosecution process, including when considering the victims of crime. All prosecution guidelines issued by the Solicitor-General should be amended to ensure they are consistent with Aotearoa New Zealand's human rights obligations including the United Nations Convention on the Rights of Persons with Disabilities, the United Nations Convention on the Rights of the Child, and the United Nations Convention on the Rights of Indigenous Peoples.

Whakaara i ētahi atu raupapa hei kōwhiri i ngā kōrero taunaki ā ngā purapura ora

Include further criteria for assessing credibility of survivor evidence

196. The prosecution guidelines require NZ Police and prosecutors to consider the credibility of a survivor's evidence under the Evidential Test when initiating or continuing a prosecution. "Credible" is defined as capable of belief.⁹⁴
197. In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry found that survivors' credibility in the eyes of NZ Police was critical to decision making.⁹⁵ Allegations made by survivors who had criminal convictions or had been in psychiatric institutions were often treated with scepticism or disbelief. Many survivors told the Inquiry that NZ Police did not investigate their complaints because they were uninterested, were under resourced, considered it a hassle, or did not believe the complainant. In some cases, this happened despite admissions of guilt from the abusers.⁹⁶ NZ Police investigating allegations at Lake Alice adopted a biased attitude against those who had been admitted to the unit, treating them as unreliable and troublesome. Conversely, NZ Police assumed staff who were accused of serious crimes were well-meaning and dedicated professionals.⁹⁷

⁹⁴ Crown Law, Solicitor-General's Prosecution Guidelines as at 1 July 2013, clause 5.4.

⁹⁵ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 242).

⁹⁶ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 242).

⁹⁷ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 339).

198. When considering the credibility (and creditability) of a complainant's evidence, NZ Police and prosecutors must recognise the potential for bias. They should ensure they obtain sufficient information (including expert advice where appropriate) on what accommodations and support may be needed to assist complainants to give evidence capable of being believed in court. NZ Police and prosecutors should assume that Deaf and disabled people, and people experiencing mental distress, can and will give credible evidence with appropriate accommodations and support, such as augmentative and alternative communication devices, alternative formats, and supported decision-making. NZ Police must disabuse themselves of the scepticism with which they have previously viewed complainants who have been in State or faith-based care.

Me whai whakaaro i te hāpori tūmatanui i roto i ngā whiu ā-ture, tērā te hapa i ūhia ki runga i te tangata i raro i te maru kaitiaki o ngā pūnaha taurima ā-Kawanatanga, ā-whakapono rānei

Include, as a public interest consideration for prosecution, that the offence was committed against a person while in the care of the State or a faith-based institution

199. In *Stolen Lives, Marked Souls*, the Inquiry noted that all children and young people at Marylands and the Hebron Trust were vulnerable, and disabled children were particularly vulnerable.⁹⁸ This finding holds true for all children, young people and adults in State and faith-based care. NZ Police and prosecutors must specifically consider the public interest in such prosecutions for abuse and neglect in care.


Me kaha ake te tohe taki uiunga e hua ai ngā whakawhiu a te ture
Strengthen the requirements for consultation on prosecution decisions

200. The Inquiry heard from many survivors that prosecution decisions were often made without adequate (or any) consultation with them. In *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui*, the Inquiry found that some disabled survivors require communication assistance to share their experiences, and that a lack of accommodations and supports creates a barrier to making a complaint.⁹⁹ Deaf survivors were prevented from communicating because sign language interpreters were rarely available.¹⁰⁰

⁹⁸ Royal Commission of Inquiry into Abuse in Care, *Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (2023, page 301).

⁹⁹ Royal Commission of Inquiry into Abuse in Care, *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui*, Volume 1 (2021, page 242).

¹⁰⁰ Royal Commission of Inquiry into Abuse in Care, *He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui*, Volume 1 (2021, page 242).

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201. The Solicitor-General's guidelines should include requirements to ensure that communication assistance and any other necessary accommodations are available to complainants who require it to enable them to participate in consultation on prosecution decisions, not just when giving evidence in court.¹⁰¹ Expert advice should be obtained where necessary. That a complainant is disabled or experiencing mental distress should not of itself be considered a practical reason not to consult.
202. A public interest consideration against prosecution arises where prosecution is likely to have a detrimental effect on the physical or mental health of a victim or witness. Before such a decision is made, prosecutors must ensure that the victim or witness has been adequately consulted and their view on the effects on them is considered. Similarly, victims of physical or sexual violence or neglect must be informed of any plea discussions so that they can make their views known to the prosecutor.

Whakatū kaupapa hei mātai i ngā mahi hāmene

Establish a process for reviewing charging decisions

203. As discussed above, for some survivors the investigation and prosecution of their abuser is an important part of redress. But once a complaint is made to NZ Police the survivor has no control over the process – it is up to NZ Police to investigate the allegations properly, and to make initial decisions whether to charge the offender.
204. In Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit report, the Inquiry found that more than 40 years passed before NZ Police finally acted on the steady stream of complaints made to them about sexual offending and serious assaults at Lake Alice and filed charges.¹⁰² Only then did they lay charges against one alleged perpetrator. The Inquiry found that the fact that only a single individual was charged was a direct result of the delay and the inadequacy of earlier investigations. This was a lost opportunity to obtain a key element of redress – accountability of perpetrators.¹⁰³
205. In Stolen Lives, Marked Souls, the Inquiry found that NZ Police made poor prosecution decisions in their first investigation into sexual offending allegations against one Brother at Marylands, which meant some crimes were never prosecuted even though the Brother admitted the offending when interviewed.¹⁰⁴

101 United Nations Convention on the Rights of Persons with Disabilities, article 13.

102 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, page 331).

103 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, page 317).

104 Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, pages 230 and 311).

206. Charging decisions are made by NZ Police and Crown prosecutors. The current guidelines for prosecuting sexual violence include a process where complainants of sexual violation offences can seek a review of decisions made by NZ Police or Crown prosecutors not to prosecute or to end a prosecution.¹⁰⁵ However, the process enables NZ Police or the Crown Solicitor to determine how a review should be conducted, and it is not available to complainants of other types of sexual offending, or for violence and neglect offending. The only guidance given by the Solicitor-General is that reviews should be conducted by persons of sufficient seniority who were not involved in the original decision. Complainants must be advised of the review process to be adopted and the likely timeframe to complete it. The Inquiry heard from Crown Law that the number of reviews sought for all types of offending since the process was formalised in 2018 is extremely small, less than five reviews per year across the entire country.¹⁰⁶ That indicates that there is little knowledge of the ability to seek a review.
207. The Inquiry considers there should be a clearer and more structured process for reviewing decisions not to prosecute, designed to ensure consistency and accountability through better oversight of investigations and decision making. It should be accessible to complainants and should apply to all sexual offending and crimes against the person in Parts 7 and 8 of the Crimes Act 1961.

105 Solicitor-General's Guidelines for Prosecuting Sexual Violence as at 3 July 2023, clause 4.

106 Crown Law, Response to Notice to Produce No 419 (6 May 2022, page 8).

Tūtohi | Recommendation 22

The Solicitor-General should amend the suite of prosecution guidelines to:

- a. include a requirement that those making decisions about whether to prosecute, and which charges to file, act consistently with Aotearoa New Zealand's international human rights obligations and other relevant international law obligations (including in particular the United Nations Convention on the Rights of Persons with Disabilities, the United Nations Convention on the Rights of the Child, and the United Nations Declaration on the Rights of Indigenous Peoples)
- b. include, in relation to the evidential test for prosecution, a requirement that those making assessments on the credibility and quality of a complainant's evidence recognise the potential for their own bias, obtain relevant expert advice where necessary, and provide appropriate accommodations where necessary
- c. include, as a public interest consideration for prosecution, that the offence was committed against a person in the care of the State or a faith-based institution
- d. strengthen obligations to engage appropriately (that is, more than consult) with complainants (including the use of communication assistance) on prosecution decisions, including when considering whether to prosecute because of the likely detrimental effect on a witness's physical or mental health
- e. establish a review process for complainants who allege offences falling under Parts 7 or 8 of the Crimes Act 1961 where a decision has been made not to prosecute by NZ Police or a Crown Solicitor, which:
 - i. is designed to ensure fairness and consistency in the approach to charging decisions nationwide
 - ii. requires an evaluative review of the evidence and the decision not to prosecute
 - iii. establishes national panels of suitably trained and experienced prosecutors to conduct reviews of decisions not to prosecute made by NZ Police and Crown Solicitors
 - iv. includes a requirement for the panel reviewing NZ Police decisions not to prosecute to seek legal advice from a Crown Solicitor where the decision is finely balanced and /or complex, or is an offence listed in the schedule to the Crown Prosecution Regulations 2013
 - v. has the power to refer a decision not to prosecute back to the decision maker for further consideration and /or investigation
 - vi. ensures complainants are consulted in person with necessary accommodations.

He tikanga ārahi hāmene me pehea te aro ki te hunga whakatakoto nawe, kaiwhakaatu, kaikawe whakapae, e hauātia ana, pehia e te mate hinengaro

Guidelines for prosecutors on how to approach cases involving complainants, witnesses and defendants who are disabled or experience mental distress

208. The Inquiry has found that the criminal justice system has not ensured access to justice for disabled people and people experiencing mental distress.¹⁰⁷ The Inquiry recommends the Solicitor-General should issue new guidelines on how to approach cases involving Deaf and disabled people and /or people that experience mental distress are afforded access to justice. Further education is required to ensure that they are afforded access to justice.

Tūtohi | Recommendation 23

The Solicitor-General should issue specific guidelines to prosecutors on how to approach cases involving complainants, witnesses and defendants who are Deaf, disabled and /or experience mental distress to ensure access to justice, and in doing so should involve those with lived experience throughout the development process to ensure concerns and aspirations are consistently understood and considered.

Tūtohi | Recommendation 24

The government should invest in training for prosecutors on these guidelines.

¹⁰⁷ Royal Commission of Inquiry into Abuse in Care, Stolen lives, marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, page 311).

Tautokohia ngā tikanga-ā-ture e tohu ana ki ngā take whakamau hara

Support judicial initiatives that address the causes of offending

209. The Care to Custody: Incarceration Rates report commissioned by the Inquiry showed that one out of every three children and young people placed in residential care by the State went on to serve a prison sentence later in life. For tamariki and rangatahi Māori, this statistic increased to 42 percent.¹⁰⁸ In comparison, for the same time period, no more than 8 percent of the general population of similar demographics went to prison.
210. As the Inquiry has reported, the impacts of abuse and neglect in State and faith-based care mean it is much more likely that survivors will commit offences themselves and interact with the criminal justice system. The Inquiry supports the approaches taken in specialist and solution-focused courts that are designed to assist defendants (many of whom are survivors) to address the causes and break the cycle of their offending.
211. Specialist and solution-focused courts are not, however, available in all parts of Aotearoa New Zealand, so not all defendants can access them.
212. The District Court is implementing its Te Ao Mārama – Enhancing Justice for All programme, which “takes best practice approaches from specialist and solution-focused courts...and applies them in the mainstream District Court”.¹⁰⁹ These best practice approaches include:
- “Adopting ‘solution-focused’ judging – i.e. asking ‘what has happened to this person to bring them to this point in their life’ and then addressing those causes.”***¹¹⁰
213. The Ministry of Justice, which is supporting the District Court to implement Te Ao Mārama – Enhancing Justice for All by funding its delivery, acknowledged that additional investment would be needed to fully implement the programme across Aotearoa New Zealand.¹¹¹

108 Synergia, Care to Custody: Incarceration rates (Royal Commission of Inquiry into Abuse in Care, August 2022, pages 1–9).

109 District Court of New Zealand, Annual Report 2023 (2024, page 12), <https://www.districtcourts.govt.nz/assets/Uploads/Publications/2024/District-Court-Annual-Report-2023.pdf>.

110 District Court of New Zealand, Annual Report 2023 (2024, page 13), <https://www.districtcourts.govt.nz/assets/Uploads/Publications/2024/District-Court-Annual-Report-2023.pdf>.

111 Ministry of Justice, Response to Notice to Produce 443 (27 June 2022, para 2.40).

Tūtohi | Recommendation 25


The government should support and invest in judicial-led initiatives, such as Te Ao Mārama – Enhancing Justice for All, that recognise and address the harm caused by abuse and /or neglect in care.

Ngā panoni ture taihara Criminal justice legislative changes

214. Several laws relating to criminal justice proceedings need to be amended to prevent further or continuing harm and stigmatisation of survivors of abuse and neglect. The Inquiry envisages that the design of these law changes (before draft legislation is introduced into Parliament) will be jointly developed by government and Māori in accordance with te Tiriti o Waitangi, as well as co-designed with communities in line with implementation Recommendations 126–127.
215. The Inquiry notes that some of the language used in existing legislation is often outdated and does not reflect a strengths-based approach to understanding the experiences of survivors of abuse, particularly the terms ‘victim’ and ‘vulnerable’. However, in order to strengthen existing legislative protections the Inquiry has opted to use the language already contained in legislation.

Whakarerekē i ngā ture taihara Amending criminal justice legislation

216. Currently there is a lack of clarity and protection in legislation for disabled people who experience abuse, ill-treatment and neglect in care. The Crimes Act 1961 does not include disability as a factor that makes someone a ‘vulnerable adult’ and this is a gap in protections for disabled people. Similarly, the Inquiry considers that amendments should be made to the Sentencing Act 2002 to ensure that vulnerabilities of young victims of abuse and neglect are specifically recognised as aggravating features where applicable.
217. This Inquiry has heard and recognises concerns from the disability community about describing disabled people as ‘vulnerable.’ This framing is deficit-based and implies that abuse occurs because of inherent traits within disabled people rather than because of abusers’ actions and systemic failures to safeguard rights. As discussed above, however, in its recommendations the Inquiry seeks to strengthen protections for disabled people in the current legislative framework so it has adopted those terms.

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218. In the Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit report, the Inquiry found that many survivors of abuse in psychiatric care ended up in the youth and criminal justice systems. Survivors committed crimes, usually theft, soon after their release from Lake Alice, to survive. The Inquiry also heard from many survivors of abuse in social welfare residences that they committed dishonesty offences to survive when running away from the place of abuse, or committed assaults on caregivers who were abusing them.
219. The Inquiry considers that convictions for such offences, where they can be established as being committed while in and / or subsequent to being in State or faith-based care and as a reasonable response to being abused in care, should not be taken into account as an aggravating factor by judges sentencing survivors in the Youth, District and High Courts for later offending. The Criminal Records (Clean Slate) Act 2004 should also apply to such convictions.



Tūtohi | Recommendation 26

The government should amend the Crimes Act 1961 to specifically include disability within the definition of a vulnerable adult.



Tūtohi | Recommendation 27

The government should amend the Sentencing Act 2002 to:

- a. include, as an aggravating feature in section 9(1), the fact that a victim was particularly vulnerable as a result of being in State or faith-based care or deprived of liberty
- b. expand the requirement for the court to consider the aggravating factors in section 9A(2) in cases of abuse and / or neglect to include children and young persons under the age of 18 years
- c. include a requirement that when considering an offender's previous convictions under section 9(1)(j) the court should ensure those with convictions for offences committed in response to abuse and / or neglect in care are not unduly penalised.

Tūtohi | Recommendation 28

The government should amend section 284 of the Oranga Tamariki Act 1989 to ensure that offending by young people abused and /or neglected in care in response to that abuse and /or neglect is not given undue weight as an aggravating factor at sentencing for later unrelated offending.

Tūtohi | Recommendation 29

The government should review the Criminal Records (Clean Slate) Act 2004 to ensure that offending committed by people abused and /or neglected in care in response to that abuse and /or neglect does not unfairly exclude them from eligibility under the Act.

Te whakarerekē i te Ture tika Hunga Pārure 2002 e āhei ai te tautoko i te hunga i pāruretia

Amending the Victims Rights Act 2002 to enable the provision of support to victims

220. In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry reported that the lack of publicly available information about all aspects of redress processes leaves many survivors confused about whether they can make a claim and how to do it.¹¹² The Inquiry also reported that survivors, especially disabled survivors or those living in provincial or rural areas, struggled to find lawyers with the necessary knowledge and experience.¹¹³
221. Victims of abuse and neglect in care must be advised of the ability to seek redress in the civil courts and through the redress system, and of their right to apply for civil legal aid for proceedings. Amendment of section 11 of the Victims Rights Act 2002 will ensure that information is provided, and an appropriate list of lawyers with the necessary experience in abuse and neglect in care cases is maintained.

¹¹² Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 211).

¹¹³ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 234).



Tūtohi | Recommendation 30

The government should amend section 11 of the Victims Rights Act 2002 to ensure that victims of abuse and neglect in State or faith-based care must be advised of the ability to seek redress in the civil courts and through the puretumu torowhānui system and scheme, and their right to apply for legal aid for civil proceedings.

Tūtohi | Recommendation 31

The Ministry of Justice should establish a list of specialist lawyers available to provide legal advice to victims about seeking puretumu torowhānui (holistic redress).

Te whakarerekē i te Ture Taunaki Kōrero e āhei ai te tautoko i ngā mahi whakawhiti kōrero

Amending the Evidence Act to enable communication assistance to be provided

222. Section 80(3) of the Evidence Act 2006 currently provides that communication assistance is available to enable a witness in criminal proceedings to give evidence. Communication assistance should also be available where necessary to enable witnesses to understand the court proceeding (as is provided for defendants under section 80(1)).
223. Communication assistance and appropriate accommodations, such as augmentative and alternative communication devices, alternative formats, and supported decision-making, can remove barriers to giving evidence and understanding court proceedings, particularly for Deaf and disabled people, and people experiencing mental distress. Communication assistance should be available as a matter of right, to enable Deaf and disabled people, and people experiencing mental distress, to participate effectively in criminal proceedings.

Tūtohi | Recommendation 32

The government should amend section 80(3) of the Evidence Act 2006 to ensure witnesses in criminal proceedings have an entitlement to apply for communication assistance to enable them to both understand the proceedings and give evidence.

Te ako me te whakamatau tau i te hunga e mahi ana i roto i te pūnaha-ā-ture

Education and training for people involved in the justice system

224. The failings that the Inquiry reported in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui¹¹⁴ and Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit¹¹⁵ indicate clearly that education of those working in the criminal justice system is required to disabuse persistent negative attitudes towards children and young people in care when they make complaints. Further, the Care to Custody: Incarceration Rates Research Report, while considering impacts historically, underscores the need for education as to the impact of placing a young person in a State care setting.¹¹⁶

Tūtohi | Recommendation 33


The Ministry of Justice, Te Kura Kaiwhakawā Institute of Judicial Studies, NZ Police, the Crown Law Office, the New Zealand Law Society and other relevant legal professional bodies should ensure that investigators, prosecutors, lawyers, and judges receive education and training from relevant subject matter experts on:

- a. the Inquiry's findings, including on the nature and extent of abuse and neglect in care, the pathway from care to custody, and the particular impacts on survivors of abuse and neglect experienced in care
- b. trauma-informed investigative and prosecution processes
- c. all forms of discrimination
- d. engaging with neurodivergent people
- e. human rights concepts, including the obligations under the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Elimination of All Forms of Racial Discrimination, and the United Nations Declaration on the Rights of Indigenous Peoples.

114 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 242).

115 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, page 317).

116 Synergia, Care to Custody: Incarceration rates (Royal Commission of Inquiry into Abuse in Care, August 2022).



Panonihiā ngā kaupapa arotake, ka whakatū ai he tira wherawhera motuhake

Amend investigation guidelines and establish a specialist investigation unit

Kia pau te kaha o te Roopu Pirihimana o Aotearoa ki te whakamau i ngā here tika tangata o te ao

NZ Police to fully implement Aotearoa New Zealand's international human rights obligations

225. As discussed above, all international obligations adopted by Aotearoa New Zealand should be considered by NZ Police during criminal investigations. Instructions and guidelines should be reviewed and amended to ensure those obligations are embedded in training material and reflected in all aspects of investigations and prosecutions. This is to ensure that NZ Police are fully aware of and give effect to the human rights of survivors of abuse and neglect who are participants in criminal cases.

Tūtohi | Recommendation 34

NZ Police should review the Police Manual and other relevant material to ensure instructions and guidelines reflect and refer to Aotearoa New Zealand's international human rights obligations and other relevant international law obligations (including the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Elimination of All Forms of Racial Discrimination, and the United Nations Declaration on the Rights of Indigenous Peoples).

He tira motuhake hei wherawhera hei whiu i ngā mahi tūkino i roto i ngā pūnaha taurima

Specialist unit to investigate and prosecute abuse and neglect in care

226. The Inquiry considers that the investigation and prosecution of allegations of abuse and neglect of people in State and faith-based care, historical or current, should be recognised as complex and as requiring specialised knowledge and expertise. Commissioned and non-commissioned staff working for the unit will need to be appropriately educated and trained on a range of issues relevant to survivors of abuse and neglect in care, such as how to address prejudice and all forms of discrimination, neurodiversity, the effects of trauma, and unconscious bias against survivors who may have gone on to commit offences themselves.

Tūtohi | Recommendation 35

NZ Police should establish a specialist unit dedicated to investigating and prosecuting those responsible for historical or current abuse and neglect in State and faith-based care.

Ngā panoni ture tikanga-ā-iwi Civil justice legislative changes

227. Several laws relating to civil justice proceedings need to be amended to remove barriers to access to justice for survivors relating to delays and financial burdens. The Inquiry envisages that the design of these law changes (before draft legislation is introduced into Parliament) will be jointly developed by government and Māori in accordance with te Tiriti o Waitangi, as well as co-designed with communities in line with implementation Recommendations 126–127.

Me noho matua ngā take ture tikanga ā-iwi

Civil proceedings to be prioritised

228. In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry found that:
- the Crown vigorously defended those claims that could not be settled with a claimant, which included the Crown causing long, avoidable delays,¹¹⁷ and
 - legal aid recipients face having to pay off large legal aid debt, unless the amount is written off as part of a settlement or covered by a court order.¹¹⁸
229. An inherent power imbalance exists for any survivor of abuse in care taking civil proceedings against an institution. Survivors must be given priority and supported to participate fully in proceedings.

Tūtohi | Recommendation 36

The courts should prioritise civil proceedings regarding care or abuse and neglect in State or faith-based care to minimise litigation delays.

Tūtohi | Recommendation 37

The government should review the Legal Services Act 2011 to remove barriers to civil proceedings regarding abuse and neglect in care, including means-testing criteria, charges over property, and repayments.

¹¹⁷ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 142).

¹¹⁸ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 234).

Te whakarerekē i te ture Taunaki Kōrero e āhei ai te tautoko i ngā take ture tikanga ā-iwi

Amending the Evidence Act to provide for communication supports in civil proceedings


230. In He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry detailed the traumatic impacts that participation in civil proceedings can have on survivors, including when preparing their case and giving evidence in court.¹¹⁹
231. Communication assistance and appropriate accommodations, such as augmentative and alternative communication devices, alternative formats, and supported decision-making, can remove barriers to giving evidence and understanding court proceedings, particularly for Deaf and disabled people, and people experiencing mental distress. Communication assistance should be available as a matter of right, to enable Deaf and disabled people and people experiencing mental distress to participate effectively in civil proceedings.

Tūtohi | Recommendation 38

The government should amend the following provisions of the Evidence Act 2006:

- a. section 80(3), to ensure that witnesses in civil proceedings have an entitlement to apply for communication assistance to both enable them to understand the proceedings and give evidence
- b. section 103(4)(b)(ii), to require a court when making directions on alternative ways of giving evidence in civil proceedings relating to abuse and neglect in care to consider the need to promote the recovery of parties and witnesses from the abuse and neglect
- c. subpart 5, to include provision for directions for alternative ways of giving evidence for parties and witnesses in civil proceedings where appropriate.

¹¹⁹ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 235).



"A bad kids
place, doom!"

ROVIN TURNBULL
NZ European

Callum and Victoria Turnbull

Child in care: Their son Rovin is autistic.

Hometown: Central Otago

Age when entered care: 9 years old

Year of birth: 2001


Time in care: Four years

Type of care facility: School for pupils with intellectual impairments
– Ruru Specialist School in Waihopai Invercargill.

Ethnicity: NZ European

Whānau background: Rovin has a brother.

Currently: Callum and Victoria describe Rovin as happy, sensitive and quirky.
He enjoys bush walks and is learning to operate a little digger.

 **Our son Rovin is profoundly affected by autism. He also has savant abilities – he’s highly intelligent and has an aptitude for learning. Rovin is self-taught and very clever. He communicates in a straightforward way but he’s not very talkative. He struggles with sensory issues, and in social situations.**

When he was nine, he began attending Ruru School in Invercargill, where he experienced physical and psychological abuse, including restraint and seclusion. He began to regress. His language and connection with us, and the world, disappeared. Looking back, we can see that Rovin’s dramatic deterioration was connected with the restraint and seclusion of him that was happening at Ruru, unbeknown to us.

When you have difficulty talking, you say 'no' the best way you can, and Rovin was trying to tell us. It became clear to us that he was unhappy. Getting him to school was a battle – he tried to exit the moving vehicle on occasions, and he'd hide under his bed in the morning, and put up a fight not to go to school.

At the time, we attributed his deteriorating behaviour at school and home, and his apparent fear and anxiety about school, due to having to be at school for the whole day, and this was how hard being at the school was for him.

His whole person changed. He began self-harming and talking about ending his life, expressing morbid thoughts. He would display aggression, strip off his clothes, cut off his hair and hit himself. It was a distressing time for our whole family.

There was an incident where he was put in a cloakroom by a teacher aide and left unsupervised after becoming upset. We recall he was taken to hospital in an ambulance with a large hematoma on his forehead.

We began noticing red flags everywhere. We spoke to the principal two or three times about bruising on Rovin's body and arms, which was put down to his interactions with other children. This included very dark bruises around his wrists.

One day, he got off the bus groaning in complete devastation. He had a hematoma on his head, his face was all puffy, and he had marks on his hands. That night, the bus driver called us to tell us a teacher aide had assaulted Rovin during the after-school pickup. The driver said kids told him the teachers would shut them in the broom cupboard.

When Rovin had started at Ruru School, he had yelled out about a 'little room'. At a meeting with the school, we asked to be shown the little room. There was a door at the back of a classroom, which opened into a tiny internal space, 1.3m x 1.8m and 3.3 metres high. It had a dark raw concrete floor, with ragged, frayed carpet stuck on the walls. There was no electric light, just light from a window at the top facing south into a hallway, so it was dark.

We were in shock and we both felt panic set in. Suddenly, the reasons for Rovin's behaviour became clear to us.

We complained to agencies – the police, the Ministry of Education, the Education Minister, the Office of the Ombudsman, and even the Children's Commissioner. The Ministry appointed someone to investigate.

The investigator's report described the room as "dark and grimy" and that children put in the room would feel that it was for punishment. She said the atmosphere of the room was not pleasant and recommended that the room be closed.

The Ministry had existing guidelines from 1998, stating that "Time-out rooms should not be used. They are not necessary and can result in teachers and schools being accused of using inhumane and cruel punishments." However, these guidelines were not provided to police or Ministry investigators. Instead in 2015, off the back of our seclusion complaint, a Ministry working group was set up to develop draft 'seclusion guidelines'. The draft guidelines allowed for seclusion. The draft was provided to and used by police investigating our seclusion complaint against Ruru in 2016–17, even though the then-Minister of Education, Hekia Parata, directed the Ministry to end seclusion in schools in October 2016, calling seclusion "intolerable".

In October 2016, new restraint guidance was issued by the Ministry, which stated, "Seclusion is an extremely serious intervention. It is potentially traumatic and can harm a student's wellbeing. It is an inappropriate response to a child's behaviour and must be eliminated." It became law in 2017.

Our complaints went to the Ombudsman for review. In his report, the Ombudsman said, "For any child or young person, let alone someone with particular disability-related needs, sensitivities and vulnerabilities, I consider that it would have been an uninviting and unpleasant place in which to spend even a short amount of time involuntarily."

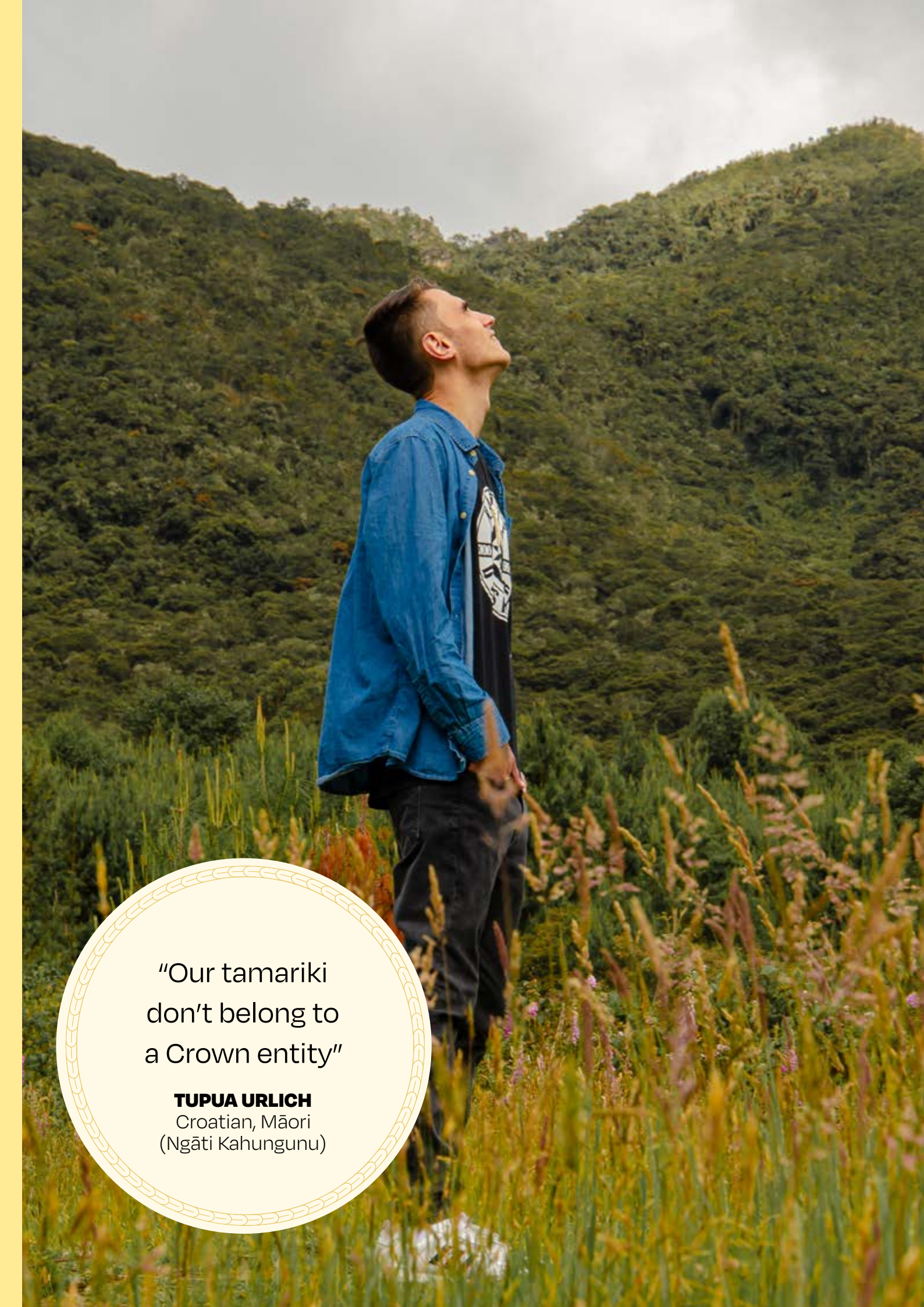
As a result of this, Rovin has missed almost all of his schooling. He spent four years at Ruru School, but four years of abuse is hardly good schooling.

As soon as we pulled him out of school, we were able to take him off all his medication and he's been off medication ever since. We can count on one hand the number of meltdowns he's had since. Once the abuse stopped, his behaviour stopped.

We've removed our son, so he is safe. But what about all the other students still there? What about the other children that were forced into the dark and grimy storeroom? Nobody spoke to the students – no agency talked to them. We were disheartened to hear from the Chief Executive of the Ministry in 2022 that they cannot know for certain that seclusion is not being used in schools, despite it being unlawful. The law change didn't prevent children from being put into seclusion or create a proper complaints and investigations process.

This entire experience had had a lifelong impact on our entire family. We are much less trusting, especially of agencies and authorities, and it will continue to have a major effect on our lives. It has been heart-breaking and stressful, and brought us overwhelming anxiety at times. Rovin's experience is common, and as hard as it is to tell our story, people – and the system – can learn from our story. That is our hope.¹²⁰

¹²⁰ Witness statement, Callum and Victoria Turnbull (9 November 2022).



"Our tamariki
don't belong to
a Crown entity"

TUPUA URLICH
Croatian, Māori
(Ngāti Kahungunu)

Tupua Urlich

Hometown: Tāmaki Makaurau Auckland

Age when entered care: 5 years old

Year of birth: 1995

Time in care: 2000–2011

Type of care facility: Foster care

Ethnicity: Croatian and Māori (Ngāti Kahungunu)

Whānau background: Tupua has seven siblings, including a younger sister who was born 11 months after him. He is the second generation on his father's side to go into the care system – his father and father's siblings all went into care.

Currently: Tupua works with VOYCE Whakarongo mai to advocate voice and connection for young people in care, empowering children's voices to be heard and listened to, and enabling a pathway to their cultural identity.



I was five years old when I was torn away from everything I had known. Out of love for us, my mother made a call to my extended whānau in the Hawke's Bay and they had a hui about our care. I have a very vivid memory of the day the whānau came to collect us. That is my first memory of true trauma. I will never forget that day, seeing my mother collapse to the ground watching us leave. I'll never forget the pain of not knowing what was going on and where we were going.

I was separated from my mother and siblings for many years. Being separated from my sister after being separated from my mother was nothing short of punishment, and it continues to have a lasting effect.

Aged five, I went to live with a caregiver in Flaxmere, via CYFS. I suffered severe physical and mental abuse while I was living with him. One day he gave me a huge beating and I was lying on the ground with a bleeding nose, when he turned to me and said, "Oh by the way, your dad is dead" and slammed the door. I was six years old.

When I was older, I took him to court for the abuse, but he was acquitted of all charges except one, for kicking me. That taught me that I was on my own. It was clear even then that I was up against the system. The second you open your mouth, the State just seems to push you from pillar to post. After that I didn't have any stable placements – I'd go to school one day, and next thing you know, I'm going home to a different town or place. I had no voice in that process. I wasn't valued – it was more like, you go where we say you're going, and it doesn't matter whether you understand it or not.

The abuse, the hopelessness, and the loneliness were terrible. You top that off with absolutely no stability, no direction, and so many things suffered – my education, but most importantly, my mental health.

I missed school because of the abuse, and nobody checked on me to see if I was doing okay. I wondered where the people who cared about me were.

I've got so many examples of racism, and I haven't met Māori in the care system who haven't experienced racism. The fact that there are so many Māori in the care system is a good indication of racism.

I had to go to lots of psychology and counselling appointments and there wasn't much room for learning te reo. When you live in a racist system, it makes you view yourself differently. The only time I saw a reference to te ao Māori was the koru patterns in the glass frosting of the meeting rooms in a CYFS building. I deserved more than that.

CYFS placed me with a caregiver who insisted on calling me Michael. That was driven by her purely religious views, and her understanding of the word 'Tupua' as evil and demonic. At school I wouldn't respond to the name and was grilled by teachers for not listening, but my name is Tupua, not Michael.

I'm not as close as I'd like to be with my family, and that's a result of the State alienating me from my whānau. We had no contact with each other for many years. You can't make up for those years lost.

We are alienated because the system did not value us as Māori tamariki as belonging to a collective whānau, hapū and iwi. They throw these words around that they don't understand, and it shows how they treat our young people. Being Māori and raised in a system that is determined to separate you from your culture and knowledge is modern-day colonisation. They want to detach us from our people and our culture, and fall into a system that feeds their privilege, it feeds their position in Aotearoa.

Our tamariki don't belong to a Crown entity. Neither did I. Knowing who you are and where you come from, along with values defined by tikanga, are the right foundations for developing strong, healthy, independent, ready young people. It's like day and night compared to the system we were raised in.

I am the second generation on my father's side that has gone into State care – my dad and his siblings all went into care. They're all gone now – I'm the oldest one left in my whānau, and I'm only 27 years old. The result of abuse and trauma, and what the State does to its people is present even in death. This mahi is important to me as I'm the eldest left in my direct whānau line. You can't say that this isn't connected, because it absolutely is. The hardest part is living in a society that denies it is real.

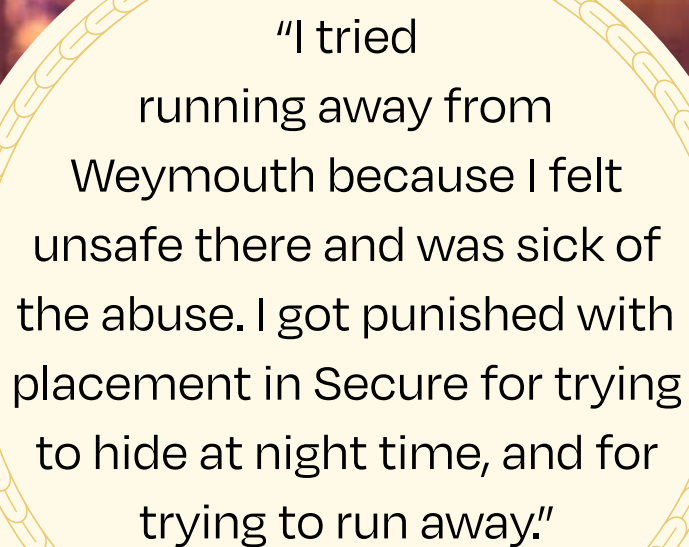
The Crown has created a system in which we fall through the gaps. They look like the helping hand up, but they're the ones pushing us down. All care and protection residences should be shut down. These environments are prison-like for children with high needs, and what part of prison is therapeutic?

Just allow Māori to exercise being Māori, tino rangatiratanga. We don't need the Crown to give us power – we have always had it, and they need to respect our power.

Now I work with VOYCE Whakarongo mai to advocate voice and connection for young people in care, empowering children's voices to be heard and listened to, and enabling a pathway to their cultural identity.

I was very fortunate that I had some strong mentors come into my life. That's what makes me passionate about this work. I had people who saw me for who I was, not the way I was acting or behaving, because you're broken and you struggle to fit in. But a person sees you and is committed enough to bring out those leadership qualities. We have hope, and we have hope because we're being heard.¹²¹

¹²¹ Witness statement of Tupua Urlich(10 August 2021).



"I tried
running away from
Weymouth because I felt
unsafe there and was sick of
the abuse. I got punished with
placement in Secure for trying
to hide at night time, and for
trying to run away!"

MR GU
Samoan

Ūpoko | Chapter 5

Te tauārai tāngata noho pūnaha taurima

Safeguarding people in care

232. In Part 7, the Inquiry set out its findings about the factors that caused or contributed to abuse and neglect in care during the Inquiry period. The Inquiry found that the State and some faith-based institutions made discrete changes in some settings to introduce some safeguarding against abuse and neglect, generally from the late 1980s onwards. However, the absence of a national framework to safeguard all children, young people and adults in State and faith-based care contributed to abuse and neglect during the Inquiry period.
233. This chapter responds to clause 32A of the Inquiry's Terms of Reference, which relates to recommendations to ensure that the factors that allowed abuse to occur during the Inquiry period do not persist. As provided for in clauses 15A and 15B of its Terms of Reference, the Inquiry has considered issues and experiences after 1999 that survivors have shared, including those set out below.¹²²

Ngā wheako purapura ora mai i te tau 1999

Survivors' experiences after 1999

234. Survivors told the Inquiry about a range of issues and experiences after 1999. These highlighted issues relating to institutional environments and practices, standards and safeguarding in care settings, vetting of staff and care workers, complaints processes, and accountability for abuse and neglect.

¹²² Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, Terms of Reference, clauses 15A, 15D and 32A.

Ngā āhuatanga me ngā tikanga o ngā whakahaerenga Institutional environments and practices

235. Māori survivor Mr RA (Rongomaiwahine), who was first placed in a care in 2001 when he was aged 12, told the Inquiry about his experience at Weymouth youth justice residence in Tāmaki Makaurau Auckland:

“I was also excessively restrained by staff members at Weymouth. The restraints included putting me in arm locks, wrist locks, neck locks or whatever they could wrap their arm around. ... I got sent to Secure a lot, where you’d be locked down for 23 hours a day.”¹²³

236. NZ European survivor Mr GG, who was placed in a care and protection residence in 2019 when he was aged 11, said:

“If I swore at someone, I would be restrained, and I have seen that result in injuries. My friend’s arm snapped from being restrained.”¹²⁴

237. Samoan survivor Sefo loelu, who was placed in Lighthouse Hillsborough youth justice residence in 2008 when he was aged 14, said:

“Lighthouse was like a small prison. We were stuck in its rooms most of the day, and there was only a bed and drawers in the room with bars over the windows. I was not given any type of schooling. We had to knock on the door and ask to be let out to use the bathroom.”¹²⁵

238. Samoan survivor Mr GU, who was in Child Youth and Family (CYF) care from 2002 when he was aged 15, told the Inquiry about his experience of sexual abuse while in a family home:

“The first time the adult son [of the care givers] sexually assaulted me occurred in a room at the Family Home. He had asked me to come in there, and then locked the door behind me. He touched my penis and tried to masturbate me. After the first assault, the adult son tried to touch me, masturbate me, or make me touch him in the car, every few days.”¹²⁶

¹²³ Witness statement of Mr RA (15 August 2022, paras 168).

¹²⁴ Witness statement of Mr GG (2 March 2022, para 39).

¹²⁵ Witness statement of Sefo loelu (22 July 2021, para 101 pages 14–16).

¹²⁶ Witness statement of Mr GU (March 2021, para 59 page 9).

239. The Inquiry heard evidence of the recent misuse of solitary confinement in education settings. Callum and Victoria Turnbull, whose son Rovin attended Ruru Specialist School in Waihōpai Invercargill from 2011 when he was aged 9, told the Inquiry:

“There was no light. It had a dark raw concrete floor, with ragged, frayed carpet stuck on the walls. It was an internal room, with a window at the top facing south into a hallway, so it was dark...we could not comprehend what we saw – it was barbaric. It was abuse. Suddenly, the reasons for Rovin’s behaviour became clear to us.”¹²⁷

He huakore o ngā raupapa mahi me te noho āhuru Inadequate standards and safeguards

240. Pākehā survivor Mr VX described his experiences of peer abuse at Korowai Manaaki youth justice residence in Tāmaki Makaurau Auckland in the early 2000s:

“I was beaten up regularly and the staff did not care what was happening... Due to inadequate supervision, I was physically assaulted by other residents every day. On one occasion I was punched and kicked around by three other residents each time. I received a black eye and a fat lip. The assaults primarily took place in the shower, courtyard, and TV room. They were a common occurrence and became part of my daily life there. ... I felt like no one cared and as a result, I began to not care.”¹²⁸

241. Māori survivor Mr RH (Ngāi Tahu), who was first placed in a family home in 2008 when he was aged 14, said:

“I do not remember being physically or sexually abused by the caregivers but they did encourage the boys to physically fight among ourselves and they would stand back and watch, clearly enjoying it. By doing this they normalised violence as a way of life and this reinforced the views I already held.”¹²⁹

¹²⁷ Witness statement of Callum and Victoria Turnbull (9 November 2022, paras 2.76 and 2.80).

¹²⁸ Witness statement of Mr VX (12 December 2022, paras 38, 40, 43).

¹²⁹ Witness statement of Mr RH (19 May 2021, para 4.8.3, page 13).

242. Māori survivor Ms QA (Ngāti Awa, Ngāpuhi) first came to the attention of Child Youth and Family Services (CYFS) when she was 9 years old in 1997 and was placed in a family home in 2001. She told the Inquiry that:

“In all the Family Homes, there were locks on the food cupboards and fridges. I felt like an intruder, like I was not welcome. It did not feel like I was living, it was like I was surviving.”¹³⁰

243. Pākehā survivor Ms QB, who was in Child Youth and Family Services (CYFS) care between 2015 and 2017, told the Inquiry that she was assaulted by an Oranga Tamariki care giver in a family home when she was aged 15:

“My social worker had told [the care giver] when I arrived there what triggered me and this included people getting ‘in my face’ because this puts me into a fight or flight phase in my mind. Despite this (or maybe because of it) [redacted] yelled got right up in my face and yelled at me to ‘shut the fuck up’. I wanted to have a shower and [redacted] pulled me up from the floor by my clothing, pushed me into the bathroom and told me to ‘have a fuckin shower’. I fell and hit the side of my head against the bath and then she slammed the door shut on me...I rang the CYF National Call Centre to report the incident and to inform them that I was unsafe. I told them that I did not want to stay there and, after initially saying that they would come to get [another young person] and I they then phoned back and they told me to go into my bedroom, lock the door and that they would visit in the morning...The side of my head was bruised and sore afterwards.”¹³¹

Ngā kaimahi me ngā kaiārahi Staff and carers

244. Māori and non-binary survivor Alex Kaspin (Ngāi Tahu), who was placed in multiple foster homes between 1989, when they were aged 1, and 2006, when they were aged 17, told the Inquiry:

“I tried to tell [my foster mother] about what [my foster father] was doing. Her response was to defend [him] and say that he will stop and that he won’t do it anymore. She said this because she was very protective of him and her situation. He didn’t stop.”¹³²

¹³⁰ Witness statement of Ms QA (19 October 2022, para 10.11, page 16).

¹³¹ Witness statement of Ms QB (28 January 2022, para 4.1).

¹³² Witness statement of Alex Kaspin (2 March 2022, para 64).

245. Māori survivor Mr RA (Rongomaiwahine) told the Inquiry:
- "I have no faith in Oranga Tamariki, or their approvals and background checks, I've always made sure my kids have stayed with whānau while in care, because I don't have any belief Oranga Tamariki can keep my kids safe."***¹³³
246. Ms VY is a Māori survivor (Ngāti Porou) who was born in 1999. In 2016, she was placed in foster care for about three months after spending time in a youth justice facility. She said that she was never visited by a social worker in this placement and thinks this is because "it was a small community, and [her foster carer] was known by the community, CYFS and the police really well, and was well-regarded".¹³⁴
247. NZ European Franky Lewis, a mother of disabled survivor Keegan, described the high turnover of staff supporting her son:
- "Over Keegan's life we have had several hundred staff working in its home. In the last 5 years since we moved... we have had 20 different staff. There have been 9 different staff in 2022 alone. The turnover and inconsistency is difficult for Keegan and also difficult for me and Tony. It is so hard to find well trained staff that stay in the job long term."***¹³⁵
248. Pākehā survivor Ms QB told the Inquiry about her experience in Child Youth and Family (CYF) care:
- "The social worker did not seem to have the skills, experience or resources to know what to do with me during the day so she took custody of me but did not help me in any way by building my skill base, making a plan for me or even really getting to know me."***¹³⁶
249. Neurodivergent survivor Ihorangi Reweti Peters (Ngāti Tūwharetoa, Ngāti Tahu-Ngāti Whaoa, Ngāti Kahungunu), who was placed in foster care, family homes and care and protection residences from the age of 10 in 2015, told the Inquiry that:
- "My own experience shows that Oranga Tamariki staff are not taking mental health seriously. I understand that there is no mental health or suicide prevention training among Oranga Tamariki staff and caregivers."***¹³⁷

133 Witness statement of Mr RA (15 August 2022, paras 375).

134 Witness statement of Mr PW (4 May 2023, para 62).

135 Witness statement of Franky Lewis (mother of disabled survivor) (1 May 2023, para 46).

136 Witness statement of Ms QB (28 January 2022, para 3.7).

137 Witness statement of Ihorangi Reweti Peters (18 January 2022, para 63).

Ngā kōamuamu me ngā here a mahi

Complaints and accountability

250. Disabled NZ European and Māori survivor Ms TR, who was placed in foster care at age 10, told the Inquiry that:

*"...when I went to the school counsellor and disclosed what had been happening, it got back to [my foster mother]. She told [my social worker] and, in my file, it says that I over exaggerated things. Nothing was ever taken seriously."*¹³⁸

251. Scottish and Papua New Guinean survivor Jamie Henderson, who was placed in Korowai Manaaki youth justice residence in Tāmaki Makaurau Auckland and then Te Aorere in Te Papaioea Palmerston North as a teenager in the late 2010s, said:

*"Complaints aren't encouraged in any of these facilities. It felt like I couldn't complain while I was in YJ and the boys' homes. ... I did not know how to complain at the time. I didn't even know the names of the staff members to allow me to make a complaint."*¹³⁹

252. Ihorangi Reweti Peters told the Inquiry that:

*"From my own experiences of engaging with the New Zealand Police, there is no direct way that young people can report what has happened to us in care via the police, and it is a daunting and traumatic experience to re-tell its accounts of abuse. ... Young people in care are scared to raise their concerns because they are worried that it may affect their current placement, put them in a bad position, or that they may experience further abuse and /or neglect."*¹⁴⁰

253. Māori survivor Takena Tauī-Stirling (Te Whānau-ā-Apanui), who was in youth justice residences from 2001, when he was aged 14 said:

*"When I got my files in 2020 I didn't know that I could make a formal complaint or seek compensation from anyone. I never have... In terms of changes I want [Child Youth and Family] to have people that children can speak to with confidence. Not be scared of the person because of what they've done."*¹⁴¹

¹³⁸ Witness statement of Ms TR (17 November 2022, para 126).

¹³⁹ Witness statement of Jamie Henderson (17 April 2023, paras 60–61).

¹⁴⁰ Witness statement of Ihorangi Reweti Peters (18 January 2022, para 60).

¹⁴¹ Witness statement of Takena Tauī-Stirling (4 May 2023, paras 55–56, page 8).

254. Callum and Victoria Turnbull, whose autistic son Rovin experienced solitary confinement at Ruru Specialist School in Waihōpai Invercargill in 2011, told the Inquiry:

“It is not good enough for the CEO of MoE to say that they can’t ensure that schools are not using seclusion. They need to come up with a way that they can ensure this. From its own experience, you cannot trust ERO to monitor or even report on the use of seclusion in schools.”¹⁴²

255. Rangatahi from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei told the Inquiry that:

“There needs to be system accountability of every assault, and not allow assaults to happen in the name of ‘correcting behaviour’ in placements.”¹⁴³

“If we in care, we should be able to report what is happening straight away and get a quick response.”¹⁴⁴

“We can ensure safety by actively monitoring [and] checking care givers who put up their hand to care for tamariki.”¹⁴⁵

256. Survivors’ issues and experiences are echoed in independent and State-commissioned reports on care settings after 1999, which are discussed in Chapter 2.

