Abuse in Care Royal Commission of Inquiry
Contextual Hearing on Thursday,
7 November 2019 at the Rydges Hotel, Auckland

Commission Members:
Sir Anand Satyanand - Chair
Commissioner S Alofivae
Commissioner A Erueti
Commissioner P Gibson
Commissioner C Shaw

TRANSCRIPT OF PROCEEDINGS

OPENING ADDRESSES

MR MOUNT: I am not seeming to be able to make myself glower, so I don't know whether our technical people -

CHAIR: No, I can't either.

MR MOUNT: I don't know if that means we can't be heard. It's normally me, Mr Chair, who trips over the cord, I hope I didn't do that.

There we are, how does that sound?

CHAIR: Excellent, thank you.

MR MOUNT: Good morning, Commissioners. Today, in terms of personnel, I am joined by Ms Spelman at the front desk.We have Ms Hill and Ms Cooper joining us today. The order of events, it's first the evidence of Beverley Wardle-Jackson. She is not able to be here today and so Ms Cooper will read the brief of evidence to the Commission. She will do that from the witness Chair, although obviously she's not a witness, she's simply reading.

The second witness Annasophia Calman will be lead by Ms Hill. We have a short adjournment between those two.

The third witness being Judge Andrew Becroft, the Children's Commissioner.

And the fourth witness will be Rosslyn Noonan, the former Chief Human Rights Commissioner.

If I may, with your permission, invite Ms Cooper to come to the witness table to read the brief of evidence of Beverley Wardle-Jackson.

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EVIDENCE OF BEVERLEY WARDLE-JACKSON

CHAIR: Ms Cooper, good morning, the Commissioners welcome you and invite you to read the evidence.

MS COOPER: Thank you. If I can just start by introducing that Beverley is actually unwell, that is the reason why I'm reading this in her place and I feel very privileged to be able to do it for her.

She is a published author and her brief of evidence comes mainly from her book, in the Hands of Strangers.

I was born on 26 December 1952. My father's name was Edward, my mother's name was Shirley. Both of my parents had been State wards as children. Although my knowledge of our family history is sketchy, I understand that both my mother and my father were put in the care of the State because their families were poor.

Although my father tried hard, we lived in extreme poverty and didn't have a lot of food. Despite this, the children kept coming. It was one of my jobs, as one of the older children, to look after the youngest ones.

My family first came to the notice of Child Welfare in October 1959 when I was almost 7 years old. We were living in a house on the property of Wadestown School. The headmaster contacted Child Welfare because of concerns about our family. Child Welfare was contacted again in May 1960 by other people who were concerned.

I am not surprised by this. Sometimes there was no food in the house at all and my mother would go out all night. I would have to go begging the neighbours for milk for the babies. Our house was also very dirty.

On 1 June 1960, I am aware that my whole family was placed under the preventive supervision of Child Welfare.

During that time, I was sent away for the first time.

If I can have the first photo, please. This is Bev first placement at Florence Booth Salvation Army in Newtown. This shows the girls in the dormitory doing their prayers at night.

I was about 7 when I was sent to the Florence Booth Salvation Army Home in Newtown, Wellington. I was taken there with my sisters, Jenny and Judy. When we got there, we were met by Major Christopher. She introduced us to other staff members and showed us our beds. I was in a different dormitory from my sisters.

We were taken to a play room to wait for the other children to get home from school. I couldn't enjoy the toys there. I was extremely frightened and upset. I could not stop thinking about what was going to happen to our family.

Some of the staff, those who saw me as the confused and scared little girl that I was, treated me with kindness but there was an underlying violent culture to the home. Most of this came from Major Christopher and Lieutenant Barker.

I was badly thrashed at Florence Booth for biting my nails. If staff saw that I had bitten them, I got a thrashing. One day I was so scared about getting a thrashing that I peed in the bath. I got hauled out of the bath by Lieutenant Barker and she thrashed me all over my body. I had bright red welts on my upper legs and thighs and white hand marks over the rest of my body. This was the worst hiding she had given me.

Another time, I lost one of the three handkerchiefs we were issued with. A staff member called Barbara found me in the locker room, slapped me across my face and sent me off to Major Christopher.

Major Christopher hit me across my palms with a

piece of pipe that she called the Rod. The pain was excruciating, and my fingers and knuckles swelled. This sort of punishment was the norm at the home.

That Christmas, all my sisters went somewhere else and I was left at Florence Booth. I remember being excited because for the first time in my life I woke up to a Christmas present at the foot of my bed. Other visitors came during the day bringing gifts and sweets. These were all taken off us at the end of the day by the staff. They said we would get them when we left but I never saw those lovely gifts again.

I was allowed to keep two sweets and one book.

The next day was my birthday, which falls on Boxing Day. Normally, the birthday of someone in the home was celebrated. However, they forgot about me that day.

There are some happy memories from my time at Florence Booth, including events that were put on by charities. However, any happy memories are overshadowed by the fear and dread that filled so much of my life during my stay.

After about a year at Florence Booth, we were taken back home to our parents. They had a house in Porirua. Even though the house was new, we had no furniture and money was tight as always. There were several kids to each bed and sometimes our power was cutoff because of the unpaid bills. We stayed under the preventive supervision of Child Welfare between May 1961 and May 1962. I am aware of records in my file that talk about my father having a violent temper.

In mid 1962, my parents were prosecuted by the Education Board because my brothers, sisters and I were not going to school. Sometimes I would be home helping to care for the younger ones, or because I was sick. Sometimes I stayed home because I had no clean clothes or

because there was a school trip on that we could not pay for.

During the time we were under the preventive supervision of Child Welfare, my father went to prison. We were never visited by Child Welfare. We had a can of spaghetti to eat on Christmas day between all of us kids. Child Welfare only turned up when Dad was due to be released from prison.

It was only when I saw my records that I could see
10.13 that the preventive supervision continued for some years. It was renewed in 1963, 1964 and 24 May 1965. I'm amazed by this. I had no idea that we actually had status with Child Welfare after returning from Florence Booth. Life did not change during that time.

In May 1965, my mother left my father and moved in with a man called Don. Don was a horrible man and, as I was to later discover, a child abuser. Child welfare also recorded how unsuitable my mother's new home was.

Miramar Girls' Home. On 11 June 1965, I got home
10.14 from school to find Child Welfare Officers there. They told me that Judy, Susan and Brenda and I were all being taken into Child Welfare care. I remember the social worker who took us to Miramar Girls' Home. She never once asked me or my siblings anything about my feelings or my home life.

Just like last time, I was separated from my siblings when we got to the Girls' Home. They got sent away to a different part of the home. A couple of days later, I was enrolled in yet another school. I was
10.15 introduced as Beverley from the Miramar Welfare Home. I couldn't concentrate at school and every night since I got to the home I had cried myself to sleep. The bullying got so bad that I wagged school.

I was found out and I had my first bad experience

with Ms Tucker. She called me wicked, stupid, selfish and ungrateful and slapped me across the face. I was sent to bed without any dinner.

The second time I wagged school, I was taken to the seclusion room by Ms Johanson. When we got to the seclusion room she thrashed my bare legs with a hearth brush until I cried. She hit me until she was exhausted. I had to spend the night in the seclusion room.

In September 1965, I was made a State Ward along with my siblings. I was 12 years old.

The only good thing about being a State Ward was that I got taken shopping for new clothes. Everything else was pretty bad. I couldn't keep up at school, so I'd wag every now and then and get into trouble each time. I also ran away from the Miramar Girls' Home. After that, I was taken down to the seclusion room again.

I was sitting on a mattress in a seclusion room when a social worker came in and said that I was going to Christchurch. I was kept in the seclusion room until it was time to leave. I cried and begged to be able to stay in Wellington but it was no use.

Stratmore Girls' Receiving Home. When I got to the Receiving Home, I was taken to a room that had no windows and a mattress on the floor. A female staff member gave me a night gown and took all my clothes.There was a pot in the room for me to use as a toilet. The staff forgot to turn the heater off and it got incredibly hot in the room. I banged and begged to be let out but nobody came. In the morning, I was taken out by another staff member and was made to scrub out my room with a bucket of water and a scrubbing brush. I was given a tray with some breakfast but had to sit on the wet floor to eat it. I was told that I would get the mattress back at bedtime.

I sat on the floor all day. I was given my lunch on

a tray and nobody would talk to me. I got my mattress back that night. Someone turned all my lights on in the middle of the night and I couldn't help but think it was done deliberately.I spent 3 nights in that room.

Most of the girls at the Receiving Home were older than me. They were surprised that a 12 year old had been sent there. Girls ran away a lot and would be put in seclusion when they returned. We all had to put our pyjamas on every day at about 3.30 p.m. when all our clothing was locked away until the next morning. I was enrolled in yet another school.I just got settled in when my social worker turned up and told me I was being moved to another home.

Riccarton Family Home. I was taken to a family home which was run by a husband and wife. They had their own children but looked after welfare children as well. The woman who ran it was Mrs Hume. I shared a room with three other girls who were all older than me. Mrs Hume was impatient and would tell me off for minor things. She also treated the welfare kids much differently to her own children.

Over Christmas, I spent time with my mother and her boyfriend Don. They were living in Christchurch by then. I was sexually abused by Don during that time. I know now that my father had asked if four of us could live with him but Child Welfare had said no. It just wasn't a done thing for a father to be a solo parent in those days. I was angry and sad when I found out.

I went back to the care of Mrs Hume after Christmas. I was enrolled in college. I got a uniform which was bits and pieces from other people. It was tatty and did not fit. I was so far behind in my school work that I did not understand what was going on and kept getting into trouble. I did a mountain of work around the house

every day. I ironed all the family's clothes and those of the other welfare children cleaned shoes, washed dishes and cleaned the bathrooms and toilets.

While I was at this family home, I told another girl that I had been touched by Don. The girl reported it to Mrs Hume. I was made to give a statement to Police and was examined by a male doctor.Mrs Hume told me that I'd got myself into a fine mess. A few weeks later, Mrs Hume told me that the Police had done an investigation and
10.21 found my complaint to be untrue. I couldn't believe it. I told Mrs Hume it was true. She told me it was not important what she believed, it was what the Police and welfare believed. I was told that this was the end of the matter.I burned with anger and resentment towards everyone for saying I was lying.

Because of my unhappiness, I managed to return to Wellington by stowing away on the boat between Lyttleton and Wellington. Unfortunately, I was found and returned to Mrs Hume.

10.21 Mrs Hume didn't allow anyone to speak to me. I had to do work around the home and in the garden.

Back to Stratmore Girls' Receiving Home. It was not long after this, that I ran away again. Mrs Hume would not take me back, so I was taken to the Girls' Home. There I was ordered to strip naked and I was locked in a seclusion room. I was given a night gown to put on. For the next 2 weeks I remained locked in seclusion. Eventually, I was let out and was allowed to spend time with the older girls. I only felt safe to cry locked
10.22 alone in my room at nights. I felt like I was in a hopeless situation.

A few months later, I was told that Child Welfare was moving me to a new home in the Wairarapa called Fareham House. I was told it was a bit like a boarding

school for girls.

And there is the photo of the outside of Fareham House. One of the first things that struck me about Fareham House, was that most of the other girls were Maori. I'd never lived with Maori girls before. I was put in a dorm with five other girls. Over the next few days, I learned the routine. We were woken at 6.00 a.m. daily, made to get dressed and then we would be put through an hour of exercise by Mr Bell, the Principal.

10.23 There were 28 girls at Fareham House then, 6 Pakeha and the rest Maori. It didn't take me long to understand that the Maori girls were just like me and that they too had been taken away from their families.

Like the other places I had been, the rules were strict. We had to do a lot of cleaning around the home. Some of the cleaning was domestic duties and quite a bit more was punishment for breaking rules.We were not allowed to leave the grounds of Fareham House for any reason, unless we had a staff escort. To deter runaways

10.24 our clothing was taken from us each night and locked away in the clothing room downstairs. We had to wear a uniform.

There was a school at Fareham House. The school had two teachers. My teacher was a Ms Weir.On my first day of school, she had us on the mat singing nursery rhymes which resulted in multiple complaints. She didn't handle the pressure very well and left the classroom.

I ended up in trouble with staff on a number of occasions, mostly for answering back and giving cheek - I

10.25 guess like any teenager does.

One of the punishments was to be locked in a seclusion room. I remember that the room had a brown gym mat on the floor in the corner. There was nothing else in the room. I had to stay in that room, sometimes for a

few days at a time.

One time, I took off during a Fareham House trip into Wellington. I made my way to Miramar Girls' Home where my older sister Judy was. The staff at Miramar were very kind to me and let me spend the night with my sister. It was the first time I had seen her for a while. The next day, Mr Bell came and picked me up.One of the things I still remember to this day, is that he tied me up like animal before I was placed in the back of
10.25 the van. Once we got back to Fareham House, he took me to the seclusion room. I had to get into pyjamas. I was locked in the seclusion room for three days.

I was put in seclusion on another occasion after Mr Bell tipped up a plate of porridge on my head. This was because I refused to eat it after being told by the girls that another girl had spat in it. When Mr Bell tipped the porridge over my head I called him a filthy pig and swore at him. I was told to stand up. When I did so, Mr Bell grabbed my arm and twisted it hard up my
10.26 back. He pushed me and forced me up the main room, into the seclusion room on the second floor.

I was not allowed to shower to get the porridge out of my hair.I was locked in the room for a day without any food. I was not allowed any books. I stayed locked in that room for a couple of days.

Another punishment for me at Fareham House was to be locked in an even smaller room in the attic. The whole room was bare. There was a small window with a metal grate across it.The room had nothing but a mattress and
10.27 a potty. On one occasion I was locked in the attic for 5 nightmarish days. I was only allowed out in the morning to go downstairs for a shower.I had nothing to do. I was sent to the attic on a second time after three of us ran away from Fareham House. I was in the attic on the

second occasion for about 9 days.

As I talk about further on in my narrative, I was sent into the psychiatric hospital system by Mr Bell where I spent many years. I had a short second admission to Fareham House after I had been in Porirua Hospital for some months but this did not last long because I was blamed for doing something I hadn't done and was returned to Porirua Hospital after spending yet another short time in seclusion.

10.28 It is fair to say that I had a mostly miserable time at Fareham House. I made some friends there, at least one of whom has been a lifelong friend. But my overwhelming impression of the place is that it was cruel, unfair and dehumanising.

While I was at Fareham House, staff decided I was to be confirmed into the Anglican Church. I had no real interest in church. I only attended because the Fareham House girls were required to. Another Fareham House girl and I started attending confirmation classes with the

10.29 vicar. One day I went on my own to the confirmation class. I realised that the vicar had been drinking. The vicar started to ask me if I'd been letting men do things with my body. He lifted up his robe and was holding his erect penis in one hand. He asked me if I wanted to touch it. He rubbed my hand up and down on his penis. He also touched my genitals. I remember that my face was burning hot with shame and I felt revolting and despairing.

The vicar told me it wouldn't be wise to mention

10.29 what had happened to anyone because it could get us both into a lot of trouble. I thought the vicar had liked me, really he just thought I was some girl he was allowed to do rude things to. Once again, I felt ashamed and guilty. In particular, I felt really bad that I had done

nothing to stop it.

Like a lot of girls at Fareham House, I ended up in psychiatric hospital care.

I was first taken to Ward 27 at Wellington Hospital where I was seen by a young doctor. I was shown to a bed in the ward and told to put on a night gown.

I wondered what sort of place it was. Everybody looked so miserable and one woman was doing strange things.

10.30 I was not long at Ward 27 before I was taken to Porirua Hospital where I was to remain on and off between June 1967 and 1973. In-between admissions, I went back to Fareham House to a sister's foster placement and back to Miramar Girls' Home. I was also briefly placed with an older sister where I was sexually abused by her husband. It was also during this timeframe I met a man and fell pregnant at age 16.

Each time I returned to Porirua Hospital when my - each time I was returned to Porirua Hospital when my

10.31 behaviour was perceived to be difficult. I was just a lonely, isolated teenage girl.

I remember being taken to Porirua Hospital in an ambulance. When I saw the sign to Porirua Hospital, I was frightened. We had referred to places like Porirua as nut houses, funny farms or looney bins. I wondered what I had done to deserve being sent here. I was only 14 years old. I remember the tears flowing again. Nobody cared about me or wanted to help me.

Porirua Hospital was another hell for me. When I

10.32 was first admitted, two nurses told me to take off all of my clothes. The only clothing I was wearing was a night gown and my dressing gown. I refused. Five nurses all descended on me and I could feel numerous pairs of hands ripping the clothing from my body, leaving me naked. I

was told to put on a night gown.

It was not long before a nurse came into the room, telling me she had come to give me an injection. When I told everyone to get away from me, the group of nurses descended on me again. Two of them sat on me, pinning me with their weight.A number of hands held me down while the one with the huge syringe thrust a needle into the top of my thigh. I remember that within a few minutes everything went black and I lost consciousness.

10.33 I spent the first couple of days at Porirua Hospital locked up in my room. Mostly I slept.

I was threatened constantly by staff about what would happen if I stepped out of line.

I soon found out that I had been placed in the admission ward of the hospital. I met another teenager there, Wendy, who also became a lifelong friend, who told me that most of the people in the ward were mad but there were a few younger people like us.

Following my first few days at Porirua Hospital, I 10.33 was often put in seclusion. This meant I was locked by myself in a dirty, dark and cold cell for between one and a few days. This often happened when I ran away. Sometimes when I was locked in my cell, I was left in there with just a nightie and a stitch blanket to cover me. I was regularly attacked and punched by nursing staff. One time when I was being dragged to seclusion by a female staff member, that staff member deliberately punched me on my body.

One of the most frightening things was being 10.34 attacked by other patients. I vividly remember one time being attacked by a female patient for sitting on an empty chair. I had handfuls of my hair pulled out.

On another occasion, I was beaten up by a female patient. On yet another occasion, a patient threw a

chair at me which hit me in the head.

I clearly remember that every little thing about Porirua Hospital seemed to reinforce the feeling of being trapped and powerless. Even when I asked permission to wear some of my own clothing, I was told that my suitcase had been lost somewhere.I had to wear ugly, shapeless dresses that hung down to my ankles. I also had to wear underpants that were big, bagging bloomers that had obviously been made to fit huge women.Knowing that many 10.35 other patients had worn them before me, made me feel disgusting.

Every day violent incidents would occur somewhere, usually ending with the nurses assaulting patients and dragging them off to their rooms, kicking them and punching them along the way. It was all wrong, so wrong, but there was no-one to tell, no-one to complain to.

Although some patients needed to be removed for everybody's protection, I still hated seeing the nurses pulling their hair and punching and kicking them as they 10.36 lay on the ground. The continual screaming, banging and swearing day and night was overwhelmingly depressing. I remember I was on edge the whole time, wary of everyone, anxious that I might end up in the thick of it.

I learned and saw many things in Porirua Hospital that were so far outside my previous experiences that I didn't know what to think. One day a woman came rushing out of her room holding her arm towards me. I felt sick when I saw a long gaping cut running down the inside of her wrist. This was the first time I had encountered 10.36 people who harmed themselves. I would witness many more acts of self-harm and many acts of violence towards others.

I also started to smoke at Porirua Hospital as all the patients, even us teenagers, were given smokes. It

was a way of keeping us calm. This was a habit I was later to strongly regret.

It took a long time for me to discover that there was a school on the grounds of the hospital. I was not there for long because one of the older boys tried to put his hand down my pants every time he came near me. I had no schooling from the age of 14. I hadn't learnt anything in school since the age of 11. My education was far behind others of my age because I had not attended
10.37 school for such a long time.

After my brief return to Fareham House, I was admitted back into villa 9 where I was locked up. I remember being utterly distraught.For the first few days, I was filled with deep despair and I could hardly bring myself to speak to anyone. I felt more alone in the world than ever before. Deep down, I knew I wasn't mad. I also knew that Child Welfare had nowhere for me to live. They had never once offered me a foster home. As each year passed, it became less and less likely to I
10.38 would ever have a home or someone who cared about me. I was getting too old for people to care about me.

During this admission, nothing had changed for the better. In fact, conditions were even worse than the first time I had been there. The violence was unbearable, as was the constant noise of patients screaming and fighting among themselves and with the staff. Even though there was some new staff, most were as cold and uncaring towards the patients as those who had gone before them.

10.39 Whenever staff wanted the ward cleaning done, the welfare kids were singled out and we were bullied and shouted at like animals until the job was done.

I remember complaining to the matron one day as she was passing through the corridor while I was down on my

hands and knees scrubbing. She told me that I got everything I needed for nothing. She told me to stop my whinging.

It was a simple choice really, we had to do every dirty job we were given or we would be locked up in our rooms and we would get a hiding on our way there.

On top of that, our basic human treatment was low on the list of priorities. It was humiliating when we had to use the ward toilet. There were no doors and no
10.40 privacy whatsoever. Being on public display was bad enough but cleaning the urine reeking toilets was one of the worse jobs of all. There were always faeces smeared everywhere and the stench clung to you long after you left. No matter how hard I scrubbed those toilets, they always smelt just as bad as when I started.

