COVERSHEET

Minister	Hon Erica Stanford	**Portfolio**	Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions
Title of briefing	Meeting Pack – 30 July 2024 Ministerial Group – Crown Response to the Abuse in Care Inquiry	**Date to be published**	8 October 2025

Withholding grounds

Information within this document has been withheld as if it had been requested under the Official Information Act 1982. Where this is the case, the reasons for withholding have been listed below. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

- Information in this meeting pack has been removed where information is subject to a confidentiality order under section 15(1)(a) of the inquiries Act 1982 and is therefore not official information by virtue of section 32 of the Inquiries Act 2013. Making this information available would be contrary to the provisions of the Inquiries Act 2013.
- section 9(2)(h) to maintain legal professional privilege

Meeting pack – 30 July 2024

Ministerial Group – Crown Response to the Abuse in Care Inquiry

Membership:

- Hon Erica Stanford as Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions (Chair) and as Minister of Education;
- Hon Dr Shane Reti as Minister of Health and Minister for Pacific Peoples (apology);
- Hon Paul Goldsmith as Minister of Justice (apology);
- Hon Louise Upston as Minister for Social Development and Employment and Minister for Disability Issues;
- Hon Judith Collins KC as Attorney-General (apology);
- Hon Mark Mitchell as Minister of Corrections and Minister of Police (apology);
- Hon Tama Potaka as Minister for Māori Development and Māori Crown Relations: Te Arawhiti;
- Hon Matt Doocey as Minister for ACC, Minister for Mental Health, and Minister for Youth (apology);
- Hon Karen Chhour as Minister for Children and Minister for the Prevention of Family and Sexual Violence; and
- Hon Casey Costello as Associate Minister of Health and Associate Minister of Police.

Meeting pack:

- Aide-memoire: agenda and items for discussion;
- Update paper: The Final Report of the Royal Commission of Inquiry into Abuse in Care: Whanaketia Through pain and trauma, from darkness to light, including an appended summary of the report.
- Background paper: Redesign of redress for survivors of abuse in care – Stepped process for agreeing key redress parameters to support a detailed design process
- Discussion paper: High-level structuring of redress functions;
- Discussion paper: Redress for Lake Alice Unit survivors who experienced torture and a separate matter relating to inequities in previous settlements; and
- Discussion paper: Treaty of Waitangi considerations in the public apology.

Aide-memoire

Agenda and items for discussion

For: Ministerial Group – Crown Response to the Abuse in Care Inquiry

Date: 29 July 2024 **Security level:**

Purpose

1. This pack provides the Ministerial group for the Crown Response to the Abuse in Care Inquiry (the Ministerial Group) with an agenda and papers to support its discussion on 30 July 2024.

Agenda

	Item	Timing
1.	The Final Report (*"Whanaketia: Through pain and trauma, from darkness to light"*) of the Royal Commission of Inquiry into Abuse in Care - Tabling of report in Parliament – observations and thoughts. - To discuss any new issues or matters that have arisen following the tabling of the report. - Any issues with the final report that may require further explanation and to describe the approach the Crown Response is taking to support Ministerial decision making.	10 minutes
2.	Consideration of potential redress for torture at the Lake Alice Child and Adolescent Unit - Informing Ministers of a new urgent Cabinet paper: Payments to terminally ill Lake Alice survivors. - Seeking feedback and endorsement of an approach to redress for Lake Alice, including the timing of those decisions. - Seeking a direction on a separate matter regarding legal fees deducted from one group of previous settlements with the Crown – which helps address matters relating to the Lake Alice Unit to be considered at the same time.	20 minutes
3.	Redress redesign – high-level structuring of redress functions - Informing Ministers of a new urgent APH paper to formally re-establish the Redress Design Group as Redress Advisory Group. - Seeking Ministerial endorsement of four primary functions for redress recommended by the Royal Commission.	20 minutes

	- Seeking feedback on high-level redress structuring of the independence and level of integration to be sought in the design of redress.	
4.	Treaty of Waitangi considerations in the public apology - Seeking agreement on the approach to responding to claims of Treaty breaches in the Royal Commission's Final Report findings and recommendations. - As part of this, seeking views on whether to direct officials to undertake at pace the analysis that would be required to allow Cabinet to decide whether to make a concession of Treaty breach as part of the public apology.	10 minutes
5.	Other business - Te Puna Aonui (Family/Sexual Violence agency) preliminary work on the Royal Commission recommendations and potential links to their work programme – Minister Chhour - Survivors care records (redactions of) - Apologies by agency chief executives	10 minutes
6.	Ministers and advisors only (closed item)	10 minutes

Item 1: The Final Report of the Royal Commission of Inquiry into Abuse in Care

2. This item updates you on the receipt of *Whanaketia: Through pain and trauma, from darkness to light*, the final report of the Royal Commission of Inquiry into Historic Abuse in State Care and in the Care of Faith-based Institutions (the Royal Commission) and conveys a summary document prepared by the Crown Response Unit to help you to navigate the final report in your own reading of it (attached to the update paper *The Final Report of the Royal Commission of Inquiry into Abuse in Care: Whanaketia Through pain and trauma, from darkness to light - Receipt and response*).

3. It also: Not subject to OIA identifies issues that may require further explanation; responds to expressions of interest by Ministers to engage with survivors of abuse in care; and describes the approach the Crown Response is taking to support Ministerial decision making.

4. As discussed at previous Ministerial Group meetings, the Crown Response Unit is working with all the Crown Response agencies to develop a phased work programme to respond to the final report for discussion at your next Joint Ministers meeting on 21 August, with a view to seeking initial Cabinet decisions in September.

Item 2: Consideration of potential redress for torture at the Lake Alice Child and Adolescent Unit

5. Following the tabling of the final report and the Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions meeting with a small number of Lake Alice survivors and survivor advocates an urgent Cabinet paper is now being progressed to support a $20,000 payment to terminally ill Lake Alice survivors (people with a terminal diagnosis with a prognosis of six months or less).
6. It is also intended that provision be made for those people to also nominate up to two people to receive the remainder of this $20,000 payment after they have died. It is proposed that this would be funded by and delivered through the current Ministry of Health existing claims/payments process.
7. Ministerial consultation is set to begin this week.
8. Following the Crown accepting that some children and young people were tortured at the Lake Alice Child and Adolescent Unit in the 1970s, the attached discussion paper (*Redress for Lake Alice Unit survivors who experienced torture and a separate matter relating to inequities in previous settlements*) provides advice on potential torture redress and recommendations to support Ministerial Group discussion and direction on the:
    a. possible components and level of redress for torture;
    b. timing for decisions relating to the provision of redress and associated costs and funding options; and
    c. process for designing and delivering of redress for torture.
9. The discussion paper also provides advice on a separate matter regarding legal fees deducted from some settlements made with Lake Alice Unit survivors, which relates to a recommendation in the Royal Commission's final report on parity for all Lake Alice settlements. A direction on the legal fees matter is sought to potentially enable all specific matters related to the Lake Alice Unit to be considered at the same time.

Item 3: Redress redesign – high-level structuring of redress functions

10. An urgent APH paper is being progressed to formally reestablish the Redress Design group. It is anticipated that membership will be unchanged, other than the possible addition of a disabled survivor to the group.
11. The Ministerial Group is working through a set of staged questions on redress for survivors of abuse in care, to support the development of a set of draft redress options for taking to Cabinet in September. A background paper is included to help provide an overview of the staged process.

12. The attached discussion paper (*High-level structuring of redress functions*) supports an initial discussion on the functions for redress and how the functions are structured in terms of independence and integration.

13. The discussion paper seeks the Ministerial Group's endorsement of the redress functions recommended by the Royal Commission and feedback on the current direction of work regarding the independence and integration of those functions to inform the subsequent options developed for Cabinet consideration.

Item 4: Treaty of Waitangi considerations in the public apology

14. At the Ministerial Group meeting of 29 May 2024, Ministers raised a series of questions about potential implications that could arise from making concessions of breach of the Treaty of Waitangi as part of the public apology to be delivered by the Prime Minister on 6 November 2024, including the authority of the Royal Commission to make Treaty of Waitangi related findings, its approach to making these findings and any liability associated with a potential Treaty breach concession.

15. Crown Law has provided advice in response to these questions, as well as advice on liability implications that could arise from the matters that are more generally acknowledged and apologised for within the public apology.

16. The attached paper *(Treaty of Waitangi considerations in the public apology)* provides details of the Royal Commission's findings in relation to Treaty breaches, a summary of the Crown Law advice, as well as a brief commentary on survivor expectations in relation to the potential inclusion of a Treaty breach concession in the public apology.

17. The paper seeks a decision on whether to progress work to assess the Royal Commission's findings relating to the Treaty at pace in order to enable the potential inclusion of a Treaty breach concession in the public apology.

Listening, learning, changing
Mā Whakarongo me Ako ka huri te tai
Crown Response to the Abuse in Care Inquiry

Agenda Item Two

The Final Report of the Royal Commission of Inquiry into Abuse in Care: *Whanaketia Through pain and trauma, from darkness to light* - Receipt and response

For: Ministerial Group – Crown Response to the Abuse in Care Inquiry

Date: 17 July 2024 **Security level:**

Purpose

1. This paper updates you on the receipt of *Whanaketia: Through pain and trauma, from darkness to light*, the final report of the Royal Commission of Inquiry into Historic Abuse in State Care and in the Care of Faith-based Institutions (the Royal Commission) and conveys a summary document prepared by the Crown Response Unit to help you to navigate the final report in your own reading of it.

2. This paper also: Not subject to OIA identifies issues that may require further explanation; responds to expressions of interest by Ministers to engage with survivors of abuse in care; and describes the approach the Crown Response is taking to support Ministerial decision making.

3. It is recommended that you:

    a. **note** that the final report of the Royal Commission of Inquiry into Abuse in Care *Whanaketia: Through pain and trauma, from darkness to light* was received by the Governor-General on 25 June 2024, with new privacy-related matters arising and printing delays meaning that Ministers received hard copies on 10 July, and it is being tabled in Parliament on 24 July at 4pm;

    b. **note** that survivors will attend the tabling, both in the Gallery and at an engagement event being held by the Survivor Experiences Service in the Banquet Hall;

    c. **note** that because the final report comprises 16 documents totalling over 2,900 pages the Crown Response Unit has drafted a summary document to help Ministers navigate the full report (attached);

    d. **note** that the Crown Response Unit has been working to identify opportunities for Ministers to engage with survivors, including at events to be held in conjunction with the public release of the report on 24 July, and will continue to identify further engagement opportunities through to the public apology in November 2024;

e. **note,** as discussed at the previous Ministerial Group meeting, the Crown Response Unit is working with all the Crown Response agencies to develop a phased work programme to respond to the findings and recommendations, for discussion at your next Joint Ministers meeting on 21 August, with a view to seeking initial Cabinet decisions in September.

The Royal Commission's final report was received on 25 June 2024 and is being tabled on 24 July

4. The Royal Commission's final report was received by the Governor-General on 25 June and an electronic version of it was provided to the offices of the Minister of Internal Affairs, Hon Brooke van Velden, and the Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith Based institutions, Hon Erica Stanford, the same day.

5. It was distributed to agencies who are either involved in the Crown Response or are central agencies over the next week,[1] and early hard copy versions were distributed to Minister Stanford and the Prime Minister on 5 July and to the Ministers who are members of this group on 10 July. A small number of privacy-related matters arose in relation to the version of the report provided to the Minister of Internal Affairs and further legal checks are still being completed by the Royal Commission, with the final version of the report expected shortly.

6. The report will be tabled in Parliament House on Wednesday 24 July at 4pm. This will be followed by speeches from Minister Stanford and the Prime Minister, and opportunities for representatives from other parties to speak. Survivors will be present at Parliament, and the Survivor Experiences Service is planning to welcome and host survivors in the Banquet Hall before, during, and after the speeches. Wellbeing services will be available for survivors who attend this event.