He ture-ā-motu hei ārai, hei tohu i te hunga kei tūkinohia i ngā pūnaha taurima

National care safety regulatory system for preventing and responding to abuse in care

257. A regulatory system is a set of formal and informal rules, norms and sanctions that are intended to shape people’s behaviours and interactions to achieve particular goals or outcomes. Regulatory systems include legislation, policies, frameworks, standards, guidelines and operational practices.


258. During the Inquiry period there were multiple regulatory systems involved in providing care across social welfare, disability and mental health, education, transitional and law enforcement, and faith-based settings. These systems were inconsistent and disconnected and had significant gaps, and ultimately failed to provide a safe environment for children, young people and adults in care.

¹⁴² Witness statement of Callum and Victoria Turnbull (9 November 2022, page 31).

¹⁴³ Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, Key asks from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei (2024, page 2).

¹⁴⁴ Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, Key asks from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei (2024, page 5).

¹⁴⁵ Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, Key asks from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei (2024, page 3).

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259. There was no collective leadership or single agency responsible for all care settings. There was no single regulatory framework for ensuring care settings were safe and fit for purpose. Each system operated as a silo, with individual agencies or entities responsible for their own performance and contribution. During the Inquiry period the State increasingly recognised that preventing abuse and neglect was important and put some standards and strategies in place. However, it did not address the fragmentation of systems and the lack of a single point of accountability.
260. A national care safety regulatory system is urgently needed to ensure all care settings are safe and that no children, young people or adults in State or faith-based care experience abuse and neglect. The scope of this new regulatory system is broad, which reflects the breadth of the scope of this Inquiry. Most of the recommendations in this chapter are all components of a new national care safety system.
261. The national care safety regulatory system will focus on the elements that make settings safe and fit for purpose.

Ngā wāhanga whakahaere pūnaha āhuru mōwai ā-motu

Components of a national care safety regulatory system


262. In summary, the national care safety regulatory system will include:
- a. Care Safety Principles for preventing and responding to abuse and neglect in care
 - b. an overarching National Care Safety Strategy that applies to all State and faith-based care settings
 - c. a single organisation (the Care Safe Agency) responsible for system leadership and coordination, and for setting, monitoring and enforcing care safety rules, standards and guidelines, and for promotion and public awareness of care safety
 - d. new legislation (the Care Safety Act) and changes to existing legislation to address duplication or inconsistencies
 - e. a set of rules, standards and guidelines that apply to all State and faith-based care providers and all staff and care workers, including:
 - i. comprehensive and consistent standards of care and sanctions for non-compliance
 - i. safeguarding and accreditation requirements for care providers
 - ii. vetting, registration and training and education requirements for all staff and care workers
 - iii. transparent and accessible complaints processes, including mandatory reporting requirements
 - iv. policies and procedures that minimise and eliminate institutional environments and practices
 - v. policies and procedures that empower people in care
 - vi. best practice data, record-keeping and information sharing requirements
 - f. independent oversight and monitoring across all State and faith-based care settings.

Kō wai ka noho ārai i raro i ngā whakahaere āhuru mōwai ā-motu

Who will be protected by the national care safety regulatory system?

263. The Inquiry intends that the national care safety regulatory system will ensure that care settings are safe and fit for purpose for all children, young people and adults "in care". The Inquiry's definition of "in care" is based on, and aligned with, the scope of its Inquiry as set out in its Terms of Reference.¹⁴⁶ The definition of who the regulatory system will protect will be set out in the Care Safety Act (Recommendation 45).

¹⁴⁶ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-Based Institutions, Terms of Reference, clauses 17.2–17.4.


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264. "In care" includes being in the care of the State or a faith-based entity, including direct care (where the State or a faith-based entity provides care directly), or indirect care (where individuals or entities provide care on behalf of the State or a faith-based entity). The Inquiry also intends that the national care safety regulatory system will ensure that people who are in pastoral care are safe. Pastoral care can include, for example, youth group activities, Bible study groups, Sunday school or children's church activities, day trips and errands, pastoral or spiritual direction, mentoring, training, or visits to congregation or community members' homes.
265. The Inquiry intends for the new national care safety regulatory system to keep children, young people and adults in State and faith-based care safe in the following current care settings:
- a. care and protection settings (including people in foster care)
 - b. youth justice settings
 - c. disability settings (people receiving disability supports and services, including while living in private residences)
 - d. mental health settings (people receiving mental health supports and services, including as an inpatient or in the community, voluntarily or under compulsion)
 - e. education settings (people attending State, integrated and private primary and secondary schools, including living in boarding facilities associated with schools)
 - f. transitional and law enforcement settings (including people in NZ Police custody, NZ Police cells, court cells, and people moving to, between, or out of the care settings in (a)–(e) above)
 - g. pastoral care.

Kō wai ka meinga kia whai i ngā whakahaere āhuru mōwai ā-motu Who will have to comply with the national care safety regulatory system?

266. Regulatory systems have what is called "regulated populations". This means the people and organisations that must comply with the rules, standards and guidelines in the system. The definition of the regulated population will be set out in the Care Safety Act (Recommendation 45).

267. Under the new national care safety regulatory system, the “regulated population” will include any individual, entity, non-governmental organisation or business who provides care to children, young people and adults in current care and protection, youth justice, disability, mental health, education, or transitional and law enforcement settings. It will include State and faith-based entities providing care directly, as well as individuals and organisations providing indirect care on behalf of the State or faith-based entities. This aligns with the scope of the care settings and of children, young people and adults in care as defined in the Inquiry’s Terms of Reference.¹⁴⁷
268. The Inquiry intends that the faith-based institutions that were investigated and reported on will be included within the definition of the “regulated population”. These include:
- a. the Catholic Church in Aotearoa New Zealand
 - b. the Anglican Church in Aotearoa New Zealand and Polynesia
 - c. the Methodist Church of New Zealand
 - d. the Presbyterian Church of Aotearoa New Zealand
 - e. the Plymouth Brethren Christian Church
 - f. the Salvation Army
 - g. Jehovah’s Witnesses
 - h. Gloriavale Christian Community Church.
269. The Inquiry intends that other faith-based entities in Aotearoa New Zealand will also be included in the “regulated population”.
270. The regulated population will include the organisations providing care supports and services and the people working for those organisations. In this chapter, the Inquiry uses the term “care providers” to refer to the entities providing care. The Inquiry expects care providers will include a range of entities, including non-governmental organisations, community groups, marae, hapū, iwi, Māori organisations, schools and churches. State agencies directly providing care will fall within the definition of “care providers”. Examples include Health New Zealand Te Whatu Ora, who are responsible for inpatient mental health facilities, or Oranga Tamariki, who are responsible for youth justice residences.
271. Care providers will include entities currently providing care, as well as new entities who emerge over time. As Aotearoa New Zealand moves closer to he Māra Tipu, the Inquiry would expect to see many more new care providers emerge who understand and can meet the needs and aspirations of their local communities.

¹⁴⁷ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-Based Institutions, Terms of Reference, clauses 17.2–17.4.

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272. People who work for care providers will also fall within the definition of the “regulated population”. In this chapter the Inquiry uses the term “staff and care workers”. The Inquiry intends this term to include paid staff and volunteers. Staff and care workers will include teachers, psychiatrists, nurses, NZ Police, board members, social workers, trustees, cleaners, foster parents, priests, chief executives, church leaders, orderlies, teacher aides, gardeners, personal care assistants, and anyone else who works or volunteers for a care provider.
273. The Inquiry does not intend parents (including adoptive parents) to fall within the definitions of “care provider” or “staff and care workers” under the national care safety regulatory system. The Inquiry also does not intend that the parents and siblings of disabled children, young people or adults who receive payment to care for their family members should fall within these definitions.

Ngā mātāpono hei ārai, hei tiaki i te hunga kei tūkinohia i ngā pūnaha taurima


Principles for preventing and responding to abuse and neglect in care

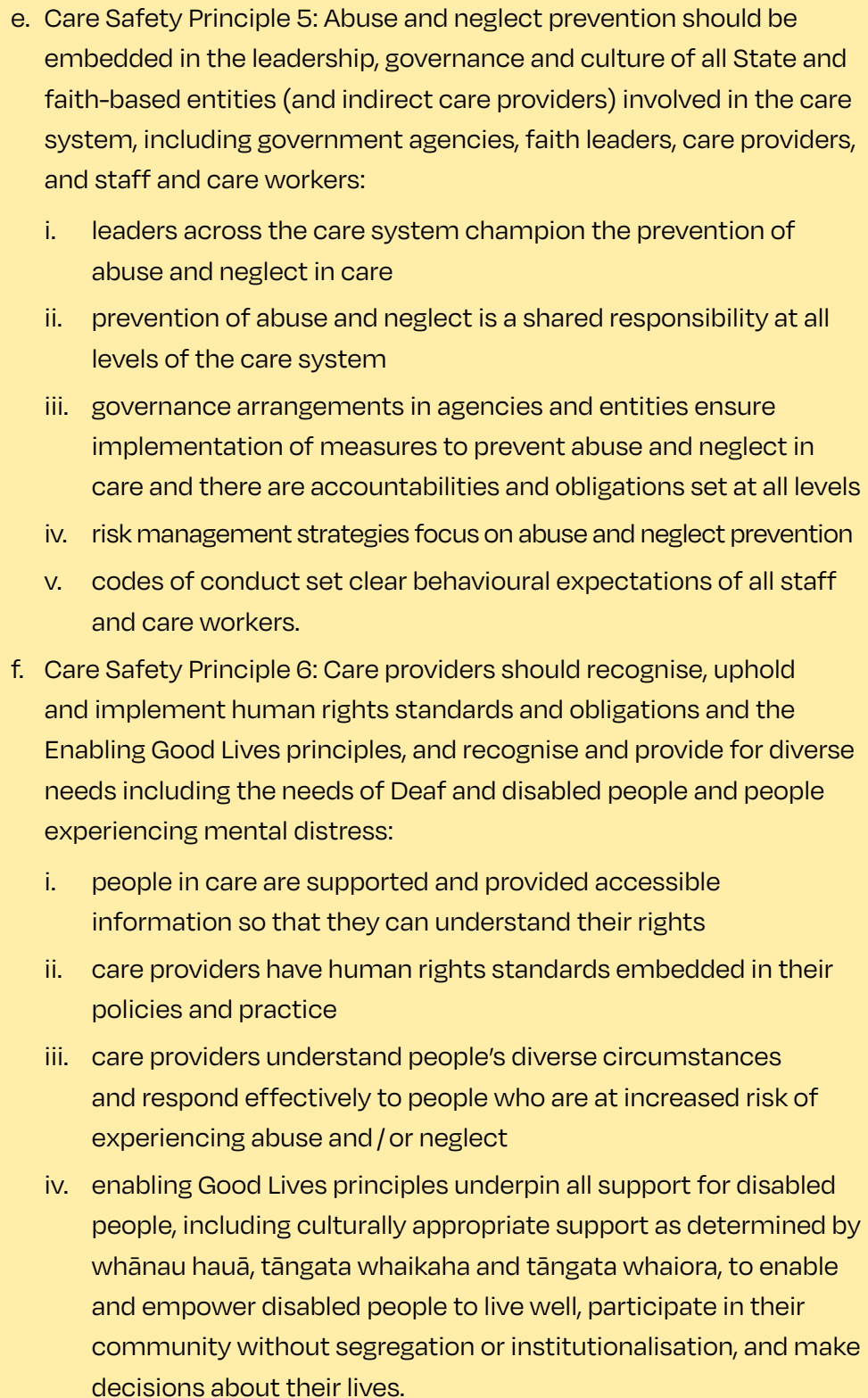
274. The Inquiry has developed a set of Care Safety Principles for preventing and responding to abuse and neglect in care. These principles have informed and underpinned the Inquiry’s recommendations. The Inquiry expects these principles to be used not only to guide the implementation of these recommendations, but also to guide the operation of the national care safety regulatory system, and the provision of care supports and services, in the future. These principles represent the minimum safeguards required to protect people in care.
275. The Inquiry also envisages that State and faith-based entities (including indirect care providers) that are currently involved in the care system will use these Care Safety Principles immediately. This includes government agencies and faith leaders, as well as care providers and staff and care workers.
276. The Inquiry intends that the principles will guide decision-making, the performance of functions, and the exercising of powers and duties at all levels in the organisations, from leadership through to front-line staff. There is no need to wait for the government or faith-based entities to decide on their responses to these recommendations, or the implementation of recommendations, for these principles to be used immediately.

Tūtohi | Recommendation 39


The State, faith-based entities (including indirect care providers) and others involved in the care system should be guided by the following Care Safety Principles for preventing and responding to abuse and neglect when making decisions, performing functions, or exercising powers and duties in relation to the care of children, young people and adults in care:

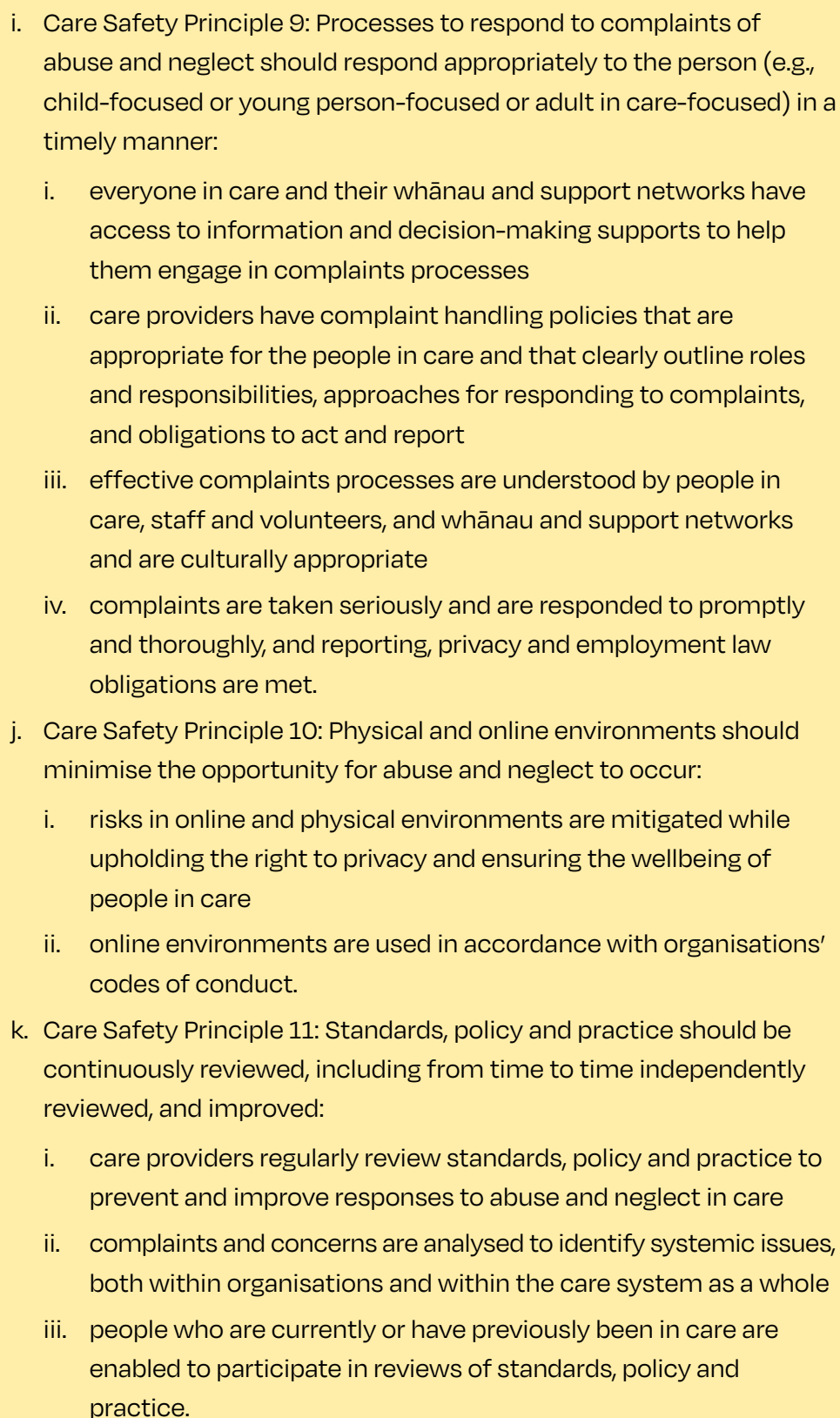
- a. Care Safety Principle 1: The care system should recognise, uphold and enhance the mana and mauri of every person in care
 - i. each person in care lives free from abuse and neglect and their overall oranga (wellbeing) is supported in a holistic way
 - ii. care providers understand and provide for each person and their unique strengths, needs and circumstances
 - iii. the importance of whānau and friendships is recognised and support from family, support networks and peers is encouraged to enable people in care to be less isolated and connected to their community
 - iv. people in care are celebrated and nurtured.
- b. Care Safety Principle 2: People in care should participate in and make decisions affecting them to the maximum extent possible and be taken seriously
 - i. people in care can participate in decisions that affect their lives, with the assistance of decision-making supports and / or an independent advocate they have chosen, where required
 - ii. people in care can access abuse and / or neglect prevention programmes and information
 - iii. staff and care workers are aware of signs of abuse and / or neglect and facilitate ways for people in care to raise concerns
 - iv. people who are currently or have previously been in care can participate in decision-making and policy-making about the care system.


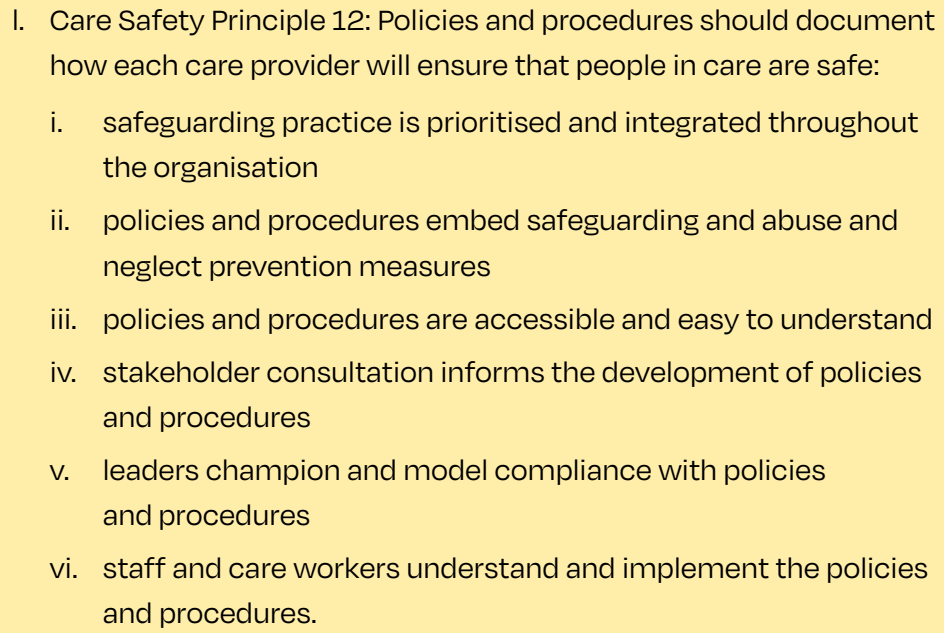
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- c. Care Safety Principle 3: Whānau and support networks should be involved in decision-making processes wherever possible and appropriate:
- i. connections between people in care and their whānau and support networks are actively supported, and whānau and support networks can participate in decisions affecting the person in care wherever possible and appropriate
 - ii. care providers engage in open communication with whānau and support networks about their abuse and neglect prevention approach
 - iii. whānau and support networks are informed about and can have a say in organisational and system-level policy
 - iv. whānau, hapū and iwi can participate in decision-making processes about their mokopuna and uri.
- d. Care Safety Principle 4: The State, faith-based entities (including indirect care providers) and others involved in the care system should give effect to te Tiriti o Waitangi and enable Māori to exercise tino rangatiratanga:
- i. whānau, hapū and iwi exercise the right to tino rangatiratanga over kāinga and are empowered to care for their tamariki, rangatahi, pakeke Māori and whānau according to their tikanga and mātauranga
 - ii. the Crown actively devolves to Māori policy and investment decisions about the care system, design and delivery of supports and services for, and specific care decisions about tamariki, rangatahi and pakeke Māori
 - iii. until the realisation of principle 4(ii), Māori and the Crown should collaborate on policy and investment decision about the care system, the design and delivery supports and services for, and specific care decisions about tamariki, rangatahi and pakeke Māori
 - iv. tamariki, rangatahi and pakeke Māori who are in need of care live as Māori and are connected to their whānau, hapū, iwi, whakapapa, whenua, reo and tikanga
 - v. wellbeing for tamariki, rangatahi and pakeke Māori is understood and supported through an ao Māori worldview, encompassing tapu, mana, mauri and wairua.

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- e. Care Safety Principle 5: Abuse and neglect prevention should be embedded in the leadership, governance and culture of all State and faith-based entities (and indirect care providers) involved in the care system, including government agencies, faith leaders, care providers, and staff and care workers:
 - i. leaders across the care system champion the prevention of abuse and neglect in care
 - ii. prevention of abuse and neglect is a shared responsibility at all levels of the care system
 - iii. governance arrangements in agencies and entities ensure implementation of measures to prevent abuse and neglect in care and there are accountabilities and obligations set at all levels
 - iv. risk management strategies focus on abuse and neglect prevention
 - v. codes of conduct set clear behavioural expectations of all staff and care workers.

 - f. Care Safety Principle 6: Care providers should recognise, uphold and implement human rights standards and obligations and the Enabling Good Lives principles, and recognise and provide for diverse needs including the needs of Deaf and disabled people and people experiencing mental distress:
 - i. people in care are supported and provided accessible information so that they can understand their rights
 - ii. care providers have human rights standards embedded in their policies and practice
 - iii. care providers understand people's diverse circumstances and respond effectively to people who are at increased risk of experiencing abuse and /or neglect
 - iv. enabling Good Lives principles underpin all support for disabled people, including culturally appropriate support as determined by whānau hauā, tāngata whaikaha and tāngata whaiora, to enable and empower disabled people to live well, participate in their community without segregation or institutionalisation, and make decisions about their lives.

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- g. Care Safety Principle 7: Staff and care workers should be suitable and supported:
- i. all stages of recruitment, including advertising and screening, emphasise the values of caring for people in care, the safety of people in care, and the prevention of abuse and neglect
 - ii. staff and care workers have regularly updated safety checks
 - iii. staff and care workers receive appropriate induction and training and are aware of their responsibilities to prevent abuse and neglect, including reporting obligations
 - iv. staff and care workers receive appropriate training to ensure they have cultural competency
 - v. education programmes for staff and care workers include units focused on understanding and preventing abuse and neglect in care
 - vi. supervision and people management include a focus on preventing abuse and neglect.
- h. Care Safety Principle 8: Staff and care workers should be equipped with the knowledge, skills and awareness to keep people in care safe through continuous education and training:
- i. staff and care workers receive training on the nature and signs of abuse and neglect in care
 - ii. staff and care workers receive training on organisational and national abuse and neglect prevention policies and practices
 - iii. staff and care workers are supported to develop practical skills in safeguarding children, young people and adults in care
 - iv. staff and care workers have the appropriate cultural knowledge.

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- i. Care Safety Principle 9: Processes to respond to complaints of abuse and neglect should respond appropriately to the person (e.g., child-focused or young person-focused or adult in care-focused) in a timely manner:
 - i. everyone in care and their whānau and support networks have access to information and decision-making supports to help them engage in complaints processes
 - ii. care providers have complaint handling policies that are appropriate for the people in care and that clearly outline roles and responsibilities, approaches for responding to complaints, and obligations to act and report
 - iii. effective complaints processes are understood by people in care, staff and volunteers, and whānau and support networks and are culturally appropriate
 - iv. complaints are taken seriously and are responded to promptly and thoroughly, and reporting, privacy and employment law obligations are met.
 - j. Care Safety Principle 10: Physical and online environments should minimise the opportunity for abuse and neglect to occur:
 - i. risks in online and physical environments are mitigated while upholding the right to privacy and ensuring the wellbeing of people in care
 - ii. online environments are used in accordance with organisations' codes of conduct.
 - k. Care Safety Principle 11: Standards, policy and practice should be continuously reviewed, including from time to time independently reviewed, and improved:
 - i. care providers regularly review standards, policy and practice to prevent and improve responses to abuse and neglect in care
 - ii. complaints and concerns are analysed to identify systemic issues, both within organisations and within the care system as a whole
 - iii. people who are currently or have previously been in care are enabled to participate in reviews of standards, policy and practice.

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- I. Care Safety Principle 12: Policies and procedures should document how each care provider will ensure that people in care are safe:
 - i. safeguarding practice is prioritised and integrated throughout the organisation
 - ii. policies and procedures embed safeguarding and abuse and neglect prevention measures
 - iii. policies and procedures are accessible and easy to understand
 - iv. stakeholder consultation informs the development of policies and procedures
 - v. leaders champion and model compliance with policies and procedures
 - vi. staff and care workers understand and implement the policies and procedures.

He rautaki āhuru mōwai-ā-motu National Care Safety Strategy

277. During the Inquiry period there was no nationwide strategic approach to preventing or responding to abuse and neglect in care. The lack of long-term strategy meant that responses to abuse and neglect in care were piecemeal and reactive. During the Inquiry period, more strategic thinking began to develop, but it was contained within individual care systems.
278. The Child and Youth Wellbeing Strategy 2019, while not focussed on abuse in care, sets out a framework for improving the wellbeing of all children and young people in Aotearoa New Zealand.¹⁴⁸ However, there is still no single strategy for preventing abuse and neglect of children, young people and adults across all care settings.
279. A National Care Safety Strategy is required to set goals, objectives and targets, to clearly explain roles, responsibilities and accountabilities of government agencies, care providers and communities, and to describe the nature and scale of the work required. The Inquiry envisages the National Care Safety Strategy would take a multigenerational approach by, for example, identifying goals, objectives and targets at 10, 25 and 50-year intervals, rather than 1–5-year intervals.
280. The Strategy will enable all government agencies, care providers and communities to work together in a coordinated and integrated manner. The Strategy should be for everyone, including children and young people, survivors of abuse and neglect of all ages, whānau, hapū, iwi, support networks and carers, communities, non-governmental organisations, indirect care providers, and State and faith-based entities. It would also support bi-partisan commitment over the long term to support and embed meaningful, fundamental change.
281. The Inquiry would expect to see the National Care Safety Strategy cover a range of work areas, including reducing and eliminating institutional environments and practices, supporting and empowering victims, survivors and whānau, prevention strategies, better abuser accountability and intervention, improving the evidence base for preventing and responding to abuse and neglect, and public awareness and education.
282. The Inquiry would also expect to see a supporting action plan that sets out the concrete actions that will contribute to achieving the Strategy. An action plan is critical to ensure transparency and monitoring of progress.
283. Consideration will need to be given to any interfaces with other strategies and whether adaptations to those strategies will be needed.

¹⁴⁸ Child and Youth Wellbeing Strategy 2019 (Department of the Prime Minister and Cabinet, August 2019).

284. The Inquiry envisages that the National Care Safety Strategy will be developed by the Care Safe Agency (Recommendation 41), guided by the Care Safety Principles (Recommendation 39), and jointly developed by government and Māori in accordance with te Tiriti o Waitangi, as well as being co-designed with communities in line with implementation Recommendations 126–127.

Tūtohi | Recommendation 40

A new comprehensive National Care Safety Strategy, required by law, on the prevention of, and response to, abuse and neglect in care should include:

- a. goals, objectives and targets that consider future generations
- b. clearly understood roles and responsibilities for different organisations and entities involved in the care system
- c. an overview of the priority programmes of work, including:
 - i. supporting and empowering victims, survivors and whānau
 - ii. strategies to prevent abuse and neglect
 - iii. better abuser accountability and intervention
 - iv. improving the evidence base
 - v. awareness raising and education
 - vi. enhancing approaches to children, young people and adults in care with harmful sexual behaviours.

Te whakatū Tira Āhuru Mōwai motuhake

Establishing a new independent Care Safe Agency

285. Aotearoa New Zealand needs a new, independent Care Safe Agency that has the mandate and investment needed to be a visible and best-practice regulator, so that all participants in the care system know how to prevent and respond to abuse and neglect of children, young people and adults in care.
286. The establishment of a new independent Care Safe Agency is needed to:
- a. provide independent leadership and coordination of the care system
 - b. set, monitor and enforce care safety rules, standards and guidelines, and
 - c. promote and increase public awareness of care safety.

Ngā mahi ā te Tira Āhuru Mōwai motuhake

Functions of independent Care Safe Agency

287. The Care Safe Agency will act as the primary regulatory agency for the new national care safety regulatory system. Its functions will include:
- a. whole of system leadership on preventing and responding to abuse and neglect in care
 - b. promoting and championing the Care Safety Principles (Recommendation 39)
 - c. developing the National Care Safety Strategy and its supporting action plan to prevent and respond to abuse and neglect in care (Recommendation 40)
 - d. setting, monitoring and enforcing care safety rules and standards (Recommendation 47)
 - e. investigating breaches of rules and standards and enforcing a range of sanctions and penalties against care providers, staff and care workers (Recommendation 47)
 - f. developing best-practice guidelines on a range of issues relevant to preventing and responding to abuse in care, including safeguarding policies and procedures, and complaints policies and procedures
 - g. investigating and reporting on complaints received directly from users of supports and services

- h. collating and keeping a centralised database of complaints and outcomes of investigations from State and faith-based care providers, other providers of supports and services, professional registration bodies, and independent oversight and monitoring entities (Recommendations 67–68)
 - i. accrediting care providers and other providers of supports and services (Recommendation 48)
 - j. registering staff and care workers who are not already covered by existing professional registration regimes (Recommendation 57)
 - k. setting training and education guidelines and standards and developing curriculums for staff and care workers
 - l. workforce development and career pathways for staff and care workers (Recommendation 61)
 - m. leading public awareness, education and prevention initiatives (Recommendations 111–112 and 121–122)
 - n. undertaking research, data analysis and horizon-scanning
 - o. publishing data and statistics on complaints of abuse and neglect in care to promote transparency and measurability of outcomes
 - p. promoting a continuous improvement and learning culture in the care system, including through facilitating regular forums and communities of practice
 - q. advising government on preventing and responding to abuse and neglect in care, including where systemic deficiencies are identified.
288. As a part of its research, data analysis and horizon-scanning function, the Care Safe Agency will need to keep up with demographic changes, societal shifts and international developments that may affect the care system. For example, it is expected that “there will be increasing demand for health and disability services as use and complexity increases with age and increasing prevalence of impairments and comorbidities”.¹⁴⁹
289. The Inquiry also expects the Care Safe Agency to establish and drive a research agenda on abuse and neglect in care, including: building evidence on the risk, extent and impact of abuse and neglect in care; more robust data; agreed key terms and definitions; met and unmet needs; and best-practice measures to prevent and respond to abuse and neglect in care.

¹⁴⁹ Health and Disability System Review, Final Report Pūrongo Whakamutunga (2020, page 17).

290. In particular, it will be important for the Care Safe Agency to keep abreast of international breakthroughs in treating trauma and preventing abuse and neglect, including considering treatment models that lie outside of the Western medical model. The best practice evidence base the Care Safe Agency gathers should be used to guide the development and refinement of policies, laws, practices and guidelines relevant to abuse and neglect, including running pilots to test initiatives in an Aotearoa New Zealand context.
291. The Inquiry expects that the Care Safe Agency will undertake its functions in accordance with te Tiriti o Waitangi and in line with implementation Recommendations 126–127. For example, it will be critical that the National Care Safety Strategy and its supporting action plan are developed with Māori in a way that gives effect to te Tiriti o Waitangi and are co-designed with communities, in consultation with current care providers and government agencies currently involved in the care system. The care safety rules, standards and best practice guidelines must meet the needs of, and reflect the experiences of, survivors and people in care.
292. The Inquiry also envisages that the Care Safe Agency will be empowered to enable individuals or other agencies to carry out specific functions where appropriate. For example, it could enable mental health district inspectors or the Education Review Office (ERO) to carry out investigations on its behalf, if appropriate.
293. The Inquiry recognises that the role, functions and powers of the new independent Care Safe Agency may overlap with roles, functions and powers of existing government departments and entities involved in the care system. The Inquiry therefore recommends that the government reviews existing government departments and entities currently involved in providing and overseeing care, to identify and address overlaps, and consolidate and disestablish, where appropriate.

Te hanga ā te Tira Āhuru Mōwai motuhake Form of the independent Care Safe Agency

294. There are currently at least 17 different agencies responsible for developing policy and strategy for various aspects of social policy that have implications for care systems. Each agency reports to a different portfolio Minister and has different priorities and different strategies to achieve its goals.¹⁵⁰ The government Child and Youth Wellbeing Strategy 2019 stated that “there are too many policies that were developed and implemented in silos”.¹⁵¹ Peter Hughes, Public Service Commissioner, told the Inquiry at its State Institutional Response Hearing that:

“The Public Service has not always worked together in the way that it should and has not been joined up as it should be around children, young people and their families and communities.”¹⁵²

295. In 2023, an interdepartmental executive board was established to strengthen system collaboration for care and provide “a single point of contact for Ministers for issues affecting the care system”.¹⁵³

296. The Inquiry considers that a new standalone independent statutory entity should be established to objectively lead and coordinate across the whole care system. It needs to be completely independent of the people (at all levels, including those involved in strategy, policy, legislation and operational policy) and organisations who have been involved in the care system to date.

297. This is because many survivors have told us they cannot trust the organisations (or their staff) associated with the abuse and neglect they suffered and find interactions with them distressing or traumatising. As set out in Part 7, senior leaders of such organisations have often deployed measures to minimise reputational risk as well as neutralise or cover over institutional abuse during the Inquiry period. In addition to being associated with abuse and neglect in care, a number of these organisations and staff have also been involved in flawed redress processes for historical abuse claims. Survivors have compared their experiences of seeking redress to the original abuse itself.¹⁵⁴

150 Te Kawanatanga o Aotearoa New Zealand Government, “Government A-Z | New Zealand Government”, (undated).

151 Child and Youth Wellbeing Strategy 2019, (Department of the Prime Minister and Cabinet, August 2019, page 13).

152 Transcript of evidence of Peter Hughes, Public Service Commissioner, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, page 1064).

153 Te Kawa Mataaho: Public Service Commission, Report: Chief Executive Board to strengthen system arrangements for State care (2023, page 5).

154 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 150).

298. In the Inquiry's view an Independent Crown Entity is required, one that is not directed by a Minister of the Crown but by an independent Board. A single, independent entity would address diffusion of responsibility, reduce fragmentation, provide cohesive leadership and accountability across the care system, provide a single, trusted point of engagement for survivors, iwi, hapū and communities and provide more responsive, effective and cohesion of functions.
299. Critical to the success of the entity is ensuring that appropriate diversity and lived experience is embedded in the leadership, governance, staffing and advisory roles for the new entity (Recommendation 134).

Tūtohi | Recommendation 41

The government should establish a new standalone Care Safe Agency, with an independent Board to oversee it. The Care Safe Agency should be tasked with functions that include:

- a. whole of system leadership on preventing and responding to abuse and neglect in care
- b. promoting and championing the Care Safety Principles (Recommendation 39)
- c. leading development and implementation of a National Care Safety Strategy and a supporting action plan to prevent and respond to abuse and neglect in care (Recommendation 40)
- d. setting care safety rules and standards (legislative and non-legislative) (Recommendation 47)
- e. monitoring and investigating compliance with the care safety rules and standards (Recommendation 47)
- f. enforcing penalties and sanctions for breaches of the care safety rules and standards (Recommendation 47)
- g. developing best practice guidelines on care safety and preventing and responding to abuse and neglect in care
- h. investigating and reporting on complaints received directly from users of supports and services
- i. collating and keeping a centralised database of issues of concern, complaints and the outcomes of investigations from all State and faith-based entities that provide care directly or indirectly to children, young people and adults in care, from professional registration bodies, and from independent oversight and monitoring entities (Recommendation 67–68)
- j. accrediting all State and faith-based entities providing care directly or indirectly to children, young people and adults in care (Recommendation 48)
- k. registering staff and care workers who are not already covered by existing professional registration regimes (Recommendation 57)
- l. promoting a continuous improvement and learning culture in the care system, including facilitating regular forums and communities of practice and evaluation
- m. setting training and education standards and developing curriculums for staff and care workers

- n. workforce development and developing career pathways for staff and care workers (Recommendation 61)
- o. leading public awareness, education and prevention initiatives (Recommendations 111–112 and 121–122)
- p. undertaking research, data analysis and horizon-scanning, including building evidence on the risk, extent and impact of abuse and neglect in care
- q. publishing data and statistics on complaints of abuse and neglect in care to promote transparency and measurability of outcomes
- r. advising government on preventing and responding to abuse and neglect in care, including where systemic deficiencies are identified.

In defining the scope and functions of the independent Care Safe Agency, the government should consider the additional points made in Chapter 3.

Tūtohi | Recommendation 42

The independent Care Safe Agency should be required to report annually to a parliamentary select committee on the implementation of the Inquiry's recommendations and its other functions.

Tūtohi | Recommendation 43

Before the independent Care Safe Agency is established, the government should review the roles, functions and powers of other government agencies involved in the care system to identify and address any duplications or gaps.



Ngā tikanga me rite i mua i te whakatūnga o te Tira Āhuru Mōwai

Interim arrangements to be in place before the setting up of the Care Safe Agency

300. Given the scale, urgency and priority of the work, the Inquiry recommends interim arrangements within the State while a new entity is established and that government should commit to a timeline for implementation. It is also important that any interim arrangements gain the trust and confidence of survivors. The interim arrangements must have no connection with the former State institutions, government departments or units associated with allegations of abuse and neglect in care, or that have been (or are still) associated or responsible for defending claims in court. This is for the same reasons as those outlined in paragraphs above for the Care Safe Agency.
301. The Inquiry thinks an appropriate arrangement would be for the Care System Office that will be responsible for implementing recommendations (Recommendations 123–124) to perform the functions of the Care Safe Agency in the interim, until it is established. The form and location of the Care System Office is discussed in Recommendation 123.

Tūtohi | Recommendation 44

Until the Care Safe Agency is established, as an interim measure the government should enable the new Care System Office responsible for implementing the Inquiry's recommendations (Recommendations 123–124) to perform the functions in Recommendation 41 above, so far as is practicable.

Te hanga Ture Āhuru Mōwai Establishing a new Care Safety Act

302. The Inquiry considers that new legislation is needed to ensure the foundations of a new, cohesive and integrated regulatory system for care are bedded down and codified. The legislation should create duties, and strengthen and clarify accountabilities, for care providers and staff and care workers. The legislation should include sanctions and penalties such as criminal convictions and fines for organisations and individuals involved in the provision of care (from Department directors, institutional managers, and individual staff) where they fail to fulfil their duty of care.
303. The Inquiry envisages that the legislation would provide for the independent Care Safe Agency to set, monitor and enforce care safety standards, accredit care providers, and register staff and care workers.
304. The Inquiry intends that the design of the legislation (before it is introduced into Parliament) will be developed by government and Māori in accordance with te Tiriti o Waitangi, as well as being co-designed with communities in line with implementation Recommendations 126–127. A review of legislation relevant to contemporary care settings (for example the Oranga Tamariki Act 1989, the Care of Children Act 2004, the Mental Health (Compulsory Assessment and Treatment) Act 1992, and the Pae Ora (Healthy Futures) Act 2022) will be required to identify and address inconsistencies or overlaps between regulatory regimes.

Tūtohi | Recommendation 45

The government should enact a new Care Safety Act and include any legislative measures required to establish a national care safety regulatory framework and to give effect to the Inquiry's recommendations, in particular and at a minimum:

- a. to embed the Care Safety Principles for preventing and responding to abuse and neglect in care (Recommendation 39)
- b. to require a National Care Safety Strategy to prevent and respond to abuse and neglect in care (Recommendation 40)
- c. to establish a new independent Care Safe Agency to lead and coordinate the care system, act as the regulatory agency, and promote public awareness of preventing and responding to abuse and neglect in care (Recommendation 41)
- d. to create a duty of care, and strengthen and clarify the accountabilities of all State and faith-based care providers and staff and care workers (Recommendation 47)
- e. to provide for the creation of care standards (Recommendation 47)
- f. to provide for an accreditation scheme for care providers (Recommendation 48)
- g. to provide for the professional registration of staff and care workers (including volunteers) who are not otherwise subject to a professional registration scheme (Recommendation 57)
- h. to provide for penalties, sanctions and offences for State and faith-based care providers and staff and care workers who fail to comply with statutory and non-statutory standards of care (Recommendation 47)
- i. to provide for mandatory reporting (Recommendation 69)
- j. to provide for a comprehensive and strengthened pre-employment screening and vetting regime for all staff and care workers (Recommendation 58).

Tūtohi | Recommendation 46

The government should review all legislation and regulations relating to the care of children, young people and adults in care to identify and address any inconsistencies, gaps or lack of coherence in the relevant statutory regimes.

Te waihanga raupapa āhuru mōwai whānui me ngā whiu mo te kore e hāngai **Consistent and comprehensive care safety standards and penalties for non-compliance**

305. The State has failed to set and /or ensure compliance with national standards, including legislative standards across all care settings. Rather, each setting has been left to set its own standards, guided by several different pieces of legislation. This contributed to abuse and neglect in care as there were inconsistent, inadequate, and sometimes absent protections for people in care.

Te waihanga i ngā kawenga a te pūnaha taurima ā-ture **Creating a duty of care in legislation**

306. In its interim report, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, the Inquiry recommended that the Crown should create, in legislation, “a right to be free from abuse in care” and “a non-delegable duty to ensure all reasonably practicable steps are taken to protect this right, and direct liability for a failure to fulfil the duty” (Holistic Redress Recommendation 75).¹⁵⁵ As the Inquiry discussed in Part 8, this recommendation has not been implemented.
307. The Inquiry considers that a statutory duty of care is a critical element of the care safety regulatory system and should be provided for in the Care Safety Act. The Inquiry envisages that the Care Safe Agency would be responsible for monitoring and enforcing compliance with the statutory duty of care.

¹⁵⁵ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, Volume 1 (2021, page 333).

Ngā paerewa whakamaru pūnaha taurima

Care safety standards

308. During the Inquiry period there were no legislated care standards in disability, mental health or faith-based settings. While national standards were introduced in social welfare and State education settings from the 1980s, they were enforced inconsistently and at times not at all. Because of the lack of or inconsistent standards, te Tiriti o Waitangi and human rights were not at the forefront of the provision of care.
309. The Inquiry recognises the progress that has been made in introducing and updating different care standards in different care settings since 1999.
310. For example, in health and disability settings, the Health and Disability Services (Safety) Act 2001 provides for the Minister of Health to approve standards for health and disability services.¹⁵⁶ The 2021 Ngā Paerewa Health and Disability Services Standard is intended to apply to all health and disability providers and services.¹⁵⁷ In social welfare settings, two sets of care standards have been created under the Oranga Tamariki Act 1989 – residential care standards¹⁵⁸ and National Care Standards.¹⁵⁹ In education settings, minimum legislative standards are set out in the Education and Training Act 2020.¹⁶⁰ Hostels and boarding facilities associated with schools have standards of care set out in the Education (Hostels) Regulations 2005.¹⁶¹
311. A consistent and comprehensive set of care safety standards is needed that apply across all State and faith-based care settings. The Inquiry envisages that the development of these standards will be led by the Care Safe Agency (Recommendation 41), guided by the Care Safety Principles (Recommendation 39), and in accordance with implementation Recommendations 126–127.
312. The Care Safe Agency may consider that some of the elements of the new care safety regulatory regime it will be responsible for, including care provider accreditation, staff and care worker registration, safeguarding policies and procedures, complaints policies and procedures, and training and education, may require supporting rules or standards. The Care Safety Act should enable the Care Safe Agency to make legislated and non-legislated standards, as appropriate.
313. As there are already a mix of legislated and non-legislated standards in some State care settings, the Inquiry envisages the government will need to consider these to identify and address any repetition or inconsistencies.

¹⁵⁶ Health and Disability Services (Safety) Act 2001, section 13

¹⁵⁷ Ministry of Health, Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (June 2021, page 1).

¹⁵⁸ Oranga Tamariki (Residential Care) Regulations 1996.

¹⁵⁹ Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018

¹⁶⁰ Education and Training Act 2020, section 127.

¹⁶¹ Education (Hostels) Regulations 2005.

Ngā whiu mo te karo tikanga

Penalties and sanctions for non-compliance

314. As a regulatory agency, the Care Safe Agency will be responsible for encouraging compliance with rules and standards through proactive measures, including information, guidance, training and education. Equally important will be taking action against those who fail in their duty of care to keep children, young people and adults in care safe, and fail to comply with legislated and non-legislated rules and standards.
315. A critical element of holding people accountable for abuse and neglect in care is the ability to enforce penalties and sanctions. The Care Safety Act needs to include a comprehensive range of meaningful penalties and sanctions for non-compliance with the care safety rules and standards, to provide a deterrent to non-compliance.
316. The Inquiry recommends that the government provides for offences in legislation as part of the range of penalties and sanctions. The Inquiry envisages that other penalties and sanctions would include monetary fines, suspension or permanent loss of accreditation for care providers (Recommendation 48), deregistration for staff and care workers (Recommendation 57) and removal from the charities register (Recommendation 49). The Inquiry envisages these could include offences like those in the Health and Safety at Work Act 2015, which include imprisonment for the most serious offences.¹⁶²
317. These penalties, sanctions and offences would be used in response to a failure to comply with the statutory duty of care and other rules and standards and guidelines set by the Care Safe Agency. These would include, for example, failure to report substantiated complaints of abuse and neglect, care providers operating without accreditation, care providers employing staff (including volunteers) who are not registered, or failure to ensure that staff and care workers are appropriately trained.
318. The Inquiry intends that these penalties and sanctions would apply to all State and faith-based entities providing care directly or indirectly ("care providers"), as well as individuals who work for those entities, including chief executives, trustees, board members, foster parents, volunteers, clergy and lay people ("staff and care workers").

¹⁶² Health and Safety at Work Act 2015, sections 47–49.

Tūtohi | Recommendation 47

The government should:

- a. establish a duty of care in the Care Safety Act that applies to all State and faith-based entities providing care directly or indirectly for children, young people and adults in care, and staff and care workers
- b. provide for the Care Safe Agency to set, monitor and enforce consistent and comprehensive care safety rules and standards (legislated and non-legislated)
- c. provide for a range of meaningful sanctions and penalties for individuals and State and faith-based entities providing care directly or indirectly for:
 - i. failure to comply with the duty of care under the Care Safety Act
 - ii. failure to comply with care safety rules and standards
- d. provide for offences, including significant monetary fines and imprisonment, for the most serious failures to comply.

He whakamana i te hunga kaitiaki me ngā tikanga noho āhuru matua

Care providers to be accredited and prioritise safeguarding

319. Many organisations providing care during the Inquiry period failed to implement and uphold appropriate standards of care when they did exist. The State failed to adequately investigate and respond to cases where organisations providing care did not comply with standards. In some cases, complaints about abuse in organisations were made, yet the organisations providing care continued to be funded and approved to operate without any action taken to address the complaints.
320. In this chapter, the Inquiry use the term “care providers” to mean all State and faith-based entities providing care directly or indirectly to children, young people and adults in care. Care providers include a range of entities, including non-governmental organisations, community groups, marae, hapū, iwi, Māori organisations, schools, churches, and State agencies directly providing care. The Inquiry intends entities that pastoral care to be included within the definition of care providers in the Care Safety Act, even if they do not provide other kinds of care supports and funded services.

321. The Inquiry does not intend for foster parents or funded family carers of disabled people to be included within the definition of care providers in the Care Safety Act. If they were included, this would require them to be accredited to legally provide care (Recommendation 48). Foster parents (but not funded family carers) will be included within the definition of staff and care workers in the Care Safety Act (Recommendation 45), which will require them to be vetted, registered and trained in order to provide care. Wraparound support should also be provided for foster carers so as to reduce the bureaucratic burden on them and lessen the risk that these additional regulatory requirements will dissuade people from becoming foster carers.

He whakamana i te hunga kaitiaki Care providers to be accredited

322. There are now accreditation requirements for social welfare care providers through Te Kāhui Kahu. The Inquiry did not see evidence of consistent accreditation requirements for disability and mental health care providers outside of any individual contractual arrangements.
323. Based on the evidence the Inquiry has seen, there is a need to strengthen measures to ensure care providers comply with national standards and safeguarding requirements via a system of accreditation. It is critical that this system applies consistently to all care providers and addresses gaps in current accreditation schemes. The Inquiry envisages that, in the immediate and medium term, State entities currently providing direct care supports and services within the Inquiry's care settings, will be covered by the accreditation regime. This would include, for example, Te Whatu Ora (which currently operates inpatient mental health facilities and provides inpatient mental health services) and Oranga Tamariki (which currently operates some care and protection and youth justice facilities and provides supports and services to children and young people in care).

324. The Care Safe Agency will be responsible for the accreditation regime, including identifying the requirements for entry (what the care provider must do to become accredited), maintaining accreditation, and loss of accreditation. The Inquiry expects accreditation to be dependent on a range of issues, including compliance with the rules, standards and guidelines set and monitored by the Care Safe Agency (such as having and following safeguarding and complaints policies and procedures in place, and vetting and training staff to a minimum standard). The Inquiry envisages that the Care Safe Agency would consider other matters that could result in loss of accreditation. These could include proven criminal conduct, such as a conviction for conversion practices¹⁶³ or worker exploitation,¹⁶⁴ or failure to comply with other relevant regulatory regimes. The Inquiry expects that care providers operating without accreditation will be heavily penalised in a manner consistent with Recommendation 47.

Tūtohi | Recommendation 48

The government should:

- a. create a system for the accreditation of all State and faith-based entities providing care directly or indirectly for children, young people or adults in care
- b. provide in legislation that, unless a State or faith-based entity providing care directly or indirectly is accredited, it will not be allowed to operate and will be penalised in a manner consistent with Recommendation 47.

Ka murua te mana roopu mākohā mo te karo tikanga Charities to lose registration status for non-compliance

325. During the Inquiry period, there was a lack of faith-based institutional accountability for abuse in care. This contributed to abuse being able to occur and continue.

326. There is an existing framework that can investigate and sanction serious wrongdoing by those faith-based entities with charitable status. The Charities Act 2005 sets out the grounds under which a registered charity can be removed from the register. This includes removal if “the entity has engaged in serious wrongdoing or any person has engaged with serious wrongdoing in connection with the entity”.¹⁶⁵

¹⁶³ Conversion Practices Prohibition Act 2022, sections 8–9.

¹⁶⁴ Crimes Act 1961, section 98D.

¹⁶⁵ Charities Act 2005, section 32.

