



Abuse in Care
Royal Commission of Inquiry

Whanaketia



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 on 25 June 2024

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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 māra 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

Design explanation

The kowhaiwhai design featured on the report is a view from above of two Toroa (Royal Albatross) - Harongarangi and Tiungarangi. Their wings are wrapped around in a circle to represent the embracing of care and wellbeing for our survivors and their whānau. Each design element within the kowhaiwhai signifies relationships, whānau, health, wealth and wellbeing, whakapapa, protection, safety, strength and perseverance.

The kowhaiwhai design represents the Inquiry's purpose and involvement in providing a space for survivors to share their experiences, the process of healing, the forming of relationships and the resilience and strength to move forward.

The ngutu kaka (kaka beak) from the kowhaiwhai pattern that borders each internal page represents the sharing of stories in safety. This protective pattern frames each page, harnessing the content within.



Pānui whakatūpato

Ka nui tā mātou tiaki me te hāpai ake i te mana o ngā purapura ora i māia rawa atu nei ki te whāriki i ā rātou kōrero ki konei. Kei te mōhio mātou 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 rongoi 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.

Kupu whakataki

Foreword

This report is made up of a number of volumes: Preliminaries; nine Parts; a Survivor Experience study and five case studies. Whanaketia should be read in full, along with the interim reports from the Inquiry to understand the overall picture of abuse and neglect in the care of State and faith-based institutions from 1950-1999.

PRELIMINARIES



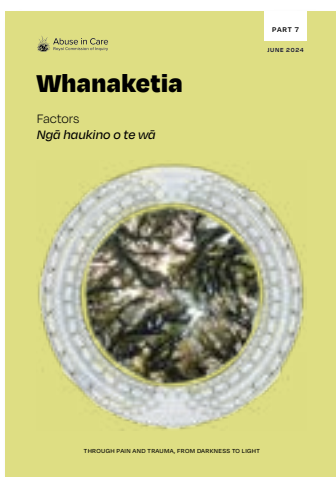
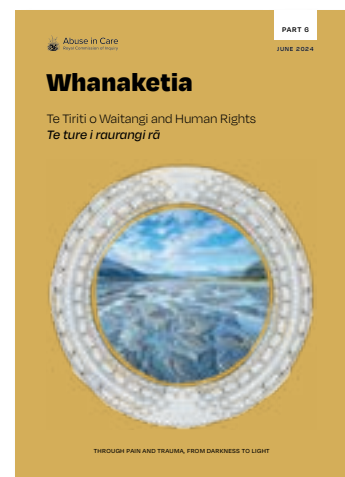
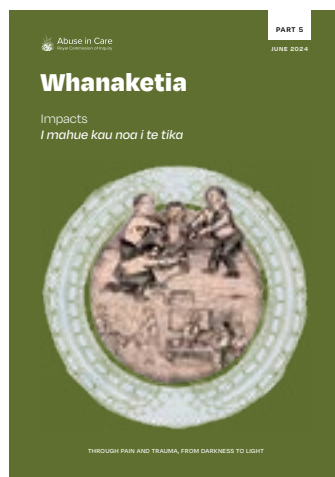
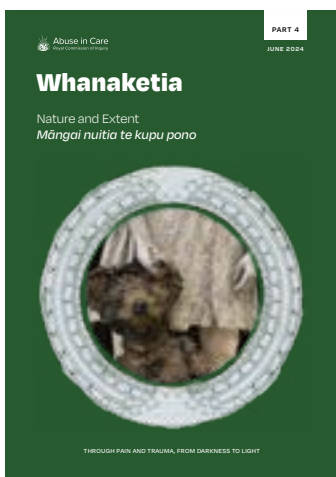
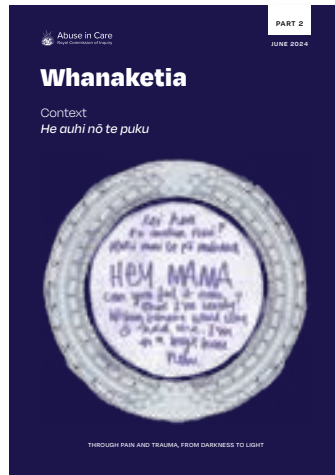
SURVIVOR EXPERIENCE STUDY



THE FIVE SETTING CASE STUDIES



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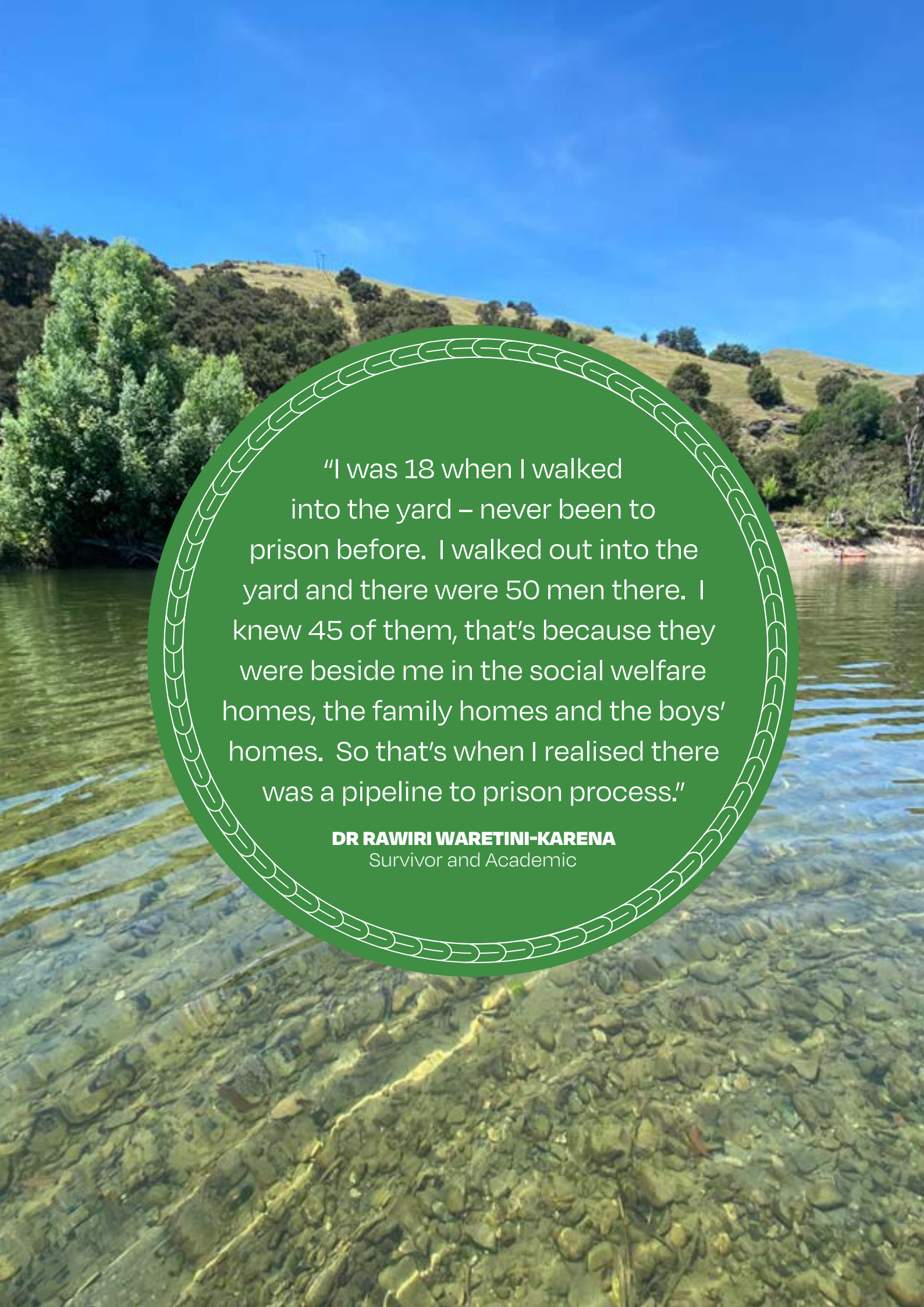
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"I was 18 when I walked into the yard – never been to prison before. I walked out into the yard and there were 50 men there. I knew 45 of them, that's because they were beside me in the social welfare homes, the family homes and the boys' homes. So that's when I realised there was a pipeline to prison process."

DR RAWIRI WARETINI-KARENA
Survivor and Academic

He mihi

Tēnā koutou i haere mai nei kāhore he aha i ō koutou ringa. He kapua pōuri e tāpoki ana i ō koutou ngākau. E taimahatia ana ngā tinana, ngā wairua me te hinengaro e pēhia kino ana e raupatu tonuhia ana e te whakamā. Ko te īnoi i ō koutou ngutu. Whakaorangia mātou.

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Whanaketia, through pain and trauma from darkness to light – e mihi ana mātou mo te īngoa i tāpaia hei ūpoko kōrero e te roopu Survivor Advisory Group of Experts me ngā Pou Tikanga. He whakamaumahara tēnei īngoa mo te hīkoi ā ngā purapura ora: mai te noho tāhanga, huna, me te kore e rāngona – kia rongohia, kia takihia ō rātou wheako, arā ināianei kia tiaho iho, ko te ora, e tau mai anō ai ko te pai.

Ka whakairi tēnei rīpoata ki te nui ō ngā mahi tūkino i ngā pūnaha taurima ā-kāwangatanga, ā-whakapono i Aotearoa. Ka aro ki ngā wheako ō ngā purapura ora, ngā mahi taurekareka i ūhia ki runga i ā rātou, ō rātou whānau, hāpori hoki.

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E mihi nui ana mātou ki te roopu Survivor Advisory Group of Experts, Te Taumata, Te Ara Takatū, te Royal Commission Forum, me ā mātou Report Reference Groups, mō ā koutou tohutohu whiringa aroha mai. He nui tā koutou tautoko mai me te pono ō ā koutou kōrero. I whakaae koutou ki te kōrero pono me te āta wherawhera i ā mātou pūnaha, ā mātou whakahaere, hei wero i ō mātou hinengaro. Tēnā koutou, mō te whakaaro nui, me te tūturu ō ā koutou kawenga, tohutohu mai.

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Acknowledgements

Greetings to you who came to us with nothing in your hands. With sorrow clouding your hearts, the burden of guilt weighing heavily on your very being. Spirits crushed by the shame that still pervades your minds proffering a simple prayer. Deliver us.

We listened to your anguished memories, heard the sobbing of your hearts, and have been tasked to give you solace from the harsh winds of time, resolution from the gravity of your abuse. May the unseen hand of providence shine upon you, the wisdom of the ages guide you, and that the truth and justice we have sought together, may you find respite.

Finally let us pay homage to those who will not see the end of this long journey, those of you who now rest beyond the collective realm of memories, into the deep recesses of the night we bid you farewell. Sleep in eternal serenity, in the embrace of your ancestors. While your voices now are silent, your words will endure. Rest in peace.


And in that peace, we hope you find solace in this report.

Whanaketia, through pain and trauma, from darkness to light – this name was given to us by the Survivor Advisory Group of Experts and Pou Tikanga, and we are grateful to them for this tāonga. This name reflects the journey that survivors have been on: from being isolated, unseen, and not listened to – to being heard, telling their experiences, and now looking to the light for healing and restoration.

This report recognises the scale of abuse and neglect in State and faith-based care in Aotearoa New Zealand. It focuses on survivors' experiences and how the betrayal of a promise of care affected them, their whānau and communities.

We acknowledge and thank all survivors, whānau, hapū, iwi, communities and support networks who advocated or played a role in bringing about this Inquiry, for their determination and tenacity, and their patience.

We thank and acknowledge those who spoke to us and shared their experiences – nothing could have been achieved without your participation and engagement. Your contributions have been indispensable in framing findings and recommendations to achieve a more inclusive society that would see individuals, whānau and communities having everything they need to flourish and to enhance their mauri and mana. We are grateful to you for reliving traumatic experiences, making that sacrifice in the hope of achieving a better future for your mokopuna and future generations.



We recognise that for some survivors this was the first time they had shared their experience. We heard you and we have tried to reflect your collective experience in this report. We learnt along the way as we carried out our investigations and gathered evidence and information.

We also mihi and acknowledge those survivors who were not able to come forward, some because they had lost their trust and confidence in authorities due to being abused and neglected, some because they did not want to talk about their experiences.

We also acknowledge those who have died, sometimes by suicide, and some while the Inquiry was underway. We pay tribute to them and acknowledge their whānau and friends.

We acknowledge those former and current staff of State and faith-based care institutions who came forward to share their experiences, as well as the experts and advocates who provided insights into abuse and neglect in care and who will continue to fight for change, as they always have.

We acknowledge and thank the advocates, supporters, whānau, community leaders, hapū, iwi and Māori, and other people and organisations who dedicated time and effort over the years and called for an inquiry, for redress and for an apology for survivors. They listened to and believed survivors, they petitioned, and they stood up and spoke up for them. There are too many to name but this Inquiry would not have been possible without their dedication and efforts in calling for a light to be publicly shone on the abuse and neglect in care that left a trail of broken lives across Aotearoa New Zealand.

We thank and acknowledge Pou Tikanga for their advice to the Inquiry and for sharing their mātauranga Māori that has helped us to frame this report in a way that is consistent with tikanga Māori, while also ensuring the kaupapa discussed is held in an appropriate manner. The tikanga Māori section, karakia and waiata you have drafted and gifted, and weaved into the reo Māori names of each Part so powerfully set the scene for the experiences and analysis that is covered throughout the report. He rawe tonu!

We are grateful to the Inquiry's Survivor Advisory Group of Experts, Te Taumata, Te Ara Takatū, the Royal Commission Forum and our Report Reference Groups for their advice and critical friendship. You were encouraging and supportive, but you also provided honest feedback. You agreed to speak truthfully and to constructively criticise our systems and processes and provoke our thinking. Thank you for your generosity of time and efforts, and for your honest engagement and advice.