Overview of the final report and attached summary document

7. The final report is titled *Whanaketia: Through pain and trauma, from darkness to light*, and it comprises 16 documents: a preliminary report, five case study reports, a book of survivor experiences, and nine volumes of the final report itself. The documents are as follows:

- **00 Preliminaries:** Executive summary, summary of findings and consolidated recommendations. (164 pages)
- **01 Purpose and Process:** How the Royal Commission was set up and the methodologies they used to gather and analyse information. (180 pages)
- **02 Background and Context:** The social, historical, and environmental factors that led to the expansion of the care system in the twentieth century. (230 pages)
- **03 Circumstances:** Describes the various pathways for entry into different care settings, including social welfare care, faith-based care, Deaf and disability settings and psychiatric care. (190 pages)
- **04 Nature and Extent:** The second largest of the documents describes the range of different types of abuse and neglect and the range of different settings in which it occurred in detail. (352 pages)

[1] These are: The Ministries of Health, Education, Social Development, and Justice, Oranga Tamariki (the Ministry for Vulnerable Children), Whaikaha (Ministry of Disabled People), Crown Law, the New Zealand Police, the Treasury, the Public Service Commission and the Ministry for Regulation.

- **05 Impacts:** Describes the individual and collective impacts of abuse in care on survivors lives and on their families and communities. (164 pages)
- **06 Te Tiriti o Waitangi and Human Rights:** A relatively short volume identifying breaches of te tiriti o Waitangi and human rights violations. (64 pages)
- **07 Factors:** A large volume outlining the factors that the Royal Commission believes led to abuse in care up to 1999. (336 pages)
- **08 Puretumu Torowhānui, Holistic Redress:** Reviews the progress to date to implement the Royal Commission's December 2021 redress recommendations. (86 pages)
- **09 The Future:** The largest of all the documents, this discusses survivor experiences post 1999, describes how a future care system could be structured, and introduces all the report's recommendations. (360 pages)
- **10 Case study: *Out of Sight, Out of Mind***, a case study of the Kimberley Centre in Levin, an institution for people with learning disabilities run by the Department of Health and closed in the early 2000s. (100 pages)
- **11 Case study: *Our Hands Were Tied***, a case study of the Van Asch and Kelston schools for the deaf. (90 pages)
- **12 Case study: Cauldron of Violence**, a case study of Hokio Beach School and Kohitere Boys Training Centre, two national residences run by the Department of Social Welfare in Levin until the late 1980s. (102 pages)
- **13 Case study: *Boot Camp***, Te Whakapakari Department of Social Welfare funded youth programme on Great Barrier Island. (110 pages)
- **14 Case study: *Jehovah's Witnesses*** (53 pages)
- **15 Survivor Experiences Book**: Describes the individual experiences of 82 survivors in a range of different care settings (348 pages)

8. These documents together total over 2900 pages and require significant time to read and absorb. The Crown Response Unit has written a summary document which provides an overview of all of the nine substantive parts of the report and is designed to be used to help guide your reading of it (attached).

Not subject to OIA

9. Not subject to OIA

10.

11. Not subject to OIA

12. 

Aspects of the report that may require further explanation: scope of the care system and estimates of numbers

13. The following section provides background on two key aspects of the report to support your understanding.

The scope of the "care system" includes a wide range of child and adult settings

14. The Terms of Reference of the Royal Commission includes a wide range of settings including all social welfare settings, all schools, early childhood centres, adoptions, law enforcement or transitional settings, and all disability and psychiatric care – including community settings.

15. The "care system" is also described in the report as including both "direct" and "indirect" care settings. Indirect care is described in the Royal Commission's Terms of Reference as being when the State has "passed on its authority or care functions to another individual entity or service provider, whether by delegation, contract, licence or any other way".

The estimates of numbers of people in care, and people who were abused in care, are complex and based on very poor data

16. Indicative estimates of the size of cohorts and levels of abuse in State and faith-based care from 1950 – 2019 were developed for the Royal Commission by Martin Jenkins. They used two approaches to estimate the numbers: a 'top-down' approach (which estimated that between 114,000 and 256,000 people may have been abused in care) and a 'bottom-up' approach (which estimated that between 36,000 and 65,000 may have been abused in care). Martin-Jenkins noted that the "large separation between the high and low ends of our estimates reflect the breadth of results from the prevalence studies … and the uncertainty in these estimates."[2]

17. The 'top-down' estimate is based on an estimate of the numbers of people in care and an estimate of the prevalence of abuse in care settings, drawn from international and local research[3]. This led to an estimate that between 17 and 39 percent of all people in care were abused – this means the estimate cannot change over time, despite changes in the nature of the care arrangements over time. Further advice can be provided on how these figures were reached, on request.

18. The 'bottom-up' estimate is based on the numbers of people who have made claims of abuse in state and faith-based care (6,500 people) and uses unreported crime multipliers developed from New Zealand and United Kingdom crime and victims surveys. Martin Jenkins placed less

[2] Martin Jenkins (1 October 2020) "*Indicative estimates of the size of cohorts and levels of abuse in State and Faith-based care 1950 to 2019*" Royal Commission of inquiry into historical abuse in State Care and in the Care of faith-based institutions.
[3] Fifteen research studies were used: Four from New Zealand, four from the Netherlands, three from the United States, three from the United Kingdom and one from Germany.

reliance on the bottom-up estimate but note that it provides an alternative view of the potential levels of abuse.

19. The size of the population is key to decision making relating to the redress system. We will schedule an item to discuss this matter further with Ministers as part of the discussion on redress funding, drawing on the insights we have received from an actuarial firm on what are the key factors that determine the size of the population that could potentially seek redress and the extent to which uncertainty around those figures can be reduced or otherwise.

Opportunities for ongoing engagement with survivors

20. Ministers have expressed an interest in engaging with survivors of abuse in care both on 24 July and on other occasions through to the public apology, which is currently scheduled for 6 November (exact date likely to be publicly announced by the Prime Minister on 22 July).

21. The Crown Response Unit has been working to identify opportunities for potential Ministerial engagement. At this stage we anticipate that Minister Stanford will be meeting with various groups including the Survivor Experiences Board, former members of the Redress Design Group, and potentially other survivors who are attending the tabling of the report in Parliament. We are also investigating an opportunity for Ministerial attendance at an art event to be held by Te Roopū Toiora, a national collective of survivor artists, on 2 - 4 August in Wellington. We understand the Governor General is planning to host a survivor event in mid-August.

22. We will continue to identify further opportunities and will work through Minister Stanford's office to support further Ministerial engagement with survivors.

An approach to responding to the recommendations will be available for your next meeting on 21 August in preparation for Cabinet decisions in mid-September

23. The Crown Response Unit is coordinating a Final Report Officials Group to identify which recommendations can be implemented immediately or with a small amount of additional work or funding or which could be incorporated into, or progressed alongside, existing work programmes. This group is currently working on developing a phased work programme to respond to the recommendations in the final report.

24. We expect that Government will come under pressure to have made a substantive response to both the report overall, and to some of the recommendations, before the public apology is delivered on 6 November 2024.

25. An update on this work will be provided to you for discussion at the Ministerial Group meeting on 21 August, with a view to Cabinet decisions to be made in mid-September 2024 (for example, consideration at the Cabinet Social Outcomes Committee on 18 September would involve a Ministerial consultation period of 27 August to 5 September, which could follow from the 21 August Ministerial Group meeting).

26. This timing also enables the outcome of the first Cabinet decisions in September to be made available to survivors (and the public) via a proactive release in October. This could be accompanied by a press release outlining the Crown's approach to the final report recommendations, and it would demonstrate momentum on the Crown's response to the report recommendations before the public apology, planned for later in 2024.

Abuse in Care Royal Commission of Inquiry

Summary of final report *Whanaketia*

July 2024 Final

Purpose and introduction

This document summarises the final report of the Royal Commission of Inquiry into Abuse in Care of the State and Faith-based Institutions (the Inquiry). The final report is titled *Whanaketia – Through Pain and Trauma, From Darkness to Light.*

The final report includes 138 recommendations for the State and faith-based institutions for redress and changing the care system. It follows the Inquiry's 95 recommendations for a new independent redress system for survivors of abuse in care, made in its 2021 interim report on redress, *From Redress to Puretumu Torowhānui*.

This short summary aims to help readers navigate the fuller final report. It does not analyse, provide advice or comment on the final report content. Wherever possible, it replicates the final report language.

The final report comprises 16 volumes. This document summarises the following sections of the final report as follows:

Individual survivor experiences are woven through the substantive content in each part. An additional document also details the experiences of 82 individual survivors, and there are five **case studies** of different settings where abuse in care occurred, as follows:

- *Out of Sight, Out of Mind*, on the Kimberley Centre in Levin, an institution for people with learning disabilities run by the Department of Health, which closed in 2006.
- *Our Hands Were Tied*, on the Van Asch and Kelston schools for the deaf.
- *Cauldron of Violence*, on the Hokio Beach School and Kohitere Boys Training Centre, two national residences run by the Department of Social Welfare in Levin until the late 1980s.
- *Boot Camp,* on the Te Whakapakari Department of Social Welfare funded youth programme on Great Barrier Island.

- *Jehovah's Witnesses*.

These are additional to the two case studies already published by the Inquiry:

- *Beautiful Children:* Inquiry into the Lake Alice Child and Adolescent Unit (December 2022)
- *Stolen Lives, Marked souls:* The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (July 2023).

Reading this summary report

This Summary report does not cover the Survivor Experience and case study documents. Content relating to abuse in faith-based care is mostly excluded, except where it is relevant to State care policies and settings.

There are frequent references in the final report to breaches of survivors' human rights and of their rights under the Treaty of Waitangi during the Inquiry period, along with recommendations that these rights are embedded as part of systemic and process changes made following this report. These references are not regularly repeated in this Summary.

For clarity, the word "report" refers to the entire 16-volume final report. Individual volumes are termed "parts". Selected direct quotes from the report authors are *italicised;* quote marks are used when the report quotes other speakers or witnesses.

Some abbreviations are used. For example, the full Royal Commission title is shortened to "the Inquiry". The Inquiry's 50-year period of focus from 1950-99 is termed "the Inquiry period." Longer references to gender and sexually diverse groups (such as Takatāpui, Rainbow and MVPFAFF+) are abbreviated to "sexually and/or gender diverse."

The report includes some quotes from chief executives of Government agencies on specific issues they discussed at the Inquiry's hearings. We have included some of these below, although they do not constitute full acknowledgements or comments made by agencies on these issues

Martin Jenkins report

The Inquiry asked consultants Martin Jenkins to provide indicative estimates of the numbers of children in care, and levels of abuse, in State and faith-based settings during the Inquiry period. This was because the Inquiry's terms of reference required it to determine the extent of abuse in care.

However, Martin Jenkins was hamstrung by poor quality or missing data, due to inadequate record-keeping during the Inquiry period. There was an inherent challenge in establishing rates of abuse in care with any confidence, along with limited research and evidence specific to New Zealand.

The Martin Jenkins report, "Indicative estimates of the size of cohorts and levels of abuse in State and Faith-Based Care 1950-2019", is prefaced with discussion on the limitations on producing reliable estimates due to the data gaps. It estimated that 655,000 children, young people and adults had been in State and faith-based care between 1950 and 2019.

It provided two estimates of how many of those may have been abused, using different methodologies – one estimate was between 114,000 and 256,000, the other between 36,000 and 65,000 (fuller explanation is set out in the Martin Jenkins report, which can be provided on request).

The Inquiry uses the upper end of these estimates – its final report repeatedly cites a figure of 200,000 abused in care and says that number may be higher. Media reporting of the Martin Jenkins report has also focused on the higher-end estimates, usually without qualification. For these reasons, we recommend that the cohort estimates cited below from the Martin Jenkins report be treated with caution.

Preliminaries document

This document (164 pages) includes three substantive sections – an **Executive Summary** of the full report, a **Summary of Key Findings**, and a full list of the report's 138 **Recommendations**.

Condensed versions of the Executive Summary and Recommendations sections follow below. The Key Findings are covered in relevant sections further down (parts 3, 4, 5 and 7).

Executive summary

- The leaders of State and faith-based institutions failed in their duty to care for the children, young people and adults entrusted to them.
- Abuse and neglect were widespread in these institutions throughout the Inquiry period.
- Critical rights were ignored, including rights guaranteed to Māori and human rights.
- If this *injustice is not addressed, it will remain as a stain on our national character forever*.