I remember that on every second day selected patients would receive electric shock treatment. Those who were not were herded from the wing to the dayroom where we were locked up until the shock treatments were
10.40 over. We often heard wailing and moaning noises coming from the ECT rooms.

There were significantly more young people in villa 9 the second time around than there were during my first stay. Many of the new arrivals were also State wards and supposedly under the care of Child Welfare. Three Fareham House girls, who I knew quite well, were admitted within weeks of each other. Then a few months later, two more State wards from Fareham House were admitted. Even at my age, I could see the injustice of dumping us girls
10.41 into mental institutions simply because there was nowhere else for us to go. It seemed as though we were some kind of social experiment.

To this day, I remember when one of the new arrivals, a girl called Jennifer, aged 15, died. Late

one evening, Jennifer had a severe asthma attack and collapsed on the floor inside the toilet. I was horrified to see her face turning blue as she gasped for breath. Although someone rang the emergency bell immediately, by the time help turned up Jennifer was unconscious. We waited anxiously for nearly a day before we found out that Jennifer had died. Those of us who knew her were terribly upset but we were warned by staff not to talk about it. We did talk about it constantly. 10.42 We all believed that Jennifer might not have died had the staff responded to the bell immediately.

I also vividly remember that after one escape, I was given electric shock treatment. A few days later, I found out that my friend, Wendy, who had escaped with me, had also received ECT the same day as me. It was clear that this was a punishment for trying to escape from that hideous place, although the medical reason given was that I was suffering from depression.

As I became more hopeless, thinking that my life was 10.43 to be locked in a mental institution, I thought about harming myself and wondered what it would be like to be dead. I began hurting myself by making scratches across my wrists using the sharp end of a hair clip. I didn't know why I was doing it. It wasn't until much later in life that I learned self-harm was often a cry for help.

I don't remember making a conscious decision to harm myself. It just happened one weekend. It was visiting day and once again nobody had come to visit me. I picked up the hair clip, bent it and cut my wrists. I told 10.43 myself that I deserved this pain and that I deserved everything that had happened to me.

Eventually, I was transferred to villa 6. There, my friend Wendy and I were the only teenagers. Many of the adult patients had been there for years. Some of the

women had vacant expressions and just sat hardly ever speaking. Others spoke continually but only to the voices in their heads.

I was given a bed in a shabby dormitory with 12 others. Most of the other patients in the dormitory appeared to be over 40, some were as old as 70.

There was very little for us to do, other than spend each day with the other patients inside the dayroom. After a few months, I got used to living in the hospital
10.44 and used to the people I was forced to live with. I no longer allowed myself to think about my future. I knew that I had to accept this mad house as my home. Boredom was one of our main problems. It was hard to find activities every day.

After taking myself into Porirua township one day for something to do, I was promptly moved to F Ward. And that's a photo of the inside of F Ward that's just come up.

This was the forensic ward of the hospital where the
10.45 criminally insane and severely mad people were locked away. I was immediately put into seclusion. All I could hear were dreadful wailing and moaning coming from the ward. I had never heard such frightening sounds coming from humanbeings.

I was left alone in a cell like room which had wooden walls and peeling cream paint smeared with dry faeces. It stank, as did the mattress on the floor which was the only item in the room. I was then moved into the dormitory, which was an orchestra of moaning, wailing and
10.46 screaming, punctuated by hysterical howling. I was terrified. I was heavily medicated and once again, forced to clean.

We will just bring up the next photo which is the outside of F Ward.

The sights in F Ward were appalling. Patients with all sorts of physical deformities and crazed behaviour were sitting in Rows of chairs or stumbling backwards and forwards across the room. All were making loud ghastly noises. Some were rocking violently back and forth chanting incomprehensively.Screeches and groans filled the room.I had seen some very strange people in villa 9 but I had never seen people quite like this and I was frightened.The instant I sat down, one of the patients 10.47 lunged towards me. Before I could do anything, she grabbed hold of my hair and tried to rip it from my head. She pulled me off the chair to the floor where she let go of my hair, clenched her fists and started punching me in the face before she was eventually restrained by nursing staff.

I was returned to villa 6 early that evening.

As referred to above, during the period of trial leave with an older sister and her husband, I fell pregnant to a man I met briefly at age 16. Nobody had 10.47 explained to me how you became pregnant or how babies were born. I didn't want a baby. I thought of killing myself so I wouldn't have to face what lay ahead of me. There was nobody I trusted enough to confide in. This was one of the occasions when Child Welfare arranged for me to be forcefully taken back to Porirua Hospital. A few days after I was taken back, I overheard two nurses talking about me and the fact that I was pregnant. I heard them say that I would probably stay in Porirua Hospital until after the birth of the baby. They said 10.48 that Child Welfare would probably take the baby and adopt it out. I spent days and days crying in my room. I begged to be let out of the hospital but my pleas were ignored.

After a few months, I discovered that one of my

friends was back in villa 9. She and I devised my latest escape plan. We managed to hitchhike to Auckland. Unfortunately, we were found by Police. My friend was taken straight to Oakley Hospital. I was held in the Police cells overnight and was then taken to appear in the Court the next day. I was remanded in custody for one month.

At first, I was taken to Mt Eden Prison. I was then transferred straight to Oakley Hospital where my friend
10.49 was.

Oakley Hospital. I remained in Oakley Hospital for a month where I lived in a constant state of terror and anxiety. I was terrified by the screaming and fighting among the patients in the ward I had been put in. The hospital was built like an old prison and every single door was locked tight.

I tried to avoid the dayroom and keep to myself in my room but every day seemed like a year.

I ended up staying there for a couple of weeks
10.49 longer because my case was adjourned by the Court.

When I eventually appeared in Court, the Magistrate said to the prosecutor that he failed to see any reason why I, as a pregnant young woman, was being held in a mental institution. He released me immediately.

My childhood, such as it was, had ended. I now faced adulthood alone.

I was scared and relieved at the same time. I knew I was ill-prepared but at least my life was in my own hands now, not in the hands of strangers.

10.50 My life after psychiatric care. I returned to Wellington but I was still not free from Child Welfare. When I returned to Wellington, I was dropped off at a Salvation Army Home for unmarried mothers. Four months later, frightened and alone, I gave birth to my daughter.

I was 17.

Within minutes of her birth, the staff took my baby from me and refused to let me see her. In the days following, Child Welfare Officers turned up at the ward with documents for me to sign releasing my daughter to them for adoption. I refused.

I was told by Child Welfare that I would have to find work or they would take my daughter from my care. I was determined that would not happen. I had to work long
10.51 days, leaving my baby with a caregiver Child Welfare had found for me.

6 months after my daughter was born, I accidentally bumped into her father. He soon realised my baby was his child. We married, although in my heart I knew it was the wrong thing to do.

We had a son. It could have been a happy time but my husband realised he was homosexual.

Over the next 5 years, I struggled desperately trying to cope with my life and with being a mother.
10.52 During this period, I struggled with many episodes of depression. I became pregnant with my third child to my husband. I made the decision during that time to leave Wellington.

Without informing Mental Health Services or my doctor, I packed up my two children and our few belongings and travelled on the overnight boat to Christchurch. I chose Christchurch not only because it was the only other place I knew well enough to find my way around but also because I wanted a fresh start.

10.52 Shortly after I arrived in Christchurch, I was given a State house to live in. My husband came to live with the family in Christchurch.We had a fourth child who was born in October 1977.

When that fourth child was 2 months old, my husband

packed up his belongings and left.Although I was devastated, I struggled through. My main concern was my four children. Even though I was on a benefit and had no savings, I made having a real home my focus. Through perseverance, I managed to buy my first house.By that stage, I was 25, alone with four children.

Despite my determination to do better for my own children, the impact of my childhood was profound. No matter how I tried to forget the things I had been
10.53 through, they haunted me. Many times over the next few years I would sink into a deep, dark depression and feel like taking my life. Although I was angry with everybody who had been involved in my care, it was myself that I took the anger out on.More than once I slashed into my wrists with razor blades causing severe injuries.

Looking back, I don't know why I did it but somehow I did get by from day-to-day, drawing on some unexplained strength within me. I reconnected with two of my sisters but being split up as children stood in the way of a
10.54 close sibling relationship with any of the others.

It's funny, for so long all I had wanted was for us to be together again but it all became too hard in the end, too much damage had been done.

I have remained in Christchurch. My children have grown up and left home. Sadly, a rough start in life means I have no connection with my oldest daughter but I have good relationships with the others. Against all odds, I did make a new life for myself.The years were never easy but somehow I must have been blessed with a
10.54 mental fortitude that made me want to get through.

In 1996, aged 43, I met Ian and fell in love properly for the first time. Ian was a successful businessman and I couldn't have been more surprised when he fell in love with me too. Not only did he love me but

he treated me like a princess. I don't think anyone had ever really loved me before and I hadn't known there was such good men in the world.

Ian enrolled me in extension study courses at the University of Canterbury where I was taught and encouraged to write my book In the Hands of Strangers. I was unprepared for the dark depths I was plunged into at times writing my book. One of the worst episodes occurred when I requested and received a copy of my files
10.55 from my days as a State ward and in the care of Child Welfare. As I read the notes that were recorded about me, I wept. Shock, anger and those old feelings of worthlessness weld up inside me. I could hardly believe the cover ups, Chinese whispers and lies that people had written to justify their treatment of me.

I'm very aware that mine is just one of the many stories of the lost children, the State wards of my generation. We were children who did not have mental illnesses when we entered mental institutions. We were
10.56 all mentally scared by our time there.

At the most basic level, most State wards were unwanted by their own families. Many of them, like me, remained unwanted as we entered into our teenage years, a time when love and boundaries are desperately needed because foster parents weren't prepared to take on older children.

I can only share my own story but I know what happened to many of them. Some ended up in Borstals and went to prison. Others still wander, lost and forlorn
10.57 through life.

Some days I cannot believe I survived but I did. I don't deny the physical and emotional scars that I still carry but the very things I was missing throughout my childhood, love and a sense of belonging eventually found

me.

The legal process. I instructed Cooper Legal to act for me in relation to my abusive experiences in care in December 2003. I am aware that my legal claim was filed in the Wellington High Court as part of a claim with three other women who had been in similar placements as me, including one of my lifelong friends, in April 2004.

I understand that Sonja Cooper and Amanda Hill have given evidence about the legal steps taken by the Crown
10.58 to delay and bar or stop the legal claims from proceeding up until at least 2009.

In the meantime, my lawyers took individual claims on my behalf against the Salvation Army in respect of the abuse I had suffered at the Florence Booth Receiving Home and against the Anglican Church in respect of the sexual abuse by the Anglican vicar in Masterton.

I met with the Salvation Army representative, Murray Houston, in the later part of 2004, from memory. I met Mr Houston with my husband Ian. I found Mr Houston to be
10.58 respectful and he listened to my story. We negotiated a settlement of $15,000. Mr Houston also paid my legal costs direct to Cooper Legal.

The Anglican Church took a different approach, instructing lawyers. I remember that my lawyers were dismayed at the very legal approach taken by the Anglican Church, particularly given what had happened to me. As part of the Anglican Church process, I met with two women who were setup as an investigation team in Wellington. I was again accompanied by my husband Ian. The two women
10.59 were very reassuring and again listened to me respectfully. I later met with the Bishop who made a personal apology to me. After that meeting, I wrote to the Bishop thanking him and saying I had found him to be very genuine. I have no memory of that letter now.

Ultimately, the Anglican Church did not offer me any compensation, although I did get a letter of apology from Bishop Brown and it did pay a small amount towards my legal fees. While I acknowledge it was helpful to speak with the church people, this is still something that feels somewhat unresolved for me.

It was many years later before the first of my State claims, my psychiatric hospital claim, was settled in April 2012.

11.00 Even though I spent many years in and out of psychiatric hospitals where I suffered physical assaults, prolonged periods in seclusion, as well as cruel and inhumane treatment, I received just $12,000 in settlement of my claim, along with an apology letter from the then defendant, the Crown Health Financing Agency. Again, my legal fees were paid for as part of this settlement at a reduced rate.

My claim against the Ministry of Social Development, whose predecessor had taken me into its care as a child, 11.00 did not settle for another 4 years. It was not until mid-2016 that I received an offer of $12,000 to settle my claim, along with payment of my legal fees and a letter of apology.

In making that offer, MSD accepted very little of what had happened to me in care, only accepting that Child Welfare Officers failed to investigate reports of concern when I was living at home, as a result of which I was exposed to neglect and physical abuse.

Child Welfare Officers did not visit me in 11.01 accordance with policy when I was living at home. Child Welfare Officers failed to visit me according to policy while I was at Porirua Hospital, and Child Welfare Officers failed to investigate my complaint that I was sexually assaulted by my mother's husband. Everything

else was rejected, mainly on the grounds that there was either nothing on my records to support the allegations or the actions were not practice failures or breaches of duty.

By the time this offer was made to me, I just wanted to put this part of my life behind me. After all, I had started taking legal steps at the end of 2003 and it was now already mid-2016, nearly 13 years later.

It was not until early 2017, however, that the final
11.02 terms of settlement were agreed and I signed a full and final settlement with the Ministry of Social Development. That was the end of my involvement with the legal process.

My book was published in 2015 while I was still waiting to resolve my claim against those who had taken me into care in the first place and who had put me in many placements where I spent many harrowing years being beaten, locked up, neglected and betrayed.

I was one of many children caught up in a welfare
11.03 system that was meant to protect us but ultimately served only to damage us.

While this was a different time, many of the things that happened to me and those I went through care with, would not be acceptable in any era.

This is my story. I hope that, by telling it, lessons will be learned.I would certainly never want anyone to experience what I did.

MR MOUNT: Thank you, Ms Cooper. Mr Chair, if we may have a short adjournment now to prepare for the
11.03 next witness.

CHAIR: Thank you. I think that is appropriate, Madam Registrar, could you please adjourn the sitting?

Hearing adjourned from 11.04 a.m. until 11.20 a.m.

ANNASOPHIA CALMAN - AFFIRMED

EXAMINED BY MS HILL

MR MOUNT: Thank you, Mr Chair. Amanda Hill will lead the next witness, Annasophia, who has a support person with her.

CHAIR: Thank you, Mr Mount.

11.23 **MS HILL:** Thank you, Sir.

Q. I would normally call you Ms Calman but is it okay if I call you Anna?

A. Yes.

Q. Anna, you have a written statement with you there with your name on it -

CHAIR: Can I intervene, just as we start, to ask you, and I am required to do this by the Inquiries Act - (witness affirmed).

MS HILL:

11.24 Q. Anna, you've seen your statement and it's got your name at the end of it and it's been signed. Is everything in that statement true?

A. True.

Q. And we're going to use a couple of pages from your records today which have just been sent to the Commissioners a little while ago, and you've got a copy of those there, don't you?

A. I do.

Q. And they are from your Child Welfare records, aren't

11.25 they?

A. I agree.

Q. Okay. Your name is Annasophia Calman but you had a different name when you were born, didn't you?

A. Yes.

Q. Do you want to tell me about your family, Anna? Take your time.
A. My real name at birth is Margaret Ross. We had a very, very poor upbringing. Sorry to be like this.
Q. That's okay, Anna, you take your time.
A. My mother couldn't carry her children around due to her being beaten up, and that's how we were brought up as well, beaten up by the same man that beat my mother up, so she couldn't run away with us. We had to stay with
11.26 him. But the CYPS knew about this, the State ward knew about it. I just can't understand why they couldn't take us away from the man that did this to us, tormented us.
Q. In your written statement, Anna, you talked about that man being your father; is that right?
A. That's correct.
Q. And you talked a bit about what home was like and things like food. Do you want to tell us a bit about that?
A. Yes. At the time, our mother took off we were children, that's how we lived, nothing in our cupboards, beaten by
11.27 our father while he was drunk, and the only people - we had to be eating out of rubbish bins to survive.
Q. At paragraph 8 of your statement, you talked about some sexual abuse at home too, didn't you? If you can talk about what you remember, if that's easier for you, Anna.
A. In our home, there was a lot of abuse. I was one of the rape victims by my brother and my mother's stepbrother. We had this taken away from us, we didn't know who to trust. Do we trust the people that victimise us or do we trust the person like myself? To me, I never found out
11.28 to be who I was. I never found out what it was like to be a woman because of me being raped.
Q. Anna, how old were you when your Mum left?
A. My Mum was 10 when she left us.
Q. So, you were 10 when your Mum left?

A. Yes.
Q. I can see from your statement that you've written or you've said there that the Child Welfare wrote a notification about you in May 1961, so you would have only been about 4 then because you were born in 1957, eh?
A. That's correct.
Q. Yeah, so 3 and a half when Child Welfare came to your house?
A. Yes.
11.28 Q. But you've said in your statement that nothing happened, that you were left at home?
A. State Ward did nothing for us, just left us there to defend for ourselves.
Q. Anna, we've got a couple of pages from your Child Welfare file here and you've seen these, and I'll just help you a bit here.

So, the first page of those records is about your family, and that's from June 1967, so just as you were 9 years old, and I can see that your school headmaster
11.29 told Child Welfare that people were kinder to dumb animals than your parents were to you; what do you think about that?
A. It was true. They tried to get protection for us but they weren't there for us, still left us in a rubble, so we didn't know who we really were, where to get our next feed from and who to protect us.
Q. And so, there's another document from your records and it's a year later, isn't it, the second page? So, it's from August 1968. This is the - it's written by a nurse
11.30 in Hawera, do you remember living in Hawera?
A. Yes.
Q. You were going to Meremere School, do you remember?
A. Yes.
Q. The note from your records say you and your brothers and

sisters always seemed to be starving and that the school would give you some meals; do you remember that?
A. Yes.
Q. What was school like around then?
A. I really don't know because I don't know how to read and write. I never knew how to read and write until I actually went to polytechnic. You ask me to spell something and I'll tell you to go and get someone because I don't know how to do it. I've been taught how to break
11.31 things up to learn how to say the words properly.
Q. You taught yourself as an adult, didn't you?
A. Yes, I did.
Q. I can see, and you can see from your own records, that another month after, the school talks about how you guys aren't getting enough to eat. The nurse again calls Child Welfare and says you don't have enough food or clothing and that they're concerned about mental cruelty. Do you want to talk to me a bit about how your Dad talked to you or treated you?
11.31 A. My Dad was a violent man. What I couldn't understand is why didn't we get put into protection? My Dad used to throw me up against the fire hearth, I'll never forget it. I can still picture him doing it to me. CYPS was told about it and they still didn't take us away from him. We had to put up with the violence of what he did to me and my siblings.
Q. We know from your records that the Child Welfare did make a complaint because that's in your statement at paragraph 10 but they left you at home.
11.32 A. Can you repeat that again, please?
Q. That's all right. So, at paragraph 10 of your written statement, you talked about this before, that you and your family came to the notice of Child Welfare and there was a complaint that you were living in what's called a

detrimental environment?
A. That's correct.
Q. But I stayed there, eh?
A. Because we had nowhere else to go.
Q. Anna, the next page from your records is from 1969, so a couple of years later since that first complaint. This is a note from Hawera School about how you and your brothers and sisters just had a bit of bread for lunch; do you remember that? This is the document with the
11.33 number 3 in the corner.
A. Yes, we went to school, we had no food in our house. We were pinching off children in the schools and the headmaster knew about it.
Q. And on that same page, it talks about your Dad drinking all of his wages, drinking all the money; do you agree with that?
A. Yes, I do.
Q. And so, in your written statement at paragraph 13, you talk about another Social Welfare complaint and being
11.34 made a State Ward and being taken away from home. Can you tell me about being taken away? Do you remember?
A. We became State Ward when our Mum, they wouldn't let us go back to our Mum, so we went to Court and that's when the State ward became involved and took us away from our Dad. We were like confused, me and my siblings. We all went separate ways, didn't know where we were going. We were all taken away from each other, they split us up completely.
Q. Where did you go?
11.35 A. I went to a Catholic convent down south called Nazareth House.
Q. You went down to Christchurch?
A. Yes.
Q. And you've talked a bit in your statement about Nazareth

House. Do you want to tell me a bit about that?
A. We were, myself and my three other siblings, were sent to Nazareth House. My brother was sent to St Halswell, we came together during school time. At the time, what the nuns did to us is exactly what my father did to us, cruelty.
Q. You talked about what would happen in school in Nazareth House. At paragraph 15 of your statement you talked about what the nuns would do in class. Can you tell me
11.36 about that?
A. The nuns would whack our knuckles if we didn't do as we were told or they'd lift your skirt up and whack your thigh. Now, that brought back memories of what our Dad did to us.
Q. What do you remember about going to school at Nazareth House?
A. We had a school built into the building of Nazareth House and there we didn't know how to, between me and myself and my three siblings, we didn't know how to read or
11.37 write, and some of us still can't do it today.
Q. In paragraph 16 of your statement, you talked about running away from Nazareth House and talking to the Police. Can you tell me about that?
A. The day that I climbed out of the fire escape window, was the day that I got touched by a nun. That freaked me out. It was bad enough a man did it to me, now a nun does it to me.
Q. And I think that was the second time you ran away, was it?
11.38 A. At that time, I ran away, I told the cops I did not want to go back there because I had felt like I'd been touched.
Q. What happened after that?
A. And then they took us away and then I was sent to

Waitara.
Q. In your written statement, you talked about telling one of the other nuns about being touched; do you remember that?
A. Yes.
Q. What happened?
A. I got slapped because they said I was lying.
Q. There's a document from your records that you will see in front of you and it's a report on you and your brothers
11.38 and sisters or four of you, which says that you've been at Nazareth House for a couple of years; can you see that one there? It has a 4 up in the corner. It says that you were placid and well behaved but you had not made very good progress at school, although I know there's big blacked out bits in it, isn't there, so it's hard to read. And it says that you and your sisters are showing signs of becoming institutionalised. What do you think about that?
A. It's one of the worse places to be, especially in a
11.39 nunnery, to be institutionalised, both me and my three siblings.
Q. Because there were seven of you altogether, weren't there, your brothers and sisters? There were four of you at Nazareth House?
A. Yes.
Q. I know from your statement, you talk about going to another foster placement in January 1972 and that's at paragraph 23 of your written statement. Because we're not using the names, we're talking about them as the
11.40 Waitara foster home, aren't we, Mr and Mrs L?
A. I was transferred from the nunnery and flown up from the South Island to the North Island to live with the Waitara whanau.
Q. In your statement, you talked about some things that

happened there. Can you tell me what the foster father was like?