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We acknowledge our staff and the counsel who have assisted the Inquiry. Our secretariat has been led over time by Mervin Singham, Helen Potiki and Benesia Smith, MNZM. Each of them has brought themselves and their many years of experience to the fore in leading a diverse and skilled group of staff through many changes to deliver a comprehensive work programme in a consummate manner. They have admirably advised and supported us in our mahi. Thank you, Mervin, Helen and Benesia – we are indebted to you for all of your advice, support and assistance. We thank Simon Mount KC and Kerry Beaton KC, our two-lead senior counsel assisting the Inquiry. Your oversight of the large team of counsel assisting and provision of legal advice has been exemplary. They also ably provided advice and support to us in our endeavours. Thank you, Simon and Kerry – we are indebted to you too for all of your advice, support and assistance.

To the many staff and counsel assisting that have worked at the Inquiry since 2018 until now, we thank you so much for working tirelessly to support survivors to tell their experiences and to ensure our interim reports and this report encapsulated those experiences.

Finally, we acknowledge all New Zealanders who have engaged with or otherwise assisted the Inquiry. We all have a role to play in ensuring that Aotearoa New Zealand recognises what happened and why, seeks to right those wrongs, and seeks to build a future where abuse and neglect has been eliminated. We now know that countless thousands of children, young people and adults in the care of State and faith-based institutions have been abused and neglected, at times by multiple abusers, and that this has occurred for generations. We all have a role in seeing that this does not continue.

		
Judge Coral Shaw Chair	Dr Andrew Erueti Commissioner	Paul Gibson, QSO Commissioner



"I was always
unwanted as a little
kid, and now I always
think I am unwanted
by other people or my
partners."

MR EC
Survivor

He whakarāpopototanga ripoata

Executive summary

1. State and faith-based institutions were entrusted to care for many children, young people and adults. New Zealanders held the leaders of these institutions in the highest esteem. These leaders had a duty to nurture, protect and help people flourish. They failed in their duty.
2. Instead of receiving care and support, children, young people and adults in care were exposed to unimaginable physical, emotional, mental and sexual abuse, severe exploitation and neglect. Abuse and neglect were widespread throughout the Inquiry period in State and faith-based care institutions. Any abuse and neglect, let alone the prevalence of it, could not be justified by the standards of the day and certainly cannot be justified now.
3. Critical rights, such as those guaranteed to Māori in te Tiriti o Waitangi and human rights, that should have protected people in care, were ignored and overlooked altogether.
4. Of the estimated 655,000 children, young people and adults in care from 1950 to 2019, it is estimated that up to 256,000 were abused and neglected. During the Inquiry period, 1950 to 1999, it is estimated around 510,000 people were in care and up to 200,000 were abused and neglected. The true number will never be fully known as records of the most vulnerable people in Aotearoa New Zealand were never created or were lost and, in some cases, destroyed.
5. It is a national disgrace that hundreds of thousands of children, young people and adults were abused and neglected in the care of the State and faith-based institutions. These gross violations occurred at the same time as Aotearoa New Zealand was promoting itself, internationally and domestically, as a bastion of human rights and as a safe, fair country in which to grow up as a child in a loving family. If this injustice is not addressed, it will remain as a stain on our national character forever.
6. This report – Whanaketia through pain and trauma, from darkness to light – shines a light on the institutional and systemic failures by recounting the experiences of people in care and their subsequent life-long pain and trauma. It sets out a path to ensure all in care are safe, cared for and supported to lead their best possible lives.



I horopa nui ngā mahi tūkinō

Abuse and neglect was pervasive

7. Abuse and neglect almost always started from the first day a person was placed in care. It often continued the entire time a person was in care – for some people this meant years or even decades of frequent abuse and neglect. For some it was a lifetime; for others it led to an unmarked grave.
8. Children, young people and adults in care were regularly treated without compassion and some were wilfully neglected. There were times that babies were left in cots with no hugs, physical interaction or other expressions of care. Many survivors were denied basic necessities such as enough food and suitable clothing. Some had no privacy while bathing or using the toilet.
9. Tamariki, rangatahi and pakeke Māori were often targeted because of their ethnicity, and this was often overlaid with racism. The effects of colonisation continued to further keep many whānau Māori in social deprivation with resulting impacts on whānau wellbeing and financial instability.
10. Once in care, Māori survivors experienced harsher treatment across many settings, being degraded because of their ethnicity and skin colour. They were denied access, sometimes violently, to their ability to practice mātauranga, tikanga, reo Māori, and the ability to connect to their whakapapa, sometimes violently. For tāngata Turi Māori, tāngata whaikaha Māori, and Takatāpui survivors, these abuses were further compounded with disablism, ableism, audism and / or homophobia.
11. Pacific children, young people and adults in care also experienced racial abuse and cultural neglect. This included the denial of access to knowledge of their specific cultural identities, the denial of opportunities to learn about their specific culture or to speak or practise their specific cultural customs and languages; and the denial of access to, and knowledge of their kainga (family). Many also had whakapapa Māori, and they often experienced multiple and compounding forms of racial abuse and cultural neglect. Further, they were often denied access to all their cultural identities and their associated knowledge, languages and customs.
12. Deaf and disabled survivors experienced ableist, disablist and audist abuse, including targeted abuse and derogatory verbal abuse. Deaf and disabled survivors, and survivors who experienced mental distress, were denied personhood and were often stripped of their dignity and autonomy. They were left unattended and ignored with no stimuli to grow or develop their individual talents or interests. Many were segregated from society, deprived of individual attention and basic educational opportunities. Disabled adults were often treated as unable to make their own choices and decisions, with or without supported decision-making. Deaf survivors were denied sign language and Deaf culture. Blind survivors were denied braille.

13. Abusive and uncaring language, shaming and humiliation and psychological harm were used to intimidate and humiliate. Physical abuse was prevalent across all settings. In some cases, staff went to extremes to inflict as much pain as possible using weapons and electric shocks.
14. Staff often pitched children and young people against each other, encouraging peer-on-peer abuse. This involved vicious attacks and humiliating rituals, which staff ignored.
15. Sexual abuse was commonplace in State and faith-based care settings. Abusers groomed children, young people and adults in care into trusting them. They also deceived other staff, volunteers and people in leadership positions into believing they were trustworthy, which meant that survivors who tried to disclose the abuse and neglect were not believed. Many survivors were sexually assaulted, raped and forced to perform sexual acts. Sexual abuse was used to punish and intimidate. In some cases, the Inquiry was told abusers organised the sexual abuse of survivors by trafficking them to members of the public.
16. Medical abuse and neglect occurred in many care settings. This included improper medical treatment and practices, misuse of medication or medical equipment and treatment without consent, including electric shocks. Chemical restraint, like sedation, was used to control behaviour and as a form of punishment in disability and mental health institutions and social welfare residences.
17. Women and girls were routinely tested for sexually transmitted infections and were often forced to have degrading internal vaginal examinations. Clinicians would sometimes use medical checks as an opportunity for sexual abuse.
18. Solitary confinement was commonly used to manage or control behaviour and as a form of punishment. In disability and mental health institutions, special schools and social welfare residences, some survivors were locked in areas with limited or no access to toilets and water.
19. Seclusion rooms were often cold, dark, and unhygienic. Survivors could be held for days, weeks or even months in these bleak places, where they were at risk of being sexually and physically abused by staff.
20. Some survivors were financially abused by their carers, including being forced to do long hours of physical labour. Survivors of disability care settings were exploited in sheltered workshops for minimal or no pay, or had their money taken by staff or caregivers.




He aha i pēnei ai?

How did this happen?

21. Many of the circumstances that made it more likely a child, young person or adult would enter care were often the same factors that placed them at an increased risk of abuse and neglect in care. These circumstances included being Deaf, disabled or experiencing mental distress with unmet needs, being raised in poverty and experiencing deprivation, and experiencing significant or multiple adverse childhood events. Being Māori, Pacific, or Takatāpui, Rainbow and MVPFAFF+ and experiencing discrimination was another factor. Another factor was having a deferential attitude to people in positions of authority, holding them in the highest regard, including faith leaders and medical professionals.
22. The people who perpetrated abuse and neglect in State and faith-based care took advantage of their positions of power over children, young people and adults in care. They were skilled at exploiting the gaps and failures in the care system. Abusers were rarely held to account for their actions or inactions, which emboldened them to perpetrate further abuse and neglect. Abusers came from all walks of life and were frequently trusted and well-regarded members of the community. Many of the institutional systems they operated in enabled abusers and institutions to abuse and neglect those in their care and act with impunity.
23. The State was ultimately responsible for the care system during the Inquiry period. This system was one of institutionalisation. Instead of addressing the social and cultural needs of whānau by resourcing and empowering families to care for their own, the State placed children, young people and adults in punitive, institutional settings that segregated and isolated them from their whānau and communities where they were of sight and out of mind.
24. Society's discriminatory attitudes towards difference, including racism, ableism, disablism, sexism, homophobia, transphobia, punitive attitudes towards whānau and individuals who need support, all had one thing in common: they devalued and dehumanised children, young people and adults in care. This made it more likely for people in care to be abused and neglected and for that treatment to be justified by abusers, bystanders and leaders of institutions. It also made it all too easy for people in care to be ignored and forgotten by the rest of Aotearoa New Zealand.

25. Successive Government ministers and heads of government agencies who were responsible for the law and policy settings had accountabilities in law to children, young people and adults in their care that they failed to uphold. The State and leaders of faith-based institutions knew, or should have known, about the abuse and neglect that was happening. They failed not only in their duty to keep people in their care safe from harm, but they also failed to hold abusers to account.
26. Many residences and institutions developed cultures and practices that were often reflective of society's attitudes to be punitive or to segregate those perceived as 'other'. These dehumanised people in care and tolerated or encouraged abuse and neglect. People with military backgrounds were assumed to be appropriate to care for children, young people and adults, and many brought with them a culture of command and control, punishment, physical violence and verbal abuse. Some staff, volunteers and carers who witnessed abuse and neglect became desensitised and went on to become abusers. Others were too afraid of being ostracised or losing their jobs to speak out or felt that they were powerless to do anything. Those that did speak up were not believed, snubbed or moved on.
27. Faith-based institutions had some unique factors that contributed to abuse and neglect in their care. The assumed moral authority and trustworthiness of clergy and religious leaders allowed abusers in faith-based institutions to perpetrate abuse and neglect with impunity. Religious beliefs were often used to justify the abuse and neglect, and to silence survivors. Hierarchical and opaque decision-making processes impeded scrutiny and making complaints.
28. Some people making decisions about care often had little understanding and limited close connection with the children, young people and adults in their care and their communities. Care standards were inconsistent across the different care settings throughout the Inquiry period. Internal care standards, as well as those set out in law, were routinely breached. The people who worked or volunteered in care residences and institutions were often inadequately vetted, trained or supervised. Often there were staff shortages, which led to neglect and provided more opportunities for abusers to act undetected.

- 
29. Only some care settings had complaints processes where children, young people and adults in care could raise concerns or disclose abuse and neglect. Very often, they were not believed or the complaint was not followed up. Senior leaders often sought to protect their own reputations and that of the residences and institutions they were responsible for. Few incidents were referred to appropriate authorities like NZ Police. Complaints were treated as employment issues or workplace incidents. In faith-based care settings, abuse was treated as a religious transgression that required survivors to forgive, let go of anger and blame and instead embrace those who had sinned against them; and abusers to merely repent. Many abusers were relocated and went on to continue abusing people in care elsewhere.
30. There was limited independent oversight or monitoring of State and faith-based care. Where there was oversight, it failed to consistently enforce the standards that were in place to protect people in care.
31. The factors that contributed to abuse and neglect in care intersected, allowing abuse and neglect to persist for decades.
32. By the end of the Inquiry period some problems had been identified and lessons learned, particularly by the State. This resulted in changes made to legislation, policies and guidelines to enhance safeguarding and address issues identified by survivors, professionals and advocates. This included closing some institutions and involving more community-based care. But most of the factors that led or contributed to abuse and neglect during the Inquiry period continue to persist.

Nā ngā purapura ora i utua

Survivors paid the ultimate price

33. Abuse and neglect in care has had lifelong impacts on survivors. Many survivors died while they were in care or by suicide following care. For others, the impacts of abuse and neglect are ongoing and compounding, making everyday activities and choices challenging.
34. Separation from whānau and being told that no-one loved them – sometimes from a very young age – deprived children and young people of their right to be loved and develop positive attachments. This has profoundly impacted how survivors view themselves and others and how they understand the world. It has impacted their ability to form stable, secure and nurturing relationships, to find and keep jobs, and to fulfil their potential.


35. Many survivors face reduced employment opportunities because they were denied an education. Some survivors were not provided with the right supports, some were not sent to school, and others were simply too traumatised by abuse and neglect to learn. Some survivors have been disproportionately and distinctly impacted due to their ethnicity, circumstances, experiences and the specific types of abuse and neglect experienced while in care.
36. Violence was so embedded in care settings that some survivors became numb to it. Others became abusers themselves. For many survivors, their time in care was their introduction to crime and it led them to prison. Some became trapped in care and remain institutionalised today. Others progressed from prison to psychiatric care due to anti-social behaviour, substance abuse and ongoing mental distress.
37. Many survivors trace their current health conditions to their time in care. Survivors experienced poor physical health and enduring disability from disease and injury caused by abuse and neglect, compounded with a lack of proper treatment. Over-medicalisation has led to chronic health conditions. Gross neglect and systemic failure to provide meaningful healthcare meant some people died in care. Experiencing trauma is also associated with a range of poor health outcomes including cancer, heart disease, addiction and depression.
38. Survivors are often triggered by sounds, tastes and smells which remind them of the abuse and neglect experienced and causes deep distress. Emotional impacts left many survivors feeling whakamā or shame. Eroded self-confidence and self-esteem led some survivors to self-harm, suicidal ideation, attempted suicide or suicide. Substance misuse is common.
39. Survivors of sexual abuse suffered immediate and lasting trauma. They have grown up with a distorted view of sexual intimacy and often have difficulty in maintaining healthy intimate relationships. Many have found it necessary to cut themselves off from this vital part of themselves altogether, leading to feelings of isolation and a profound impact on their emotional and psychological well-being.
40. The traumatic effect of being separated from close siblings caused survivors to feel guilt and worry about their lost brothers and sisters, and often resulted in lifelong estrangement. Abuse and neglect in care also impacted survivors' whānau with serious consequences for subsequent generations. Survivors talked about not knowing how to parent and struggling to form close relationships, including with their own children. Children of survivors told the Inquiry about the grief of growing up with a parent who experienced abuse and neglect in care, and the damage it did to their own childhoods.