Abuse and neglect was pervasive

- Abuse and neglect almost always started from the first day a person was placed in care and continued throughout.
- Children, young people and adults in care were regularly treated without compassion. Some were wilfully neglected, denied basic necessities and had no privacy.
- Māori and Pacific in care often experienced harsher, racist treatment because of their ethnicity. They were denied access to their cultural practices and languages, sometimes violently.
- Deaf and disabled survivors experienced targeted abuse and were often stripped of their dignity and autonomy. Many were segregated from society and deprived of individual attention and basic education. Disabled adults were treated as unable to make their own choices. Deaf survivors were denied sign language, and blind survivors were denied braille.
- Emotional abuse included abusive and uncaring language, shaming and humiliation. Physical abuse happened in all settings. Sometimes, staff used weapons and electric shocks.
- Staff often pitched children against each other through vicious attacks and humiliating rituals.
- Sexual abuse was common. Abusers groomed victims into trusting them. Abusers deceived other staff and leaders, which meant survivors who disclosed abuse were not believed. Sexual abuse was used to punish and intimidate. Sometimes, abusers trafficked survivors to be abused by members of the public.
- Medical abuse and neglect included improper medical treatment and practices, treatments such as electric shocks without consent, and chemical restraints, like sedation, to control behaviour.
- Women and girls were routinely tested in institutions for sexually transmitted infections and some were forced to have degrading vaginal examinations. Clinicians sometimes used medical checks as opportunities for sexual abuse.
- Solitary confinement was commonly used to control behaviour and as punishment. Seclusion rooms were often cold, dark and unhygienic, and survivors could be held in them for months.
- Some survivors were financially abused, including being forced to do long hours of physical labour. Some worked in sheltered workshops for minimal or no pay, or had their money taken by staff.

How did this happen?

- Some people had a higher likelihood of being taken into care, including those who were Deaf, disabled or mentally unwell, raised in poverty, or who suffered adverse events as children. These same factors made them more vulnerable to abuse and neglect.
- Abusers took advantage of their positions of power. They were rarely held to account. They came from all walks of life, and frequently were well-regarded and trusted in the community.
- The State was ultimately responsible for the care system. Instead of supporting families to care for their own, the State placed people in punitive institutions and isolated them from their families and communities.
- Social attitudes devalued and dehumanised people in care and made it easy for them to be forgotten by other New Zealanders.
- Successive government ministers and agency heads had legal responsibilities to people in care that they failed to uphold. *They failed not only in their duty to keep people in their care safe from harm, but they also failed to hold abusers to account.*
- Many residences and institutions used punitive practices and segregated people in care from wider society. Often staff were recruited from military backgrounds – they used command and control methods including punishment, physical violence and verbal abuse. Some staff who witnessed abuse became desensitised and went on to become abusers. Others were too afraid to speak out.
- Care standards were inconsistent across care settings and were routinely breached. Staff were often inadequately vetted, trained or supervised.
- Only some care settings had complaints processes. Very often, complainants were not believed, or the complaint not followed up. Senior leaders prioritised protecting their personal or institutional reputations.
- There was limited oversight and monitoring of care.
- By the end of the Inquiry period, some problems had been identified and lessons learned, particularly by the State. Changes were made to legislation, policies and guidelines. Some institutions were closed, and more people went into community care. *But most of the factors that led to or contributed to abuse and neglect during the Inquiry period continue to persist.*

Survivors paid the ultimate price

- Abuse in care has had lifelong impacts on survivors. Many died in care or committed suicide following care. For others, the impacts are ongoing and compounding.
- Children were deprived of their right to positive, loving human attachments. This impacted on their ability to form stable, secure relationships and to fulfil their potential.
- Many survivors face reduced employment opportunities through being denied education.
- Some survivors became numb to violence. Others became abusers themselves, leading to prison. Others need psychiatric care due to anti-social behaviour, substance abuse and mental distress.
- Many survivors have poor physical health and enduring disability due to abuse and neglect in care such as over-medicalisation or neglect of health needs.
- Survivors often experience ongoing emotional impacts from abuse in care, including being triggered by sounds, tastes or smells. They may have feelings of shame, self-harm, attempt suicide, or abuse substances.
- Sexual abuse survivors experience immediate and lasting trauma, and may be unable to form healthy intimate relationships.

- Separation from siblings causes worry and guilt for survivors and may cause permanent estrangement.
- Some survivors told the Inquiry that they did not know how to parent or form close relationships, including with their own children. Their children talked about the damage their abused parents did to their own childhoods.

Collective impacts

- For Māori, the trauma of abuse has led to much larger social problems, along with loss of culture and of generations of future leaders. It removed the ability of whānau, hapū and iwi to nurture the next generation. Institutionalisation removed their individual and collective identities, so it was culturally and spiritually abusive for many.
- Many Pacific survivors lost their connections to culture and language.
- Segregation from family and community caused acute pain for many Deaf and disabled survivors. They were denied personhood and culture, and lost generations of future leaders. Deaf were forced to communicate through speech and were physically abused for using sign language.
- Sexually and/or gender-diverse survivors suffered abuse, harm and hate, leading to mental and physical distress and suicidality.

Cost of abuse and neglect is too high

- There are very high economic costs of abuse and neglect in care to survivors, their families, communities and wider society.
- The Martin Jenkins report "Economic Costs of Abuse in Care" estimates the total cost of abuse in care between 1950 and 2019 at between $96 - $217 billion. Of this, up to $46.7 billion falls to taxpayers, with around $172 billion borne by survivors. *Ignoring survivors for decades compounded the harm.*
- Repeated survivor calls for justices were unheard, disbelieved, ignored or silenced. Any recognition they did receive was piecemeal, insincere and inadequate. *Even this paltry redress took years or decades to extract from the State and faith-based entities. Political and public service leaders spent time, energy and taxpayer resources to hide, cover up and then legally fight survivors to protect the potential perceived costs to the Crown, and their own reputations.*

Survivors' dreams for the future

- Survivors want a total care system overhaul and fundamental change to ensure this national catastrophe does not continue.
- *This would see the State handing over power, funding and control of preventative supports and care services to local communities and communities of interest.*
- Survivors want whānau supported to provide loving care themselves. From time to time, out-of-whānau care will be required, but this must be short-term and delivered by the community in plain sight, with multiple safeguards for children.
- Local schools must be welcoming and inclusive of the diverse needs of all students, with support for disability or mental health needs.
- Communities, hapu and iwi must be empowered to design and control how care systems operate for their communities, including preventative work, support services and out-of-whānau care.

- *Survivors acknowledge that devolving power, funding and control from the State into local hands will take time…[they want] the State to radically change its attitudes and practices related to decision-making and investment, which are characterised by low trust and a focus on risk aversion and crisis response rather than empowering whānau and communities to look after their own.*

State and faith leaders must right the wrongs of the past

- Survivors are united in calling for public apologies and taking accountability for harm caused.
- An apology is hollow without change. With urgency, the Inquiry's 2021 redress recommendations must be implemented. *There must be no further delay.*

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

- Complaints must be listened to, investigated and acted on in a timely manner. Care system leaders must prioritise safeguarding and be held accountable for any failures.
- The care workforce must be valued and invested in, with thorough screening, accreditation and training, and good working conditions and pay.

Recommendations

The report's 138 recommendations for change are noted or grouped and summarised below. The focus is on recommendations for the State and therefore recommendations specific to faith-based care are excluded.

General

- Review street names or public amenities named after proven abuse perpetrators or institutions where abuse took place.
- Review all Lake Alice settlements to ensure parity, given legal expense deductions from some settlements.
- Appoint an independent advisory group to investigate potential unmarked graves at former hospitals, institutions and relevant sites.
- Take all practicable steps to ensure the safety of children, young people and adults in care at Gloriavale.

Apologies

- The Prime Minister should make a national apology for historical abuse and neglect, developed and agreed with a representative group of survivors, including specific apologies to individual survivor groups.
- Leaders of faith groups, the public sector and relevant professional bodies should also make public apologies.

New redress scheme (Puretumu Torowhānui)

- Implement the Inquiry's 95 recommendations on redress issues in 2021 as an immediate priority.
- Government to take all practical steps to ensure that faith-based and indirect care providers join the new redress scheme.
- Backdate the effective start date for the new redress scheme to 1 December 2021.

- Open the new scheme to all survivors, including those who may have previously agreed to full and final settlements.
- Provide meaningful compensation, including through civil litigation or ACC reforms.
- Performance indicators and annual progress reports should accompany the new redress scheme.
- Establish an independently operated joint government/faith based fund to promote community healing from the impact of abuse in care, as have been established in Canada and Australia.
- Create a whānau harm payment of $10,000 for family members who have been cared for by survivors.

Justice sector

- Police should establish a specialist unit to open or re-open investigations into historic or current allegations of torture or cruel treatment in care where credible new information exists, with reasonable assistance from care providers.
- Implement specific recommendations around prosecution decisions relating to abuse in care, including steps to eliminate investigator bias, appropriate engagement with complainants, review of decisions not to prosecute, Crown Law review of finely-balanced decisions.
- Implement specific prosecution guidelines and prosecutor training for Deaf, disabled and mentally unwell people.
- Legislative changes, including:
    - Including disability within the definition of "vulnerable adult" in the Crimes Act 1961;
    - Including abuse or neglect in care as aggravating features in sentencing abusers;
    - Ensuring that offending by young people abused in care in response to that abuse is not given undue weight when sentencing young offenders;
    - Ensuring that abuse victims can seek civil redress and have access to legal aid.
- Education and training for justice sector workers, including on the Inquiry findings and on trauma-informed investigation and prosecution processes.
- The courts should prioritise civil proceedings related to abuse in care. Barriers to participation in civil proceedings should be removed, and participants should be entitled to communications assistance and alternative evidence provision methods.

Care safety

- Develop a statutory *National Care Safety Strategy* and adopt 12 *Care Safety Principles*, including: allowing people in care to take part in decisions affecting them, allowing whānau and support networks to be involved when appropriate, ensuring staff and care workers are suitable, and ensuring appropriate complaints response processes.
- Establish an independent *Care Safety Agency* charged with: system leadership on preventing and responding to abuse in care; managing the National Care Safety Strategy and Care Safety principles, setting rules (with penalties for non-compliance), monitoring compliance and investigating complaints, enforcing penalties, public awareness, research, collecting data on abuse in care and advising government.
- Enable the new *Care System Office* (see "Report Response" below) to perform the Care Safety Agency functions in the interim, until it can be established.
- Enact a new *Care Safety Act* to establish a national care safety regulatory framework, including: giving effect to the Principles, Strategy and new Agency, a new professional

registration system for staff and care workers, mandatory reporting of abuse, and screening and vetting of care workers.
- Reviewing all existing legislation and regulations for consistency around care safety.
- Accreditation of all providers, including charities, safeguarding to be prioritised and resourced, whistleblowers to be protected.
- All staff and volunteers to be vetted, registered and well trained.
- The Care Safety Agency to develop a strategy for the care sector to have a diverse workforce with the right skills, experiences and values.
- Legislated responses to complaints, including mandatory reporting and centralised recording to enable re-investigation of complaints when necessary, and to prevent perpetrators from moving to new locations.
- Faith-based entities that provide care must be subject to the new care safety regime.

Institutions and related practices

- Prioritise closure of care and protection residences.
- Ban pain compliance techniques.
- Govern and minimise the use of restrictive practices.
- Minimise, then eliminate the use of solitary confinement.
- Review building and design features that may place people in care at risk.

Support for people in care

- All people in care should have access to an independent advocate of their choice.
- The Care Safety Agency should support the development of independent advocates with lived experience.
- Decision makers and care providers should ensure that everyone placed in care has supported connections to community and family.

Record keeping

- Full and accurate care records should be kept for at least 75 years, including all incidents and responses.
- Records to be disposed of in accordance with law or policy.
- Individuals have rights to access and amend records about themselves.
- Consider improving current information sharing arrangements across organisations to be better able to respond to abuse.

Independent oversight and monitoring

- Review existing oversight arrangements to remove duplication, encourage collaboration and remove any barriers to investigating complaints.
- Consolidate existing monitoring bodies.

Community empowerment and public awareness

- Prioritise work on contemporary care approaches based on devolution of care to families and communities, avoiding State-led models.
- People in care enabled to more effectively take part in decisions affecting them.
- Government to implement new social and educational campaigns to address attitudes and beliefs that lead to harmful care experiences.

- Commissioners Erueti and Gibson (but not the Chair, Commissioner Shaw) consider the Government should establish *an independent entity to commission care and protection, youth justice, community mental health, disability and preventative services*. It would monitor and evaluate care delivery and related services, and invest in capacity-building of local community groups and organisations. The new entity would take over commissioning relevant services and supports from Oranga Tamariki, the Ministry of Health, Whaikaha and Te Puni Kokiri.