A. He was very abusive, pulled my hair, used the jug cord on me and when I told the State care, they didn't believe me. Who am I supposed to believe if I'm going to tell my story to them?

Q. In your written statement, you talked about some sexual abuse in that home.

A. While living with the Waitara whanau, I was abused by somebody in that house. I was totally raped three times in that house.

Q. Did you tell anyone about it?

A. Yes, I told the State care.

Q. And what happened?

A. And they said to me you better be telling the truth if we have to ask these people questions. I said I'm telling the truth. I started to get angry with the lady. Then they asked the Waitara people, this girl is saying that so and so here has raped this girl. And I just said - then they tried to say that I was lying. I said I'm not lying. Why would I be saying these things? And why was this thing happening on my bed?

Q. And you talked about being hit with the jug cord by the foster father, how often would those sorts of things happen?

A. Once.

Q. The next page from your records that's in front of you, it has a little 5 up in the corner, that's from 10 November 1972. Have you got that there? This is a long note written by your social worker. In it she says that you told her about being hit with the jug cord and having your hair pulled, doesn't it?

A. Yes.

Q. And it says, and the social worker wrote, "I warned

Margaret that she must tell me the truth as I was taking her back to Mrs L and she would have to repeat these things in front of her". And you were willing to do that, weren't you?

A. Yes.

Q. And so, the note from the social worker wrote, it talks about taking you back there and you saying the same things again?

A. Yes.

11.44 Q. And then you showed your social worker a big bruise on your thigh?

A. Yes.

Q. And the note says, the social worker wrote that the foster mother agreed that her husband had hit you with the jug cord?

A. Yes.

Q. And that she told her that they weren't allowed to hit State wards and took you away, is that right?

A. That's correct.

11.44 Q. Did anybody ever talk to you about that again?

A. The school at Waitara.

Q. Yeah. But do you know if anything else happened after that with the Waitara whanau?

A. I got taken away from them.

Q. Okay. After you left there, where did you go?

A. Opunake.

Q. That's at paragraph 29 of your written statement, you went there in August 1973. We have called them Mr and Mrs E but I think today we'll call them the Opunake

11.45 family?

A. Correct.

Q. And your records say that you stayed there for about a year and a half, does that sound right?

A. Yes.

Q. Do you want to talk to me about the foster Dad there?
A. He raped me too. He took me to his room and raped me. I was meant to be looked after by them but, no, I got raped.
Q. Did anyone know about it?
A. The State care knew about it.
Q. So, you've said in your statement that the foster mother found out about it and she didn't want you living there anymore; is that right?
11.46 A. That's correct.
Q. While you were living there, you got pregnant, didn't you?
A. I didn't get pregnant by the Opunake man.
Q. To someone else, isn't it?
A. That's correct.
Q. And at paragraph 33 of your statement, you talked about adopting the baby out. Do you remember what happened?
A. I don't remember adopting him out. I remember I found out I was pregnant and then I overheard the State ward
11.47 telling the Opunake family that I'm going to have the baby taken from me. I started to flip out, so I was taken into Hawera Hospital to have my baby, I was made to travel back with him in an ambulance. I asked the man in the ambulance what's the baby doing, who's the other baby? He said it's yours. I said what's it doing here? I'm not supposed to look at him. We got him back to Opunake, both myself and the baby, and I was made to breastfeed my baby.
Q. And then what happened?
11.47 A. Two days later he was gone.
Q. There is a page in your records, Anna, page 6 in the corner, there is a note about your baby being adopted and that you came back together to Opunake. You can see there that's at the bottom of that page from July 1974.

There is an instruction to the social worker, "Could you please see the baby at Opunake and let me know how Maori it looks"; can you see that?
A. Yes.
Q. What do you think about that?
A. It's very racist because he was just a baby.
Q. After you left the Opunake family, where did you go?
A. I was sent back to my Dad where I didn't really want to go and then I ended up in a relationship.
11.48 Q. What was your Dad like by that time?
A. Still the same, still drinking.
Q. You were still under Child Welfare, weren't you?
A. That's correct.
Q. Do you remember the social worker visiting you?
A. Yes.
Q. And did they meet your Dad?
A. Yes.
Q. You've talked about starting to live with the man you met, and I can see in your records it talks about you
11.49 living with him and his mother?
A. Yes.
Q. So, that's at paragraph 37 of your statement. You were 17 when you had another baby, weren't you?
A. Yes, I had a little girl.
Q. And so, can you tell me a bit about what life was like for you then?
A. When I met up with my partner, he became very abusive, like my father did. He was totally worse than my father. And my children saw the abuse I was going through but the
11.50 State ward knew all about it because I was battered and bruised and nothing got done to save my life. My kids would have been left without a Mummy.
Q. And there's another page from your records, Anna, it's got a 7 in the corner for you. That talks about you

going in to visit your social worker with two black eyes and a big lump on your face, doesn't it?
A. Yes.
Q. And it talks about how that had been done by your partner. And it says there that you were talked about the care you should expect from him because it looked like you thought being beaten up was inevitable, it was just always going to happen, I guess is another way of looking at it.
11.51 Do you remember what happened about that? Do you remember what Social Welfare did?
A. They did nothing. They didn't even press charges.
Q. It says in that record there that they checked you'd been to a doctor; and there's nothing else there, is there?
A. No.
Q. So, you were still living with him when Child Welfare discharged you, weren't you?
A. That's correct.
Q. And the last document in that pile from your records has
11.52 a little 8 in the corner, that talks about how you were pregnant, doesn't it, and how they're going to see how you care for your baby and decide whether to discharge you?
A. Yes, I was pregnant with my third child.
Q. Yeah. And that record says, it's your social worker writing, "As far as I can see, she is a waste of our time. She's changed addresses and I gather she's back living with her de facto"?
A. That's correct.
11.52 Q. And you were discharged a little while after that, weren't you?
A. Yep.
Q. You talked in your statement about the time after Social Welfare care. What was life like?

A. After I was discharged from the State care, they were coming around checking on me after I had left to see if I was coping with my other children, I coped really well. I felt that if I could treat my children right, why couldn't I be treated right?

And then I left this relationship and met up with a lovely man who I love so much. It helped me on my journey to get to where I am today.

Q. You've talked a little bit about the effect on your
11.53 childhood on you in your written statement, do you want to talk a bit about that?

A. My childhood?

Q. About how you think it affected you as an adult?

A. My childhood has been affected due to being raped. When I was raped at a younger age, I felt there was no adult part of me inside me. My adulthood is actually starting now. I don't remember my age, I do now. And just everything was just taken. I don't know who I really am.

Q. Anna, in your written statement at paragraph 44, you
11.54 talked about changing your name so Annasophia. Can you tell us why you did that?

A. Yes, I changed my name to Annasophia because of being abused under my real name was enough to put a record on me. I am not going to be discriminated with the pain I've got today. I love my name, Annasophia Calman.

Q. That last name is your husband's name?

A. That's correct.

Q. You talked a little bit about how your mental health has been over the years. Do you want to talk to me a bit
11.55 about that?

A. I have been placed on medication due to Post Traumatic Stress Disorder. I thought I was going mental but I was told by my doctor, no, it's due to the pain I've been going through, throughout my life. I'm under counselling

as well. I've got a lovely counsellor, she's beautiful. I forgot to tell her I was coming here today.

Q. You're going to have quite a story when you get home.

The last thing that I wanted to talk to you about before I see if there's anything else you want to say, is about your legal claim. And you've said that you instructed Cooper Legal about a legal claim against the Ministry of Social Development; that's right, isn't it?

A. That's correct.

11.56 Q. And the very last paragraph of your written statement you have said that your claim documents were sent to the Ministry on 4 August 2015 and you haven't heard anything back; is that right?

A. That's correct.

Q. Anna, we talked a little earlier about education and your reading and writing. Do you want to talk about how you learnt to read and write and when? When did you learn?

A. I learnt to read and write when I first went to polytechnic. I was taught how to breakdown words and how

11.57 to put it together and how to say it together. The only thing I never - I really wanted to learn was maths, I didn't know anything about maths until I met the man I'm with today because he's a carpet layer, you've got to know the metres, everything. So, I'd look at my husband and think, oh my golly gosh, I wouldn't want to be a carpet layer. I'm still trying to mend what I have to do today but he wishes me all the best on my journey and to do the thing at polytechnic, how to read, I never, like last year I got my first degree in looking after elderly

11.57 people. I love looking after elderly people.

Q. So, you care for other people now?

A. I do. The elderly people are like my parents that I didn't have in my life.

Q. Anna, I know that we were talking earlier about your

whanau, is there anything you want to say about how you get on with your family and your own children?

A. After I had done my book and then went to one of my visiting days with one of our Commissioners that's sitting here with us, I rung up my siblings. It's something I wouldn't want anybody to go through because I lost all my siblings. I never thought we could come together but we did it.I encouraged my siblings to do what I'm doing but not to push it. Be honest with
11.59 yourself and carry on with yourself.Like, I spoke to my sister this morning, she was heartbroken. So, it's very hard to see what I'm doing and for them to do the same.

Q. And you talked to me a bit about your children and your grandchildren.

A. Last night I went to visit my grandchildren and my 6 great grandchildren.My daughter, who's also a social worker, praise her, she's also taking on two children, two of my grandchildren that were placed into CYPS, she's taken on that role model now of being the mother to these
11.59 two grandchildren. She's doing a wonderful job. I just wish we had State people like her. She's also doing psychology work to help younger people out there today and we'd never been so close enough I spoke to one of them on the phone today, my son.

Q. Anna, is there anything else that you want to say that we haven't talked about or that is important to you?

A. I want to read the story that my daughter sent me.

Q. Yep. Just for the Commissioners' knowledge, Anna's daughter has sent her a letter and she would like to read
12.00 it.

CHAIR: Thank you.

MS HILL: It is just on her phone.

A. When I find it. "To my dearest mother. I can imagine how hard today will be for you. After all these years,

you are able to tell your story about the truth of what happened to you in State care and hold those accountable to the drama that you have been through in care and your daily living and you as a person. I pray today will bring you a voice, some healing, tears of joy and some relief. I know no amount of korero will fully heal what no child should ever go through, experience and endure while in the care of others or welfare care but this will show them, the Royal Commissioners, State care and your perpetrators how strong you are today. Thank you for speaking up.

Q. I don't have any more questions for you. Some other people might want to talk to you, so just stay where you are and just take a minute, okay? You've done so well.

CHAIR: Thank you, Ms Hill. Ms McKechnie.

MS McKECHNIE: My name is Sally, and I am here on behalf of the Bishop and congregational leaders of the Catholic Church and I would like to acknowledge your evidence on their behalf today and thank you for your courage in speaking to us.

Representatives of the Catholic Church of Te Ropu Tautoko are here and they heard what you have had to say, they have listened very carefully and on their behalf I thank you for your courage.

The current leadership of the Sisters of Nazareth were not aware of what had happened to you in St Joseph's Orphanage [Nazareth House] until they saw your evidence and they are very concerned to hear what has happened to you. They hope they can meet with you and talk to you about how to help with your healing. I have written to Amanda about that and she will talk to you about that when you're ready, and that will not be today, I'm sure, but when you are ready the Sisters of Nazareth would like to speak to you about how they can help. Thank you very

much for speaking to us today.

A. Thank you.

CHAIR: Thank you, Ms McKechnie. Colleagues, are there any of you that wish to ask any questions? No, there aren't.I want to thank you for your evidence. It is very difficult to speak in public about these things but your bravery is remarkable and we are all very grateful to have what you have said to the Royal Commission now in front of us on the record.Thank you.

12.04

MR MOUNT: Thank you, Mr Chair. Perhaps if we could have another short adjournment before the next witness?

CHAIR: Thank you.

Hearing adjourned from 12.05 p.m. until 12.15 p.m.

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JUDGE ANDREW BECROFT - AFFIRMED

EXAMINED BY MS SPELMAN

MS SPELMAN: I'd like to call our next witness who is Judge Andrew Becroft.

CHAIR: Thank you, good morning, Judge Becroft. I am required by the Inquiries Act to ask you, just as you commence, as follows - (witness affirmed).

MS SPELMAN:

Q. Before we begin, Judge Becroft, if I could ask you to refer to the statement in the folder before you. And I believe it's signed by you on page 16?

A. Signed and dated.

Q. And could you confirm the statement is true to the best of your knowledge and belief?

A. I do.

Q. Thank you. Before I begin with questions, I understand you want to outline briefly the evidence that you're going to give today?

12.19

A. If I could begin (talks in Te Reo Maori). Can I begin by making six brief introductory points which I hope both set my evidence in context and provide a summary of the key issues that my evidence raises?

Firstly, I begin by acknowledging the suffering, hurt and violence experienced by the many who have been victims of State care and the abuse they have suffered and the strength and courage they have demonstrated already in sharing their experiences.

12.20

As the current Children's Commissioner, as a father, brother and son, I want to acknowledge it is a harrowing experience, as it must be for all of us, to hear about the extent of abuse that children and young people have experienced and it is particularly hard knowing that the

abuse in State care continues today.

I need to acknowledge too that as a Judge and as a Pakeha male, I come from a position of privilege and have enjoyed a stable and loving family myself. But my current role comes with significant responsibilities and obligations to give voice to children and young people today, particularly children and young people in care, and I want to do justice to that responsibility.

Number two. I need to be very honest from the
12.21 start, to say that since 1989 the Office of the Children's Commissioner has been the independent monitor of both Child, Youth and Family and more recently Oranga Tamariki, with a responsibility to monitor the practices and policies of the State care system.

To the extent that that system has failed our children, there is at least, by implication, a recognition that the office has failed to properly monitor the system. And I make that acknowledgement carefully and I hope responsibly, acknowledging at the
12.22 same time that the government has never funded the office to comprehensively monitor those in care and successful Governments, despite requests to do so, have not, in my view, sufficiently funded in any way nearly sufficiently funded a state monitoring agency such as myself to carry out the job. And that, in a sense, is a light motif that I think will flow through the Inquiry, that to have a statutory mandate for independent monitoring is one thing. To resource it and to commit resources to it is quite a different thing and there has been a wholesale
12.23 failure by successful Governments to ensure its system of Care and Protection has been adequately comprehensively resourced to carry out that monitoring mandate.

Number three. In alignment with our statutory mandate, the focus on this submission is based on State

care institutions.But all children have the right to be free from abuse. Can I suggest that in pursuing this goal, the Commission will face many difficult issues along the way.

One, for instance, is the issue of privilege, that is legal privilege that's asserted. An example is provision in the Evidence Act that means communications with Ministers of religion are legally protected. If someone discloses that they have perpetrated or are
12.24 perpetrating abuse against a child, such admissions are legally privileged. The issue as to whether this privilege should be abolished is but one example of the issues that this Commission will face. An issue that faced the Australian Royal Commission also.

Can I say generally that privilege is a particularly adult concept, usually asserted to protect adults.

I hope that privilege is not asserted too often to this Commission. And if it is, I would urge you to examine it carefully as to whether it's really necessary.
12.25 As I say, it is an adult concept usually to protect adults and I hope privilege, wherever possible, can be waived so that children are enabled to have their story told clearly and what happened to adults as children is told. Privilege, it seems to me, is a peculiarly adult centered rather than child centered concept.

The fourth thing by way of introduction, is to say that a particularly profound and deep issue is the disproportionate number of Maori in State care and therefore the disproportionate number of Maori who have
12.25 been abused while in State care.

In 1989, through Puao-te-Ata-Tu and then legislation, we had the opportunity for a genuine evolution in the way we care for children. Frankly, that opportunity withered on the vine very early.Now, in

2019, we have a second chance for the revolution that never materialised the first time. This is an obligation now on us to get it right a second time.

The fifth thing to say by way of introduction, is in my view urgent transformational change is required to the Care and Protection system. I highlight that, in my view, the time has come to appoint a separate statutory body, a Commissioner for Children in care, maybe two Commissioners, at least one of whom must be Maori.

12.27 There must be a truly independent monitor of the Care and Protection system, empowered when necessary to speak out publically as a watchdog. There must be a truly independent complaints system. The systems that are in place now and have been in place have not been independent and are fundamentally flawed.

There must be closure of the large scale Care and Protection residences in New Zealand. They should be replaced by much smaller family based homes for two, three or four children or young people but as a temporary 12.27 option and as a last resort. I am not advocating we change a bad system to a less bad system. Wherever possible, if a child needs to be removed, placement should be with properly resourced, supported and assisted wider family or kincare.

And the final point to make by way of introduction, point 6, is that I urge the Commission, with great respect, to exercise your discretion regularly and consistently to consider issues and experiences of those in care after 1999 through to the present day. I say 12.28 that because it's often asserted there is a bright line in the past where abuse has stopped. No-one can tell me when that date is. And while one hopes that the extent and depth of abuse has reduced, we know that it is still happening. Oranga Tamariki, I commend them on this, are

producing quarterly reports of abuse and neglect of children in care which reveals a 7-10% current abuse rate. Frankly, that is likely to be the rock bottom number because we know that the power imbalance for children in care inhibits making complaints. The actual percentage is likely to be greater and we know from the Australian Royal Commission it's about 22.9 years before adults make disclosures of abuse as a child. So, please exercise the discretion to go beyond 1999.

12.29 So, they are the six introductory comments and the summary of where my submission will go and I'm happy to be led through those submissions that need further amplification.

Q. Kia ora, Judge, thank you for that. In terms of the first point you make, you outline in your brief the role of the Office of the Children's Commissioner in terms of the monitoring function and you've outlined that in your introduction right now. Is there anything else in terms of the current monitoring role and under resourcing that

12.30 you wish to say at this point?

A. I think the submission is clear that we've got a widespread statutory mandate that's never been resourced or funded to match the legal mandate. We've talked a good game about monitoring, it hasn't been delivered and to the extent that the office is implicated in that, that's admitted.

Q. And as I understand it, the focus of the monitoring function the office can fulfil has been on residences as a primary point of focus?

12.30 A. That is correct. About half the office's operational resources go towards monitoring and assessment of Oranga Tamariki. In 2012, that was two staff and a director. It soon became four staff and a director. Now nine staff and a director for 6,400 children in care. The decision

has been made to prioritise those most vulnerable in State detention, you're right, in the 9 Care and Protection and Youth Justice residences.

Q. In terms of the pace for our stenographer and sign interpreters, just to keep an eye on them as we're going through, so they can capture everything.

In terms of the point you outlined about a separate and independent monitor for children being so vital, could you tell us a little about the current state of play in terms of what was announced in April this year of the proposed changes to how that independent monitoring might work?

A. The Cabinet released a paper, you are correct, talking about a review of the monitoring and oversight systems for children in care and the complaint system. General, big picture decisions were made but the detail is being worked through now. An important point to make is that it would be important, in my view, for government not to set in stone decisions about that monitoring and complaint system before it had the full advantage of the Royal Commission's findings or at least leave the door open for amendments to that new system, pending your findings. Because this really is a once in a lifetime opportunity to overhaul the system and what you will determine ought to significantly influence the new monitoring and complaint system that is being built.

Q. And you've said in your brief that the intention of the review is to strengthen the independent oversight of children in the care of Oranga Tamariki. Has anything emerged thus far to show whether that intention will be realised in terms of the new proposal?

A. No final decision has been made but all the public communication has been that the government is committed to not just small increases but a fundamental change in

resourcing and oversight. Calculations made by our office, to properly discharge the role of staff are between 80-100 would be required and a significantly bigger budget but nothing less will do if we are going to take seriously independent monitoring of every child in State care. But the final decisions are still to be made. They are happening right now.

Q. So, that's 80-100 staff to do it properly, as compared to currently I think you said 9 staff?

12.34 A. 9 and a director. We're talking about a radical and qualitative change.And that, I might say, is not dreaming of a Rolls Royce system. That's simply getting in place what is needed to discharge the statutory mandate.

Q. So, in terms of what else that might look like, you mentioned just briefly in your introduction a new role, a Commissioner for Children and Young People in Care, can you tell us first a little about why you think that's so important?