327. Currently, the Charities Service can investigate any charity for serious wrongdoing where there is potential criminal offending or proven instances of abuse.¹⁶⁶ Between 2009 and 2022, the Charities Service carried out eight investigations into faith-based charities. Two of these investigations related to Gloriavale, and the other six were faith-based institutions not investigated by this Inquiry.¹⁶⁷ Most faith-based institutions the Inquiry examined have received tax benefits as registered charities.
328. The Care Safety Act (Recommendation 45) will include sanctions that permit or require the de-registration of a charity where abuse or neglect is proven, or where accreditation is removed in the most serious cases, rather than requiring a separate investigation into the same wrongdoing by the Charities Services.
329. In addition, the Inquiry envisages the Care Safety Act will include a requirement for charities who fall within the definition of care provider (having children, young people and adults in their care) to comply with the rules, standards and guidelines to acquire or maintain their charitable status. Failure to comply should include sanctions that permit or require the refusal of registration or the deregistration of a charity that cares for children, young people or adults in care.

Tūtohi | Recommendation 49

The government should:

- a. provide for the Care Safe Agency to investigate complaints or reports of abuse or neglect in the care of registered charities, rather than requiring a separate investigation into the same wrongdoing by Charities Services
- b. provide for the Care Safety Act to require that registered charities that care for children, young people or adults in care must comply with care standards
- c. provide for deregistration of a charity from the register as one of the available suite of sanctions for non-compliance with care standards
- d. amend the Charities Act 2005 to ensure alignment with the Care Safety Act.

¹⁶⁶ Charities Services, Response to Notice to Produce (16 June 2022, paras 3.14–3.16).

¹⁶⁷ Charities Services, Response to Notice to Produce (16 June 2022, para 5.1, Appendices M–R).

Ka whakapiki te hunga kaitiaki i ngā rawa me ngā tikanga whakahaumarū

Care providers to prioritise and resource safeguarding practices

330. During the Inquiry period, the failure of institutions to prioritise clear and effective safeguarding procedures contributed to abuse and neglect. Leaders failed to sufficiently resource the care system, including staff, carers, caregivers and the facilities. This made it easier for perpetrators to not only abuse but also to not be held to account.
331. Effective leadership within organisations is critical to creating an organisational culture where people in care are valued and safeguarding is embedded at all levels. Leaders and staff need to be committed to safeguarding to ensure organisations can implement safeguarding policies effectively. Clear leadership of monitoring and accountability mechanisms is needed together with robust data collection and management.

Tūtohi | Recommendation 50

The leaders of all State and faith-based entities providing care directly or indirectly should ensure there is effective oversight and leadership of safeguarding at the highest level, including at governance or trustee level where applicable.

Tūtohi | Recommendation 51

The leaders of all State and faith-based entities providing care directly or indirectly should ensure that safeguarding is a genuine priority for the institution, key performance indicators are in place for senior leaders, and sufficient resources are available for all aspects of safeguarding.

Tūtohi | Recommendation 52

All State and faith-based entities providing care directly or indirectly should ensure they collect adequate data on abuse and neglect in care and regularly report to the governing bodies or leaders of each institution, based on that data, so they can carry out effective oversight of safeguarding.

Tūtohi | Recommendation 53

The leaders of all State and faith-based entities providing care directly or indirectly should ensure staffing, remuneration and resourcing levels are sufficient to ensure the effective implementation of safeguarding policies and procedures.

Tūtohi | Recommendation 54

The senior leaders of all State and faith-based entities providing care directly or indirectly to children, young people and adults should take active steps to create a positive safeguarding culture, including by:

- a. designating a safeguarding lead with sufficient seniority
- b. supporting the prevention, identification and disclosure of abuse and neglect
- c. ensuring the entity providing care directly or indirectly complies with its health and safety obligations
- d. protecting whistleblowers and those who make good-faith notifications
- e. ensuring accountability for those who fail to comply with safeguarding obligations
- f. prioritising and supporting training and professional development in safeguarding and in abuse and neglect in care including the topics set out in Recommendation 63
- g. actively promoting a culture that values all children, young people and adults in care and addresses all forms of discrimination
- h. ensuring there are sufficient resources for safeguarding
- i. identifying and correcting harmful attitudes and beliefs, such as the disbelief or mistrust of complainants or racist or ableist actions and beliefs
- j. ensuring there is adequate data collection and information on abuse and neglect in care, including relevant data on ethnicity and disability, to allow analysis and reporting
- k. learning from any incidents and allegations
- l. publicly reporting on the matters including any issues arising in relevant annual reports.

Me whakatinana ngā kaupapa me ngā tikanga tauārai

Safeguarding policies and procedures to be implemented

332. The Inquiry found many institutions had no, inadequate, or poorly implemented safeguarding procedures including training, reporting and investigation systems to prevent and respond to abuse and neglect. Many institutions providing care paid insufficient attention to preventing and detecting the abuse and neglect of children, young people and adults in care. This was particularly evident in social welfare and youth justice residences, psychiatric and psychopaedic hospitals, special schools, faith-based children's homes and faith-based boarding schools.
333. This began to shift from the mid-1980s onwards, where the State began to make changes to legislation that embedded discrete components of safeguarding in the policies, rules, standards, and practices of most institutions operating in health, social welfare and educational settings. This was not the case for disability and mental health settings or faith-settings, where the Inquiry found little evidence of national standards until the 1990s. These also did not apply to all people in those settings.
334. Safeguarding policies and procedures must reflect Aotearoa New Zealand's commitment to te Tiriti o Waitangi and human rights instruments. They must express how the rights of children, young people and adults in care will be upheld while simultaneously keeping them safe.
335. Children, young people, and adults in care need safeguarding before, during, and after care. Evidence shows that lack of consistent safeguarding processes increases the risk of abuse and neglect. This is consistent with other international inquiries that note a lack of, or poor, policies, rules, standards and practices to safeguard children and adults in care, and a failure to ensure these are followed, contributes to abuse and neglect.¹⁶⁸
336. All State and faith-based care providers and all relevant professional registration bodies must have accessible, effective and culturally appropriate safeguarding policies and procedures in place. The Inquiry envisages that care providers will develop these policies and procedures guided by the Care Safety Principles (Recommendation 39) and any guidance or standards developed by the Care Safe Agency (Recommendation 41). The Inquiry intends that care providers' ability to maintain accreditation status (Recommendation 48) will be dependent on having best practice safeguarding policies and processes in place and demonstrating that these are being followed.

¹⁶⁸ Australian Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report: Nature and cause, Volume 2 (2017, pages 172–173); United Kingdom Independent Inquiry into Child Sexual Abuse, Child sexual abuse in contemporary institutional contexts: An analysis of Disclosure and Barring Service discretionary case files (July 2021, page 92–93).

Tūtohi | Recommendation 55

All State and faith-based entities providing care directly or indirectly should have safeguarding policies and procedures in place that:

- a. are consistent with the Care Safety Principles (Recommendation 39)
- b. are consistent with the National Care Safety Strategy (Recommendation 40)
- c. are compliant with care safety rules and standards (Recommendation 47)
- d. are consistent with best practice guidelines issued by the Care Safe Agency
- e. are tailored to the risks of the particular organisation and care provided
- f. are clearly written
- g. are published in a readily accessible format
- h. give effect to te Tiriti o Waitangi
- i. are culturally and linguistically appropriate
- j. are responsive to the needs of children, young people and adults in care, including Māori, Pacific Peoples, Deaf and disabled people, and people experiencing mental distress, and Takatāpui, Rainbow and MVPFAFF+ people
- k. are regularly reviewed, including periodic external reviews
- l. are audited for compliance, including periodic external audits.

Tūtohi | Recommendation 56

All State and faith-based entities providing care directly or indirectly should have safeguarding policies and procedures that address, at a minimum:

- a. how the entity providing care directly or indirectly will protect children, young people and adults in care from harm
- b. how the entity providing care directly or indirectly will comply with the applicable standards and principles
- c. how people can make complaints about abuse and neglect to the entity, the Care Safe Agency or independent monitoring entities (Recommendation 65)
- d. how complaints, disclosures and incidents will be investigated and reported, including reporting to the Care Safe Agency, professional bodies or NZ Police and other authorities (Recommendation 65)
- e. the protections available to whistleblowers and those making good faith notifications of abuse and neglect
- f. how the entity providing care directly or indirectly will use applicable information-sharing tools
- g. how the entity will publicly and regularly report on these matters.

Ngā kaimahi me ngā kaitiaki, kia tōtika, kia āta wherawherahia, me rēhita, me tautoko, kia tika te ako

Staff and care workers to be appropriate, vetted, registered, supported and well trained

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337. From 1950–1999, the Inquiry found there was widespread poor practice in relation to the recruitment, vetting, training and support of care staff, volunteers and carers. In many cases there were no or inadequate policies in place to ensure that people providing care were appropriate and well supported to provide a safe care environment to tamariki, rangatahi and adults.

338. In this chapter, the Inquiry uses the term “staff and care workers” to mean all people who work for State and faith-based entities providing care directly or indirectly to children, young people or adults in care. The Inquiry intends this definition to be broad, to include any person who may come into contact with children, young people and adults in care through working or volunteering for a care provider. This includes foster parents, teachers, religious leaders, teaching assistants, psychiatrists, social workers, doctors, nurses, NZ Police, orderlies, chief executives, gardeners, priests, board members, trustees, cleaners, cooks, personal care assistants. The Inquiry intends for clergy and lay people who work or volunteer for entities that provide pastoral care to be included within the definition of staff and care workers in the Care Safety Act, even if the entity that provides pastoral care does not provide other kinds of care supports and funded services.
339. The Inquiry does not intend for parents (including adoptive parents) to be included in the definition of staff and care workers in the Care Safety Act. If they were, then this would require parents to be vetted, registered and trained to legally provide care for their children. The current adoption process (including private adoptions) requires prospective adoptive parents to be formally assessed and approved, including NZ Police, medical and referee checks.¹⁶⁹ The Inquiry is aware of significant concerns held by the disabled community and Māori about current adoption laws and practices,¹⁷⁰ and that the Ministry of Justice is “currently undertaking work to reform Aotearoa New Zealand’s adoption laws”.¹⁷¹ The recommendations in this report are not intended to affect or influence those reforms.
340. The Inquiry does not intend for funded family carers of disabled people to be included within the definition of staff and care workers in the Care Safety Act. If they were included, it would require parents and siblings to be vetted, registered and trained to legally provide care for their disabled family members. The Inquiry is aware that there has been a recent Court of Appeal decision on the employment status of funded family carers of disabled people.¹⁷² The Inquiry does not intend these recommendations to affect or influence those matters.

169 Ministry of Justice, *Adoption in Aotearoa New Zealand Discussion Document* (June 2021, page 43).

170 *Adoption Action Inc v Attorney-General* [2016] NZHRRT 9, para 203; Ināia Tonu Nei, Submission by Ināia Tonu Nei on the review of adoption laws (17 January 2022, page 1), <https://www.inaiatonunei.nz/post/review-of-adoption-laws-submission>; Ināia Tonu Nei and Pou Tikanga National Iwi Chairs Forum, Draft notes from Whāngai Wānanga (10 August 2022, page 4), <https://www.inaiatonunei.nz/post/news-update-3>.

171 Ministry of Justice, *Response to Notice to Produce 443* (27 June 2022, para 7.2).

172 *Attorney-General v Christine Fleming* [2024] NZCA 92 [9 April 2024]; *Fleming v Attorney-General* [2021] NZEmpC 77.

Me rēhita ngā kaimahi me ngā kaiārahi

Staff and care workers must be registered

341. There were poor standards and practices relating to the registration of care workers across the different care systems during the Inquiry period. Many sectors' workforces were professionally unregulated, and many staff did not have the values, skills, experience and training to provide safe and appropriate care to children, young people and adults in care.
342. In disability and mental health settings, the Medical Council of New Zealand was the regulatory body responsible for the registration and discipline of medical practitioners, including psychiatrists. The Medical Practitioners Act 1995 tightened restrictions on registration. The Nursing Council of New Zealand decided who could become a registered nurse. Throughout most of the Inquiry period the only restrictions outlined in the governing legislation were that the nurse had to be a certain age and "of good character and reputation".¹⁷³
343. Until 1989, the Department of Education registered teachers, with no requirement to vet teachers before they worked in education settings. The Teacher's Registration Board was established in 1989. Most other staff, including social workers and non-medical staff in disability and mental health settings were professionally unregulated for the entire Inquiry period.¹⁷⁴
344. Since 1999 there have been changes to professional regulation of the care workforce. Social workers were regulated under the Social Workers Registration Act 2003, with registration being voluntary until 2021 when it became mandatory.
345. There are professional registration bodies for social workers, teachers, psychiatrists, NZ Police, nurses and medical practitioners, but there are no such bodies for other people who work (or volunteer) for care providers, such as teacher aides, clergy, orderlies, chief executives, trustees, lay people, religious leaders and personal care assistants.
346. In its view it is critical to ensure all staff and care workers are covered by an appropriate registration scheme. It also provides an additional safeguard to prevent abusers from working with children, young people and adults in care. A consistent system of professional registration will also better enable the provision of specialised support, education, training and professional development opportunities to for staff to work effectively, provide safe care environments and improve career satisfaction.

¹⁷³ Nurses and Midwives Act 1945, section 16; Nurses Act 1971, section 19; Nurses Act 1977, section 19.

¹⁷⁴ For example, see Social Work Registration Act 2003.

347. The Inquiry therefore recommends the creation of a new professional registration scheme that covers all staff and care workers who are not already covered by an existing professional registration regime. The Care Safe Agency will be responsible for the registration scheme, including identifying the requirements for registration, maintaining registration, suspension of registration, or de-registration. The Inquiry envisages registration to be dependent on staff and care workers complying with relevant rules, standards and guidelines set and monitored by the Care Safe Agency, including being vetted and trained.
348. The Inquiry envisages that a relevant criminal conviction or substantiated complaint of abuse or neglect would prevent a person from being registered or would result in deregistration. The Care Safe Agency will need to exercise careful judgement about what criminal convictions would create a barrier for registration, so that it does not prevent people with lived experience of care from entering the care workforce. As the Inquiry has reported, the impacts of abuse and neglect in State and faith-based care mean it is much more likely that survivors will commit offences themselves and interact with the criminal justice system. Some of these offences may not automatically mean that the survivor would not be safe to provide care.

Tūtohi | Recommendation 57

The government should create a system of professional registration for all staff and care workers who are not already covered by a professional standards regime. The Care Safe Agency should be empowered to establish and maintain standards of training, conduct and professional development and with the power to enforce these through fitness to practice procedures. The government should consult on the scope and nature of the professional registration system and phase in the introduction of the system.

Me mātai, me āta wherawhera ngā kaimahi me ngā kaimahi pūnaha taurima

Staff and care workers to be screened and vetted

349. Nearly all State and faith-based settings the Inquiry investigated lacked adequate vetting and safety checking processes for potential or existing employees. Safety checks of staff or carers were not a mandatory part of recruitment processes, exposing people in care to higher risk of harm.
350. Care settings that did have safety checking processes in place tended to rely on prospective employees to self-declare any criminal activity. In the absence of system-wide policies requiring vigorous and mandatory safety checking, abusers gained access to children, young people and adults in care, with some serial abusers operating across multiple settings.
351. In addition, when safety checking processes were in place within institutions, they were often inconsistently applied. If and how safety checking for employees was implemented or followed varied from setting to setting.
352. The State made some improvements to safety checking in the latter part of the Inquiry period for foster or adoptive parents and for education. NZ Police vetting was not mandatory during the Inquiry period and was limited to some settings and some individuals. From the 1980s onwards, vetting requirements were part of service contract requirements in social welfare and disability and mental health settings. The Inquiry saw limited evidence of initiatives to improve safety checking for staff and volunteers in most faith-based settings during the Inquiry period.
353. Since 1999 there have been changes to vetting requirements for care workers and volunteers. Some settings have specific statutory requirements to vet, like education settings, and others have statutory requirements depending on whether they are a government agency, or they are funded by a government agency to provide a "regulated service" – these statutory requirements are set out in the Children's (Requirements for Safety Checks of Children's Workers) Regulations 2015 and apply to paid staff and volunteers in certain contexts.
354. In disability and mental health settings, it is a complex mix of professional requirements for vetting, service contract requirements, and statutory requirements like the Children's (Requirements for Safety Checks of Children's Workers) Regulations 2015 where these apply. For example, for community residential services funded by Whaikaha, which provides 24-hour support for disabled people, the requirements for service providers to vet their staff, paid and voluntary, is set out in the Whaikaha tier two service specification.¹⁷⁵

¹⁷⁵ Whaikaha Ministry of Disabled People, Disability support services: Tier two service specifications community residential support services (August 2023, para 6.8.1(c)).


355. The Children's Act 2014 increased staff vetting and screening processes for all people working with children and the Children's (Requirements for Safety Checks of Children's Workers) Regulations 2015 require all those working with children and young people in government-funded organisations to undertake safety checks that are updated every three years.
356. In its most recent report in 2023, the Independent Children's Monitor found that:
- "In its response to the Inquiry last year, Oranga Tamariki noted it was concerned by the finding that caregivers were not always assessed prior to placing tamariki and rangatahi in their care. They noted it would remedy this with urgency... There has been no evidence of change this year, however it may be too soon to see changes."*¹⁷⁶
357. At the Inquiry's State Institutional Response Hearing, Police Commissioner Andrew Coster said that:
- "The Police Vetting Service deals with more than 15,000 approved agencies who collectively request more than 600,000 vets annually. The lack of a clear statutory framework for vetting creates uncertainty about what information can be considered as part of the vetting process."*¹⁷⁷
358. The Inquiry has found that poor safety checking policies and practices in care settings contribute to abuse and neglect. Comprehensive pre-employment screening practices should include thorough reference checks, examining employment history and verifying identity using multiple sources.¹⁷⁸ Organisations should not solely rely on background checks or assume that there is no risk of abuse and neglect once a candidate has been vetted. For this reason, safety checking needs to be included within broader safeguarding policies of all entities providing care directly or indirectly.
359. In addition to safety checking, pre-employment screening should test whether potential caregivers, including foster parents and volunteers, have appropriate values and ethics to uphold the rights of people in their care. Further, they must have the capability and capacity to remain reliable, sensitive and responsive to the needs of people in care, including their ability to tolerate difficult and challenging behaviours. People in care need to develop attachment to their caregivers in order to thrive. This is particularly true for tamariki and rangatahi of all ages, as attachment is a critical part of childhood development.¹⁷⁹ In promoting secure attachment caregivers also need to be able to meet the cultural needs of the people they care for.

176 Aroturuki Tamariki, the Independent Children's Monitor, Experiences of Care in Aotearoa: Agency Compliance with the National Care Standards and Related Matters Regulations 1 July 2022–30 June 2023 (2024, page 88).

177 Transcript of evidence of Chief Social Worker Peter Whitcombe for Oranga Tamariki at the Inquiry's State Institutional Response Hearing (24 August 2022, page 786).

178 South, S, Shlonsky, A, Mildon, R, Scoping review: Evaluations of pre-employment screening practices for child-related work that aim to prevent sexual abuse (Royal Commission into Institutional Responses to Child Sexual Abuse, 2014, page 7).

179 Calvert, S, Expert Opinion report for Royal Commission (2022, page 15).

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360. The ability of caregivers to build relationships and provide consistent, sensitive and responsive care profoundly affects the organisation and security of attachment with the people they care for. Attachment-informed practice (which is also culturally responsive) may require a policy and culture shift to ensure that people's needs are appropriately met when they are cared for away from home. This is something that should be rigorously tested as part of the pre-employment process, using a range of methods including methods appropriate to a range of cultural world views, for example Māori and Pacific Peoples.
361. There needs to be a consistent and comprehensive pre-employment screening and vetting regime that applies to all staff and care workers. As described earlier in this chapter, staff and care workers includes all people working for care providers, including paid and volunteer workers, people in religious ministry and lay people. The Inquiry intends this will include foster parents, as well as extended whānau carers who are currently included in statutory vetting requirements. The Inquiry does not intend that funded family carers of disabled people would be subject to these requirements.
362. The Inquiry envisages that this comprehensive and consistent pre-employment screening and vetting regime will be enabled through the Care Safety Act. This will require a review of current statutory arrangements, including those in the Children's Act 2014, to identify and address gaps and overlaps.
363. The United Kingdom's Safeguarding Vulnerable Groups Act 2006 could be reviewed for learnings and relevance to the Aotearoa New Zealand context. This Act established the Vetting and Barring Scheme, which is administered by a central agency that holds criminal records (the Disclosure and Barring Service). Under this scheme, all people working with children or adults in care have a statutory requirement to undergo a vetting process. Under the Act there is a centralised children's barred list and adults in care barred list. Certain groups (including certain employers and local authorities) must provide information about individuals to the Disclosure and Barring Service.¹⁸⁰

180 Llwodraeth Cymru Welsh Government, Safeguarding Vulnerable Groups Act 2006 (England and Wales).

Tūtohi | Recommendation 58

The government should:

- a. provide in the Care Safety Act for a comprehensive and consistent pre-employment screening and vetting regime, so that all entities seeking to engage a person to care for children, young people or adults in care (whether as an employee, contractor, volunteer or otherwise and whether in a State or faith-based institution providing care directly or indirectly context) have timely access to comprehensive information to ensure the person is safe and suitable for the relevant role
- b. ensure the regime for children's worker safety checking remains fit for purpose
- c. consider whether to introduce a barring regime similar to that established by the Safeguarding Vulnerable Groups Act 2006 in the United Kingdom.

Tūtohi | Recommendation 59

All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should ensure all prospective staff, volunteers and any other person working with children, young people or adults in care ('prospective staff') have a satisfactory report from the applicable vetting regime and up to date registration status.

Tūtohi | Recommendation 60

All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should ensure their pre-employment screening checks include:

- a. thorough reference checks, including asking direct questions about any concerns about the applicant's suitability to work with children, young people or adults in care
- b. employment interviews that focus on determining the applicant's suitability to work with children, young people or adults in care
- c. critically examining an applicant's employment history and / or written application (for example to identify and seek an explanation for gaps in employment history, or to explain ambiguous responses to direct questions about criminal history)
- d. verifying the applicant's identity, education and qualifications
- e. assessing the ability of caregivers, including foster parents and volunteers, to build relationships and provide consistent, sensitive and responsive care, including being able to meet the cultural needs of the people they care for.

Me manawapā, me huhua ngā kaimahi me ngā kaimahi pūnaha taurima

Valued and diverse staff and care workers


364. During the Inquiry period, the Inquiry found that quality of care was impacted by negative conditions and employment practices for staff and care workers. Poor supervision and management practices meant that staff were often left unsupported. Care settings were also understaffed, which contributed to abuse as staff were overworked, tired and under pressure which affected their ability to provide individualised care, and led to emotional, physical, and educational neglect of people in care.

365. Providing care has been and continues to be undervalued by society. Activities that involve caring for and supporting other people have often been invisible and underpaid. The Inquiry heard of the many different ways that care work was undervalued throughout its Inquiry period. For example, in Part 3, the Inquiry discussed how there was a lack of government support for whānau wishing to support disabled tamariki, rangatahi or adults within their homes, which meant disabled people were more likely to enter care. Within care settings, the fact that care work was not valued was evident in how many staff and care workers were not appropriate or appropriately trained, were under paid, experienced poor working conditions and were otherwise not supported to provide safe and therapeutic care. These factors contributed to environments in which abuse was more likely to occur.
366. In 2021, the Oranga Tamariki Ministerial Advisory Board reported that:
- “We are particularly concerned about the wellbeing of (particularly) care and protection staff. They carry high and complex workloads with minimal support beyond regional offices.”***¹⁸¹
367. The 2020 Health and Disability System Review, in its findings about developing a valued workforce said:
- “Retaining and upskilling staff will be critical, as well as attracting new workers with appropriate skills and ensuring that the workforce is delivering culturally responsive services. This is particularly relevant for home and community support services (HCSS). These services have been delivered by a semi-trained workforce with low wages, low qualification levels and poor working conditions.”***¹⁸²
368. The Inquiry wants to see a shift to care and support being recognised for the skilled, professional work that it is. The Inquiry wants to see whānau and foster carers provided with support to provide a caring whānau environment for people in care and to meet their own wellbeing needs. This will require shifts in terms of social attitudes about the value of care, as well as conditions.

181 Oranga Tamariki Ministerial Advisory Board, Hipokingia ki te Kahu Aroha, Hipokingia ki te Katoa:

The initial report of the Oranga Tamariki Ministerial Advisory Board (Oranga Tamariki, September 2021, para 55, page 30).

182 Health and Disability System Review, Final Report Pūrongo Whakamutunga (2020, page 143).

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369. Staff and care workers often support children, young people and adults with complex needs and challenging circumstances. The Inquiry see positive working conditions, where staff and care workers feel valued, have support, are not overworked and under resourced and can maintain a healthy work life balance as a key way to improve quality of care and prevent abuse and neglect. There is also a need to improve work and personal satisfaction for the care sector and address issues such as poor retention and burnout. Critical to this is ensuring a positive workplace culture.
370. In addition were Pākehā, hearing and non-disabled. This lack of diversity and lived experience contributed to a lack of understanding of the experiences of people in care and in some cases contributed to, and created, discriminatory environments.
371. In his evidence to the Inquiry, Public Service Commissioner Peter Hughes said:
“The Public Service workforce has not reflected the make-up of its society and it has not fostered workplaces that are inclusive of all groups. In my view, if you are looking for an antidote to bias and prejudice in organisations or in institutions, it is diverse and inclusive workforces.”¹⁸³
372. A more systemic and consistent approach to increase the diversity and representation of both employers and carers is required. This includes ensuring there are career pathways and support for people with lived experience of care and from diverse backgrounds, including prioritisation of peer support networks. People with care experience bring significant value, knowledge and understanding but may require additional support. An example may be additional support for people with low literacy or accommodations for disabled or neurodivergent people to ensure they can participate in the workforce.
373. The Inquiry envisages that a part of the role of the Care Safe Agency (Recommendation 41) will be to develop a workforce strategy that addresses these issues.

¹⁸³ Transcript of evidence of Peter Hughes, Public Service Commissioner, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, page 1064).

Tūtohi | Recommendation 61

The Care Safe Agency should develop a workforce strategy for the care sector that includes:

- a. ensuring there are enough people with the right skills, experiences and values to meet needs of people in care including developing strategies to address skill gaps
- b. identifying training needs
- c. fostering positive workplace cultures where people in care and staff and care workers are valued and have their voices heard
- d. strengthening support, supervision and management practices
- e. improving workplace conditions including wellbeing, safe ratios, workloads and remuneration
- f. removing barriers to enter into the care workforce in a safe manner
- g. ensuring opportunities for professional development and career progression, including targeted measures to support career pathways for:
 - i. people with lived experience of care
 - ii. Māori, Pacific Peoples, Deaf and disabled people, people who experience mental distress, and Takatāpui, Rainbow and MVPFAFF+ people
- h. measuring staff and carer wellbeing and satisfaction.

Tūtohi | Recommendation 62

All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should recruit for and support a diverse workforce, including in leadership and governance roles, so far as practicable reflecting the care communities they serve and care for.

Te ako me te tautoko i ngā kaimahi pūnaha taurima me te hunga tūao

Training and support for care workers and volunteers

374. During the Inquiry period the Inquiry found that that many staff and volunteers across both State and faith-based settings did not have sufficient skills, experience, training and support to provide safe and appropriate care to children, young people and adults. This contributed to people in care experiencing abuse and neglect.
375. In 2021, the Oranga Tamariki Ministerial Advisory Board reported that:
- “The current quality and provision of training and professional development is not at an acceptable standard. The reduction in provision of training since 2017, with the expectation that supervisors and practice leaders will primarily be the trainers, has impacted on the capacity of these professional leaders to carry out their responsibilities effectively.”¹⁸⁴*
376. It is critical that people providing care have access to appropriate training and support to contribute to positive outcomes for people in care, building on their strengths and goals. We've identified key areas where training and support can be strengthened. These are in relation to safeguarding policies and procedures, recognising abuse and neglect, meeting the needs of people in care and addressing prejudice and discrimination.
377. The Care Safe Agency (Recommendation 41) will have a role in setting minimum training requirements and standard curriculum and may engage with professional registration schemes to link completion of certain training to registration and accreditation.

Ngā pouhere mahi me te ako kaimahi hei tauārai i ngā kaupapa me ngā tikanga Staff codes of conduct and training in safeguarding policies and procedures

378. The Inquiry has made a range of recommendations about care settings instituting safeguarding policies to better protect people in care. These focus on developing safeguarding policies that are consistent with the National Care Safety Strategy (Recommendation 40) and Care Safety Principles (Recommendation 39) and ensuring appropriate leadership and resourcing for the implementation of safeguarding policies (Recommendations 55–56).
379. Another key component of having effective safeguarding policies in place is having codes of conduct in place and providing training for staff and volunteers so they understand the policies, the organisational culture prioritising safeguarding that underpins the policies and their responsibilities to safeguard people in care.

¹⁸⁴ Oranga Tamariki Ministerial Advisory Board, Hipokingia ki te Kahu Aroha, Hipokingia ki te Katoa: The initial report of the Oranga Tamariki Ministerial Advisory Board (Oranga Tamariki, September 2021, para 55, page 30).

Me ako, me tautoko, hei tohi, hei ārai i ngā mahi tūkino

Training and support to identify and prevent abuse and neglect

380. The Inquiry saw that, in many cases, individuals failed to intervene to prevent abuse, despite warning signs that should have alerted them to the fact that children, young people and adults were being abused. In its view, training about how to prevent, identify and respond to abuse and neglect, is an important tool in raising understanding that abuse prevention is everyone's responsibility.
381. Many settings did not provide adequate training and the training that was provided did not focus on creating a supportive care environment and preventing abuse and neglect. This led to the over-use of restrictive practices and solitary confinement and higher risks of harm to people in care.
382. During the Inquiry period, faith-based institutions had very limited training, relying on faith instruction rather than providing tools to train and oversee religious ministry and lay volunteers.
383. From the 1980s there was increased awareness about abuse and neglect, leading to the development of handbooks, guidelines and other training materials for staff in social welfare settings. However, training in disability and mental health institutions and most faith-based care remained limited.
384. A 2021 report from Te Kāhui Tika Tangata Human Rights Commission into the violence and abuse of disabled people in Aotearoa New Zealand found that:
- “There are no nationally mandated specialized qualifications, competency requirements, or standardized training programmes for people working in the disability and violence sectors.”¹⁸⁵***

¹⁸⁵ Te Kāhui Tika Tangata Human Rights Commission, Whakamahia te tūkino kore ināianei, ā muri nei – Acting now for a violence and abuse free future: violence and abuse of disabled people in Aotearoa New Zealand evidence and Recommendations (December 2021, page 42).

385. The same report found that:

*"...there are few trained services /professionals who can respond appropriately to violence, neglect and abuse of disabled people. This situation is particularly acute for people who are non-verbal and those who require support for comprehension and decision-making."*¹⁸⁶

386. All staff and care workers who work for State and faith-based care providers, providing care directly or indirectly for children, young people and adults should be trained to understand their safeguarding responsibilities, and to understand and identify abuse and neglect. This should be included in educational and qualification programmes for the care workforce and tied to staff and care worker registration (Recommendation 57).

Me ako, me tautoko ngā kaimahi ki te tutaki i ngā manako o te hunga i roto i ngā pūnaha taurima

Training and support for staff to meet the needs of people in care

387. In Part 7 the Inquiry found that poor or inadequate training and development specific to care roles was a factor that allowed abuse to occur and continue, and that many Māori, Pacific Peoples, Deaf and disabled people, and people experiencing mental distress did not have their distinct needs met in care. Many staff and carers did not have the training and development needed for their roles and the demands they faced in care settings.

388. In Mana Mokopuna's 2021 monitoring report into te Oranga residence, they said "Staff must be appropriately trained to manage mokopuna with complex mental health needs without resorting to the use of secure as a way of managing".¹⁸⁷

389. Support, supervision, training and professional development should be provided to all caregivers, including foster parents and volunteers, on a frequent and regular basis to ensure that they are able to develop and maintain their capacity to provide reliable, sensitive and responsive care to the people they are looking after, including their ability to tolerate difficult and challenging behaviours. Training should also focus on the values and ethics needed to work appropriately support people in care, including respect and understanding of diversity and recognising people's strengths and inherent value.

¹⁸⁶ Te Kāhui Tika Tangata Human Rights Commission, Whakamahia te tūkinō kore ināianeī, ā muri nei – Acting now for a violence and abuse free future: violence and abuse of disabled people in Aotearoa New Zealand evidence and Recommendations (December 2021, page 37).

¹⁸⁷ Office of the Children's Commissioner, Te Oranga OPCAT Monitoring Report (October 2021, page 9).

Ngā mahi ako hei tutaki i ngā mahi parahako ngā āhua toihara katoa **Training that responds to prejudice and all forms of discrimination**

390. Society shaped attitudes about the people in care and impacted how they were treated. This included the attitudes and views of staff and carers.
391. The Inquiry found that Māori, Pacific, Deaf, disabled, Takatāpui, Rainbow, and MVPFAFF+ survivors, and survivors who experienced mental distress were targeted and faced additional trauma as a result of abuse and neglect in State and faith-based care. In many cases, staff and carers' attitudes reflected those in broader society which were discriminatory and reflected racism, ableism, sexism, homophobic and transphobic views.
392. At the Inquiry's State Institutional Response hearing, the Chief Executive for Oranga Tamariki, (Chappie) Te Kani, acknowledged that one of the reasons Oranga Tamariki is trying to lift cultural capability across its workforce is because personal biases still exist and could be held by some Oranga Tamariki employees.¹⁸⁸
393. At the Inquiry's Ūhia te Māramatanga Disability and Mental Health Hearing, expert panellist Dr Tristram Ingham (Ngāti Kahungunu, Ngāti Porou) described how the differential quality of care received "is perpetuated, in particular, by culturally unsafe models imposed on tāngata whaikaha Māori and Māori experiences of institutional racism and explicit and implicit racism within services".¹⁸⁹ Recent developments in relation to social attitudes are discussed further under Recommendation 128.

¹⁸⁸ Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 August 2022, page 638).

¹⁸⁹ Transcript of evidence of Dr Tristram Ingham at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institution Hearing (Royal Commission of Inquiry into Abuse in Care, 20 July 2022, page 647).

Tūtohi | Recommendation 63

All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should ensure:

- a. they have a code of conduct in place, which requires those providing care to comply with applicable safeguarding policies and procedures
- b. all staff, volunteers and any others (ordained and non-ordained) working with children, young people or adults in care ("staff and care workers") receive an induction promptly after they begin their employment and are aware of their safeguarding responsibilities including reporting obligations
- c. supervisors and people leaders have a safeguarding focus, all staff receive training that ensures understanding about the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40), and all statutory requirements under the Care Safety Act (Recommendation 45), including care standards, accreditation and vetting
- d. all staff are trained and kept up to date in applicable safeguarding policies, procedures and practices
- e. all staff receive up to date training on how to identify and prevent abuse and neglect
- f. all staff are trained in appropriate trauma informed practice, disability informed practice, an understanding of neurodiversity, te Tiriti o Waitangi, Māori cultural practices, Pacific and ethnic cultural practices, human rights and an understanding of abuse and neglect in care both historically and present-day
- g. all staff are trained to identify and address (in themselves and others) prejudice and all forms of discrimination
- h. all staff are provided with support, supervision, training and professional development on a frequent and regular basis to ensure they are able to develop and maintain their capacity to provide reliable, sensitive and responsive care to the people they are looking after
- i. all staff receive appropriate professional development support, including in how to protect children, young people and adults in care from abuse and neglect and respond to disclosures
- j. there are no adverse employment or other consequences for those making good faith notifications or disclosures of abuse and neglect.

Tūtohi | Recommendation 64

All State and faith-based entities providing care directly or indirectly to children, young people and adults in care should ensure that the same rules and standards in relation to vetting, registration, training and working conditions that apply to employees apply equally to volunteers or others with equivalent access to children, young people and adults in care. In particular, faith-based entities should ensure the same rules apply to people in religious ministry and lay volunteers as to employees.

Kia tika te whakaea i ngā tautohenga Complaints are responded to effectively

394. During the Inquiry period there was a lack of accessible, effective and culturally appropriate complaints processes in both State and faith-based institutions. Some settings, such as faith-based care, did not have any complaints processes in place to follow. Where there were complaints processes in place they could be unclear and their use highly dependent on the individual institutions and staff in charge.
395. The Inquiry heard that survivors were often not believed, and employee rights were prioritised over the rights of survivors to be heard. Institutions protected their or the abuser's reputation over the survivor needs. The Inquiry also saw instances where abusers held positions where they had responsibility for receiving and investigating complaints. There was also a failure to report complaints to NZ Police. For the limited number that NZ Police heard about there was again a failure to believe the survivors, resulting in inadequate responses and follow up and poor record keeping of any of complaints.
396. All of these factors meant that few perpetrators received any consequences for their actions.
397. Implementing the recommendations in this report will result in four possible pathways for people who use care supports and services and their whānau and support networks to make complaints, disclosures or report incidents of abuse and neglect in care:
- a. complaints to the relevant State or faith-based care provider
 - b. complaints to the relevant professional registration body
 - c. complaints to the Care Safe Agency
 - d. complaints to independent oversight and monitoring bodies.

398. Care providers and relevant professional registration bodies will be required to have consistent and comprehensive complaints policies and procedures (guided by the Care Safe Principles). They will also be required to hold perpetrators to account, by taking appropriate professional disciplinary action, and reporting substantiated complaints to the Care Safe Agency and NZ Police.

Me whakarite ngā kaupapa me ngā tikanga takinga kōamuamu Complaints policies and procedures are in place

399. During the later part of the Inquiry period, more comprehensive complaints processes were introduced, for example, the Children and Young Persons (Residential Care) Regulations 1986 introduced rights to a grievance procedure (further expanded in 1996), and the Mental Health (Compulsory Assessment and Treatment) Act 1992 included a complaints procedure.
400. The Inquiry saw limited evidence of formal investigative processes within faith-based institutions during the Inquiry period. In 1998 some progress was made in the Catholic Church with the introduction of Te Houhanga – A Path to Healing, but this guidance only dealt with sexual abuse. More recently, other faith-based institutions have begun developing guidance for complaints processes.
401. A review of Disability Support Services in 2013 found a recurring theme in one of the services run by a charitable trust was the “fear of retribution if a family member or resident complained about the quality of the service.” A report from the temporary managers of the service noted that:
- “The Residents are too scared to complain, because past experience has taught them that complaining could be very punishing.”¹⁹⁰*

¹⁹⁰ Grammer, B, Russell, D, & Van Eden, K, Putting People First: A Review of Disability Support Services Performance and Quality Management Processes for Purchased Provider Services (November 2013, page 38).

402. A 2013 report on the experiences of disabled people living in the community found that disabled people faced numerous barriers to making complaints:
- “In all situations where a complaint was made to the police the allegedly abused individual remained in the residence or home during the investigative period. Further, in the majority of cases there was insufficient evidence to arrest or remove the perpetrator from the residence. This placed the complainant at considerable risk of retribution.”*¹⁹¹
- Numerous accounts were offered where a complaint of abuse was negated on the grounds that the disabled person’s testimony lacked veracity. This generally involved some form of disparagement of the individual complainant. ... On other occasions the complainant’s strength of character was questioned. This was reported as most commonly occurring when individuals possessed a mental health diagnosis.”*¹⁹²
403. Issues with the way that school boards handle complaints and investigations persist. They were highlighted in the media in June 2023 in an incident involving a five-year-old boy being physically and sexually assaulted by two older pupils in the toilets of his Waikato school. The boy’s father was “astounded the two boys involved had not been immediately suspended” and believed that that the principal was not taking the “situation seriously because the parents of the alleged abusers are involved in the school community”.¹⁹³
404. Workplace culture in care settings must enable and support people to make complaints when they want to report any concerns about abuse and neglect. There also needs to be more accountability, transparency and monitoring of responses to complaints received and how they were resolved and to see where and how improvements can continue to be made. By increasing the monitoring for complaints processes and consistently reviewing and sharing this information the Inquiry can aim to improve trust in the care system.

191 Roguski, M, The Hidden Abuse of Disabled People Residing in the Community: An exploratory study (Kaitiaki Research and Evaluation, 18 June 2013, page 44).

192 Roguski, M, The Hidden Abuse of Disabled People Residing in the Community: An exploratory study (Kaitiaki Research and Evaluation, 18 June 2013, page 34).

193 Mather, M, “School’s inaction astounds parents after alleged sexual assault in toilets” (Waikato Times, 1 June 2023).

405. All State and faith-based care providers and all relevant professional registration bodies must have accessible, effective and culturally appropriate complaints and investigation policies and procedures in place. The Inquiry envisages that care providers will develop these policies and procedures guided by the Care Safety Principles (Recommendation 39) and any guidance or standards developed by the Care Safe Agency. The Inquiry envisages that care providers' ability to maintain accreditation status (Recommendation 48) will be dependent on having best practice complaints policies and processes in place and demonstrating that these are being followed.
406. The relevant professional registration bodies include the Royal Australian and New Zealand College of Psychiatrists, the Medical Council of New Zealand, the Aotearoa New Zealand Association of Social Workers, the New Zealand Nurses Association and the Teaching Council of Aotearoa New Zealand

Tūtohi | Recommendation 65

All State and faith-based entities providing care directly or indirectly to children, young people and adults in care and relevant professional registration bodies should ensure they have appropriate policies and procedures in place to respond in a proportionate way to complaints, disclosures or incidents of abuse and neglect, including:

- a. the policies and procedures are guided by the Care Safety Principles (Recommendation 39) and any relevant rules, standards or guidelines issued by the Care Safe Agency (Recommendation 41)
- b. the policies and procedures are clearly written, accessible to people in care, their whānau and support networks, and to staff and care workers, and kept up to date
- c. the policies, at a minimum, outline roles and responsibilities, how different types of complaints will be handled, including potential employment outcomes and reporting obligations
- d. the policies set out how actual or perceived conflicts of interest will be addressed if they arise
- e. there are clear protections in place for whistleblowers and those making good faith notifications
- f. it is as easy as possible for people to make disclosures or complaints
- g. complaints processes are appropriate for Māori, Pacific People, Deaf and disabled people, people who experience mental distress, and Takatāpui, Rainbow and MVPFAFF+ people, including ensuring there is access to appropriate support

- h. complainants are supported and kept informed throughout the handling of their complaint, including with the assistance of their independent advocates (Recommendation 76) if applicable
- i. complainants are kept safe throughout the handling of their complaint, including if they have complained about another person in care or a person who directly provides them care
- j. complaints are responded to promptly and robustly, including:
 - i. as soon as a complaint is made, carrying out an initial risk assessment to identify the risks to the complainant and to other children, young people and adults in care
 - ii. mitigating identified risks while the complaint is being investigated, proportionate to the seriousness of the allegation
 - iii. continuing to investigate and report on complaints even if the subject of the complaint voluntarily leaves employment and / or cancels their professional registration
 - iv. carrying out a robust investigation at a level proportionate to the seriousness of the complaint
 - v. applying a standard of proof consistent with civil law (“on the balance of probabilities”) when investigating complaints, but doing so flexibly, proportionate to the seriousness of the allegation
 - vi. using external investigators where appropriate for the most serious allegations
 - vii. meeting all privacy and employment law obligations
 - viii. ensuring appropriate accountability, including through reporting to NZ Police and relevant professional registration bodies if the complaint is substantiated (Recommendation 66)
- k. all complaints must be reported to the Care Safe Agency (Recommendation 41) regardless of the outcome of the investigation
- l. each complaint must be reviewed for lessons identified and possible improvements
- m. publicly report annually on how many complaints they are dealing with, whether they have been resolved, whether they have been substantiated, and how long the complaint took to be resolved.

Me whiu rawa te hunga kua tūturu ngā kōamuamu mahi tūkino People must be held to account for substantiated complaints of abuse and neglect in care

407. During the Inquiry period, individual abusers were frequently not held accountable for abuse and neglect. The lack of appropriate complaints processes combined with poor supervision or performance management meant abusers were not identified and often able to act with impunity. Staff and carers who failed to report abuse and neglect, and people who failed to investigate complaints properly and report were also regularly not held to account.
408. In Part 7 and Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit report, the Inquiry found that professional bodies failed to take timely and appropriate disciplinary action when complaints of abuse about staff were made. There was a lack of appropriate safeguarding standards to ensure prompt disciplinary action occurred. This meant that abusers were able to face minimal repercussions, with some able to continue working despite their abuse of children, young people or adults in care being known.
409. The Inquiry found that the Aotearoa New Zealand branch of the Australian and New Zealand College of Psychiatrists learned of Dr Selwyn Leeks' conduct in the late 1970s but did not confront Dr Leeks or forcefully advocate for change.¹⁹⁴ Dr Leeks' membership with the College remained in place until his death in 2022.¹⁹⁵
410. Although schools must report teachers to the Teaching Council if they are subject to a complaint of abuse and neglect,¹⁹⁶ the Teaching Council told the Inquiry that teachers can currently seek voluntary deregistration and thus avoid an investigation into the complaint:
- “Currently, a teacher is prohibited from voluntarily deregistering when a conduct or competence investigation is underway but a formal investigation may not be initiated until some weeks after the receipt of a report or complaint.”¹⁹⁷*
411. The Teaching Council of New Zealand told the Inquiry that when it censures a teacher and cancels their registration for sexually grooming or abusing a person in care, this information would not be shared with NZ Police as a matter of course. The information would therefore not be evident in any future vetting unless the survivor reported the abuse to NZ Police.¹⁹⁸

194 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, page 336).

195 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice child and adolescent unit (2022, page 299).

196 Education and Training Act 2020, sections 489–493.

197 Teaching Council of Aotearoa New Zealand, Response to Notice to Produce 544 (2023, page 7).

198 Transcript of evidence of Lesley Hoskin, Teaching Council of Aotearoa New Zealand, at the Inquiry's State Institutional Response Hearing (19 August 2022, page 550).

412. Care providers and professional registration bodies must consistently and transparently hold people to account for credible allegations of abuse and neglect in care. Having clear and transparent disciplinary policies and procedures in place, and prompt disciplinary action when warranted, will strengthen safeguarding culture amongst care providers and staff and care workers. Effective professional discipline processes will also support public trust in care systems, which was fairly and understandably eroded due to a lack of accountability for abuse during the Inquiry period.
413. All State and faith-based care providers and professional registration bodies must report substantiated complaints to the Care Safe Agency and NZ Police. Care providers must also report substantiated complaints to the relevant professional registration body. The Inquiry would expect substantiated complaints of abuse or neglect to result in permanent deregistration.
414. The Inquiry is aware that there may be privacy implications and legislative or regulatory provisions relevant to care providers' and professional registration bodies' ability to report. The Inquiry envisages the government would review all relevant legislation to identify and address any such barriers.
415. The Inquiry intends that the Care Safety Act (Recommendation 45) will include appropriate penalties and sanctions for a failure to report substantiated complaints. The Inquiry also expects that the Care Safe Agency (Recommendation 41) will develop guidelines in relation to complaints, accountability and disciplinary action, that will include timeframes for investigations and action from relevant parties.

Tūtohi | Recommendation 66

Where a complaint has been substantiated, State and faith-based entities providing care directly or indirectly and relevant professional bodies should take steps to ensure the person or people responsible are held accountable, including:

- a. professional disciplinary action
- b. reporting to the relevant professional registration body or bodies
- c. reporting to the Care Safe Agency
- d. reporting to NZ Police
- e. reporting in accordance with any other applicable information sharing or mandatory reporting obligations.

Me whakaemi ngā kōamuamu, ngā whakakitenga me ngā pānga mahi tūkinu

Centralised record of complaints, disclosure and incidents of abuse and neglect in care

416. The Inquiry has seen no evidence of a centralised database of complaints, disclosures and incidents of abuse and neglect in care, substantiated or unsubstantiated, across State and faith-based care settings. It is important that a single entity has the whole picture of complaints against individuals across the care system so that perpetrators cannot slip through the cracks. It will also facilitate building an evidence base and data analysis to create new insights into abuser behaviours, which can in turn inform new prevention and response strategies and practices.
417. The Inquiry intends that all complaints, disclosures and incidents of abuse and neglect in care will be reported to the Care Safe Agency by care providers, professional registration bodies and independent monitors. Reporting needs to have enough specificity about the person or persons subject to the complaint, the nature and extent of the complaint, and the outcome of the investigation, to enable the Care Safe agency to keep a centralised record.
418. The Inquiry intends that all complaints, even where they are not substantiated following investigation, will be reported to the Care Safe Agency. The Care Safe Agency may choose to conduct its own investigation, as it may have received complaints about the same person from other entities. Careful judgment will be required to mitigate the risks that a person could be unjustly targeted by malicious or spurious complaints. The Inquiry does not intend for the Care Safe Agency to use unsubstantiated complaints as a reason to automatically deregister staff and care workers. If a reinvestigation results in the complaint being substantiated, then the Care Safe Agency must report this to NZ Police.
419. The Inquiry expects the Care Safe Agency to maintain a consistent focus on individuals identified as being at risk in the care system, ensuring people about whom a complaint or concern has been raised remain visible as their case is investigated and do not fall through the gaps. It is critical that the approach to complaints goes beyond a transactional process to include a holistic view of the person at the centre of the complaint. This will include ensuring that the views of the person identified as being at risk have been sought so that the Care Safe Agency understands that person's reality and uses it to inform its investigations.

420. The centralised record of complaints must not be made publicly accessible, as it will include complaints against people that have not been substantiated following investigation. Its data will need to be internally protected to avoid inappropriate access from within the Care Safe Agency.
421. The Inquiry recognises the privacy and human rights implications of reporting unsubstantiated complaints between entities and keeping a centralised record of these. There may be existing legislative or regulatory barriers relevant to care providers' and professional registration bodies' use and transfer of this information. The Inquiry envisages the government would review all relevant legislation to identify and address any such barriers.

Tūtohi | Recommendation 67

All State and faith-based entities providing care directly or indirectly and relevant professional registration bodies should report all complaints, disclosures or incidents to the Care Safe Agency, whether substantiated or not substantiated following investigation.

Tūtohi | Recommendation 68

The government should enable, in legislation, the Care Safe Agency to collate and keep a centralised database of complaints, disclosures or incidents of abuse and neglect of children, young people and adults in care, for the purposes of:

- a. reinvestigation, if considered necessary or appropriate
- b. having a whole-of-system view to ensure that:
 - i. proven perpetrators cannot move between geographic locations, professions or care settings without detection
 - ii. people subject to multiple unsubstantiated complaints from different geographic locations, professions or care settings can be identified and steps taken if considered proportionate and appropriate
- c. creating an evidence base and undertaking data analysis to create new insights into perpetrator behaviours, which can in turn inform new prevention and response strategies and practices.