Te Tiriti o Waitangi and human rights

- The Government should partner with Māori to give effect to Te Tiriti o Waitangi and the UN Declaration on the Rights of Indigenous Peoples in relation to developing strategy, policy and implementation of care functions.

Abuse and neglect prevention

- Government to invest in programmes that help young people in care to learn about abuse to help protect themselves, including recognising grooming behaviour, understanding what constitutes abuse and neglect, understanding their rights and how they can report concerns.
- Government programmes for people who may perpetrate abuse and neglect.

Report response

- Establish a new *Care System Office* to lead implementation of the Inquiry's recommendations. It would be housed in a central agency but operate independently of government agencies that are or have been involved in the care system.
- The Government should publish its response on whether it accepts the Inquiry report within two months of tabling in the House, with reasons for any disagreements. Formal responses on each recommendation should be published with four months of tabling.
- The Government should issue annual progress updates on implementation of the Inquiry report for at least nine years, at which time an independent review should establish the extent of implementation and any further steps that may be needed.

Part 1 – Purpose and process

This Part (180 pages) covers:

- Why the Inquiry was established
- The Inquiry's terms of reference, and changes to the initial version
- People who took part in the Inquiry
- How the Inquiry carried out its work
- Frameworks underpinning the Inquiry.

This Inquiry is the largest and most complex Royal Commission of Inquiry ever established in Aotearoa New Zealand. It was established following efforts over many decades by survivors of abuse in care to gain recognition of their experiences.

Although there was growing awareness of abuse in care from the 1960s and 70s, few State or faith-based institutions had clear processes for dealing with complaints. From the early 2000s, following a well-publicised settlement for victims of abuse at the Lake Alice Child and Adolescent Unit, large numbers of claims began to be lodged with the Ministry of Social Development and other agencies. There were also claims through the courts, although the State strongly defended these.

Survivors shared their abuse experiences through forums, in particular the State-funded Confidential Listening and Advice Service (CLAS) from 2008-15. In the run-up to the 2017 Election, there were growing calls for a public apology and an Inquiry. The incoming Labour Government agreed to an Inquiry, announcing this intention on 1 February 2018.

The Inquiry was formally established in November 2018. The initial Chair was Sir Anand Satyanand, supported by Commissioners Ali'muamua Sandra Alofivae, Dr Andrew Erueti, Paul Gibson, and former Judge Coral Shaw. Sir Anand resigned in August 2019 and was replaced as Chair by Coral Shaw. Julia Steenson was appointed as a Commissioner in June 2020, resigning in October 2022. Sandra Alofivae resigned in August 2023.

The Inquiry scope was broader than other similar inquiries in Australia, Canada, England and Wales, Northern Ireland, Scotland and Ireland. For example, the inquiries in those other countries were limited to specific groups such as children, indigenous people or disabled people or specific types of abuse.

The Government updated the Inquiry's terms of reference several times to record resignations or appointments of Commissioners, three extensions to the reporting date (final date 26 June 2024), and changes to the Inquiry scope.

There were two major scope changes. The first extended the original State care focus to include faith-based care, following nationwide consultation led by Sir Anand in 2018. In July 2021, the Government removed the Inquiry's mandate to examine current (post-1999) frameworks to prevent and respond to abuse in care, though confirmed it could still hear from survivors about their experiences post-1999 and make recommendations on redress and future changes to address factors that allowed abuse to occur. The 2021 changes were made to avoid further delays to delivery of the Inquiry's final report.

Altogether, 2797 people shared their experiences and insights with the Inquiry. Of these, 2329 were survivors – the rest were family members, current and former staff, advocates, experts or leaders.

Survivors who spoke with the Inquiry – breakdown by numbers (***note: numbers do not add to 2329 because many individuals identify with more than one of the groups below)***	
Male	1,378
Female	932
Age – 50 and over	1,445
Age – under 50	853
Pākeha	1,483
Māori	1,018
Pacific Peoples	113
Mentally distressed	1,921
Disabled	624
Deaf	130
Sexually and/or gender diverse	162
In State care only	1,346
In both State and faith-based care	375
In faith-based care only	466
Had been to prison	683
Gang members or family	333

The report says that some survivor groups were disproportionately represented in care, citing a Crown statement at the Inquiry's State Institutional Response hearing acknowledging "disproportionate representation of Māori, Pacific peoples, disabled people and Deaf people in care".

The Inquiry gathered evidence and information in a wide variety of ways. More than 270 witnesses gave evidence at its 16 themed public hearings held over 133 days between June 2019 and October 2022. These included: State and faith-based institutions and redress; Māori; Pacific; Deaf disabled and mental health; foster care; State and faith-based institutional responses; and case studies of Marylands school and the Lake Alice Child and Adolescent Unit. The public hearings were live streamed, getting more than 145,000 views.

Most of the public hearings were at the Inquiry's facility in Auckland. Commissioners also travelled to smaller centres around the country, holding special hui with groups including communities, iwi, Pacific peoples, and gang members.

Commissioners conducted 1630 face-to-face interviews with survivors in private sessions, and the Inquiry received 1,545 sworn witness statements. The Inquiry's engagement was assisted by a Survivor Advisory Group of experts.

Part 2 – Context

This Part (230 pages) covers:

- Traditional social attitudes to care
- Social attitudes relevant to the Inquiry period
- The start of colonisation
- State intervention in family life
- Moral panic and the growth of the welfare state
- 1970-99 economic upheaval and social change
- State and faith-based care settings during the Inquiry period.

In the 1800s, faith-based care was often the only care option outside the family unit. From 1867, children charged in the courts were sent to industrial schools, run after 1880 by the newly-established Department of Education.

Soon after the Treaty of Waitangi was signed, the State pursued laws and policies aimed at assimilating Māori. This, along with land confiscation, resulted in mass alienation of Māori from their land, making it difficult to retain their traditional ways of living and depriving many Māori of their economic base. By the 1920s, most Māori were living in rural poverty.

Social attitudes expected people to fit in and conform with a narrow definition of what was normal. Social attitudes like racism, ableism and disablism, rigid gender roles and homophobia persisted across the Inquiry period. Power and control was held by politicians, judges, police, doctors and clergy. Eugenics ideas, although discredited by Nazi-era policies, influenced laws, policies and attitudes towards Deaf, disabled and mentally unwell people.

The 50 years before the Inquiry period saw large-scale Māori urbanisation and arrivals of Pacific peoples. By the 1950s, there was emerging evidence for "attachment theory", which holds that children need secure, loving care from parents or caregivers as a fundamental factor in their development. The final report says that although officials *would have been aware of the theory*, there was a sharp rise in the numbers of children removed from their families and placed into institutions or foster care during the 1950s-80s. There was little awareness of child abuse and neglect.

Official reports reinforced the trend towards institutionalisation and assimilation. The 1951 Aitken report promoted large-scale facilities as the best care model for disabled people. The 1960 Hunn report found that Māori were marginalised and lagged behind Pakeha in all socio-economic indicators, yet the solution was seen to be more assimilation and integration.

Concerns about juvenile delinquency in the 1950s and the resulting "moral panic" lay behind the 1954 Mazengarb report. Mailed to every household in New Zealand, the report castigated juvenile immorality and advocated morals-based law changes that were quickly enacted.

From the 1960s and 70s, the care and protection system began to be challenged by Māori, Pacific, gay rights and disability rights advocacy groups.

Māori were more likely than non-Māori children, young persons and adults to be taken into care during the Inquiry period. Concerns increased about poor conditions, ill-treatment and racism in overcrowded Social Welfare institutions.

Economic reforms that began in 1984 increased unemployment, widened the rich-poor gap and disproportionately impacted on Māori and Pacific children and young people.

The landmark 1986 Social Welfare report *Puao-te-Ata-tu* found that State institutions had contributed to the breakdown of traditional Māori society. There was institutional racism and over-representation of young Māori in criminal justice, social welfare and psychiatric settings.

The report led to an increased focus on biculturalism in the public sector. It recommended devolving State care funding to tribal authorities to nurture children within family groups as the primary alternative to going into care.

These ideas informed the 1989 Children Young Persons and their Families Act (CYPF), which was considered ahead of its time. But experts told the Inquiry that the transformative change envisioned by the new law never eventuated, due to lack of resourcing and a shift in political focus.

The new Government elected in 1990 emphasised mainstreaming service delivery to Māori. Services were organised around support for the not-for-profit sector and Māori entities tendering for Crown contracts.

From the 1970s to the 1990s, large-scale institutions began to close. From 1974, the State stopped building new psychiatric and psychopaedic hospitals, and gradually closed existing ones – the last, Kimberley, closed in 2006. Mental health services were largely devolved to outpatient services and community providers. But many of the same issues in large institutions, such as regimentation, and isolation, persisted in smaller-scale care such as group homes. The 1996 Mason Report into shortcomings in the mental health system led to increased funding for community mental health support services.

Knowledge continued to grow about the impact of child abuse and trauma. State agencies began to adopt policy responses to child sexual abuse. In education, the trend towards mainstreaming learning-disabled children led to falling special school rolls through the 1980s.

The Child Welfare Act 1925 governed State care, covering both child welfare and youth justice settings. The subsequent Children and Young Persons Act 1974 distinguished children (aged 14 and under) from young persons (aged 15-16), in order to divert children from the court system. The CYPF Act 1989 gave families more authority over decisions about their children and was intended to be bolstered by Family Group Conferences. This Act also shifted youth justice responsibilities to the new Youth and Family Courts.

Initially, child welfare was the responsibility of the Child Welfare branch of the Department of Education. In 1972, this shifted to the newly-formed Department of Social Welfare (DSW). By the mid-1980s, the former child welfare officers had become known as social workers.

Foster care was the most common State care setting during the Inquiry period. Social welfare residences were district-based and segregated by gender. Over the 1980s, the number of national residences fell from 26 to four (Weymouth, Epuni, Kingslea and Eliot Street).

Until 1955, most adoptions were arranged privately. The Adoption Act 1955 promoted closed adoptions and a complete break between birth and adoptive families. Birth mothers could consent to adoption within 10 days of birth, one of the shortest periods of any county. Traditional Māori whāngai adoptions, whereby children were cared for by wider whānau, were not recognised under the Act.

The Child Welfare branch was active in identifying babies for adoption and cooperating with unmarried mothers' homes. Adoption rates peaked at 3976 in 1971, or 6% of all live births. The Adult Adoption Information Act 1985 allowed adopted people to obtain their original birth certificates and apply for information about their birth parents.

Youth justice settings from the 1950s-90s included borstals, detention centres and youth prisons. Some Social Welfare residences had a corrective training element. From 1924 to 1975, young people convicted of an offence punishable by imprisonment could be sent to borstals for corrective training. There were also four detention centres that closed by the late 1980s.

In the 1990s, children and young persons could be sent to contracted third party providers such as Moerangi Treks and Whakapakari. These "boot camp"-style institutions featured regimented and often harsh corrective training programmes and poor living conditions.

The Mental Defectives Act 1911 set out conditions for admissions to mental institutions. The Mental Health Act 1989 continued this approach, whereby anyone defined as "mentally disordered" could be required to undergo treatment through a compulsory order. Placement to psychiatric hospitals was often compulsory through the Inquiry period, until the 1992 Mental Health (Compulsory Assessment and Treatment) Act introduced recognition of peoples' rights, including cultural factors.

State special schools were established for children and young people who were Deaf, blind, had additional learning needs or "behavioural management challenges." There were five residential special schools during the Inquiry period, as well as several schools for Deaf or blind students. The Education Act 1989 formalised the move away from special schools towards assisting them moving into mainstream education.

This part also includes a section on how faith-based care worked during the Inquiry period at settings run by major denominations and others including Gloriavale. It said that State and faith-based care worked together - the State subsidised church-run children's homes, and it placed State wards (children formally in State care) into church homes, due to overcrowding in State institutions. Church activities received substantial State funding until the 1980s.

Part 3 – Circumstances

This Part (190 pages) covers:

- **Key findings – circumstances that led to people being placed into care**
- Circumstances – Social welfare settings
- Circumstances – Faith-based settings
- Circumstances – Deaf and disabled people
- Circumstances – Psychiatric and mental health care
- Circumstances – Other care settings.