12.34 A. It is a specialist skillset to know the legislation, policy and practice of the State care organisation. It is a significant and demanding role in itself. I envisage a Children's Commissioner and perhaps co-Commissioners for children in care, one of whom must be Maori, working together under the same governance structure, in the same office, supporting each other. But I think the time has come if we're going to prioritise monitoring to have that specialist, focused, independent watchdog for children in care.

12.35 Q. Structurally, you mentioned that that Commissioner and the Commissioner for Children could become Parliamentary officers?

A. Absolutely. I think that should be the model. You know, there is a Parliamentary Commissioner for the

Environment, so the taonga, treasures of our mountains, rivers and lakes are watched over, cared for and given a clear watchdog mandate. Surely, our children are no less treasures than the physical resources? Why in principle would we not have a truly independent Parliamentary Commissioner for Children? That is something, in my view, that needs urgent attention.

Q. You mentioned earlier that a motif throughout this work may be the issue of resourcing. What are the differences
12.36 in terms of how resourcing would function if the role was a Parliamentary Commissioner?

A. At the moment, the resourcing comes through vote, Ministry of Social Development. The Minister for Social Development and the Minister for children, the office has a close relationship with. I think it would be far cleaner and have a much greater appearance and actual reality of independence, if that resourcing came from Parliament, from the Speakers Committee, so that it was crystal clear that this was an absolutely independent
12.37 role. 23% of our population are under 18 children. They don't have much of a voice, certainly not a vote. It, in my view, defies belief as to why we haven't had a Parliamentary Commissioner for Children from the beginning.

Q. Is it right that the other aspect structurally of being a Parliamentary Commissioner, would be there's no reporting line to a Minister? The administration is done effectively through the Committee, The speakers Committee?

12.38 A. Absolutely correct. And there's always a tension reporting to the body that funds the watchdog, especially if the watchdog is speaking out about a closely related government department. It would be much better in my view to remove that structural tension.

Q. And you've mentioned the need for Maori representation at that high level. Just so I'm clear, is it your suggestion that the Commissioner for Children role would be a co-Commissioner model?

A. And the Commissioner for Children in Care as well. I think for all that we have learnt and heard already, and know about the New Zealand demography, to reflect the Treaty and to reflect a true governance model the time has come for that role, yes.

12.39 Q. Can I move to the third heading in your brief which is at page 6, this is the obligation to get it right which you touched on earlier.

The first point you made about whether children are, in fact, better off as a result of state intervention, could you unpack that for us a little?

A. In doing so, I want to highlight the primacy, the beginning point, being both the Convention on the Rights of the Child and particular articles of that Convention that provide an obligation for special protection and
12.39 assistance for those who have been deprived of or removed from their family. But the Principal starting point to give the Treaty, it seems to me, is vital to assert. As an aside, the Convention on the Rights of the Child, the Children's Convention, is not taken seriously enough across government in New Zealand and as a symmetry, it's time that we prioritised in all that we do, careful application of the Convention. But as to your specific question, yes, on the evidence that we have currently for children in care, it shows a pattern of high health
12.40 education needs, poor educational achievement, a higher likelihood of criminal offending for children in State care, when compared to the general population. There isn't enough information to show whether outcomes for children in care are improving.

Q. And Judge, we had some evidence earlier in the week, on Monday, from Professor Stanley, and she gave evidence about the way the State assesses risk in terms of intervention and began to explore this idea that risks, in terms of an individual or particular family or whanau, were prioritised without as much thought being given to the risks of state intervention and the negative things that may come from even benign State intervention.

I just wondered if you would like to comment on that thought?

12.41

A. I agree, and I think that is the danger and the trap for every government and State intervention agency, to over estimate the advantages of its intervention and to underestimate the risks associated from that very intervention itself. It always struck me in the Youth Court, the number of boys who were remanded elsewhere who were in State care, when they breached their bail it was invariably for one thing to run back to the very home they had been removed from. So, the pull towards the family of origin is incredibly strong and perhaps underestimated.

12.42

Q. And you mentioned earlier, I think, your suggestion that really the focus is first on supporting within a family or whanau or wider family with appropriate resourcing; have I got that right?

A. Absolutely. And what is more, it is now the new statutory mandate, the new Oranga Tamariki legislation, as from 1 July this year, no longer is the old Child, Youth and Family mandate in place. That was last resort, intervene when there was a need for removal, almost the ambulance at the bottom of the cliff. The new statutory mandate is early support, assistance, intervention whenever there is any risk of removal to get a preventive. That is a great model. It's going to take a

12.42

paradigm shift in the way the State agency has previously worked but it is the right principle and it is now the law and we will have to be vigilant to ensure that the necessary changes, the fundamental changes in approach actually take place.

Q. In terms of this section of your brief, you also spoke a little about what the office has learned as part of the routine monitoring most recently, I believe, is the 2017-2018 year. Did you want to share any of those
12.43 points with us, in terms of the current experience of those young people?

A. Given that we have focused, in terms of our agreed performance expectation, on those in secure residences, the message loud and clear, especially for those in Care and Protection residences, is in the words of one young girl there, it's a hard place to be happy. it is a difficult experience, especially for those who are there for a prolonged time, aggregated with other children from traumatic and violent backgrounds, it's not a recipe for
12.44 enduring rehabilitation. It is a tough place. I have quotes in my submission from children, and it talks of the - some have talked about the self-harm and the attempts of self-harm that have taken place. I mean, that is not to say that the stories universally of those in State care residence are negative. Some talked about it saved my life. But the general theme following 3, is that it has been a hard place to be happy and we have recommended that the State care, Care and Protection big residences be closed but we come to that.

12.45 Q. Yes. Just to finish off in terms of this section, you've mentioned just briefly the four reviews that are ongoing currently. I understand they all have their own different timeframes of when they will be completed but what is your comment in terms of how those Inquiries might inform the work that's taking place here at Royal

Commission?
A. They are all looking at separate issues. They have clearly different Terms of Reference. I hope they will be of significant assistance for the Commission. And indeed, the first of those reviews, the Oranga Tamariki internal review of the specific Hastings case, I understand is due for release at 3.00 today. So, the first step in the instalment, it will be of assistance, is due for release in less than 3 hours.
12.45 Q. We will certainly keep an eye out for that at the time.
Your next point, Judge Becroft, you made at the beginning given its importance but I want to come back to it in some more detail, and that is the experience of Maori both in terms of being placed in State care at high rates and also experiencing abuse in care at high rates.
Can you talk us through your thoughts on this section?
A. The statistics are well-known. In fact, there are similar statistics in terms of poor outcomes for Health
12.46 and Education and child poverty.This isn't simply a State care issue, it's a much wider issue. And, in my view, it's impossible not to begin by recognising the enduring legacy of colonisation, together with modern day systemic bias, and that's an issue for every decision-maker in every government department throughout New Zealand. And I would have thought that the research and current understanding makes that arguable.
Q. In terms of modern day systemic bias, as you've put it, can you help us by way of examples in terms of your
12.47 experience being someone who's worked in the system for many years, what that might look like practically?
A. It's easy to use a term like systemic bias or systemic racism. I think what is meant by that, is the collection of individual decisions, often made unconsciously or with

sometimes the best intentions but when aggregated together, result in a pattern that disadvantages, in this case, Maori.

I know from my own experience in a different forum in the Youth Court, there was a clear statutory injunction that, in terms of indigenous Maori children, that whanau, hapu and iwi be involved in decision-making and be encouraged to develop their own means of response. I realised with some shame myself, a practice with the
12.48 version of the Act had the words hapu and iwi twinked out, there was a full stop after whanau. It was seldom raised in Court or developed and I did not fully give full force to the power of the Act. And I think if decisions are made in the Care and Protection context that don't explore more widely whakapapa links, resources that are available within wider whanau, hapu and iwi, and if decisions are made that narrow the focus and exclude those options, and if they are made regularly, that may well be the basis of what you would call systemic bias or
12.49 racism against Maori.

It's an easy concept to assert but it needs to be unpacked and we all need to be challenged because it's likely that all decision-makers in New Zealand, not just Oranga Tamariki decision-makers, are susceptible to that unconscious bias.

Q. And you've pointed out in your brief that's something that has been well documented in multiple reports in the last 30 years and you've referenced Puao-te-Ata-Tu in particular. What are your comments in terms of, I know
12.49 you mentioned earlier the full vision of the 1989 Act as informed by Puao-te-Ata-Tu hasn't been realised but have any of those concepts or ideas filtered through in terms of the work that you've been doing?

A. I mean, I would like to think that the clear statutory

vision is before all of us, before our office too. It was a wonderful dream in 1989, a vision that was very clear, just a dream, it was legislative lee set out, a new way of doing things. As I say, that vision quickly withered on the vine, decision-making shrunk back into a State care dominated model. Some of you will know exactly that experience. It almost became that which it was designed not to be. So, as at now, the challenge is to give full life to that revolutionary approach which
12.50 ought to mean a huge reduction of Maori children in State care.

Q. And just to skip ahead for a moment. You mentioned at point D that legislative change on its own is not enough and there's been some reference to the new 7AA in evidence in this hearing. What are your thoughts on the significance of that particular provision?

A. As a lawyer and a Judge, perhaps I trusted too much in the power of the law in itself to change behaviour. The 1989 law and subsequent experience, gives lie to the fact
12.51 that law automatically changes behaviour. The new 7 AA provision, in fact no more than makes or does no more than makes explicit what ought to have been implicit for 30 years. It could always be seen, I think, now, as a damning indictment on 30 years of failure. I mean, 7 AA shouldn't be touted as a brave new world and new section. It is simply basic Treaty law put in place and it makes very clear what should have been the case for 30 years. But I look forward to it because if those new provisions are given proper life, there must be change.

12.52 Q. Just on that point, we also had some evidence last week from Dr Moana Jackson, who was also asked about 7AA, and he commented at page 244 of the transcript in relation to agreements in particular between iwi and Oranga Tamariki, "they are systemically flawed because they do not address

the power imbalances which exist, they retain the power of decision-making with the Crown and do not acknowledge the right inherent in Te Tiriti o Waitangi for iwi and hapu to make those decisions".

Is that in line with what you're saying or do you have a comment on Dr Jackson's evidence?

A. I agree. And, in fact, for every government organisation in New Zealand, there is a question about devolution of resources and decision-making power to iwi and Maori
12.53 organisations, not just Oranga Tamariki. But for Oranga Tamariki, there are a number of models or steps that could be taken at the least to devolve power to iwi, so that they have the resources to provide care for their own mokopuna, their own Tamariki.

Another model is to go further and to have two divisions within Oranga Tamariki, one for Maori, one for non-Maori. A further and most radical step, would be to have separate institution, one for Maori children, one for non-Maori children.

12.54 The point is that the current structure needs to be transformed. All those options, it seems to me, are on the table and decisions will need to be made about them.

Q. Another point, Judge, that you've referred to in your brief, is the experience of people with disabilities in State care. Just to go back to page 8 for a moment.

A. Yes.

Q. And I just wondered if you'd like to talk us through your thoughts in terms of that part of your brief?

A. I can simply say this, in our office we have had
12.55 continued and clear urgings from the disability community that special attention needs to be given to the experiences of disabled people in State care because they are doubly vulnerable, not just because of their disability but also because of State care itself. And I

have been challenged to make clear that, with great respect, the Commission should not treat lightly the particular challenges in State care for those who are disabled. And early research indicates, and relatively new research, indicates that is a significant issue.

Q. You mentioned earlier your view around the closure of big residences, secure Care and Protection residences, and you go into this in a little more detail at page 9 of your brief.

12.56 A. The Office's Director of Monitoring and Investigation, Ms Liz Kinley, is here. She leads our monitoring work. The clear conclusion of all our monitoring and visits to the secure Care and Protection residences are they should be closed. I understand, at least informally, that is the view of Oranga Tamariki but I will not speak for them. And I look forward to Oranga Tamariki confirming how and when those residences will be closed. It is an old-fashioned model. It is, as young people would say, so last century, the model of segregating children from
12.57 violent and traumatic backgrounds and then aggregating them together is inherently problematic and very risky, not least of which is the potential for bullying and abuse from other children and young people when grouped together.But the system is flawed, outdated, anachronistic and it needs to go, just as we abolished orphanages and Borstals, so these residences should be closed down. And they should be replaced, we have said, by much smaller community-based family homes with specialist staff but they should not become the default
12.58 option. That's what I meant by saying we don't want to replace a bad system with a less bad system. They should be short-term, temporary, last resort because what must be prioritised is placement within family, wider family or kincare that's properly resourced one-on-one.

Q. And just so we're clear, Judge, we've heard a lot of evidence about some of the historic residences but today, in 2019, can you just clarify which ones you are referring to? I understand some of them may be physically the same institution but with a different name these days?

A. There are five Care and Protection residences. One in South Auckland, one in Epuni in Wellington, two in Christchurch, one in Dunedin. They are varying sizes but 12.59 can I say this, it has been encouraging to us that residences known as Whakatakapokai South Auckland has been already significantly down sized, it is a different institution, it's probably only limited to three, four or five children or young people as an assessment centre, as a hub, and they are moved out very quickly to spokes, the spoke model, the spoke being much smaller community based homes. And that's a positive step in the right direction and long may it continue. In fact, quickly may it continue.

12.59 **MS SPELMAN:** Chair, I am conscious of the time.

CHAIR: Yes, and I sense you are about to go on to page 11?

MS SPELMAN: That's right.

CHAIR: That may be a suitable time for the Commission to take its lunch adjournment.

MS SPELMAN: Thank you.

Hearing adjourned from 1.00 p.m. until 2.15 p.m.

MS SPELMAN:

Q. Judge Becroft, I turn to page 11 which is the fourth detailed point in your brief. I want to ask you about your suggestion of creating a child-centred complaints mechanism. Perhaps we could start with you outlining

first what is the current process?

A. Yes. This section deals with the need for a truly independent complaints system. At the moment in the residential context, the complaint system is dealt with by grievance regulations with grievance Panels drawn in the community, the system being known now as Whaia te Maramatanga.Essentially, it demands and requires that the process be commenced by obtaining from the residence or a staff member the form to complete detailing the
14.17 grievance. You can immediately see the flaw in a system which requires a child or young person to initiate the complaint with a staff member who may, in fact, be a colleague of the person being complained about.

It is very clear that children and young people themselves see the system as inadequate because of that reason and the proof of the pudding, sadly, is in the history. No or virtually no serious instance of abuse, neglect or any form of complaint has been uncovered using that system. It has worked very well, in terms of
14.18 complaints about the operation of the residence, food, lost clothing, other issues of that magnitude, but sadly after near 30 years of operation, that system hasn't been able to consistently uncover significant abuse or neglect that has usually come through other channels, often when the child or young person has left the residence.

So, relying on the current process as it is, without independence, has proved to have been flawed and inadequate. For those not in residential care, there are limited opportunities to make complaints and usually, they
14.19 are accessed through the social worker which again may be the very person in respect of whom the complaint is about.

Q. And so, in terms of the process at least within the residences, after accessing the form it has to be in writing; is that correct?

A. Correct.
Q. What is the role of the Grievance Panel at that point?
A. Submitted to the residence's manager for investigation internally, which we have pushed hard for there to be a standard practice but there are still variations within residences. And if the child or young person doesn't like the result, then there is escalation to the Grievance Panel who try to advertise themselves, try to make sure that they are available, go to the residences
14.20 for meals to get to know the children, but by and large to get to the Grievance Panel you have to get through the internal process, through the manager and be dissatisfied with the result. Everything we know about the power imbalance of being detained, tells us that children who are vulnerable are going to find it incredibly difficult to make a complaint to begin with but to ask them to jump the extra hurdle of making a complaint to the very system in which abuse may have taken place has proved just about an insuperable hurdle.
14.20 Q. Historically, what has the role been, if any, of advocates to assist in the grievance process?
A. Ironically, the legislation makes it clear that advocates should be provided by Child, Youth and Family, Oranga Tamariki, the residence. But it goes on to say there is no obligation on them to fund it. So, in the end, it's become empty and it has relied on a series of voluntary advocates who have come and gone and there's been no widespread consistent provision of advocates and it is a classic example of adults designing a system, saying
14.21 children should have advocates, adults agree with that, but as to who pays it, not our responsibility. In the end, it's been something of a dead letter for 30 years and incredibly frustrating.
Q. And you mention in your brief a new organisation, VOYCE

Whakarongo Mai, what is their role?

A. This could be a game changer. It is designed to be a widespread advocacy service for every child in care. If this doesn't appear to be too conflicted a description, it's an NGO setup by the government, funded by the government, but an NGO, free to be independent and grow and develop and be an advocate and supporter of every child in care to help children negotiate complaints, to stand with them and to be their mouth piece, supporter and mentor. It is a terrific model, still in its early days, but we have high hopes for it.

Q. And I appreciate it's still in its early days but is there some current advocacy work that advocates from VOYCE Whakarongo Mai are already engaged with?

A. Yes, they have started in the residences and they are starting slowly but surely to cover the whole country in residences, and they are proving useful in developing long-term relationships. At last, at last, children in care are beginning to have access to someone who can help them and speak for them when necessary.

Q. And so, you've mentioned that Oranga Tamariki have made a commitment to develop a new child-centered complaints process, is that to replace the current grievance process?

A. No, the grievance process will be amended and is being amended and it certainly needs to allow an independent exit route for a complaint from the beginning. But Oranga Tamariki have made clear that they want a new, fit for purpose, internal complaints system. And all power to them, in terms of developing that. But it won't be sufficient by itself unless there is a separate door that complaints can enter and make complaints to, directly, that bypasses Oranga Tamariki. Frankly, I think everything I have seen in my various roles, is that we

should be wary of trusting government agency to design complaint system. That is the frank position. I could go on and say because they're not independent, they are not fully funded and they use the language of adults to say it will be a way of continuous system improvement. That's great but actually it has to be child-centred, fully funded and utterly independent, and children need to know that and they need to be able to trust it.

Q. Thank you. The other point is the new review that the 14.24 Office of the Commissioner plans to undertake. What is the thinking beyond doing that?

A. Just go back to the complaints point. There is one point I need to stress. There has been a, in one sense, understandable, if not commendable determination to design a new complaints system for an adult eye, as if having a Rolls Royce complaints system internally is going to solve it. Even externally, it may not solve it because the real question is, unless you get a complaint to investigate, it doesn't matter much.We have to be 14.25 thinking about how do we create environments and systems that enable our most vulnerable children and young people, often detained in a situation of power imbalance, to complain. That is why the Australian Royal Commission says it's 22.9 years on average before complaint is made. We should be wanting 22.9 seconds before complaints are made. Somehow we have to get an environment where the complaints can be made. Great having a good system to carry out investigation but we have to encourage the complaints to be made at the time.

14.26 So, what we're hoping to do next year, what we are committed to do in our director of monitoring, is here we want to follow-up and carry out a review of children and young people who have been in detention, 6 months to a year later. Say now you're out of State care, out of

detention, out of the residence, is there anything more you want to tell us? Are there things you can say now that you felt you couldn't say then? It will be a way of us testing and getting information as to whether indeed there is a power imbalance that has inhibited complaints. We want to give that evidence to you, give that report to you, when we've got it but we think it will be very helpful for you and for us to understand why it is that children may not make complaints while detained and in
14.26 State care.

Q. Judge, the next point in your brief relates to the way that the Royal Commission interprets its Terms of Reference which you mentioned at the beginning of your comments. What was your thinking behind your strong encouragement to take a wide interpretation of the post 1999 time period?

A. Not for me to be too strong about this, it is a matter for the Commission, but point 10 in the Terms of Reference, 10(b) says, "the Inquiry may at its
14.27 discretion consider issues and experiences prior to 1950 and in order to inform its recommendations for the future the Inquiry may also consider issues and experiences after 1999. "

In my view, there is no principled basis for drawing the line in 1999 as it was in the first place. I am glad there is that discretion. Please, please, please, exercise it in a large and liberal way because, and this is the reason I ask for it, abuse is still happening. We know that. Even on the self-disclosed figures of Oranga
14.28 Tamariki, it's between 7-10% abuse rate and it's likely to be much higher. It would be wholly in my view inappropriate, it would be unwise and it would be sad if the 1999, 31 December, deadline was only rarely passed. I think there's every reason to think we will get a lot

of good information to inform good recommendations if we regularly go past 1999. I've said it as clearly as I can. It is a matter for you but with great respect I would urge you to use it wherever possible.

Q. In terms, Judge, of the work of the Office of the Children's Commissioner, some of the reports you've cited in your brief, has that been borne out in terms of more recent experiences of young people, the ongoing nature of those issues?

14.29 A. Exactly. We still hear the sad and harrowing accounts of both abuse by staff and abuse by other young people sharing the residence.

Q. Just coming to the end of this section, Judge, I just wanted to give you a chance at this point if there was anything else you wanted to share with the Commission in terms of your encouragement as to where the focus should be in the next few years?

A. Well, that's an enticing invitation that I should exercise wisely. I mean, there are so many issues that I

14.30 haven't mentioned and perhaps should have done.