He kāpuinga pāpātanga

Collective impacts


41. Māori have been affected by abuse and neglect in care as a collective and across generations. Taking tamariki and rangatahi from their whānau, iwi and hapū has meant tamariki, mokopuna and uri have been deprived of their reo, tikanga and mātauranga Māori. Generations of future Māori leaders have been lost. The trauma of abuse and neglect has led to much larger social problems such as declining health, higher rates of incarceration, family harm, unemployment, homelessness, mental distress and substance harm, and reduced educational opportunities.
42. When tamariki, rangatahi and pakeke Māori were placed or taken into care, whānau, hapū, and iwi were deprived of one of their most critical roles – to exercise tino rangatiratanga over their kāinga. It removed the ability and power of whānau, hapū and iwi to care for and nurture the next generation, to regulate the lives of their people and to transfer mātauranga Māori.
43. Institutionalisation created a unique form of dehumanisation for Māori and Pacific Peoples due to the role that collective identity plays in socialisation, including identity development. The removal of individual and collective identity through institutionalisation was therefore culturally and spiritually abusive for many. This was also a collective abuse upon Māori collectives – whānau, hapū and iwi.
44. Many Pacific survivors lost their connections to their kainga (family), culture and language. Survivors spoke of the devastation and harm caused by cultural disconnection and the loss of cultural identity, causing harm to the vā (the 'space between' that holds people together) and impacting on fakatupuolamoui (the ability to live vigorously and abundantly).
45. For many Deaf and disabled survivors, and survivors experiencing mental distress, being segregated and experiencing restricted contact and separation from whānau and community has caused acute pain and has had lifelong negative impacts. Many were institutionalised to the extent they struggled to live independently. They were denied personhood and their culture, as well as the opportunity to practice life and community skills. Disability communities, and Aotearoa New Zealand, lost generations of future leaders.

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46. Deaf survivors were denied any understanding that a Deaf culture and community existed, to which they could belong. They were forced to communicate through speech and they were physically abused for using sign language. They did not develop language competency, resulting in a loss of confidence, ability to develop their own culture or their future leaders. Tāngata Turi Māori were also unable to develop reo Māori competency or become familiar with ao Māori.
47. Takatāpui, Rainbow, MVPFAFF+, gender diverse and transgender survivors and their communities suffered abuse, harm and experienced hate, leading to mental distress, PTSD, suicidality, poor physical health and relationships. The impact was emotionally and socially debilitating, meant people could not be their authentic selves, and damaged the ability to thrive as communities.
48. Some survivors suffered trauma when they left their faith because of abuse and neglect. For some, leaving their church community meant losing their family, friends and job. Some survivors left their churches voluntarily, but others told the Inquiry they were excommunicated (forced to leave), shunned and blocked from seeing their family. The impact was a complete loss of identity, community, physical and financial assets and was emotionally devastating.
49. Many survivors have broken the cycle of violence and offending, creating better outcomes for their tamariki and future generations. Some have found healing by helping others, and through arts, sport and other community activities.

He nui te utu o ngā mahi tūkino

Cost of abuse and neglect is too high

50. In addition to the profound individual and social costs to communities in Aotearoa New Zealand, the economic costs of abuse and neglect in care are very high.
51. The average lifetime cost to the survivor of the loss of enjoyment of things that New Zealanders think are normal day-to-day activities was estimated in 2019 to be approximately \$673,000, which is almost 80 percent of the estimated lifetime costs of abuse per survivor of \$857,000.
52. Based on the estimated number of people abused and neglected in care between 1950 and 2019, the total cost is estimated to be between \$97.5 billion and \$219 billion. Of this the smallest proportion, estimated to be approximately \$47.1 billion, is borne by the taxpayers of New Zealand. The largest cost, estimated to be approximately \$172 billion, is borne by survivors.

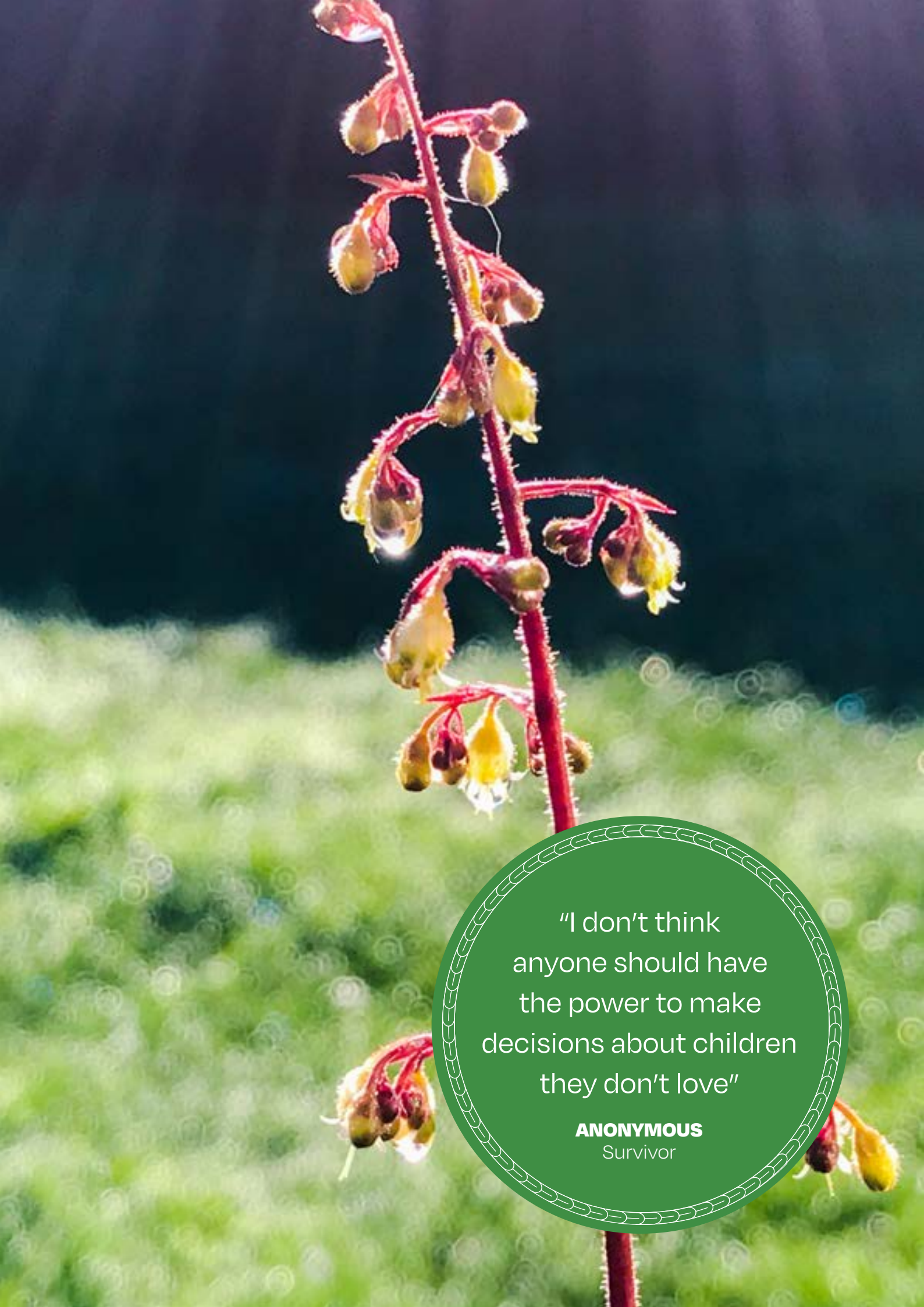
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53. Abuse and neglect in care has financially affected survivors, families, hapū and iwi, communities and society as a whole. The ongoing associated intergenerational harm and trauma have contributed to social inequities as well as vast economic costs.

Nā te hia tekau tau o te karo purapura ora ka kino kē atu te whara Ignoring survivors for decades compounded the harm

54. For decades, survivors repeatedly called for justice but were unheard, disbelieved, ignored and silenced. Their experiences were minimised or dismissed, and they were told abuse and neglect in care was not systemic. When they did receive recognition it was often piecemeal, insincere, and fell far short of any notions of fair redress. Even this paltry redress took years or decades to extract from the State and faith-based entities. Political and public service leaders spent time, energy and taxpayer resources to hide, cover up and then legally fight survivors to protect the potential perceived costs to the Crown, and their own reputations.
55. Faith leaders similarly fought to cover up abuse by moving abusers to other locations and denying culpability.
56. Survivors were right to call for an Inquiry. There has been widespread abuse and neglect in State and faith-based care which has had a devastating personal and multigenerational impact on survivors, their whānau and society as a whole. It has been minimised and covered up by the institutions responsible. Significant resources have been used to deny survivors their voice and to defend the indefensible. This must stop.


He moemoeā - he tauārai me te manaaki mo te heke mai He moemoeā – a safe and caring future

57. Survivors shared their moemoeā (dreams) for the next generation 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.



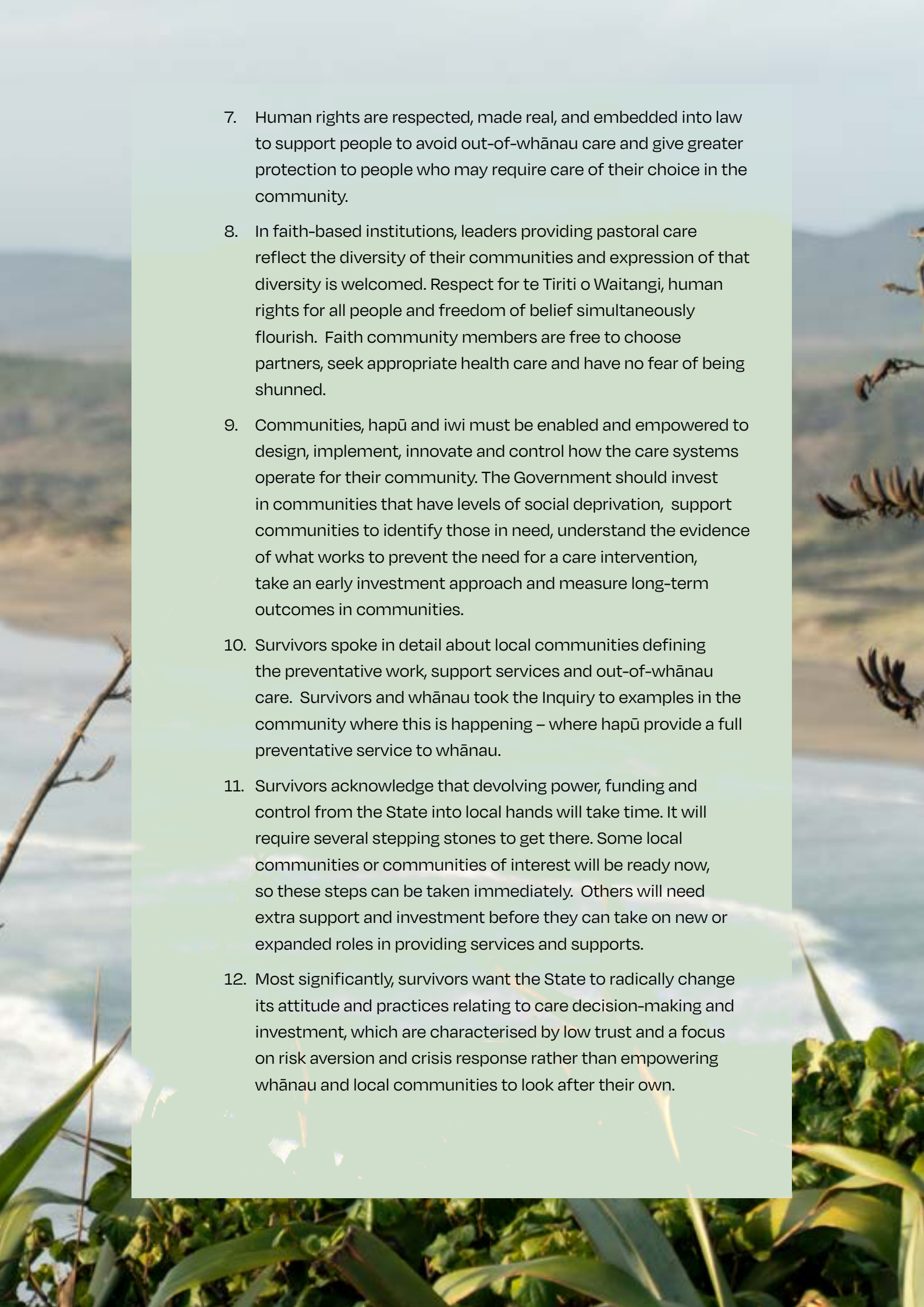
"I don't think
anyone should have
the power to make
decisions about children
they don't love"

ANONYMOUS
Survivor



He moemoeā ō ngā purapura ora mo te heke mai Survivors' dreams for the future

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.

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7. 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.
 8. 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.
 9. 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.
 10. 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.
 11. 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.
 12. 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.



He whakarāpopoto o ngā tūtohi a te Pakirehua

Summary of Inquiry's recommendations

58. Survivors' moemoeā are the foundation of the Inquiry's vision for the future – he Māra Tipu (a growing garden) and at the heart of the Inquiry's recommendations. The State and faith leaders must right the wrongs of the past, the care system must be made safe for every child, young person and adult in care, and Aotearoa New Zealand must entrust, empower and invest in whānau and communities to care for their loved ones.