Key findings - summary

- People were more likely to be placed into State and faith-based care if they experienced poverty, family crisis or violence, parental abuse and neglect, or were Deaf, disabled or mentally distressed (particularly if there was lack of support for the household from others).
- Decision makers believed, usually genuinely but often without foundation, that out-of-whānau care would lead to better life outcomes.
- Parents were often convinced that care placements outside the home or mainstream education would be better for their children.
- Decision-makers included social workers, police, judges, health professionals and needs assessors who generally had little involvement or connection with affected communities.
- The State used formal powers and compulsory and institutional care options in a discriminatory way, more often against Māori.
- Many survivors experienced multiple placements, often due to perceived delinquency or lack of support.
- People in care did not always understand why they were being moved, or to where.
- The State often failed to assess, or inadequately assessed, people's trauma and support needs in care.

Māori

- The effects of colonisation, urbanisation, breakdown of social structures and racism meant Māori were more likely to be placed in State care.
- Tamariki and rangatahi Māori made up the majority in social welfare care and were over-represented in other care settings. They were more likely to be sent to harsher institutions such as borstals.
- The State almost always failed to recognise a Māori or Pacific world views when removing or placing Māori and Pacific, and did not typically consider placements with whānau, hapū and iwi.
- Between the 1950s and 1980s, Māori and Pacific peoples experienced heightened surveillance and targeting by Police and other State agencies.

Deaf, disabled and mentally distressed

- Decision-making was often influenced by ableist or disablist attitudes, which led to segregation and social exclusion of Deaf, disabled and mentally distressed people.
- Institutional care was over-used for deaf, disabled and mentally distressed people.
- Formal State care was the only option provided for many, often for their entire lives.

- They were often denied involvement in decisions about their own lives.

Unmarried mothers and adoptions

- Between the 1950s and 1970s, many unmarried pregnant girls and women were placed in faith-based homes which often facilitated adoptions. These placements and adoptions were usually the result of family, religious and societal attitudes including racism.
- Adoption practices were discriminatory and ignored Māori practices. From 1950 to the mid-1980s, adoption practices legally separated tamariki and rangatahi Māori from their whakapapa and identity.

Social Welfare care

From 1950 to 1999, an estimated 178,443 people were placed in Social Welfare care, including 67,566 in youth justice. By decade, numbers peaked at 51,478 in the 1980s, dropping to 28,410 in the 1990s before rising again.

Children entered care through the court system. A minority were placed at their own or their family's request. Many survivors spoke of abuse or neglect at home before they entered care, with some questioning why their families were not supported to care for them at home. They spoke of "acting out" or truanting due to their home experiences, drawing the attention of teachers, social workers and police.

There are data gaps across all survivor groups during the Inquiry period, but especially for Pacific, who were often grouped with Māori or did not have their ethnicity recorded. Available records show that Pacific people were over-represented in care.

Some people were placed into care for extremely low-level offending. Sometimes, the State had valid reasons for intervening, especially when abuse or neglect was present in homes, but often authorities only became involved due to the child's problematic behaviour, while deeper causes were not addressed.

People were often reluctant to foster tamariki and rangatahi Māori, leading to more of them being placed in institutions or short-term home stays. Child Welfare paid "kin placements" at a lower rate than other foster carers, resulting in fewer Māori foster homes.

In 1979 an "Intensive Foster Scheme" was tried for "difficult" children, though more than a quarter of foster carers would only take Pakeha children. Some Māori survivors said the State would not allow them to live with whānau who were willing to take them in. The 1983 Maatua Whangai scheme sought to find more Māori foster parents, but inadequate investment and overly bureaucratic process meant the scheme did not continue beyond 1992.

Running away from residences, often to find siblings, was common. Foster home breakdowns often occurred because foster parents were inadequately supported by the State. The State sometimes transferred children and young people from social welfare care to psychiatric settings, often as punishment for unwanted behaviour like running away.

Oranga Tamariki Chief Executive Chappie Te Kani told the Inquiry's State Institutional Response hearing that the care and protection system did not put enough emphasis on alternatives to State care placement.

Inquiries in the 1970s revealed poor living conditions and treatment at social welfare institutions. By 1989, only a third of available beds at institutions were occupied, and several had already been closed. But Māori continued to be the majority of those placed.

Deaf and disabled

From the 1950s to the 1970s, the State pursued large-scale institutional care for Deaf and disabled people. Between 1952 and 1972, the number of psychopaedic care beds rose from 549 to 2017.

Disabled people were often identified at a young age. Medical professionals commonly put pressure on parents, saying it was in the best interests of their children to be placed in a residential facility that offered specialist care.

Placing Deaf and disabled people into institutions led to a lifelong denial of personhood and being unable to realise their life potential.

The Education Act 1964 continued provisions for segregated schooling at special schools for Deaf and disabled children. Referrals were made by the Education Department's Psychiatric Service or the Child Welfare Division. The Education Act 1989 recognised the rights of Deaf and disabled children to attend mainstream schools.

From the early 1970s, there was a shift from large institutions to community-based care, encouraged by the 1973 Royal Commission into Psychiatric Hospitals. But there was little infrastructure to provide disabled people with the supports they needed. There was a lack of culturally appropriate Māori and Pacific disability services, nor was there support for them to be cared for in their communities.

Mental health

People could be referred by their family doctor or the courts for psychiatric assessment, leading to voluntary or involuntary admission.

The Inquiry acknowledges that not all pathways into psychiatric and mental health care and support settings, and the care provided within those settings, was abusive. However, the experiences the Inquiry heard…often reflected inappropriate and discriminatory reasons for admission, which was followed, in many cases, by abusive treatment.

Admissions to psychiatric hospitals increased rapidly during the 1940s and 50s, peaking in the 1960s and gradually declining in the 1970s. The admission rate in 1953 was 478 per 100,000 population, declining to 257/100,000 by 1981. By the mid-1980s, Māori made up 14% of admissions despite comprising only 7% of the general population. There is limited data on Pacific peoples, although 1999 data indicates that they were over-represented. By the late 1990s, almost all large-scale mental health institutions were closed.

Survivors often said they were unclear about the reasons for their entry to mental health care – lack of transparency around this was a common theme. Neuro-diverse children could be labelled naughty or delinquent, increasing their likelihood of hospital admission.

At the Inquiry's State Institutional Response hearing, Director-General of Health Dr Diana Sarfarti acknowledged that people were placed in psychiatric hospitals for reasons that would not be acceptable today.

Other care settings

Pregnant single women faced significant pressure to adopt their babies. The Adoption Act 1955 continues today to allow the Family Court to dispense with consent if a disabled parent or guardian is considered unfit. Churches and the Salvation Army ran homes for unmarried mothers. Babies not placed with adoptive parents could be made State wards and be placed into care.

Before 1989, young people were placed on remand in adult prisons – this happened disproportionately to Māori. Survivors spoke of being abused and targeted by Police.

Health camps were a short-term option for children and young people considered to be in need of rest, exercise or nutritious meals. During the 1950s and 60s, they were sent to health camps for behavioural and emotional issues following referrals from doctors or schools. From the 1970s, some State-run residences ran their own outdoor camps.

Sheltered workshops provided employment for disabled people. Some survivors described them positively, although *they were a continuation of a segregated and exploitive environment, and therefore abusive in nature.*

Part 4 – Nature and Extent

This Part (352 pages) covers:

- **Key findings – nature and extent of abuse and neglect in care**
- Types of abuse and neglect in care
- Abuse and neglect in particular care settings
- Extent of abuse and neglect in care

Key findings - summary

- Forms of abuse and neglect included: entry into care, psychological and emotional, physical, sexual, racial and cultural, spiritual and religious, medical, solitary confinement, financial and forced labour, and educational.
- Physical, sexual and emotional abuse (in that order) were the most common forms.
- Neglect occurred across all settings and varied according to the setting.
- Racism and ableist and disablist practices were common across all settings.
- In some settings, some people experienced the over-use of seclusion, over-medicalisation, lobotomies, sterilisation, invasive genital examinations and experimental psychiatric treatments without informed consent.
- Abuse and neglect were pervasive in Social Welfare and Deaf, disabled and mental health residences and institutions. The State often used punishment and control rather than care.
- Some survivors endured multiple forms of extensive and extreme abuse, with severe physical pain and/or mental suffering.
- The highest levels of physical abuse were at residential and institutional care in Social Welfare, education and health and disability care settings. The highest levels of physical abuse in those settings were at Wesleydale and Owairaka Boys' homes in Auckland.
- Māori and Pacific endured higher levels of physical abuse. Deaf and disabled survivors suffered higher levels of all forms of abuse than non-disabled survivors.
- Sexual abuse was more prevalent in faith-based settings than in State care. The highest reported levels of sexual abuse were at Dilworth School, Marylands School and at Catholic institutions in general.
- The highest rates of abuse were in the 1970s, followed by the 1960s, then the 1980s.
- Males experienced higher levels of abuse, including sexual abuse, than females. Females were more likely to experience emotional and sexual abuse than other forms.

Institutions – case studies

- At the Lake Alice Child and Adolescent Unit, there were electric shocks and injections of paraldehyde as punishment, misuse of solitary confinement, and patients were exposed to unreasonable medical risks.
- At the Marylands Catholic School and Hebron Trust, there was pervasive sexual abuse and extensive and extreme abuse and neglect, with evidence suggesting that abuse was used as punishment and to intimidate.
- At Te Whakapakari Youth Programme on Great Barrier Island, there was extreme abuse and neglect, severe physical violence, isolation on an island for days at a time, and death threats through mock executions.

- At the Kimberley Centre (for disabled people) near Levin, there was severe and chronic abuse and neglect, severe physical and sexual abuse, extreme neglect, poor nutritional practices and absence of purposeful activities for 80% of the time.
- At Kelston School for the Deaf in Auckland and Van Asch College in Christchurch, there was regular sexual, physical, verbal and psychological abuse, linguistic abuse, and punishment for using Sign Language.
- At Hokio Beach and Kohitere Boys' Training Centre near Levin, there was normalised and pervasive violence, staff condoning peer-on-peer violence, pervasive sexual abuse, misuse of solitary confinement, normalised racism and cultural abuse, and punishment with extreme physical training and inhumane tasks.

Types of abuse and neglect

Often people were lied to or not told why they were being taken into care, or for how long. Discrimination led to care placements. Removing children into care had huge impacts on their existing relationships and ability to form new attachments. Multiple care placements compounded their trauma and disconnection.

Psychological and emotional abuse included verbal abuse and threats of harm, abandonment, humiliation and isolation. Survivors of institutions spoke of depersonalisation, highly regimented lives and harsh abuse – *this constituted systemic abuse*.

There were inadequate ratios of carers to persons in care. Caregivers had little training, and what they had was focused on health issues – feeding, changing, bathing and cleaning – rather than interacting. Daily routines were organised for staff convenience, and staff often came across as cold.

Survivors described severe emotional neglect. Some experienced so much physical abuse that they became immune to it. Corporal punishment included withholding food and shelter, sometimes in rain or cold weather. Some survivors were repeatedly targeted by the same or different sexual abusers.

The Inquiry heard *deeply suspicious* evidence of organised sexual abuse in State care by people in public positions of power and influence, but it was unable to make a finding on this.

Foster care

Foster care and state-run family homes were the settings where children and young people in social welfare care were most often placed. Foster parents controlled the lives of children and young people in their homes, and survivors felt trapped. Some foster parents were adept at putting on a show to hide abuse and neglect from visiting social workers. Survivors were often denied basic needs like adequate shelter, food and drink.

Some foster carers kept money that was meant to be spent on their foster children. Some treated foster children very badly compared with their biological children. Many foster children experienced extreme physical violence and sexual abuse from their foster carers or their carers' children. Foster children were often used as forced labour, some in conditions described as slavery.

Between 1947 and 1954, 549 children and young people from the United Kingdom were sent to New Zealand under the Child Migrant Programme. Many had to do intensive and unpaid farm work at the expense of their education. In 2009 the Australian Government apologised to survivors of this programme in that country. The same year, the former Social Development and Employment Minister said they considered the treatment of children in New Zealand under that programme had been better than in other countries.

Social welfare institutions

Institutions were hierarchical, so that staff and residents took advantage of younger and weaker residents. Institutions separated children from their identities and cultures. Many were told they were "born criminals" destined to lives in prison or psychiatric care.