He taki ripoata motuhake

Mandatory reporting

422. During the Inquiry period, the State failed to ensure that effective and mandatory reporting practices were in place. Without mandatory reporting requirements, abusers were able to avoid accountability and go on to abuse more children, young people and adults in different care settings. Additionally, the lack of clear reporting requirements meant bystanders to abuse did not have clear guidance about when to report things of concern they had witnessed. The Inquiry found that bystanders frequently failed to intervene and report the abuse and neglect to relevant authorities.
423. Aotearoa New Zealand currently has a mix of criminal and setting-specific mandatory reporting laws for children and adults in care and broad-based voluntary reporting laws regarding children under the age of 18. Anyone can report suspected abuse or neglect of children. Abuse or neglect does not need to have happened; it can be enough that someone is concerned it is going to happen.
424. Staff and carers can voluntarily report abuse or neglect, or suspected abuse or neglect of children, to Oranga Tamariki or the police.¹⁹⁹ Many (but not all) staff and carers work in a care setting that must have a child protection policy in place that covers identifying and reporting abuse and neglect.²⁰⁰ Reporting in these policies is linked to the voluntary reporting provision in section 15 of the Oranga Tamariki Act. Excluding the Crimes Act, its reporting laws do not apply to adults in care.
425. For many professions and settings (for example teachers), people must report concerns of abuse or neglect and will face serious sanctions if they do not. Sanctions include professional discipline, the loss of employment or a contract, and the loss of a license to operate.
426. Under the Crimes Act 1961, there are criminal sanctions for certain people who fail to take reasonable steps, which would include reporting abuse, to protect a child or adult, where they are at risk of sexual assault, grievous bodily harm or death.²⁰¹ The Inquiry note, however, that the Crimes Act is not a mandatory reporting regime, as it does not provide protection to those making the report, and would likely apply only in fairly extreme cases.

199 Oranga Tamariki Act 1989, section 15.

200 Children's Act 2014, sections 14 and 19.

201 Crimes Act 1961, section 195A.

427. There are mandatory reporting laws relating to teachers.²⁰² Schools must report teachers to the Teaching Council in cases of dismissals, issues of concern or complaints where the teacher has resigned or their contract has expired, and possible serious misconduct or competence issues. Court Registrars must report convictions of teachers to the Teaching Council. Teachers who have been convicted must also self-report to the Teaching Council. School boarding facilities must also report abuse or neglect.²⁰³
428. There has been ongoing debate about whether Aotearoa New Zealand should adopt widespread mandatory reporting (where all professionals who work with children are mandated to report suspected abuse to Oranga Tamariki). There continues to be no consensus on this issue. Widespread mandatory reporting was rejected in 1986 and in 1993. Dilworth survivors petitioned the Inquiry to make recommendations about a Dilworth Law, that would require a person or entity to report to police if a child or young person were at risk of serious harm.²⁰⁴
429. When considering mandatory reporting, the Inquiry contemplated recommending a comprehensive new widespread mandatory reporting regime covering all cohorts, professions and settings. While this would have benefits, including being a strong public repudiation of abuse and providing clarity about responsibilities to report, the Inquiry is concerned that it would have unintended systemic consequences. These could include an increase in surveillance, racism, discrimination and prejudice for Māori, Pacific Peoples, disabled parents, and communities experiencing persistent disadvantage. There is also a risk that the system could become overwhelmed and would be less able to focus on abuse prevention and community wellbeing initiatives.
430. The Inquiry recommends a balanced approach that seeks to ensure that mandatory reporting laws apply consistently across all the care settings the Inquiry investigated, to both State and faith-based entities providing care directly or indirectly, and consistently to people who come into contact with children, young people and adults in care, not just specific professions such as teachers.

²⁰² Education and Training Act 2020, sections 489–493.

²⁰³ Education and Training Act 2020, sections 489–493; Education (Hostels) Regulations 2005, clause 58.

²⁰⁴ Transcript of evidence of Neil Harding on behalf of Dilworth School survivors at the Inquiry's Faith-based Institutional Response Hearing (22 October 2022, page 541).

431. The Inquiry also wants to recognise the steps taken following the Australian Royal Commission into Institutional Responses to Child Sexual Abuse regarding mandatory reporting and the Confessional Seal. Several Australian states enacted mandatory reporting laws in 2019. These laws now explicitly extend to religious and spiritual leaders, requiring them to report disclosures of abuse including those received during religious confession. Dr Christopher Longhurst, survivor advocate and national leader of SNAP (the Survivors Network of those Abused by Priests), has urged this.²⁰⁵
432. Because of the particular implications of mandatory reporting that may affect Māori, the Inquiry intends that the details of a coherent mandatory reporting regime, including who has a duty to report, what they must report on, and which entity or entities they have to report to, will be jointly developed by government and Māori in accordance with te Tiriti o Waitangi, tino rangatiratanga and self-determination. The Inquiry also expects the regime will be designed in line with implementation Recommendations 126–127.

Tūtohi | Recommendation 69

The government should introduce legislation where necessary to create a coherent mandatory reporting regime which:

- a. applies to all State or faith-based entities providing care directly or indirectly to children, young people and adults in care
- b. applies to all staff and care workers who work for the entities, , outlined in (a) above, including foster parents, volunteers, chief executives, trustees, board members, clergy and lay people and people in religious ministry who receive disclosures of abuse and neglect during religious confession
- c. ensures obligations are clear, consistent, established in legislation and should include protections from liability for those making good faith notifications
- d. ensures access to timely advice on reporting obligations.

²⁰⁵ Transcript of Dr Christopher Longhurst, on behalf of SNAP (The Survivors Network of those Abused by Priests) at the Inquiry's Marylands School public hearing (17 February 2022, page 602).

Ngā wahi tiaki me ōna tikanga kia iti iho te mana, kia kore rawa atu rānei a tōna wa

Institutional environments and practices to be minimised and ultimately eliminated

433. During the Inquiry period, the environments and practices of many State and faith-based institutions contributed to the abuse and neglect of children, young people and adults in their care.
434. Many institutions across all settings the Inquiry investigated applied a heavily regimented one-size-fits-all model of care, with the same form of care applied to everyone regardless of their age, gender, abilities, culture, needs and reasons for being in care. Features of one-size-fits-all care, which are consistent with the defining elements of institutions identified by the United Nations Committee on the Rights of Persons with Disabilities,²⁰⁶ included:
- rigid routines that people in care had little influence or control over
 - identical activities shared by people in care, or groups of people in care
 - people in care having limited or no influence over who provided their care
 - a lack of control over day-to-day decisions, like activities or mealtimes
 - a lack of choice about who they lived with
 - isolation or segregation from the community
 - a disproportionate or high number of disabled people living in the same environment.
435. Other institutional practices that contributed to abuse and neglect in care included an emphasis on conformity, rules and order, which were often prioritised over the needs of people in care and enforced with harsh and abusive discipline. The use of pain compliance techniques, restrictive practices and solitary confinement constituted abuse.
436. Overcrowding and unsuitable facilities compromised basic standards of care and contributed to abuse and neglect. Overcrowding was common in psychiatric institutions, social welfare residences and in family homes, which led to reduced or absent oversight and reduced individualised care. Many institutions had substandard physical environments, such as old buildings that were poorly designed, or reflected military or prison-like environments.

²⁰⁶ United Nations Committee on the Rights of Persons with Disabilities, Guidelines on deinstitutionalization, including in emergencies, CRPD/C/5 (10 October 2022, para 14).

Te turaki nohonga pūnaha taurima Deinstitutionalisation of residential care settings

437. In the 1970s and 1980s, the State began responding to calls for deinstitutionalisation of care settings, particularly large psychopaedic and psychiatric institutions.
438. The Committee on the Rights of Persons with Disabilities recommended in 2022 that Aotearoa New Zealand should:

*Develop a comprehensive deinstitutionalisation strategy, with specific timeframes and adequate budgets, to close all residential institutions, including group homes and residential specialist schools to provide community supports for persons with disabilities to live independently in the community.*²⁰⁷

Kāinga kaitiaki, tū ārai mai Care and protection residences

439. In 2022 / 23, Oranga Tamariki reported that there were 34 children and young people admitted to care and protection residences, and that there were four care and protection residences in operation.²⁰⁸
440. The Oranga Tamariki Future Directions Plan from September 2021 includes the intention to “close its current care and protection residences and replace them with a model that enables tailored care for tamariki with high and complex needs”.²⁰⁹ In August 2022, Oranga Tamariki Chief Executive, Chappie Te Kani, told the Inquiry at the Inquiry’s State Institutional Response Hearing that Oranga Tamariki “has a clear view that the care and protection residences need to be closed down”.²¹⁰ However, at that time Oranga Tamariki did not have a planned timeframe for the closure of care and protection residences.²¹¹

Tūtohi | Recommendation 70

The government should prioritise and accelerate current work to close care and protection residences, which perpetuate the institutional environments and practices that led to historical abuse and neglect in care.

207 United Nations Committee on the Rights of Persons with Disabilities, Concluding observations on the combined second and third periodic reports of New Zealand (2022, para 40(b)).

208 Oranga Tamariki, Response to Notice to Produce 541 (25 August 2023, page 35).

209 Oranga Tamariki, Future Direction Action Plan, Action 1.7 (September 2021, page 6).

210 Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, page 719).

211 Oranga Tamariki, Response to Notice to Produce 541 (25 August 2023, page 35).

Ētahi atu kāinga noho

Other residential facilities

441. There are residential facilities in youth justice, education, Deaf, disability and mental health settings. It is critical that the children, young people and adults in care in these facilities do not experience the kinds of institutional environments and practices that led to historic abuse and neglect in care. Any changes in this space will take time and should facilitate grandparenting of current arrangements alongside work to reduce and eliminate institutional environments and practices.

Ngā kāinga taiohi ā-ture

Youth justice residences

442. In 2022 / 23, 471 children and young people were admitted to youth justice residences. There were 24 operational youth justice facilities – five secure residences, 14 remand homes and five community bail homes.²¹²
443. As set out in Chapter 3, the Inquiry envisages that very few children and young people would be placed in youth justice residences, because they would have had access to the supports and services they needed to flourish and would demonstrate fewer behaviours resulting from trauma or unaddressed needs. The Inquiry recognises that, in the immediate and medium term, there will still be situations where it is both necessary and appropriate for some children and young people to be placed into youth justice facilities to ensure their own, and the public's, safety.
444. Oranga Tamariki Deputy Chief Executive Nicolette Dickson told the Inquiry that "there are some slightly different imperatives in a youth justice setting in terms of public interest and safety" than there are in care and protection residences. She also said that Oranga Tamariki is working to ensure that youth justice residences do not have "the harmful impact of a large, institutional environment".²¹³

Ngā kāinga tōpū hunga whaikaha

Group homes for disabled people

445. In 2019 / 20, although half of people receiving disability support services lived in their own homes, 16 percent were living in a group home (called a community residential home).²¹⁴

²¹² Oranga Tamariki, Response to Notice to Produce 541 (25 August 2023, pages 42, 70–71).

²¹³ Transcript of evidence of Nicolette Dickson, Deputy Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (23 August 2022, page 720).

²¹⁴ Ministry of Health, Demographic Report of Disabled People Accessing Manatū Hauora (the Ministry of Health) Disability Support Services: 2020 update (Ministry of Health, 2022, pages xiv–xvi).

446. A 2013 report to the Minister of Health found, in relation to how the Ministry of Health handled complaints of abuse against three service providers, that:
- “In all three cases there is evidence that attitudes existed that were reminiscent of an institutional approach to the care of people with disabilities. This culture, which sees people as a group, rather than as individuals with individual needs and preferences, is a clear warning signal of a lower quality of care.”*²¹⁵
447. A 2013 report on the experiences of disabled people recounted the experience of a new manager who had recently taken over a running a residential service:
- “When I came here, emotional, and psychological abuse was prevalent ... The abuse was pervasive. Every single client got it. ... The place was institutionalised. The carers were not carers they were jailers. Clients just sat in corners and no rehab happened.”*²¹⁶

Ngā kura ā-noho motuhake Residential specialist schools

448. There are currently three Residential Specialist Schools in Aotearoa New Zealand for students who have social, behaviour and / or learning needs that are highly complex and challenging – Westbridge Residential School in Auckland, Salisbury School in Nelson, and Halswell Residential School in Christchurch. The total number of students enrolled in the three schools was 71 in 2014 and fell to a low point of 17 students in 2021. Enrolments have recently increased across all three schools, totalling 40 students in 2023.²¹⁷
449. In August 2022, at the Inquiry's State Institutional Response Hearing, Secretary for Education Iona Holsted acknowledged that “there are instances where some disabled and Deaf tamariki are still not able to access the full curriculum and wider education experience”.²¹⁸

²¹⁵ Grammer, B, Russell, D, & Van Eden, K, Putting People First: A Review of Disability Support Services Performance and Quality Management Processes for Purchased Provider Services (November 2013, page 29).

²¹⁶ Roguski, M, The Hidden Abuse of Disabled People Residing in the Community: An exploratory study, (Kaitiaki Research and Evaluation, 18 June 2013, page 24).

²¹⁷ Education Counts, Student Rolls by School 2010–2023 (undated) https://www.educationcounts.govt.nz/statistics/school-rolls/downloads/2-Student-rolls-by-School_2010-2023.xlsx.

²¹⁸ Transcript of evidence of Iona Holsted, Secretary for Education, at the Inquiry's State Institutional Response Hearing (18 August 2023, page 335).

450. In September 2022, the United Nations Committee on the Rights of Persons with Disability recommended that Aotearoa New Zealand should close and stop investing in Residential Specialist Schools and significantly increase supports and services for children with disabilities and their families to prevent out of home placements, including in Residential Specialist Schools.²¹⁹ It also recommended the devolution of “segregated education settings” into a mainstream inclusive education system.²²⁰
451. In March 2023, the Ministry of Education included, in its list of actions that would require the input of the Minister of Education by the end of June 2023, “decide on how to respond to the recommendations from the UN Committee on the Rights of Persons with Disabilities regarding residential specialist schools.”²²¹ A Cabinet paper published in August 2023 seeking agreement to the government’s response to the Committee’s observations included “the role of specialist schools” and “the role of residential special schools” in its list of “significant and contested areas of government policy”.²²² The Cabinet paper noted that:
- “The UN Committee has provided recent guidelines on deinstitutionalisation. They clearly indicate that schooling settings like residential specialist schools are seen as institutional given that they are only available to children based on impairing factors like behaviour. The Guidelines also indicate that institutional settings cannot be seen as an authentic choice for students and their families. The Ministry of Education has noted recommendations related to Residential Specialist Schools subject to further consideration of New Zealand based research and evidence and decisions by the Minister of Education. Unlike other noting recommendations, there is a possibility that these could be changed after the Minister’s consideration.”***²²³
452. The Inquiry has not seen evidence that the government has made any decisions relating to Residential Special Schools since June 2023.

219 United Nations Committee on the Rights of Persons with Disabilities, Concluding observations on the combined second and third periodic reports of New Zealand (2022, 40(b), 40(d), 46(c)).

220 United Nations Committee on the Rights of Persons with Disabilities, Concluding observations on the combined second and third periodic reports of New Zealand (2022, para 48(a)).

221 Ministry of Education, Education Report: Briefing to the Incoming Minister (3 February 2023, page 14), <https://assets.education.govt.nz/public/Documents/our-work/information-releases/Issue-Specific-release/BIMs/BIM-Minister-of-Education-Ministry-of-Education.pdf>.

222 New Zealand Government Cabinet paper, Office of the Minister for Disability Issues, United Nations Convention on the Rights of Persons with Disabilities: Government response and proposed mechanisms to support implementation (August 2023, paras 29, 29.2–29.3).

223 New Zealand Government Cabinet paper, Office of the Minister for Disability Issues, United Nations Convention on the Rights of Persons with Disabilities: Government response and proposed mechanisms to support implementation (August 2023, para 41.2).

453. In the Australian Disability Commission report, Commissioners had differing views about the ongoing role of specialist schools. Three Commissioners, including the two disabled Commissioners, considered that all special schools should be closed on the grounds that they constituted segregation of disabled people, which is a significant human rights issue. The other three Commissioners did not agree, stating that they did not share the assumption that specialist schools for students with complex support needs “inevitably must isolate those students from their peers in other educational institutions”.²²⁴

Ngā kura ā-rangi motuhake

Day specialist schools

454. Day specialist schools offer specialist teaching to students who have a high level of need from Years 1 to 13. In addition to having a base school, many day schools have satellite classes attached to mainstream schools. There are around 28 day specialist schools in Aotearoa New Zealand with a combined total roll of around 4,000 children and young people.²²⁵
455. The Inquiry heard from families of survivors about institutional practices and environments being experienced at day specialist schools:
- “Our son, Rovin Turnbull, experienced physical and psychological abuse, including restraint and seclusion, while at school.”²²⁶*
- “Keegan was excluded from school camp due to his high needs.”²²⁷*
456. The Inquiry heard voices in support of inclusive education as evidence-based and meeting human rights obligations, with some viewing special schools as incompatible with the right to inclusive education.²²⁸ Survivor and advocate Matthew Whiting told the Inquiry that special schools should be closed, but that to do so “we need to support people really well...at home, at school, anywhere”.²²⁹
457. There is a diversity of views in Aotearoa New Zealand about segregated education settings. In its engagements with the Deaf community, a strong theme was that education in mainstream settings often does not work for them and that there is a need for Deaf students and teachers to have spaces together, as the education system is hearing-centric.²³⁰

224 Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Final Report: Volume 7, Inclusive education, housing and employment: Summary and Recommendations (2023, pages 92–93).

225 <https://educationcounts.govt.nz>

226 Witness statement of Callum and Victoria Turnbull (9 November 2022, page 1).

227 Witness statement of Franky Lewis (May 2023, para 35).

228 Transcripts of evidence at the Inquiry’s Ūhia te Māramatanga Disability and Mental Health Hearing, of Sheree Briggs (12 July 2022 page 187), Allison Campbell (11 July 2022), and Caroline Arrell (13 July 2022, page 293).

229 Transcript of evidence of Matthew Whiting at the Inquiry’s Disability and Mental Health Hearing (19 July 2022, page 582).

230 Summary of Community Conversation: Deaf community (Royal Commission of Inquiry into Abuse in Care, 6 July 2022, pages 2–3), Summary of Community Conversation: Deaf community (Royal Commission of Inquiry into Abuse in Care, 20 October 2022, page 3).

458. Disability organisations have called for inclusive education to become a reality so that disabled students and whānau can make genuine, informed choices about their education. A 2015 submission from a group of Aotearoa New Zealand disability organisations summed it up as follows:

“... people in New Zealand often hold different views on how to ensure the best education for disabled children. We do not always agree with each other. Some people view a special school or unit is the best choice for their child...For choice to be real, however, there must be universal access to a fully inclusive education in local early childhood, compulsory primary and secondary and tertiary settings and equity of funding.”²³¹

Tūtohi | Recommendation 71

The government should, as a priority, support and invest in the development of disability and mental health, educational and youth justice models of care that do not perpetuate the institutional environments and practices including segregation that led to historic abuse and neglect in care.

²³¹ Network of Disabled Persons Organisations and disability NGO organisations, Submission to the Committee on the Rights of Persons with Disabilities: Day of General Discussion on the right to education for persons with disabilities, (Disabled Persons Assembly NZ, 2015, page 3).

Me muru rawa ngā tikanga whakamamae me te here tangata Pain compliance techniques and other restrictive practices to be banned

459. During the Inquiry period, many survivors shared that staff would use restrictive and violent practices to manage the behaviour of children, young people and adults in care.
460. The Inquiry notes that not all forms of restraint constitute restrictive practice. If restraint is necessary and appropriate to ensure safety, such as the use of safety belts in wheelchairs, then it does not amount to a restrictive practice. The unnecessary and inappropriate use of restraint would, however, be considered a restrictive practice. Examples of inappropriate use of restraint include using physical or chemical restraint (using medication such as sedatives) to control a person's behaviour. The Inquiry also heard about care workers removing wheelchair batteries to prevent their ability to move. Restraint also frequently had elements of punishment.
461. Ms PX, who worked at Kingslea Residential Centre (later Te Oranga) from early 2000 to 2005 as a youth worker, told the Inquiry that she witnessed staff using "excessive force with an inappropriate restraint" multiple times.²³²
462. In 2022, the Office of the Children's Commissioner reported to the United Nations Committee on the Rights of the Child that:
- "Between July 2017 and March 2021 [school students] between the ages 4 and 18 were restrained 7,662 times.*
- Restraint [in youth justice residences] is often used excessively, inappropriately, and has resulted in harm and injury to mokopuna, including for those who witness it.*
- Restraint chairs are still being used by the New Zealand Police for mokopuna as young as 13, despite being considered 'inherently degrading'".²³³*
463. A 2023 Oranga Tamariki report acknowledged that "it is likely that physical restraint is disproportionately used on young people who identify as Māori, simply by virtue of the fact that Māori youth are significantly overrepresented in Oranga Tamariki youth justice residences".²³⁴

²³² Witness statement of Ms PX (22 August 2022, paras 100, 104).

²³³ Office of the Children's Commissioner, The New Zealand Children's Commissioner's report to the United Nations Committee on the Right of the Child (15 August 2022, pages 2728).

²³⁴ Oranga Tamariki, Physical restraint and de-escalation: Best international practice as applicable to secure youth justice residences – Summary report (March 2023, page 4), <https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Research/Latest-research/YJ-residences-best-international-practice-evidence-reviews/Summary-report-restraint-and-de-escalation.pdf>.

464. A 2020 report commissioned by Te Kāhui Tika Tangata Human Rights Commission to review the use of restrictive practices in (among other settings) care and protection, youth justice, health and disability and police settings, found that:

“Without a significant shift in the very way that detaining agencies think about the extreme tools of seclusion and restraint, a meaningful change will be impossible to achieve.”²³⁵

465. There is a need to set clear standards and expectations that prohibit the use of pain compliance techniques and the use of restrictive practices in all State and faith-based care settings and to promote alternative practices.

Tūtohi | Recommendation 72

The government should take steps to ban pain compliance techniques in any care setting for children, young people or adults in care.

Tūtohi | Recommendation 73

The government should ensure there are adequate frameworks in place to govern the use of restrictive practices for children or young people and adults in care to minimise the use of those practices (ensuring they are used only as a last resort) and provide for adequate safeguards and checks.

Te mauhere tū tāhanga, me whakaiti, ā tōnā wā me muru rawa atu Solitary confinement to be minimised and ultimately eliminated

466. The damaging effects of solitary confinement are considerable. Research demonstrates that solitary confinement causes long lasting physiological and psychological impacts on people’s intellect and behaviours, social and emotional regulation, mental and physical health, memory, and on their brain structure and function.²³⁶

²³⁵ Shalev, S and Te Kāhui Tika Tangata Human Rights Commission, *Seclusion and Restraint: Time for a Paradigm Shift* (Wellington, 2020, page 12).

²³⁶ Clarke, A, “Juvenile solitary confinement as a form of child abuse,” in *The Journal of the American Academy of Psychiatry and the Law*, 45(3), (2017, page 350); Shalev, S, *Thinking outside the box? A review of seclusion and restraint practices in New Zealand* (Te Kāhui Tika Tangata Human Rights Commission, 28 April 2017).

467. During the Inquiry period, some care settings had standards that limited the use of solitary confinement (often called “seclusion”). For example:
- a. in social welfare settings, standards from 1957 stated that solitary confinement was generally only to be used as an emergency procedure, and 1986 regulations stated it was not to be used for punishment²³⁷
 - b. in education settings, 1986 guidelines on the use of timeout stated that it should not be used for longer than a matter of minutes²³⁸
 - c. in mental health settings, legislation allowed its use only if necessary, where, and for as long as, it was necessary for the care or treatment of the patient, or the protection of other patients.²³⁹
468. At the Inquiry’s State Institutional Response Hearing in August 2022, Chappie Te Kani, Chief Executive of Oranga Tamariki, agreed that the “history of treatment of children in solitary confinement” in children’s homes was inhumane.²⁴⁰ At the same hearing, Dr Diana Sarfati, Director-General of Health, acknowledged that there was inappropriate use of seclusion and restraint in psychopaedic and psychiatric settings during the Inquiry period.²⁴¹ The Inquiry found that there was overuse of seclusion and solitary confinement, at times unlawfully, during the Inquiry period.
469. In its 2022 concluding observations on the combined second and third periodic reports of Aotearoa New Zealand, the United Nations Committee on the Rights of Persons stated it was:
- “...seriously concerned about the continued, and in some cases prolonged use of solitary confinement, seclusion, physical and chemical restraints and other restrictive practices on persons with disabilities, in particular persons with psychosocial and/or intellectual disabilities, in places of detention.”²⁴²***

237 Ministry of Social Development, Legislation and social work guidance over the years (undated, pages 19–20).

238 Ministry of Education, Response to Notice to Produce 422 (Royal Commission of Inquiry into Abuse in Care, 17 June 2022, pages 103–105).

239 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 71.

240 Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry’s State Institutional Response Hearing (23 August 2022, page 724).

241 Transcript of evidence of Dr Diana Sarfati, Director-General of Health and Chief Executive of the Ministry of Health, at the Inquiry’s State Institutional Response Hearing (17 August 2022, page 207); Transcript of evidence of Whaikaha at the Inquiry’s State Institutional Response Hearing (17 August 2022, page 216).

242 United Nations Committee on the Rights of Persons with Disabilities, Concluding observations on the combined second and third periodic reports of New Zealand (2022, para 29).

470. In 2019, the Health Quality and Safety Commission launched its Zero Seclusion: Safety and dignity for all project,²⁴³ which aimed to “contribute to the goal of eliminating solitary confinement in mental health. In April 2023, the Ministry of Health’s updated guidelines on preventing and safely reducing and eliminating seclusion and restraint in mental health settings observed that “seclusion and restraint have no therapeutic benefit, and in fact can be harmful and traumatic to tāngata whaiora [and] their whānau”.²⁴⁴
471. The Director of Mental Health and Addiction Services noted that, between 1 July 2021 and 30 June 2022, Māori were 5.5 times more likely than non-Māori to have been placed in solitary confinement while under a compulsory treatment order, which was “an increase in the rate for Māori and a decrease for non-Māori, widening the inequity gap between the populations”.²⁴⁵
472. It is critical that action be prioritised to eliminate the use of solitary confinement and ensure that the individual needs of people in care are met. Focus should be placed on reducing overrepresentation of Māori people experiencing solitary confinement.

Tūtohi | Recommendation 74

The government should prioritise and accelerate work to minimise and eliminate solitary confinement in all care settings as soon as practicable, with an emphasis on person-centred and culturally appropriate approaches to reduce the use of solitary confinement safely.

243 Te Tāhū Hauora Health Quality & Safety Commission, Zero seclusion: Safety and dignity for all (2019, page 2).

244 Ministry of Health, Guidelines for Reducing and Eliminating Seclusion and Restraint Under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (April 2023, page 1).

245 Office of the Director of Mental Health and Addiction Services, Regulatory Report 1 July 2021 to 30 June 2022 (Ministry of Health, September 2023, page 29).

Te waihanga papa ā-noho, e iti iho ai, ngā mahi tūkinō i ngā pūnaha taurima

Physical environments designed to reduce risks of abuse and neglect in care

473. During the Inquiry period, the physical design of some settings failed to provide residents with their rights to privacy, dignity and respect. International inquiries have found that substandard physical living conditions that fail to afford human dignity contribute to abuse.²⁴⁶
474. Some settings, particularly residential institutions, were designed to contain and restrict movement, rather than create safe and homely environments. The Inquiry saw this through the regular use of solitary units and seclusion rooms where children, young people and adults were placed into individual cells with limited visibility and oversight. Solitary cells enabled perpetrators unsupervised access to survivors and were one of the most common locations of abuse that survivors shared with the Inquiry. Some facilities, such as Kimberley Centre, had open toilets without doors, which prevented residents' basic rights to privacy and dignity.
475. Institutions such as Hokio Beach School and Kohitere Boys' Training Centre, and Te Whakapakari Youth Programme were some of the most extreme examples the Inquiry saw of substandard living conditions. They demonstrated the harmful impacts that punitive or corrective bootcamp-style approaches to care have on children and young people. Experts agree that this approach is more likely to lead young people into the criminal justice system.²⁴⁷
476. A 2020 Office of the Ombudsman inspection report on the mental health inpatient unit at Waikato Hospital found that:
- "There were still no coverings to provide privacy for service users in seclusion rooms. While external bedroom windows had mirrored covers to prevent observation from the courtyard, internal windows remained uncovered. Service users in seclusion rooms could be observed when sleeping, or in various stages of undress, through the internal windows."***²⁴⁸

²⁴⁶ Independent Inquiry into Child Sexual Abuse, The Report of the Independent Inquiry into Child Sexual Abuse (2022, pages 124, 177); Historical National Abuse Inquiry, Report of the Historical Institutional Abuse Inquiry (2017, page 28).

²⁴⁷ Gluckman, P, It's never too early, never too late: A discussion paper on preventing youth offending in New Zealand (Office of the Prime Minister's Chief Science Advisor, 2018, pages 6–7).

²⁴⁸ Office of the Ombudsman, OPCAT report on an unannounced follow up inspection of Wards 34, 35 and 36, Waikato Hospital, under the Crimes of Torture Act 1989 (March 2020, page 12).

477. A 2021 Office of the Ombudsman inspection report on the Te Whare Ahuru mental health inpatient unit at Hutt Hospital found that:
- “The Unit, which opened in 1995, was no longer fit for purpose. The standard of cleanliness was a significant issue and maintenance was not being attended to within acceptable timeframes. Carpet in communal areas was observed by Inspectors to be badly stained and in a state of disrepair. One client told Inspectors they had to open a window in the acute ward TV lounge due to the overwhelming smell of the soiled carpet.”²⁴⁹*
478. A 2023 inspection report by the Children’s Commissioner on Te Puna Wai ō Tuhinapo youth justice residence in Christchurch observed that:
- “The showers were in a disgusting state and in need of repair. A staff member said, “I wouldn’t want to shower in there”. There was crumpled toilet paper that had been thrown on the ceilings, and marks on the walls that resembled faeces. The bedrooms were full of tagging, the floors were filthy, and the communal rooms are generally in poor condition. ... The units are in poor condition and are unfit for mokopuna. Graffiti is present on the walls, windows, and the ceilings. Units are dirty, wet tissue paper has been crumpled up and thrown on the ceilings and many rooms in the residence smell damp. Bedrooms are dark with poor ventilation, and room temperatures range from extremely hot to freezing cold.”²⁵⁰*
479. At the Inquiry’s State Institutional Response Hearing in 2022, the Inquiry was told by Chief Social Worker Peter Whitcombe that “we have CCTV camera footage of the areas throughout secure. The parts of secure that aren’t covered are the young person’s bedrooms and bathroom and toilet, but that is the only areas that are not covered by CCTV footage”.²⁵¹ There needs to be an appropriate balance between upholding the rights of people in care to privacy and dignity and mitigating the risks associated with isolated spaces that could be used by abusers to escape scrutiny. International inquiries have found that isolated physical spaces can contribute to abuse and neglect.²⁵²

249 Office of the Ombudsman, OPCAT report on an unannounced inspection of Te Whare Ahuru Mental Health Inpatient Unit, Hutt Hospital under the Crimes of Torture Act 1989 (June 2021, page 25).

250 Office of the Children’s Commissioner, Te Puna Wai ō Tuhinapo youth justice residence Visit June 2023 OPCAT Monitoring Follow Up Report (August 2023, pages 11, 15).

251 Transcript of evidence of Peter Whitcombe, Chief Social Worker at Oranga Tamariki at the Inquiry’s State Response Hearing (23 August 2022, page 728).

252 Independent Inquiry into Child Sexual Abuse, The Report of the Independent Inquiry into Child Sexual Abuse (2022, pages 124, 177); Historical National Abuse Inquiry, Report of the Historical Institutional Abuse Inquiry (2017, page 28).

480. The physical design of care settings needs to meet human rights obligations and standards and be designed to prioritise safeguarding. This may mean significant renovation of some settings to meet these standards and obligations. Care settings should not be physically or geographically isolated and must support connections to the wider community, be developmentally appropriate and accessible for visitation. The Inquiry also considers there is merit in exploring whether technology such as CCTV and body cameras can be used to enhance residents' safety without unduly infringing personal privacy and remaining aligned with the principles in the Privacy Act 2020.

Tūtohi | Recommendation 75

All State and faith-based entities providing direct or indirect care to children, young people and adults should review physical building and design features to identify and address elements that may place children, young people and adults in care at risk of abuse and neglect. This should include:

- a. consideration of how best to use technology such as CCTV cameras and body cameras without unduly infringing personal privacy, including taking into account any applicable guidance documents and the legal requirements for the collection of personal information under the Privacy Act 2020
- b. reviewing any policies or processes that place children, young people or adults in care with others who may put them at risk (for example, children and young people in care and protection being placed together with children, young people or adults in the justice system)
- c. if care settings include physically isolated spaces, for example private offices or a confessional box, ensuring there are tailored measures in place to address the risks arising, including the risk of undetected abuse and neglect
- d. if care is to be delivered in a geographically isolated or remote area, ensuring there are tailored measures in place to address the risks arising from the geographical setting, including the risk of undetected abuse and neglect.

Me whakamana, me tautoko te hunga kei ngā pūnaha taurima

People in care are empowered and supported

Te whakatū kaupapa motuhake hei reo mo te hunga kei ngā pūnaha taurima


Setting up a system of independent advocates for all people in care

481. Many of the Inquiry's findings have emphasised the disempowered position of people in care, particularly those whose human rights to self-determination and decision-making, including rights under te Tiriti o Waitangi, were overridden or denied. Children, especially tamariki Māori, young people including rangatahi Māori, and disabled children and young people including tamariki and rangatahi hauā were undervalued, had no voice and were often not understood or believed.
482. In Part 7 the Inquiry observed that many survivors lacked access to an independent advocate, to tell them about their rights while in care, and to support them or represent them to make complaints and prevent and respond to abuse and neglect.
483. Independent advocacy should be freely available to all children, young people and adults in care, to support them to understand and exercise their rights.
484. The Health and Disability Commissioner has acknowledged that "advocacy numbers have not kept pace with population growth and health service activity, and do not necessarily reflect the diversity of their communities".²⁵³ Dr Mhairi Duff, a Deputy Clinical Director at the Mason Clinic told the Inquiry:
- "If I had a pot of gold to invest in, I would have far more consumer advisors and advocacy. The number of consumer advisors is grossly inadequate. You could very easily have someone on every unit."***²⁵⁴
485. In their monitoring report into Te Whare Tuhua and Te Whare Matariki remand homes in 2022, Mana Mokopuna found:
- "Mokopuna in Te Whare Tuhua me Matariki do not have access to independent advocates like VOYCE Whakarongomai. Neither staff or mokopuna we spoke to knew how to access this service."***²⁵⁵

²⁵³ Health and Disability Commissioner, Response to Notice to Produce 479 (Royal Commission of Inquiry into Abuse in Care, 5 August 2022, page 18).

²⁵⁴ Witness statement of Dr Mhairi Duff (26 September 2022, para 12.5).

²⁵⁵ Children's Commissioner, Te Whare Tuhua, Te Whare Matariki – Community Remand Homes – Visit: May 2022, OPCAT Monitoring Report (October 2022, page 15).

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486. The Independent Children's Monitor's 2024 annual report noted that:
- "...we continue to hear that tamariki and rangatahi in care do not routinely understand their rights. This raises the question of whether this may be impacting on their ability to voice complaints."*²⁵⁶
487. The Inquiry recommends that each child, young person and adult in care and protection, youth justice, disability and mental health settings has access to an individual advocate, and that they can exercise choice in deciding which advocate is right for them. In education settings, the Inquiry recommends that each State, integrated and private school has at least one advocate per school to support the children and young people in school to understand and exercise their rights. This would complement existing support programmes such as Social Workers in Schools.²⁵⁷
488. Independent advocates will need to be subject to the same regulatory standards and safeguards as others in the care workforce. They will need to be vetted, registered, and appropriately trained. Some may be unpaid volunteers. For people who require more than short-term care, the Inquiry would expect advocates to aim for long term relationships with the person in care. Independent advocates with recent lived experience of being in care would be a significant asset in this workforce and will add value to care environments. The Inquiry recommends the Care Safe Agency should develop a career pathway for people with lived experience of care to become independent advocates. This pathway will need to consider how to remove barriers that restrict care experienced people, people with neurodiversity and low literacy skills (for example) from employment.

²⁵⁶ Aroturuki Tamariki, the Independent Children's Monitor, Experiences of Care in Aotearoa: Agency Compliance with the National Care Standards and Related Matters Regulations 1 July 2022–30 June 2023, (2024, page 60).

²⁵⁷ Oranga Tamariki, Response to Notice to Produce No 418 (10 June 2022, para 5.3(d)).

Tūtohi | Recommendation 76

The government should:

- a. provide sufficient investment to enable children, young people and adults in care to have access to an independent advocate of their choosing to support them to understand and exercise their rights, specifically:
 - i. each child, young person and adult in care and protection, youth justice, disability and mental health settings should have access to an individual independent advocate
 - ii. children and young people in State, State-integrated and private schools should have access to at least one independent advocate per school
- b. provide that independent advocates:
 - i. have appropriate communication skills (including for Deaf and disabled people in care)
 - ii. be independent from the care provider, and staff and care workers
 - iii. be independent from the direct and immediate whānau of the person in care
 - iv. proactively and regularly engage with the person in care, be available to respond in times of need, support the person in care when they need to raise issues with their carer, advocate for the right conditions, and /or generally provide peer support
 - v. have no power over the individual
- c. provide that advocates are subject to the same regulatory standards and safeguards, including vetting, registration and training as other staff and care workers.

Tūtohi | Recommendation 77

The Care Safe Agency should develop a career pathway for people with previous lived experience of care towards becoming an independent advocate.

Me whānui ngā whiringa tokonga hiahia e rite ana mo ngā manako o ia tangata

Needs assessment to be comprehensive and respond to needs of the person

489. Many care settings did not identify the individual needs of those in care. Instead, many settings prioritised a “one-size fits all” approach focused on discipline, order and conformity, and paid insufficient attention to avoiding and detecting abuse and neglect.
490. All individuals have different perspectives and challenges and catering to those will have a bigger impact on lives than a ‘one-size fits all’ approach. For tamariki, rangatahi and pakeke Māori in care, this would include understanding and providing for cultural needs in a way that enhances their mana and mauri. All entities providing care directly or indirectly should understand these perspectives and challenges to ensure that the care and support provided meets their individual needs.

Tūtohi | Recommendation 78

All State and faith-based entities providing care directly or indirectly should seek the best possible understanding of the background, culture, needs and vulnerabilities of every child, young person and adult in their care, and should include the protection and enhancement of the mana and mauri of Māori in care.

Kia tōtika ai ngā tokonga mahi atawhai kōhuki, me pātata mai te whānau o taua tangata ake e mau tonu ai ngā here atawhai

All involuntary care placements to be appropriate and located near the whānau of the individual in care to maintain attachment

491. Across many care settings during the Inquiry period, people in care were often removed involuntarily and placed far away from their whānau, communities, culture, support networks and mainstream society. This geographical isolation not only physically separated survivors from those closest to them, but disrupted their emotional connections, support and attachments, causing psychological harm. For Māori and Pacific survivors, separation from whānau played a major role in the cultural disconnection they then experienced.

492. The Inquiry found that moving children, young people and adults in care away from their whānau and communities also increased their vulnerability to abuse and neglect in care. Separation meant they had limited access to people they could trust and disclose abuse and neglect to and therefore undermined the development of protective factors.
493. A 2022 Mana Mokopuna monitoring report into the Epuni care and protection residence found:
- “At the time of the visit, there were no mokopuna who were local to the Wellington region. Many mokopuna were from Auckland and said they felt isolated from whānau, friends and a familiar environment.”²⁵⁸*
494. It is critical that clear action is taken by government and State and faith-based care providers to identify and address barriers to maintaining connections and attachments to whānau for people in care. This includes identifying and promoting good practice in supporting whānau connections.

Tūtohi | Recommendation 79

The government and all relevant decision-makers should review existing policy, standards and practice to ensure that all involuntary care placements are suitable and support connection to whānau and community. This includes placements being located as close as reasonably practicable to the family or whānau of the children, young person or adult in care.

Tūtohi | Recommendation 80

All State and faith-based entities providing care directly or indirectly should review existing policies and practice to ensure they promote and support the maintenance of connections and attachment to family and whānau wherever possible and appropriate.

²⁵⁸ Office of the Children's Commissioner, Epuni Residence Visit May 2022 OPCAT Monitoring Report (October 2022, page 11).

Kia tōtika ngā kohinga me ngā tukunga raraunga, me ngā tuhinga kōrero

Best practice data collection, record keeping and information sharing

Me whakatinana ētahi mātāpono tiaki takinga kōrero Implement records and record-keeping principles

495. The Inquiry found that many State and faith-based institutions had poor record keeping and data practices. This led to a lack of accountability and external scrutiny and missed opportunities for detecting abuse and neglect. It also contributed to abuse and neglect continuing. To build social inclusion in a rapidly diversifying society, public sector agencies need to be able to collect the right data on Aotearoa New Zealand's population to enable analysis of the implications of changing ethnic, disabled and religious demographics and the development of appropriate policy responses.
496. Having accurate and up to date records is critical to understanding the individual needs of those in care, meeting those needs and providing continuity of care while a child, young person or adult is in care.
497. Accurate data is also required to assess impacts and outcomes of policies and practices on meeting needs of the groups most represented in care. In Part 7 the Inquiry found that record-keeping issues, such as ethnicity not being recorded or the loss of records, meant the numbers of Māori and Pacific Peoples, Deaf and disabled people, people who experience mental distress, and Takatāpui, Rainbow and MVPFAFF+ people who were in care will never be known.
498. Today there are gaps in data collection. For example, the Ministry of Education has said that neurodiversity and disability are not characteristics collected by the Ministry in student data in ways that allow system analysis. Additionally, many neurodivergent students are undiagnosed.²⁵⁹ The Independent Children's Monitor noted in its 2022 / 23 annual report that while "monitoring over the last three years has shown a continuous improvement by Oranga Tamariki in completing assessments and individual plans that include the health needs of tamariki and rangatahi in care...the ongoing absence of reliable data is a major barrier to understanding how well tamariki and rangatahi in care are having their health needs met".²⁶⁰

²⁵⁹ Ministry of Education: Response to Notice to Produce 536 (15 August 2023, page 27).

²⁶⁰ Aroturuki Tamariki, the Independent Children's Monitor, Experiences of Care in Aotearoa: Agency Compliance with the National Care Standards and Related Matters Regulations 1 July 2022–30 June 2023 (Independent Children's Monitor 2024, page 99).

499. More comprehensive, granular data collection about the demographics and needs of people in care and independent evaluation of that data will mean better informed decisions and ensure that the benefits of government policies and programmes can be shared equitably. This analysis must inform policy decisions across the care system, and more broadly across social policy settings. They are complex and critical to addressing the social inequities that persist in Aotearoa New Zealand today.
500. This data must also be maintained appropriately and in an indexed, logical and secure manner to ensure that an individual's rights to access, amend or annotate records about themselves should be recognised to the fullest extent.

Tūtohi | Recommendation 81

All State and faith-based entities directly or indirectly providing care to children, young people, Deaf and disabled people and people who experience mental distress should adopt and comply with best practice guidelines for record keeping and data sovereignty, including the following principles:

- a. Record-keeping Principle 1: To create and keep full and accurate records
- Creating and keeping full and accurate records relevant to safety and wellbeing is in the best interests of children, young people or adults in care and should be an integral part of institutional leadership, governance and culture. Institutions that care for or provide services to children, young people and adults in care must keep the best interests of the child uppermost in all aspects of their conduct, including recordkeeping. It is in the best interest of children, young people or adults in care that institutions foster a culture in which the creation and management of accurate records, including detailed information about ethnicity and impairments, are integral parts of the institution's operations and governance.

b. Record-keeping Principle 2: Records to include all incidents and responses


Full and accurate records should be created about all incidents, responses and decisions affecting the safety and wellbeing, including abuse and neglect in care, of children, young people or adults in care. Institutions should ensure that records are created to document any identified incidents of grooming, inappropriate behaviour (including breaches of institutional codes of conduct) or abuse and neglect in care, and all responses to such incidents. Records created by institutions should be clear, objective and thorough. They should be created at, or as close as possible to, the time the incidents occurred, and clearly show the author (whether individual or institutional) and the date created.

c. Record-keeping Principle 3: Records to be maintained in an indexed, logical and secure manner

Records relevant to the safety and wellbeing, of children, young people or adults in care, including abuse and neglect in care, should be maintained appropriately and in an indexed, logical and secure manner. Associated records should be co-located or cross-referenced to ensure that people using those records are aware of all relevant information.

d. Record-keeping Principle 4: Records only be disposed of in accordance with law or policy

Records relevant to the safety and wellbeing, including abuse and neglect in care, of children, young people or adults in care should only be disposed of in accordance with law or policy. Records relevant to the safety and wellbeing, including abuse and neglect in care, of children, young people or adults in care must only be destroyed in accordance with records disposal schedules or published institutional policies. Records relevant to abuse and neglect in care should be subject to minimum retention periods that allow for delayed disclosure of abuse and neglect by victims and survivors and take account of limitation periods for civil actions for abuse and neglect in care.

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- e. Record-keeping Principle 5: Individuals' rights to access, amend or annotate records about themselves to be recognised to the fullest extent

Individuals' existing rights to access, amend or annotate records about themselves should be recognised to the fullest extent including in a way that is compliant with the Convention on the Rights of Persons with Disabilities. Individuals whose childhoods are documented in records held by all entities providing care directly or indirectly should have a right to access records made about them. Full access should be given unless contrary to law. This includes the right to access records without redaction. Specific, not generic, explanations should be provided in any case where a record, or part of a record, is withheld or redacted. Consent of the person who is currently or was previously in care should be proactively sought if information needs to be shared with family members.



Tūtohi | Recommendation 82

All State and faith-based entities providing care directly or indirectly to children, young people or adults should, together with the person in care, document an account of their life during their time in care.



Tūtohi | Recommendation 83

All State and faith-based entities providing care directly or indirectly to children, young people or adults should be required to retain records relating to alleged abuse and neglect in care for at least 75 years in a separate central register, to allow for delayed disclosure and redress claims or civil litigation.

Me aromātai tonu ngā whakaritenga toha kōrero e hāngai tonu ai te kaupapa

Information sharing provisions to be reviewed to ensure fit for purpose

501. During the Inquiry period, the State failed to ensure that effective information sharing arrangements practices were in place. This prevented different government agencies from collaborating to prevent abuse and meant there were missed opportunities for detecting abusers.
502. There were attempts to encourage government agencies to collaborate, through information sharing arrangements or memoranda of understanding, however they were ineffective with little evidence that their collaborative efforts prevented abuse and neglect.
503. Since 1999, legal requirements to collect data and arrangements to share information between agencies have been introduced. In 2015, an Information Sharing Agreement was signed for Improving Public Services for Vulnerable Children between the Ministries for Social Development, Health, Justice, Education, and NZ Police. This included information about people who may pose a risk to children and information about that risk.
504. At the Inquiry's State Institutional Response Hearing, Chief Executive of Oranga Tamariki, Chappie Te Kani, highlighted barriers to information sharing experienced by Oranga Tamariki as part of its safety checking process:
- "We don't have an agreed protocol which shares that information. So to answer your question, if there are a number of unsubstantiated allegations against teachers held in a centralised place by the Ministry [of Education] or the teacher's discipline tribunal, we wouldn't have access to that as an organisation by right."²⁶¹*
505. There is a need to ensure information sharing arrangements are reviewed and strengthened to ensure agencies have access to the best information to prevent abuse in care.

²⁶¹ Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (24 August 2022, page 827).

Tūtohi | Recommendation 84

The government should consider, in consultation with the Privacy Commissioner, whether existing information sharing provisions are sufficient to enable adequate sharing of information to prevent and respond to abuse and neglect in care, or whether additional tools are needed. This work should take into account the recommendations of the Australian Royal Commission into Institutional Responses to Child Sexual Abuse, “establishing a national information exchange scheme across sectors”. The purpose of the review should be to ensure all bodies (whether State or non-State) providing care to children, young people or adults can access the information they need to prevent and respond to abuse and neglect. The review should consider, among other things, whether non-State bodies should be empowered to share information more readily with both State and non-State bodies to prevent and respond to abuse and neglect.

He taurite me te whai rawa i ngā mahi aroturuki motuhake Independent oversight and monitoring is coherent and well-resourced

506. During the Inquiry period, the State failed to ensure that there was robust, independent oversight and monitoring of all care settings that interacted effectively for people at risk. Robust and independent oversight and monitoring is a critical way of ensuring that care providers fulfil their duties to people in their care, including detecting when they are not complying with applicable laws, regulations, policies, or providing safe and quality care.
507. Until the 1990s, limited monitoring enabled State and faith-based institutions providing care to operate in closed environments away from external scrutiny. There were minimal checks to ensure the rights and safety of children, young people and adults in care were being upheld. What oversight and monitoring did exist lacked the independence required to scrutinise institutions effectively and impartially, or to focus on people at risk. This led to missed opportunities to identify and prevent systemic abuse and neglect and rendered people at risk invisible within the system overviews that were available.

508. During the Inquiry period, the State implemented independent or semi-independent oversight and monitoring mechanisms in social welfare and education settings, including the creation of visiting committees for children's residences and the creation of the Education Review Office to monitor state and state-integrated schools.
509. Several independent monitoring entities, including the Te Kāhui Tika Tangata Human Rights Commission, Children's Commission and Health and Disability Commissioner were established towards the end of the Inquiry period, which added greater independence and rights protection for people in care. However inadequate resourcing meant that these functions had little capacity to undertake system level monitoring let alone focus on people at risk. There were also gaps in monitoring regimes, for example private schools. The Inquiry saw no evidence of any Māori-specific monitors during the Inquiry period.
510. Currently, the Ombudsman, as an Officer of Parliament, remains the only monitoring entity that is completely independent of the government. Other independent entities that currently have an oversight and /or monitoring role in relation to care settings include the Te Kāhui Tika Tangata Human Rights Commission, Health and Disability Commissioner and Mana Mokopuna – Children and Young People's Commission.
511. In relation to the independence of monitoring and the Independent Children's Monitor, the former Children's Commissioner Judge Eivers told the Inquiry that:
- "...the State cannot monitor itself. No matter how many non-interference agreements we are told are in place, or assurances that it is independent, the Independent Children's Monitor that will undertake most of the monitoring of the care system is a departmental agency and can't be independent of government."***²⁶²
512. Te Kāhui Tika Tangata Human Rights Commission shared similar views in their submission to the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill:
- "Independence is crucial for the Independent Children's Monitor to achieve its objectives of providing objective and impartial monitoring of the Oranga Tamariki system...A monitor that is not completely independent of government will struggle to gain the public trust and confidence...that is necessary to address (the failures of abuse in care)."***²⁶³

²⁶² Transcript of evidence of the Office of the Children's Commissioner at the Inquiry's State Institutional Response Hearing (25 August 2022, page 963).

²⁶³ Submission of Te Kāhui Tika Tangata Human Rights Commission on the Oversight of Oranga Tamariki System and Children and Young People's Commission Bill (26 January 2022, paras 40–44).