The continuing option to remand young people into adult Police cells in solitary confinement must be considered in the structural sense a form of abuse.

The remand to large scale institutions unnecessarily because there aren't enough smaller community-based homes, must be considered a form of structural abuse.

The rather absurd two witness rule of the Jenovah Witness Church based institution, in my view both mangles Biblical principles and fails to understand the dynamics

14.30 of sexual offending.

There is a list of individual issues that I could raise but in conclusion, I think what I really want to say is that, nothing less than a genuine revolution in our approach to Care and Protection will do. This is the

opportunity to bring that about. Most of us in this room won't get the chance again in our lifetime to do it. I hope that we grasp it. Incremental change won't do.

In terms of Maori, the revolution is through devolution of power and resources. We need a specific and well funded truly independent monitoring agency with a designated Commissioner for Children in Care, Co-Commissioners. As long as I have life and breath, that is what I will advocate for. You need to know
14.31 again, I said beware of trusting government agencies to establish an independent complaints commissions. Beware of governing agencies establishing monitoring institutions that are independent. We know, under the Official Information Act an aide memoire was produced for us where government thinking had been that the monitor should be a government agent monitoring another government agency. Frankly, it defies belief that that would give not only public confidence but also necessary confidence for children in care. I mean, we have to
14.32 hold the line on utter full and complete independent. We are a watchdog, we necessarily can bark loudly and bark publically. We know there is an opportunity at the moment in designing the new independent monitor to fully involve Maori, designed by Maori for Maori. These are matters that are happening at the same time as your Commission work parallel. I hope that reports can be issued in a stage manner that can feed into what's going on now, otherwise the danger is the horse will have bolted and the stable closed, legislation in place and
14.32 you haven't reported back. We need an independent complaints system, we need the closure of our Care and Protection residences. I am committed in this role to transformational change, that is my respectful challenge to this Commission also.

MS SPELMAN: Chair, in terms of questions from counsel, I have had indications from Ms McCartney QC and Ms Leauga that they may have some questions for Judge Becroft. You may need to check that that is still the case.

CHAIR: Thank you. Have you organised an order between you Ms McCartney and Ms Leauga?

MS MCCARTNEY QC: We have, thank you.

A. This is now an unusual experience for me, normally I ask the questions. 14.34

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JUDGE ANDREW BECROFT

QUESTIONED BY MS McCARTNEY QC

Q. Judge Becroft, I am appearing for the National Collective of Independent Women's Refuges in New Zealand together with Zoe Laughton who I think Your Honour knows.

The Women's Refuge have an interest obviously in the placement of children and young people in homes where they can be, places where they can be protected. They also have an interest in the impact of the violence and the recycling of the violence intergenerationally.

In relation to the questions I have for you today, your evidence, your oral evidence has defined and clarified a lot of the areas or a number of the areas that I was going to go to. Understanding that the revolutionary change that you are advocating is the closure of the State care institutions, the movement on a last resort and short-term basis?

A. Correct.

Q. To community based units. And in that regard, I have a number of questions.

In phasing out the big institutions, are you recommending to the Royal Commission, and have you given consideration to this, a timeline for the phasing out?

A. Yes and yes. A part of me thinks nothing less than a bulldozer would do tomorrow. The other part of me recognises as a responsible Commissioner, that there's got to be alternatives and other options in place, and that's a responsible thing to say.

But as has been shown with the drastic downsizing of whakatakapokai, these things can happen very quickly. I would be very disappointed if by the end of next year

they weren't all closed, that's very doable. Given the $1.1 billion injection into Oranga Tamariki, surely this is the sort of thing it should be spent on?

Q. In relation to the last resort and short-term community based units that you've spoken of, is there a period of time in which you think a young person have you considered this would stay in those units?

A. I haven't exactly considered it but I know we've had examples of 9 months to a year, and much longer in the
14.37 current residences. And I'm certainly not thinking that long. But there are children and young people who come from such damaging and violent and volatile backgrounds that at least in the short-term specialist expert intensive care is required. It's a small cohort of young people.The previous Commissioner felt as a pediatrician there were 200 or so children in New Zealand who had very high and very complex needs, and I think that's a useful starting point. But, no, I don't have an exact month figure to give you as to how long it should be there.
14.38 Suffice to say, even better is specialised one-on-one living arrangements and care.

Q. Perhaps, I'd be interested in your answer to this, with the provision for application to be made if that community based unit care had to be extended, application to the Court I'm saying?

A. Yes, I think there should always be monitoring. A great example just happening now in the Youth Justice context, Ngapuhi social services wanted to provide remand care for young people. I visited Ngapuhi in Kaikohe a couple of
14.38 weeks ago. Interestingly, they were thinking originally of four or five bed homes for young people. They did the research and the thinking and said that is just so not appropriate.Much better to have one-on-one care. They now have a suite of homes throughout Northland where

young people can go one-on-one with experienced trained family caregivers and mentors to look after them. That's a way better model. That's what shows what can happen when the community and Maori in this case, are given resources and power to come up with their own options. That's a significantly better model, in my view, than anything that's in place now. We could do the same for Care and Protection.

Q. Can I come then to the resourcing issue that you're talking of. While we talk about whanau based care, and this can sometimes mean a relative for a wider line of family member, that person or persons, I understand your evidence, would still need to be fully funded for the care that they are providing to the young person?

A. Exactly, and I think there has been a false assumption that that sort of care ought to be free but stranger foster care is resources supported and paid. Actually, they should both get the same. There's no reason to differentiate. Wider more distant family who may be ready and willing still will face a significant and unexpected financial burden and need help and resources, just as stranger foster care is entitled to, and that's been long, I think, a glaring and unacceptable difference.

Q. Would the Commissioner for Children in Care, the role that you are proposing -

A. Parliamentary Commissioner, yes.

Q. Parliamentary Commissioner, let me use the full term. Would that person or persons have the role of monitoring the whanau based care, home care positions?

A. All care.

Q. All care?

A. All care, without reservation.

Q. And in relation to the role of the supervisors, if you

like, the monitors, they would require specialist training?
A. Absolutely.
Q. In order to get into that level of monitoring?
A. And coming from a background of understanding child and youth development, child and youth dynamics. In our office at the moment, we have a mixture of trained social workers, child psychologists, research teachers in learning and behaviour, speech therapists, youth workers,
14.41 all that sort of expertise is required. As I said, the tragedy is the 6400 children in care, we're only giving detailed attention to the 200 in the residence.
Q. Of course, if we closed the residences, as you've suggested, they could bring the focus perhaps wider because of the young people being in a number of homes?
A. Correct but the 9 current staff in a directorate will not be enough to visit in a comprehensive way all 6400 in care. That's why we came up with the 80-120 staff and probably $20 million budget. We have to be realistic,
14.42 that's the figures we're talking about to do properly what we have never done properly until now.
Q. Putting on my role as acting for Women's Refuge, would you agree that support would be required for the carers, so that they are protected in the role that they are undertaking?
A. Absolutely.
Q. Because, as you've told the Royal Commission, the people, young people they're looking after, come from often very damaged violent backgrounds themselves and we would want
14.43 to ensure that cycle of violence has stopped?
A. Correct.
Q. Judge Becroft, are you aware of, we heard the evidence of it yesterday, economic research and papers coming out of Oxford University about the benefits of putting the money

in at the beginning and not at the end after the damage has happened?

A. I am and I agree. In fact, one of the reasons I took this job from my current job, is everything that I'd seen as a Judge was that all roads lead back to much earlier intervention, first thousand days, first 7 years, were crucial times. And a brief summary of that evidence, I think, is while we can be effective in the Courts, it's twice as expensive and half as effective as getting in earlier, particularly in the first thousand days, when it's half as expensive but twice as effective.

14.44

MS MCCARTNEY: Thank you.

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JUDGE ANDREW BECROFT
QUESTIONED BY MS LEAUGA

Q. I appear on behalf of survivors who have claims before the Waitangi Tribunal. The Commission will have heard from my senior Mr Stone over the last few days and I just have a few questions on behalf of our claimants.

14.44 Thank you very much for your evidence. It is a privilege to stand before the Commission and you today to ask these questions.

Firstly, just in relation to the first page of your evidence where you note the systemic failings of the Crown and how these have impacted Maori and that your office is implicated in that failure. You also mention how your office has not been fully resourced or sufficiently resourced to discharge its duty.

Would you agree that these failings would amount to
14.45 a failing on the part of the Crown to discharge its duties owed to Maori under the Treaty of Waitangi, taking into account the principles of good faith, partnership, care and protection?

A. Yes, as part of a wider systemic failure, yes.

Q. Thank you. And you also mention that successful Governments have known about the lack of resourcing, so they have been aware of what's going on, they've been aware of the shortcomings, they are aware of the statistics that you've mentioned today, yet despite these
14.46 failings and this knowledge of the shortcomings, it seems that children are still being let down; would you agree to that?

A. In substance, yes. I mean, every government, not that I am here to defend governments but every government has

resourcing decisions to make but it's been crystal clear that this many children in care at any one time exist and our office has only been able to visit that many. That's been well-known.

Q. Yes. And given there are known statistics that Maori are disproportionately represented in State care, you would agree that Maori children in particular are being failed even more so?

A. Yes, and I think I've said in the opening paragraph of
14.47 the submission that the brunt of this failure in State care has been experienced by Maori, my very words.

Q. Thank you. And you also mention in your evidence that the Puao-te-Ata-Tu report and how the Children, Young Persons and Their Families Act 1989 has failed to live up to the vision of that report.

In that report, Maori speak about wanting more of a role, more of a say and more responsibility in regards to their Tamariki. Would you accept that one reason the Act did not live up to the vision of Puao-te-Ata-Tu, and
14.47 acknowledging of course that there are potentially other reasons, but that racism in particular played a very large part in Maori effectively being sidelined?

A. That's probably unarguable as a contributing factor, as I confessed myself. The unconscious bias and racism. If there were more Andrew Becroft's let’s say in the Justice System, add them all together and the collection of decisions cumulated, results in a systemically racist system as it may well do and probably certainly does with any other government department faced with making
14.48 decisions.

Q. Thank you. So, today, here we are, 31 years after that report came out, same issues have not gone away and again they are at the front of social conscious. Would you agree that including Maori in a far greater capacity and involving Maori more in decision-making than has

previously been done, that could go some way to assist change and to implement what was envisioned by the report?

A. Yes, absolutely.In fact, I'd add what you suggest is no more what the law said then and says now, to involve whanau, hapu, iwi and wider family in all decisions. I mean, there are 32 times in the new legislation where the phrase whanau, hapu, iwi and wider family groups are used collectively as being both the decision-maker, those who
14.49 receive the resources and are empowered to provide support and bring about rehabilitation for their own children and young people. But you could go much further, as I talked about, full devolution of power to iwi and Maori organisations, two twin houses within the same organisation, Maori/non-Maori. And one model for others to decide, is two parallel Care and Protection system; one for indigenous New Zealand children, one not, reflective of the Treaty. In fact, you could go much further than what you just suggested.

14.50 Q. Absolutely, thank you. And lastly, you've mentioned Oranga Tamariki in your evidence and we know that Oranga Tamariki in particular with a lot of recent public pressure as well, have begun to work more with Maori which is a good thing and a step in the right direction. In your opinion, however, why is it that that seems to be the exception and not the norm?

A. Well, for 30 years it was the exception, contrary to what was implicit in the legislation. You ask a massive question that is bigger than just Oranga Tamariki, the
14.50 answer for which relates to why there are the absolutely inappropriate disproportionate figures in health and in education and in Youth Justice and adult justice and life expectancy and rheumatic fever. Those are the big questions for our country. This Commission, in a sense,

is facing in this Inquiry one of the big and entractable questions that we have as a country to grapple and to wrestle with, and that is the position, the disproportionate disadvantage of Maori and the brunt of all the negative statistics that they are facing. This is just but one instance of a much wider issue but it can't be escaped and it can't be avoided.

MS LEAUGA: Thank you for your time, Judge.

CHAIR: Thank you, Ms Leauga. I will now invite my colleagues or as many of them that wish to, to ask you questions of their own.

14.51

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JUDGE ANDREW BECROFT
QUESTIONED BY COMMISSIONERS

COMMISSIONER ERUETI: It is a real concern, isn't it, that your resources are devoted towards the residences and so foster care and these other arrangements of care are therefore outside of the scope of your work, in effect?

A. In practice, that's right, yeah. We keep an eye on the trends and we keep an eye on the principles but in terms of visiting and supervising and interviewing and supporting and hearing from those children in those other forms of care, you're right, that is outside our practical scope.

COMMISSIONER ERUETI: Okay, thank you. I understand VOYCE is providing an advocacy service for these children and that's an NGO, although it's funded by the State. It seems there is an advocacy role that's being established by the MSD. Is that the case? If that is the case, there seems to be some duplication where you have two services being offered?

A. The current Grievance Panel regulations for 30 years have provided for advocates for those in lock up residences but there's no obligation to fund it. I see it as inevitable that a growing and competent resource takeover all those services. Based on a model from Scotland, a key plank of the Expert Advisory Group in 2016, Child, Youth and Family Services. VOYCE got off to a slow start but there's every reason to believe that it will deliver a much needed advocacy service that's been a hole in the system and it's inappropriate conceptually for the

monitor to also be the advocate. To have a separate advocacy service is just terrific and long overdue and what's needed and we support it.

COMMISSIONER ERUETI: Thank you. We heard yesterday too about the need for targeted specialist services for those who are in care, not just the more general services that are provided to children. And that seems to be a major gap in Aotearoa today. Would you agree with that?

14.54 A. It is a significant gap, yes, and I think for those 200 or so children and young people with very high and very complex needs, I think it's easy to underestimate the depth and extent and profound nature of those needs and they do need some very significant expert well resourced services. Too many of them really have been failed by education and health systems as well. One thing I'd urge, is we broaden the discussion and not simply have Oranga Tamariki left, literally, holding the baby. Health and education have to be there too. There are 14.54 children now in the Care and Protection residences who actually should be under the health umbrella and they should be provided with humane, compassionate, expert health intervention. We have allowed a system where Oranga Tamariki has really become, in some sense, I use this not callously, the dumping ground for the very most challenging children and young people and it's not fair just to say it's Oranga Tamariki's problem. It's not, it's much wider than that. I hope you hear from Health and Education services as to 14.55 where they are in all of this.

COMMISSIONER ERUETI: Thank you, Sir. I just wanted to clarify your vision is of the Children's Commissioner, that would also have two Co-Commissioners, your current office and then a specialist care and -

A. Two Commissioners, I think so, yes.

COMMISSIONER ERUETI: There has been a call recently for a Maori Commissioner, I wondered what your views were on that?

A. I can give you our stop press update, if you want. The most that I can do under the current legislation is to appoint an Assistant Maori Commissioner for Children. It sounds a bit, in my daughter's term, a debuzz but it's the most that I can do, it's not meant to be disrespectful.

14.56

We're appointing a chief Maori adviser to help us with the job specification. We would like to appoint one by July next year. We are doing all that we can within the office to try to reflect a Treaty approach to our structure and we are committed to that. And I look forward to the improvements that will bring. I think ideally having two Commissioners, you could say at least one of whom should be Maori in a Co-Commissioner role, I think that would be an exciting and creative way forward that's never been attempted in New Zealand before.

14.56

That's what I mean by radical transformation and structural change.

COMMISSIONER SHAW: Thank you very much for your evidence. You must feel as though you've been beating the drum for a very long time.

A. As with others but yes.

COMMISSIONER SHAW: Indeed. And one of the drums that I think you have been beating, you've referred to it briefly, I would just like a bit more detail about this, about the limitations on the office of the Children's Commissioner due to under resourcing. You just note on the bottom of page 3, "These limitations have been frequently drawn to the attention of the government of the day by

14.57

successive Children's Commissioners". This is not to question that that is true but one of the things that we are looking at right across our Terms of Reference is, what did the government know and not act on? And so, to that end, I'm asking you, are you able to give us a little more information about the way in which these failings have been reported to successive Governments by all the Commissioners who have come before you and yourself?

14.58 A. Well, at least I can speak for myself and say that I have said as of now 6400 children in care, we haven't got the money to visit them all. Where do you think the priority is? We have, as all Commissioners do, raised specific performance expectation signed up. It was agreed that we would focus on those in detention because they were the most vulnerable and who operated most beneath the radar. At the time there was the Australian controversy of revelations of abuse current in Australian youth detention centres and we thought at the very least we
14.59 have to go in, and we visited each residence twice for three days in each year. Now, that was done well, as well as humanly speaking, as well as could be done but still left the other 6,200 children without independent visitation and interviews. Yes, they had their own social worker, yes, they had access to support and services but it was the reality. If you take an example, I had a chance to see British Columbia when I first got the job, roughly similar population,similar issues in Canada. There were 60 staff there and a
14.59 budget of
20 million and that was just seen as the basic infrastructure that was required. I came away thinking how far short are we in New Zealand? How can it be?

COMMISSIONER SHAW: You have been thinking about it undoubtedly and doing as much as you can in your resources. What I am really trying to nail you on

this, in what form did you tell the government? We've heard you on Morning Report?

A. Face-to-face.

COMMISSIONER SHAW: In written reports?

A. Yes, with the nod, we produce annual state of care reports. I know the previous Children's Commissioner, pediatrician Dr Russell Wills, he did too because I checked with him.

COMMISSIONER SHAW: That's really what I'm getting at. There's no way in which a government of the day could say we didn't understand?

A. I had to sign specific performance expectations.They knew what we were monitoring and whether or not we weren't absolutely, it is a matter of public record,I am not blowing their whistle, it just was what it was.

COMMISSIONER SHAW: That is what I was looking for. My second question is one that may well be picked up by my other colleagues but I'm just interested in the existing legislation, the now Oranga Tamariki Act, it sounds from what you've said to us, that you don't think there's a great deal wrong with that, except perhaps, as you said in answer to Ms Leauga, perhaps the need to devolve to Maori more. Taking the Act as a whole, do you think it is currently fit for purpose? Are you in a position at this stage to say that or do you think there's something that needs significant and urgent attention?

A. It's a good question. The first comment is, I've always thought, maybe too much the language of a lawyer, that it was quite an inspirational Act and was well worded. The issue has never been with the words, it's been with the practice. Even in terms of devolution, section 7AA strongly hints at that in terms of the Chief Executive being able to receive applications for new initiatives

and new ways of doing things. And the Mahuru remand service, small but significant step is an example of that.

So, I think there is, the Act enables much that has never taken place, much that could take place. And it's been seen, I think, rightly, as quite a principled and visionary piece of legislation that has fallen down woefully in the practice, as far as Maori are concerned in particular.

15.02 **COMMISSIONER SHAW:** I thought that was where you were going and I think that probably is. So, it's the way it's been implemented, it's perhaps the racial undertones that are going through the interpretation, the overlooking of those, that is the issue, rather than the substance of the Act; correct?

A. Yes.

COMMISSIONER SHAW: Thank you so much for your evidence.

A. If asked, I could come up with a wish list of amendments but fundamentally it's in sound shape.

15.02

COMMISSIONER SHAW: Thank you.

CHAIR: Thank you, Judge Shaw.

COMMISSIONER GIBSON: Thank you, Judge Becroft.

Welcoming your challenge from the disability community. You made a comment about the research, is that again describing some of the problem or is part of the - is there solutions coming out of that research which fits into your vision of transformation?

15.03 A. Yes is the answer and I simply rely, and it may have been a report during your time with the Human Rights Commission, 2017 research. Not a small slice of 18 disabled children but that was a pretty damning revelation of what was going on for them. I think the

answer to my question is, more research needs to be done but I simply wanted to plead with the Commission that we don't overlook the particular needs of the disabled community because in general their needs are often overlooked and they were doubly at risk when placed in State care, it seems.

COMMISSIONER GIBSON: Almost a parallel question about, is the system systemically racist?I would ask is the system systemically ableist? There's almost a preceding question to be answered; is ableism understood so deeply entrenched in the system that it's not noticed, it's invisible?

A. It is probably not an area of prime expertise for me but so far as what you are saying goes, I accept it. It's a much more community-wide issue, isn't it, than all of us are probably to some degree unconsciously ableist..

COMMISSIONER GIBSON: To what extent you talk about the health education, to what extent are solutions transformations tied up in a joined up whole of government approach to try and deal with the intractable issues?

A. Totally, completely and utterly.

COMMISSIONER GIBSON: A monitoring regime that monitors children in care, can that respond to the complexity of cross government issues?

A. Yes, indeed the Cabinet Paper specifically indicates that the monitoring system has to be wider and has to monitor, and it mentions Health and Education as services that are provided for children in care. And it can't be a mono-focused monitoring of just Oranga Tamariki, it's got to be, I think, whole of government. That's one of our current failings in the legislation, the Children's Commissioners Act, it doesn't explicitly give us the power to monitor Health and Education, and I wish we could because so many of those in care are out of education and

have had long-standing health issues.

COMMISSIONER GIBSON: A specific question about neurodisability. The extrapolating the international research in New Zealand, indicates probably 70-80% of children in Youth Justice have a neurodisability. What is your sense of the scale of the issue and the solutions in Aotearoa New Zealand?