Institutions were harsh, lacking aroha, care and affection. *Cruelty, violence and abuse were embedded in the way Social Welfare settings functioned and were ritualised in survivors' day to day lives.*

Race-based violence was sometimes incited by staff. Initiation beatings were common, as was the use of violence to control and punish even minor behavioural issues. Sometimes staff organised fights for their own entertainment. So-called "Kingpins" were residents who would violently discipline other residents and be rewarded by staff.

Sexual abuse was pervasive by staff, peers and visitors. Rainbow residents were often targeted. There was routine use of solitary confinement and people in solitary confinement experienced demeaning treatment and sometimes sexual abuse. Medication was used to control and restrain residents.

Deaf, disabled, mental health

People experienced violent, pervasive physical and sexual abuse that created a climate of fear. Disabled people were especially vulnerable to sexual abuse. Most abuse was by staff, often intentionally, although also by other residents. Ministry of Health Director-General Dr Diana Sarfarti acknowledged physical abuse in these settings during the Inquiry period, saying that "they did not adequately safeguard people from harm".

The Inquiry heard: "many of us working in the disability sector [thought] it is unlikely people would leave an institutional or faith-based setting without being abused or assaulted in some form or another." (Mark Benjamin, former Chief Executive of Standards and Monitoring Services New Zealand).

Neglect, including educational, physical, medical, dental and emotional neglect, was the most pervasive form of abuse. Personhood – that is, dignity, autonomy and identity -was denied. There was no privacy. Residents were stripped off and made to shower together. Often they had no personal possessions or clothing. They led regimented, unstimulating lives, often with no activities apart from monotonous duties like setting meal tables. Hygiene was poor, including being made to wear dirty or soiled clothes for long periods.

Medicalisation overlaid abuse – it allowed for the justification of abuse and dehumanising practices. Medical equipment and medicines were used to control or punish residents, instead of for medical purposes.

Research trials and treatments were used on patients, including hallucinogenic drugs like LSD and psilocybin. Electric shocks were used for control, and as an aversion technique with homosexuals, at places including Tokanui and Kingseat hospitals. There was denial of reproductive rights through contraception, sterilisation and abortion, often without informed consent and sometimes forcibly.

There was physical, sexual and psychological abuse at Deaf institutions, transitional and youth justice settings, and at health camps. Deaf culture and identity was suppressed through oralism – that is, teaching that sought to mirror English language, syntax and grammar. Deaf students would be punished for using sign language, such as having their hands tied to prevent them signing. The "Total

Communication" programme at schools for Deaf in the 1980s was based on oralism (lip reading and speech).

Extent of abuse in care

Numbers of people abused in care cannot be stated conclusively. The Inquiry's report [Martin Jenkins] estimated that between 114,000 and 256,000 people (17 to 39% of the total population in care) may have been abused or neglected during the Inquiry period.

Knowledge is limited due to under-reporting, delayed reporting, unrecorded reporting, obstruction of reports and information, information accuracy and ethical considerations. *Information collection processes of Oranga Tamariki and its predecessors have been, and remain, unsatisfactory.*

MSD had provided data to the Inquiry showing 7014 abuse allegations and 1490 practice failures from 1268 unique claimants between 1940 and 1999. By October 2022, MSD's Historic Claims team had received 1000 sexual abuse allegations in welfare settings.

Neither the Ministry of Health nor the Ministry of Education have kept centralised records of abuse and neglect allegations at Deaf, disabled, mental health settings or at special schools.

Quantitative analysis of survivors' accounts shared with the Royal Commission show:

- Physical abuse was the most common abuse type, followed by sexual and emotional abuse
- The decade with the highest rates of abuse and neglect was the 1970s, followed by the 1980s and then the 1960s
- Children aged 10 – 14 years endured high levels of sexual and physical abuse, Māori and Pacific survivors endured higher levels of physical abuse, and disabled survivors reported higher levels across all abuse types.

Part 5 – Impacts

This Part (164 pages) covers:

- **Key findings – impacts of abuse in care**
- Impacts of abuse and neglect on survivors and their whanau
- Impacts of abuse and neglect on particular groups
- Impacts of abuse and neglect on communities and society
- Recognising the determination of survivors

Key findings

- Many survivors have gone on to lead fulfilling lives, and some have worked courageously to improve the future for people in care.
- Some people who were abused in care took their own lives or died because of their experiences.
- There is evidence of unmarked graves for patients who died at some psychiatric hospitals, particularly at Porirua, Tokanui and Sunnyside hospitals.
- Most survivors suffered harm and have not been able to live their lives to their full potential.
- Impacts have included: difficulty with maintaining intimate and family relationships, damaged physical, mental and emotional health and wellbeing, lack of education and reduced employment opportunities, increased financial insecurity, periods of homelessness and reduced trust in authority.
- For some, their experiences became pathways to addiction, sex work, criminality and prison, gangs, entrapment in institutional care, and struggles with sexuality and gender identity.
- Māori and Pacific survivors also experienced family and cultural disconnection, loss of identity, and resulting loss of confidence.
- More than 30% of survivors of Social Welfare institutions went on to serve prison sentences.
- Abuse and neglect had inter-generational impacts.
- Often, reintegration was difficult, and sometimes never achieved, for people in care returning home.
- Deaf, disabled and mentally distressed survivors experienced ongoing discrimination which limited their ability to leave care.
- The lack of acknowledgement or apology from those in power creates further trauma for survivors.
- Abuse and neglect, and inter-generational harm, have contributed to social inequities.
- *The average lifetime cost to the survivor of the loss of enjoyment of things that New Zealanders consider are normal day-to-day activities is estimated to be approximately $857,000.* [Martin Jenkins report "Economic Costs of Abuse in Care"].

Impacts of abuse

Many survivors said they had reduced capacity for affection and intimacy. They struggled to form healthy, trust-based relationships and had a distorted view of sexual intimacy, including hypo-sexualisation. Separation from parents and siblings and parents and siblings not knowing about or not believing survivors' accounts of abuse in care caused feelings of guilt and permanently destroyed connections. Some survivors said they lacked parenting and grandparenting skills due to abuse.

Survivors spoke of physical problems caused by abuse and neglect, including long-term head injuries, hearing loss, weight loss and inability to control their body due to medication abuse, cognitive

impairment and brain haemorrhages requiring multiple surgeries. Psychiatric patients who received electric shocks suffered electrode burns, tinnitus and memory loss. Stress and anxiety from abuse contributed to other conditions like cancer, diabetes and strokes.

Mental health disorders included anxiety, PTSD and depression. Because of this, some survivors are unable to work. Mental health impacts can be triggered by distinctive behaviours, smells or noises. Many survivors have compensatory coping behaviours including alcohol and drug use. Many have low self-confidence and self-esteem. Some have committed or attempted suicide, or self-harmed.

For some survivors, violent and sexually abusive behaviour learned in care continued long after they had left. Some found freedom living on the streets. The Inquiry's *Care to Custody* report *found that one in five, and sometimes as many as one in three, individuals placed in Social Welfare residential care between 1950 and 1999 went on to serve a custodial sentence later in life.*

Social Welfare institutions were significant in gang formation. Many survivors were away from their families and cultures, and felt forgotten by society – some said they joined gangs because they had finally found a place they belonged, had a family and experienced comradeship.

Some disabled and mentally distressed survivors had no pathway after institutional care, having developed learnt helplessness. Many remain in institutional care today.

The Inquiry received evidence of people being buried in unmarked graves. These included evidence of 765 Sunnyside Hospital patients buried at Sydenham Cemetery, 469 buried at Tokanui Hospital Cemetery, 1840 Porirua Hospital patients at Porirua Cemetery, and 172 unmarked graves at Waitati Cemetery, Otago, mostly from the former Cherry Farm and Seacliff institutions.

For Māori survivors, impacts include disconnection from culture, whānau, whakapapa and te reo and an associated sense of intense whakamā (shame). The trauma of abuse was transferred down through generations and whānau, hapū, iwi and hāpori Māori have been overwhelmed by the cumulative impact of this trauma. Māori lost generations of whānau who would have been participating with their hapū and iwi and disrupted their collective ability to live as Māori. The Acting Chief of Whaikaha, Geraldine Woods, told the Inquiry's Institutional Response hearing that health and disability care "failed to consistently and meaningfully support the cultural needs of tāngata whaikaha Māori" during the Inquiry period.

Contrary to what families believed, Deaf and disabled survivors regressed in care through losing the opportunity to practice life and communications skills due to neglect. Family members felt guilt and regret from seeing the impact of abuse and neglect on their loved ones.

Pacific survivors often had their identities mislabelled in care, experiencing despair and profound confusion later in life. Many also became separated from their faith which, for many, is entwined with identity.

Sexually diverse and gender-diverse survivors often hid their sexuality in care for fear of discrimination.

Wider community impacts continue today. People who had been in Social Welfare settings were at least five times more likely to go on to serve a prison sentence than others. Māori were even more likely to end up in prison. Other impacts include gangs, long-term healthcare needs, lack of disabled leaders and role models, and the ongoing need for social support services.

In 2019, the estimated lifetime cost for an individual abused in care was $857,000 [Martin Jenkins report "Economic Costs of Abuse in Care"]. About $184,000 of this is financial cost to the economy,

such as increased healthcare and welfare spending. The remaining $673,000 is non-financial cost reflecting the pain, suffering and premature death of survivors.

All survivors who spoke to the Inquiry showed determination and strength despite the immeasurable harms they had suffered in care and the ongoing impacts and adversity many continue to suffer. Their healing journeys include reconnecting to whanau, community, cultures, faiths and spirituality. Many pursued education, employment, advocacy, sports and art. Many expressed a desire to change the system to prevent ongoing abuse and end inter-generational trauma – this was the most common reason survivors gave for sharing their experiences of abuse and neglect in care.

Part 6 – Te Tiriti o Waitangi and Human Rights

This Part (64 pages) covers:

- Te Tiriti o Waitangi
- Human rights themes
- Key observations

The report includes a series of findings of Treaty breach. It says that, under its Terms of Reference, the Inquiry was required to make findings about how the Treaty/Te Tiriti has been implemented or neglected in State care settings in the Inquiry period. It says the experiences of Māori in care meant it had no option but to make extensive findings of Treaty breach.

The scale of Treaty breach could be said to amount to cultural genocide. Equivalent Inquiries in Canada and Australia have made cultural genocide findings targeted at indigenous peoples. Conditions in New Zealand are not very different from the settings and experiences that led to the Canadian and Australian findings.

Although the Inquiry does not make a specific finding of cultural genocide, it says there is *strong evidence of numerous breaches of te Tiriti and its principles*. It says these breaches caused significant detriment to many Māori in care and to their whānau and next generations, adding: *The Inquiry is profoundly concerned about this conclusion*.

Specifically, the Inquiry finds:

- *Grave breach* of the Crown's obligations of active protection.
- Significant neglect of the Treaty in the design, development and implementation of care systems, breaching principles of tino rangatiratanga, kāwanatanga, partnership, active protection, options, equity, equal treatment, good government and redress.
- Breach of the how the Crown should have legitimately exercised kāwanatanga, requiring the Crown to foster rangatiratanga and ensure laws and policies were just, fair and equitable
- Breach of the principle of options, including through the lack of kaupapa Māori options as part of the care systems. This is particularly where the Royal Commission consider there is *a serious question whether aspects of the care system contained elements of cultural genocide… the laws and practices of removing tamariki, rangatahi and pakeke Māori involved elements of both systemic racial discrimination and cultural genocide*.
- Breach of the principle of equity and equal treatment, evidenced by disparities in abuse and the disproportional impact on Māori and the effect of racism.
- Breach of the principle of good government, considering that the Crown *was or should have been aware of the abuse and neglect suffered by Māori while in care*.
- Failure to uphold the principle of redress, including through ongoing failures to provide consistent redress processes and to address breaches in respect of the care system.

The Report says: *It is clear the Crown has acted in excess of its kāwanatanga powers and breached te Tiriti in a number of ways. The Crown failed to transform the care system in a manner that would uphold rangatiratanga and reflect a true partnership*.

It says these breaches have been at individual and intergenerational and collective levels, transferred from survivors to their tamariki, mokopuna, whānau, hapū, and iwi. This is manifested in ways including social problems, indicating clear breaches to the Royal Commission principle of active protection.