Me whakatika i ngā hē ō ngā ra o mua e ngā kaitiaki matua Kāwanatanga, ā-whakapono

State and faith leaders must right the wrongs of the past

59. Survivors are united in calling for State and faith leaders to make public apologies and take accountability for the harm caused to children, young people and adults. This includes the Prime Minister and faith leaders, but it goes much deeper. All public sector leaders, leaders of relevant professional bodies, leaders of care providers and leaders of faith-based institutions need to apologise to survivors publicly.
60. An apology is hollow without change. With urgency, State and faith-based institutions must implement the Inquiry's 2021 recommended puretumu torowhānui system and scheme. There must be no further delay.
61. Aotearoa New Zealand must not put survivors through further hurt. The courts should prioritise civil proceedings regarding care or abuse and neglect in State or faith-based care to minimise litigation delays.
62. Additionally, NZ Police should establish a specialist unit dedicated to investigating and prosecuting those responsible for historical and / or current abuse and neglect in State and faith-based care.

Me tiaki ia tamariki, ia rangatahi, ia pakeke noho pūnaha taurima, ināia tonu nei


Make every child, young person and adult safe in care today

63. Aotearoa New Zealand must do everything in its power to make sure that our care system is safe for every child, young person and adult. This will require political leadership on preventing and responding decisively and effectively to abuse and neglect in care.
64. Critically, complaints need to be listened to, investigated and acted on in a timely manner to keep children, young people and adults in care safe. Leaders within the care system must prioritise safeguarding and be held accountable for any failures.
65. The care workforce must be valued and invested in. They provide care and aroha to our most vulnerable children, young people and adults. This workforce needs to be thoroughly screened, accredited and trained, and provided with good working conditions and pay. The care work force should reflect the diversity of people in care and include care-experienced workers.
66. The government should take all the measures within its power to shift from the State and faith providing care to empowering communities to provide care whilst maintaining connection to whānau. Residences and institutions will never deliver 'care'; nor can they ever replace a loving parent or caregiver.

Te whakamana, whakapakari me te tautoko i ngā whānau, hāpori hoki

Entrust, empower and invest in whānau and communities

67. Everyone in Aotearoa New Zealand has a part to play in preventing abuse and neglect in care. Everybody needs the knowledge and tools to achieve this, so that the beliefs that contribute to harmful and discriminatory experiences in care can be eliminated, and abusers can be identified and stopped.
68. All whānau must be invested in so they can care for their loved ones, with support from the community and funding by the State. Poverty and deprivation must be addressed. Accessibility, disability and mental health supports are required. If out-of-whānau care is required, institutional environments and practices must be eliminated and communities supported to care for their own.
69. All entities must uphold te Tiriti o Waitangi and the rights of Māori in care as Indigenous peoples of Aotearoa New Zealand, and act consistently with New Zealand's international human rights obligations.

A close-up photograph of several yellow orchids with red and white speckled centers. The flowers are in focus, with some in the foreground and others slightly blurred in the background. A green circular graphic with a white chain-link border is overlaid on the lower half of the image, containing text.

"Sending children
to institutions was
very traumatic for families
despite it being the only option
for disabled children at the time.
This was particularly so for people
in rural communities. There was no
play group, no respite; there was
absolutely nothing."


ANNE BELL
sister of Vicki Golder

Whakarāpopoto o ngā whakakitenga Summary of Key Findings

70. The key findings of the Inquiry are listed below. These key findings should be read alongside the more specific findings contained in the case studies, the Inquiry's previous interim reports, and in the text of this final report.

Wāhanga 3: Ngā tipua whakawai Part 3: Circumstances

71. Clause 31(d) of the Terms of Reference requires the Inquiry to make findings on the circumstances that led to individuals being taken or placed into care during the Inquiry period.
72. Between 1950 and 1999 State and faith-based institutions had hundreds of thousands of people in their care. The wide definition of care in the Inquiry's Terms of Reference means there were many different pathways into care, from State-enforced removals, court orders, or a lack of alternative options through to voluntary relationships such as private schooling and pastoral care.
73. The Inquiry finds:
- a. People were more likely to be placed in State and faith-based residential and institutional (direct or indirect) care if they had experienced poverty, family crisis or violence, parental abuse and neglect, or were Deaf, disabled or mentally distressed; particularly if there was a lack of support for the household from others.
 - b. The effects of colonisation, urbanisation, the break-down of social structures, and racism saw Māori more likely to be placed in State care.
 - c. In some situations, a care placement was necessary for the health and safety of the person concerned. Decision-makers believed that out-of-whānau care would lead to better life outcomes. Those beliefs were usually genuinely held but often without foundation.
 - d. Parents were often convinced, sometimes through religious affiliation, that care placements outside the home or mainstream education would provide superior environments or opportunities for their children.

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- e. In the State care system, decision-makers included social workers, police, judges, health professionals and needs assessors who generally had limited involvement in, connection with, or understanding of the most affected communities (including Māori, Pacific, Deaf or disabled communities, those with mental distress).
 - f. The State often used formal powers as well as compulsory and institutional care options in a discriminatory way. Formal legal orders were more often used against Māori rather than supporting in-home, whānau, hapū, iwi or community care.
 - g. Many survivors experienced multiple placements, between different settings, often due to perceived delinquency or a lack of support within care residences or institutions.
 - h. Children, young people and adults in care did not always understand why they were being moved or where they were going next. They were often scared, confused, and missed their whānau.
 - i. Decision-making was often influenced by ableist and disablist attitudes which led to the segregation and social exclusion of Deaf people, disabled people and people experiencing mental distress.
 - j. Tamariki and rangatahi Māori were the majority in social welfare care settings and were over-represented in all other institutional and compulsory care settings.
 - k. Tamariki and rangatahi Māori were more likely to be sent to harsher institutions such as borstals and social welfare residences and institutions.
 - l. 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.
 - m. 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. These failures were both in the method of removal and the appropriateness of placements.
 - n. The State did not typically consider placements with whānau, hapū or iwi for tamariki, rangatahi and pakeke Māori. Nor did the State actively support sustained connections to whānau, hapu, iwi or community for those in care.


- o. Between the 1950s and 1980s, tamariki, rangatahi and pakeke Māori experienced heightened State surveillance and targeting by NZ Police and other State agencies, which contributed to a disproportionate number of tamariki, rangatahi and pakeke Māori entering State care. Wāhine Māori experienced heightened State surveillance for running away, staying out or behaving in ways perceived as promiscuous.
- p. Deaf, disabled and mentally distressed children, young people or adults were placed in most care settings. Many settings were established only for disabled and mentally distressed people. There were special, segregated residential schools for Deaf children and young people.
- q. There was an over-use of institutional care for Deaf, disabled and mentally distressed children, young people, and adults.
- r. Deaf, disabled and mentally distressed children, young people and adults were often denied or restricted from involvement in decisions about their own lives.
- s. For many Deaf, disabled and mentally distressed people, formal State care was the only option the State provided, often for their entire life. The State failed to provide any alternatives.
- t. The State generally failed to consider or recognise Pacific world views, cultural values (fa'asamoa, anga, fakatonga), Pacific languages and Pacific knowledge when removing or placing children (fanau), young people (tagata talavou) or adults (tagata matua) in all care settings. These failures were both in the method of removal and the appropriateness of placements. Wider kainga (family) or Pacific communities were not generally considered as an alternative option for care. Between the 1950s and 1980s, Pacific Peoples experienced heightened State surveillance and targeting by NZ Police and other State agencies, contributing to a disproportionate number of Pacific Peoples entering State care. Challenges with immigration, including language barriers, poverty and societal attitudes also contributed to Pacific Peoples entering care settings.
- u. Between the 1950s and 1970s, many unmarried pregnant girls and women were placed in faith-based homes. These homes often facilitated the subsequent adoptions of babies. These placements and adoptions were usually the result of family, religious and societal attitudes including racism.
- v. Adoption practices facilitated by the State or faith-based institutions for Māori were discriminatory and ignored whāngai Māori practices. From 1950 to the mid-1980s, adoption practices legally severed tamariki and rangatahi Māori from their whakapapa and identity.

Wāhanga 4: Māngai nuitia te kupu pono

Part 4: Nature and Extent

74. Clause 31(a) of the Terms of Reference requires the Inquiry to make findings on the nature and extent of abuse and neglect that occurred during the Inquiry period.
75. The Inquiry finds:
- a. The best available estimates indicate that up to 200,000 people were abused in care between 1950 and 1999. Precise figures are impossible due to data inadequacies and poor records kept by the State and faith-based institutions, the passage of time, barriers to disclosure, abuse going unreported, and steps commonly taken to conceal abuse. The total number may be higher than this estimate.
 - b. Many different forms of abuse and neglect were reported to the Inquiry. These included:
 - i. entry into care caused trauma
 - ii. psychological and emotional abuse and neglect
 - iii. physical abuse and neglect
 - iv. sexual abuse; racial abuse and cultural neglect
 - v. spiritual and religious abuse and neglect
 - vi. medical abuse and neglect
 - vii. solitary confinement
 - viii. financial abuse and forced labour
 - ix. educational neglect.
 - c. Sexual, physical and emotional abuse were the most common forms of abuse in care. Neglect was pervasive across all care settings and varied according to the setting.
 - d. People experienced racism in all care settings.
 - e. Policies and practices that would now be understood as ableist and disablist were common across all settings.
 - f. In some residential and institutional care settings, some children, young people and adults in care experienced the over-use of seclusion, over-medicalisation, lobotomies, sterilisation, invasive genital examinations and experimental psychiatric treatments without informed consent.
 - g. Abuse and neglect were pervasive in social welfare, Deaf, disability, and mental health residences and institutions.
 - h. State care, particularly in social welfare residences and institutions, often used punishment and control rather than care.

- i. Tamariki, rangatahi and pakeke Māori placed in Pākehā value-based institutions often experienced severe abuse and neglect including patu (hitting/striking), whakamamae (inflicting pain) and whakarere (neglect). This was a transgression against whakapapa, personal tapu, mana, mauri and wairua.
- j. Some survivors endured extensive and extreme abuse and neglect. At times, surviving severe physical pain and / or mental suffering.
- k. From the over 2,300 survivors who spoke to the Inquiry:
 - i. many survivors experienced multiple forms of abuse and neglect, for example, 82 percent of survivors who spoke to us about sexual abuse also reported physical abuse
 - ii. abuse and neglect were particularly prevalent in social welfare settings, faith settings (particularly Catholic, Anglican, and Gloriavale) and disability and mental health settings
 - iii. residential and institutional care in social welfare, education and health and disability care settings typically had highly regimented systems. These types of institutions had high levels of physical abuse. The highest levels of physical abuse were reported at Wesleydale Boys' Home and Ōwairaka Boys' Home, both in Tāmaki Makaurau Auckland
 - iv. tamariki, rangatahi and pakeke Māori were more likely to experience neglect compared to non-Māori children, young people, and adults in care
 - v. children aged 10-14 endured high levels of sexual and physical abuse
 - vi. Māori and Pacific survivors endured higher levels of physical abuse than other ethnicities
 - vii. disabled survivors suffered higher levels of all forms of abuse than non-disabled survivors
 - viii. Deaf and disabled survivors were more likely to report physical, emotional, and sexual abuse than other forms of abuse
 - ix. a higher proportion of survivors in faith settings than in State care were sexually abused. The highest reported levels of sexual abuse were at Dilworth School in Tāmaki Makaurau Auckland (Anglican), Marylands School in Ōtautahi Christchurch (Catholic) and at Catholic institutions in general
 - x. children and young people in foster care experienced the highest levels of sexual abuse among social welfare care settings
 - xi. the decade with the highest rates of abuse and neglect was the 1970s, followed by the 1960s and then the 1980s

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- xii. some survivors reported the misuse of solitary confinement or seclusion
 - xiii. male survivors reported higher levels of abuse than females, including sexual abuse. Males experienced higher levels of physical abuse than other forms of abuse
 - xiv. female survivors were more likely to experience emotional and sexual abuse, compared to other forms of abuse. Females experienced higher levels of neglect compared to males.
- l. At the Lake Alice Child and Adolescent Unit, as set out in the Inquiry's interim report *Beautiful Children*, abuse included:
- i. electric shocks and injections of paraldehyde as punishment, administered to various parts of the body including the head, torso, legs and genitals
 - ii. the misuse of solitary confinement
 - iii. patients exposed to unreasonable medical risks.
- m. At Marylands School and Hebron Trust, as detailed in the Inquiry's interim report *Stolen Lives, Marked Souls*:
- i. abuse and neglect was extensive and extreme
 - ii. sexual abuse was pervasive
 - iii. physical, emotional, and psychological abuse led to some survivors living in perpetual fear
 - iv. evidence suggests the abuse was used as punishment as well as to intimidate
 - v. there was pervasive neglect including neglect of basic needs as well as cultural, medical, and emotional needs
 - vi. children and young people suffered mental and physical pain
 - vii. cultural and religious abuse was extensive
 - viii. survivors experienced racism.
- n. At Te Whakapakiri Youth Programme on Aotea Great Barrier Island, as detailed in the Inquiry's case study:
- i. abuse and neglect were pervasive and extreme
 - ii. young people experienced severe physical violence
 - iii. young people were sent alone to an isolated island for days at a time as punishment
 - iv. there is evidence of young people being threatened with death through mock executions.