A. I think at the moment we see through a glass dimly, as it were, regarding neurodevelopmental disability. We haven't taken it nearly seriously enough in New Zealand. Dyslexia was only recognised in 2006. Autism became liable to disability support services in 2011. Foetal alcohol spectrum disorder could be one of the great crises of our time but we are simply, I think, sitting on our hands largely on that issue. We had a 4 year FASD action plan that was high on plan but very low on action.

15.06

I think we don't have prevalent studies of FASD or some other issues. I think we simply don't know the scale of the issue but I do think, and I say this carefully, that there is a strong argument that we have placed in care and in prison a cohort of young people and young adults whose real issues are undiagnosed neurodevelopmental disability and the history will Judge us harshly because of it.

15.06

COMMISSIONER GIBSON: Kia ora, thank you, Judge Becroft.

COMMISSIONER ALOFIVAE: Good afternoon, Your Honour, very lovely to be in a position to be able to ask you questions this afternoon.

15.07

As you well know, I am very interested in the system and the system's blocks. I was really wanting to just understand and get it on the record that when you're talking about transformative change, because it's easy to look at things in silos, so I appreciate the parameters of

your brief in terms of the OCC. But a child does not grow up in a vacuum, it grows up in a whanau. Talking about the moment of conception, following them the different milestones in their life, to be able to get to the point where I think its 25 is the age that they age out of the system, making sure the dots actually connect to truly give them the priority that we often talk about but we don't deliver on as a nation; is that correct?

A. I agree with you. I know of your concern and I agree. In fact, as a small aside, with the foetal alcohol spectrum disorder we'd be going pre-conception and being much clearer as a country about the risks of any alcohol consumption while being are behaving in a way that may lead to conception.

COMMISSIONER ALOFIVAE: So, despite best efforts in determines of research availability but also evidence and just what families and young people are telling us, we still haven't been able to do that well enough to get even to almost like where we feel like there's transformative change happening.

A. There's been progress towards co-ordinated joined up interventions, it would be wrong to say it hasn't happened, but it's been incremental.

COMMISSIONER ALOFIVAE: And that's not enough?

A. Correct.

COMMISSIONER ALOFIVAE: The other point is around diversity and inclusivity. Thank you very much and we appreciate the statistics around Maori and the damming impacts on Maori children. But what we also know is a lot of children of mixed heritage are coming through, Maori Pasifika and Pakeha Maori something else.

A. Yes.

COMMISSIONER ALOFIVAE: Were you seeing some of those in your work in terms of trends around children of mixed heritage in the care system. Can you offer us a perspective on maybe some numbers?

A. Actually, on data as a whole, I think that's one area that should be of interest to the Commission. The old Child, Youth and Family's data was very patchy. Dr Russell Wills' previous report on the State of care said there was very limited outcome data. One of the challenges for Oranga Tamariki, which it is try to meet, is produce regular unarguable state of the nations statistics on all the things you are talking about and the data. We know when there are 67% of children in care who are Maori, some of those, about 9% are Maori Pasifika. So, it's important to unpack the statistics. But there's never been clear statistics available. Even now when you talk about removal of Maori babies, different time periods are taken, sometimes 0-3 months, some first 7 days, sometimes first year. It becomes very confusing. I think we need a clear data set, particularly for all connection with children in care. That should be designed with but not solely by Oranga Tamariki. That is something we've been trying to do.

COMMISSIONER ALOFIVAE: And of course another group of young people that fall within our Terms of Reference are those that would - another cohort of young people that fall within our Terms of Reference would be those in the LGBTQI community, any comments around some of those young people that you've seen in care?

A. No, only that those I've met personally talk more about bullying and marginalisation or being bullied and being marginalised and alienated, yes. More than I had realised actually.

COMMISSIONER ALOFIVAE: And obviously, in terms of possible solutions, different matrix to be able to work out what would work better to keep them safe?

A. Correct.

COMMISSIONER ALOFIVAE: I'm really interested in the vulnerability of our young people is embedded in the legislation. You say you have this Act, you have to do this work but they don't fund you to do it. And 7 AA, like you said, it is almost like an indictment for us as a nation, that we had to physically write it in, you will consider the Treaty of Waitangi. We now have kids transitioning to independence coming out of care and we have section 386A which of course is still a work in progress because it means that those who have been in care, Oranga Tamariki are still responsible for them up to the age of 25. But when we talk about the practice implication, this is where the variability comes in.Have you had any experience or any young people discuss that with you or your office?

MS KINLEY: Can I say, it is probably a little bit too early at this stage for us, given that service, including the community partners in that service, is quite new.

A. That is Ms Kinley, Director of Monitoring and Investigation is giving unsworn, unaffirmed, helpful comments to the Commission but the gist of it being too early for us to say yet because it was 1 July that took effect and we're now only 3 or 4 months in but glad you're here, thank you.

COMMISSIONER ALOFIVAE: Thank you for that but already we are hearing noises around how that is actually not serving some young people well and I was

wondering if your office -

A. Too early for us to say.

COMMISSIONER ALOFIVAE: Okay, thank you. No further questions. Just very, very great grateful for outlining your big picture and where you think we should be going to as a nation in this area, thank you, Sir.

A. Thank you.

CHAIR: Judge Becroft, I've got three aspects of questions.

15.14

Number one relates to your challenge, your wero, to the Royal Commission to use the discretion in the Terms of Reference to look at items post 1999. At page 3 of your written brief, you speak of Oranga Tamariki today servicing 30,000 people with 6,400 in care. And you speak of these 200 high needs people. Are you able to give us something of a picture, seeing that your office will be 30 years old shortly, 10 years ago and 20 years ago, how that - has that 30,000 figure grown

15.15

exponentially over that time?

A. I think it's best that we give you an addendum written response to that and the figures but I know for instance that above that 30,000 are reports of concern. Now, as is known, they have increased significantly. Numbers in care have also increased. Whether it's exponential or gradual on the graph, we can provide that information for you.

CHAIR: I think I speak for all of my colleagues when I say that will be helpful because we will, of

15.15

course, consider this matter of going beyond 1999 but we will need the figures to do it.

A. Certainly, the numbers in care after 1999 have increased. And they've increased significantly lately, some of which will be due to the increase in the age jurisdiction for

the service. But, yes, numbers have certainly increased in children in care.

CHAIR: My second question is related to your strong submission made to the effect that the Children's Commissioner ought to be a Parliamentary Officer funded by Parliament and responsible to Parliament in the same way as the Ombudsman and the Clerk of the House and the Auditor-General and as you referred when speaking to the Parliamentary
15.16 Commissioner for Environment.

You will know that those Officers of Parliament receive their funding from an appropriation by Parliament. In other words, there is no Cabinet resolution that results in their remuneration. Do you think it would be a disadvantage for the Office of the Children's Commissioner not to have a voice at the Cabinet table supporting the efforts of the Children's Commissioner?

A. That's a penetrating and deep question. I would still
15.17 have thought that the relevant Ministers whom the Commissioner monitors would want to have a view as a Cabinet. But, in the end, I think it's cleaner and purer for the Commissioner, the Parliamentary Commissioner, to make a case for sufficient and necessary independent funding. I still think that outweighs the disadvantage perhaps that you bring up.

CHAIR: In other words, you're saying that you think that the Parliamentary Commissioner that you have in mind would be able to make submissions to the
15.18 relevant Parliamentary Select Committee of a sufficient kind that would ensure the whole of Parliament agreeing that the funding for the Children's Commissioner should be sufficient to undertake his or her job?

A. That's what I would hope. It seems to me, one of the big dangers that when you have an independent statutory watchdog, inevitably you are forced sometimes to bite the hand that feeds you and it is much better that you're fed and quartered and housed by the whole of Parliament because children should be a whole of Parliament issue. And it's potentially at least and theoretically too easy to get off side with the government of the day if the watchdog barks in a way that causes embarrassment, for instance about child poverty.

15.19

CHAIR: Thank you. My third question is related to Puao-te-Ata-Tu. We have heard almost every day in the public Contextual Hearing about the 1988 report and about how what it said in such clear terms was not taken up and it remains just lying there 30 years on. Do you think that Puao-te-Ata-Tu is fit for purpose and capable of being reconsidered now?

A. Yes but I should also add, much of Puao-te-Ata-Tu found its way into the 1989 legislation. So, in a sense, it performed and still performs and still speaks by the fact that many of its recommendations are now legislatively enshrined. If you go back to your question, Ma'am, the legislation itself is fundamentally and in a principled way sound, amongst other things because of Puao-te-Ata-Tu. It doesn't sit on the sideline but it's pretty much enshrined in legislation now. But the answer to your question is yes, there is room to do that.

15.20

CHAIR: So, Puao-te-Ata-Tu could be reconsidered as the Royal Commission does its work?

15.20

A. I think so. And why it's mentioned by so many people, particularly Maori, is it's seen as still speaking.

CHAIR: I join, I hope I make obvious my colleagues in thanking you for the clarity and the breadth of the

submissions you have made as Children's Commissioner. They will undoubtedly be very, very helpful in our ongoing deliberations.

I want to say also, that this may not be the first time on which you will be giving evidence at public hearings of the Royal Commission because there may well be further matters as we come towards later aspects of the Royal Commission's life where what you might say will be helpful to us. Thank you.

15.22 A. Thank you. Can I add one addendum just for the record to Commissioner Shaw? You asked about speaking to government about this many children in care but only being able to monitor this much.

In fact, the Cabinet Paper is a response to that very concern that was raised. In fact, that was heard. What is planned is a pretty gigantic change that does show there was two ears hearing it and action promised in the Cabinet Paper. And it's, I think, responsible for me to say that. Of course, we wait to hear the decision.

15.22 **COMMISSIONER SHAW:** Thank you for that. It just took a little while, didn't it?

A. Yeah, about 31 years.

COMMISSIONER SHAW: Thank you.

CHAIR: Thank you. Madam Registrar, I am going to suggest that, and if counsel are in agreement, this might be a useful time for us to take the afternoon adjournment, so that the last session of the day can have a clear run from about 3.35 until the end of the day.

15.23

Hearing adjourned from 3.23 p.m. until 3.40 p.m.

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ROSSLYN NOONAN - AFFIRMED

EXAMINED BY MR MOUNT

MR MOUNT: Good afternoon, Chair. The next witness is Rosslyn Noonan.

CHAIR: Thank you. Ms Noonan, as you commence your evidence, in terms of the Inquiries Act 2013, may I
15.42 inquire of you as follows - (witness affirmed).

MR MOUNT:

Q. Good afternoon, Ms Noonan. Just with some formalities. In front of you, we have a copy of your statement of evidence which is 94 paragraphs long with some appendices. Can you just confirm for us that you have signed that today and confirm it's true and correct to the best of your knowledge?

A. I have and it is.

Q. Thank you. In a moment, I will invite you to make any
15.43 introductory comments that you wish but could I just confirm that you are currently the Director of the Human Rights Centre at the University of Auckland School of Law and you were previously Chief Human Rights Commissioner for a decade from 2001-2011?

A. That's correct.

Q. Obviously, your evidence, in light of that background, will have a particular human rights focus?

A. Yes.

Q. I understand you may have some introductory comments that
15.43 you would like to make?

A. Thank you. (Opening comments in Te Reo Maori). Commissioners, survivors, advocates, Commission staff, Royal Commission staff, tena koutou tena koutou tena koutou tena koutou katoa.

I wanted to start by acknowledging the courageous testimony you heard today from Beverley and Annasophia and those survivors who appeared earlier in this Contextual Hearing and those we are still to hear from.

Whether in State care or abused in faith-based institutions, it's clear from their stories and from the response of the State and of the faith-based institutions to date, that massive constitutional, structural, cultural, legal and moral and behavioural changes are
15.44 required in the way we protect the rights of our children and young people and those children and adults with disabilities who are in care.

The focus of my submission, perhaps slightly different from some others, is the State's response to the claims of abuse in care since 1999.

So, like Judge Becroft, I urge the Royal Commission to interpret broadly section 10.1 of the Terms of Reference in relation to its ability to consider matters after 1999. And just very briefly, the reasons I do so,
15.45 and there's probably two or three of them, is one, that how the State has responded to claims of abuse since 1990 reflect very much the reason why this Commission is necessary. Because effectively, successive Governments and agencies of the State sought to suppress general public knowledge of the abuse and violations that have gone on over many decades and actually, in my observation, took a number of measures to try to prevent an independent Inquiry of this nature being established.

The problem is that those same agencies will be
15.46 providing advice to Ministers about how to respond to this Royal Commission and its recommendations and are already doing so. And so, the extent to which - if their behaviour post-1999, and I will be giving some of examples of that, is not called into account, and if they

are not required to acknowledge the extent of their responsibilities at the highest level for the persistence of the abuse over many decades, then I'm afraid, no matter what you recommend, won't make any difference.

And, I mean, this is the critical, you know, this is looking at where power lies and what needs to be done to ensure that those with power are required to change and do in fact change.

And that won't happen if you don't look post-1999 because they have assured us all too often that they've sorted everything. Bad things happened before 1999 but since, you know, we've got it right, we changed the law, the law looks pretty good and don't bother us. You know, just sort out the historic stuff. But, as we know and as we've heard from Judge Becroft, the fact is abuse does continue but more importantly, there's no recognition. I think most - well, the abuse should be stopped but it won't be stopped unless there's recognition of the systemic failures of those at the highest level of government and government agencies with respect to this issue.

Q. In paragraphs 9 and 10, you have given us more detail about your personal background. Are there any aspects that you would highlight for the Commission?

A. Well, just very briefly, when I was preparing this, I realised that in the early 80s or the first half of the 80s, as an industrial officer with the Public Service Association, I represented social workers and assistant social workers. These were people working in the very institutions that we've been hearing how extensive abuse was.

And later on, from 1988 until the mid 90s, I was the National Secretary of Te Riu Roa, again representing teachers, psychologists, education advisers and others,

who were working with these children, either in state schools or integrated schools which they attended from the residences or schools attached to the institutions themselves.

So, I am concerned that the Royal Commission actually hear from those people because I think we know now, and we know a lot more probably about the impact that an environment of bullying, violence and intimidation has on staff, as well as on children and
15.50 young people.I am not excusing staff in any situation where children violated if they could have prevented it. But, again, I think this is where issues relating to leadership, management. What we know is any institution, the tone, the behaviour, the environment, is set by the leadership, it's set by the senior management. And in the State, in the case of state institutions, that senior leadership was at the national level. In the government agencies education, Social Welfare or MSD, health, as well as the heads, the managers, of the institutions
15.51 themselves. So, again, if there's really going to be any change, and it's unlikely that institutions as a whole will vanish, even though ideally that might be desired, we need to understand what the mechanisms are that allow culture, a culture of violence and bullying and intimidation to persist. And that means focusing on the management and the leadership, not just the so-called bad apples which again has been the approach of the State to date.

Q. I take it, you would advocate that we hear not only from
15.52 the people at those senior levels but also from those who were at the coalface?

A. Totally. I mean, I think you need to start with them because we need to hear what their experiences were, you know how they came to be caught up in some very, very

disturbing environments. And also, we do know that some of them tried to draw to the attention of Wellington what was happening, we know that now, and with no success. I mean, similar to the response to ACORD, the centre chose to ignore the evidence that was presented to them about what was going on and did nothing about it, other than try to suppress and hide it, they did do that.

And the other thing is, just again in preparing this, most recently I've Chaired the Te Korowai Ture
15.53 a-Whanau, which was the independent panel examining the 2014 family justice reports reforms. In that process we discovered a whole raft of systemic issues across the family justice services, that includes Family Court as a whole but all the related services around it, none of which had been adequately addressed. And those systemic issues are absolutely central to the considerations of this Royal Commission. And again, I mean, obviously you can have access to the Te Korowai Ture a-Whanau report but in relation to the system wide issues that need
15.54 addressing.

In addition to the failure to the cultural and the failure to take account of Te Reo Maori in any respect, they're also not responsive to Pasifika cultural needs or to those of our new migrants. But to me equally shocking was the fact that there was no systematic accommodation of people coming before the Family Courts with disabilities and many of the family justice services, including the Courts but not limited to the Courts, were not accessible basically. We discovered that hearing
15.54 loops weren't regularly serviced and fixed and there was no way, there was no provision for asking people beforehand formally what support they needed to effectively be able to participate in the Court's proceedings, although we were assured by Judges that of

course if they knew someone was disabled they'd go out of their way to help them. So, a totally inappropriate charity model which should have gone out with the - you know, disabled people shouldn't have to beg for something extra in order to get equal access to justice.

And I think that the fact that that was still the case with respect to the Courts, and I am sure it applies across all, not just to the Family Court, really reflects, in my view, the seriousness of the issues
15.55 relating to disabled people, disabled children and adults who require significant care or in State care or other institution care.

Q. If we move to part 1 of your statement, paragraph 20, perhaps to introduce the topic, we've heard over the last 8 days of this hearing of the numerous claims of abuse in State care over the years. I take it, during your time as Chief Human Rights Commissioner you became aware of those claims and formed a view about the government's response. Would you like to introduce your views?

15.56 A. Yes. I will try to summarise them. So, essentially what happened, was that after the Gallen J Lake Alice compensation process and the publicity that surrounded that, you know the media coverage, and I mean I think we've heard this from Sonja Cooper and Amanda Hill, what effectively happened was that a lot of people who had been in Lake Alice or in other psychiatric institutions in New Zealand and who had suffered appalling treatment in one form or another, came forward and said, you know, we need to be treated in the same way.

15.57 At the Human Rights Commission, the first case that came to us called Kelly's case. She was a young woman who was obviously very naive, very young, young 21 year old committed to Lake Alice for reasons I can't go into but she was actually placed in the Adolescent Unit. And

she came to us because she thought that it was unfair that just because she was not, you know she was over the age, even though she'd been in the Adolescent Unit and had been treated the same way as many of the young people, you know, there was evidence of the treatment of young people, including use of ECT and so on, that she couldn't be compensated for that because it had really damaged her life in many, many ways.

Anyway, I won't go through it. I'll summarise what
15.58 I see as the key characteristics that prove to be common to the State's response to virtually all these claims throughout.

First of all, the Ministry of Health and Crown Law simply, the mediator who was working with her said, swatted the complaint away, claiming they didn't even have to sit with her, come to the Commission, mediate, because the Lake Alice' process were only for children, who were children at the time. So, they wouldn't even enter into mediation or listen to her. They claimed of
15.59 course if she was 21, then she couldn't be in the Adolescent Unit.

Actually, when we were able to retrieve what records existed, for the most part they provided corroborative evidence that she had been in the Adolescent Unit. And there weren't many details of the ill-treatment she received but there was enough to suggest that it had gone on.

And we took those back to Crown Law as evidence that it should come to the party and mediate with her. The
15.59 Crown Law Office informally met with her but nothing came of it. Just to say, following that, I mean, she didn't have - she couldn't face going public over what had happened to her, which is why she didn't join any of the class actions that were being put together for other Lake

Alice patients, and she didn't feel she could go to the Human Rights Review Tribunal on the age discrimination claim that she'd come to us with for the same reason, that she'd have to publically disclose what had happened to her.

But what we did do with her instead, was help her put together her story in detail with her records and so on, which she took to the Confidential Listening and Assistance Service. And she did find that experience
16.00 affirming, not closure, you know, nobody would think there would be closure but certainly that was a positive experience.

But the key characteristics, as I said, the unwillingness to look at a non-adversarial approach to dealing with these claims. The difficulty in accessing her records, we did manage to get some. I did actually at one stage, myself, meet with the then Deputy Secretary of the Ministry of Health and, you know, I tell you, New Zealand's public sector records they've been subject
16.01 to more fires, more floods, you know, worms, other things that have affected them and caused surprising and usually very specific files to disappear. You know, we were given all sorts of reasons why her records were intact.

But fundamentally, and this is again what I found hugely problematic, was a complete lack of empathy for her situation, until she went to the Confidential Listening and Assistance Service. And it was as if the government officials, the Crown Law lawyers, Ministry of Health lawyers, as if somehow they had a stake in proving
16.02 her wrong, in dismissing her claim, as if there was, you know - I couldn't understand why, given this had happened a long time ago, they weren't personally responsible, I don't think there would be anybody left in the Ministry of Health who, you know, would have been responsible at

that time, and so why they needed to be so denigratory and dismissive of her and that attitude persisted.

Q. Just to refresh people's memories, we've heard that the abuses at Lake Alice were sufficiently acknowledged by the government, that I think a $10 million compensation fund was created. And the report of Gallen J condemned in the strongest terms what had happened there, so there was no secret about the existence of the abuses?

A. No.

16.03 Q. I take it, that's the background to your concern about the response to Kelly?

A. Yeah because, clearly, even on the basis of the limited records that we were able to access for her, it was clear she was there at the time when the abuses took place, that she was almost certainly for a period in the Adolescent Unit, given the staff that she could identify who were in that unit etc.

Q. Your hope might have been that she could push on an open door, rather than having the door slammed in her face?

16.04 A. Yes, exactly. In the expectation that there would be - you know, I think it was definitely in the State's interests to, you know, recognise that these abuses had gone on and to find a way to face up to them and provide some redress. And certainly, in human rights terms that's what was required. New Zealand had signed up to the Convention Against Torture, there was clearly inhumane and degrading treatment etc. but it was like, no, we're going to deny them or we're going to minimise them or we're going to try and suppress them.