Part 7 – Factors

This Part (336 pages) covers:

- **Key findings – factors which caused or contributed to abuse in care**
- **Findings of fault against the State**
- The people at the centre of abuse and neglect
- Care standards were routinely breached
- Poor employment practices
- Complaints processes were absent or easily undermined
- Oversight and monitoring did little to change care experiences
- The State's responsibility for care
- Society's responsibility for care

Key findings

- People in care had rights to care standards that should have prevented abuse and neglect during the Inquiry period. In some settings, especially disability, mental health and education, government failed to set adequate or overarching care standards. In Social Welfare settings, social workers and foster parents breached standards set out in relevant manuals.
- Police breached standards set out in their General Instructions by interrogating young people with violence and without another adult present, and by holding them in Police cells.
- Standards were routinely breached, with daily breaches in many institutions and foster care places, due to lack of resourcing, poor training, and confusion about statutory powers and roles.
- Breaches varied in severity. Some breaches were abuse in themselves, others allowed abuse to happen. They included the failure of some social workers to visit State wards in care.
- Abusers misused their positions of power and control. They were often predatory, acted with impunity, concealed their actions, and avoided accountability. Some abusers were peers. Many bystanders – staff, volunteers and carers – failed to stop or report abuse.
- At institutions, individual care needs were not accurately identified or assessed. There were poor employment practices, including lack of vetting, and variable, absent or poorly implemented complaints processes.
- The State did not act to address signs of system failure. There should have been legislation to protect Te Tiriti and human rights, measures to support home care and minimise institutionalised care, and a national care safety framework.
- People in care, and their families and communities, had limited input into State decisions about care. The State did not ensure people in care were safeguarded from abuse and neglect, and there was lack of State accountability.
- Discriminatory social attitudes, negative views of people in poverty and on welfare, views that some children were delinquent, naughty and not to be believed; and condoning of institutionalisation all contributed to abuse in care.

Findings of fault

- ***Social Welfare:*** Ministers and heads of the Child Welfare Division, then the Department of Social Welfare and its successors, were at fault for matters including: Failing to fully meet the needs of those in care; ensure people were kept safe from harm; properly train, support and

monitor caregivers; detect and report abuse and neglect; ongoing impacts; failing to consistently believe or follow up reports of harm, and failure protect and preserve records and case files.

- ***Health and Mental Health:*** Ministers and Directors-General were at fault for matters including: Institutionalisation policies that led to abuse and neglect (despite World Health Organisation advice that institutionalisation was not best practice at the time); ableism and racism in legislation, policies and systems; failing to meet care needs and to keep people in care safe from harm; inadequate reporting, inappropriate use of seclusion, restraint, medication, aversion practices and shock treatment; and failing to maintain accurate records.
- ***Education:*** Ministers, Secretaries and Chief Executives were at fault for matters including: Failing to provide education fit for different groups; failing to support NZ Sign Language; failing to identify and support the needs of neurodivergent people; having less oversight of private schools; and failing to keep children safe in some schools and boarding facilities.
- ***NZ Police*****:** Successive Commissioners of were at fault for: Failing to respond to the distinct needs of Māori, Pacific peoples and Deaf and disabled people; a singular focus on enforcement rather than alternatives to criminal proceedings for children and young people; not consistently following General Instructions related to children and young people; failing to understand or investigate Police abuse of people in transitional law enforcement; lacking a dedicated policy around investigating sexual and serious physical abuse of children; negative bias against victims of abuse and neglect who were not believed; and failures to investigate abuse and neglect allegations against people in care.
- ***Governments*** were at fault for matters including: racism and ableism in legislation, policies and systems; alienation of Māori, Pacific peoples and Deaf peoples from their families, communities and cultures; abuse and neglect of people in care, failure to ensure people in care were safe and to consistently stop abuse and neglect when it was reported, gaps in and loss of records.
- ***State or Public Service Commissioners*** were at fault for failing to hold chief executives to account for matters including: preventing abuse in care, not adequately identifying and investigating abuse or responding to complaints; not providing holistic redress for survivors; and lack of coherent safeguarding of people in care across the public service.
- The State made discrete changes to safeguard against abuse and neglect in care during the Inquiry period, generally from the late 1980s. Toward the end of the Inquiry period, new legislation, policies and standards were created. Well-intentioned changes were made to prevent and respond to abuse, but these were not always realised. The State learned lessons about institutionalisation and segregation of Deaf, disabled and mentally distressed, but was slow to take action. Changes were inconsistent and substantially smaller than the scale of abuse and neglect in care.

Many abusers were adept at hiding their abuse and avoiding accountability. They lied, manipulated and deceived those around them, relying on their authority and status and relationships with colleagues. Some bystanders made excuses for the abuser or dismissed disclosures as lies. People in their care had become dehumanised to them. They gave abusers the benefit of the doubt, feared reprisals, and were not trained to identify signs.

The State learned that some families needed support, including financial, for home care and made law changes from the 1970s. The CYPF Act 1989 enabled families and communities to have much greater direct roles in care. Towards the end of the 1980s, the State began to legislate to protect the basic rights of people in care, such as visits from family and complaints processes. Safety checks were

introduced, like vetting and reference checking, training and effective complaints processes, but changes were piecemeal and inconsistent. From 1995, legislation required Social Welfare to promoted abuse awareness, prevent and report it, and monitor reporting by care workers.

Care standards

Common institutional care standards were in place from 1911, including making violent or sexual offending by staff against people in care an indicatable offence. Between 1950 and 1992, it was left to agencies and institutions to decide whether and how they would protect the rights of people in their care.

From 1992, the basic rights of people subject to compulsory protection orders were protected in legislation, including a complaints process. From 1993, the Ministry of Health set care standards in health service contracts with disability and mental health service providers. From 1996, the Code of Health and Disability Services Consumers' Rights set service standards for most people in care.

From 1957 to 1989, the Department of Education Field Officers' Manual (later the Department of Social Welfare Social Workers' Manual) set default care standards in Social Welfare settings. These were not legally binding and in practice were treated as guides. From 1986, legislative standards of care were put in place for all Social Welfare residences but did not include foster care, private home and third-party providers. From 1992, standards of care were set for third party providers. The standards were expanded in 1996. Social workers had to see State wards personally during their visits, though often this happened when caregivers were present. Some staff cut corners because of caseloads.

In education, there were no legislated care standards specifically for schools. From 1950 to 1989, blind, Deaf and disabled children generally did not attend mainstream schools. After the 1989 Education Act they could enrol at State schools. As part of the Education Act 1989, Ministers could issue national education guidelines and this was used to require boards to provide a safe environment for school students. School boards could decide how to implement national education guidelines, including how to provide a safe environment for students. In 1997, the Ministry of Education set out a circular setting out its views on responsibilities for safety.

Police General Instructions included standards for treating people in care, including having an adult present when interviewing a young person, and not keeping arrested young people in lock-ups. Survivors gave many instances of these standards being breached.

Care standards were compromised by overcrowded and unsuitable facilities which, along with geographical isolation, increased the risk of abuse and neglect. Care standards were routinely breached during the Inquiry period. There was confusion within agencies around their roles and responsibilities in relation to care standards oversight.

Employment practices

Many staff and carers tried to do the best they could for those in their care, though poor leadership and management could make it hard to provide effective safeguarding.

Generally, employment policies and practices were left to each care setting. There was no statutory requirement to vet prospective staff or carers. Before 1978, Police allowed only limited enquiries into a person's background. Health settings often deferred to medical professional bodies, although such bodies did not always *ensure that people in care were safe from doctors who should not have been*

practicing. Vetting of foster carers became required between 1970 and 1980, but there was no mandatory staff vetting requirement across all settings during the Inquiry period.

There were many examples of staff with child sexual abuse histories being unknowingly employed at institutions due to lack of vetting. Sometimes, abusers were appointed to positions despite employers knowing of their former child sexual abuse convictions. Under-resourcing contributed to abuse and neglect through staff being overworked and tired and inadequate oversight or supervision. So too did lack of respect for diversity.

There was inadequate training and development. Most staff and carers, including volunteers, were unregulated. Few staff had formal qualifications or training. Social workers started to receive formal training in the 1980s. In 1984, the Education Department issued guidelines on dealing with sexual abuse of pupils, and the Department of Health issued child safety guideline in 1992. Poor supervision or performance management contributed to abuse and neglect.

Complaints processes

Before 1986, there were no legislated rights to complaints processes for people in care. That changed after 1986, but processes varied widely. There were not enough district inspectors to visit mental health settings – only two in the 1960s, rising to 27 by 1997 – and their roles were poorly defined.

Until 1986, social workers were the primary way people in care could raise complaints. They could not access advocates, a problem made worse by institutions preventing them seeing their families. The 1996 updated Residential Care regulations gave residents the right to access a grievance procedure with an independent advocate. Until 1989, there was no legislated complaints process for children in special schools, and most did not have such processes. Survivors were generally not believed if they reported abuse and neglect. Some senior leaders and managers prioritised the reputations of institutions and abusers over people who had been abused.

Often, staff sanctioned for abuse were allowed to continue to work and abuse again. There was no legal or mandatory direction to report suspected abuse to the Police. The 1989 CYPF Act provided for reporting abuse if the disclosure was made in good faith. Health settings developed their own policies on reporting to Police, but staff were reluctant to do so.

Few records were kept of abuse and neglect. Although manuals had detailed instructions, in practice recording was left to individual social workers who usually noted limited information, and only on personal files. This meant aggregated abuse information for 1950-2010 was not collated, because doing so would have involved reviewing each individual case file. This made it difficult to identify patterns of abuse and resulted in abusive staff being rehired. Also, it was difficult to track complaints before the introduction of electronic systems in the 1990s. Education could not provide documentation to the Inquiry on its predecessor agency's record-keeping practices. Police could not locate complaint records because they had not been recorded or had been lost or destroyed.

The State learned that State and faith-based care settings needed detailed direction on processes for raising and responding to concerns or complaints, and for record-keeping.

Oversight and monitoring

Nearly all oversight and monitoring bodies during the Inquiry period lacked the ability to require change to prevent or respond to abuse and neglect in care.

In mental health, the role of district inspectors was quite vague. Patients did not know how to access them, and concerns they raised were not always taken seriously. Official visitors highlighted issues

with hospital management like neglect and inadequate facilities, but their roles also lacked independence, definition and direction.

The State failed to properly monitor care of children and young people in institutions, family homes and foster homes. There were infrequent and ineffective monitoring visits by social workers and inspectors, and unreliable paper-based monitoring. There was no single monitoring body covering all care settings.

At the Inquiry's State Institutional Response hearing, Oranga Tamariki representatives accepted there were widespread failings with social worker monitoring. Visits by inspectors lacked regularity and consistency. Institutions were supposed to provide annual reports by principals, but the Inquiry saw little evidence of their use. Visiting committees, made up of local community members, did sometimes identify issues at particular residences, but their roles were ill-defined. Many residents knew nothing about them. They were phased out in 1987. The Commissioner for Children told the Inquiry that since its inception in 1989, it has been "chronically underfunded to carry out its monitoring role."

Youth justice monitoring was done by the Inspector of Penal Institutions and Visiting Justices, though young people were often not aware these bodies were available or were reluctant to use them because of the "no narking" culture in youth justice. In the 1990s, the NZ Community Funding Agency failed to oversee and monitor third party care providers like Moerangi Treks and the Eastland Trust, where there were serious assaults on residents.

The number of oversight and monitoring bodies has increased but there is no single body with these responsibilities across all care settings.

The State's responsibility for care

The State failed to uphold its responsibilities for the care system, which contributed to abuse and neglect. Its failures included: discriminatory legislative and policy settings that ignored people's rights; deficient care standards that were easily breached with little consequence; limited decision-making input from people in care; there was no comprehensive regulatory framework enforced and funded across care settings; not ensuring that people in care were safeguarded from abuse and neglect; and the State's highest-level decision-makers rarely took accountability for abuse and neglect.

The State knew from the 1970s that widespread and unlawful abuse and neglect was occurring. While steps were taken with specific institutions, and reports like the Mason report and Puao-te-ata-tu led to change, the State did not address system-wide problems. The State should have tried to understand during the Inquiry period whether abuse and neglect was systemic, and how the State's changes were helping or not. The structure of government agencies meant visibility of systemic problems was clouded and frequent restructuring of government agencies during the 1990s contributed to the problems. Strategies failed to deliver widespread change, due for example to lacking clear targets and progress reviews. The State should have implemented a national care safety framework, designed in partnership with Māori and people in care, to prevent and respond to abuse and neglect.