- o. At the Kimberley Centre near Taitoko Levin, as detailed in the Inquiry's case study:
 - i. disabled children, young people and adults suffered severe and chronic abuse and neglect
 - ii. physical and sexual abuse of disabled children, young people and adults was pervasive and severe
 - iii. physical abuse was common and normalised. This was reflected by the 'Kimberley cringe' where survivors would cower and protect their head if they were approached quickly
 - iv. people experienced extreme neglect of their physical, emotional, psychological, educational, medical, and dental needs
 - v. nutritional practices were poor with some disabled children, young people and adults not fed for long periods or fed with feeding tubes that were later assessed as not medically required
 - vi. the physical environment was neglectful with few activities and little to occupy disabled children, young people, and adults in care, who spent 80 percent of their time engaged in no purposeful activity.
- p. At Kelston School for the Deaf in Tāmaki Makaurau Auckland, and Van Asch College in Ōtautahi Christchurch, as detailed in the Inquiry's case study:
 - i. Deaf students experienced regular sexual, physical, verbal and psychological abuse
 - ii. physical violence was normalised and pervasive
 - iii. all Deaf children and young people experienced linguistic abuse, and neglect and language suppression
 - iv. Deaf children and young people were punished for using Sign Language and their Deaf culture and identity were not supported.
- q. At Hokio Beach School in Taitoko Levin and Kohitere Boys' Training Centre in Taitoko Levin, as detailed in the Inquiry's case study:
 - i. there were cultures of normalised and pervasive violence, with many experiencing severe corporal punishment, sometimes inflicted with weapons and to the genitals
 - ii. staff condoned and encouraged peer-on-peer violence through a king-pin system including violent 'stomping' initiations of new boys
 - iii. sexual abuse was pervasive
 - iv. solitary confinement was misused
 - v. racism and cultural abuse was normalised
 - vi. staff punished boys with extreme physical training and inhumane tasks, often physically assaulting them at the same time.

Wāhanga 5: I mahue kau noa i te tika

Part 5: The Impacts of Abuse in Care

76. Clause 31(c) of the Terms of Reference requires the Inquiry to make findings on the impact of the abuse and neglect on individuals and their families, whānau, kainga (family), hapū, iwi, and communities during the Inquiry.
77. The Inquiry finds:
- a. Many survivors who were abused or neglected in care have gone on to lead fulfilling lives, and some have worked courageously to improve the future for children, young people, and adults in care in Aotearoa.
 - b. Some people who were abused or neglected in care took their own lives or died because of their experiences in care.
 - c. Evidence of unmarked graves for patients who died at some psychiatric hospitals across Aotearoa New Zealand, particularly at Porirua, Tokanui and Sunnyside Hospitals.
 - d. Most survivors suffered harm and have not been able to live their lives to their full potential. The impacts have been life-long or temporary. These were and are co-occurring, where one type of impact of abuse or neglect will intersect with other impacts. Impacts have included:
 - i. difficulty with establishing intimate relationships
 - ii. difficulty with maintaining family relationships
 - iii. devastating effects on their health and wellbeing
 - iv. damaged mental health and emotional wellbeing
 - v. lack of education opportunities impacting on ability to participate in society
 - vi. reduced opportunities for gaining and maintaining employment opportunities
 - vii. increased financial insecurity
 - viii. experiencing periods of homelessness
 - ix. reduced trust in authority
 - x. for some, pathways into addiction
 - xi. for some, pathways into sex work
 - xii. for some, pathways into criminality and prison
 - xiii. for some, pathways into gang membership
 - xiv. for some, entrapped in institutional care
 - xv. struggles with sexuality and gender identity.

- e. For Māori survivors in addition to the impacts outlined above, they experienced:
 - i. disconnection from whakapapa and te ao Māori
 - ii. loss of identity as Māori, te reo, tikanga and matauranga Māori
 - iii. loss of confidence resulting from this loss of identity.
- f. Survivors struggled to understand their identity.
- g. Many survivors were already at risk of poor life outcomes before they went into care due to poverty, trauma, and the need for additional support from others. Instead of receiving support and protection in care, these survivors experienced abuse and neglect.
- h. During the Inquiry period, harm was pervasive in social welfare institutions. over 30 percent of children and young people went on to serve prison sentences later in life. Tamariki and rangatahi Māori were significantly over-represented in these numbers.
- i. Māori survivors, including tāngata Turi Māori, tangata kāpō Māori, whānau hauā Māori, tāngata whaikaha Māori and tangata whaiaora Māori often experienced disconnection and isolation from their whānau, hapū, iwi and whenua, and their ability to access and participate in te ao Māori. This disconnected them from their tūrangawaewae, causing many to feel a deep sense of whakamā and isolation. This disconnection and the ongoing impacts of colonisation and urbanisation compounded the impacts of the abuse and neglect they suffered. These impacts were felt intergenerationally, particular by survivors' children and grandchildren, and collectively by hapū and iwi.
- j. The intergenerational impact of abuse and neglect has been experienced by their children, grandchildren, whānau and future generations. The impacts have also affected their support networks, hapū, iwi and communities.
- k. Some whānau, support networks, hapū, iwi or communities of survivors experienced guilt and regret for the harm experienced by their loved-ones while they were in care.
- l. Whānau, hapū and iwi were deprived of exercising tino rangatiratanga over kāinga (home) by caring for and nurturing the next generation.
- m. For tamariki, rangatahi and pakeke Māori, the impacts of abuse and neglect in care caused a disruption to the collective ability of Māori to live as Māori and to participate and contribute to Māori social, cultural, and political life within whānau, hapū and iwi. There has been a loss of members to transfer cultural practices, tikanga, te reo and mātauranga Māori which also has inter-generational impacts, a loss of potential leadership to sit on taumata or on the paepae and is a transgression of whakapapa.

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- n. Often when children, young people and adults in care returned home reintegration was difficult, or never achieved. Some people were never able to return or have any ongoing connection with their whānau, support networks, hapū, iwi or communities.
 - o. Deaf, disabled, and mentally distressed survivors, including tāngata Turi Māori, tangata kāpō Māori, whānau hauā Māori, tāngata whaikaha Māori and tangata whaiaora Māori experienced ongoing daily discrimination which further impacted their lives, led to invisibility and sometimes limited or restricted their ability to leave care.
 - p. Pacific survivors often experienced a loss of connection to their kainga (family), culture, language, and cultural identity. This breached the vā, resulting in trauma that has been carried from generation to generation.
 - q. The lack of acknowledgement or apology from those in power creates further trauma for survivors. Where acknowledgements have been made, they were often too little and too late.
 - r. Abuse and neglect, and the ongoing associated intergenerational harm and trauma, have contributed to social inequities.
 - s. The average lifetime cost to the survivor of the loss of enjoyment of things that New Zealanders think are normal day-to-day activities was estimated in 2019 to be approximately \$673,000, which is almost 80 percent of the estimated lifetime costs of abuse per survivor of \$857,000.
 - t. Based on the estimated number of people abused and neglected in care between 1950 and 2019, the total cost is estimated to be between \$97.5 billion and \$219 billion. Of this the smallest proportion, estimated to be approximately at \$47.1 billion, is borne by the taxpayers of New Zealand. The largest cost, estimated to be approximately \$172 billion, is borne by survivors.

Wāhanga 7: Ngā haukino o te wā

Part 7: Factors

Ngā takahi paerewa

Breaches of relevant standards

78. Clause 33 of the Terms of Reference allows the Inquiry to make findings that relevant standards have been breached. In summary, during the Inquiry period the Inquiry finds:

Ngā takahi i te Tiriti o Waitangi

Breaches of te Tiriti o Waitangi

- a. Te Tiriti o Waitangi guaranteed rights to Māori throughout the Inquiry period that should have been protected and upheld.
- b. The Crown deprived whānau, hāpu and iwi of exercising tino rangatiratanga over their kāinga (home), to care and nurture the next generation and regulate the lives of their people, and that this breached the principle of active protection in te Tiriti o Waitangi.
- c. The Crown's failure to address the on-going effects of colonisation that contributed to tamariki, rangatahi and pakeke Māori being placed in care and breached the guarantee of tino rangatiratanga and the principle of active protection in te Tiriti o Waitangi.
- d. The Crown failed to protect Māori survivors from losing their whakapapa and connection to whānau, hapū and iwi. This breached the principles of tino rangatiratanga, kāwanatanga (just, fair, and equitable policies and laws), partnership, active protection, and options in te Tiriti o Waitangi.
- e. The Crown excluded Māori from decision-making, developing and implementing policies that directly impacted the care of tamariki, rangatahi, and pakeke Māori. This breached the guarantee of tino rangatiratanga and the principles of partnership and active protection in te Tiriti o Waitangi.
- f. The Crown's general exclusion of Māori models of care breached the principles of partnership, active protection, equity, and options in te Tiriti o Waitangi.
- g. The Crown stripped Māori of their cultural identity through structural racism. This breached the guarantee of tino rangatiratanga and the principles of kāwanatanga, partnership, active protection, and equity in te Tiriti o Waitangi.
- h. The Crown denied the use of te reo Māori through the introduction of policies and practices in care settings and this breached the principle of active protection in te Tiriti o Waitangi.

- i. The Crown failed to protect Māori from many forms of abuse and neglect once in care. This breached the principle of active protection in te Tiriti o Waitangi.
- j. The Crown failed to collect accurate records of the abuse and neglect experienced by tamariki, rangatahi and pakeke in care. This breached principle of good governance in te Tiriti o Waitangi.
- k. The Crown failed to ensure that tamariki, rangatahi and pakeke in care did not experience racism. This breached the principles of equity and equal treatment in te Tiriti o Waitangi.
- l. Through failing to appropriately address trauma, caused by abuse and neglect in care the Crown failed to prevent inter-generational impacts on Māori, whānau, hapū, and iwi. This breached the principle of active protection in te Tiriti o Waitangi.
- m. The Crown failed to provide appropriate redress for those who suffered abuse and neglect.

Ngā takahi i ngā paerewa atawhai

Breaches of standards of care

- n. People in care had rights to standards of care that prevented abuse (ill-treatment) and neglect during the Inquiry period. However:
 - i. in some settings, particularly disability and mental health, education and faith, the government failed to set adequate or overarching standards of care
 - ii. in Deaf, disability and mental health settings, institutions breached the standards they set. Specifically, survivors' rights to dignity and respect, adequate protection from abuse, neglect and exploitation and proper daily care were consistently breached
 - iii. in social welfare settings, staff, social workers, and foster parents breached the standards of care set out in Department of Education Field Officers Manual and its later versions (including the Social Workers Manual)
 - iv. in transitional and law enforcement settings, NZ Police breached the standards set in their General Instructions. Specifically, by interrogating young people with violence and without the presence of an adult and by holding them in police cells.
- o. There were regular and routinely breaches of standards of care with significant impacts for many children, young people and adults in care whose standards were breached.
- p. In many institutions, residences, and foster homes, standards were breached every day, due to a lack of resourcing, poor training and confusion about statutory powers and the role of staff or foster parents.

- q. Breaches of standards varied in severity. Many were extremely serious. Some breaches of standards were in themselves abuse, while others allowed abuse and neglect to occur.
- r. Breaches of standards of care included:
 - i. neglect and abuse (ill-treatment), including sexual abuse, that was severe, extensive, extreme or pervasive in some institutions
 - ii. wrongful use of seclusion, solitary confinement and secure care
 - iii. frequent use of corporal punishment, which at times was extreme, perverse punishment involving weapons and humiliation
 - iv. frequent breaches of health care standards, at times unlawfully, including:
 - > lobotomies, sterilisation, forced adoptions, invasive genital examinations, over medicating, and experimental psychiatric treatments without informed consent
 - > in psychiatric facilities, electric shocks and injections of paraldehyde as punishment, and exposing patients to unreasonable medical risks
 - > medical neglect and abuse
 - > medicating people in care for long periods without review
 - > not providing access to doctors or health specialists for extended periods
 - > failing to provide a medical certificate on admission to a residence or institution
 - v. the failure of some social workers to visit State wards in care, a key intervention and rescue point for people experiencing abuse or neglect
 - vi. serious breaches of transitional and law enforcement standards, such as:
 - > people in care questioned without the presence of a parent, guardian or lawyer
 - > interrogations using physical violence
 - > coercion to confess to crimes, even when innocent
 - > stays in police cells, overnight, sometimes up to weeks.



Ngā take i hua ai te mahi tūkino i ngā pūnaha taurima


Factors which caused or contributed to abuse in care

79. Clause 31(b) of the Terms of Reference requires the Inquiry to make findings on the factors, including systemic factors, which caused or contributed to abuse and neglect.
80. Clause 10.2 of the Terms of Reference refers to factors that include, but are not limited to, the standards that applied in care settings, the vetting, recruitment, training, development and supervisions of staff and carers, the processes available to people in care for raising concerns or complaints, the processes in place to respond to those complaints and how effective they were.
81. In summary, during the Inquiry period the Inquiry finds:

Te hunga i te pū o ngā mahi tūkino

The people at the centre of abuse and neglect

- a. Children, young people, and adults in care were diverse, with different care and support needs.
- b. Children, young people, and adults in care needed support, protection, and safeguarding when in care.
- c. Strong protective factors significantly reduces the risk of abuse and neglect and the likelihood of entry into care.
- d. Strong protective factors include connection to whānau, strong self-esteem, supportive trustworthy adults and friends and an understanding of inappropriate behaviour and what to do in difficult situations.
- e. The rights guaranteed in te Tiriti o Waitangi are a layer of protection for whānau, hapū, and iwi and their tamariki, rangatahi and pakeke. These rights also reinforce protective factors.
- f. Human rights are a layer of protection for children, young people, and adults in care, and their families, whānau, and individual mothers and fathers. Human rights also reinforce protective factors.
- g. Many people entering care had weakened protective factors, contributing to the risk they would experience abuse and neglect.
- h. Many tamariki, rangatahi and pakeke Māori entered care with few protective factors.

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- i. Many of the circumstances that made it more likely a person would enter care often became the circumstances for why they were more susceptible to abuse and neglect in care. Those circumstances included:
 - i. being raised in poverty and experiencing deprivation
 - ii. being disabled with unmet needs
 - iii. being Māori and racially targeted
 - iv. being Pacific and racially targeted
 - v. being Deaf with unmet needs
 - vi. experiencing mental distress with unmet needs
 - vii. being Takatāpui, Rainbow, MVPFAFF+, gender diverse or transgender and targeted
 - viii. experiencing significant or multiple adverse childhood events, including:
 - > experiencing violence, abuse, or neglect in private homes or in other care settings
 - > witnessing violence in private homes or in the community or in other care settings
 - > having a family member or a peer in a care setting pass away, or attempt or die by suicide
 - > aspects of their environment that undermined their sense of safety, stability, and bonding, such as
 - I. growing up in a private home or in other care settings:
 - with parents, caregivers, or peers experiencing substance use problems
 - with parents, caregivers, or peers experiencing mental distress
 - where there is instability due to parental separation or household members being incarcerated
 - II. living in an under-resourced private home or becoming homeless
 - III. experiencing unsupported and weakened family and cultural structures
 - IV. being in families and communities that were unsupported because their needs had not been adequately assessed or met
 - ix. having a deferential attitude to people in positions of authority, including faith leaders and medical professionals
 - x. other circumstances such as age or gender, and
 - xi. experiencing or being any combination of the above.