513. In an article on the Oversight of Oranga Tamariki System Bill in 2022, Jonathan Boston and David King wrote that:
- “...two types of monitoring and two types of advice are required. One type of monitoring and advice is fully independent. Such monitoring and advice is necessary to provide public confidence that there is a credible ‘watchdog’ for children and young people. The other is monitoring ‘responsive’ to government policy and advice that is ‘trusted’ and ‘responsive’.”*²⁶⁴
514. Te Kāhui Tika Tangata Human Rights Commission also told the Inquiry that, in terms of resourcing of monitoring functions:
- “...until 2019, the Commission had not received additional funding since 2007. In 2019, the Commission received a baseline funding increase for the first time in several years.”*²⁶⁵
515. Mana Mokopuna told the Inquiry that over the years they have received additional places of detention to monitor “with minimal baseline adjustment [to funding] to supplement staffing levels”.²⁶⁶ Limited funding has enabled them “to monitor, some, but not all, places of detention on an annual basis”.²⁶⁷
516. In 2022 the Chief Ombudsman told the Inquiry he has received increased funding to be able to carry out his new functions:
- “I am funded at a level that enables me to undertake inspections of places of detention within my current jurisdiction under the Crimes of Torture Act 1989 at least once every four years – more regular inspections would require more resources.”*²⁶⁸
517. In terms of capacity to undertake systemic monitoring, the Health and Disability Commissioner acknowledged it is under significant pressure from the increasing volume of complaints and its “ability to undertake systemic Commissioner-initiated inquiries in the absence of a complaint has become somewhat constrained.”²⁶⁹

264 King, D and Boston, J, Improving a system when young lives are at stake: a public policy analysis of the Oversight of Oranga Tamariki System and Children and Young People’s Commission Bill (2022, page 2).

265 Te Kāhui Tika Tangata Human Rights Commission, Response to Notice to Produce 476 (September 2022, para 82).

266 Brief of evidence of Fiona Rose Cassidy for the Office of the Children’s Commissioner at the Inquiry’s State Institutional Response Hearing (17 August 2022, para 11).

267 Brief of evidence of Fiona Rose Cassidy for the Office of the Children’s Commissioner at the Inquiry’s State Institutional Response Hearing (17 August 2022, para 12).

268 Chief Ombudsman response to Notice to Produce 472 (9 August 2022, page 3).

269 Health and Disability Commissioner, Response to Notice to Produce 479 (Royal Commission of Inquiry into Abuse in Care, 5 August 2022, page 18).

518. Judge Eivers also highlighted concerns about system coherence:
- "...instead of it all [oversight functions] being in one agency, we've now got three agencies [the Independent Children's Monitor, Mana Mokopuna and the Ombudsman], where its whānau have to navigate their way through three agencies."*²⁷⁰
519. Dr Tristram Ingham told the Inquiry that, in relation to safeguarding arrangements for disability settings:
- "None of the existing processes for service oversight, monitoring and safeguarding are sufficiently robust, all-encompassing or with sufficient teeth to provide timely and appropriate safeguarding for tāngata whaikaha Māori."*²⁷¹
520. The Inquiry considered and rejected recommending that a new independent oversight and monitoring entity be created for the care system. The Inquiry thinks there is already a possibility of unnecessary duplication and overlap, especially in relation to independent monitoring of care and protection and youth justice settings.
521. The Inquiry recommends the government reviews existing entities' roles and functions to:
- a. identify and address any unnecessary duplication of effort as an immediate priority. The Inquiry envisages this will include consolidation of care and protection and youth justice independent monitoring into a single entity
 - b. determine the extent to which the existing entities are resourced and enabled to maintain a consistent focus on individuals at risk in the care system, ensuring people about whom a complaint or concern has been raised remain visible as their case is investigated and do not fall through the gaps.
522. The Inquiry intends that the independent monitoring and oversight entities, as they stand following this review, will have a critical role in providing an extra layer of oversight for the care system that operates at arm's length from care providers and the Care Safe Agency. The monitoring and investigation roles of the Care Safe Agency do not constitute an overlap of responsibility with independent oversight entities. They are an additional layer of protection to ensure that there is a holistic view of people at risk in care, as well as the system level views they will provide.

²⁷⁰ Transcript of evidence of the Office of the Children's Commissioner at the Inquiry's State Institutional Response Hearing (25 August 2022, page 967).

²⁷¹ Transcript of evidence of Dr Tristram Ingham at the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institution Hearing (20 July 2022, pages 660–661).

523. The role of independent oversight and monitoring entities is separate and additional to the monitoring functions of the Care Safe Agency. The Care Safe Agency will proactively monitor and enforce compliance with statutory requirements, standards and rules under the new care safety regulatory system, including that care providers must be accredited, have complaints procedures in place, have safeguarding policies and procedures in place, vet employees, and ensure employees are registered and appropriately trained. The Care Safe Agency will also be responsible for investigating and responding to complaints, disclosures or incidents of abuse and neglect in care, as well as concerns or reports about breaches of rules, standards and guidelines under the care safety regulatory system.
524. The independent monitoring entities will also operate proactively to inspect care providers and visit facilities, as well as reactively investigating and responding to complaints about abuse and neglect in care or failures breaches of rules, standards and guidelines under the care safety regulatory system. The Inquiry also considers that the independent monitoring entities may choose to collaborate, as appropriate. Some independent entities are already working together to monitor children and young people in care and protection.
525. This means that people receiving care supports and services, whānau, staff and care workers, and anyone else who wishes to make a complaint, raise a concern or report abuse and / or neglect, will have four pathways to do so:
- a. to the relevant State or faith-based care provider
 - b. to the relevant professional registration body
 - c. to the Care Safe Agency
 - d. to independent oversight and monitoring entities.
526. These bodies range from least independent (care providers) to most independent (independent monitoring entities). Complainants will be able to contact one or more entity about the same issue if they wish. Care providers and professional registration bodies will be required to report substantiated complaints to the Care Safe Agency (Recommendation 66). Complaints about the Care Safe Agency itself could be made to the Agency or to the independent monitoring entities.
527. The independent monitoring entities may require extra resourcing to investigate complaints or concerns and monitor additional statutory requirements, standards and rules under the new care safety regulatory system. They may also require extra investment to collaborate to enable a whole-of-system view when needed.

Tūtohi | Recommendation 85

The government should:

- a. review the roles, functions and powers of independent monitoring and oversight entities to identify and address any unnecessary duplication and encourage collaboration
- b. consolidate the existing care and protection and youth justice independent monitoring and oversight entities into a single entity.

Tūtohi | Recommendation 86

The government should ensure that there are no unreasonable barriers preventing all responsible oversight bodies from investigating complaints, proactively monitoring the care system, and collaborating as appropriate to enable a whole of system view, including:

- a. reviewing and addressing any barriers or constraints in the entities' enabling legislation, and
- b. ensuring the entities are adequately resourced.

Tūtohi | Recommendation 87

The responsible oversight bodies should:

- a. investigate complaints about care workers, State and faith-based care providers and / or the Care Safe Agency, including both proactive and reactive site visits
- b. proactively monitor the way in which State and faith-based care providers and the Care Safe Agency investigate and respond to complaints
- c. proactively monitor the care system, including collaboratively to ensure a whole of system view, as appropriate
- d. publish reports on their activities including on the outcomes of specific investigations or other monitoring functions
- e. share information with the Care Safe Agency, including:
 - i. data, statistics and other information about the prevalence and nature and extent of abuse and neglect in care
 - ii. insights about abuse and neglect in care including the effectiveness of different practices to prevent and respond to abuse and neglect in care
 - iii. refer the results of their investigations and other monitoring functions to enforcement or regulatory bodies including NZ Police, the Charities Commission or the Care Safe Agency.

Ngā whakataua mō Gloriavale

Recommendation about Gloriavale


528. In August 2022, the government established a new function to coordinate the operational activities of government agencies in relation to Gloriavale. Briefings to government released under the Official Information Act in March 2024 noted that this coordinating function came to an end on 31 December 2023.
529. A 20 December 2023 briefing to the Ministers for Workplace Relations and Safety, Education, Social Development and Employment, Police, Children and Women noted that:
- “There are several other legal proceedings underway relating to labour exploitation and physical and sexual abuse at Gloriavale, including charges of indecent assault relating to historical offending against young women, against the community’s Overseeing Shepherd Howard Temple. He is currently on bail outside the Gloriavale compound, with a condition of compliance with an Oranga Tamariki safety plan. This includes supervision to prevent any inappropriate contact with a child or young person.*
- ...Oranga Tamariki and Police continue to respond to allegation or disclosures of harm towards children in the community, including those relating to harmful or concerning sexualised behaviour in children.”²⁷²*
530. A briefing to the Minister of Social Development on the same day noted:
- “A number of risks and challenges remain... These include risks to child wellbeing, education provision, and risks to the stability of Gloriavale’s commercial enterprises.”²⁷³*
531. The Inquiry is concerned to ensure that the government does everything it can to prevent the factors that led to historical abuse and neglect in care at Gloriavale.

Tūtohi | Recommendation 88

The government should take all practicable steps to ensure the ongoing safety of children, young people and adults in care at Gloriavale.

²⁷² Briefing: All-of-Government Response to Gloriavale (Ministry of Business, Innovation and Employment, New Zealand Police, Ministry of Social Development, Worksafe, Oranga Tamariki, Ministry of Education and Ministry for Women, 20 December 2023, paras 9 and 21), <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/official-information-responses/2024/march/28032024-all-correspondence-sent-and-received-by-the-ministry-by-the-ministry-27-november-2023-in-regards-to-gloriavale-christian-community.pdf>.

²⁷³ Report to Minister for Social Development and Employment, The Ministry of Social Development’s role in regard to Gloriavale (Ministry of Social Development, 20 December 2023, para 25), <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/official-information-responses/2024/march/28032024-all-correspondence-sent-and-received-by-the-ministry-by-the-ministry-27-november-2023-in-regards-to-gloriavale-christian-community.pdf>

A portrait of a young person with short, dark hair, wearing a grey and blue plaid button-down shirt. They are standing outdoors with a background of trees with yellow and orange autumn leaves. A circular graphic with a decorative border is overlaid on the bottom left of the image.

"I didn't tell
anybody, because
I was scared."

SKYLER QUINN
NZ European and Māori

Skyler Quinn

Hometown: Ōtautahi Christchurch

Age when entered care: 8 years old

Year of birth: 2003

Time in care: 2011–2014

Age now: 21 years old

Type of care facility: Foster homes – various; residential family homes in Spencerville and Oxford

Ethnicity: NZ European and Māori

Whānau background: Skyler has an older half-sister, who was taken into care before Skyler was born.

Currently: Skyler lives in Ōtautahi Christchurch.



I'm aware that Child, Youth and Family (CYFS) was involved with my mother before I was born, and that my older half-sister was taken from my mother. My mum was sterilised when I was born, so she couldn't have any more children. Dad says that CYFS told her she had to have the operation or I would get taken away as well. He says it affected my mother's mental health, and their relationship as well.

My parents separated when I was about 18 months old. I lived with my mother, then my parents lived together for a while – co-parenting in the same house. Later, my mother moved out and was living with a guy who had a criminal conviction for sex with a minor. I went into my father's care because of that, for about a year and a half.

When I was 6 years old, there was an incident while we were camping where I broke my arm. I just remember that I tried to get out of the car door, and my father grabbed me and I got hurt. It was recorded that I told the doctors that my father hurt me on purpose, but I never said that. After that, I had to live with my uncle and aunt in Swannanoa. I was there for about a year before I got sent away.

I was 8 years old when I went into foster care. The first six homes I went to were so close together, they're all muddled. At times, I was only at one place for one night, and then a week or two weeks. I started having panic attacks. I would wake up thinking really fast and I couldn't stop it. I told my social worker at the time and I know that she tried to get help, but nothing happened.

I remember really liking some of the carers. Mostly though, I ran away from the homes. At one place, there were two boys about a year or two younger than me. Some things happened there, like those childish games you play, like 'doctor, doctor' and all that. I can't explain what happened, because I felt like it was my fault, but I didn't know. I remember crawling out the window and running away with one of the boys.

I don't really remember much about the others that I ran away from. I was either running away because of where I was, because of the way I was treated or because of the place. I was having problems and I couldn't handle it. Sometimes I ran away with some of the other kids and we would get into trouble.

I went to 18 different foster homes in a short period of time, before I went back to my uncle's home for about a year when I was 9 years old. They're not all documented, but I believe I was placed in 30 different homes overall, not including the times I went back to places. I also went to almost as many different schools. No-one ever told me why I was leaving any of my foster homes, except one.

I also lived in residential homes – I think there were two that I went to. When I was about 8 years old, I went to one in Spencerville. That was when I first started developing my personalities. All of a sudden, I would have this burst of anger that I had never had before. I have a scar from breaking a window with my hand one time.

There were three boys and four girls living there at that time, but all older than me—13 to 16 years old. Once I woke up with a bloody nose as one of the older girls had punched me. That was also around the same time I first self-harmed. For whatever reason, I was removed from this home, then I was in and out of foster homes again.

I went back to the Spencerville home when I was 10 years old and I was assaulted again by some of the older girls. I was still the youngest – the others were all teenagers. I woke up to girls punching and kicking me, and I got dragged out of bed by my hair. I hid in the bathroom curled up in a ball. The worker in the home found me and the girls were locked outside to protect me. I had to make a statement about what happened, and I had an x-ray on my jaw. One of the bones is dislodged and is still uncomfortable.

The next year, I was also sexually assaulted multiple times at a residential family home out in the country, near Oxford. I stayed at this home on four occasions. The last two times, a boy who was staying in the home assaulted me. The first stay with him was not as bad, but it was more severe the next time. It happened almost every night I was there.

On one occasion, I woke up not being able to breathe. I was on my period and I told him to fuck off. He wouldn't listen. Then I blacked out. I woke up naked and bloody because of my period. It still carried on after that. I didn't tell anybody what was happening at the time because I was scared and I knew I would get blamed for it.

When my social worker first mentioned the idea of going to Australia, I said yes. My mum's sister and her husband lived there, and I wanted to be with family. I was 11 years old when I went to live with my aunt and uncle in Toowoomba. I stayed there for almost four years.

They were sweet and nice to begin with, but then by halfway through year six, stuff started going downhill. The verbal abuse in the house from my uncle was bad. There was also an incident with my uncle near the end of that year, where he pulled me from one room into another by my hair because I didn't clean my room properly.

At around the same time, a boy at school started forcing me to do certain things. It was constant and, because of everything that had happened to me, I just shut up about it. I didn't know how to say no or stop it happening.

Another incident with my uncle ended with me leaving. He got angry after collecting me from an event, and I was crying a little in the car, sniffing. He threw his phone at me and asked if I wanted something to cry about. He grabbed my hair and pushed me down to the seat, then straight up so my head hit the ceiling of the car.

After school the next day, I went to the house of the boy I was dating at the time and told his mother everything. They took me to the police and I filed a report. I ended up in the Australian foster care system and went to emergency housing in Ipswich.

My aunt and uncle went to court because of what happened. The outcome was that I had suffered emotional and physical harm as a result of neglect from them. After everything that happened with my uncle and the boy, I spiralled. I abused alcohol and drugs. I ended up pregnant twice and miscarried both times.

My first suicide attempt was in mid-2013, when I was 10 years old. I started to drink some bleach, but my sister turned up and saved my life. By the time I left Australia when I was 15 years old, I had been in hospital six times for suicide prevention, six times for self-harm prevention and twice because I nearly died because I cut myself so deep on my legs.

During those difficult times, I had a 'second mum' who helped me get back to New Zealand. I wanted to see my mum and they said that if I was free of self-harm for a month and no drugs in the system, then I could go. I returned to New Zealand in 2018.

I live with multiple personalities and severe depression. At times, my mental health is not good and I have been in Hillmorton Hospital. I have anxiety related tics, borderline personality disorder and bipolar disorder.

You should be able to feel safe as a child. My parents were in care as children and then it happened to me. It has lifelong effects and I can't see that I will ever be able to work.

I haven't had good help around me to support me with my trauma, mental health and disabilities. I think there should be more support and help for people that suffered abuse in care.²⁷⁴

²⁷⁴ Witness statement of Skyler Quinn (20 April 2023).



Ūpoko | Chapter 6

Kia āhuru ngā mahi atawhai-ā-hāhi

Making faith-based care safe

532. Faith-based entities must act to prevent further abuse and neglect of children, young people and adults in their care. In addition to recommendations above that include faith-based entities, the below recommendations are further steps which each faith-based entity must take to ensure factors that caused abuse are unable to persist.
533. This chapter responds to clause 32A of the Inquiry's Terms of Reference, which relates to recommendations to ensure that the factors that allowed abuse and neglect to occur during the Inquiry period do not persist. As provided for in clauses 15A and 15B of its Terms of Reference, the Inquiry has considered issues and experiences after 1999 shared by survivors, including those set out below.²⁷⁵

Ngā wheako purapura ora mai i te tau 1999

Survivors' experiences after 1999

534. Survivors told the Inquiry about a range of issues and experiences in faith-based care after 1999. These experiences included abuse, difficulties disclosing abuse and challenging complaints processes.
535. Pākehā survivor Rosanna Overcomer, former member of Gloriavale Christian Community located in Haupiri on the West Coast of the South Island, told the Inquiry she was sexually abused in 2000 or 2001 when she was 14 years old by another member of Gloriavale and that, when she disclosed this abuse:
- "...[Howard Temple, Overseeing Shepherd of Gloriavale] told me that I had to stay away from [redacted] because he was doing stuff he should not be doing. I am not sure whether he said that I was the problem, but I felt like I was the problem and that I was making a problem. I understood that it was my fault that [redacted] was having this problem, and it was my responsibility to stay away from him. ... It was then that the Leaders shifted [redacted] away to another farm up the valley."²⁷⁶*

²⁷⁵ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, Terms of Reference, clauses 15A, 15D and 32A.

²⁷⁶ Witness statement of Rosanna Overcomer (17 June 2021, para 4.1.5.8).

536. Rosanna Overcomer provided evidence on behalf of the Gloriavale Leavers' Trust during the Inquiry's Faith-based Institutional Response Hearing and called for lasting change to provide a safe environment for their family members that still reside within the Gloriavale community:

*"We can hope and heal and work for a better life. But we want lasting change for our families still inside. We want a safe place for our nieces and nephews to grow up in. We want them to have the same liberties, opportunities, education and care any New Zealander deserves. We need to know there will be significant changes to the systems and leadership that brought us here today."*²⁷⁷

537. Ms CU, who is Tongan, told the Inquiry about her experience of reporting the abuse of her 15-year-old niece by Father Sateki Raass to NZ Police and the Catholic Church in 2018. She explained that reporting threatened the vā or the cultural relationships between Ms CU and her family, and that this can be a barrier to Pacific Peoples reporting abuse:

*"In Tongan culture, you become almost cursed for going up against the church. If you go up against the church and do something against what everyone believes in, anything wrong that later happens in your life or any problems that arise are considered to be a result of you speaking up against the church. There is a very powerful sense of being observed and judged by the Tongan community."*²⁷⁸

538. Ms CU also told the Inquiry that she found out about previous incidents involving Father Raass:

*"A prominent Tongan leader told me that he had received a complaint about Sateki while he was working in Auckland. This leader took the complaint to a senior Tongan priest, who told him to take it to the Cardinal. He told me that he did that but nothing was done about it. It was about another young girl. It looks to me as though when the Church found out about the incidents involving Sateki and young women, they just shut it down and moved him on, shut it down and moved him on. If they had a process for dealing with this, they didn't follow it."*²⁷⁹

²⁷⁷ Transcript of Rosanna Overcomer on behalf of the Gloriavale Leavers' Trust at the Inquiry's Faith-based Institutional Response Hearing (13 October 2022, page 29).

²⁷⁸ Witness statement of Ms CU (10 June 2021, para 170).

²⁷⁹ Witness statement of Ms CU (10 June 2021, paras 109–110).

539. In 2019, Pākehā survivor Annie Benefield made a complaint to the Catholic Church about being abused by a parish priest, which started in 2012 when she was age 19. Annie outlined her experience of disclosing abuse she suffered, the church's response and her experience with the church's redress process Te Houhanga Rongo – A Path to Healing:

“There also needs to be more of a deterrent for behaviours such as what [redacted] did. When I complained, all that happened was he went on a course and then returned to another parish. I don't think this is enough of a deterrent not to do what he did. ... I am still concerned that [redacted] continues to travel to India to the very vulnerable communities he goes to.

I also believe the Church needs to consider the faith aspect with respect to the power imbalance that the clergy have. Lay people hold the clergy in such high regard and often do exactly what is asked of them. This aspect needs to be considered when a complaint of abuse is reported. It is a huge power imbalance ... I believe each diocese needs their own safeguarding officer who people feel safe to go to and report abuse, for both lay people and priests.”²⁸⁰

540. Cooper Legal acted for 20 clients who suffered abuse in Presbyterian care.²⁸¹ In its statement to the Inquiry in July 2022, Cooper Legal noted the difficulty bringing claims due to the lack of consistency in the response to abuse claims across the different Presbyterian organisations. It told the Inquiry:

“Similarly, we have encountered some difficulty with bringing claims against the different Presbyterian Support organisations, because each take a completely different approach to responding to claims. For instance, we have previously settled three claims against Presbyterian Support Otago, but when we approached Presbyterian Support Northern about another client, it was clear that they do not have systems in place for responding to claims, meaning we essentially have to create a process with them from scratch. In addition, each organisation has different funding available for them to respond to claims, which seems to lead to inconsistent resolutions.”²⁸²

541. Survivors' issues and experiences are echoed in independent and State-commissioned reports on care settings after 1999, which are discussed in Chapter 2.

²⁸⁰ Witness statement of Annie Benefield (10 April 2021, paras 3.8, 5.5 and 5.7–5.8).

²⁸¹ Second witness statement of Sam Benton, Sonja Cooper and Amanda Hill of Cooper Legal (28 July 2022, para 182).

²⁸² Second witness statement of Sam Benton, Sonja Cooper and Amanda Hill of Cooper Legal (28 July 2022, para 6).



Ngā whakataau e hāngai ana ki te katoa o ngā tira whakapono o Aotearoa

Recommendations to all faith-based entities in Aotearoa New Zealand

542. During the Inquiry period, faith-based institutions were largely left to design and implement policies and practices within their care settings. The State had little input into the way faith-based institutions provided care to children, young people and adults, even those who were State wards.
543. The following recommendations are for all faith-based entities involved in providing care directly or indirectly to children, young people and adults including pastoral care.

Me tōtika tonu ngā whakahaere e hāngai ana ki te rautaki āhuru mōwai i roto i ngā pūnaha taurima ā-motu a ngā hinonga whakapono, me te mau tonu ki te Ture Āhuru Mōwai Pūnaha Taurima

Faith-based entities to effectively implement the national care safety strategy and comply with the Care Safety Act

544. The Care Safety Principles for preventing and responding to abuse and neglect in care (Recommendation 39) and the national care safety regulatory system apply to all faith-based entities in Aotearoa New Zealand.
545. The Inquiry considers that faith-based entities involved in providing care, and all people in religious ministry and lay people (whether employed or volunteers) involved in providing care, will be subject to the national care safety regulatory system. This means they will need to comply with statutory requirements under the Care Safety Act (Recommendation 41), including complying with national care standards, accreditation, vetting and training.



Tūtohi | Recommendation 89

All faith-based entities that provide activities or services of any kind, under the auspices of a particular religious denomination or faith, through which adults have contact with children, young people or adults in care, should comply with the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40) and all statutory requirements under the Care Safety Act (Recommendation 45), including care standards, accreditation and vetting. Faith-based entities in highly regulated sectors, such as schools and out-of-home care service providers, should also report their compliance to the religious organisation to which they are affiliated.



Tūtohi | Recommendation 90

All faith-based entities should adopt the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40) and all statutory requirements under the Care Safety Act (Recommendation 45), including care standards, accreditation and vetting, for each of their affiliated institutions.



Tūtohi | Recommendation 91

All faith-based entities should drive a consistent approach to the implementation of the Care Safe Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40) and all statutory requirements under the Care Safe Act (Recommendation 45), including care standards, accreditation and vetting, in each of their affiliated institutions.

Tūtohi | Recommendation 92

All faith-based entities should work closely with the independent Care Safe Agency and independent oversight bodies to support the implementation of and compliance with the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40), and all statutory requirements under the Care Safety Act (Recommendation 45), including care standards, accreditation and vetting, in each of their affiliated institutions.

Me rite i ngā kaihautū hinonga whakapono, he akonga, tikanga mātai me ngā kaupapa tauārai e kimi putanga i ngā ripoata mahi tūkinu

Faith-based entities to put in place leadership training, monitoring and safeguarding specifically in relation to preventing and responding to reports of abuse

546. This Inquiry has found instances where religious leaders have perpetrated abuse on those in their care. Religious leaders have also made poor decisions regarding placements of abusers, destroyed evidence of abuse and have failed to adequately respond to reports of abuse.
547. Although safeguarding mechanisms and the handling of reports of abuse are now mostly managed by independent, specialised bodies, faith-based leaders remain engaged in both creating safer churches and are often directly involved in responding to reports of abuse. Some faiths continue to direct survivors to contact faith-based leaders in the first instance.
548. There is evidence of gaps in abuse prevention and response training provided to religious leaders, including both a complete absence of training and instances where the training is solely rooted in religious doctrine rather than evidence-based practices, such as trauma-informed and survivor-centric approaches.
549. It is imperative that faith-based leaders are provided with comprehensive training both prior to and during their appointment, that are survivor-centric and trauma-informed and that these leaders are consistently held to account to an appropriate authority or body specifically in relation to identifying, preventing and responding to abuse and neglect in care cultural awareness, and addressing prejudice and all forms of discrimination.



Tūtohi | Recommendation 93

All faith-based entities should ensure their religious leaders are provided with leadership training both pre- and post-appointment, including identifying, preventing and responding to abuse and neglect in care, cultural awareness, and addressing prejudice and all forms of discrimination.



Tūtohi | Recommendation 94

All faith-based entities should ensure that religious leaders are accountable to an appropriate authority or body, such as a board of management or council, for the decisions they make with respect to preventing and responding to abuse and neglect in care.

Me rite i ngā hinonga whakapono ētahi tikanga tōtika hei taki i ngā mahi mātai mo rātou i raro i te atawhai a ngā hāhi

Faith-based entities to put in place effective oversight and supervision mechanisms for those in religious or pastoral ministry

550. In addition to ensuring religious leaders are accountable to an appropriate oversight and supervision authority, those in religious or pastoral ministry must be subject to effective management and oversight bodies. This must include mandatory professional development delivered through professional supervision and annual performance appraisals, with compulsory components including in relation to boundaries, ethics in ministry, identifying and preventing abuse and neglect in care, cultural awareness, addressing prejudice and all forms of discrimination.
551. Throughout the Inquiry period, high trust has been placed in individuals within religious ministry. This unchecked trust has been identified as a contributing factor to the occurrence of abuse within faith-based institutions. Although improvements have been made internally by most faiths, the introduction of the new care safety regulatory system will provide the necessary shift towards more robust oversight and supervision mechanisms.



Tūtohi | Recommendation 95

All faith-based entities should ensure that all people in religious or pastoral ministry, including religious leaders, are subject to effective management and oversight and undertake annual performance appraisals.

Tūtohi | Recommendation 96

All faith-based entities should ensure that all people in religious or pastoral ministry, including religious leaders, have professional supervision with a trained professional or pastoral supervisor who has a degree of independence from the institution within which the person is in ministry.

Mā ngā hinonga whakapono anō e āta tiaki ngā take tōtara wāhi rua **Faith-based entities to manage conflicts of interest**

552. At times, those in leadership positions within faith-based entities have struggled to act in the best interest of the complainant, instead prioritising or struggling to balance their obligations to provide support to alleged perpetrators and / or their longstanding relationships with alleged perpetrators. Faith-based entities need to develop a clear conflict of interest policy to ensure that no such conflict exists by those assessing the behaviour of others.
553. Although most faith-based institutions have established entities or committees that oversee and implement processes relating to abuse complaints, until the establishment of a national independent redress scheme, there will continue to be a risk of personal or institutional bias when responding to allegations of abuse. As an interim measure, faith-based entities must adopt conflict of interest policies that apply to all individuals who have a role in responding to complaints of abuse and neglect in care. This will ensure a more impartial and objective process when responding to survivors of abuse and neglect.

Tūtohi | Recommendation 97

Each faith-based entity should have a policy relating to the management of actual or perceived conflicts of interest that may arise in relation to allegations of abuse and neglect in care. The policy should cover all individuals who have a role in responding to complaints of abuse and neglect in care.

Me rite i ngā hinonga whakapono ētahi tikanga tōtika hei āta wherawhera me te ako mahi tauārai ki ngā ākonga o te hāhi

Faith-based entities to put in place effective initial screening and safeguarding training for candidates for religious ministry

554. Throughout the Inquiry period, faith-based institutions were slow to implement both screening processes and safeguarding training for all staff, including religious leaders. This complacency was often caused by the prevailing belief that religious staff could be trusted to be good people. There was a reluctance to acknowledge the potential for misconduct or abuse, leading to a lack of proactive measures to safeguard against such risks.
555. Often there was a lack of formality and consistency with the selection of clergy and other religious staff, instead based on personal familiarity, informal recommendations and standing within the community.
556. Likewise, during the Inquiry period, most faiths did not have safeguarding training or boundaries training policies. The Salvation Army did not establish safeguarding training until 2010. Gloriavale did not introduce a safeguarding policy until 2019. The Plymouth Brethren currently do not require Elders to undergo any safeguarding training, but instead rely on religious scriptures to prepare for the role. Faith-based entities have acknowledged that the absence of such policies has contributed to the abuse suffered by those in their care.
557. Other issues acknowledged by faith-based entities is the siloing within branches or dioceses, which was acknowledged by the Anglican Church to be one of the biggest issues when dealing with abuse and redress.²⁸³ The Anglican Church recognised a “fundamental need for safeguarding policies to be consistent across the core Church” and that the “approach of Anglican entities to safeguarding and redress does need review”.²⁸⁴

²⁸³ Closing submissions on behalf of the Anglican Church in Aotearoa, New Zealand and Polynesia at the Inquiry's Faith-based Institutional Response Hearing (26 March 2021, para 34).

²⁸⁴ Closing submissions on behalf of the Anglican Church in Aotearoa, New Zealand and Polynesia at the Inquiry's Faith-based Institutional Response Hearing (26 March 2021, para 36).

Tūtohi | Recommendation 98

Each faith-based entity should ensure that candidates for religious ministry undertake minimum training on preventing and responding to abuse and neglect in care and related matters, including training that:

- a. equips candidates with an understanding of the Care Safety Principles (Recommendation 39), the National Care Safety Strategy (Recommendation 40), and all statutory requirements under the Care Safety Act (Recommendation 45), including care standards, accreditation and vetting
- b. educates candidates on:
 - i. professional responsibility, boundaries and ethics in ministry
 - ii. identifying and preventing abuse and neglect in care
 - iii. cultural awareness
 - iv. addressing prejudice and all forms of discrimination
 - v. policies regarding appropriate responses to allegations or complaints of abuse and neglect in care, and how to implement these policies
 - vi. how to work with children, young people and adults in care.

Tūtohi | Recommendation 99

Each faith-based entity should require that all people in religious or pastoral ministry, including religious leaders, undertake regular training on the institution's safeguarding policies and procedures. They should also be provided with opportunities for external training on best practice approaches to people safety.

Tūtohi | Recommendation 100

Wherever a faith-based entity has children, young people or adults in its care, they should be provided with age-appropriate prevention education that aims to increase their knowledge of abuse and neglect and build practical skills to assist in strengthening self-protective skills and strategies. Prevention education in religious institutions should specifically address the power and status of people in religious ministry and educate children, young people and adults in care that no one has a right to invade their privacy and make them feel unsafe.

Me turaki e ngā hinonga whakapono ngā pou ārai whākinga tūkino

Faith-based entities to reduce barriers to disclosure

558. Faith-based institutions had unique barriers to reporting abuse or making complaints. There was often a strong preference for secrecy and silence and a lack of transparency. Due to the high moral regard that faith leaders were held in, many survivors simply did not think they would be believed. In some faiths, some survivors feared that disclosure would result in their excommunication from the faith and their community.
559. Barriers to disclosure were further exacerbated by daunting disclosure or complaint processes.
560. Trauma-informed and survivor focused approaches to disclosure require flexibility about how victims of sexual abuse can disclose their abuse, such as members having the option of disclosing to women and to be able to choose and direct with support how their disclosure of abuse is dealt with. Failure to accommodate a survivor's preference can further traumatise that survivor or prevent disclosure.

Tūtohi | Recommendation 101

All faith-based entities should revise their policies to reduce high barriers to disclosure including through flexibility for disclosures of abuse.

Tūtohi | Recommendation 102

Each faith-based entity should make provision for family and community involvement by publishing all policies relevant to preventing and responding to abuse and neglect in care on its website, providing opportunities for comment, and seeking periodic feedback about the effectiveness of its approach to preventing and responding to abuse and neglect in care.



Me rite i ngā hinonga whakapono ētahi tikanga hautū kōamuamu tōtika
Faith-based entities to put in place effective complaint handling policies

561. This recommendation is in addition to Recommendations 65–68 above on effective complaints processes for both State and faith-based entities.
562. During the Inquiry period, the responses to disclosures of abuse and approaches to redress has largely been inadequate and inappropriate. As explained in *He Purapura Ora, he Māra Tipu: From Redress to Pūretumu Torowhānui*, survivors of abuse in faith-based institutions have often faced minimisation or denial of their abuse allegations.
563. The Inquiry found evidence of attempts to hide or cover up abuse within the Anglican Church. Religious leaders within the Catholic Church were found to have repeatedly failed to act on known allegations of abuse, destroyed reports of abuse without investigation and moved perpetrators between its institutions. Presbyterian Support Otago destroyed records except for registers of names and dates. Survivors in Gloriavale Christian Community were actively prevented from reporting their abuse throughout the entire Inquiry period.
564. The Plymouth Brethren do not have any policies (written or otherwise) relating to responding to reports of abuse at either a national or assembly level and instead rely on religious doctrine.
565. These failures to respond to reports of abuse, or to do so adequately, have left survivors with feelings of powerlessness, isolation and have led to further emotional distress and retraumatisation. The failure to address reports of abuse has also led to the continuation of abuse and harm, where perpetrators have remained in positions of power or are reemployed or relocated within the faith-based entity.
566. Although most faith-based entities are learning lessons from the past and making improvements to complaint handling processes by establishing specialised independent bodies to manage the reports of abuse, there is still more to be done. There must be a shift away from prioritising institutional protection and using legalistic, disciplinary focused complaints process with unrealistic standards of proof. There is a need for faith-based entities to have more accessible and survivor-focused complaints processes with an emphasis on survivor safety and the minimisation of harm to the people in their care.



Tūtohi | Recommendation 103

All faith-based entities' complaint handling policies should require that, upon receiving a complaint of abuse and neglect in care, an initial risk assessment is conducted to identify and minimise any risks to children, young people and adults in care.



Tūtohi | Recommendation 104

All faith-based entities' complaint handling policies should require that, if a complaint of abuse and neglect in care against a person in religious ministry is credible, and there is a risk that person may come into contact with children in the course of their ministry, the person be stood down from ministry while the complaint is investigated.



Tūtohi | Recommendation 105

All faith-based entities should, when deciding whether a complaint of abuse and neglect in care has been substantiated, consider the principles set out by the courts in applicable case law in accordance with the seriousness of the allegation.²⁸⁵



Tūtohi | Recommendation 106

All faith-based entities should apply the same standards for investigating complaints of abuse and neglect in care whether or not the subject of the complaint is a person in religious ministry.

²⁸⁵ Z v Dental Complaints Assessment Committee [2008] NZSC 55.

Tūtohi | Recommendation 107

Any person in religious ministry who is the subject of a complaint of abuse and neglect in care which is substantiated on the balance of probabilities, applied flexibly according to the seriousness of the allegation in accordance with the principles set out by the courts in applicable caselaw, or who is convicted of an offence relating to abuse and neglect in care, should be permanently removed from ministry. Members of the Church should be notified of the persons permanent removal from ministry. Faith-based entities should also take all necessary steps to effectively prohibit the person from in any way holding himself or herself out as being a person with religious authority.

Te kore o ngā hinonga whakapono e tohe i te hunga kaihora kia tapaea mo a rātou mahi hē

Faith-based institutions not holding convicted perpetrators to account

567. Faith-based institutions have often failed to respond adequately to reports of abuse and have prioritised support for perpetrators even after they had been convicted of sexual or violent offences. Perpetrators remained unaccountable by being regularly moved around the care settings, while leaders escaped accountability for enabling the cover-ups. This impunity, combined with the extreme efforts to protect the institution's reputation and prioritising perpetrators' interests over survivor well-being, led to abuse within these religious communities.
568. Convicted perpetrators were allowed to return to ministry. Catholic Provincial Father Frederick Bliss of the New Zealand province of the Society of Mary appointed Father Alan Woodcock to a teaching position at St Patrick's College, Silverstream, knowing he was a convicted sex offender.²⁸⁶ Hopeful Christian was able to return to his role as leader of the Gloriavale Christian Community when he was released from prison after being convicted of sexual offending.²⁸⁷

²⁸⁶ Transcript of evidence of Father Timothy Duckworth for the Catholic Church at the Inquiry's Faith-based Institutional Response Hearing, (17 October 2022, page 122).

²⁸⁷ Transcript of opening statement for Gloriavale Leaver's Trust at the Inquiry's Faith-based Institutional Response Hearing (13 October 2022, page 27).

569. In 2011, Bishop Patrick Dunn, Emeritus Bishop of Auckland received a complaint of sexual abuse against a priest, Father Sateki Raass. While the complaint was still being investigated in 2012, Bishop Dunn offered Father Raass to minister as a parish priest in another location within the Auckland Diocese. In late 2012, Bishop Dunn appointed Father Raass as a parish priest in Mt Albert with the 2011 complaint still under investigation. After an apology from a delegate of the investigating committee, the adult complainant did not wish to take the matter further, instead seeking forgiveness directly from Father Sateki Raass. A further complaint was made about Father Raass in 2018, this time to National Office of Professional Standard and then the Police. Bishop Dunn was questioned about Father Raass at the Inquiry's Faith Institutional Response Hearing and was comfortable with his decision to take a pastoral approach.²⁸⁸
570. The safety of the community and particularly those in the care of faith-based entities must be paramount. There have been devastating consequences when reputation management, pursuing perpetrator rehabilitation and religious reconciliation have been prioritised over survivors' wellbeing.
571. There must be a move toward the implementation of an absolute dismissal policy that unequivocally states that any individual in religious ministry convicted of an offence relating to abuse and neglect in care must be permanently removed. The inherent risks associated with the high levels of trust and access granted to those in religious ministry must be acknowledged. A zero-tolerance approach will not only serve as a deterrent and protect congregants from potential harm but will uphold the ethical standards and values that form the foundation of religious communities.
572. Similarly, when faith-based entities become aware that any person attending any of their religious services or activities is the subject of a substantiated complaint of abuse and neglect in care or has been convicted of an offence of this nature, their first priority must be the safety of the complainant and any other congregants. Safeguarding must take precedence over the interests of the person who is the subject of the complaint or prior conviction. There is a need to reassess current practices, such as temporary removal or confinement, to ensure the safety of those at risk.
573. In addition to the safeguarding mechanisms referred to in the preceding paragraphs, there is a need for a centralised register that includes reports of misconduct, behavioural concerns, reports of abuse and convictions. This will enable faith-based entities to conduct thorough background checks and risk assessments before appointing individuals to positions within the religious community.

²⁸⁸ Transcript of evidence from the Inquiry's Faith-based Institutional Response Hearing (17 October 2022, page 208).



Tūtohi | Recommendation 108

Any person in religious ministry who is convicted of an offence relating to abuse and neglect in care should:

- a. in the case of Catholic priests and religious, be dismissed from the priesthood and /or dispensed from his or her vows as a religious
- b. in the case of Anglican clergy, be deposed from holy orders
- c. in the case of an ordained person in any other religious denomination that has a concept of ordination, holy orders and /or vows, be dismissed, deposed or otherwise effectively have their religious status removed.

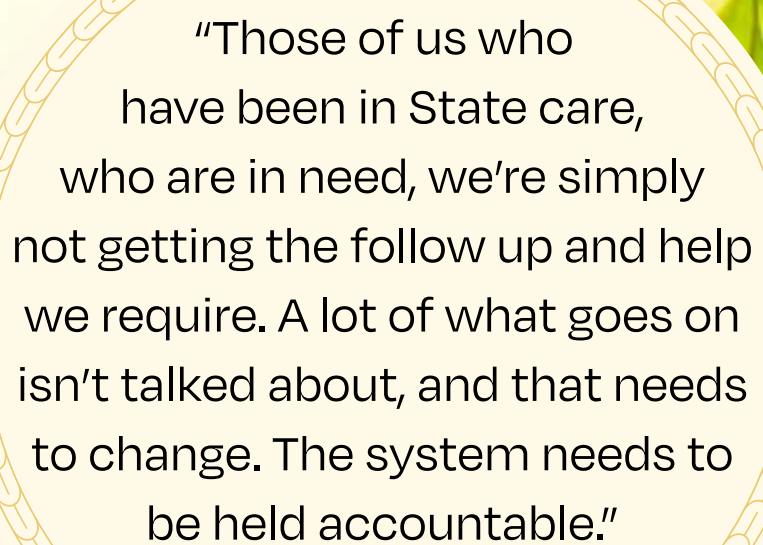
Tūtohi | Recommendation 109

Where a faith-based entity becomes aware that any person attending any of its religious services or activities is the subject of a substantiated complaint of abuse and neglect in care, or has been convicted of an offence relating to abuse and neglect in care, the faith-based entity should:

- a. assess the level of risk posed to children, young people and adults in care by that perpetrator's ongoing involvement in the religious community, and
- b. take appropriate steps to manage that risk.


Tūtohi | Recommendation 110

Each faith-based entity should consider establishing a national register which records limited but sufficient information to assist affiliated institutions identify and respond to any risks to children, young people and adults in care that may be posed by people in religious or pastoral ministry.



"Those of us who have been in State care, who are in need, we're simply not getting the follow up and help we require. A lot of what goes on isn't talked about, and that needs to change. The system needs to be held accountable."

MR. OB
Pākehā



"I started to
question the belief
that the leaders saw
themselves as anointed
by God"

ZION PILGRIM
NZ European

Zion Pilgrim

Hometown: Springbank

Age when entered care: From birth

Year of birth: 1978

Time in care: 1978–2020

Type of care facility: Faith-based communities – Springbank, Gloriavale

Whānau background: Zion is the son of Faithful Pilgrim, who was a Shepherd and school principal at Gloriavale. Zion has 12 siblings.

Ethnicity: NZ European

Currently: Zion is married and has 13 children. Zion and his family left Gloriavale in 2020 and he is actively involved with the Gloriavale Leavers' Support Trust. Five of his siblings have also left Gloriavale. One of Zion's sons was a plaintiff in an Employment Court case against Gloriavale leaders.



My wife and I married when I was 21 years old. We were taught that any form of birth control is evil and sinful so we immediately started a family. Eventually, we were sharing a two-bedroom space with our 12 children – we were given a third room in early 2020, which helped a lot.

We were also taught that every man and woman at Gloriavale must have greater loyalty to the leaders than to their spouse. This means if the husband wants to leave Gloriavale, the wife cannot.

I was a trustee of the Gloriavale Christian Community Trust. The trust owned various businesses, including a passenger plane service from Greymouth to Wellington. I worked as a pilot in this business from 2004 to 2008. Then from 2008 until 2020, I was the head guide at Wilderness Quest New Zealand, a division of Canaan Farming Deer Ltd, also owned by the trust. We catered for predominantly American tourists and turnover was NZD\$1.4 million per annum. Once a year, a colleague and I would travel to America to attend trade conferences to promote our business. This role created conflict with my personal life because some of Gloriavale's core principles relate to being 'separate' to the world.

I became a Servant at Gloriavale, which is like a church deacon. I acted as support management for the Shepherds, who were the senior managers. We dealt with financial, administration, spiritual and disciplinary matters. If someone was not 'towing the line' we would interview them, and people were encouraged to report those who may have acted in a way that did not reflect the leaders' teachings. Discipline from the Servants and Shepherds was seen as an act of mercy and love because if you were held to account and repented, then your soul was saved.

When I was at Gloriavale the leaders were not really concerned about sexual abuse. Their thinking was that women were the ones that have control, and you can't blame men for wanting or having sexual desires. Nothing can happen if women do not encourage it. If something of a sexual matter does happen, it is the woman's fault because she must have caused it by encouraging it to happen. It is never seen as the male perpetrator's fault.

If someone made an allegation of sexual abuse against a male member of the community, the leaders did not let the rest of the community know, even if children are involved. For example, a youth leader had a sexual relationship with an underage girl. When she left the community and made a legal complaint against him, he was initially allowed to keep his position and the leaders chose not to make the rest of the community aware of the potential risk to the young girls he interacted with on a daily basis or to take any steps to make sure it didn't happen again. He was only later stood down following pressure by an external report. I believe that the people at Gloriavale are still unaware of his sexual offending.

Parents who are unhappy with such situations can choose to stand up to the leaders, but this is extremely difficult. It may also make their children the subject of increased scrutiny and pressure.

I am aware that a young girl made an allegation against a teacher, Just Standfast, and the leaders blamed the girl for her involvement. Just Standfast was found guilty but the leaders took his side. He was signed off as a fit and proper person to teach.

The leaders also knew a young man in the community was sexually offending against young boys but they did not report his offending to any outside authority. The leaders told the parents of one victim they needed to better supervise their children so these things do not happen. They also told parents of other young boys to closely monitor their children and ensure they did not go out at night. They gave no reason for this warning and parents did not know the risk they were being warned about.

Eventually, this led to a police investigation relating to 63 people in the Gloriavale community – multiple perpetrators were identified and charges have been laid but there has been no accountability for the issues that allowed for this intergenerational sexual offending. The leaders knew about the offending, but were more concerned that someone had called the police, therefore betraying the community.

Because I spent a lot of time outside Gloriavale, I had access to outside scriptures and preaching through the internet. I started to question the belief that the leaders saw themselves as anointed by God, and that when they read the scriptures there was no difference between God and themselves.

I wrote a letter to Howard Temple, the overseeing Shepherd. I wrote the letter because I felt very strongly that changes needed to be made. When I spoke to him he said, "We are not going to change. We have been living this life for 40 years. People have had concerns but we are not going to change."

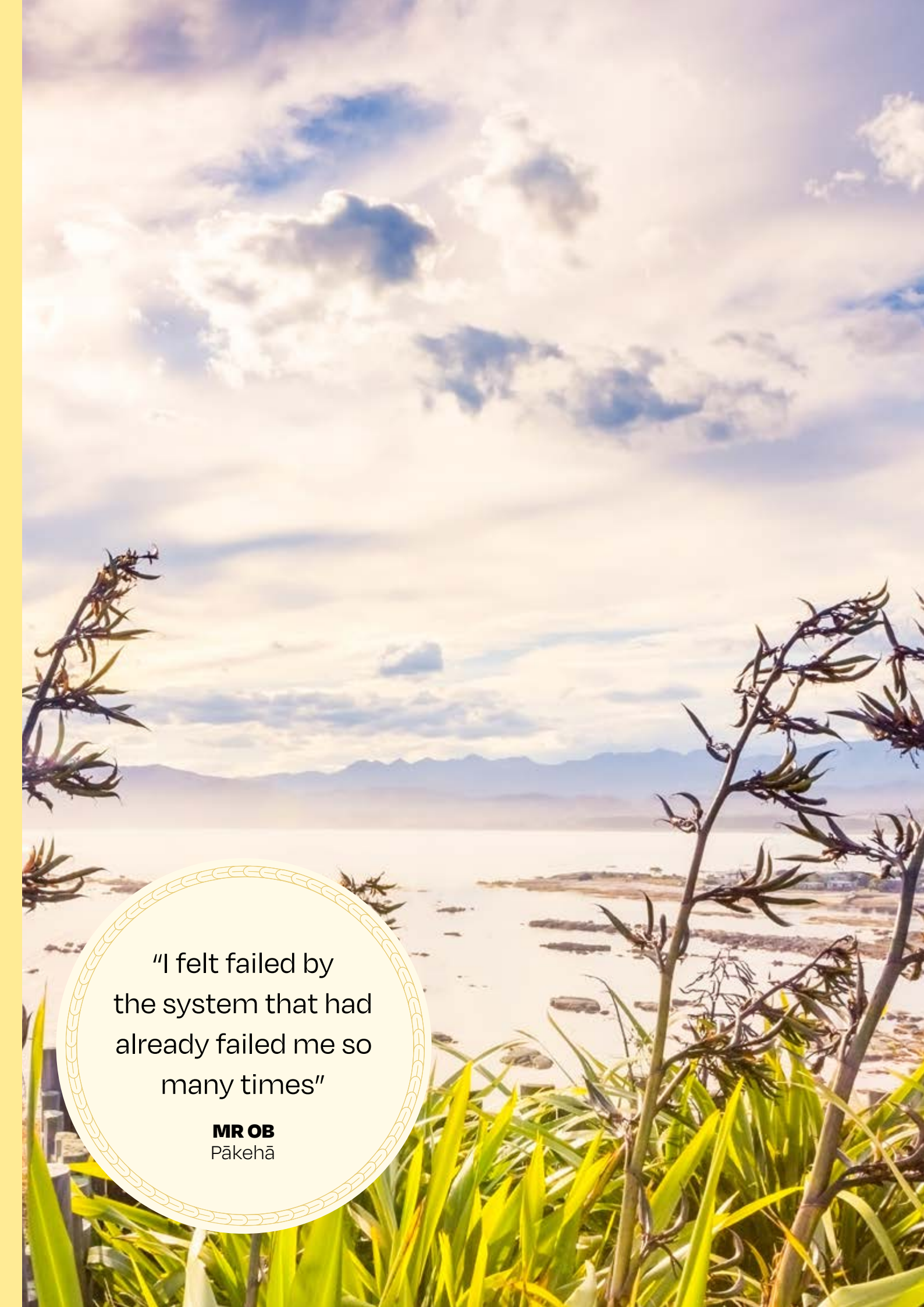
I was very disappointed with this response and sent a resignation letter to the trustees the following week. I was summoned to a disciplinary meeting and told in the opening statement that I would have to leave Gloriavale because I had talked with others in the community about my thoughts.

At a final meeting on 19 September, Howard Temple told me that my letter was judged to be completely wrong and it was rejected and unacceptable. My wife and eldest son were also required to be at the meeting and we were told that if we wanted to stay then we would have to reject all outside preaching, submit to the will of the leaders and give up our own thoughts and questions. We were also told we would have to reject our son if he would not reject outside preaching.