16.05 Q. Did she ultimately have any compensation?

A. Unfortunately, we haven't been able to track down the final outcome because my recollection, and I've sworn to tell the truth so I might be wrong, but my recollection is that eventually, you know, because there was a kind of

health, you know, the Crown Health Financing Authority did do a kind of class settlement and she did receive something in that process.

Q. Further down the track?

A. Much further down the track but that may not be the case. And the mediator who worked with her was very unsure when I tried to - I haven't have a chance to really - the records now, the Human Rights Commission records will be well stored somewhere and it would take a huge effort to - so, she may have got something and I want to acknowledge that.

But anyway, yes.

Q. Shall we move to access to records which is from paragraph 32 of your statement?

A. As I say, one of the things that's consistently consistent in terms of the State's response to all of these cases, is either very poor or lost records. And certainly when care leavers have sought to access their records, they've had a hugely difficult time of it. And often, you know, I am aware of care leavers who receive - the first time they ask for their records they received records that were redacted virtually every page, like you know 100 pages and hardly a single non-redacted sentence.

Given that the records, all of the mechanisms that the successful Governments put in place to respond, put in place in the 2000s to respond to claims of abuse, all required, all required the claimants to be able to produce records that proved that they were there at a particular time. But also, not only that, but that specific things happened to them. And if it wasn't referenced in the records, the tendency, and again you know I'll leave it to Sonja Cooper and Amanda Hill to provide you with a lot of that detail, but the outcome was, well, we don't accept your claim because there's

nothing in the records. So, you know, that affected the compensation levels.

One of the things that we did as part of - as we were advocating for an independent Inquiry, and this was prior to the change of government, so the National Government, the Human Rights Centre supported by the New Zealand Archives Professional Association organised a round table about the records and that involved people from National Archives but also from a number of the
16.08 faith-based institutions in terms of what records they had kept, as well as the Department of Internal Affairs etc.

What I've provided for in the submission is the sort of detailed summary of what came out of that day. I will perhaps highlight some points from it.

Basically, care leavers generally found that the only personal records that existed of their childhood are held by government departments who often choose to redact much or most of the personal information about the people
16.09 that they were surrounded by in childhood and those redactions were often also inconsistent.

If I can just tell you, one of the people who participated, a care leaver, and I hope she might come before the Royal Commission at some point, at the time of the symposium she was 79, so she had been put in foster care as a young child and because her mother was deemed to be developmentally or learning disabled to an extent, and it turned out that she had been put - it was later accepted that she had been fostered into a family where
16.10 the mother turned out to be seriously sort of psychotic, so she said before I die, I would just like to know everything that happened to me. And endlessly, request after request, complaints to the Ombudsman. At that stage, 2017, she had still not received a fully

unredacted copy of her records. Now, what possible harm could a 79 year old woman do to anyone who's mentioned in those records? Most of them would no longer be alive, at any rate.

And I am putting some emphasis on this area because I think it's something that probably the Commission needs to deal with sooner rather than later, is the fundamental question of who owns those records.

And if you think about it, virtually every other
16.11 record made about us here in New Zealand, our health records, school records, credit records, they're ours under the privacy legislation, we can ask for them, we can get them completely. But here, children who were in State care cannot get their records.

And then when they do get them, and I think we've heard this from one of the survivors, they only put negative stuff in.

And then very recently I've heard that people have
16.11 had experience where there has luckily been maybe some school photos or whatever, that the photos are being redacted on some spurious privacy grounds. Now, we know if you take - so, only the child's, the care leaver's face has been left. I mean, what sort of thinking is doing this? The care leavers themselves, following their symposium, they have never done this before but they were supported to make a submission to the Oranga Tamariki legislation on what should go into that legislation in terms of the records.But just to summarise what they themselves said in that submission, they provided details
16.12 of accounts of insensitive, disrespectful interactions at the point of hand-over.So, that's stuff that was happening in the 2000s and beyond.

Insulting, judgmental opinions.

Redactions which are neither consistent or fair.

Inaccurate, incomplete information and omissions.

They go on, and I think again I would urge you to look at what they recommended about what they see should be available to care leavers in terms of records from now on. And I think that what they propose is very practical, reflects a human rights approach, in a sense. That those who are most affected should be able to have a say about what should happen. So, here they've done that.

16.13 And it really gives voice to the children in care about the sort of records that would be appropriate for them.

So, as I say, I would like to ask that this be looked at early on, so that people no longer seeking their records no longer have to go through the sort of hoops.

And it may well come down to the issue of who owns these records. And, again, I mean, at the time we did have a look at the legislation and it's difficult to see 16.14 on what legal basis the agencies concerned claim that they own the records, as opposed to these being personal, you know, records which ultimately the ownership should be of the person about whom they are.

And obviously, there always has to be an exception, if there was a real threat of violence if someone found out the name of somebody who they felt had mistreated them, maybe that, but generally that's pretty rare.

Q. Just for the record, the full submission from Kelly's association is Appendix 2 to your statement, so the 16.15 Commissioners will be able to look at that in their own time.

A. I don't think the Oranga Tamariki legislation sufficiently took account of their submission, so that's an area that definitely needs change.

Q. Shall we move now to the Crown's litigation strategy from para 39?

A. Yes. Obviously amongst, you know, if we - if you think about the Crown's response to claims of abuse, I mean, the Crown summarised their approach as, and paragraph 22 of my submission I quote them directly, "At a systemic level, allegations of ill-treatment in a given institution".

Q. Just pause there for a second. I am mindful of those who
16.16 are having to interpret this for others, just do it slowly.

A. Okay. Paragraph 21, I quote the government's response to, the government's own summary of how it responded and it said, "At a systemic level, allegations of ill-treatment in a given institution are thoroughly investigated."

Well, I think we've heard enough to know I am not sure when that thorough investigation started.

And then, "For individuals who raise allegations,
16.16 Court and Police procedures have been supplemented with the Confidential Listening and Assistance Service which can provide support and other assistance and with an alternative resolution process which can provide compensation, apologies and other remedies".

And the very self satisfied summary, "The result is an integrated and comprehensive approach to addressing such allegations".

If you didn't know anything about it and you looked at the list of what they provided, so the confidential
16.17 psychiatric forum, Confidential Listening and Assistance Service, the Ministry of Social Development's care, claims and resolution process, the Crown Health Financing Agency, civil litigation, judicial settlement conferences, direct negotiations and criminal procedures;

it sounds like, you know, they had it covered. And that's what they sought to present internationally as well as nationally. But each one of those, while they had some positive elements had very, very significant flaws. And I guess we start with the Crown's litigation strategy.

Q. The first thing you've talked about at 39 is the Atkinson case?

A. Yes.

16.18 Q. Which is a reasonably well-known case but perhaps you can highlight for those who are not so familiar with it?

A. Yeah. So, this was a group of parents of severely disabled adult children whose adult children had been assessed as eligible for payment for care because they needed very substantial levels of care, personal care, and whom the State, and the State would pay anyone to provide that care except family members, direct family members.

In the case of I think the nine plaintiffs, all of
16.19 them had tried alternatives, in some case tried out-of-home care, in other cases had tried home based, but like stranger home based carers, all of whom had had serious problems, not least of which was because the adult children were so severely disabled people didn't stay for very long. If they were lucky to get someone who was - if they were lucky to get someone, and then they were lucky to get someone who was sufficiently skilled, it is such a demanding responsibility there was constant churn.

16.19 At any rate, the thing was these families came on the basis that it was family status discrimination which is unlawful in the Bill of Rights Act and Human Rights Act.

Once again, in the Human Rights Commission we try

always to find solutions because we accepted that, you know, complex environment, the Crown had very real resource constraints and other considerations, but the human rights approach says, you know, look at all of those with human rights involved and how can you provide with them, provide for them, without derogating from the human rights but obviously taking into account the real life complex issues?

And in this case, the Human Rights Commission had
16.20 developed, in co-operation with the Office of Disability Issues, so the government agency responsible, an approach which formed the basis of a Cabinet Paper which provided that family members could be paid providing they underwent same checks non-family members underwent and they were prepared to sign the same contract.

So, this was no question of, you know, risk to the government's finances at all. Everything was kept within a controlled framework.

Just before - I mean, it was on the Cabinet agenda
16.21 and went onto the Cabinet agenda. It was pulled by the Minister of Health and the Ministry of Health.

And so, rather than even come back and say, well, we need some further discussion. They took an extremely hard adversarial line that resulted in the family's concerned having to go through the Human Rights Review Tribunal, the High Court. So, one of the Human Rights Review Tribunal, very, very detailed decision. The Crown appealed. They won at the High Court. The Crown appealed, they won at the Court of Appeal.

16.22 In this process, two things. After the High Court decision, we'd been approached by the media, well I'd been approached by the media to give the Commission's response as at the Minister of Health at the time, this was Tony Ryall, it was the National Government. The

Minister rang me to say that he really wanted to warn me that these parents were rip off artists, they were just trying to scam taxpayers and that I should be very, very wary of them because, you know, evidence was going to come out about how they'd been defrauding the system and so on.

I was able to tell them that actually I knew, personally knew them, I knew that was complete rubbish, I knew where it was coming from and that if he went public
16.23 with that, he would be the one who didn't look good. That these parents were salt of the earth and while they may have made the odd mistake, it had only ever been desperately trying to do the best for their disabled adult children.

The Minister chose not to go on television but to issue a statement saying that he respected the parents. But that was typical.

Now, these cases went well over 10 years it took to come to an end. But the other thing the State did, and
16.24 again you've heard this in respect to abuse in care cases, the State used all its powers to, I don't even know what the right word is, but to really review every aspect of these parents' lives. And they found in one case that one of the parents had used money that she was given for respite care I think to put a fence around their little property because the disabled adult desperately wanted to have a dog and they couldn't have one without a fence. So, she did use money for respite care for the fence.

16.25 When MSD and health discovered that, they charged her with fraud which was an outrageous thing to do. It was part of them really seeking to intimidate the people who had the gall to bring a case against the State. Without going into all the details, anyway she went

before the Wellington District Court. She chose a jury trial and the jury found her not guilty in about 30 minutes. The thing about that because I will come on to say some harsh things about the courts but the thing about that is, it's almost certain if that had been a Judge alone case, he would have found her guilty because theoretically, not theoretically, you know, strictly speaking, she was guilty, she did spend the money for something other than what it was given to her but the
16.26 jury could see beyond that to what was justice.

And we came to see this very hard ball attitude. In the other case -

Q. Just before you do, have you summarised at 46 the key elements in your view of the Crown's response?

A. Yes. Rejected the option of a negotiated settlement in favour of litigation. Used every resource available to date to zealously defend their complaints. Attack the character of the complainants rather than taking a principled approach to litigating solely on the issues.
16.26 And ultimately, this is probably almost the worst, when they finally lost at the five bench Court of Appeal, under budget secrecy and urgency they introduced legislation which overturned the Court's decision, largely overturned it, and removed human rights protections for people in that situation, so there could never be another similar claim.

So, you know, if this had been any other country where a government had acted like that, we would have regarded it as an outrageous breach of human rights.
16.27 This was New Zealand.

I mean, the current government has a commitment to amend the legislation, restore the human rights entitlements, but it hasn't happened yet, as far as I'm aware.

Q. Shall we move then to the White case which is something that Keith Wiffin talked about and Sonja Cooper and Amanda Hill?

So, we have some information about the White case but would you like to summarise your perspective?

A. Yeah. So, I won't go into the detail because you know what it was about.

I mean, it was actually when I read this, that I realised that the decision in this case, that I realised
16.28 the Human Rights Commission had a responsibility to get involved in this area because effectively, two young boys, who had certainly been severely, you know, assaulted etc., abused by their parents, and were taken into care but then were further abused at Epuni and Hokio Boys, the decision of the Court acknowledges that. It acknowledges the bullying, it acknowledges the assaults by staff, it acknowledges the derogatory language used by staff and it acknowledges that one of them at Hokio was sexually assaulted by the cook. So, there's no question
16.29 that that actually happened.

But what shocked me was the decision in this case. The High Court found that basically because damage had been done by the family as well as by the State institutions, that there was basically no way that you could work out which was which. And so, taking into account the statute of limitations, which the Crown invoked, and the ACC legislation, there was no compensation. But I think even worse, if you read the decision, I mean there's various points in it and again I
16.30 urge every member of the Royal Commission, it's like 100 pages or something but you should read it, because it illustrates the extent to which the Judge himself kind of treated them like criminals. And certainly if you read the transcript, the Crown's counsel treated them as if

they were the criminals, not the victims, and subjected them to the same sort of cross-examination, the same denigration, that they do of alleged criminal offenders.

At one point, for example, I mean if you read the decision it looks as if the Judge even is kind of blaming the boys for the fact that they were assaulted and bullied and things because of the way they behaved and their behaviour was difficult etc., etc.

In the transcript, at one stage the Crown counsel, 16.31 who to her shame was a woman, was suggesting that the boy who was molested did so because he liked to get cigarettes, so there was mutual benefit. He was 12 or 13. The Judge intervened at that stage and said, where are you going with this? You're not really suggesting consent, are you? And she said, oh no, no, it will soon emerge. But he didn't stop her. You know, I mean, this case, you know, a psychiatrist was called by the Crown to give evidence that because there wasn't a lot of publicity about sexual abuse in the 1970s, if you were a 16.32 child sexually abused in the 1970s it wasn't as damaging because there hadn't been media coverage, you know, it was the publicity that caused people to think they were damaged.

You know, and a number of other things but I think it showed conclusively that while the Court, and I'm not questioning, you know, the finer legal decisions of the Judge but in terms of justice for these men who had been severely damaged, there was none.

And I also, you know, the other thing that struck me 16.32 is I realised, of course, and again I think this is a fact you have to take into account in looking at why we allowed this abuse to continue for so long, is that those in positions of power were the Judges, Crown counsel, senior officials in government agencies, came and still

come from seriously privileged backgrounds for the most part. And the ability to even begin to intellectually kind of grasp what happened to these children and young people was clearly beyond them.

And all they saw was the outcome which, as we've been inclined to do, we then blamed on them. They got into drugs, you know, they committed crime, they ended up in prison, there was something fundamentally wrong with them, so you can't really, you know, be too concerned
16.34 about what happened to them previously because clearly there was something wrong with them that people treated them like that, and that is what has to change, you know, it really does.

But this was, you know, so in a sense both the Atkinson case - well, the Atkinson case, the Courts came to the party because actually, to be honest, the discrimination on the basis of family status, you know, it was so blatant that I don't think they could do anything else but they did and that was good.

16.34 But as far as the White case, it totally highlighted the attitude of the State to people who had the cheek to claim compensation for what had been done to them. And it was at that point that, you know, I recommended to the Human Rights Commission that we needed to monitor the State's response to see if it was meeting our international human rights standards.

Having done that and made that public, I have to say that what I was then faced with was senior officials coming up to me and telling me, off the record of course,
16.35 that I should be very careful not to get too close to Sonja Cooper from Cooper law because she was basically just out to make money out of Legal Aid, by encouraging these people to take claims, which, you know, and really raising their expectations when she shouldn't be doing

that.

And I know from the staff member who worked on this, who worked on the Commission's review and monitoring of the State's response, that he got several of those warnings as well, probably with more graphic detail than I got because I basically shut them down quite quickly.

So, this was a whole - it was a strategy. About 2 years ago, before the Royal Commission was established and while we were advocating for its establishment and I
16.36 was quoted on the media at some point, I was contacted by a former senior official who said, he was ringing me to apologise to say that everything I'd said about their behaviour was absolutely correct and he was part of the interdepartmental group that was responsible for developing the strategy.

So, you know, that was the Crown's response and, to be honest, you know, my fear is that apart from superficially, it hasn't necessarily changed and that the Royal Commission is going to have to be incredibly
16.37 careful and skillful in terms of what you take from the government agencies about this whole - because we can see how self-satisfied they were with what they provided.

And after this government announced the establishment of the Royal Commission, they produced a paper that showed that really it wasn't necessary because they'd fixed everything.

So, you know, I don't know if they've now changed their mind but -

Q. Just before we leave the White case, you didn't have this
16.37 information at the time but of course I believe an Inquiry last year found both the Crown Law and MSD in breach of the Code of Conduct for their use of private investigators in the case with the potential use of surveillance against the White claimants?

A. Mm.
Q. I take it, that would be consistent with your statement at 50, that the Crown strategy was to use any means within or outside the legal toolbox to defend the claims?
A. Yeah, and that's obviously - I mean, they did that with the Atkinsons as well. The way they surveilled those families trying to find dirt on them, it was the same strategy.
Q. We will, of course, come back to the White case, I am a
16.38 sure, as part of the redress examination.
A. And I think what it raises is the whole issue of what was the litigation strategy and who was responsible for it? And I think somebody, oh I think Judge Becroft, you know, raised at the very beginning of his submissions the whole issue of privilege and what's protected by privilege, and I'm conscious that Crown Law has insisted that the litigation strategy is protected by privilege. Well, I think if the Crown is going to be open and fully transparent with this Royal Commission, it needs to
16.39 provide the litigation strategy that it used in the 2000s but which seem to have continued without much modification until recently and you need to get that.

Because I think it also gives rise to the question of, to what extent did the Attorney-General, who for most of this was, it would have been Michael Cullen, to what extent was he briefed and to what extent did he specifically sign off on this sort of behaviour? Because, I mean, you know, mostly I think that the senior officials, the Crown Law officials in the Ministry of
16.40 Health and MSD, should be held to account. But I think the politician, if there's a question about how much and at what point particularly the Attorney-General, Minister of Social Welfare, knew and approved of the particular approach, given how drastic it was.

Q. The next section of your statement addresses the non-legal mechanisms for responding, including the Confidential Forum for Former Psychiatric Patients and the Confidential Listening and Assistance Service.

We have heard about those to some extent already. Is there anything you'd like to highlight?

A. So, I'll just highlight two things. One is, I think they were setup, in the first case the Psychiatric Forum was definitely set up to try to stave off claims compensation
16.41 following Lake Alice when so many accounts of abuse in psychiatric care came forward. And I think if you look at the Terms of Reference and the extent to which nothing would be made public, even if people were prepared to have it made - you know, obviously you want to provide really genuine confidentiality but actually, these Terms of Reference really were intended to suppress any general knowledge of widespread ill-treatment in the Psychiatric Services and then subsequently even tighter, more restrictive Terms of Reference applied to the
16.41 Confidential Listening and Assistance Service.

You know, people will tell you that not necessarily, you know, I don't necessarily think we need lawyers or the time for everything but I think it was shocking that provisions, the Terms of Reference for both these services prevented people who came before them from having a lawyer with them if that's what they chose. Lawyers were banned. And I mean, again, you have to ask why? You know, the positive, you know, the seller, the PR version would be because we wanted it to be all
16.42 pally-pally and not legalistic or whatever but actually in reality, it was again I think much more to try to prevent anything that might be useful in claims against the Crown emerging in that process. So, that's what I would say. I would say, look, I admire the job that was

done by both, and particularly by the Confidential Listening and Assistance Service who went to huge lengths to get people's records, to provide support, you know, to get them decent support etc. So, the people, Judge Henwood and the team that she worked with, I mean they did a remarkable job but that was in spite of not because of the process. And, again, the intention of the State was clearly to keep all of this out of the public eye, again which is why this Royal Commission is so important
16.43 because, you know, I've had care leavers say to me, survivors say to me, the thing is, nobody knows what went on, you know, people in my family don't know, or friends or people in my workplace and if I was to tell them, they would think I was lying or that couldn't possibly be true.

And so, you know, for lots of survivors just knowing that the wider community understands that a whole lot of abuse went on and, you know, people were damaged by it, you know, so they don't have to say this is exactly what
16.44 happened to me but just like I was there at that time, you know, and even today I've heard of a case where only because of this Royal Commission, you know, a family has discovered that their family, one of their family members was abused in an educational institution in that instance.

This is why it's so important.

Q. Would you like to move on to monitoring mechanisms, paragraph 64?

A. Yes. Again, Judge Becroft has spoken about the
16.45 monitoring mechanisms. They were used as an excuse to make 1992 the cutoff date for the Confidential Listening service, the forum and the Confidential Listening service. And yet, not one of those monitoring mechanisms is or has been appropriately resourced really at any

time.

So, there's been a history of establishing monitoring mechanism. And I have to say, I do want to acknowledge in its very early days the Human Rights Commission, this is the early 80s, was the only State agency or State institution to respond to the ACORD evidence, and did undertake their own review and published a report about it which I have to say the Judge in the White case thought wasn't worthwhile his even
16.46 looking at, he preferred to have a report from the government agency concerned.

Yeah. So, and I think Judge Becroft, I mean, I think the issue around why the existing monitoring mechanisms weren't more effective, and obviously for the most part they were really only established late 80s/90s but I'd have to say I'm not sure that they've been hugely effective or as effective as they should be. Since then, in fact, there's some evidence that they haven't.