- j. Abusers were able to misuse their positions of power and control over people in their care to inflict at times extreme and severe abuse and neglect.
- k. Abusers were often predatory.
- l. Abusers exploited the powerlessness and vulnerability of those they were abusing or neglecting.
- m. Abusers often acted with impunity.
- n. Some survivors were abused by peers. The risk of peer-on-peer abuse increased when the abuser knew that staff or carers would not hold them to account.
- o. Most abusers took steps to conceal their actions. They ensured that survivors' complaints about abuse and neglect were ignored or suppressed.
- p. Many abusers avoided accountability, allowing them to abuse for extended periods and across multiple residences and institutions.
- q. Many bystanders (staff, volunteers and carers) failed to stop or report abuse and neglect that they observed or suspected was occurring

Take hinonga

Institutional factors

- r. The following institutional factors contributed to abuse and neglect in care:
 - i. inadequate, inconsistent and inaccessible standards (including the lack of commitment to human rights and te Tiriti o Waitangi) of care which were routinely breached with little consequence or accountability
 - ii. individual care needs were not routinely or accurately identified, recorded and met
 - iii. poor employment policies and poor senior leadership and management practices, including:
 - > poor or inadequate vetting policies, exacerbated by a lack of access to NZ Police vetting for most settings
 - > senior leaders and managers sometimes skipping vetting requirements
 - > senior leaders and managers sometimes knowingly employing abusers with criminal convictions for sexual abuse
 - > a lack of staff and carer diversity
 - > under investment in staff and carers
 - > recruitment of people with service or military backgrounds that contributed to punitive, command and control models of care in some institutions
 - > poor or inadequate training and development specific to care roles, and on how to recognise the signs of abuse and neglect in care

- iv. widely variable, absent, or inaccessible complaints processes that were poorly implemented, including:
 - > barriers faced by people in care to raise concerns or complaints, including a lack of access to whānau, communities, and advocates
 - > consistent failures to believe people in care when they reported abuse or neglect, underpinned by societal attitudes like racism, ableism and disablism
 - > concerns or complaints being treated as an employment issue or as a sin to be forgiven, rather than (in many cases) criminal behaviour
 - > senior leaders or managers prioritising institutional reputations over the safety of people in care
 - > senior leaders or managers prioritising abusers' reputations and future careers over the safety of people in care, including shifting the abuser to other residences or institutions and using confidential settlements
 - > consistent failures to report complaints of abuse and neglect to NZ Police
- v. ineffective, ad hoc and insufficient oversight and monitoring, which did little to prevent or respond to known abuse and neglect
- vi. consistent accountability failures, that allowed abuse and neglect to continue and gave many abusers a sense of impunity.

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- s. The State did not take the steps it should have when it saw signs its care system was failing people in care. Those steps should have included:
- i. legislation specific to care settings to give effect to the guarantees made to Māori in te Tiriti o Waitangi, particularly tino rangatiratanga
 - ii. legislation specific to care settings to respect, protect and fulfill the human rights of people in care
 - iii. a suite of concrete supports or special measures that prioritised the reduction of inequities for families, whānau and communities, supported them to provide care and support at home, and minimised entry into care
 - iv. steps to minimise and ultimately end institutionalised environments and practices
 - v. a national framework for safety in care, designed in partnership with Māori and co-designed with people in care, their families, whānau and communities, set out in legislation and made up of:
 - > a single, overarching national strategy for safety in care that applied to all care settings, seeing them as part of one care system inclusive of faith-based care settings
 - > a set of easily accessible standards of care that applied to everyone in care, that could be tailored to their needs and culture, regardless of who they were and where they were
 - > the core requirements of transparent, accessible and responsive complaints processes, including access to advocates
 - > blanket safety checking requirements that applied to all staff and carers, regardless of their status and role
 - > consistent mandatory reporting requirements for staff and carers
 - > consistent accountability for abuse and neglect in care, with swift and effective penalties for non-compliance
 - vi. best practice training and development standards for staff and carers, and
 - vii. independent, strategic, well-funded independent oversight and monitoring that looked across all care settings and consistently reported abuse and neglect to NZ Police.

Take ā-whakapono ake


Faith-specific factors

- t. The following faith-specific factors contributed to abuse and neglect in care:
 - i. the authority and impunity of faith-based institutions created opportunities for abuse and neglect to occur and continue
 - ii. discriminatory attitudes, policies and practices that contributed to abuse and neglect
 - iii. harmful use of beliefs and practices which created environments that fostered abuse and neglect.

Take ā-pūnaha

Systemic factors

- u. The following systemic factors contributed to abuse and neglect in care:
 - i. people in care, whānau and communities had limited input into State decisions about care
 - ii. the State's attempts to deal with institutional discrimination, which impacted who went into care and who experienced abuse and neglect in care, were lack lustre
 - iii. legislative and policy settings were discriminatory, underpinned by societal attitudes like racism, ableism and disablism, and negative stereotypes of children, young people as delinquents, and negative attitudes towards people living in poverty
 - iv. the State generally ignored the rights of people in care:
 - > the State did not give effect to rights guaranteed in te Tiriti o Waitangi, particularly tino rangatiratanga
 - > the State did not progressively respect, protect and fulfil the human rights of people in care and their whānau
 - v. the State lacked diversity and lived experience of care in its leadership
 - vi. the State did not ensure people in care were safeguarded from abuse or neglect, or had effective oversight and monitoring
 - vii. there was a lack of State accountability for abuse and neglect, particularly those with statutory responsibilities to people in care
 - viii. the State did not ensure there was a comprehensive regulatory care framework that was enforced and properly invested in and resourced
 - ix. the State failed to respond to signs of systemic abuse and neglect, taking no steps to understand if its system of care was failing
 - x. the State's structure clouded its response to signs of system failure.

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- v. The State did not take the steps it should have when it saw signs its care system was failing people in care. Those steps should have included:
 - i. legislation specific to care settings to give effect to the guarantees made to Māori in te Tiriti o Waitangi, particularly tino rangatiratanga
 - ii. legislation specific to care settings to respect, protect and fulfill the human rights of people in care
 - iii. a suite of concrete supports or special measures that prioritised the reduction of inequities for families, whānau and communities, supported them to provide care and support at home, and minimised entry into care
 - iv. steps to minimise and ultimately end institutionalised environments and practices
 - v. a national framework for safety in care, designed in partnership with Māori and co-designed with people in care, their families, whānau and communities, set out in legislation and made up of:
 - > a single, overarching national strategy for safety in care that applied to all care settings, seeing them as part of one care system inclusive of faith-based care settings
 - > a set of easily accessible standards of care that applied to everyone in care, that could be tailored to their needs and culture, regardless of who they were and where they were
 - > the core requirements of transparent, accessible and responsive complaints processes, including access to advocates
 - > blanket safety checking requirements that applied to all staff and carers, regardless of their status and role
 - > consistent mandatory reporting requirements for staff and carers
 - > consistent accountability for abuse and neglect in care, with swift and effective penalties for non-compliance
 - vi. best practice training and development standards for staff and carers, and
 - vii. independent, strategic, well-funded independent oversight and monitoring that looked across all care settings and consistently reported abuse and neglect to NZ Police.

Take ā-iwi

Societal factors

- w. The following societal factors contributed to abuse and neglect in care:
 - i. discriminatory societal attitudes like racism, ableism, disablism, sexism, homophobia, transphobia and negative stereotypes, directly contributed to survivors entering care and suffering abuse and neglect in care, with Māori, Pacific Peoples, Deaf, disabled people, people experiencing mental distress, and Takatāpui, Rainbow and MVPFAFF+ people being disproportionately affected
 - ii. negative views about people living in poverty and welfare dependency
 - iii. belief systems that upheld reverence and trust in faith-based institutions and members of faith
 - iv. negative views towards children and young people, as delinquents, naughty and not to be believed
 - v. society condoned and tolerated institutionalisation of people for decades.

Whakataau hē

Findings of fault

82. Clause 33 of the Terms of Reference allows the Inquiry to make findings of fault. In summary, the Inquiry finds that, during the Inquiry period:

Te Kāwanatanga

The State


Ngā takinga toko i te ora

Social welfare settings

- a. Relevant Ministers, the Superintendent of the Child Welfare Division, Department of Education and then subsequently the Director-General and Chief Executive of the Department of Social Welfare and its successors were at fault for:
 - i. failing to address structural racism in the care system
 - ii. the adverse effects of structural racism on tamariki, rangatahi, and pakeke Māori in care, their whānau, hapū, and iwi, and has an ongoing detrimental impact on the relationship between Māori and the Crown
 - iii. failing to address structural ableism and disablism in the care system
 - iv. not consistently supporting whānau to prevent people from entering care
 - v. insufficient emphasis on whānau-based alternatives to State care
 - vi. often ignoring Māori perspectives and solutions
 - vii. failing to fully meet the needs of all of those in care
 - viii. failing to ensure people in care were kept safe from harm
 - ix. failing to ensure caregivers in social welfare settings were properly vetted, trained, supported, and monitored
 - x. inadequate policies, processes and practices to always detect and facilitate the reporting of abuse and neglect
 - xi. the ongoing impacts of abuse and neglect for survivors and their whānau
 - xii. failing to consistently believe or follow up reports of harm in social welfare settings
 - xiii. inadequate protection and preservation of the records and case files of all people in care, which impacts survivors today.

Ngā takinga ā-Turi, whaikaha, hauora hinengaro
Deaf, disability and mental health settings

- b. Relevant Ministers, Directors-General of Health and Directors of Mental Health were at fault for:
 - i. the policy of institutionalisation from the 1950s to 1970s which resulted in Deaf, disabled people, and people experiencing mental distress being placed in settings where many experienced abuse and neglect. This was despite advice from the World Health Organisation that institutionalisation was opposite to best practice at the time, which was reiterated in the 1959 Burns Report by the Aotearoa New Zealand branch of the British Medical Association
 - ii. institutional and societal ableism in legislation, policy and systems that contributed to the abuse of Deaf, disabled people, and people experiencing mental distress in health and disability institutions
 - iii. institutional racism in legislation, policy and systems that contributed to the abuse of Māori and Pacific Peoples in health and disability settings
 - iv. ableist health and disability care settings that did not always meet the needs of Deaf, disabled people, and people experiencing mental distress
 - v. ignoring the perspectives and solutions of disabled people and their whānau
 - vi. Māori, Pacific Peoples, Deaf, disabled people, and people experiencing mental distress being particularly negatively impacted, through being overrepresented in care, or their distinct needs not being met in care, including because of abuse suffered
 - vii. Deaf, disabled people, and people experiencing mental distress not always being supported to make decisions about their own lives especially adults
 - viii. legislative and policy settings that did not ensure sufficient emphasis on alternatives to placing Deaf, disabled people, and people experiencing mental distress into institutionalised care, like exploring family or community-based care options
 - ix. legislative and policy settings that did not always provide adequate support and resourcing to whānau, including disability support and resourcing
 - x. failing to fully meet the needs of all of those in care

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- xi. not consistently and meaningfully ensuring the cultural needs of all Māori in care were met, including culturally appropriate health care options, causing disconnection from their culture, identity, language and communities, with ongoing impacts for them, and their whānau, hapū and iwi
 - xii. not consistently and meaningfully ensuring the cultural needs of all Pacific Peoples in care were met, including culturally appropriate health care options, causing disconnection from their culture, identity, language and communities, with ongoing impacts for them, and kainga and wider communities
 - xiii. failing to ensure people in care were kept safe from harm when they should have been
 - xiv. inadequate policies, processes and practices to safeguard people in care
 - xv. inadequate policies, processes and practices, including reporting, to detect abuse and neglect
 - xvi. people in care experiencing abuse and neglect, which has had ongoing impacts for survivors and their whānau
 - xvii. inappropriate use of seclusion and restraint in psychopaedic and psychiatric settings and inappropriate use of medication, aversion practices, and shock treatment, and acts that met the Solicitor-General's definition of torture
 - xviii. failing to maintain accurate records, including not recording ethnicity, Deaf, disability or mental distress or impairment, compounded by the loss of records, has resulted in the true number of those in care will never be known.

Ngā takinga mātauranga

Education settings

- c. Relevant Ministers, Secretaries and Chief Executives of Education were at fault for:
 - i. failing to provide education fit for different groups, including Blind, Deaf, and disabled children and young people
 - ii. failing to support New Zealand Sign Language and the language and cultural needs of Deaf people
 - iii. failing to identify and support the needs of neurodivergent people
 - iv. ignoring Deaf and disabled peoples' and communities' perspectives and solutions
 - v. failing to actively protect te reo and encourage its use by Māori, which was in breach of te Tiriti o Waitangi, and has had an ongoing detrimental effect for Māori
 - vi. not sufficiently valuing Māori culture
 - vii. failing to respond to the identity, language, and culture of Māori which has been harmful, and contributed to poor education outcomes
 - viii. having consistently lower expectations of tamariki and rangatahi Māori
 - ix. having less oversight of private schools than State or State-integrated schools, which may have increased opportunities for abusers
 - x. failing to keep children safe, during the school day and in overnight / boarding care
 - xi. failing to keep children in some schools and boarding facilities connected with whānau.