We knew this was wrong and we could not go against our conscience and give them complete and unfettered control of everything in our lives.

Our family left Gloriavale on 20 September 2020.²⁸⁹

²⁸⁹ Witness statement, Zion Pilgrim (10 August 2021).



"I felt failed by
the system that had
already failed me so
many times"

MR OB
Pākehā

Mr OB

Hometown: Ōtepoti Dunedin, Tauranga

Age when entered care: 14 years old

Year of birth: 1972

Type of care facility: Boys' home – Dunedin Boys' Home (Lookout Point Boys' Home) in Ōtepoti Dunedin; psychiatric hospital – Ward 17, Tauranga Hospital.

Ethnicity: Pākehā

Whānau background: Mr OB has a younger brother and two older sisters. His early memories of family life are of violence and alcohol abuse. His parents separated when he was young and split the children up. His father quickly remarried someone who treated Mr OB and his sister badly.

Currently: Mr OB has been married twice and has daughters. He is a patched member of the Mongrel Mob and considers it to be family. He hasn't had much contact with his children, as their mothers have kept them away from him.



When I was growing up, there was a lot of violence in our house. My siblings and I were all beaten up from a very young age. One of my relatives contacted Social Welfare to let them know about the abuse but nothing happened.

When I was 5 years old, our parents got divorced and a social worker asked each of us which parent we wanted to go with. We never got to talk together about what we wanted. My older sister and I ended up going with my father. It was the last time I'd see my mother and other siblings for years. My dad didn't talk to my mum from then so he didn't want us to have any contact either.

My dad remarried quite quickly and when I was 7 years old his new wife and her kids moved in with us. She was horrible and her kids were older and heavily addicted to sniffing solvents. She would tell our dad we'd been bad so he'd beat us up. I had to share a bedroom with her eldest son – he was about six or seven years older than me. When I was 8 years old, he started to sexually abuse me. I told my dad but got a hiding for 'lying'. It's hard to explain what that does to your head.

The abuse at home only got worse and at school, I was fighting and getting in trouble. When teachers told my parents, I'd get a massive hiding so it was a vicious cycle. I'd wag school so I could shut myself away. At 10 years old, I started sniffing solvents – I just wanted to get away from it all.

When I was 11 years old I ran away and ended up living on the streets. I was sleeping in bushes, always cold and hungry – but it was better than being at home. I got into stealing cars and eventually got busted by the police. Social Welfare took me back to my father. They didn't even care about where I'd been.

I started drinking, stealing and fighting, I ran away a few more times, and eventually Dad and his wife told me to get out. I was about 12 or 13 years old and went to live with Mum but found it hard to fit in. I went to high school for a few months but left to start working on a dairy farm. I liked working but my addiction and mental health issues meant I only lasted about six months.

When I was about 14 years old the police picked me up and took me to Lookout Point Boys' Home. I'm not sure why. That place was horrible. Rather than helping troubled kids, it just made us more fucked up. I saw a lot of kids get beaten up and kicked by the staff. We'd be denied food or confined to our room for days if we got in trouble, or sent to isolation – a bare room, with no bed or toilet. We were never asked about our home lives, or why we behaved like we did. We were just treated like prisoners.

I got out when I was about 16 years old and went back on the streets – it was better than going home. It was around this time that I first started hanging out with the Mongrel Mob in Dunedin. No one ever gave a shit about me until I met the Mob. They took me in and took care of me. Finding them was the best thing that ever happened to me. I finally had a place where I belonged.

I moved to Oamaru when I was 17 years old and things went well for a few years. I got married, but when I found out my wife was cheating on me, I was shattered and angry. I got a divorce and moved to Queenstown. I still had serious mental health issues and started having health issues too, probably related to the daily beatings I got as a kid.

In the early nineties, I became an ambulance officer for a few years. I loved it. But I was plagued by issues with alcohol and anger. I was also looked down upon because I was in the Mob. I left but keep on volunteering for 18 years.

After several years, I moved to Wellington and became a Level 4 social worker – the training was tough because a lot of my own hurt and grief came to the surface. At this time, I decided to report the sexual abuse I had experienced to the Lower Hutt Police. They said they would chase it up but nothing ever happened.

I met my second wife, we had a daughter and moved to the Bay of Plenty where I worked as a youth social worker. I loved helping kids who were going through what I had been through. I was encouraged to report the sexual assault again, so I went to the Tauranga Police and the detective was good. The police found my stepbrother and said they had 10 charges against him. But those charges were whittled down to two. I was horrified. I felt failed by the system that had already failed me so many times.

A restorative justice meeting was set up, which was portrayed as being for me, the victim, so I could sit with the perpetrator and talk about what had happened and how it affected me. But the meeting wasn't about me, it was about him. I was there on my own and he had all these support people. I was asked to share a bit about what happened and how the charges came about. But for the rest of the meeting, he got to tell his side of the story. I realised it was just a way for him to get a lesser sentence.

After that meeting I never heard from restorative justice again. I don't know what happened, whether he went to Court or not. I've since found out his marriage broke up because he was sexually abusing his own kids.

I was in a bad way after that. I was angry, carrying all the stuff around from the past and hating myself. I ended up having a massive breakdown in 2004, made several suicide attempts and ended up in Ward 17 of Tauranga Hospital, which is a mental health ward. I was there for five and a half months and it was awful. At one stage I got put into a very secure unit, which was very similar to Lookout Point. The room had no toilet or window and brought back terrible memories.

I was diagnosed with chronic depression and given ECT four times a week, even though I never gave consent. ECT was horrible and affected me heavily. They told me I might get short-term memory loss, but I still have major memory loss. When I got out, I couldn't even remember my wife and daughter's name – I had to get their names and birthdates tattooed on my arms so I could remember who they were.

My time in mental hospitals only made my mental issues worse and I became even more depressed. I found out my wife had been with another man while I was in the mental hospital, and she ended up leaving me and taking my daughter with her. When I got home, she had packed up all my stuff and left it on the doorstep. Since then, I've been on the sickness benefit and in and out of hospital feeling depressed and suicidal. I've mostly been unemployed, and I've struggled for money and a place to live. I was in emergency housing for about eight months. Once I got a job they kicked me out – if you have a job then you can't be in emergency housing. How does that work?

People need support when they get out of a mental health unit, and I don't feel I've been given that. I've never been offered counselling. Not once has anyone sat down with me and simply listened. How can people begin to understand me without ever having heard where I come from and what I've been through? The system shuts a lot of people up, but someone should start listening. That can happen.

A few years ago, I got drunk at a friend's house, found his sawn-off shotgun and I said I was going to shoot myself. He pulled the gun off me and hid it, then called the police, who were meant to make a welfare check on me. But they also notified the Armed Offenders Squad, who turned up. I woke up hearing them calling my name outside. I walked outside – I was unarmed and still intoxicated – and walked down the driveway and got onto my knees. They kned me in the side and I was flat on the ground. Then they kicked me in the head and knocked me out. They dragged my face and body all over the rough concrete. I was transferred back to Ward 17, covered in cuts, bruises and scratches. I asked if staff could clean me up but they said I was okay – but the cuts got badly infected. I took the issue to the Independent Police Conduct Authority, but they said there was no grounds for a complaint and what the officers did was fine. How is it right to beat up an unarmed, mentally ill man? I felt the system had let me down once again.

The only ones who have supported me is the Mongrel Mob. Without them I would've topped myself. I've faced a lot of discrimination because I'm a gang member. But I'm not a bad person, I've never been to prison. Many gang members have experienced abuse and trauma as kids. The majority have been in State care and got abused there. Their mental health isn't good either. Gang members ring me saying they are struggling and want help. We've been abandoned by the system and our families, so we make our own system and we are family. All I can do is listen, but counselling would help too.

Those of us who have been in State care, who are in need, we're simply not getting the follow up and help we require. A lot of what goes on isn't talked about, and that needs to change. The system needs to be held accountable. That needs to change and we need people like me to help make those changes.

We need input from the people who are going through it themselves.²⁹⁰

²⁹⁰ Witness Statement of Mr OB (2 August 2021).

Ūpoko | Chapter 7

Te whakamana me te whakapakari hāpori

Entrusting and empowering communities

574. This chapter responds to clause 32A of the Inquiry's Terms of Reference, which relates to recommendations to ensure that the factors that allowed abuse and neglect to occur during the Inquiry period do not persist. As provided for in clauses 15A and 15B of its Terms of Reference, the Inquiry has considered issues and experiences after 1999 shared by survivors, including those set out below.²⁹¹

Ngā wheako purapura ora mai i te tau 1999

Survivors' experiences after 1999

575. Survivors told the Inquiry about a range of issues and experiences after 1999 including experiences of persistent disadvantage, a lack of support in the community, not having a say in the design and delivery of care, and the impacts of discrimination. They also told the Inquiry about their experiences of abuse and neglect, and the issues they had understanding what was happening to them and who to turn to for support.

Ngā wheako o te noho pēhia tonu

Experiences of persistent disadvantage

576. Scottish and Papua New Guinean survivor Jamie Henderson, who was first placed in youth justice residential care in 2016, when he was aged 14, told the Inquiry:

*"I remember having no food growing up...my mum was a good mum, she just needed support and I think I would've had a better life if she got the support she needed."*²⁹²

²⁹¹ Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, Terms of Reference, clauses 15A, 15D and 32A.

²⁹² Witness statement of Jamie Henderson (17 April 2023, para 11)

577. Rangatahi from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei told the Inquiry that:

“Lack of support for caregivers to provide the best care possible puts good people off. Neither parents or caregivers are given the support needed.”²⁹³

My mum was put in to care when she was really young and wasn’t good. When she was 15 she started taking off. She was abused so badly. That is why me and 8 other siblings were put into care.... I am always mamea about the support she didn’t get.”²⁹⁴

(We need a) space where you’re not just talking about problems - you are talking about life skills and flourishing like how to grow a garden, how to be useful ... if we had programmes like this people would feel more support.”²⁹⁵

578. Pākehā survivor Ms QB, who was take into the care of Child, Youth and Family in 2015, when she was aged 15, shared:

“When I reflect on my experiences with CYF I believe that the system set me up to fail by first being so unwilling to become involved in the early stages when intervention would have been the most useful, then by offering piecemeal care which was not appropriate.”²⁹⁶

Te whai wāhi o ngā hāpori i ngā mahi atawhai me whakatau kaupapa hoki

Community involvement in care and decision-making

579. Māori survivor Mr RA (Rongomaiwahine), who was first placed in a care and protection residence in 2001 when he was aged 12, told the Inquiry:

“In terms of what changes need to be made for children who are now going through the care system... it’s letting iwi, hapū and whānau have more say in the care of children. That’s the only way we are going to be able to keep our kids safe and make sure they are being cared for properly.”²⁹⁷

²⁹³ Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, Key asks from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei (2024, page 5).

²⁹⁴ Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, Key asks from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei (2024, page 5).

²⁹⁵ Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, Key asks from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei (2024, page 6).

²⁹⁶ Witness statement of Ms QB (28 January 2022, para 4.3.4).

²⁹⁷ Witness statement of Mr RA (15 August 2022, para 389).

580. The Inquiry heard from NZ European Franky Lewis about her experiences seeking support for her son Keegan, who has high and complex needs including cerebral palsy and autism spectrum disorder, and was in care between 2001 and 2014:

*"I have interacted with many government departments and NGOs over the years... It is almost impossible to get consistent support and funding in place that is focused on outcomes for Keegan... Families like ours carry a large amount of the practical and emotional burden of caring for a disabled person, and so we should have input into government policies... It is hugely important that whanau have a say on things like funding options."*²⁹⁸

581. Māori and Croatian survivor Tupua Urlich (Ngāti Kahungunu), who was placed into foster care in 2000 when he was aged 5, talked about the resources that communities have to offer:

*"The knowledge exists and the supports are out there. So rather than reinvent the world, it's about connecting with iwi. They are experts of their own."*²⁹⁹

582. Mr OB, a Pākehā survivor who has been in youth justice and inpatient mental health care, also believes communities have the potential to be more involved in addressing disadvantage:

*"I still have gang members ringing me up saying that they are struggling and wanting help. They don't go to the Government, no way. They come see another gang member. But what can I do other than simply listen?"*³⁰⁰

583. Rangatahi from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei told the Inquiry that:

*"Care and institutions don't mix together as a concept. Good Lives Model which is guiding the Disability Strategy reflects on the move from institutions to community alternatives. Disability sector is more advanced in their thinking than the care sector."*³⁰¹

*More about allowing iwi and community to do the healing. Governments have given us all the evidence they are not worthy of our trust and they have too much power."*³⁰²

298 Witness statement of Franky Lewis (May 2023, paras 41, 80)

299 Witness statement of Tupua Urlich (4 February 2022, para 54).

300 Witness statement of Mr OB (2 August 2021, para 9.13).

301 Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, Key asks from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei (2024, page 8).

302 Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei, Key asks from Te Rōpū Kaitiaki mō ngā Teina e Haere Ake Nei (2024, page 8).

Ngā waiaro me ngā mātauranga ā-iwi mo ngā mahi tūkino

Societal attitudes and understanding abuse and neglect

584. Scottish and Papua New Guinean survivor Jamie Henderson told the Inquiry about the racism he faced at Korowai Manaaki youth justice residence in Tāmaki Makaurau Auckland:

“Some staff would also say racist things to me. They would say “oi you back cunt” or “oi black shit” or any word to do with black.”³⁰³

585. Samoan survivor Mr GU, who was in the Weymouth residence in Tāmaki Makaurau Auckland in 2003–2004 as a teenager, was also subjected to racism while in care:

“I remember that staff members would sometimes make jokes about Samoans, and that other staff members did not even know I was Samoan and would assume I was Māori.”³⁰⁴

586. Survivors’ behaviour as children was often viewed as deliberate naughtiness. Mr GU ran away from the Weymouth youth justice facility in Tāmaki Makaurau Auckland he had been placed in because of sexual abuse:

“At Weymouth I was sexually assaulted by a male staff member ...I tried running away from Weymouth because I felt unsafe there and was sick of the abuse. I got punished with placement in Secure for trying to hide at night time, and for trying to run away.”³⁰⁵

587. Tupua Urlich also encountered this negative view of young people:

“One of the youth justice workers said to me: “Oh are you youth justice?” I replied “No, I’m care and protection.” He replied, “Oh future justice then.” I will never forget that comment, it really stuck with me...Children in care are viewed as less than other children and young people.”³⁰⁶

588. The Inquiry heard that some survivors did not understand that what was happening to them was abuse and neglect at the time. Māori survivor Ms QA (Ngāti Awa, Ngāpuhi), told the Inquiry that in youth justice care in the mid-2000s:

“...I experienced physical abuse and neglect. At the time, I did not identify that I was not having my needs met or that I was experiencing abuse. I felt like I deserved to be in the system and that I deserved everything that happened to me.”³⁰⁷

303 Witness statement of Jamie Henderson (17 April 2023, para 55)

304 Witness statement of Mr GU (13 April 2021, para 65).

305 Witness statement of Mr GU (13 April 2021, paras 13, 21, 22).

306 Witness statement of Tupua Urlich (4 February 2022, paras 21, 51).

307 Witness statement of Ms QA (19 October 2022, para 9.3).

589. Reflecting on his experiences, Scottish and Papua New Guinean Jamie Hendersen believes that:

“Children need to have education much earlier about inappropriate touching and what abuse is to help them identify that it is wrong. They also need to be taught who to talk to, what to say, and how to respond when abuse happens to them.”³⁰⁸

590. When survivors did disclose abuse, it sometimes was not believed. This was the case for Pākehā and Māori survivor Mr RG (Ngāti Tuwharetoa) who was sexually abused by a teacher while at McKenzie Residential School in Ōtautahi Christchurch in 2005–2006:

“I talked to mum...about some of the things that were happening to me but I could not bring myself to disclose the sexual abuse to her while I was there. She didn’t believe me about the things I did disclose and said that she thought that I was seeking attention.”³⁰⁹

591. Ms QA told the Inquiry that adults need to know more about the signs of abuse and neglect as well:

“I think Oranga Tamariki need to have better systems in place to identify patterns of abuse and at risk children. The State got it wrong in calling my mother’s violence discipline. I was being neglected and abused.”³¹⁰

592. Survivors’ issues and experiences are echoed in independent and State commissioned reports on care settings after 1999, which are discussed in Chapter 2.

308 Witness statement of Jamie Henderson (17 April 2023, para 70).

309 Witness statement of Mr RG (2 May 2023, para 17).

310 Witness statement of Ms QA (19 October 2022, para 71.1).

He whakaāhei i ngā whānau ki te āta aukati i ngā mahi kaitiaki i waho i te whānau

Communities are empowered to minimise the need for out of whānau care

593. In Part 7 the Inquiry found that the circumstances that made it more likely someone would enter care during the Inquiry period also increased the likelihood that the person would experience abuse and neglect in care. These circumstances included discriminatory attitudes against Māori, Pacific Peoples, young people, disabled people and people experiencing mental distress, homophobia and sexism, persistent disadvantage, a lack of awareness of how to detect and respond to abuse and neglect, and a lack of community involvement in the design and delivery of care.

He takinga take hāpori me te mātauranga e tahuri kē ai ngā waiaro ā-iwi me te whakapiki māramatanga ki ngā pātukinga o ngā mahi tūkinō

Social and education campaigns to change societal attitudes and increase understanding and impacts of abuse and neglect

594. Throughout the Inquiry period, society shaped attitudes about the treatment of people in care and the institutional cultures of care settings.

595. With the introduction of the New Zealand Bill of Rights Act 1990 and Human Rights Act 1993, as well as various international and national campaigns and social movements and reports condemning attitudes toward people in care, the end of the Inquiry period saw the beginnings of social change and a growth in acceptance. After 1999 this understanding and acceptance has continued to grow but many in the care system still experience discrimination based on wider societal attitudes. For example, Pākehā transgender survivor Ms NT, who was in inpatient mental health care in the mid-2000s, told the Inquiry that:

"...transgender people face stigma, exclusion and marginalisation. I have...been treated very badly by the medical practitioners in the past refusing to even use my chosen name or gender pronouns in their reports, and when speaking to me."³¹¹

596. At the Inquiry's State Institutional Response hearing the Chief Executive for Oranga Tamariki, Chappie Te Kani, agreed that structural racism plays a part in the disproportionate numbers of Māori and Pacific peoples in care.³¹²

³¹¹ Witness statement of Ms NT (January 2022, page 7).

³¹² Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki at the State Institutional Response Hearing (August 2022, page 627).

597. Concerns raised by the United Nations in 2022 about human rights issues included concerns “about the negative perceptions and the devaluing of persons with disabilities that were expressed during the passage of the end of Life Choice Act 2019.”³¹³
598. The following year, the United Nations Committee on the Rights of the Child noted that “the Committee remains seriously concerned about the persistent rates of abuse and neglect of, and violence against, children... noting the higher risk faced by Maori, Pasifika and lesbian, gay, bisexual, transgender and intersex children, and children with disabilities”.³¹⁴
599. The government needs to invest in a nationwide programme to counter the stigma and discrimination that sits at the heart of many people’s experiences in care. The Inquiry envisages this programme would be developed and delivered by the Care Safe Agency (Recommendation 41), in accordance with implementation Recommendations 126–127.
600. The media has an important part to play in the programme. Part 2 discusses the role of the media in reinforcing negative stereotypes against Māori and Pacific Peoples as well as people living in poverty, young people, disabled people and people experiencing mental distress. Media has a powerful impact on collective views of society, encouraging audiences to develop a sense of who ‘we’ are by contrasting with ‘others’ – people and groups depicted as ‘not us’ due to their beliefs, practices, or attributes. Stuff media’s Our Truth, Tā Mātou Pono campaign from 2020 is an example of the role media can take in dispelling harmful stereotypes and making clear what its part in maintaining them has been.
601. The programme should include practical ways to share ideas and information, research and evaluation, and include a national media campaign, community conversations and other actions to bring about social change. In the Inquiry’s view, a campaign would be best delivered via a connected brand or organisation that can act as a front door or hub for sharing information and campaign messaging. It should also target key agencies and organisations, such as schools, NZ Police and care providers, including education and professional development providers for these sectors. This will ensure that the care workforce is specifically engaged.

313 United Nations Committee on the Rights of Persons with Disabilities, Concluding observations on the combined second and third periodic reports of New Zealand (2022, page 4).

314 United Nations Committee on the Rights of the Child, Concluding observations on the fifth periodic report of New ZealandCRC/C/NZL/CO/5 (2016, page 6).

Tūtohi | Recommendation 111

The government should invest in a nationwide social and educational campaign to address attitudes and beliefs that contribute to harmful and discriminatory experiences in care and promote positive understanding and awareness of the diversity of experiences in Aotearoa New Zealand. This campaign should focus on addressing:

- a. negative attitudes towards children and young people
- b. attitudes reflective of discrimination on the basis of race, gender and sexuality
- c. attitudes reflective of eugenics, ableism and disablism.

602. Over time, there has been developing awareness of abuse and neglect and the factors that help prevent it occurring. However, there is an ongoing need for general education and awareness raising about abuse and neglect, what it can look like and how to respond when it is happening to yourself or someone around you, and how to recognise and respond to grooming and other inappropriate behaviour. This should emphasise that everybody has a role to play in preventing abuse and neglect in care and provide information about what to do if you are concerned that someone is being abused or neglected or is at risk of perpetrating abuse.

603. New Zealand European survivor Ms VQ, who was placed in foster care in 2006 when she was aged 7, illustrated the lack of awareness about the reality of abuse and neglect in care when she told the Inquiry about going to court in 2015 to testify about the abuse she experienced:

*"I knew the jury could see the evidence, but I also think this kind of thing [abuse in care] is just too hard for people to swallow. You get a jury and they are strangers. For any of them, this kind of thing would have been completely mind-blowing."*³¹⁵

604. In addition, there is also a need for more targeted education for people in care or people who are accessing early support to prevent placement into care about understanding your rights and how to access advocacy and support. As above, the Inquiry envisages this programme would be developed and delivered by the Care Safe Agency (Recommendation 41), in accordance with implementation Recommendations 126–127.

³¹⁵ Witness statement of Ms VQ (3 February 2023, pages 8–9).

Tūtohi | Recommendation 112

The government should invest further in nationwide social and educational campaigns to:

- a. challenge myths and stereotypes about abusers, bystanders and survivors of abuse and neglect in care
- b. help victims and survivors of abuse and /or neglect, and their whānau and support networks, to minimise shame and self-stigma, and recognise the abuse and /or neglect was not their fault and to safely disclose and report as soon as possible
- c. help people understand what constitutes abuse and neglect
- d. help people recognise the signs of abuse and neglect
- e. help people recognise grooming and other inappropriate behaviour
- f. help people understand how to respond appropriately to abuse and neglect, including complaints, reports and disclosures.

605. The abuse and neglect in care settings were in almost every community in Aotearoa New Zealand in the Inquiry period. A few settings such as Lake Alice, Dilworth School and Epuni Boys' Home have become household names. However, the true scale and extent of survivors' experiences in these and many other settings has been invisible and unheard until now.
606. Despite many changes to Aotearoa New Zealand society and the care system since 1999, abuse and neglect is continuing to occur.
607. The reality that survivors experienced challenges some of the most deeply held parts of our national identity – that Aotearoa New Zealand is a place of equality and opportunity. However, that was not the reality for survivors.
608. The impact on survivors, their whānau, kainga, family and support networks can be seen in our health, welfare and justice systems and is a contributor to some of the most intractable social issues we have struggled as a country to resolve. New Zealanders must understand and accept that reality so that it is not tolerated in the future.
609. In the face of all of this, survivors have been steadfast in their determination to tell their stories, many of them in the hope that by doing so we can stop the cycle of abuse in our institutions and end the intergenerational suffering it causes. It is now on the State and faith-based entities to amplify their message and begin the work.



Tūtohi | Recommendation 113

The government and faith-based entities should disseminate and publicise the findings and recommendations of this Inquiry in the widest and most transparent manner possible.

Whakaahei te whai wāhi tōtika ki ngā tikanga whakatau kaupapa Enable participation in effective decision-making processes

610. During the Inquiry period, children, young people and adults were removed from their families and communities and placed into institutional or compulsory care by people exercising the coercive legislative powers of the State. In Part 3, the Inquiry found that the people making decisions about care in the State care system included social workers, NZ Police, judges, health professionals and needs assessors. These decision-makers generally had limited involvement in, connection with, or understanding of the most affected communities, including Māori, Pacific Peoples, Deaf and disabled people and people who experience mental distress.
611. The Inquiry also found that the State often used its formal powers in a discriminatory way, such as using formal legal orders more often against Māori, rather than supporting in-home, whānau, hapū, iwi or community care. Decision-making was often influenced by ableist and disablist attitudes, which led to the segregation and social exclusion of disabled people by placing them in institutional care. The State often failed to assess, or inadequately assessed, children, young people and adults in care for trauma and support needs when deciding on care options.
612. The State almost always failed to consider or recognise an ao Māori (Māori world) view, tikanga, te reo and mātauranga Māori when removing or placing tamariki, rangatahi and pakeke Māori in all care settings. Deaf and disabled people were often denied or restricted from involvement in decisions about their own lives.
613. During the Inquiry period, the State learned that families, whānau and communities needed to have much greater, direct roles in care, and that people in care have a right to participate in decisions that affect them. From the 1980s onwards, the State made some legislative changes to bring families and communities closer to care, such as introducing Family Group Conferences in social welfare settings.

614. The State continues to hold significant legislative power to intervene and make compulsory decisions about people's lives, including removal and placement in out-of-whānau care, for example, the power to remove children and young people from their families, and the power to treat and / or detain people who are experiencing mental distress without their consent. Legislation relevant to the care settings within the Inquiry's scope that includes these kinds of powers includes:
- a. the Oranga Tamariki Act 1989
 - b. Mental Health (Compulsory Assessment and Treatment) Act 1992
 - c. Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
615. Proposals for making significant changes to the exercise of State power have been provided to or worked through by the government. Examples of this are set out below.
616. Article 12 of the United Nations Convention on the Rights of Persons with Disabilities provides that disabled people should be provided with support to make decisions.³¹⁶ In 2023, Cabinet agreed to changes to mental health legislation to improve its alignment with Aotearoa New Zealand's domestic and international human rights obligations. The changes included:
- a. additional rights and obligations for tāngata whaiora to be supported to make decisions and express their views, including any communication assistance required. This would include the provision of appropriate accommodations for people with physical, sensory, learning and other impairments.³¹⁷
 - b. membership of the Mental Health Review Tribunal to include the following members:
 - i. an appropriately qualified health practitioner
 - ii. a Māori member appropriately knowledgeable in tikanga and mātauranga Māori
 - iii. a tangata whaiora who has lived experience of being subject to compulsory mental health assessment and treatment
 - iv. a lawyer.³¹⁸
 - c. that district inspectors can rely on advice from Māori experts to assist them in upholding the rights of tāngata whaiora Māori. This will support consideration of Māori needs in complaints resolution processes.³¹⁹
617. These changes have not yet been passed into law.

³¹⁶ United Nations Convention on the Rights of Persons with Disabilities, article 12.3.

³¹⁷ New Zealand Government, Office of the Minister of Health, Cabinet Social Wellbeing Committee paper, Transforming Mental Health Law: Second Tranche of Policy Decisions (undated, para 24).

³¹⁸ New Zealand Government, Office of the Minister of Health, Cabinet Social Wellbeing Committee paper, Transforming Mental Health Law: Second Tranche of Policy Decisions (undated, para 35).

³¹⁹ New Zealand Government, Office of the Minister of Health, Cabinet Social Wellbeing Committee paper, Transforming Mental Health Law: Second Tranche of Policy Decisions (undated, para 30).

618. In 2019, a review of family justice reforms recommended that the government should work “with iwi and other Māori, the Court and relevant professionals, to develop, resource and implement a strategic framework to improve family justice services for Māori.”³²⁰ In particular, the report recommended that the government should provide for “a Mana voice to ensure the Family Court has access to mana whenua and Māori community knowledge” to strengthen family justice services.³²¹
619. In 2022, Dame Naida Glavish and Rāhui Papa, on behalf of the Iwi Chairs Forum, proposed a shared decision-making model for care and protection proceedings called Te Pae Kōti-ā-Whānau (Family Court Panels). The proposal was for “a three-person panel consisting of a legally trained convenor and representatives from iwi and the community, delivering therapeutic justice based on tikanga Māori, available to and serving people of all ethnicities.”³²² This proposal has not been progressed by government. It has similarities to the changes agreed by Cabinet in 2023 to the composition of Mental Health Review Tribunals under the Mental Health (Compulsory Assessment and Treatment) Act 1992, which add a member with knowledge of tikanga and mātauranga Māori to the tribunal.
620. At the Inquiry’s State Institutional Response Hearing, Chappie Te Kani, Chief Executive of Oranga Tamariki, told the Inquiry that the focus of the agency’s nine strategic partnership agreements with iwi and Māori is on “preventing entry into State care through joint decision-making and a focus on whānau care”.³²³ He also stated that the Future Direction Action Plan, which aims to prevent children from coming into the care of Oranga Tamariki, commits to “place the voices of tamariki and rangatahi at the centre of decision-making at all levels and support [them] to participate in and be central to decision-making”.³²⁴
621. Bringing people and their whānau closer to decisions that affect them is in line with best practice and international human rights instruments, including the United Nations Convention on the Rights of People with Disabilities and the United Nations Declaration on the Rights of Indigenous Peoples. Bringing the diverse perspectives and knowledge of communities into decision-making using the State’s legislative powers will improve the quality of the decisions. This includes by mitigating against decisions influenced by discriminatory attitudes or lack of cultural competency, which the Inquiry found was a contributing factor to abuse and neglect in care during the Inquiry period.

320 Te Korowai Ture ā-Whānau: The final report of the Independent Panel examining the 2014 family justice reforms (Ministry of Justice, May 2019, page 8).

321 Te Korowai Ture ā-Whānau: The final report of the Independent Panel examining the 2014 family justice reforms (Ministry of Justice, May 2019, page 8).

322 Papa, R and Glavish, KN, Co-Chairs, Pou Tangata Iwi Leaders Groups – Te Ora o Te Whānau and Justice (on behalf of the Iwi Chairs Forum), Submission to the Justice Committee on the Family Court (Family Court Associates) Legislation Bill (September 2022, paras 42–45).

323 Witness statement of Chappie Te Kani, Chief Executive of Oranga Tamariki (August 2022, para 81).

324 Witness statement of Chappie Te Kani, Chief Executive of Oranga Tamariki (August 2022, para 236).

622. In its Vision for the future, he Māra Tipu, the Inquiry pictures that very few children, young people and adults will need out-of-whānau care because they will have the supports they need to flourish and stay with whānau. The Inquiry recognises that, in the immediate and medium term, there will still be situations where it is both necessary and appropriate for the State to exercise its coercive legislative powers to intervene in the lives of children, young people and adults.
623. The Inquiry recommends the government accelerate and prioritise current policy and legislative work to bring people closer to the decisions that affect them, including through supported decision-making, and to bring the strength of communities into decisions that use the State's coercive powers. The Inquiry also recommends that the government review relevant legislation, operational practice and guidance to identify new opportunities for improvement in these areas.

Tūtohi | Recommendation 114

The government should:

- a. accelerate and prioritise current policy and legislative work to enable children, young people and adults in care and their whānau to more effectively participate in decisions that affect them, and to bring the strength of communities into decision-making
- b. review legislation, policy, investments, operational practice and guidelines related to the care of children, young people, and adults in care to identify opportunities to enable children, young people and adults in care and their whānau to more effectively participate in decisions that affect them, and to bring the strength of communities into decision-making.

Te aro tonu ki ngā pēhitanga me te kore tautoko

Addressing persistent disadvantage and lack of support

624. In Part 7 the Inquiry found that the circumstances that made it more likely that people were placed in care also increased the likelihood that the person would experience abuse and neglect in care. People were more likely to be placed in State or faith-based care if there was a lack of early support in the home and if they had experienced poverty, family crisis or violence, disability (including experiencing mental distress), or parental abuse and neglect. Many families and communities continue to experience persistent disadvantage today:

697,000 New Zealanders experience persistent disadvantage, with sole parents and Pacific peoples experiencing the highest rates, followed by Māori and people with disabilities. An estimated 172,000 people experienced complex and multiple forms of persistent disadvantage in both 2013 and 2018.³²⁵

625. Persistent disadvantage can stem from various underlying factors, such as prolonged unemployment, significant disabilities, past or present homelessness, discrimination, institutional racism and trauma. These issues often span multiple generations, leading to stressful and unstable lives. Having spent time in care is now recognised as also being a factor behind persistent disadvantage.³²⁶

626. Since 1999, there has been an increasing understanding that early intervention and investment to support whānau and communities experiencing persistent disadvantage is needed. Major reviews and inquiries into this include the Welfare Expert Advisory Group (WEAG), the Tax Working Group, the Expert Advisory Group on Solutions to Child Poverty and the Productivity Commission's inquiry into More Effective Social Services. The Productivity Commission found that:

Failing to provide effective and early support, especially in early childhood, can have long-term and intergenerational impacts.³²⁷

³²⁵ New Zealand Productivity Commission, A fair chance for all: Breaking the cycle of persistent disadvantage, (2023, page 8).

³²⁶ New Zealand Institute for Economic Research, Let it go: Devolving power and resources to improve lives - NZIER working paper 2023/02, (2023, page 1).

³²⁷ New Zealand Productivity Commission, A fair chance for all: Breaking the cycle of persistent disadvantage, (2023, page 30).

627. In 2018, the Office of the Prime Minister's Chief Science Advisor reported that:
- Early, positive engagement can stop intergenerational cycles of trauma, offending and prison involvement. The effects of abuse, neglect and maltreatment on children's development and behaviour can be successfully addressed at home, at school, in the community and in targeted mental health and other services, for a fraction of the cost of imprisonment.***³²⁸
628. The social investment approach also recognises the importance of early intervention. The Social Wellbeing Agency defines social investment as:
- a. understanding people's needs using data and evidence
 - b. setting clear, measurable goals and focusing on what works
 - c. improving services by systematically measuring and comparing their effectiveness and feeding this information back to decision-making
 - d. enabling local providers to deliver services tailored to the needs of their communities.³²⁹
629. The social investment approach focuses on proactive and preventative measures at the point in people's lives where it will make the most difference. Early investment in addressing persistent disadvantage will address some of the circumstances that contributed to children, young people and adults entering care and experiencing abuse and neglect during the Inquiry period.

³²⁸ Office of the Prime Minister's Chief Science Advisor, *It's never too early, never too late: A discussion paper on preventing youth offending in New Zealand* (12 June 2018, page 7).

³²⁹ Social investment approach | Social Wellbeing Agency (<https://www.swa.govt.nz>)

630. There are already many examples of good and promising contemporary practice in existing programmes and initiatives that seek to address persistent disadvantage. Many of these are delivered in partnership between government and community organisations including hapū and iwi. Examples include:
- a. Ngā Tini Whetū, a programme implemented by Te Puni Kōkiri, Oranga Tamariki, the Accident Compensation Corporation and the Whānau Ora Commissioning Agency, which aims to support whānau and improve the safety and wellbeing of tamariki, “averting a care, protection or youth justice intervention from Oranga Tamariki”.³³⁰ It was developed as a specific approach to address the overrepresentation of Māori in State care, using devolved, whānau-centred approaches and the unique partnership approach of the delivering agencies and organisations.
 - b. Whānau Ora is an approach derived from te ao Māori that is Māori led, whānau-centred and holistic and has a devolved commissioning model. The intent of the commissioning approach is that investment decisions are made as close as possible to local communities, maximising the effectiveness of interventions at the local level and ensuring that new opportunities for investment are identified based on data and evidence.
 - c. the Enabling Good Lives Principles and Programme, a facilitation-based support model built around individuals’ needs and aspirations, rather than around groups of people. Enabling Good Lives includes:
 - i. self-directed planning and facilitation
 - ii. cross-government individualised / portable funding
 - iii. strengthening families / whanau
 - iv. community building.
631. The Enabling Good Lives general purpose is described as being to:
- incrementally transition existing services to a facilitation-based support model. The focus of facilitation-based support would be on enabling disabled people to do everyday things in everyday places in communities, rather than on provision of ‘special’ places or activities for disabled people. It would include support funding from across government agencies that would be individualised and flexible.***³³¹
632. These and other programmes will provide valuable lessons and examples of successful practice that the State and communities can draw on in implementing Recommendation 115.

³³⁰ Aiko Consultants, Ngā Tini Whetū, Report prepared for: Whānau Ora Commissioning Agency, Te Puni Kōkiri, Oranga Tamariki and ACC (May 2021, page 6).

³³¹ Boxall, G and Benjamin, M, Enabling Good Lives, Waikato draft report (August 2012, page 4).

Anga atu ana ki te whakamana hāpori Towards community empowerment

633. During the Inquiry period, the system did not prioritise or place the needs of children, young people, and adults in care at the centre. People in care and their whānau, hapū, iwi, communities and cultures were frequently disregarded and disrespected. The Inquiry repeatedly saw the system being focussed on its own processes and meeting bureaucratic requirements, rather than the needs, experiences and outcomes of children, young people, and adults in care.
634. State and faith-based institutions also maintained power, resources and control, while people in care and their whānau and communities were excluded from decision-making. The disempowerment of affected people, whānau and communities in the design, implementation, and control of care systems led to decisions, practices and behaviours that, for many, were discriminatory and harmful.
635. In 2023 the Productivity Commission noted that:
- “For people experiencing persistent disadvantage, there’s a fundamental mismatch between what is required to help them improve their lives and how government departments operate ... The government should introduce a deliberate strategy of using a people-centred, devolved approach to address persistent disadvantage. The twin aims of devolution are to support people to make changes in their lives that will enable them to convert their material resources into what they regard as a good life and to ensure that people have the level of resources they need.”³³²*

³³² New Zealand Institute for Economic Research, Let it go: Devolving power and resources to improve lives - NZIER working paper 2023/02, MSC0500625 (2023, page i).

636. The practice of shifting decision-making power and resources from the State to communities is often called devolution. Devolution is not a new concept. Recently there has been increasing recognition and evidence in support of devolution to more effectively tackle complex social issues.³³³

“Devolution is more effective. Small-scale, nimble organisations that take time to build trust can help people feel safe, revealing the true extent of their needs. They are better placed to identify the changes that individuals and their families want to make to their lives. Through a process of co-production, organisations and people experiencing persistent disadvantage can work together to design and deliver the personalised assistance they need.”³³⁴

Te tuku mana ki te waihanga me te whakahaere ratonga ā-iwi Devolving design and delivery of social services

637. Since the 1980s there have been considerable efforts by the State to move towards more community and whānau-led approaches to services. The way the State has sought to make this shift has been criticised, as rather than innovating, governments have largely responded by focusing departments on:
- a. increasing cash benefits and transfers (Working for Families) and in-kind services like counselling and housing, targeted by way of often overlapping eligibility thresholds, with little, if any, regard for people’s overall needs
 - b. seeking to improve coordination across departments at the top, using ministerial groups, executive committees and cross-departmental agencies
 - c. writing detailed contracts for outputs with NGO providers as a way of imposing accountability.³³⁵

333 New Zealand Productivity Commission, *More effective social services: Summary version (2015)*; New Zealand Institute for Economic Research, *Let it go: Devolving power and resources to improve lives – NZIER working paper 2023/02 (2023)*; Te Rūnanga o Tūrangānui a Kiwa, *Te Rūnanganui o Ngāti Porou, Manaaki Tairāwhiti, Self-determination in Te Tairāwhiti: Social services devolution – the roadmap and evidence (2023)*.

334 New Zealand Institute for Economic Research, *Let it go: Devolving power and resources to improve lives – NZIER working paper 2023/02 (2023, page ii)*.

335 New Zealand Institute for Economic Research, *Let it go: Devolving power and resources to improve lives – NZIER working paper 2023/02 (2023, page 7)*.

638. While disability support services in Aotearoa New Zealand showed a rise in alternative care options like Choice in Community Services, individualised funding, carer support, and Enabling Good Lives in 2019/20, the Health and Disability System Review report in 2020 noted that access to disability support services through the Needs Assessment and Service Coordination System was:

"... complex and confusing...there is wide unexplained variability in the way assessment processes work around the country, and this should be addressed...Assessment and reassessment processes should be streamlined so that those who require more service coordination support receive this in a timely manner, the need for regular reassessment is reduced, and people gain more freedom to manage their own support."³³⁶

639. Some government and public organisations have signalled intentions to shift towards truly devolved models and approaches. For example, Oranga Tamariki has plans to increasingly devolve services to communities.³³⁷

640. The Inquiry notes that it is critical that devolution involves not only shifting the responsibility of service delivery, but also the decision-making power to design, fund and implement social services to communities. As Te Rūnanga o Tūrangānui a Kiwa, Te Rūnanganui o Ngāti Porou and Manaaki Tairāwhiti set out in their case for devolution of services in te Tairāwhiti:

"We ask for the allocation and authorisation of the necessary power and decision-making to iwi in Te Tairāwhiti, so that whānau and the local community can engineer their own solutions to social issues. Devolution means not handing over current services but the power to design the necessary solutions as we see fit."³³⁸

³³⁶ Health and Disability System Review, Final Report Pūrongo Whakamutunga (2020, page 145).

³³⁷ Witness statement of Chappie Te Kani, Chief Executive of Oranga Tamariki (August 2022, para 52).

³³⁸ Te Rūnanga o Tūrangānui a Kiwa, Te Rūnanganui o Ngāti Porou, Manaaki Tairāwhiti, Self-determination in Te Tairāwhiti: Social services devolution – the roadmap and evidence (2023, page 16).

Te whakapiki i te āhei me te tāea o te kawē kaupapa

Building capability and capacity

641. In devolving power to communities, the government will need to ensure there is investment in and provision for building the capability and capacity in communities to lead devolved approaches so that they can flourish. The Centre for Social Impact indicates that:

“Research has consistently shown that the capability and capacity of boards and committees in the community sector is variable...while there are many innovative practices in community sector governance, especially in Māori organisations and iwi boards, some community organisations and NGOs are not well governed.”³³⁹

642. Both communities and government have important roles to play in a devolved model. Communities have resources such as volunteer hours, relationships, skills and local knowledge.³⁴⁰ Government can provide technical support such as coaching and mentoring, evaluation and learning support.³⁴¹ In addition, necessary safeguarding functions such as national standards, regulation, and data collection may need to remain centralised.³⁴²

“The skill mix of the people working in devolved organisations is likely to vary. Some specialised capabilities will be required, such as clinical support for addressing addictions. For others, empathy, lack of judgment and the ability to connect deeply with individuals and their families and the wider community will be paramount.”³⁴³

Te whakarahi ake i te aro tautoko ā-whānau

Expanding whānau-centred approaches to support

643. Related to devolution are whānau-centred approaches. Whānau Ora is an example of a whānau-centred approach, which is a “culturally grounded, holistic approach focused on improving the wellbeing of whānau as a group, as well as the individuals within the whānau”.³⁴⁴ This enables services to meet the needs of the whole whānau as an interconnected family system, rather than focusing on a single individual.

339 Center for Social Impact, National action plan for community governance (2020, pages 7, 9).

340 Quigley and Watts, Effective community level change: What makes community-level initiatives effective and how can central government best support them? (Social Policy Evaluation and Research Unit 2015, page 49).

341 Quigley and Watts, Effective community level change: What makes community-level initiatives effective and how can central government best support them? (Social Policy Evaluation and Research Unit 2015, page 51).

342 New Zealand Productivity Commission, More effective social services: Summary version (2015, page 10).

343 New Zealand Institute for Economic Research, Let it go: Devolving power and resources to improve lives – NZIER working paper 2023/02 (2023, page iii).

344 Te Puni Kōkiri, Understanding whānau-centred approaches: Analysis of phase one Whānau Ora research and monitoring results (2015, page 17).

644. In recent years, some public organisations (including government departments) have begun to signal a willingness to take whānau-centred approaches to the design and delivery of services with the goal of improving outcomes for Māori and Pacific Peoples.³⁴⁵ In 2023, the Office of the Auditor-General recommended that the Treasury and Te Kawa Mataaho Public Service Commission provide proactive guidance about existing joint working and funding arrangements that would support the use of whānau-centred approaches.³⁴⁶

Tūtohi | Recommendation 115

The government should prioritise and invest in work to support contemporary approaches to the delivery of care and support, including devolution, social investment and whānau-centered and community-led approaches, such as Enabling Good Lives and Whānau Ora, and avoid the State-led models that contributed to historical abuse and neglect in care.

Te anga atu ki te kaupapa, He Māra Tipu, hei te toko i ngā manako o te iwi ma te kohinga kōrero

Moving towards He Māra Tipu through investing in people's needs using data and evidence

645. In Chapter 3, the Inquiry set out its vision for the future – He Māra Tipu. In this future, by 2040 the State will have transferred power, funding and control of care supports and services to collectives and / or local communities. This would facilitate evidence-based design and investment to deliver supports and services that meet the needs of local communities. In he Māra Tipu all individuals and whānau would have everything they need to flourish and as a result few, if any, children, young people or adults would need out-of-whānau care. Whānau, hapū and iwi could exercise tino rangatiratanga over their kāinga and are empowered to care for their tamariki, rangatahi, pakeke and whānau according to their tikanga and mātauranga.
646. The Inquiry acknowledged in Chapter 3 that devolving power, funding and control from the State into local hands will take time. It will require several stepping stones along the pathway to get there. It will also require good data analysis and evidence of what is working, what is not working and what opportunities there could be to direct investment at the local level to trial new and innovative practices and supports.

³⁴⁵ Controller and Auditor-General, How well public organisations are supporting Whānau Ora and whānau-centred approaches (February 2023, page 33).

³⁴⁶ Controller and Auditor-General, How well public organisations are supporting Whānau Ora and whānau-centred approaches (February 2023, pages 45–46).

Ngā aro whakaaro o Kaikōmihana Erueti rāua ko Gibson mo te whakatū tira taki kaupapa motuhake

Commissioners Erueti and Gibson's views on establishing an independent commissioning agency

647. Commissioners Erueti and Gibson consider that, in addition to Recommendation 115, a new independent Commissioning Agency, as described in the vision set out in Chapter 3, should be established as soon as possible to create an immediate shift towards devolution of social services investment decisions away from the State. In Commissioner Erueti and Gibson's view, it is imperative that this shift begins now, to put power into local hands as soon as possible. Commissioners Erueti and Gibson recognise that it will take time, so planning for this change and the establishment of the independent Commissioning Agency should begin immediately.
648. The independent Commissioning Agency would allocate funding to collectives and/or local communities. Using their allocated funding, collectives and/or local communities would procure supports and services tailored to meet the needs of the individuals and whānau in their communities, based on data and evidence. They would also invest in community capacity and capability building to design and deliver supports and services. Collectives and/or local communities could procure supports and services from many kinds of care providers, such as individuals, rūpū, Pacific communities, disability communities, NGOs, faith-based entities, organisations, hapū, marae, etc. Care providers could have previously been involved in delivering care services, or could be newly involved in the care system.
649. Collectives and/or local communities would define themselves and group together according to shared values, goals, experiences, needs, location, interests, ancestry, whakapapa, ethnicity, religion and/or culture. Collectives and/or local communities could include, for example, iwi or groups of iwi, regional groups, or nationwide collectives representing a specific community of interest, such as the Deaf community. The detail of how many collectives and/or local communities there would be, how many people and whānau they would procure services and supports for, and how the Commissioning Agency would identify their investment allocation, should be worked through jointly with Māori in accordance with te Tiriti o Waitangi, as well as co-designed with communities in line with implementation Recommendations 126–127.

650. The Commissioning Agency should start immediately with responsibility for allocating funding to collectives and/or local communities for the design and delivery of the following supports and services:
- a. care and protection and youth justice supports and services (currently commissioned by Oranga Tamariki)
 - b. community mental health services and supports (currently commissioned by the Ministry of Health via Health New Zealand Te Whatu Ora)
 - c. disability supports and services, including Enabling Good Lives (currently commissioned by Whaikaha)
 - d. Whānau Ora preventative supports and services (currently commissioned by Te Puni Kōkiri via Whānau Ora commissioning entities).
651. Responsibility for care and protection, youth justice, community mental health, disability and preventative (Whānau Ora) supports and services would be transferred from the government agencies that are currently responsible to the Commissioning Agency. Legislation to establish the independent Commissioning Agency should provide for any statutory powers or functions needed to support its role. The Inquiry envisages this would include the transition of any existing contracting arrangements between Oranga Tamariki, Whaikaha, Te Puni Kōkiri and current care providers.
652. The government should ensure that the total amount of investment into care and protection, youth justice, community mental health, disability and preventative supports and services is sufficient and sustainable. This would ensure that all individuals and whānau nationwide receive the services and supports they need to address the circumstances that made individuals more likely to be placed in out of whānau care, and experience abuse and neglect.
653. The Commissioning Agency should be a single Independent Crown Entity at arm's length from government. Leadership and governance arrangements for the Commissioning Agency will reflect appropriate diversity and lived experience, in accordance with implementation Recommendations 129.
654. The care providers that collectives and / or local communities procure supports and services from would be subject to the new national care safety regulatory system, just like other care providers. The Care Safe Agency (Recommendation 41) would be responsible for ensuring that they comply with the same rules, standards and guidelines as all other care providers, including accreditation, vetting, and registration of staff and care workers.

Tūtohi | Recommendation 116

Commissioners Erueti and Gibson consider the government should:

- a. develop, plan for and establish an independent entity, as soon as possible, responsible for:
 - i. commissioning care and protection, youth justice, community mental health, disability and preventative services and supports from self-identified local (or in some cases, national) community groups and organisations (including hapū, iwi, urban Māori authorities, NGOs, Pacific, disability, mental distress communities, faith-based entities and other collectives) across Aotearoa New Zealand
 - ii. monitoring and evaluation of the delivery of care and protection, youth justice, community mental health, disability and preventative services and supports by local community groups and organisations to ensure that they are meeting the needs of individuals and whānau in their communities
 - iii. investing in local community groups and organisations to build their capacity and capability to design and deliver these supports and services to meet the needs of their communities
 - iv. reporting to government, Parliament and the public on the delivery of care and protection, youth justice, community mental health, disability and preventative services and supports by local community groups and organisations to ensure that they are meeting the needs of individuals and whānau in their communities
- b. provide sufficient and sustainable investment to the Commissioning Agency to enable it to commission care and protection, youth justice, community mental health, disability and preventative supports and services that will meet the needs of individuals and whānau nationwide
- c. transfer responsibility and investment for commissioning the following services and supports to the Commissioning Agency:
 - i. care and protection supports and services, from Oranga Tamariki
 - ii. youth justice supports and services, from Oranga Tamariki
 - iii. community mental health supports and services, from the Ministry of Health / Health New Zealand Te Whatu Ora
 - iv. disability supports and services, from Whaikaha
 - v. preventative supports and services, from Te Puni Kōkiri / Whānau Ora commissioning entities.