But I think it's more than just saying so we need to
16.47 establish another one on a slightly different basis. I mean, I think the Royal Commission, and those of us who have been involved in monitoring mechanisms, need to give quite a lot of thought to what's worked and what hasn't. What do we need to do to really create critical mass? In a small country like New Zealand, a whole lot of separate, you know, siloed institutions, I think have a great deal of difficulty delivering. And while I was Chief Human Rights Commissioner, and again this is on the record and raised at the time with the Children's
16.47 Commissioner of the day, I did express concern about the extent to which MSD restricted and provided, put pressure on the Office of the Children's Commissioner. And I thought most appropriately, it should become parts of the Human Rights Commission, still have a completely, you

know, the Children's Commissioner, you know, properly staffed, it wasn't properly staffed at the time but, you know, at least staffed as it was at the time within the Commission and that would - because the liaison department, the Ministry for the Human Rights Commission was the Ministry of Justice, whereas the Children's Commissioner had the mandate to investigate Child, Youth and Family etc. but MSD was their liaison department. So, that relationship was really problematic. Secondly,
16.48 National Human Rights Institution, of which the New Zealand Human Rights Commission is an accredited human rights intuition, they have to meet international standards of independence and those are reviewed every 4 or 5 years internationally. And so, there is more scrutiny of the extent of the independence than there can be with the Office of the Children's Commissioner. So, I think there's lots of things to explore. I often say to people who say Parliament is the answer, actually Parliament is always controlled by the government of the
16.49 day. Occasionally, Parliament steps, shows that it can do more but mostly in New Zealand the outcomes from Parliament is what the government of the day was.

But I think Judge Becroft has raised a very important issue and, as I say, it is something that the Royal Commission does need to consider.

Q. Shall we move on to the draft report prepared towards the end of your time as Chief Commissioner? This is from about 68 of your statement.

A. Yes. I'm kind of conscious of the time. I provided the
16.50 full draft report as an appendix because it is the one actually contemporary account that had gone through various iterative drafts with all of the agencies involved.

So, the information there is factually correct at

that time. I do want to say and acknowledge the work of the Commission staff, that through the process, and we had good engagement with MSD, less so with Education and the Crown Health Financing Agencies. But just the process of monitoring and engaging and having discussions with them, led to some strengthening particularly of the MSD process.I will give one example of that.

Again, the Crown was able to use its resources to contract qualified researchers to undertake research on
16.51 what were the rules, regulations, covering various institutions, what was the situation in those institutions, you know, in the 60s, 70s, what was the practice of the day? And initially, that information was denied to the claimants on the grounds of, guess what, legal privilege.

So, the Crown, and when you remember that most of the claimants were poor, most of them were legally aided, none of them would have been able to afford equivalent research to be able to challenge the research, so it was
16.51 an obvious example of complete lack of justice and we were able to, you know, point this out. And eventually, MSD made that material available I think on its website to everybody. That was just one example of kind of making the process at least a bit better.

But as the review undertook concludes, all of the processes had some flaws. And I've talked about the flaws in terms of the Terms of Reference for the Confidential Listening Assistance Service and the forum, the Psychiatric Forum.

16.52 In terms of the MSD claims resolution, the Crown Health Financing Agency and education, there was no independence at all in the way in which those services operated. The staff involved in them were outraged that we should suggest that they weren't independent.

They were doing their best. But they were staff of the agency against which the claims were and, you know, they weren't going to be doing that job forever and they had to look to their future prospects.

So, even if we allow, and I do, that they were trying their best, the fact of the matter is that they couldn't possibly be seen as independent by, you know, people who had been abused by parts of that agency in the past. I mean, you know, and, I mean, although some
16.54 people had, you know, not a bad experience and they were quick to send us examples of thank you letters from people who had found it helpful and gratefully accepted the very modest amounts of compensation that were provided, it wasn't independent, it wasn't even impartial, and there were other issues associated with them but those are all in the report.

But what happened was, you know, and I feel extremely responsible for failing in this respect, what happened was when we sent the last draft around to say
16.54 I've incorporated everything you've told us, and we always sent copies to Crown Law but they never responded. In this instance, they came back saying, oh no, well, you can't publish that report, it's full of mistakes and errors and interpreting the international human rights obligations etc.

So, to cut a long story short, I organised a meeting. I offered to have a meeting with the Attorney-General. Instead a meeting was setup with at the time the Deputy Crown Solicitor and the person in
16.55 charge of the litigation strategy etc. for the Crown at Crown Law. Any rate, there were no factual errors. The two mistakes, according to Crown Law, was one that we said there was systemic issues that merited an independent Inquiry because none of these - none of the

processes actually looked at the systemic issues because they were looking at individual cases and trying to deal with those individual cases.

I was really surprised at this because I thought it was so obvious by now, there was enough evidence of the type of claims that were coming forward that clearly the whole raft of systemic issues needed to be looked at, not least, you know, management, monitoring by National Office of what went on in the regions etc., a whole lot
16.56 of things.

But when I said, I said, "What do you understand by systemic issue?" and I was told that, well, there's no, not a shred of evidence that national office, of any of the agencies, ever sent out any instructions about abusing children or mistreating them or inhumane punishment. No, they had done nothing. They had certainly not. There were no systemic issues. There were only issues that related to bad people in individual institutions at the local level. That was one thing.

16.57 The second thing related to the Convention on Torture requires an impartial process, and so they argued that. We said there was a need for an independent process and we were, as I say, misinterpreting the international requirements.

Anyhow, I think that - I mean, in order to get it published, we tweaked the wording with respect to independent and impartial, re-emphasised the fact that taken as a whole there was some good parts to all of these different, you know, so putting it in the positive,
16.58 but our recommendations were still that there needed to be both, you know, an independent Inquiry and end process for compensating people. But that was right at the end of my term as Chief Commissioner and so, we hadn't managed to have it published before I finished. In fact,

the draft you have is the one that was ready to go to the printer as I finished up. And I handed it over to my successor. I said, you know, if you prefer, it can be published in my name so you don't have to be responsible for it or it can go under your name but acknowledging that obviously it was done beforehand. And before he had a chance to do any of that, he received some very intimidating correspondence, I should say, I am trying to think of the right word for it, from the then
16.59 Attorney-General who was Chris Finlayson. And as a result of that correspondence, the report was put in the bottom drawer and never saw the light of day until Aaron Smale, the journalist who uncovered so much of this, was able to OIA it and put it back in the public arena.

So, again, I mean, I think that, you know, again, without necessarily wanting to single out a particular Attorney-General because I suspect that whoever had been there might have written the same, because of what I see as the overall trend of the government's responses, I
17.00 think again using any means to repress the government's inadequate failure to respond appropriately. And whether it's, you know, I mean, I think the public service is permeated with unduly risk averse, I think that's - you know, again, politicians have to take some responsibility for that, not just the agencies. But there's a number of issues.

So, yeah, but I think the report still has value, in terms of - and when you think, again from the evidence that Cooper Law have provided, Cooper Legal and some of
17.00 the survivors in terms of the length of time it's taken to get their cases dealt with, we're 2019 now and some of the cases, I mean, that were there in 2011 are only just being resolved now, so it's a shocking, really we should be shocked and ashamed that that's how long it has taken.

Actually, the Convention on Torture does require speedy response. So, I don't think even Chris Finlayson would claim it met that requirement.

Q. I don't want to limit you in any way but I am mindful of leaving enough time for the Commissioners to ask you questions, which I am sure they would like to do. Is there anything you would like to say on that topic before you summarise your conclusions in part 3?

A. No, I think that's enough. Of course, I am happy to answer any questions.

Q. Of course, we will come back to any of these topics at later hearings.

A. Exactly. So, well, again, I just want to reiterate my really extraordinary respect for survivors like Keith Wiffin and others whose persistence and advocacy and courage really led to two journalists, in particular Aaron Smale and Mike Wesley-Smith undertaking such highly professional job that the whole issue of claims of abuse in State care but also, you know, faith-based institutions, came back onto the national agenda. I mean, it really did.

And also because, as I've said to you, in terms of what, you know, how Sonja Cooper was smeared to me, I really think, you know, she deserves huge respect and admiration for persisting, and again you will have heard her, the evidence that she gave and the difficult times they went through, but persisting because without her and one or two other lawyers, again, we wouldn't be aware of what's been done in our name. And I think the efforts of the Human Rights Commission up until 2012 and then from 2016 also contributed. And I want to acknowledge particularly Commissioner Paul Gibson and Race Relations Commissioner Dame Susan Devoy who in very difficult circumstances again advocated that something needed to

happen and persisted in that advocacy.

I think I've probably said repeatedly the State has not hesitated to use its powers and greater resources to oppose and minimise the claims of those who have been abused and ill-treated and the Courts have not been able to right the massive imbalance between the State and survivors.

I've already said my concern about the extent to which government agencies opposed the establishment of
17.04 this Royal Commission.

But they succeeded, you see. I mean, they didn't succeed completely but they did succeed in getting the Terms of Reference formally limited to 1999. And I think the challenge for this Commission is not to perpetuate that imbalance.

And it's really my observation and experience over many years that if government agencies and the Ministers are not held to account for their failures since 1999 to meet New Zealand's human rights obligations, if they are
17.05 not held to account, then nothing will change. That's the thing. They will have succeeded. They are picking up little bits here and there, tweaking this and that. It's good to see some response but actually, a lot more than tweaking is required.

When we were doing the review of the family justice services, what became clear to me was that there's still within the government sector, there is no regular systematic incorporation of New Zealand's human rights standards into the development of legislation policy and
17.05 practice. Despite, you know, the Bill of rights Act, you know, reviews that go to Parliament and some very limited circumstances, there's virtually nothing else.

So, actually, and this was true for the Convention on the Rights of the Child. These are conventions that

were ratified many years ago but still are not regularly taken into account. Sometimes somebody will discover them, you know, when the policy or the practice or the draft Bill is already drafted by which time it's usually too late to do anything substantive but that has to be an absolutely fundamental requirement, that we mainstream the human rights stance. We often let the negotiations on, we were very actively involved in the development of the Universal Declaration of Human Rights, something we
17.06 can be proud of, and of course in New Zealand diplomat-led the negotiations on the Convention on the Rights of Persons With Disabilities. And yet, despite that, despite us accepting as a State international acclamation and awards for that role, we still haven't mainstreamed the requirements of the Convention on the Rights of Persons with Disabilities, even at a most superficial level. And that puts at risk every particularly severely disabled person who needs significant levels of care, for example.

17.07 So, that's the context in which you are working and which this Royal Commission has been established. But can I just conclude by saying that I think these two weeks of contextual hearings have really already begun to make a difference. So, thank you for the way you've organised these and I'm looking forward to more of the same in the next stage because they are complex issues.

But having this public profile and people beginning to hear what's going on, I know it is already beginning to have an impact, so thank you.

17.08 **MS MOUNT:** Thank you very much for your evidence, Ms Noonan. Please wait there because there may be some more questions. If I may check with Rachel Opie who assisted with the drafting of the brief.

Thank you, Mr Chair, I haven't been advised by any

of my colleagues as co-counsel, as counsel for participants, that there are any questions but I'm sure they will bounce up if there are. Otherwise, it is a matter for you as Chair whether there are any further questions.

CHAIR: Thank you, Mr Mount. I'll go through the motions, in any event. First of all, I will ask if any counsel, despite the Practice Note to which Mr Mount has referred, is there any counsel who
17.09 wishes to address questions to this witness, Rosslyn Noonan? There isn't, okay, thank you.

I then provide that opportunity for questions to be asked to my colleagues.

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ROSSLYN NOONAN

QUESTIONED BY COMMISSIONERS

COMMISSIONER ALOFIVAE: Ms Noonan, you have provided such a full and comprehensive brief. Can I thank you for that evidence. You've actually answered the questions that I had in your brief around the level of transformation that's actually required and actually where the power lies and dot dot dot. Thank you.

COMMISSIONER GIBSON: Thanks very much, Rosslyn, that was incredibly powerful and comprehensive. I will stick to questions which I wasn't involved in.

You talked about the need for fundamental change about how the human rights standards get integrated into legislation, policy and practice. Early in the Contextual Hearing Moana Jackson talked about the need for constitutional reform, constitutional transformation over a period of time, including Te Tiriti and international human rights standards. How do you see that linking, joining up?

A. I mean, I agree with Moana completely. I think we do need some very significant change. But I also think that the thing about New Zealand is we tend not to make dramatic changes. So, the challenge for the Royal Commission is what really substantial evolutionary changes which will then lead on to other things, you know, can be recommended and can be encouraged and developed?

I mean, I think, you know, yeah, I think that's the answer. But a lot of it, I do think there are

fundamental changes within the State sector. I think, you know, the whole development of, well really of, I won't say devolving power, I would say sharing power with iwi Maori, I think that's - I think we're seeing some very tentative steps towards that in one or two very limited places but that needs to be the continuing approach.

And I think that within the State sector as a whole, there needs to be a review of - really of, I suppose it's
17.12 of the principles that guide the State sector and that guide, you know, I mean it seems like the public element of the public service is vanished. And that public servants, and I mean, you know, they're doing what they need to do to survive but they see their only responsibility because don't get me wrong, of course they are responsible to Ministers and they are responsible for implementing government policy, but they're seeing that as their only responsibility and not the responsibility for the wider public.

17.13 And I don't think, I mean, apart from the Secretary of Treasury, I can't think of a single senior public servant these days that you will hear a major think piece about where things should be heading. And yet, if you look back to some of our periods of really great change in New Zealand, whether in education, somebody like Dr Bebe, or if you look at, you know, the Secretary of Justice like John Robson, you can go through and identify public servants who shared thinking to help generate discussion. Whereas, now you basically have people who
17.14 are scared to recommend anything that might give rise to controversy.

That's not just their fault. That's also because of the way politicians are operating and Ministers are operating. But I think it's really dangerous for us,

particularly in an environment that's so complex, where, you know, as a society we face so many challenges. And there aren't simple answers, that's the thing. There isn't like a magic wand that you can wave and say that will fix it all, there isn't.

So, we need to have an environment where robust discussion is welcomed but we also need to have an environment - what shocked me personally has been, as I said earlier, the lack of empathy that I have witnessed
17.15 in public, senior public servants, for the victims of abuse in State care or, you know, in other circumstances. And there's something wrong where people feel that they've got to defend the State right or wrong, there's something fundamentally missing in that, that that happens.

That's why I think, I mean, if they were required to actively take account of the international human rights standards, that we have willingly signed up to, I mean that would put a different slant on things. I think it
17.15 would engender a different behaviour, a different frame of mind, and it's certainly needed absolutely, otherwise they will continue just to - the people who get into trouble are the people who deserve it, that's basically, you know, that's basically the approach now.

COMMISSIONER GIBSON: You talk about principles guiding public servants, the public service. In your statement, you refer to a human rights approach, particularly around I think it was records and the voice of the affected having a say in decisions
17.16 that affect them. Sometimes, is there a role sometimes for understanding the human rights approach, some of the principles that sit behind that, what is the role in communicating something to the public that will help transform how we care

in Aotearoa New Zealand?

A. Actually, that's a really good question. You're absolutely right.I think for too long human rights were equated with legal constitutional or legal guarantees of human rights. And human rights were seen as something that were mostly defended in Courts or could be taken to the Courts to litigate. Whereas, actually, having human rights make a difference in people's lives day-to-day. They're about how we treat each other, they're about what
17.17 opportunities we have to grow and flourish. They're about whether we've got the basics for a decent life, which includes things like healthy affordable housing and is there enough to eat? And those are - it's much more - the human rights, the impact of human rights I think is much more felt.I mean, the law is important, good to have the law, but actually it's really about what are the policies and what are the practices? A human rights approach, as you say, is really a practical way of thinking about that. You know, what are all the rights
17.18 of everybody we're looking at in a particular scenario? What are all the rights involved? How do we balance those? And the human rights approach says if you need to balance them, then they should be balanced in favour of the most vulnerable? And then how do the people who are directly affected participate in the decisions that affect them? You know, are they empowered? Is there accountability, which obviously there's been missing. And is there non-discrimination? So, these are not, it's not rocket science. And actually, again, people in the
17.18 past, you know, when we've explained this to them, with Commission's submissions and things, have said how helpful having that sort of scheme to think through things has been but it's not widespread. And, of course, one of the problems is that for the most part we don't

incorporate the whole Human Rights Covenant Convention in our legislation. Usually, there's references to it or there's bits of it that are put in but we don't put the whole Covenant or Convention say as an addendum.

In the case of the Convention on the Rights of the Child, it is included as a whole but it doesn't have a status as its own right in our law. Lots of Judges, of course, never learnt anything about human rights law, even the Bill of Rights Act, when they were in their 17.20 legal training. So, it's a new thing for them as well. There's only a few that consistently you see in their decisions are looking at what are the human rights issues here or what are the Treaty issues. So, we need more of that at every level. But I think there are some things that can be done, you know, to strengthen the law by more fully incorporating the standards as we ratify them, so they can be called on.

COMMISSIONER GIBSON: Thanks very much.

COMMISSIONER ERUETI: We are short of time, so I'll get 17.20 straight to my main question which is about redress because it was a priority for your report in 2011. And you will be aware that in 2018 there was a review carried out by MSD of the MSD historical claims process which included looking at the role of tikanga and its process, tikanga Maori.

I am wondering what you think of the - well, perhaps the best way to answer this is, whether you think that review had an impact? And also, what are the core qualities that you think are necessary for an effective 17.21 redress scheme?

A. Well, I probably - the question about what impact it's had is probably better directed at the lawyers who have been representing because I don't feel I've got enough knowledge of enough cases to make a general comment.

In the - I will quickly find it. In the report, we listed what we thought were the elements of a - yeah, so we said building on the strengths of the Confidential Listening and Assistance Service and the MSD care claims and resolution team and the lessons learnt by the direct negotiations taken by MSD and Crown Health Financing Authority, the priority must be to establish an independent and impartial in the fuller sense of the word process. To hear, investigate -

17.22 So, the process must apply to all claimants regardless of whether their claims relates to psychiatric hospitals, Social Welfare homes or institutions, foster care arrangements or education facilities. That's number one. Instead of having these disparate claims, there needs to be one process that applies.

It must be one, you know, that gives the Crown reasonable assurance that allegations have substance. So, you know, we never said people shouldn't have to provide some evidence but what has happened until now, is

17.23 that, I mean even though you've heard about Epuni, Hokio, Kohitere, Owairaka Boys etc., and we know now that even if you were not directly assaulted in one of those environments, where bullying etc. was widespread, you will have been affected as a child, seriously affected. So, you know, we're not saying that people should have to find records that show that they were actually hit but if they were in the institution at the time, where there is now overwhelming evidence of ill-treatment generally, you know, that should be sufficient.

17.24 It needs to operate fairly and demonstrate good faith. Provide claimants with access to impartial advisory service. And so, that's drawing on the sort of thing that CLAS did.

And does not leave claimants disadvantaged if

there's no settlement.

Meet the various needs of claimants, including those looking for redress other than financial compensation.

And those who cannot readily take part in traditional dispute resolution processes.

Leaves open the possibility of civil litigation where there's no settlement.

Allows individuals to be prosecuted.

Is not so rigorous or time consuming as to render 17.25 the process unattractive.

And uses public resources efficiently.

And we talked about drawing on international experience because one of the arguments most often used has been the fiscal risk to government. But, in fact, the Irish and Queensland responses show that you can mitigate that risk by saying this is the big bag of money, this is the bag of money, and then that has to be what's available to all of the claimants.

So, those were the kind of elements and we don't see 17.25 those available as yet as a group.

COMMISSIONER ERUETI: That's right, as yet. The emphasis on independence and also the report talked about the idea of streamlining the process. Instead of going to all these different MOH, MOE , MSD, it's a one stop shop?

A. Yes.

COMMISSIONER ERUETI: I understand, thank you.

A. I think there were a few other bits and pieces. All findings must be published at least in general terms etc. 17.26 We did go into quite some detail about what a really good process would look like. Looking at it now, it's still possible and it's not - it shouldn't be that difficult.

COMMISSIONER SHAW: Thank you very much for your evidence, Ms Noonan. I want to thank you for your

tenacity on this issue. Your efforts go back a long way and I hope you find that at least coming here today is some sense of achievement, at least an interim achievement that we've got this far, but I think you are very much, largely responsible for the drive, so I want to acknowledge that and thank you for your evidence.

A. Thank you.

CHAIR: Thank you. I have the privilege of the final comment. I just wish to state for the record that your own particular broad knowledge of relevant items for the Royal Commission stand alongside your courage in expressing the views that you have and what you have said and what you have provided will be of considerable interest and importance for the work of the Royal Commission, so thank you.

A. Thank you.

MR MOUNT: Mr Chair, thank you very much, thank you very much again, Ms Noonan. Tomorrow we have a 10.00 a.m. start. We have three witnesses scheduled, Mr Mike Ledingham, Professor Des Cahill and Dr Peter Wilkinson who will be the final three witnesses for this phase of the hearings.

CHAIR: Thank you, Mr Mount. We can, therefore, conclude today's proceedings by asking you, Madam Registrar, to bring Ngati Whatua into the important matter of concluding our sitting today.

(Closing waiata and karakia)

Hearing adjourned at 5.35 p.m.