Ngā takinga whakatika, mauhere ā-ture

Transitional and law enforcement settings

- d. Successive Commissioners of NZ Police were at fault for:
- i. negative Māori experiences with policing
 - ii. failing to recognise the importance of te Tiriti o Waitangi until the mid-1970s
 - iii. failing to understand the role of NZ Police in the disproportionate representation of Māori in the criminal justice system
 - iv. NZ Police responses to Māori over-representation in the criminal justice system that fell short of a full commitment to the principles of te Tiriti o Waitangi
 - v. NZ Police responses that did not reflect the needs of Māori communities or the best way to resolve situations for Māori
 - vi. failing to value tikanga Māori as part of policing practice, for most of the Inquiry period
 - vii. Pacific Peoples' negative experiences with policing
 - viii. failing to understand whether ableism within NZ Police contributed to disproportionate representation of disabled people in the criminal justice system
 - ix. inadequate policies, processes, and procedures to support Deaf, disabled people, and people experiencing mental distress to engage with NZ Police
 - x. during the 1950s to 1970s, a singular focus on enforcement
 - xi. during the 1950s to 1989, not consistently considering alternatives to criminal proceedings for children and young people
 - xii. before 1989, not being inclusive whānau in the decision-making impacting the person in their care
 - xiii. failing to consistently follow General Instructions and related policies regarding children, young people and adults in their care, such as questioning people under the age of 14 without the presence of any parent, guardian or lawyer
 - xiv. the use of police cells to detain children and young people (due to lack of alternatives), which was, and remains, unsuitable for children and young people, particularly those in care and protection
 - xv. the abuse and neglect people experienced while in transitional and law enforcement settings, including physical abuse
 - xvi. failing to understand or investigate the nature and extent of police abuse of people in transitional and law enforcement care settings


- xvii. general instructions that limited who could access vetting during the Inquiry period, particularly between 1977 and 1991
- xviii. lacking a universal policy on how to respond to allegations of abuse and neglect in care
- xix. before 1995, lacking a dedicated policy relating to investigation of sexual abuse and serious physical abuse of children
- xx. lacking awareness of the risk of sexual offending by people in positions of authority
- xxi. negative bias against victims of abuse and neglect who were not believed or considered reliable or credible, for example at times assuming that Deaf, disabled people, and people experiencing mental distress may not be credible witnesses, or assuming promiscuity of a young survivor when investigating allegations of sexual abuse in care
- xxii. failures to investigate abuse and neglect against children, young people and adults in care
- xxiii. lacking statistical data on allegations of abuse and neglect in care
- xxiv. the racism and discrimination exhibited by some leaders within NZ Police
- xxv. failing to collect data on the diversity of the NZ Police workforce, specifically ethnicity and the number of Deaf or disabled police.



Ngā takinga ā-pūnaha taurima katoa

Whole of care system settings

- e. Successive governments were at fault for:
 - i. institutional, structural racism and ableism in legislation, policy and systems that contributed to the disproportionate representation, and discriminatory treatment of Māori, Pacific Peoples, Deaf, disabled people, people experiencing mental distress, and Takatāpui, Rainbow and MVPFAFF+ people in care
 - ii. the alienation of tamariki, rangatahi, and pakeke Māori from their whānau, hapū, and iwi, and their culture, identity, language, and the ongoing impacts of that alienation
 - iii. the alienation of Pacific Peoples from their kainga, culture, identity, language, and the ongoing impacts of that alienation
 - iv. the alienation of Deaf people from their whānau and communities, and their culture, identity, language, and the ongoing impacts of that alienation
 - v. the abuse and neglect people experienced while in care
 - vi. failing to ensure that people in care were safe from abuse and neglect
 - vii. failing to consistently stop abuse and neglect in care when it was disclosed or reported
 - viii. record-keeping issues, including gaps and loss of records, which mean the true number and make up of children, young people and adults in care is unlikely to ever be known.

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- f. Successive State or Public Service Commissioners (responsible for the integrity and conduct of public servants, and the appointment and performance of chief executives) were at fault for failing to hold chief executives to account for:
 - i. preventing abuse and neglect in care
 - ii. not adequately identifying and investigating abuse and neglect in care
 - iii. appropriately responding to complaints of abuse and neglect in care by both protecting people in care and holding abusers to account
 - iv. providing holistic redress for survivors of abuse and neglect in care
 - v. addressing the role the public service played in being responsible for the abuse and neglect people experienced and the ongoing impacts of such abuse and neglect while in State care
 - vi. addressing the public servants not following the standards of successive codes of conduct
 - vii. the lack of a cohesive public service to provide joined-up, comprehensive and coherent safeguarding of children, young people and adults in care
 - viii. there being no appropriate public service framework for:
 - > ensuring the care workforce were diverse and reflected the makeup of society
 - > ensuring workplaces were inclusive of all groups in society
 - > focusing on developing and maintaining public service capability to engage with Māori and understand Māori perspectives.





Ngā whakapono Faiths


- g. The Catholic Church was at fault for:
 - i. the harm that has taken place in some Catholic educational institutions. That harm includes:
 - > serious sexual harm and inappropriate physical punishment
 - > inadequate steps taken in response to complaints of abuse and neglect
 - > putting students at risk of harm by appointing abusers to the school without effective methods in place for protecting students
 - > placing a heavy reliance on the opinions of psychiatrists in determining the ability of an abuser to rehabilitate and continue working in certain areas or in ministry, which resulted in abusers being transferred to other areas of ministry where re-offending occurred
 - ii. being slow to act when sexual abuse was occurring
 - iii. children being harmed in Catholic institutions where they should have been cared for and safe
 - iv. harm caused to children because of mistakes made by the Church which could have and should have been avoided
 - v. not doing more to prevent the pain and suffering of all those who should have been kept safe in the church's care
 - vi. the following factors which caused abuse to occur or prevented its disclosure:
 - > prioritising forgiveness over safeguarding and accountability for those who perpetrated the abuse and the leadership at the time with knowledge of the abuse
 - > creating a power imbalance between religious / clergy and their parishioners
 - > lack of resources of, and investment in, those with the care of children, young people and adults (when they should not have been in those positions)
 - > lack of training for those in care of children, young people and adults
 - > care for the reputation of the church.

h. The Anglican Church was at fault for:

- i. the failures of those within the Church who were meant to protect and care for people in their care
- ii. abuse and neglect in the care of the Church
- iii. abuse and neglect that included sexual abuse, physical abuse, verbal abuse and emotional abuse and neglect
- iv. perpetuating societal attitudes in its institutions, like corporal punishment, normalised bullying in schools, and suppressing Māori and Pacific Peoples' culture
- v. failing to implement institutional monitoring, leaving the responsibility of management up to individual leaders
- vi. failing to implement an overarching Church policy or process to guide the handling of complaints of abuse, including record-keeping
- vii. leaving allegations and complaints of abuse to be handled by those who knew the alleged abusers well, with some unwilling to accept a fellow clergy member could be an abuser
- viii. abuse that was ignored or covered up within the Church, which failed to protect people in care and failed to hold abusers to account
- ix. perpetrators of abuse who were protected by the sanctity of their role within Anglican institutions
- x. failing to believe the survivor when they first came forward, instead survivors were often deemed untrustworthy or deceitful
- xi. survivors having to live with the consequences of the trauma they suffered for decades
- xii. the families of survivors having to carry the long-term consequences of abuse and neglect
- xiii. the role of patriarchy within the Church in failing to listen and respond to issues of abuse and neglect
- xiv. being too trusting of individuals within the Church, which contributed to the Church's failure to address its mistakes sooner.

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- i. The Methodist Church was at fault for:
 - i. failing in its duty to ensure the protection and wellbeing of those in its care
 - ii. the pain and suffering of all those who were abused in the Church's care, including:
 - > those who suffered abuse while at Wesley College in Pukekohe
 - > those who suffered abuse in former children's homes, in Ōtautahi Christchurch, Whakaoriori Masterton, and Tāmaki Makaurau Auckland
 - > those who suffered abuse by a Minister, foster parents or in other Methodist Church parish settings
 - > those who suffered abuse, which remains unreported
 - iii. abuse and neglect, including sexual, physical, emotional and psychological abuse and neglect
 - iv. insufficient monitoring, oversight and safeguarding of those in their care, which enabled abuse to occur
 - v. failing to implement protection policies and procedures across all its Church-related entities
 - vi. failing to implement mandatory NZ Police vetting
 - vii. failing to consistently implement key changes on an "all of Church" approach to ensure those providing care were adequately trained and resourced
 - viii. failings in addressing complaints, including not always accepting and acting appropriately on reports of abuse and complaints
 - ix. responding to complaints with a traditional legal approach that included:
 - > requiring survivors to report their abuse to NZ Police before conducting its own inquiries
 - > declining to progress claims in a way that meant survivors had to pursue legal claims in the courts
 - > failing to recognise it had a duty to take action to discipline a member of the Church, particularly a Minister
 - x. failing to recognise the Church's role to deliver a restorative response to reports or complaints of abuse
 - xi. the additional harm caused to survivors when the Church initially refused to believe them, sought to contest their concerns, or refer the complaint elsewhere, and failing to recognise the Church needed to address their complaint
 - xii. the trauma experienced as a result of abuse, which has had long term impacts on the lives of survivors, their whānau and loved ones
 - xiii. failing to have record keeping policies relating to reports or complaints of abuse and neglect.

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- j. From Gloriavale's inception in 1969 through to the end of the Inquiry period, the Overseeing Shepherd and senior leadership of the Gloriavale Christian Community were at fault for:
 - i. allowing physical and sexual abuse to happen within the community
 - ii. failing to address intergenerational sexual abuse within the community which perpetrated a cycle of harm
 - iii. failing to prevent and protect survivors within the community against abuse
 - iv. responding to allegations of abuse by seeking to create repentance from the offender and forgiveness from the victim
 - v. failing to recognise the harm of abuse on survivors
 - vi. failing to deal with perpetrators of abuse appropriately, allowing them to continue living in the community and allowing abuse to continue within the congregation as a result
 - vii. failing to recognise the scale and extent of abuse in the community
 - viii. dealing with complaints of abuse themselves and not engaging any other authorities or professionals, including NZ Police or Oranga Tamariki and its predecessors
 - ix. the role the community's Doctrines had in creating a culture that allowed abuse to occur.

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- k. The Presbyterian Church were at fault for:
- i. its reluctance to confront abuse
 - ii. failing to remove people who posed risks to children, young people and adults in their care from unsupervised participation in the Church
 - iii. its reluctance to make binding rules
 - iv. failing to recognise ministers, elders or leaders as people who could cause harm
 - v. its dynamic of protecting the congregation from outside interference, creating a risk of abuse and neglect
 - vi. discounting complaints of abuse
 - vii. failing to report complaints of abuse to proper Church authorities or to NZ Police, allowing perpetrators to continue abusing
 - viii. not supporting survivors to make complaints, making them feel isolated, discouraging them from taking complaints further and not believing them
 - ix. removing perpetrators from one area but allowing them to continue in other areas without considering the risks
 - x. deliberately attempting to suppress reports of abuse at times
 - xi. failing to apply its policy of zero tolerance of abuse of people in the case of the Church consistently and thoroughly
 - xii. failing to consistently uphold its Code of Ethics in relation to pastoral care adopted in 1995
 - xiii. failing to consistently report breaches of its Code of Ethics.
- l. Additionally, Presbyterian Support Services Central was at fault for:
- i. failing to properly record the ethnicities of Māori and Pacific children in the care of Berhampore Home in Te Whanganui-ā-Tara Wellington
 - ii. failing to prioritise any understanding of how to better deliver care to disabled people.

m. The Salvation Army was at fault for:

- i. lack of understanding of the abuse and neglect of children, young people and adults in their care, and its effects on survivors, sometimes lasting for a lifetime
- ii. wide-ranging abuse and neglect in their care, which included sexual, physical and psychological abuse and neglect and mistreatment
- iii. abuse and neglect carried out by staff and officers of the Salvation Army, by other residents or visitors to homes, and foster parents and caregivers
- iv. abuse and neglect in their homes for unwed mothers, including Bethany homes, including pressure to have their children adopted, while being denied relevant information, medical and emotional help and support
- v. abuse and neglect in children's homes in Whakaoriori Masterton, Temuka, Tāmaki Makaurau Auckland, Putaruru, Eltham in Taranaki, Te Whanganui-ā-Tara Wellington, and Kirikiriroa Hamilton
- vi. serious neglect in some children's homes and homes for unwed mothers, including inadequate nutrition, hygiene and healthcare
- vii. abuse that included racism, ableism, and discrimination based on gender and sexuality.

Ngā roopu hunga mātanga

Professional bodies

n. The New Zealand Medical Association and Medical Council of New Zealand were at fault for:

- i. actions that the New Zealand Medical Association and Medical Council of New Zealand should have taken, but did not, to protect the public
- ii. decisions in relation to complaints of abuse, that the Medical Council of New Zealand cannot now explain due to the incompleteness of records
- iii. the New Zealand Medical Association prioritising fairness to doctors (including psychiatrists) over the safety and wellbeing of patients when investigating complaints
- iv. accepting much of Dr Selwyn Leeks' response to allegations without question when investigating a complaint against Dr Leeks in 1977.

o. The Nursing Council of New Zealand and its predecessors were at fault for not taking appropriate care of survivors, and their whānau, involved in its processes, resulting in unacceptable instances of harm. For some survivors, those processes have had a significant and ongoing impact.

p. The Teaching Council of Aotearoa New Zealand and its predecessors were at fault for not taking appropriate care of survivors, and their whānau, involved in its processes, resulting in unacceptable instances of harm. For some survivors, those processes have had a significant and ongoing impact.



Ngā akonga i kitea he mea panoni

Lessons identified and changes made

83. Clause 31(e) of the Terms of Reference requires the Inquiry to make findings on the lessons learned, and what changes were made to prevent and respond to abuse. The Inquiry finds:

Te hunga i te pū o ngā mahi tūkino

The people at the centre of abuse and neglect

- a. The State made discrete changes to safeguard against abuse and neglect and increase protective factors for people in care during the Inquiry period, generally from the late 1980s onwards.
- b. Some faith-based institutions began to introduce some safeguarding and protective factors from the late 1980s onwards.
- c. There were discrete changes to support the role of staff and carers in detecting and responding to abuse, mainly relating to training and voluntary reporting from the late 1980s onwards.