Te whakamana i te Tiriti o Waitangi me ngā mōtika tāngata

Giving effect to te Tiriti o Waitangi and human rights

Te whakatoka i te Tiriti o Waitangi hei kaupapa here, waihanga me te whakatinana kaupapa e hāngai ana ki ngā mahi i ngā pūnaha taurima

Embed te Tiriti o Waitangi in the policy, design and implementation of care functions

655. In February 1840 the rangatira who signed te Tiriti o Waitangi did not cede their sovereignty. That is, they did not cede their authority to make and enforce law over their people or their territories. Rather, they agreed to share power and authority with the Governor. They agreed to a relationship: one in which rangatira and the Crown were to be equal while having different roles and different spheres of influence. In essence, Rangatira retained their authority over their hapū and territories, while Hobson was given authority to control Pākehā.
656. The Inquiry found little evidence of measures to provide for te Tiriti o Waitangi in the design and implementation of Crown policy and legislation relating to the care system during the Inquiry period. Tamariki, rangatahi and pakeke Māori were more vulnerable to abuse and neglect as a consequence of long standing and ongoing deprivations and intergenerational harm caused by colonisation. This included the loss of land, language, tikanga, and economic and political power which broke down the traditional structures in Māori society that acted as strong protective factors for individuals and whānau, hapū and iwi. In the context of the care system this resulted in:
- a. whānau, hapū and iwi being excluded from decision-making regarding their mokopuna and uri
 - b. tamariki, rangatahi and pakeke Māori being removed or placed into care
 - c. a lack of support for Māori designed and delivered care services and supports, thereby stifling Māori exercise of tino rangatiratanga
 - d. a care system that was Pākehā-centric and structurally racist, contributing to the abuse and neglect of Māori survivors.

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657. Successive governments have taken some measures to provide for te Tiriti o Waitangi in policy and law since the 1970s. Legislative references to the principles of te Tiriti o Waitangi (often called "Treaty clauses") emerged in the Treaty of Waitangi Act 1975, the State-Owned Enterprises Act 1986 and environmental laws.³⁴⁷
658. The New Zealand Health and Disability Act 2000 (repealed and replaced by the Pae Ora (Healthy Futures) Act 2022) included the following provision:
- In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.***³⁴⁸
659. In 2019, the Oranga Tamariki Act 1989 was amended to require the Chief Executive to provide a practical commitment to the principles of te Tiriti o Waitangi.³⁴⁹ The Education and Training Act 2020 includes provisions "that recognise and respect the Crown's responsibility to give effect to Te Tiriti o Waitangi".³⁵⁰ The Pae Ora (Healthy Futures) Act 2022 provides for "the Crown's intention to give effect to the principles of te Tiriti o Waitangi" through a range of measures.³⁵¹
660. Giving effect to te Tiriti o Waitangi will not only ensure that the implementation of these recommendations is tika and pono, it will also lay the foundation for the realisation of the Inquiry's vision, a care system where the rights of Māori under te Tiriti o Waitangi are upheld. Ultimately, the vision of this Inquiry includes the State handing over power and resources for the delivery of care to whānau that are supported by hapū, iwi, and Māori and community organisations at the local and regional level, with any wrap-around support and care for tamariki, rangatahi and pakeke that require outside of home care and support. Any such care and support would be delivered in accordance with the relevant tikanga and mātauranga.

347 Te Arawhiti The Office for Māori Crown Relations, Providing for the Treaty of Waitangi in legislation and supporting policy design (March 2022, page 2).

348 New Zealand Health and Disability Act 2000, section 4.

349 Oranga Tamariki Act 1989, section 7AA.

350 Education and Training Act 2020, section 9.

351 Pae Ora (Healthy Futures) Act 2022, section 6.

Tūtohi | Recommendation 117

The government should partner with iwi to give effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples in relation to the development of strategy, policy, design, implementation and direct or indirect delivery of care functions, including where it has passed on its authority or care functions to any faith-based institution, or to any other individual, entity, or service provider (whether by delegation, contract, licence, or in any other way).

Te pupuri ki ngā here tika ā-tangata o te ao mo te hunga kei ngā pūnaha taurima

Upholding international human rights obligations for people in care

661. The Inquiry found that during the Inquiry period the human rights of people in care were insufficiently protected.
662. In the Inquiry's view, a significantly greater focus on human rights in care is required. Part of this involves understanding how Aotearoa New Zealand's international human rights obligations are relevant to care, including that those receiving care are rights-holders. It also involves recognising that these rights and obligations should form part of the core framework within which care occurs and ensuring that they are implemented in care.
663. The rights of children, young people and adults in care and the corresponding obligations under the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the Convention on the Elimination of All Forms of Racial Discrimination, the United Nations Declaration on the Rights of Indigenous Peoples, and the Convention on the Elimination of All Forms of Discrimination against Women should underpin the provision of care.
664. While Aotearoa New Zealand is renowned internationally for strong protection of the rights of Indigenous Peoples, particularly through law and policy, "New Zealand is comparatively less advanced in relation to many other states in respecting and recognising indigenous authority over indigenous places and spaces".³⁵² The advancements of indigenous self-determination and self-governance in child welfare matters internationally provide models for fundamental change in Aotearoa New Zealand to give effect to te Tiriti o Waitangi.

³⁵² Charters, C, Kingdon-Bebb, K, Olsen, T, Ormsby, W, Owen, E, Pryor, J, Ruru, J, Solomon, N & Williams, G, He Puapua: Report of the working group on a plan to realise the UN Declaration on the Rights of Indigenous People in Aotearoa / New Zealand (2019, page 7).

665. The importance of the United Nations Declaration on the Rights of Indigenous Peoples has been emphasised through the Waitangi Tribunal. The Tribunal has said the Declaration contains principles that are “consistent with the duties and principles inherent in the Treaty”.³⁵³ Both the courts and the Tribunal have acknowledged the Declaration is relevant to interpreting the principles of te Tiriti o Waitangi.³⁵⁴
666. Part of realising these rights includes addressing any barriers that may impact on people’s ability to communicate their needs and participate fully in decisions that affect them. For Deaf and disabled people and people experiencing mental distress, communication assistance could include augmentative and alternative communication devices, alternate formats, and supported decision-making. Māori, Pacific Peoples and others from linguistically or culturally diverse backgrounds may face additional barriers. Communication assistance could include, for example, te Reo Māori sign language interpreters, and support people with appropriate cultural and language competency.

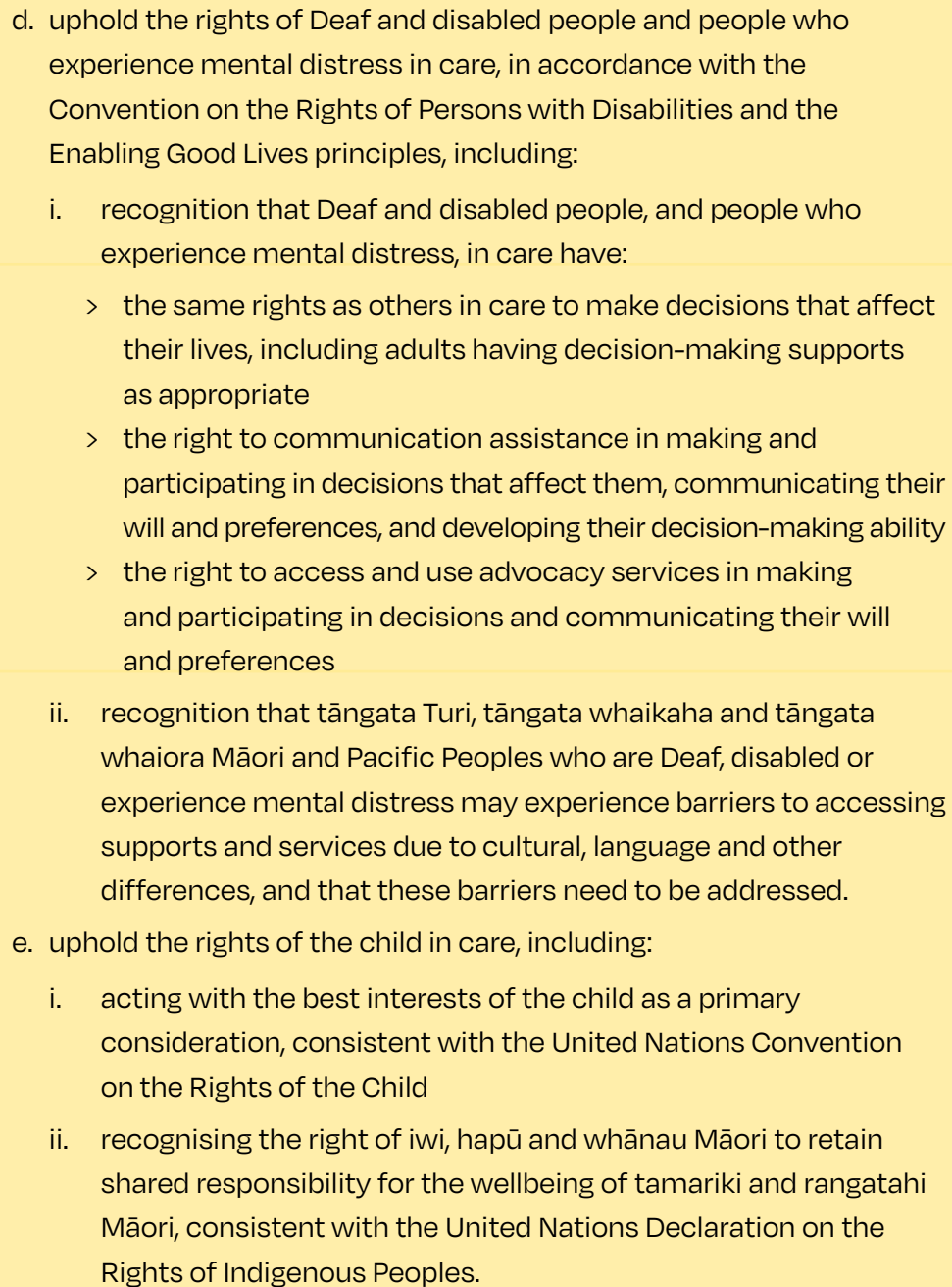
Tūtohi | Recommendation 118

All entities providing care directly or indirectly on behalf of the State or faith-based entities should:

- a. uphold the rights of Māori in care as indigenous peoples of Aotearoa New Zealand in accordance with United Nations Declaration on the Rights of Indigenous Peoples
- b. uphold the rights of Māori, Pacific Peoples, and people from other linguistically or culturally diverse backgrounds in care, in accordance with the Convention on the Elimination of All Forms of Racial Discrimination
- c. uphold the rights of girls and women in care, in accordance with the Convention on the Elimination of All Forms of Discrimination against Women

³⁵³ Waitangi Tribunal, Whaia te Mana Motuhake: Report on the Māori Community Development Act Claim, WAI 2417 (2015, page 36).

³⁵⁴ Waitangi Tribunal, Whaia te Mana Motuhake: Report on the Māori Community Development Act Claim, WAI 2417 (2015, page 38).

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- d. uphold the rights of Deaf and disabled people and people who experience mental distress in care, in accordance with the Convention on the Rights of Persons with Disabilities and the Enabling Good Lives principles, including:
 - i. recognition that Deaf and disabled people, and people who experience mental distress, in care have:
 - > the same rights as others in care to make decisions that affect their lives, including adults having decision-making supports as appropriate
 - > the right to communication assistance in making and participating in decisions that affect them, communicating their will and preferences, and developing their decision-making ability
 - > the right to access and use advocacy services in making and participating in decisions and communicating their will and preferences
 - ii. recognition that tāngata Turi, tāngata whaikaha and tāngata whaiora Māori and Pacific Peoples who are Deaf, disabled or experience mental distress may experience barriers to accessing supports and services due to cultural, language and other differences, and that these barriers need to be addressed.
 - e. uphold the rights of the child in care, including:
 - i. acting with the best interests of the child as a primary consideration, consistent with the United Nations Convention on the Rights of the Child
 - ii. recognising the right of iwi, hapū and whānau Māori to retain shared responsibility for the wellbeing of tamariki and rangatahi Māori, consistent with the United Nations Declaration on the Rights of Indigenous Peoples.

Te aromatawai i te raupapa tika tāngata haukāinga e mau tūturu tonu ai te tiaki pai i te hunga kei ngā pūnaha taurima

Review domestic human rights framework to ensure it adequately protects people in care

667. During the Inquiry period, there was no specific framework aimed at ensuring that human rights in all care settings were respected, protected and fulfilled. There was no systematic, regular monitoring of care against human rights standards during the Inquiry period.
668. As set out in Part 1, human rights protections in Aotearoa New Zealand's domestic laws are "piecemeal". They are set out in a variety of statutes and the common (court-made) law, which means they cannot all be found in one place. The Inquiry considers that in order to realise and protect the human rights of all New Zealanders in care, more needs to be done immediately.
669. The Inquiry considers that the rights of Māori to be free from abuse and neglect in care and the relevant rights in the United Nations Declaration on the Rights of Indigenous Peoples should be provided for in law. The Human Rights Act 1993 should be reviewed to identify whether any amendments are needed to address abuse and neglect in care.

Te tika o te noho haumaruru a te tangata

Right to security of the person

670. In its concluding observations in Part 7, the Inquiry referred to there not being a general right to security of the person in the New Zealand Bill of Rights Act 1990.
671. The International Covenant on Civil and Political Rights, which Aotearoa New Zealand has ratified, states at Article 9(1) that everyone has the right to security of the person. This right is concerned with "freedom from injury to the body and the mind, or bodily and mental integrity".³⁵⁵ The right "protects individuals against intentional infliction of bodily or mental injury, regardless of whether the victim is detained or non-detained".³⁵⁶
672. This right is profoundly important for individuals and society more generally.³⁵⁷ It is particularly relevant to abuse and neglect in care. However, because there is no general right to security of the person in the New Zealand Bill of Rights Act 1990,³⁵⁸ people in care in Aotearoa New Zealand cannot directly rely on this right in the courts. In contrast, overseas there are many cases brought to the courts which are based on this right.³⁵⁹

355 United Nations Human Rights Committee, International Covenant on Civil and Political Rights General Comment No 35 CCPR/C/GC/35 (2014, para 3).

356 United Nations Human Rights Committee, International Covenant on Civil and Political Rights General Comment No 35 CCPR/C/GC/35 (2014, para 9).

357 United Nations Human Rights Committee, International Covenant on Civil and Political Rights General Comment No 35 CCPR/C/GC/35 (2014, para 2).

358 Butler, A & Butler, P, *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015, para 35.6.16).

359 Butler, A & Butler, P, *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015, para 35.6.16).

673. There is a right in the New Zealand Bill of Rights Act not to be subjected to torture or to cruel, degrading, or disproportionately severe treatment or punishment. But Aotearoa New Zealand courts have found that this right only applies in “truly egregious” or “outrageous” cases.³⁶⁰ Less serious cases may in some instances be covered by the right of arrested or detained people to be treated with humanity and with respect for the inherent dignity of the person, as set out in section 23(5) of the Act. However, that right only applies to people deprived of liberty. As set out above, the international human right to security of the person applies to everyone, whether or not they are in detention. Abuse and neglect in care occurs inside and outside of detention.
674. There is therefore an important gap in the New Zealand Bill of Rights Act which needs to be filled. That could be done by adding a general right to security of the person in Part 2 of the Act, following the heading “Life and security of the person”.

He take tūturu e mau tonu ai te Kāwanatanga i ngā tika ā-tangata me te Tiriti o Waitangi

The State has positive duties in relation to human rights and te Tiriti o Waitangi

675. The State has positive duties under each human rights instrument, and under te Tiriti o Waitangi. This means it has an obligation to take action to ensure rights are respected and upheld.
676. In relation to te Tiriti o Waitangi, the Inquiry noted in Part 6 that the Crown obligations as a Tiriti o Waitangi partner and signatory to te Tiriti o Waitangi that include:
- a. ensuring the Crown and institutions recognise Māori rights and values
 - b. ensuring the Crown and institutions act in accordance with te Tiriti o Waitangi obligations of the Crown
 - c. monitoring the activities of institutions, and auditing institutions' performance in the context of te Tiriti o Waitangi relationship between Crown and Māori.
677. Te Tiriti o Waitangi is relevant to interpreting legislation even where legislation is silent on te Tiriti o Waitangi. Given that tamariki, rangatahi and pakeke Māori are taonga, te Tiriti o Waitangi colours all legislation dealing with the status, future and control of tamariki, rangatahi and pakeke Māori.

³⁶⁰ Falwasser v Attorney-General [2010] NZAR 445 (HC) at [73], referring to the observations of the majority Judges in Taunoa v Attorney-General [2007] NZSC 70, [2008] 1 NZLR 429.

678. In Part 1 the Inquiry discussed some of the positive duties the State has to people in care under relevant human rights instruments. Aotearoa New Zealand must respect, protect and fulfil human rights. In practice, this means the State has a duty to:
- a. respect human rights by not interfering with them
 - b. protect human rights by preventing private institutions or other people from violating them
 - c. fulfil human rights by taking positive steps to ensure they are realised, including enacting laws and implementing appropriate policies and programmes.
679. The State has a duty to ensure that victims of human rights breaches can receive effective redress, which can be individual or collective, depending on the nature of the right breached. It must also be responsive to the fact that human rights protections must evolve over time as societal understanding grows, increasing the obligations on Aotearoa New Zealand. Human rights knowledge should influence care practices, ensuring that care relationships are positively affected. Any failure to meet this standard should be identified and corrected.

Te whakatinana i ngā tika o te hunga whaikaha kei ngā pūnaha taurima Realising the human rights of disabled people in care

680. Aotearoa New Zealand took a lead role in negotiating the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and ratified it in 2008. The government's position is that the Convention is given effect, and the rights of disabled people provided for, through:

*...New Zealand's general human rights law, the New Zealand Bill of Rights Act 1990, in its specialised non-discrimination law, the Human Rights Act 1993, and in specific recognition in legislation governing health, education and other social services. Before ratifying the Convention, New Zealand reviewed its law for consistency with the Convention and made necessary amendments.*³⁶¹

681. Since ratification, the State has focused on implementing the Convention through non-legislative mechanisms such the New Zealand Disability Strategy and Disability Action Plan, implementing the Enabling Good Lives approach and establishing Whaikaha Ministry of Disabled People.³⁶²

³⁶¹ New Zealand Government, First New Zealand report on implementing the United Nations Convention on the Rights of Persons with Disabilities (March 2011, paras 4, 14–15).

³⁶² United Nations Committee on the Rights of Persons with Disabilities, Concluding observations on the combined second and third periodic reports of New Zealand (2022, 4(b), 4(d)).

682. The Inquiry notes that the Australian Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability's central recommendation was to create a Disability Rights Act, complementing their current Disability Discrimination Act, which has associated standards with positive duties.³⁶³ The Inquiry thinks that increasing the visibility of the human rights of Deaf and disabled people, and people who experience mental distress, in care through standalone legislation would strengthen protection of these rights and will be an important step in removing a persistent factor that contributed to abuse and neglect of Deaf and disabled people and people experiencing mental distress in care.
683. The Inquiry envisages that the design of this new law change (before draft legislation is introduced into Parliament) will be undertaken in accordance with implementation Recommendations 128–129. This would include identifying whether any changes are required to other laws that are relevant to realising the human rights of Deaf and disabled people, and people who experience mental distress. These laws include the Adoption Act 1955, the Protection of Personal and Property Rights Act 1988, the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Tūtohi | Recommendation 119

The government should review Aotearoa New Zealand's human rights framework to ensure it adequately addresses abuse and neglect in care, including:

- a. introducing a stand-alone right to security of the person in the New Zealand Bill of Rights Act 1990
- b. ensuring statutory protection in a Disability Rights Act of the rights of disabled people to be free from abuse and neglect in care and the relevant rights in the Convention on the Rights of Persons with Disabilities
- c. providing statutory protection of the rights of Māori to be free from abuse and neglect in care and the relevant rights in the United Nations Declaration on the Rights of Indigenous Peoples
- d. making any necessary amendment to the Human Rights Act 1993 to address abuse and neglect in care
- e. the provision of effective implementation of the relevant rights, including positive duties.

³⁶³ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, Executive summary: Our vision for an inclusive Australia and Recommendations (Commonwealth of Australia, September 2023, page 57).

Te whakatū tohu tika hei taki kaupapa atawhai tangata

Establishing human rights indicators for care settings

684. In the Inquiry's view the government should, in order to prevent ongoing abuse and neglect in care:
- a. establish performance indicators to measure human rights performance in care settings
 - b. assist in identifying gaps and other issues
 - c. promote human-rights consistent decision-making and conduct in care, and
 - d. increase the visibility of human rights in care.
685. Indicators are used to assess and monitor human rights realisation in care.³⁶⁴ Indicators could include, for example, the number of complaints reported to care providers during an annual reporting period alleging breach of the right to security of the person and the number of those complaints which were resolved within a year of being made. Further indicators could include the number of those complaints which were upheld and the number of complainants with upheld complaints who received effective redress.
686. Indicators should be chosen with reference to Aotearoa New Zealand's domestic and international human rights obligations, including those under the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the Convention on the Elimination of All Forms of Racial Discrimination, the United Nations Declaration on the Rights of Indigenous Peoples, and the Convention on the Elimination of All Forms of Discrimination against Women.
687. The process of choosing indicators involves considering which human rights are relevant to care, how those human rights apply in practice to care settings, and the information required in Aotearoa New Zealand to measure over time whether applicable human rights obligations are being met or not. The advantages of carrying out this work include that it will require government, other entities providing care directly or indirectly involved in care, survivors and other interested groups to analyse and make transparent decisions on how broad human rights standards apply to care in this country, and to revise those decisions periodically. It will also result in the establishment of an Aotearoa New Zealand-specific human rights framework for care, which the Inquiry found was lacking during the Inquiry period.

³⁶⁴ United Nations Office of the High Commissioner for Human Rights, Human Rights Indicators: a Guide to Measurement and Implementation (Geneva, 2012, page 16).

688. The guidance from the Office of the United Nations High Commissioner for Human Rights³⁶⁵ provides some direction and Te Kāhui Tika Tangata Human Rights Commission's indicators for the right to adequate housing in Aotearoa New Zealand, including the process it followed to choose relevant indicators, provides a useful example of how this work could be done.³⁶⁶

Tūtohi | Recommendation 120

The government should establish performance indicators for all entities providing care directly or indirectly on behalf of the State or faith-based entities based on Aotearoa New Zealand's domestic and international obligations.

He aronga tūturu ki ngā kaupapa ārai mahi tūkino Targeted abuse and neglect prevention programmes

Te tautoko i te hunga kei ngā pūnaha taurima e mārama e tāea ai e rātou te pārai ngā mahi tūkino

People in care supported to understand abuse and neglect and protect themselves

689. In Part 7, the Inquiry identified that critical protective factors for people in care include understanding their rights and how they should be treated, and understanding appropriate and inappropriate behaviour, personal safety, and what they can do in difficult situations. The Inquiry has found that peer-on-peer abuse is more likely in care settings that have a pervasive culture of physical and sexual violence. People in care learn to be abusive and violent in these environments and can become a victim and perpetrator of abuse.
690. However, many survivors told the Inquiry that they did not understand that what was happening to them was abuse and they were often never taught what abuse was or how to recognise it, including recognising signs of grooming and inappropriate behaviour. In addition, survivors often did not know where to get help and what to do if something does not feel right.

³⁶⁵ See United Nations Office of the High Commissioner for Human Rights, *Human Rights Indicators: a Guide to Measurement and Implementation* (Geneva, 2012).

³⁶⁶ See Te Kāhui Tika Tangata Human Rights Commission, *Right to a decent home: measuring progress*, (undated).

691. Targeted programmes are required to ensure that children, young people and adults in care understand what abuse and neglect is, what acceptable and respectful behaviours and relationships look like and what to do if they have concerns. There should also be programmes for parents and caregivers to increase knowledge of abuse and neglect and its impacts and build skills to help reduce the risks of abuse and neglect. This is in addition to the general social and educational campaigns directed at the broader public in Recommendations 111 and 128.

Tūtohi | Recommendation 121

The government should support and adequately invest in:

- a. programmes for children, young people and adults who are in care or are at risk of being placed in care that are delivered through community organisations, and preschool, primary, and secondary schools including kura kaupapa, private, charter and State integrated schools, that aim to increase knowledge about abuse and neglect and build their skills and tools to help them to protect themselves (both in person and online safety), including a focus on:
 - i. recognising grooming and other inappropriate behaviour
 - ii. understanding what constitutes abuse and neglect
 - iii. recognising the signs of abuse and neglect
 - iv. understanding their rights and how they should be treated
 - v. understanding respectful and appropriate behaviour and relationships
 - vi. what to do and where to get help if you have concerns.
- b. programmes to help support parents, whānau and caregivers delivered through day care, preschool, school, sport and recreational settings, and other institutional and community settings to increase knowledge of abuse and neglect and its impacts and build skills to help reduce the risks of abuse and neglect.

Te whakapiki tahua tautoko hei ārai i ngā mahi tūkino

Increasing investment to support abuse prevention programmes

692. programmes to help support parents, whānau and caregivers delivered through day care, preschool, school, sport and recreational settings, and other institutional and community settings to increase knowledge of abuse and neglect and its impacts and build skills to help reduce the risks of abuse and neglect.
693. The Education Review Office released a special review report on Wesley College (in Pukekohe) in June 2023. Concerns for the safety of students at Wesley College and its hostel were raised by the Education Review Office and the Ministry of Education which led to the review. The report stated:
- “Although on the decline, there is evidence that entrenched practices and harmful traditions continue to persist that place students at risk of violence, bullying and discrimination.”***³⁶⁷
694. Oranga Tamariki has reported that 84 percent of the harm experienced in residences in 2023 was caused by other children, with 11 percent caused by staff.³⁶⁸ The Inquiry also heard reports of peer-to-peer abuse in disability settings:
- “Staff told me “off the record” that Paul’s injuries were the result of him being regularly assaulted by other residents. They told me that Paul had been pinched and punched by other residents.”***³⁶⁹
695. Part 5 explained that the Inquiry heard from a range of survivors who had abused and assaulted their peers in care due to abuse they had previously experienced, the culture of the care setting or due to previous adverse experiences such as abuse and violence in their home. It is critical that children, young people and adults in care who have abused others or are at risk of abusing others have access to appropriate specialist support, including from mental health professionals.

³⁶⁷ Special Review Report – Wesley College (Education Review Office, 9 June 2023, page 7).

³⁶⁸ Oranga Tamariki, Safety of children in care annual report July 2022 to June 2023 (January 2024, page 30).

³⁶⁹ Affidavit of Gay Rowe (12 February 2020, page 5, para 36, 39).

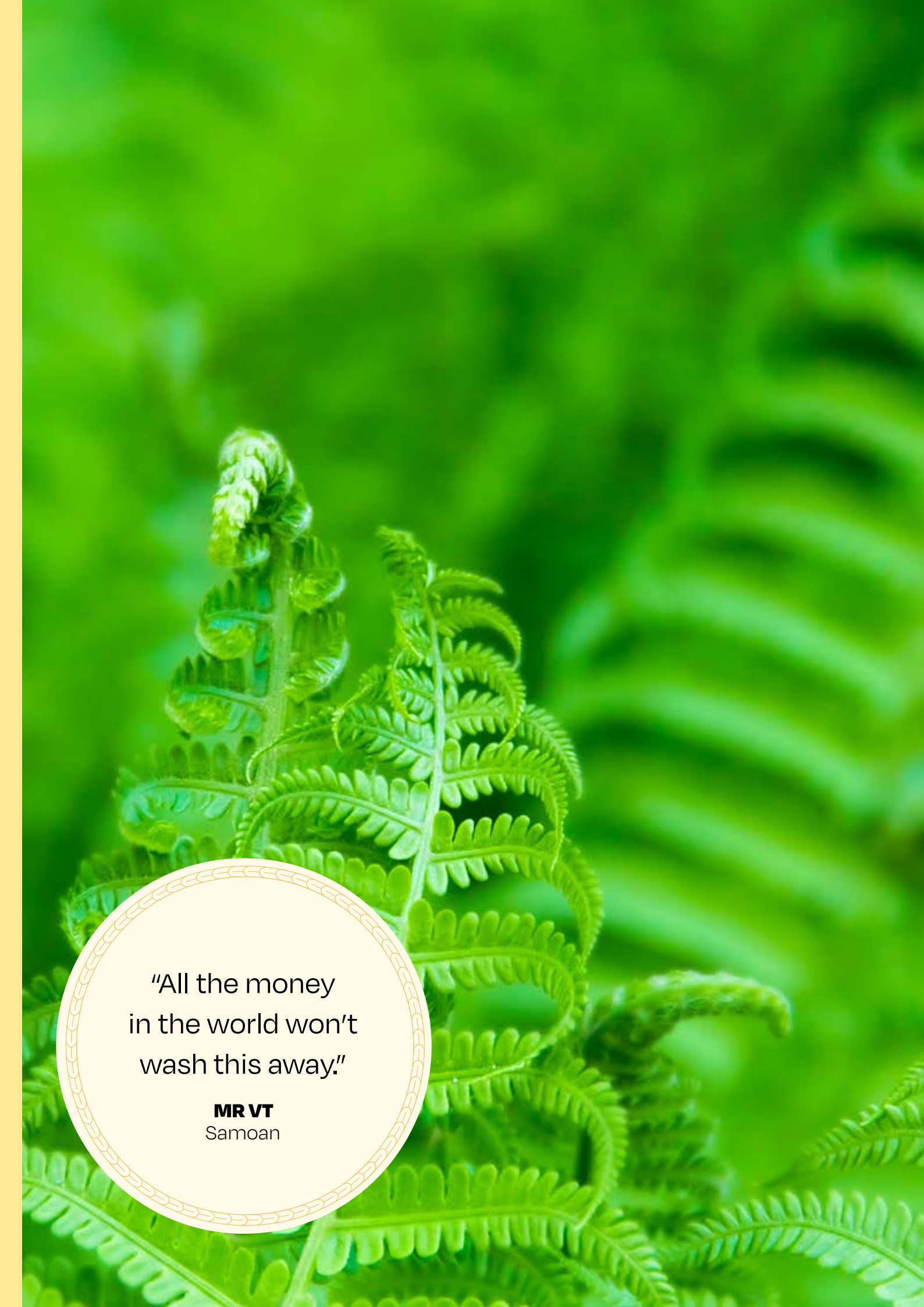


Tūtohi | Recommendation 122

The government should support and adequately invest in:

- a. abuse and neglect prevention programmes, including for those who may be at risk of perpetrating abuse and neglect
- b. access to specialist support, including rehabilitation programmes, for children, young people and adults who exhibit harmful or abusive behaviours or are at risk of abusing others, including concerning or harmful sexual behaviours
- c. online information and a helpline to provide support for those concerned about:
 - i. an adult they know may be at risk of perpetrating abuse and /or neglect
 - ii. a child or young person or adult in care they know may be at risk of abuse and /or neglect
 - iii. a child, young person or adult in care they know may be displaying potential abusive behaviours.





"All the money
in the world won't
wash this away!"

MR VT
Samoan

Mr VT

Hometown: Born in Samoa; then Ōtautahi Christchurch

Age when entered care: 10 years old

Year of birth: 1986

Year of birth: 1986

Time in care: 1996–2003

Type of care facility: Foster homes; Family Homes; youth unit – Kingslea Care and Protection Unit in Ōtautahi Christchurch; youth programme – Eastland Youth Rescue Trust near Omaio; youth justice residence – Lower North in Te Papaioea Palmerston North.

Ethnicity: Samoan

Whānau background: Mr VT's grandparents adopted him when he was about 4 years old, and he did not find out he was adopted until he was 19 years old. Mr VT grew up assuming his birth mother was his sister. He has not had much contact with his birth father. He has a younger brother, who did not go into care.

Currently: Mr VT has two daughters from previous relationships and does not have any contact with one of them; the other daughter has had kids, so Mr VT is a grandfather.



Growing up, I thought family violence was normal. It was just 'discipline' – it was the norm.

Someone at school noticed I was turning up with bruises and black eyes, and alerted Children, Young Persons and their Families Service. I got hit by my dad if I was backchatting, being disrespectful, or not listening. It was discipline, but it was quite violent. In my CYFS notes there's a report that my mum had tied my legs together and beaten me. A paediatrician told CYFS I had bruising consistent with being assaulted with an electrical cord.

CYFS received many reports of the abuse I was experiencing and the injuries I had, but nothing much was done to help me.

In 1996 CYFS made an application to put me into interim care. I was 10 years old. My family tried to hide me, but eventually I went to a foster family, then I was admitted to Kingslea and I was there on and off for several years.

Like any 10-year-old, I missed my parents and just wanted to be at home. I cried a lot, and I was angry that I had to be away from my family. I hated Kingslea so much that I tried to numb the hurt by drinking shampoo and window cleaner and got taken to hospital.

I was restrained a lot by the staff at Kingslea. At times, they'd use so much force it would make me think, "I'm sure they can't do that to a kid". They'd throw me to the ground and put a knee in the back of my neck or head. Sometimes they'd pin me down using their knees.

At Kingslea, I was bullied, assaulted and intimidated by other residents. I was depressed and wanted to harm myself. In my notes I was described as feeling lonely, unloved, worthless, sad and withdrawn. CYFS was still recording that under no circumstances should I go home, because it wasn't safe – but even after writing that, they sent me home to my parents.

In 1999 I was sent to Eastland, an outdoor pursuits programme for boys aged between 14 and 17 years old who were physically strong and under Youth Court orders. I was only 13 years old, and under care and protection orders, not a supervision with activity order. I should never have been sent there.

I was meant to be at Eastland for six months, but I ran away. The two and a half weeks I spent there were incredibly brutal.

The man who ran Eastland, Neville Walker, had been involved with a previous similar programme, which had been investigated by CYFS for abusing kids. Neville started Eastland on the same property almost straight away and got paid by CYFS to take boys on his programme.

As soon as the social worker dropped me off, I was made to sit on a log and have my hair shaved off. When I protested, I was hit around the ears. I was threatened with violence if I ran away. The first few days were spent doing hard labour, while Neville ordered us around, yelling and swearing at us. He also said racist things to me, such as calling me a "coconut cunt" or telling me to move my "black ass".

Almost all the other boys on the programme were violent towards me. They stole all my new clothes, beat me on a daily basis, and threatened me with more hidings. Once, they smashed an old-fashioned washing machine roller over my back.

Other times, the older boys tied me up or chained me and other boys to a pole outside at night-time. They'd yank on the chains from their tents. Sometimes, we had dog chains tied around our necks and the other boys would drag us around and urinate on us. They stubbed out cigarette butts on my face and made me lie down in the freezing river in my underpants. Once, while tied up, another boy cut a tattoo out of my arm with a pocket knife.

I told Neville about it, but he didn't do anything. Once, his kids shot me and another boy with BB guns, while he sat there watching and laughing.

I ran away with another boy and stole a rifle and some bullets. Neville caught the other boy first, then fired several shots from another rifle into the bush to try to draw me out. I came out of the bush with my hands up and surrendered. Neville made me kneel down, took the rifle off me and smashed the butt of it into my head, splitting my head open. I bled everywhere. He kicked me in the ribs and threatened to kill me if I tried anything else.

I tried to run away again and I was made to stay up all night scrubbing a tarpaulin floor with a toothbrush, wearing only my underpants. The punishment lasted three nights, and one of the nights I had to do it completely naked. I was really sleep deprived and several times I fell asleep, then got woken up by being kicked in the face. During those nights, I was sexually abused by two different boys, and I had injuries to my anus as a result of one of those assaults.

I told Neville about the sexual assaults. He got angry and tied one of the boys to the back of a horse by his hands, then rode the horse around and dragged the boy behind him.

I ran away again, was picked up by a stranger and taken to hospital. A doctor called CYFS and informed them I had been physically assaulted. The police interviewed me and I said I'd been beaten by Neville with a rifle butt. The police later faxed through an eight-page statement to CYFS about my allegations at Eastland, but they only ever investigated the sexual assault allegations, and nothing about Neville. Even then, the sexual abuse allegations weren't investigated for more than a year. Not only did CYFS put me in a dangerous place, but they absolutely failed to address the things that happened to me.

I know now that because of what happened to me, CYFS stopped using Eastland and took all the boys off the programme. I should never have been sent there. It was incredibly violent and what happened there scarred me for life.

I had a medical examination, which showed a lot of scars on my body including a four-centimetre scar on my scalp from where I was smashed with the rifle butt. The doctor also noted scars on my anal region. But later, police said no charges could be laid, because there was no medical evidence to support my allegations.

I was put back in Kingslea again later in 1999 until April 2000. This long period of time in Kingslea was because I was waiting for CYFS to organise a placement with my family in Samoa. There were huge delays with this, mostly caused by my social worker. In September 1999, the same CYFS manager who said I should go to Eastland wrote that she was worried I would become "yet another Christchurch case that sits in residence". The proposed placement fell through and I stayed in Kingslea.

I wrote to the CEO of CYFS in 2000, saying: "I just want to know how long I am in this place. I am just confused. I do not know when I am getting out. I do want to make some changes in my life. I just want to go home."

In 2002 I was sent to Lower North Youth Justice Residence in Palmerston North. I was bullied and threatened by other residents, and in response I fought back. The staff saw me getting beaten up. The only thing I could do was defend myself. All I remember from being in the secure unit is getting locked down a lot. I was isolated and let out for an hour a day. Most of the day I just sat and stared out of the window. I didn't do any school work.

In 2003 when I was 16 years old, I was remanded to prison. I shifted from one State institution to another. CYFS closed their file on me a few weeks later.

I've been in and out of jail ever since. I've probably spent two years in the community since 2005. I am quite institutionalised – I don't know how to live in the real world, I feel safer in prison.

I hate the system, and I don't trust anyone in it. The system abandoned me and traumatised me.

I got an apology and a settlement, but it felt hollow. All the money in the world won't wash this away. They knew not to put me in places like Eastland but did it anyway. I feel like I was a happy kid who had to create a mask to survive, and I had so many different masks that it got confusing.

There's a photo of me in my CYFS file from when I was a teenager. I wasn't very big or scary. I was just a kid.³⁷⁰

³⁷⁰ Witness statement of Mr VT (5 July 2021).

Ūpoko | Chapter 8

Mai i kōnei ki tua i ngā tūtohi a te Kōmihana

Implementing the Inquiry's recommendations and beyond

696. This chapter describes how the recommendations in this report must be implemented.
697. Strong commitment and action is required from everyone in Aotearoa New Zealand to ensure that we can work towards a future where children, young people and adults who need care and support are safe and thrive. This commitment starts with cross-political agreement, which will send a strong message that decision makers are united and clear on the changes needed beyond three-year electoral cycles.
698. To enable participation of survivors and other key parties in this change, it is important that there is a clear action plan for the implementation of recommendations that is collaborative and transparent. It should contain clear accountabilities and enable the public tracking of progress.

Te whakatū Tari Āhuru Mōwai motuhake hei arataki i te kaupapa Establishing a Care System Office to lead implementation

699. In the Inquiry's view, a dedicated government agency is needed to lead the implementation of its recommendations. This will include coordinating with government agencies involved in the care system and with faith-based entities that will be involved in implementing recommendations.
700. This agency needs to have sufficient centrality and seniority to lead and coordinate the care system across the different sectors and settings. It also needs to be independent from the government agencies currently involved in the care system and the people and organisations that have been involved in the government's response to the Inquiry's Holistic Redress Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui.

701. The Inquiry made this same point in He Purapura Ora, he Māra Tipu: From Redress to Pūretumu Torowhānui, in relation to setting up an independent entity to run the pūretumu torowhānui system and scheme:

“By operating independently, the scheme is much more likely to gain the trust and confidence of survivors. This independence will require the scheme to have no connection with the care institutions or the individuals within them, except as needed to carry out its functions.”³⁷¹

702. The Inquiry recommends that a Care System Office is set up within one of the central agencies (the Treasury, Te Kawa Mataaho Public Service Commission or the Department of the Prime Minister and Cabinet). As discussed in this Part and in Part 7, transforming the way care is delivered requires a whole of government approach. The central agencies work together to ensure the machinery of government operates smoothly. Locating the Care System Office within a central agency would provide leadership and accountability within government and a single, trusted point of engagement for survivors, iwi, hapū and communities.

703. The Care System Office will also be responsible for drafting, and then administering, the Care Safety Act, for establishing the Care Safe Agency and for monitoring its performance on behalf of government and providing whole of system advice to government on the care system. Once the new Act is in place we would see the new Care System Office becoming the Ministry for the Care System.

704. The Inquiry envisages that the Care System Office would not be led, or staffed, by senior officials or middle managers who are currently or have been employed by government agencies responsible for delivering and overseeing care including responding to historical claims. As discussed in Recommendations 41–44, this is because many survivors have been traumatised by their interactions with staff and organisations involved in providing care or responding to historical claims, and will never be able to trust any system associated with them. In addition, senior leaders of such organisations have often deployed measures to minimise reputational risk as well as neutralise or cover over institutional abuse during the Inquiry period.

³⁷¹ Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Pūretumu Torowhānui, Volume 1 (2021, page 279).

Tūtohi | Recommendation 123

The government should establish a Care System Office later to become the Ministry for Care System that:

- a. is independent from, and has no association with, the government agencies currently involved in the care system (including those involved in historic claims processes and in implementing the Holistic Redress Recommendations in the Inquiry's interim report He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui)
- b. is set up within one of the central agencies (the Treasury, Te Kawa Mataaho Public Service Commission or the Department of the Prime Minister and Cabinet) as a departmental agency
- c. does not employ senior officials or middle management who have been involved in the care system as described in (a) above.

Tūtohi | Recommendation 124

The Care System Office should be responsible for:

- a. leading the implementation of the Inquiry's recommendations set out in this report and the Holistic Redress Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui
- b. leading and coordinating the work of government agencies involved in the care system
- c. establishing and then monitoring the independent Care Safe Agency
- d. providing whole of system advice to government on the care sector, settings and system
- e. drafting and administering the Care Safety Act (Recommendation 45).



Me mahi ngā mea katoa e rite e whai take ai ēnei whakatau

Taking any and all actions needed to give effect to these recommendations

705. The government and faith-based institutions (including indirect care providers) should take any and all actions necessary to implement these recommendations, including changes to:
- a. investment
 - b. public policy
 - c. legislation or regulations
 - d. operational practice
 - e. guidelines.

Tūtohi | Recommendation 125

The government and faith-based institutions should take any and all actions required to give effect to the Inquiry's recommendations set out in this report and the Holistic Redress Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, including changes to investment, public policy, legislation or regulations, operational practice or guidelines.

Te waihanga me te whakatinana i ēnei tūtohinga katoa, e hāngai ai ki te Tiriti o Waitangi, me te Whakaputanga ā te Whakaminenga o te Ao mo ngā iwi taketake, ia whai wāhi atu hoki te ringa waihanga o ngā hāpori
Design and implementation of all recommendations to give effect to te Tiriti o Waitangi and UNDRIP and be co-designed with communities

706. During the Inquiry period, Māori were denied their tino rangatiratanga and mana by being deprived of the resources and autonomy to care for and raise their whānau who were placed in care. Māori were also excluded from decision-making and influence regarding the design and delivery of the care system. In Part 6, the Inquiry found that the State's failure to give effect to the preexisting rights it had guaranteed to Māori in te Tiriti o Waitangi had devastating effects on whānau, hapū and iwi and directly contributed to tamariki, rangatahi and pakeke entering care and experiencing abuse and neglect in care.
707. Implementing the recommendations through giving effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples will ensure that they reflect the needs of Māori and the implementation is tika and pono. It will also lay the foundation for the Inquiry's vision, in which the State has devolved power, investment and decision-making, so that hapū, iwi and Māori organisations can care for and support their mokopuna and whānau in accordance with their tikanga and mātauranga.
708. The Inquiry expects that in giving effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples, mātauranga Maori will be given equal importance alongside Western research and knowledge in the design and implementation of the recommendations.

Tūtohi | Recommendation 126

The State and faith-based entities should partner with iwi to give effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples in relation to researching, designing, piloting, implementing and evaluating the Inquiry's recommendations to ensure that recommendations are implemented in a manner that:

- a. reflects the rights, experiences and needs of Māori in care
- b. embeds the right to tino rangatiratanga over their kāinga guaranteed to Māori in te Tiriti o Waitangi
- c. empowers hapū, iwi and Māori organisations to care for their whānau and implement solutions.

709. The importance of lived experience and co-designing care setting policy and practice with affected communities was not recognised during the Inquiry period.

710. Luamanuvao Dame Winnie Laban told the Inquiry that:

*...there is some goodwill in policy-making agencies but... there's a lack of connection direct with the communities and families that they serve... what needs to happen is there needs to be a greater coherence and listening to what the needs are from our grassroot communities and families so that the policies and responses that are developed meet those needs.*³⁷²

711. The 2018 He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction observed that:

*...at a practice and implementation level, we need to see more examples of genuine co-design processes ... in agencies commissioning and delivering services.*³⁷³

712. The Inquiry pictures the level of public participation in the design and implementation of these recommendations operating at the "collaborate / co-design" level on the IAP2 Spectrum of Public Participation. This means that the State and faith-based entities would partner with communities in every aspect of decision-making, including determining the issue / problem, developing solutions, assessing options and making choices.³⁷⁴

372 Transcript of evidence of Associate Professor the Honourable Luamanuvao Dame Winnie Laban, Tulou – Our Pacific Voices: Tatale e Pulonga (Royal Commission of Inquiry into Abuse in Care, 19 July 2021, page 18).

373 Government Inquiry into Mental Health and Addiction, He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (Wellington, 2018, page 161).


374 International Association for Public Participation, IAP2 Spectrum of Public Participation (2018), <https://iap2.org.au/resources/spectrum/>. Involve means "to work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered", collaborate means "to partner with the public in each aspect of the decision including the development of alternatives and the identification of a preferred solution" and empower means "to place final decision making in the hands of the public".

713. The Inquiry expects that international breakthroughs in treating trauma, including treatment models that lie outside of the Western medical model, will be considered in the design and implementation of the Recommendations. Communities will have deep knowledge of best practice relevant to them and should be encouraged to bring this forward in the design and implementation process.

Tūtohi | Recommendation 127

Government and faith-based entities should research, design, pilot, implement and evaluate the Inquiry's recommendations through co-design with communities, including children, young people and adults in care, survivors, iwi Māori, Pacific Peoples, culturally and linguistically diverse communities, Deaf and disabled people, people who experience mental distress, and Takatāpui, Rainbow and MVPFAFF+ people, to ensure that reforms:

- a. reflect the rights, experiences and needs of people in care
- b. reflect the diversity of affected communities
- c. are tailored to reach, engage and provide access to all communities.



Te whakamōhiotanga tūmatawhānui me te whakaako ki te whakatikai tewhakahāwea me te whakaiti tangata

Public awareness and training to address prejudice and discrimination

714. The Inquiry found that ignorance of the signs of abuse and neglect contributed to failures to identify and intervene to prevent abuse and neglect in State and faith-based care during the Inquiry period. Public awareness, education and training about how to prevent, identify and respond to abuse and neglect are critical elements of preventing abuse and neglect in the future. This includes:
- a. challenging myths and stereotypes about abusers, bystanders and survivors of abuse and neglect in care
 - b. helping victims and survivors of abuse and /or neglect, and their whānau and support networks, to minimise shame and self-stigma, recognise the abuse and /or neglect was not their fault and to safely disclose and report as soon as possible
 - c. understanding what constitutes abuse and neglect
 - d. recognising the signs of abuse and neglect
 - e. recognising grooming and other inappropriate behaviours
 - f. understanding how to respond appropriately to abuse and neglect, including complaints, reports and disclosures.
715. The Inquiry found that survivors of abuse and neglect in State and faith-based care during the Inquiry period experienced discrimination and targeted abuse based on prejudice. The Inquiry also found that social attitudes, ignorance, prejudice and discrimination contributed to people being placed into State and faith-based care and being abused and neglected while in care. The most common forms of prejudice and discrimination seen were:
- a. racism, particularly against Māori and Pacific Peoples
 - b. ableism and disablism, particularly against Deaf and disabled people, and people who experience mental distress
 - c. sexism against girls and women
 - d. homophobia and transphobia against Takatāpui, Rainbow and MVPFAFF+ people
 - e. negative attitudes towards children and young people.

716. A March 2024 report by Mana Mokopuna – the Children and Young Person’s Commission on racism experienced by children and young people noted that:
- “Across all of our engagements, mokopuna emphasised that education was a key solution to help eliminate racism in Aotearoa New Zealand.”***³⁷⁵
717. A 2022 report on the state of disability rights found that “disabled people continue to face widespread discrimination in Aotearoa New Zealand”.³⁷⁶ A 2023 report on the experiences of Takatāpui and Rainbow rangatahi in care found that “most rangatahi experienced ongoing and normalised transphobic, biphobic, homophobic or interphobic microaggressions while in care.”³⁷⁷
718. The Inquiry have a range of recommendations relating to public awareness, training and education programmes, including social and educational campaigns (Recommendation 111), and training and education of NZ Police, investigators, prosecutors, lawyers, and judges (Recommendation 33), staff and care workers (Recommendation 63), and people in religious or pastoral ministry (including clergy, lay people and volunteers) (Recommendation 64).
719. The Inquiry envisages the Care Safe Agency (Recommendation 41) will take a lead role in developing consistent modules on identifying and preventing abuse and neglect in care, and on addressing prejudice and all forms of discrimination, in accordance with its implementation recommendations in Chapter 6.

375 Mana Mokopuna – Children and Young People’s Commission, Without racism Aotearoa would be better, MSC0500563 (March 2024, page 55).

376 Disabled People’s Organisations (DPO) Coalition, the Ombudsman and Te Kāhui Tika Tangata Human Rights Commission, Disability Rights: How is New Zealand doing? An update report about the state of disability rights in New Zealand, MSC0008921 (2022, page 21).

377 Clunie, M, Fenaughty, J, Haunui, K, Hamilton, T, Lockie, A, Mackie, K, Metzger, N, Radford-Poupard, J, Sade-Inia, J, Shippam, M & Wi-Hongi, A, Making Ourselves Visible: The Experiences of Takatāpui and Rainbow Rangatahi in Care, MSC0010279 (Point and Associates and the Community Design Team, 2023, page 33).

Tūtohi | Recommendation 128

In implementing all recommendations relating to public awareness and training and education programmes, the government and faith-based entities should ensure that these programmes include:

- a. preventing, identifying and responding to abuse and neglect, including:
 - i. challenging myths and stereotypes about abusers, bystanders and survivors of abuse and neglect in care
 - ii. helping victims and survivors of abuse and /or neglect, and their whānau and support networks, to minimise shame and self-stigma, recognise the abuse and /or neglect was not their fault and to safely disclose and report as soon as possible
 - iii. understanding what constitutes abuse and neglect
 - iv. recognising the signs of abuse and neglect
 - v. recognising grooming and other inappropriate behaviours
 - vi. understanding how to respond appropriately to abuse and neglect, including complaints, reports and disclosures
- b. addressing prejudice and all forms of discrimination, including:
 - i. racism
 - ii. ableism and disablism
 - iii. sexism
 - iv. homophobia and transphobia
 - v. negative attitudes towards children and young people.

Ko ngā kaimahi o tēnei tari me whai pukenga whānui, wheako purapura ora, e hua ai ngā pānga ki te Tiriti o Waitangi

New entity appointments to reflect diversity, survivor experience and expertise and give effect to te Tiriti o Waitangi

-
720. During the Inquiry period, the State lacked diversity and lived experience of care in its leadership and across the public service. This contributed to policy that did not reflect the needs and experiences of people in care.

721. The 2018 He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction noted that “...people with lived experience are too often on the periphery; they should be included in mental health and addiction governance, planning, policy and service development”.³⁷⁸
722. The Inquiry also found that Māori were frequently excluded from decision-making and participation in the design and implementation of Crown policy and legislation relating to the care system, as guaranteed in te Tiriti o Waitangi. This was a key finding of the Waitangi Tribunal in their inquiry into Oranga Tamariki.³⁷⁹ It also noted the ongoing failure of the Crown to “adopt and implement recommendations” of the Puao-te-ata-tu report.³⁸⁰
723. Diversity of experience in leadership, governance, staffing and advisory roles ensures that a range of perspectives can inform decision-making and give effect to te Tiriti o Waitangi. Having a range of people with different experiences, competencies and skills also ensures that the new entities will be more flexible, responsive and open to new ideas. This is a key part of enabling good decisions, governance and management that can achieve better outcomes for people in care and their whānau and communities.

Tūtohi | Recommendation 129


The government should ensure, in implementing the recommendations in the Inquiry's final report and the Holistic Redress Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui, that appointments to governance and advisory roles:

- a. appropriately reflect survivor experience and expertise
- b. appropriately and proportionately reflect the diversity of people in care
- c. give effect to te Tiriti o Waitangi.

³⁷⁸ Government Inquiry into Mental Health and Addiction, He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, MSC0008109 (Wellington, 2018, page 161).

³⁷⁹ Waitangi Tribunal, Wai 2915, He Pāharakeke, He Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry, Pre-publication version (2021, page 18).

³⁸⁰ Waitangi Tribunal, Wai 2915, He Pāharakeke, He Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry, Pre-publication version (2021, page 18).



Kia mārama, kia pono ki ngā whāinga tūmatanui e hua ai ngā tūtohinga o tēnei Pakirehua

Transparency and public accountability for implementing the Inquiry's recommendations

Ko ngā whakahoki kōrero mo ngā whakakitenga me ngā whakatau o te Pakirehua, me whakapuaki tūmatanui i roto i te 6 marama

Responses to the Inquiry's findings and recommendations must be made publicly available within 6 months

724. To further build trust and promote transparency with survivors, whānau and communities, the government and faith-based institutions must ensure that their responses to the findings and recommendations are published along with their commentary on which findings have been accepted. Where findings have not been accepted, government and faith-based institutions must include commentary explaining why they have not been.
725. The Inquiry envisages that all organisations and entities specified in its recommendations will transparently respond to the recommendations relevant to them.

Tūtohi | Recommendation 130

The government and faith-based institutions should publish their responses to this report and the Inquiry's interim reports, including whether they accept each of the Inquiry's findings in whole or in part, and the reasons for any disagreement. The responses should be published within two months of this report being tabled in the House of Representatives.

Tūtohi | Recommendation 131

The government and faith-based institutions should issue formal public responses to this report about whether each recommendation is accepted, accepted in principle, rejected or subject to further consideration. Each response should include a plan for how the accepted recommendations will be implemented, the reasons for rejecting any recommendations, and a timeframe for any further consideration required. Each response should be published within four months of this report being tabled in the House of Representatives.

Me māwhiti i ngā roopu tōrangapū katoa te whakaetanga ki te whakatinana i ngā whakatau

Cross-political party agreement to implement recommendations required

726. During the Inquiry period, despite numerous reports and recommendations to improve the different aspects of care systems and settings, the government's responses were often piecemeal and reactive. A lack of commitment, transparency and accountability for recommendations has meant that many have not been implemented or they have been superseded by subsequent reports and recommendations.
727. Children, young people and adults in care have the right to be safe from abuse. The changes needed to ensure care in Aotearoa New Zealand is safe are significant and will take time to be effectively implemented. Short-termism and incremental changes have been a barrier to progress in the past and the Inquiry calls on all political parties and policy makers to ensure that this does not inhibit future changes. A significant step has been taken with the completion of this Inquiry, however, there remains a bigger task in implementing the changes needed. Cross-party agreement on the implementation of these recommendations will ensure that as a nation, we can transform the way the we care for children, young people and adults.

Tūtohi | Recommendation 132

The government should seek cross-party agreement to implement this Inquiry's recommendations.

Te whakamau i ngā kaiwhakatau kaupapa kia ū te tohe e hua ai he tikanga kē

Holding decision-makers to account for ensuring change

728. In Part 7 the Inquiry found there was a consistent lack of accountability for decision makers for their failure to keep people in care safe and to address the systemic causes of abuse in care. There was also a lack of strategic direction and transparency about the piecemeal changes to the care system.

729. The government Child and Youth Wellbeing Strategy 2019 stated that “there are too many policies that were developed and implemented in silos”.³⁸¹ A 2024 report from the Independent Children’s Monitor on agency compliance with national care standards found that:

“Our monitoring over the last three years has shown that government agencies do not always work effectively together to support tamariki and rangatahi in care. Particularly in education and health, individual government agency policy settings can sometimes delay or prevent access to services and support.”³⁸²

730. It is therefore critical to ensure that accountability mechanisms are built into the implementation process for the Inquiry’s recommendations. Public, annual reporting of progress of implementation enables visibility by the public and key parties including survivors. This will support accountability but also allows communities to remain informed of progress and meaningfully participate in the implementation process.

731. The Inquiry recommends the annual reports of all entities implementing the Inquiry’s recommendations are considered by a parliamentary select committee to ensure that there is appropriate parliamentary scrutiny of the implementation of the recommendations.

Tūtohi | Recommendation 133

The government, faith-based institutions and any other agencies that implement the Inquiry’s recommendations should:

- a. publicly report on the implementation of the Inquiry’s recommendations contained in the final report and all previous interim reports, including the implementation status of each recommendation and any identified issues and risks
- b. publish the implementation report annually for at least 9 years, commencing 12 months after the tabling of this report in the House of Representatives and provide a copy to the Care System Office and Care Safe Agency.

Tūtohi | Recommendation 134

The annual implementation reports should be submitted to and considered by a parliamentary select committee.

³⁸¹ Child and Youth Wellbeing Strategy 2019 (Department of Prime Minister and Cabinet, August 2019, page 13).

³⁸² Experiences of Care in Aotearoa: Agency Compliance with the National Care Standards and Related Matters Regulations 1 July 2022–30 June 2023 (Independent Children’s Monitor, 2024, page 12).

He wātaka, he ahunga mahi e tinana ai ngā whakataua o te Pakirehua

Timeframe and approach for the implementation of Inquiry recommendations

732. In the past, regulation of care systems and changes that were made tended to occur without appropriate partnership and collaboration. To ensure that government, faith-based entities and communities across Aotearoa New Zealand can make the transformation needed together, the approach to implementing the Inquiry's recommendations must be open and transparent. As described in Part 8, the Inquiry is concerned that the government response to He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui has not been adequately communicated to survivors and stakeholders, and progress has stalled. Aotearoa New Zealand cannot afford to delay action any longer.
733. As discussed in Chapter 2, the Inquiry foresees at least three phases of work on the pathway to realising he Māra Tipu between now and 2040:
- a. Phase 1 (2024–2030):** Implementing the Inquiry's recommendations and consolidating change
 - b. Phase 2 (2031):** Review Phase 1 and implement next steps towards he Māra Tipu
 - c. Phase 3 (2032–2040):** Review Phase 2 and implement final next steps towards he Māra Tipu
734. Chapter 9 sets out the Inquiry's recommended approach to implementation timeframes, including the leading or coordinating entity or entities.

Tūtohi | Recommendation 135

The government and faith-based entities should implement the Inquiry's recommendations in line with the timeframes described in this report, whilst ensuring there is open and transparent communication with communities with whom they are co-designing the future arrangements for care.

Te arotakenga motuhake mo te whakatinanatanga o ngā whakatau o te Pakirehua, me tīmata i roto i te 9 tau

Independent review of implementation of Inquiry's recommendations to be initiated in 9 years

735. As discussed in Chapter 3, the Inquiry recommends three stages of work to implement the Inquiry's recommendations and achieve He Māra Tipu. After the recommendations are implemented and consolidated (Phase 1 and 2), Phase 3 will involve reviewing and deciding on next steps.
736. This consists of a pause and reassessment – where the State, faith-based institutions, people in care, whānau and communities come together and consider progress and the next steps that are needed to progress to He Māra Tipu.
737. An independent review should be undertaken seven years after the tabling of this report. It needs to be independent to ensure there is objective scrutiny of progress. It is also critical there is an open process where survivors, non-government organisations, hāpori Māori, iwi and hapū, Te Kāhui Tika Tangata Human Rights Commission and other significant bodies can make submissions to the review panel.
738. It will require the scrutiny of a parliamentary select committee, and State and faith-based institutions should publish formal responses to the review. This will enable transparency about how each setting will address recommendations and the next steps to progress to He Māra Tipu.

Tūtohi | Recommendation 136

The government should initiate an independent review to be completed by 9 years after the tabling of the final report. This review should:

- a. establish the extent to which the Inquiry's recommendations have been implemented 9 years after the tabling of the final report
- b. examine the extent to which the measures taken in response to the Inquiry have been effective in preventing abuse and neglect in care, improving the responses of all entities providing care directly or indirectly to abuse and neglect in care and ensuring that victims and survivors of abuse and neglect in care obtain justice, treatment and support
- c. advise on what further steps should be taken by governments and all entities providing care directly or indirectly to ensure continuing improvement in policy and service delivery in relation to abuse and neglect in care.




Tūtohi | Recommendation 137

The government's implementation reports, and the independent 9-year review should be tabled in the House of Representatives and referred to a parliamentary select committee for consideration.



Tūtohi | Recommendation 138

The government and faith-based institutions should publish formal responses to the independent 9-year review, indicating whether its advice on further steps is accepted, accepted in principle, rejected or subject to further consideration. Each response should include a plan for how the accepted recommendations will be implemented, the reasons for rejecting any recommendations, and a timeframe for any further consideration required. Each response should be published by 31 December 2033.



"In Tongan culture, you become almost cursed for going up against the church. If you go up against the church and do something against what everyone believes in, anything wrong that later happens in your life or any problems that arise are considered to be a result of you speaking up against the church. There is a very powerful sense of being observed and judged by the Tongan community!"

MS CU
Tongan

Ūpoko | Chapter 9

He wātaka whakatinanatanga

Implementation timetable

739. The tables below summarise the Inquiry’s recommended approach to implementation. The tables identify the entity or entities that the Inquiry expects will lead or co-ordinate implementation, and the timeframe by which the recommendation will be implemented. The timeframes set out in the tables below, such as “within 6 months”, means within that timeframe after the Inquiry’s final report is tabled in the House of Representatives. The Inquiry expects that all recommendations will be implemented in accordance with Recommendations 126 and 127.

Te whakatika i ngā hē o ngā ra o mua

Righting the wrongs of the past

Implement the new puretumu torowhānui system and scheme as an immediate priority

Recommendation	Lead or co-ordinating entity/ies	Timeframe
1. Implement the 95 Holistic Redress Recommendations in He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui	Care System Office (co-ordinator) Some of the 95 Holistic Redress Recommendations will be led by other government agencies. For example, the lead agency for Holistic Redress Recommendation 78 (amending the Limitation Act 1950 and Limitation Act 2010) is the Ministry of Justice.	Start immediately, complete within 18 months

Key leaders to make public acknowledgements and apologies

Recommendation	Lead or co-ordinating entity/ies	Timeframe
2. National apology in the House of Representatives	Department of the Prime Minister and Cabinet	Complete within 6 months
3. Public acknowledgments and apologies	All senior leaders of State and faith-based entities (including indirect care providers) and relevant professional bodies that have provided, or are providing, care	Complete within 6 months
4. Order of the Brothers of St John of God in Papua New Guinea	The Archbishop of Wellington (Catholic)	Complete within 6 months

Review the appropriateness of street names, public amenities named after a proven perpetrator

Recommendation	Lead or co-ordinating entity/ies	Timeframe
5. Streets, public amenities, public honours and memorials	All State and faith-based entities (including indirect care providers) that have provided, or are providing, care Local authorities and other relevant entities	Complete within 24 months

Take steps to determine liability for torture, or cruel, inhuman, or degrading treatment or punishment

Recommendation	Lead or co-ordinating entity/ies	Timeframe
6. Investigations to determine to determine liability for torture, or cruel, inhuman, or degrading treatment or punishment	NZ Police	Start immediately
7. Assist with NZ Police investigations into liability for torture, or cruel, inhuman, or degrading treatment or punishment	All State and faith-based entities (including indirect care providers) that have provided, or are providing, care	Start immediately

Ensure faith-based institutions and indirect State care providers join the puretumu torowhānui system and scheme

Recommendation	Lead or co-ordinating entity/ies	Timeframe
8. Faith-based institutions and indirect care providers to join puretumu torowhānui system and scheme	Puretumu Torowhānui Agency	Start immediately, complete within 12 months
9. Survivor awareness of puretumu torowhānui system and scheme and support options	All faith-based entities and indirect care providers that have provided, or are providing, care	Start immediately, complete within 18 months

Backdate eligibility for the puretumu torowhānui system and scheme to December 2021

Recommendation	Lead or co-ordinating entity/ies	Timeframe
10. Backdate eligibility for the puretumu torowhānui system and scheme	Care System Office	Complete within 12 months

Compensate survivors of abuse and neglect in care

Recommendation	Lead or co-ordinating entity/ies	Timeframe
11. Reform accident compensation (ACC) scheme to provide compensation for survivors	Ministry of Business, Innovation and Employment	Complete within 24 months

Order of the Brothers of St John of God specific actions

Recommendation	Lead or co-ordinating entity/ies	Timeframe
12. New and reopened claims about Marylands School, St Joseph's Orphanage and Hebron Trust	The Bishop of the Diocese of Christchurch	Start immediately First public report within 6 months
13. Marylands School, St Joseph's Orphanage and Hebron Trust survivors awareness of the new puretumu torowhānui system and scheme	The Bishop of the Diocese of Christchurch and the Provincial of the Oceania Province of the St John of God Brothers	Complete within 12 months

Give effect to te Tiriti o Waitangi in the puretumu torowhānui system and scheme

Recommendation	Lead or co-ordinating entity/ies	Timeframe
14. Puretumu torowhānui system and scheme gives effect to te Tiriti o Waitangi	Puretumu Torowhānui Agency	Complete design within 6 months

Embed human rights into the puretumu torowhānui system and scheme

Recommendation	Lead or co-ordinating entity/ies	Timeframe
15. Puretumu torowhānui system and scheme upholds human rights	Puretumu Torowhānui Agency	Complete design within 6 months
16. Performance indicators for puretumu torowhānui system and scheme	Puretumu Torowhānui Agency	Complete within 6 months
17. Report on performance of puretumu torowhānui system and scheme	Puretumu Torowhānui Agency	Within 12 months of completing implementation of Recommendation 16

Review Lake Alice settlements for parity

Recommendation	Lead or co-ordinating entity/ies	Timeframe
18. Independent review of Lake Alice Child and Adolescent Unit settlements	Care System Office	Appoint independent reviewer within 3 months Complete review within 9 months after appointment

Establish an independent investigation of unmarked graves and urupā

Recommendation	Lead or co-ordinating entity/ies	Timeframe
19. Independent investigation of potential unmarked graves and urupā	Care System Office	Appoint independent advisory group within 6 months Complete investigation within 2 years after appointment

Establish a fund for projects connected to community harm arising from the cumulative impact of abuse and neglect in care

Recommendation	Lead or co-ordinating entity/ies	Timeframe
20. Fund for projects addressing collective harm	Care System Office, and faith-based institutions that provided, or provide, care	Establish fund and start operating it within 18 months

Whānau payments for whānau of survivors of abuse and neglect in care

Recommendation	Lead or co-ordinating entity/ies	Timeframe
21. Whānau harm payment to address intergenerational harm	Care System Office	Commence payments within 18 months

Amend prosecution guidelines

Recommendation	Lead or co-ordinating entity/ies	Timeframe
22. Amend the Solicitor-General's prosecution guidelines	Crown Law Office	Complete within 12 months
23. Prosecution guidelines for complainants, witnesses and defendants who are Deaf, disabled and /or experience mental distress	Crown Law Office	Complete within 12 months
24. Training for prosecutors on new and amended guidelines	Crown Law Office	Start within 13 months

Support judicial initiatives that address the causes of offending

Recommendation	Lead or co-ordinating entity/ies	Timeframe
25. Support and invest in judicial-led initiatives that recognise and address harm	Ministry of Justice	Secure new investment within 12 months

Criminal justice legislative changes

Recommendation	Lead or co-ordinating entity/ies	Timeframe
26. Amend the Crimes Act 1961	Ministry of Justice	Complete within 2 years
27. Amend the Sentencing Act 2002	Ministry of Justice	Complete within 2 years
28. Amend the Oranga Tamariki Act 1989	Oranga Tamariki / Ministry of Social Development	Complete within 2 years
29. Review the Criminal Records (Clean Slate) Act 2004	Ministry of Justice	Complete within 2 years
30. Amend the Victims' Rights Act 2002	Ministry of Justice	Complete within 2 years
31. List of specialist lawyers to give legal advice on puretumu torowhānui system and scheme	Ministry of Justice	Complete within 2 years
32. Amend the Evidence Act 2006	Ministry of Justice	Complete within 2 years

Education and training for people involved in the justice system

Recommendation	Lead or co-ordinating entity/ies	Timeframe
33. Training for investigators, prosecutors, lawyers, and judges	Ministry of Justice, Te Kura Kaiwhakawā / Institute of Judicial Studies, NZ Police, Crown Law Office and New Zealand Law Society	Start training within 12 months

Amend investigation guidelines and establish a specialist investigation unit

Recommendation	Lead or co-ordinating entity/ies	Timeframe
34. Review the Police Manual	NZ Police	Complete within 12 months
35. Specialist unit for investigating and prosecuting abuse and neglect in care	NZ Police	Set up immediately

Civil justice legislative changes

Recommendation	Lead or co-ordinating entity/ies	Timeframe
36. Prioritise civil proceedings to minimise litigation delays	District Court, High Court, Court of Appeal and Supreme Court	Start immediately
37. Review the Legal Services Act 2011	Ministry of Justice	Complete within 2 years
38. Amend the Evidence Act 2006 (civil proceedings)	Ministry of Justice	Complete within 2 years



Te tauāraitanga o te tangata noho pūnaha taurima

Safeguarding people in care

Principles for preventing and responding to abuse and neglect in care

Recommendation	Lead or co-ordinating entity/ies	Timeframe
39. Implement Care Safety Principles	Care System Office, Care Safe Agency and All State and faith-based entities and providing care (including indirect care providers)	Start immediately

National Care Safety Strategy

Recommendation	Lead or co-ordinating entity/ies	Timeframe
40. Implement a National Care Safety Strategy on the prevention of, and response to, abuse and neglect and in care	Care Safe Agency	Complete within 12 months of the establishment of the Care Safe Agency

Establishing a new independent Care Safe Agency

Recommendation	Lead or co-ordinating entity/ies	Timeframe
41. Establish a new independent Care Safe Agency (in Care Safety Act)	Care System Office	Complete within 18 months
42. Care Safe Agency to report annually to a parliamentary select committee (in Care Safety Act)	Care System Office	Complete within 18 months
43. Review the roles, functions and powers of government agencies involved in the care system	Care System Office	Start immediately and complete within 9 months
44. Establish a Departmental Agency to perform Care Safe Agency functions in interim	Public Service Commission	Start immediately

Establishing a new Care Safety Act

Recommendation	Lead or co-ordinating entity/ies	Timeframe
45. Enact Care Safety Act	Care System Office	Complete within 18 months
46. Review all legislation and regulations relating to the care of children, young people and adults	Care System Office	Start immediately and complete within 9 months

Consistent and comprehensive care safety standards and penalties for non-compliance

Recommendation	Lead or co-ordinating entity/ies	Timeframe
47. Establish a duty of care, statutory ability to set, monitor and enforce care safety rules and standards, and provide for sanctions and penalties (in Care Safety Act)	Care System Office	Complete within 18 months

Care providers to be accredited and prioritise safeguarding

Recommendation	Lead or co-ordinating entity/ies	Timeframe
48. Create a system for the accreditation of entities providing care (in Care Safety Act)	Care System Office	Complete within 18 months
49. Make changes to charities regulation and legislation (in Care Safety Act)	Care System Office and Department of Internal Affairs	Complete within 18 months
50. Ensure there is effective oversight and leadership of safeguarding	Leaders of all State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established
51. Ensure that safeguarding is a genuine priority, key performance indicators are in place, and sufficient resources are available for all aspects of safeguarding	Leaders of all State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established
52. Collect adequate data on abuse and neglect in care and regularly report to the governing bodies or leaders	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established
53. Ensure staffing, remuneration and resourcing levels are sufficient to ensure implementation of safeguarding policies and procedures	Senior leaders of all State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established

Recommendation	Lead or co-ordinating entity/ies	Timeframe
54. Take active steps to create a positive safeguarding culture	Senior leaders of all State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established
55. Safeguarding policies and procedures are in place	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established
56. How safeguarding policies and procedures work	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established



Staff and care workers to be appropriate, vetted, registered, supported and well trained

Recommendation	Lead or co-ordinating entity/ies	Timeframe
57. Create a system of professional registration for all staff and care workers not already covered by a professional standards regime (in Care Safety Act)	Care System Office	Complete within 18 months
58. Provide for a comprehensive and consistent pre-employment screening and vetting regime (in Care Safety Act)	Care System Office, Oranga Tamariki and NZ Police	Complete within 18 months
59. Ensure all prospective staff and volunteers have a satisfactory vetting report and up to date registration status	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established
60. Ensure all pre-employment screening checks meet requirements	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and after Care Safe Agency established
61. Develop a Care Workforce Strategy	Care Safe Agency	Complete within 12 months of the establishment of the Care Safe Agency
62. Recruit for and support a diverse workforce	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safe Agency established
63. Code of conduct and appropriate training in place for staff	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safe Agency established
64. Ensure workforce rules and standards apply equally to all staff and care workers, including volunteers, people in religious ministry and lay people	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and Care Safe Agency established

Complaints are responded to effectively

Recommendation	Lead or co-ordinating entity/ies	Timeframe
65. Ensure appropriate complaints policies and procedures are in place	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and Care Safe Agency established
66. Person responsible is held to account for substantiated abuse and /or neglect	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately Make any necessary changes within 12 months after Care Safety Act comes into force and Care Safe Agency established
67. Report all complaints, disclosures or incidents to the Care Safe Agency	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately after Care Safe Agency established
68. Collate and keep a centralised database of complaints, disclosures or incidents of abuse and neglect	Care Safe Agency	Set up database within 18 months of the establishment of the Care Safe Agency
69. Create a coherent mandatory reporting regime (in Care Safety Act)	Care System Office	Complete within 18 months

Institutional environments and practices to be minimised and ultimately eliminated

Recommendation	Lead or co-ordinating entity/ies	Timeframe
70. Prioritise and accelerate current work to close care and protection residences	Oranga Tamariki	Start immediately Complete within 2 years
71. Support and invest in models of care that do not perpetuate institutional environments and practices, including physical redesign where needed	Care System Office (lead) with Oranga Tamariki, Ministry of Health, Te Whatu Ora Health New Zealand, Whaikaha and Ministry of Education	Start immediately Complete within 2 years
72. Take steps to ban pain compliance techniques	Care System Office (lead) with Oranga Tamariki, Ministry of Health, Te Whatu Ora Health New Zealand, Whaikaha and Ministry of Education, NZ Police	Start immediately Complete within 2 years
73. Ensure there are adequate frameworks in place to govern and minimise the use of restrictive practices	Care System Office (lead) with Oranga Tamariki, Ministry of Health, Te Whatu Ora Health New Zealand, Whaikaha and Ministry of Education, NZ Police	Start immediately Complete within 2 years
74. Prioritise and accelerate work to minimise and eliminate solitary confinement as appropriate in all care settings as soon as practicable	Care System Office (lead) with Oranga Tamariki, Ministry of Health, Te Whatu Ora Health New Zealand, Whaikaha and Ministry of Education	Start immediately Complete within 2 years
75. Review physical building and design features and address risks	All State and faith-based entities that are providing care (including indirect care providers)	Complete within 12 months

People in care are empowered and supported

Recommendation	Lead or co-ordinating entity/ies	Timeframe
76. Set up a system of independent advocates for all people in care	Care System Office and Care Safe Agency	Secure investment within 18 months Advocates trained and starting to come on board within 2 months of establishment of Care Safe Agency
77. Develop a career pathway for people with previous lived experience of care towards becoming an independent advocate	Care Safe Agency	Complete within 12 months of the establishment of the Care Safe Agency
78. Seek the best possible understanding of the background, culture, needs and vulnerabilities of people in care	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately
79. Review existing policy, standards and practice to ensure care placements are suitable and support connection to whānau and community	Care System Office (lead) with Oranga Tamariki, Ministry of Health, Te Whatu Ora Health New Zealand, Whaikaha, Ministry of Justice, District Court (Family Court and Youth Court)	Start immediately, complete within 12 months
80. Review existing policies and practice to ensure they support connections and attachment to family and whānau	All State and faith-based entities that are providing care (including indirect care providers)	Within 18 months of the establishment of the Care Safe Agency

Best practice data collection, record keeping and information sharing

Recommendation	Lead or co-ordinating entity/ies	Timeframe
81. Comply with best practice guidelines for record keeping and data sovereignty, including record keeping principles	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately
82. Document an account of person in care's life	All State and faith-based entities that are providing care (including indirect care providers)	Start immediately
83. Require records relating to alleged abuse and neglect in care to be kept for least 75 years in a separate central register	Department of Internal Affairs	Complete within 6 months
84. Consider whether existing information sharing provisions are sufficient	Care System Office and Privacy Commissioner	Complete within 12 months

Independent oversight and monitoring is coherent and well-resourced

Recommendation	Lead or co-ordinating entity/ies	Timeframe
85. Review independent monitoring and oversight entities for duplication and to encourage collaboration	Care System Office (lead) with Ministry of Justice, Ministry of Social Development, Ministry of Health	Complete within 2 years
86. Ensure that there are no unreasonable barriers to responsible oversight bodies being able to investigate complaints and proactively monitor the care system	Care System Office (lead) with Ministry of Justice, Ministry of Social Development and Ministry of Health	Complete within 2 years
87. Oversight bodies investigate complaints, proactively monitor care providers, publish reports and share information with the Care Safe Agency	Responsible oversight bodies	Start immediately Make any necessary changes within 12 months after Recommendations 86 and 87 implemented

Recommendation about Gloriavale

Recommendation	Lead or co-ordinating entity/ies	Timeframe
88. Ensure the ongoing safety of children, young people and adults in care at Gloriavale	Care System Office	Start immediately



Kia āhuru ngā mahi atawhai ā-whakapono

Making faith-based care safe

Recommendations to all faith-based entities in Aotearoa New Zealand

Recommendation	Lead or co-ordinating entity/ies	Timeframe
<p>89. Comply with Care Safety Principles, National Care Safety Strategy and Care Safety Act statutory requirements and report compliance</p>	<p>All faith-based entities providing care</p>	<p>Comply with Care Safety Principles immediately</p> <p>Comply with National Care Safety Strategy within 3 months of it being published</p> <p>Comply with statutory requirements under Care Safety Act immediately after it comes into force</p> <p>First compliance report within 6 months (and annually after that)</p>
<p>90. Adopt Care Safety Principles, National Care Safety Strategy and Care Safety Act statutory requirements</p>	<p>All faith-based entities providing care</p>	<p>Adopt the Care Safety Principles immediately</p> <p>Adopt National Care Safety Strategy within 3 months of it being published</p> <p>Adopt statutory requirements under Care Safety Act immediately after it comes into force</p>
<p>91. Drive consistent approach to implementing Care Safety Principles, National Care Safety Strategy and Care Safety Act statutory requirements</p>	<p>All faith-based entities providing care</p>	<p>Drive a consistent approach in relation to the Care Safety Principles immediately</p> <p>Drive a consistent approach in relation to National Care Safety Strategy immediately after it is published</p> <p>Drive a consistent approach in relation to statutory requirements under Care Safety Act immediately after it comes into force</p>

Recommendation	Lead or co-ordinating entity/ies	Timeframe
92. Work with Care Safe Agency and independent oversight bodies	All faith-based entities providing care	Start working closely with independent oversight bodies immediately Start working closely with the Care Safe Agency immediately after it is established
93. Leadership training for religious leaders	All faith-based entities providing care	Start training within 12 months
94. Lines of accountability for decisions about preventing and responding to abuse and neglect	All faith-based entities providing care	Complete within 6 months
95. Performance management and oversight for people in religious or pastoral ministry	All faith-based entities providing care	Performance management and oversight in place within 6 months
96. Independent professional supervision for people in religious or pastoral ministry	All faith-based entities providing care	Supervision operational within 12 months
97. Conflict of interest policy about allegations of abuse and neglect	All faith-based entities providing care	Policy and procedure in place within 6 months
98. Training candidates for religious ministry	All faith-based entities providing care	Start immediately
99. Regular safeguarding training for people in religious or pastoral ministry	All faith-based entities providing care	Start immediately
100. Prevention education for people in faith-based care	All faith-based entities providing care	Start immediately
101. Reduce high barriers to disclosure of abuse and neglect	All faith-based entities providing care	Policy and procedure in place within 3 months
102. Publish all policies on preventing and responding to abuse and neglect	All faith-based entities providing care	Publication within 3 months
103. Initial risk assessment when complaint received	All faith-based entities providing care	Policy and procedure in place within 3 months
104. Stand down procedures for people in religious ministry subject to complaints	All faith-based entities providing care	Policy and procedure in place within 3 months
105. Assess complaints according to case law standards	All faith-based entities providing care	Policy and procedure in place within 3 months



Recommendation	Lead or co-ordinating entity/ies	Timeframe
106. Same investigative standards regardless of whether person is in religious ministry	All faith-based entities providing care	Policy and procedure in place within 3 months
107. Permanently remove a person in religious ministry if complaint is substantiated	All faith-based entities providing care	Policy and procedure in place within 3 months
108. Remove status of a person in religious ministry convicted of abuse and neglect offence	All faith-based entities providing care	Policy and procedure in place within 3 months
109. Risk assessment where congregant has substantiated complaint or conviction	All faith-based entities providing care	Policy and procedure in place within 3 months
110. National register of people in religious or pastoral ministry with complaints and convictions	All faith-based entities providing care and Care System Office	Register operational within 12 months



Te whakamana me te whakapakari hāpori

Entrusting and empowering communities

Communities are empowered to minimise the need for out of whānau care

Recommendation	Lead or co-ordinating entity/ies	Timeframe
111. Nationwide social and educational campaign to address discriminatory beliefs	Care System Office (investment) and Care Safe Agency (campaign)	Secure investment within 2 years Complete campaigns within 5 years
112. Nationwide social and educational campaigns to challenge myths and stereotypes	Care System Office (investment) and Care Safe Agency (campaign)	Secure investment within 2 years Complete campaigns within 5 years
113. Disseminate and publicise the findings and recommendations of this Inquiry	Care System Office and faith-based entities that provided, or provide, care	Complete within 6 months
114. Accelerate existing work, and review existing laws and other arrangements, to enable participation, and bring communities into, in decision-making	Care System Office (lead), Ministry of Health, Te Whatu Ora Health New Zealand, Oranga Tamariki, Ministry of Justice, District Court (Family Court and Youth Court)	Complete with 2 years
115. Prioritise and invest in contemporary approaches to delivery of care and support	Social Investment Agency	Start immediately
116. Establish an independent commissioning entity	Care System Office and Social Investment Agency	Complete within 18 months

Giving effect to te Tiriti of Waitangi and human rights

Recommendation	Lead or co-ordinating entity/ies	Timeframe
117. Partner with iwi to give effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples in relation to care functions	All State entities providing care (including indirect care providers)	Start immediately
118. All entities providing care uphold the human rights of people in care	All State and faith-based entities providing care (including indirect care providers)	Start immediately
119. Review Aotearoa New Zealand's human rights framework	Ministry of Justice (lead) with Whaikaha (regarding the rights of disabled people)	Complete within 2 years
120. Establish human rights performance indicators for all entities providing care	Care System Office	Complete within 12 months

Targeted abuse and neglect prevention programmes

Recommendation	Lead or co-ordinating entity/ies	Timeframe
121. Targeted abuse and neglect prevention programmes for communities	Care System Office (investment) and Care Safe Agency (programme delivery)	Secure investment within 18 months Start programmes within 12 months after establishment of Care Safe Agency
122. Targeted programmes for those who may be at risk of perpetrating abuse and neglect	Care System Office (investment) and Care Safe Agency (programme delivery)	Secure investment within 18 months Start programmes within 12 months after establishment of Care Safe Agency

Mai i kōnei ki tua i ngā tūtohi a te Pakirehua

Implementing the Inquiry's recommendations

Establishing the Care System Office to lead implementation

Recommendation	Lead or co-ordinating entity/ies	Timeframe
123. Establish the Care System Office	Public Service Commission	Complete within 2 months
124. Set functions of Care System Office	Public Service Commission	Complete within 2 months

Taking any and all actions needed to give effect to these recommendations

Recommendation	Lead or co-ordinating entity/ies	Timeframe
125. Take all actions required to give effect to all recommendations	Care System Office and faith-based entities that provided, or provide, care	Start immediately

Design and implementation of all recommendations to give effect to te Tiriti o Waitangi and UNDRIP and be co-designed with communities

Recommendation	Lead or co-ordinating entity/ies	Timeframe
126. Partner with iwi to give effect to te Tiriti o Waitangi and the United Nations Declaration on the Rights of Indigenous Peoples	All entities responsible for implementing Recommendations	Start immediately
127. Implementation of Recommendations co-designed and evaluated with communities.	All entities responsible for implementing Recommendations	Start immediately

Public awareness, training and education programmes to identify and prevent abuse and neglect, and address prejudice and discrimination

Recommendation	Lead or co-ordinating entity/ies	Timeframe
128. Public awareness, training and education programmes cover preventing abuse and neglect	All entities responsible for implementing public awareness, training or education programme Recommendations	Start immediately

New entity appointments to reflect diversity, survivor experience and expertise and give effect to te Tiriti o Waitangi

Recommendation	Lead or co-ordinating entity/ies	Timeframe
129. Appointments to governance and advisory roles reflect care population and give effect to te Tiriti o Waitangi	Care System Office	Start immediately

Transparency and public accountability for implementing Inquiry recommendations

Recommendation	Lead or co-ordinating entity/ies	Timeframe
130. Publish responses to the Inquiry's recommendations	All entities responsible for implementing Recommendations	Within 2 months
131. Issue public responses to this report including implementation plans.	All entities responsible for implementing Recommendations	Within 4 months
132. Seek cross-party agreement to implement the recommendations.	Parliamentary political parties	Start immediately
133. Report annually on implementation of the recommendations.	All entities responsible for implementing Recommendations	First report within 12 months, and then annually
134. Annual implementation reports to be considered by a parliamentary select committee	All entities responsible for implementing Recommendations (draft reports), Care System Office (collate reports), Responsible Minister (table reports) and House of Representatives (refer to select committee)	First report within 12 months, and then annually
135. Ensure transparent communication with communities	All entities responsible for implementing Recommendations	Start immediately
136. Initiate an independent review for completion 9 years after the tabling of the final report	Care System Office	Start review within 7 years, complete review within 9 years
137. Implementation reports and the 9-year review tabled in the House of Representatives and referred to a parliamentary select committee	All entities responsible for implementing Recommendations (draft reports), Care System Office (collate reports), Responsible Minister (table reports) and House of Representatives (refer to select committee)	Within 3 months of completion of 9-year review
138. Publish formal responses to the 9-year review	All entities responsible for implementing Recommendations	Publication by 31 December 2033



Ūpoko | Chapter 10


Ngā mahi me oti wawe

Urgent need for action

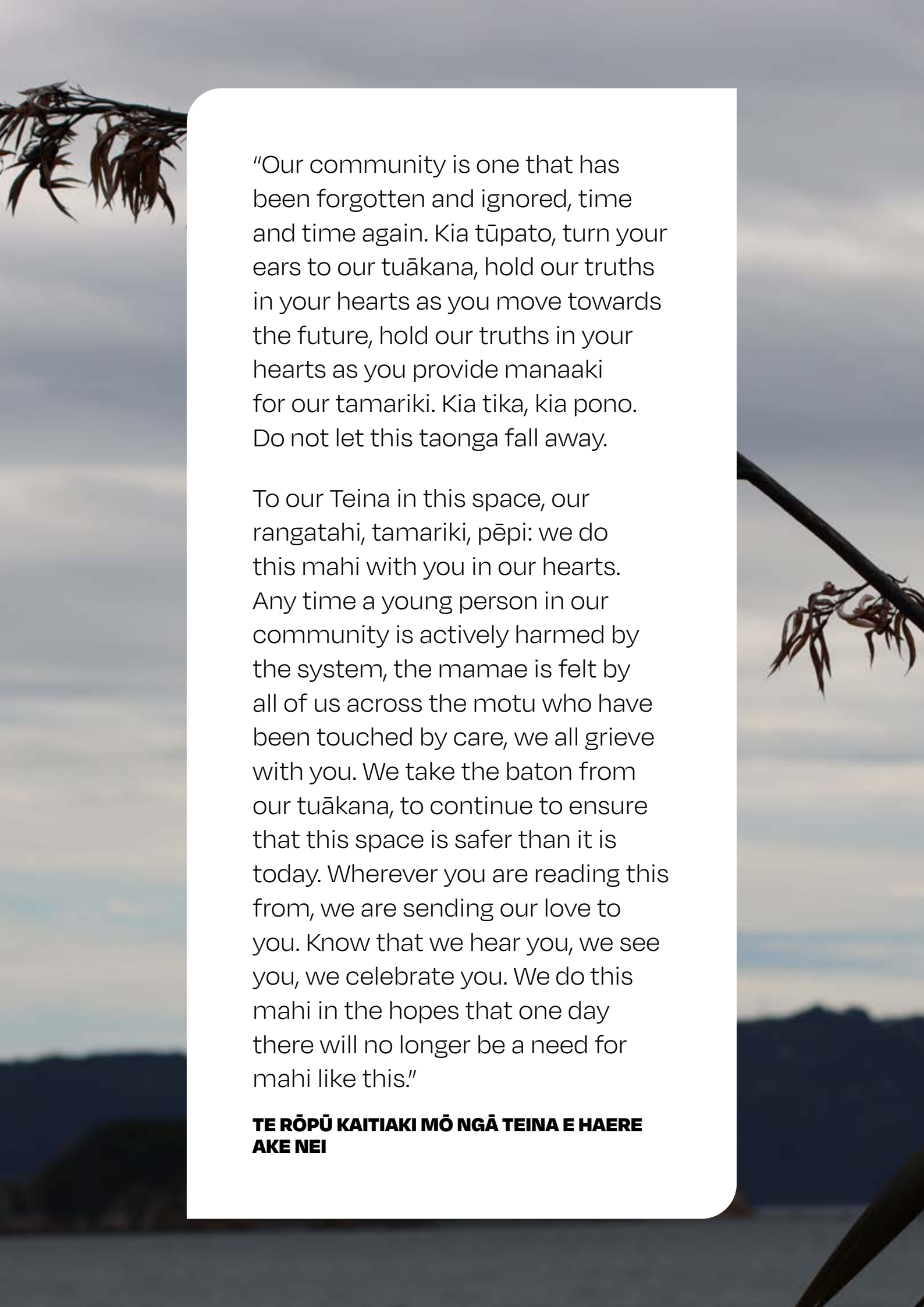
740. This Inquiry was the first of its kind to comprehensively examine Aotearoa New Zealand's care systems, revealing pervasive and systemic abuse and neglect in State and faith-based care during the Inquiry period. The widespread harm the Inquiry has documented has caused long-term trauma to survivors, affecting every aspect of their lives. This harm was not due to a few isolated incidents but was systemic and deeply embedded across all levels of care.
741. In this report, the Inquiry has set out the urgency and importance of the change needed to address the harm, stop abuse and neglect in care and to reach he Māra Tipu. The findings call for a complete overhaul of Aotearoa New Zealand's State and faith-based care systems in social welfare, disability, mental health, education, and transitional and law enforcement and pastoral care settings. The ultimate goal is to ensure that no individual experiences abuse or neglect and that families receive the necessary support to lead fulfilling lives.
742. Full implementation of the Inquiry's recommendations is crucial for improving the lives of survivors and all New Zealanders. The recommendations comprise mutually reinforcing strands woven together into a kākahu (cloak) to right the wrongs of the past and protect against abuse and neglect in care in the future. These recommendations cannot be selectively implemented – missing out any of the strands will create gaps and points of weakness in the kākahu which mean the cycles of abuse and neglect in care will continue. Abuse and neglect in care does not just harm individuals – it imposes a significant burden on whānau, kainga and society. The long-term impacts include poor health outcomes, welfare dependency, and increased crime rates. In Part 7 the Inquiry discussed adverse childhood experiences (ACEs). Having multiple adverse childhood experiences is linked with poor outcomes in adulthood.³⁸³ In the United States, it has been calculated that eradicating multiple adverse childhood experiences would reduce “the overall rate of depression by more than half, alcoholism by two thirds, and suicide, IV drug use and domestic violence by three quarters...it would also vastly decrease the need for incarceration”.³⁸⁴

383 van der Kolk, B, *The body keeps the score: Brain, mind and body in the healing of trauma* (Penguin 2014, page 148).

384 van der Kolk, B, *The body keeps the score: Brain, mind and body in the healing of trauma* (Penguin 2014, page 150).

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743. Imagine an Aotearoa New Zealand where every individual, regardless of age or circumstance, can live without fear of mistreatment, where our reality reflects our ideals, where we have made inroads on some of our most intractable social issues across crime, health and poverty, and where the annual cost of alcoholism, mental distress and domestic violence alone, which collectively cost Aotearoa New Zealand over \$23 billion a year,³⁸⁵ have been more than halved. What could our country be then? What potential might we realise?
744. The Inquiry has completed its investigations, but the work is just beginning. The State and faith-based entities, survivors, activists, academics, journalists, whānau, kainga, collectives and local communities will need to ensure the Inquiry's work is taken forward and the cycle of abuse and neglect in care is transformed into healing and a new era of wellbeing.

³⁸⁵ See for example Government Inquiry into Mental Health and Addiction, He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (Wellington, 2018, page 29); Kahui, s and Snively, S, Measuring the economic cost of child abuse and intimate partner violence in New Zealand (MoreMedia Enterprises, 2014); <https://www.actionpoint.org.nz>.



“Our community is one that has been forgotten and ignored, time and time again. Kia tūpato, turn your ears to our tuākana, hold our truths in your hearts as you move towards the future, hold our truths in your hearts as you provide manaaki for our tamariki. Kia tika, kia pono. Do not let this taonga fall away.

To our Teina in this space, our rangatahi, tamariki, pēpi: we do this mahi with you in our hearts. Any time a young person in our community is actively harmed by the system, the mamae is felt by all of us across the motu who have been touched by care, we all grieve with you. We take the baton from our tuākana, to continue to ensure that this space is safer than it is today. Wherever you are reading this from, we are sending our love to you. Know that we hear you, we see you, we celebrate you. We do this mahi in the hopes that one day there will no longer be a need for mahi like this.”

**TE RŌPŪ KAITIAKI MŌ NGĀ TEINA E HAERE
AKE NEI**

He waiata aroha mō ngā purapura ora

Kāore te aroha i ahau mō koutou e te iwi I mahue kau noa
i te tika
I whakarerea e te ture i raurangi rā Tāmia rawatia ana te
whakamanioro
he huna whakamamae nō te tūkinu
he auhi nō te puku i pēhia kia ngū
Ko te kaikinikini i te tau o taku ate tē rite ai ki te kōharihari o tōu
Arā pea koe rā kei te kopa i Mirumiru-te-pō
Pō tiwhatiwha pōuri kenekene
Tē ai he huringa ake i ō mahara
Nei tāku, 'kei tōia atu te tatau ka tomokia ai'
Tēnā kē ia kia huri ake tāua ki te kimi oranga
E mate Pūmahara? Kāhorehore! Kāhorehore!
E ara e hoa mā, māngai nuitia te kupu pono i te puku o Kareāroto
Kia iri ki runga rawa ki te rangi tihore he rangi waruhia ka awatea
E puta ai te ihu i te ao pakarea ki te ao pakakina
Hei ara mōu kei taku pōkai kōtuku ki te oranga
E hua ai te pito mata i roto rā kei aku purapura ora
Tiritiria ki toi whenua, onokia ka morimoria ai
Ka pihi ki One-haumako, ki One-whakatupu
Kei reira e hika mā te manako kia ea i te utu
Kia whakaahuritia tō mana tangata tō mana tuku iho nā ō rau kahika
Koia ka whanake koia ka manahua koia ka ngawhā
He houkura mārīe mōwai rokiroki āio nā koutou ko Rongo
Koia ka puta ki te whaiāo ki te ao mārama
Whitiwhiti ora e!

– Paraone Gloyne

A Love Song for the Living Seeds

The love within me for you, the people, remains unchanged

Left alone, abandoned by justice and order

Subjected to the silent suffering of mistreatment

A heaviness in the core, silenced into stillness

The gnawing of my heart cannot compare to the anguish of yours

Perhaps you are hidden in the depths of the night, Mirumiru-te-pō

A night dark and dense

Where there may be no turning in your memories

But here's my thought: 'Do not push open the door to enter'

Instead, let us turn to seek life and well-being

Is memory dead? No, certainly not!

Arise, friends, let the truth resound loudly from the heart of Kareāroto

To ascend to the clear skies, a sky washed clean at dawn

Emerging from the troubled world to a world of promise

A path for you, my flock of herons, to life

So, the precious core may blossom within you, my living seeds

Scattered across the land, cherished and growing in abundance

Rising in One-haumako, in One-whakatupu

There, my friends, lies the hope to fulfil the cost

To restore your human dignity, your inherited mana from your ancestors

Thus, it will thrive, flourish, and burst forth

A peaceful feather, a treasured calm, a serene peace from Rongo

Emerging into the world of light, into the world of understanding

A crossing of life indeed!

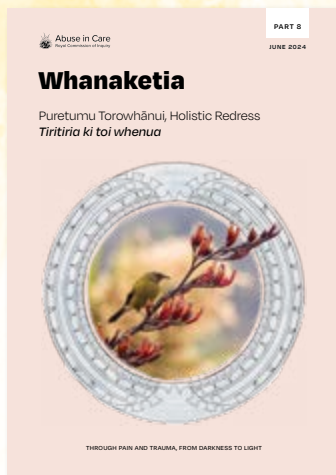
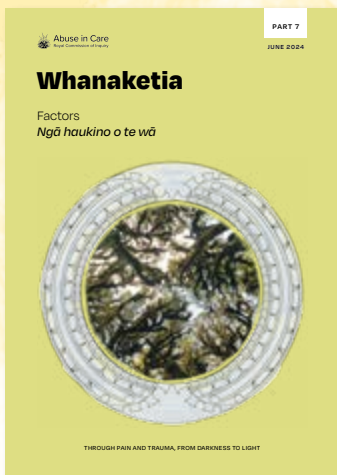
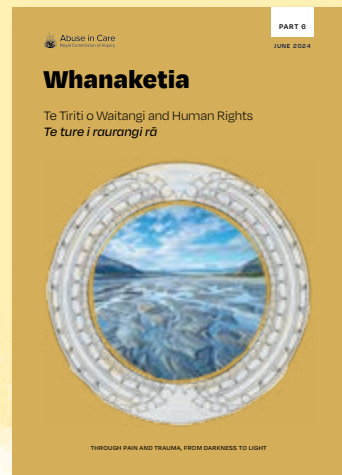
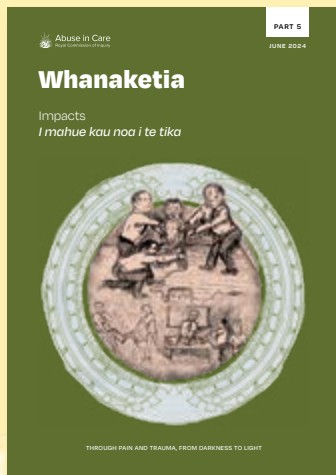
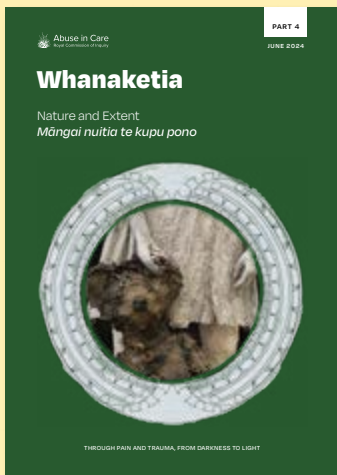
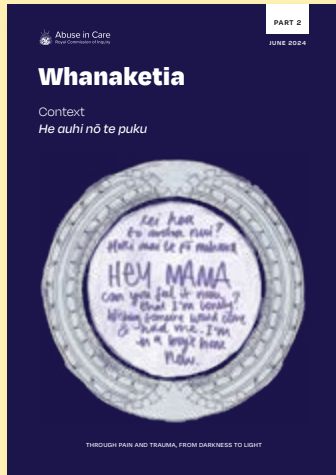
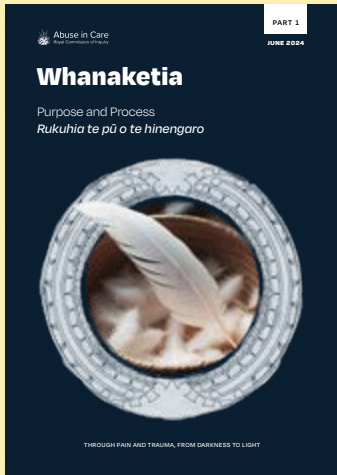
– Paraone Gloyne



Whanaketia

The report is made up of a preliminary, nine parts and five case studies. Whanaketia should be read in full, along with the other reports from the Commission to understand the overall picture of abuse in State and faith-based care from 1950 to 1999.

THROUGH PAIN AND TRAUMA, FROM DARKNESS TO LIGHT





Abuse in Care
Royal Commission of Inquiry