Ngā kawenga atawhai a ngā hinonga me ngā kāinga tamariki atawhai

The institutions and foster homes responsible for care

- d. The State legislated for standards of care in some settings from the mid to late 1980s onwards.
- e. The State made changes to regulate some staff in some care settings, such as teachers, and progressively developed policies in State settings on recruitment, vetting, training, development and supervision from the 1970 onwards.
- f. The State introduced detailed regulations on complaints processes for people in social welfare residences and institutions in 1986 and people subject to a compulsory mental health assessment or treatment order in 1996.

Ngā kawenga atawhai ā-whakapono


The faiths responsible for care

- g. Faith-based care settings either did not make changes or were slow to make changes to prevent and respond to abuse during the Inquiry period.

Ngā kawenga atawhai a te Kāwanatanga

The State's responsibility for care

- h. The State was slow to learn and act on critical lessons identified about abuse and neglect in care and many changes were not made until the 1980s onwards.
- i. The State made many changes toward the end of the Inquiry period, including the creation of new legislation, policies and standards as new lessons were being identified and calls for change were being made.
- j. The State made changes to prevent and respond to abuse and neglect with good intentions but these were not always realised due to implementation failures.
- k. The State learned lessons about the impact of institutionalisation and segregation on Deaf, disabled people, and people experiencing mental distress but was slow to take action in response.
- l. The State learned lessons about the overrepresentation of Māori across all care settings, but changes were generally not made until the late 1980s to try to address this.
- m. Changes made throughout the Inquiry period to prevent and respond to abuse and neglect were inconsistent across care settings.
- n. Changes made were substantially smaller than the scale of abuse and neglect in care.
- o. Many discrete policy changes were made to respond to abuse and neglect in Social Welfare settings.
- p. Changes by the State were slow and few to prevent and respond to abuse and neglect in Deaf, disability and mental health settings.
- q. The State did not make changes to prevent or respond to abuse and neglect in many faith-based settings during the Inquiry period.
- r. Societal attitudes changed over the Inquiry period.
- s. The State made some changes to try and eliminate discriminatory institutional policies and practices.



"I have not been
able to find my
whakapapa. I had hoped to
let my son know so that he
could one day let his children
know. But my son is dead now.
He committed suicide in
prison."

MR JP
Faith survivor

Ngā Tūtohi

Recommendations

TŪTOHI | RECOMMENDATION 1

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

Tūtohi | Recommendation 1

As an immediate priority, the government and faith-based institutions should implement the 95 Recommendations in the Inquiry's interim report on redress, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui (2021), together with the recommendations of the design group, subject to any further recommendations made in this report.

NGĀ TŪTOHI | RECOMMENDATIONS 2–4

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

Key leaders to make public acknowledgements
and apologies

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) 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 Recommendations from the Inquiry's interim report, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui (2021)
- 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 that 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 (family), 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 (2021), make a specific apology to groups who were harmed, including Māori, where appropriate.

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 in Aotearoa 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 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, Solicitor-General, 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

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- c. the leaders of relevant professional bodies, including the Royal Australian and New Zealand College of Psychiatrists, Medical Council of New Zealand, Aotearoa New Zealand Association of Social Workers, New Zealand Nurses Association, 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:

- e. developed and agreed with a representative group of survivors
- f. 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.

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.

TŪTOHI | RECOMMENDATION 5

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

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 any 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 address the harm caused to survivors by the memorialisation of proven perpetrators and institutions where abuse and neglect took place.

NGĀ TŪTOHI | RECOMMENDATIONS 6–7

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

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

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.

NGĀ TŪTOHI | RECOMMENDATIONS 8–9

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 torowhānui

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



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 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 support options available to them.

TŪTOHI | RECOMMENDATION 10

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

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.

TŪTOHI | RECOMMENDATION 11

**Me whakatau he utu ki ngā purapura ora i pākia e
ngā mahi tūkino i roto i ngā pūnaha taurima**

Compensate survivors of abuse and neglect in care

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 flowing 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.

NGĀ TŪTOHI | RECOMMENDATIONS 12–13

He whakatau motuhake mō te Order of St John of God Order of the Brothers of St John of God specific actions

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.

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 puretumu torowhānui system and scheme and support options available to them.



TŪTOHI | RECOMMENDATION 14

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



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.

NGĀ TŪTOHI | RECOMMENDATIONS 15–17


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

Embed human rights into the puretumu torowhānui system and scheme

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, 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, 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

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- 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.



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.

TŪTOHI | RECOMMENDATION 18

Tirohia anō mehemea kei te ōrite ngā whakatau mō Lake Alice

Review Lake Alice settlements for parity

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.

TŪTOHI | RECOMMENDATION 19

Whakatūria he arotakenga motuhake mō ngā poka ingoa kore me ngā urupā

Establish an independent investigation of unmarked graves and urupā

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.

TŪTOHI | RECOMMENDATION 20

Whakatū tahua pūtea mo ngā kaupapa e hāngai ana ki ngā parurenga 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

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, like those established in Canada and Australia. The entity holding and distributing the funding should be independent from State and faith-based entities.

TŪTOHI | RECOMMENDATION 21

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

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 TŪTOHI | RECOMMENDATIONS 22–24


Panonihia ngā tikanga whakawhiu-ā-ture

Amend prosecution guidelines

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 New Zealand's international human rights obligations and other relevant international law 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 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 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

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- 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.



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.

TŪTOHI | RECOMMENDATION 25

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

Support judicial initiatives that address the causes of offending



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 TŪTOHI | RECOMMENDATIONS 26–32

Ngā panoni ture taihara

Criminal justice legislative changes



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 arising from 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 or neglect, does not unfairly exclude them from eligibility under the Act.



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).



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 to give evidence.

TŪTOHI | RECOMMENDATION 33

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

Education and training for people involved in the
justice system

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, Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Elimination of all forms of Racial Discrimination, and the United Nations Declaration on the Rights of Indigenous Peoples.



NGĀ TŪTOHI | RECOMMENDATIONS 34–35

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

Amend investigation guidelines and establish a specialist investigation unit

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, Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Elimination of all forms of Racial Discrimination, and the United Nations Declaration on the Rights of Indigenous Peoples).

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 TŪTOHI | RECOMMENDATIONS 36–38

Ngā panoni ture tikanga-ā-iwi

Civil justice legislative changes



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.



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 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 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.

TŪTOHI | RECOMMENDATION 39



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


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, iwi and Māori 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, iwi and Māori 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 decisions 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 need 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, the Enabling Good Lives principles, and recognise and provide for diverse needs including Deaf, disabled people, and people experiencing mental distress:
 - i. people in care are supported and provided accessible information to 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, safety of people in care and 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 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, decision-making supports to engage in complaints processes
 - ii. care providers have complaint handling policies appropriate for the people in care which 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, 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 whilst upholding the right to privacy and ensuring 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, 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.

TŪTOHI | RECOMMENDATION 40

He Rautaki Āhuru Mōwai-ā-Motu

National Care Safety Strategy



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, 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.

NGĀ TŪTOHI | RECOMMENDATIONS 41–44


Te whakatū Tira Āhuru Mōwai Motuhake

Establishing an independent Care Safe Agency

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 sanction 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 (Recommendations 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)

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- 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 of Part 9.



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.



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.

NGĀ TŪTOHI | RECOMMENDATIONS 45–46


Te hanga Ture Āhuru Mōwai

Establishing a new Care Safety Act

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).



"I'm in this for my
kids. I don't want a fourth
generation State ward, so,
yeah. So I'm in it for the cause
for the next generation."

ANONYMOUS SURVIVOR

Gang independent submission



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.

TŪTOHI | RECOMMENDATION 47

**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**



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.

NGĀ TŪTOHI | RECOMMENDATIONS 48–56

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

Care providers to be accredited and prioritise safeguarding

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.

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.



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.

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, disabled people, 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 TŪTOHI | RECOMMENDATIONS 57–64

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

**Staff and care workers to be vetted, registered,
and well trained**

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.

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 like 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.

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 the 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, 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.

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, people leaders and all staff have a safeguarding focus, and 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 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, and in particular, faith-based entities should ensure the same rules apply to people in religious ministry and lay volunteers as to employees.

NGĀ TŪTOHI | RECOMMENDATIONS 65–69


Kia tika te whakaea i ngā tautohenga

Complaints are responded to effectively

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 are 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, 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



"My trust in humanity faded and I had nowhere to go... Instead I felt the one decision I still had was the streets. Stealing food and clothing and eventually prostitution were added to my survival kit."

WAIANA KOTARA

Māori survivor
(Ngāti Hako, Ngāti Maniapoto)

- 
- 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 Safety 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.

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.

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.



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.

NGĀ TŪTOHI | RECOMMENDATIONS 70–75

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



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 historic abuse and neglect in care.



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.



Tūtohi | Recommendation 72

The government should take steps to ban pain compliance techniques in any care setting for children, young people and 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, 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.



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.

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.

NGĀ TŪTOHI | RECOMMENDATIONS 76–80

Me whakamana, me tautoko te hunga kei ngā pūnaha taurima

People in care are empowered and supported

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 their 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.



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.



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.

NGĀ TŪTOHI | RECOMMENDATIONS 81–84

Kia tōtika ngā kohinga me ngā tukunga raraunga, me ngā tuhinga kōrero

Best practice data collection, record keeping and information sharing

Tūtohi | Recommendation 81


All State and faith-based entities directly or indirectly providing care to children, young people, Deaf, 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 or 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 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.

- 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.



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 consider 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.

NGĀ TŪTOHI | RECOMMENDATIONS 85–87

He taurite me te whai rawa i ngā mahi aroturuki motuhake

Independent oversight and monitoring is coherent and well-resourced

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
- b. ensuring the entities are adequately resourced.



"This was a trusted man in a position who took advantage of a 14-year-old boy. This was six months after my mother passed away. Why did men do this to me?"

DESMOND ADAMS
Māori survivor (Ngāpuhi)



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.

TŪTOHI | RECOMMENDATION 88

Ngā whakataurua mo Gloriavale

Recommendation about 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.

NGĀ TŪTOHI | RECOMMENDATIONS 89–110

Ngā whakataua e hāngai ana ki te katoa o ngā tira
whakapono o Aotearoa e whakarato tiaki

**Recommendations to all faith-based entities
providing care in Aotearoa New Zealand**

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 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.



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.

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.

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.



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.



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.

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.

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.¹



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.



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.

¹ Dental Complaints Assessment Committee [2008] NZSC 55.



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
- 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 to 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.

NGĀ TŪTOHI | RECOMMENDATIONS 111–116

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

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 based on race, gender and sexuality
- c. attitudes reflective of eugenics, ableism and disablism.

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.



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.

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.

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, 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.

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.

NGĀ TŪTOHI | RECOMMENDATIONS 117–120

Te whakamana i te Tiriti o Waitangi me ngā mōtika tāngata

Giving effect to te Tiriti o Waitangi and human rights

Tūtohi | Recommendation 117

The government should partner with hapū, iwi and Māori 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).





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
- d. uphold the rights of Deaf, 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, 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 whānau, hapū, iwi and 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.

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. 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.

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.

NGĀ TŪTOHI | RECOMMENDATIONS 121–122

He aronga tūturu ki ngā kaupapa ārai mahi tūkino

Targeted abuse and neglect prevention programmes

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.

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, 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.

NGĀ TŪTOHI | RECOMMENDATIONS 123–124

Te whakatū Tari Pūnaha Āhuru Mōwai motuhake hei arataki i te kaupapa

Establishing a Care System Office to lead implementation

Tūtohi | Recommendation 123

The government should establish a Care System Office later to become the Ministry for the Care System that:

- 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)
- 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
- 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 new Care System Office should be responsible for:

- 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
- leading and coordinating the work of government agencies involved in the care system
- establishing and then monitoring the independent Care Safe Agency
- providing advice on the content of the Care Safety Act (Recommendation 45) and then administering the new Act
- providing whole of system advice to government on the care sector, settings and system.

TŪTOHI | RECOMMENDATION 125

**Me mahi ngā mea katoa e rite e whai take ai
ēnei whakataurua**

**Taking any and all actions needed to give effect to
these recommendations**

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.

NGĀ TŪTOHI | RECOMMENDATIONS 126–127

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, i whai wāhi atu hoki te ringa waihanga o ngā hāpori

Implementation of all recommendations to give effect to te Tiriti o Waitangi and UNDRIP, and be co-designed with communities

Tūtohi | Recommendation 126

The State and faith-based entities should partner with hapū, iwi and Māori 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 the 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.

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, Māori, Pacific Peoples, culturally and linguistically diverse communities, Deaf, 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.

TŪTOHI | RECOMMENDATION 128

Whakatū kaupapa hautū aronga ako me te whakamātau i te iwi whānui kia mōhio me te ārai i ngā mahi tūkino, whakahāwea, whakaiti tangata Public awareness and training to prevent abuse and neglect, and address prejudice and discrimination

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, and 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. 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.

TŪTOHI | RECOMMENDATION 129

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 give effect to te Tiriti o Waitangi

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 Mara 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.

NGĀ TŪTOHI | RECOMMENDATIONS 130–138

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

Tūtohi | Recommendation 130

The government and faith-based institutions should publish their responses to this report and the Inquiry's interim reports on 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.

Tūtohi | Recommendation 132

The government should seek cross-party agreement to implement this Inquiry's 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.



Tūtohi | Recommendation 135

The government and faith-based entities should implement the Inquiry's recommendations within 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.



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.

A close-up photograph of a pine branch with several bright green, needle-like leaves. Two clusters of small, orange-brown, cone-like structures are visible, one in the upper left and one in the lower left. The background is a soft, out-of-focus green.

"I was bullied there
and tried to run away.
Because I tried to run away,
they made me stay for
another six months."

WILLIAM WILSON
Survivor

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 tūkino
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 tīhore 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 mārie mōwai rokiroki āio nā koutou ko Rongo
Koia ka puta ki te whaiao 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



Abuse in Care
Royal Commission of Inquiry