Societal factors that were present throughout the Inquiry period contributed to abuse and neglect including racism, ableism, sexism, discrimination against Deaf people, homophobia, transphobia and negative attitudes towards children and young people. The State has made efforts to address discriminatory practices but some are maintained by many faiths.

Part 8 – Puretumu Torowhānui, Holistic Redress

This Part (86 pages) covers:

- Puretumu Torowhānui implementation to date
- Conclusions on the implementation of its recommendations

In 2021, the then Government amended the Inquiry's terms of reference to achieve faster delivery of the Inquiry's redress recommendations so it could make improvements more quickly. In December that year, the Inquiry delivered its interim report, "From Redress to Puretumu Torowhānui". It made 95 recommendations around establishing a new scheme, independent of government or faith-based organisations, to provide redress for survivors of abuse in care.

On the day the report was made public, the Government announced that survivors would have access to a new, independent scheme. It said that, following a design process, final decisions would be made by mid-2023, with introduction soon after that. *Since then, there has been very little clear progress by the Government in implementing the Inquiry's recommendations.*

The Government's initial timeframes were delayed. In mid-2023, a redress design group was announced, supported by an advisory group. Membership of both was predominantly survivors from different groups, with Māori co-chairs. The responsible Minister did not receive the group's high-level design proposals until February 2024. No timeframe has been announced for progressing those proposals.

The design process did not follow the Inquiry recommendations to be led by an independent Māori collective, consistent with Te Tiriti and reflecting the disproportionate number of Māori in care. Also, the new scheme may not be open to survivors of faith-based institutions from the outset. The Government's early indicative cost estimates were at the lower end of comparable overseas schemes. The Inquiry welcomes the Government's intention to deliver a public apology, although it is concerned about the roles Māori, faith based and indirect State care institutions will have in planning and delivering it.

The Government has established an interim listening service for survivors, as the Inquiry recommended. Some work has happened on improving survivor access to records of their time in care, although the Inquiry is concerned at the rate of progress, saying work should be prioritised and completed in six months.

The Government has not provided the advance payments to survivors who are seriously ill or old in the way the Inquiry recommended. Instead, it has introduced rapid payments schemes at MSD and Education.

MSD's maximum rapid payment is $30,000. More than 80% of claimants offered a rapid payment have taken it up. The Inquiry accepts that prompt claim determination is important, but is concerned at the absence of meaningful apologies, and that the payments don't take individual abuse into consideration – time spent in care is the main criterion. Survivors accepting a rapid payment have to sign a settlement agreement with MSD. It is unclear whether those survivors will have access to the new scheme, as MSD says the Government has not made final decisions on this.

Education provides a rapid payment scheme of up to $20,000 for survivors of Waimokoia Residential School. It also offers prioritised settlement payments of $10,000 for terminally ill eligible claimants. Waimokoia survivors cannot get both payments. Education also offers a new wellbeing support

service, which the Inquiry welcomes, although it objects to the settlements being full and final, and says the amounts are *plainly inadequate* and have *no principled basis* given what happened at Waimokoia. The Inquiry is also concerned that MSD and Education have different redress processes that increase complexity for survivors.

The Inquiry recommended that claims be resolved before establishment of the new independent scheme, without prejudicing their rights to the new scheme. The Inquiry recommended a transformative workforce strategy for providing wellbeing services to survivors. It also recommended government funding for memorials for survivors, removing memorials to abusers, and a national project to investigate unmarked graves at mental health settings. The government attempted to purchase the water tower at Lake Alice for use as a memorial, but its offer was rejected by the landowner. The Inquiry is unaware of any other decisions on these proposals.

The Inquiry recommended a new right to be free from abuse in care, allowing an exception to the ACC bar against civil litigation for abuse in care claimants, and the removal of limitation periods for abuse in care cases. In January 2024, the Government advised that work on these recommendations would be deferred until after the Inquiry had provided its final report. The Inquiry is concerned at this approach, saying there is no reason why substantial work could not proceed on this already.

There is little scope to bring a court case in New Zealand for abuse in care outside of ACC. The Inquiry considers that ACC has generally not provided survivors with adequate compensation, compared with what survivors in comparable countries can access through litigation. The Inquiry is aware that, in at least one forthcoming litigation case, the Crown will rely on the limitation defence. The Government has not carried out the Inquiry's recommendation to raise legal aid rates and provide training for lawyers in abuse in care proceedings.

Meaningful reform which provides fair, holistic and comprehensive redress will inevitably be expensive for the Government and faith-based institutions. The alternative is for many survivors and their whanau, and society at large, to continue bearing these costs.

Part 9 – The Future

This part (364 pages) covers:

- How the Inquiry developed its recommendations
- Survivors' dreams for the future
- Righting the wrongs of the past
- Safeguarding people in care
- Entrusting and empowering communities
- Implementing the Inquiry's recommendations
- Implementation timetable
- Urgent need for action

Most of the discussion and recommendations in this part, covering future vision and proposed key elements of a new care safety system, titled *he Māra Tipu,* are summarised in the Executive Summary and Recommendations at the beginning of this document. Other discussion around righting past wrongs through the new redress system are covered in the Part 8 summary.

Additional points:

- The Inquiry said the estimated total economic cost of abuse and neglect in care between 1950 and 2019 is around $200 billion [based on the Martin Jenkins report estimates discussed above]. This cost is greater than the combined totals of government spending on war and rehabilitation during WWII; the Governments Covid-19 response; the Canterbury earthquake response and recovery; and the cost of the Auckland Anniversary floods and Cyclone Gabrielle recovery.
- *The State continues to make incremental and disconnected attempts to improve care systems despite the increasing calls for urgent radical changes…the State-led model cannot be described as anything less than a dismal failure.*
- *The Inquiry's vision for the future includes one of the most fundamental changes to systems of care this country has ever seen. It would see the State handing over power, function and control of supports and services to individuals, groups and organisations chosen by collectives and/or local communities.*
- The Inquiry foresees three work phases towards realising the new care system by 2040:
    - Implementing the Inquiry's recommendations and consolidating change (2024-2030)
    - Review phase one and implementing next steps (2031)
    - Review phase two and implementing final steps (2032-2040).
- There should be public acknowledgement and apology from the Pope and the Archbishop of Canterbury for abuse and neglect in the Catholic and Anglican Churches respectively, as well as other New Zealand-based church leaders.
- *The Government should take all practicable steps, including incentives and, if necessary, compulsion, to ensure that faith-based institutions and indirect care providers join the puretumu torowhānui system and scheme once it is established*.
- There should be cross-party agreement to implement the Inquiry recommendations.
- Decision makers should be held to account for ensuring change.

Agenda Item Three

Listening, learning, changing
Mā Whakarongo me Ako ka huri te tai
Crown Response to the Abuse in Care Inquiry

Redesign of redress for survivors of abuse in care – Stepped process for agreeing key redress parameters to support a detailed design process

For: Ministerial Group – Crown Response to the Abuse in Care Inquiry

Date: 17 July 2024 **Security level:**

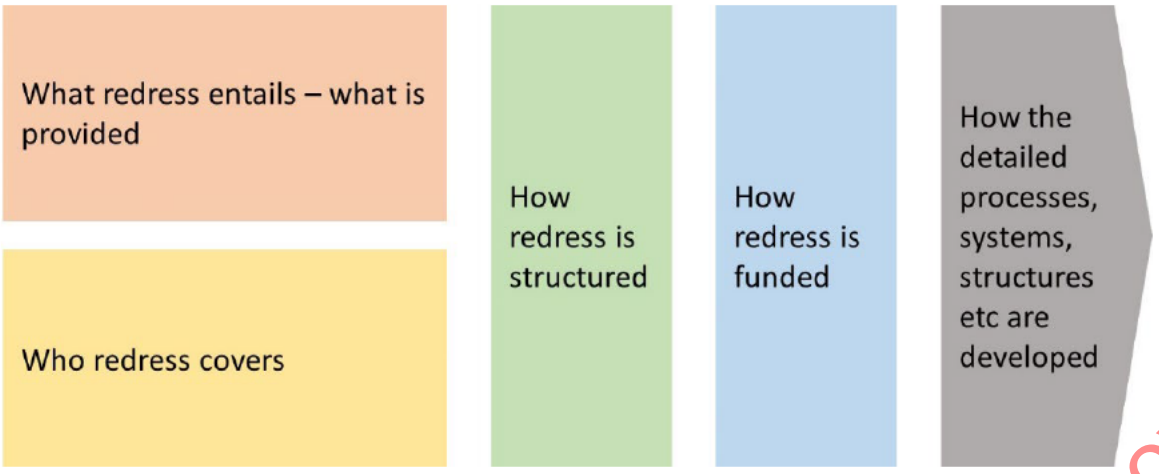
Purpose

1. This paper provides an overview of the stepped process being used for Ministerial consideration of key parameters for the redesign of redress for survivors of abuse in care, and helps place the Ministerial Group's discussion on redress functions at its July meeting in the overall context of the work.

A. Structuring of the work and core objectives

2. In June 2024 Cabinet endorsed a phased work programme [CBC-24-MIN-0050 refers] to respond to the recommendations of the Abuse in Care Royal Commission of Inquiry (the Royal Commission) regarding redress for survivors of abuse in care, and high-level redress design proposals produced by an independent Redress Design Group commissioned by the previous administration in response to the Royal Commission's recommendations.
3. Cabinet agreed the Crown Response Unit, under the oversight of the Ministerial Group and working with relevant agencies, develop redress options that are informed by the Royal Commission's recommendations, the high-level design proposals, and lessons from national and international redress schemes, and that draft options be considered by Cabinet prior to testing and refining them with former members of the Redress Design Group, and other survivors as required.
4. Cabinet agreed options for redress be developed and assessed against the following core objectives:
    a. delivers accountability for survivors, including apologies and financial payments, where applicable, that serve to acknowledge the harm survivors experienced and further obligations to prevent future abuse in care;
    b. supports improved outcomes for survivors – which could, depending on a survivor's circumstances and preference, encompass improved quality of life, and the ability to more fully participate in all aspects of community, social, cultural, and economic life;
    c. manages affordability, risks, and liability, including avoiding significant unintended consequences, and helping to ensure the sustainability of redress for as long as it is needed;
    d. contributes to reducing the negative social, cultural, and economic costs arising from the poor outcomes experienced by survivors as a result of the injury and trauma caused by abuse.

B. The overall redress questions for Cabinet to consider in 2024



C. Staged consideration of parameters within each overall question by the Ministerial Group to inform the redress options subsequently considered by Cabinet

Overall question	Decisions	Implications	Ministerial Group initial consideration
The first tranche of options for Cabinet consideration are to cover the following three overall questions, with the following timing: • Cabinet consideration of draft options – September • Cabinet consideration of final options (following survivor engagement) – November			
What redress entails – at a high level	Redress functions	Key guide for nature and scale	July
How redress is structured	The high-level structuring of the redress functions – the levels of independence and integration sought	Guides complexity of the system, shaping design process and legislation that may be needed	July
Who redress covers	Redress eligibility: • care settings/level of care responsibility to be covered – *the Ministerial Group endorsed options should include non-State care* • forms of abuse to be covered – *the Ministerial Group endorsed physical, sexual, emotional, and psychological abuse and neglect as forms for redress cover* • length of time the redress system needs to operate • care time period to be covered (tied to the above)	Determines eligibility and the number of people accessing redress	First two scope parameters, June Remaining four scope parameters, August

Overall question	Decisions	Implications	Ministerial Group initial consideration
	• extent to which those who have previously settled claims through existing processes can access the system • whether deceased survivors and whānau are included		
Second tranche of options for Cabinet consideration are to cover the following three overall questions, with the following timing: • Cabinet consideration of draft options – November • Cabinet consideration of final options (following survivor engagement) – December			
How redress is funded	Funding model: • overall funding approach • non-State organisations contribute	Determines both short and long-term fiscal implications for the Crown and non-State organisations Affects organisational design alongside decisions on structuring of functions across entity/entities	August
What redress entails – building off the high-level decisions above	Apology framework: • principles and high-level process for developing a personal apology to a survivor • explore legislative changes to support more meaningful apologies	Guides key aspect of redress shaping survivor experience Affects legislative programme and part of the legislative basis for redress	September
	Payment framework: • categories of payments • nature of payment steps and levels for each category • evidentiary standards for payment categories • treatment of the payments – tax status, influence on other payments or benefits, whether they are 'full and final'	Guides key aspect of redress shaping survivor experience Affects processes and overall cost	September

Overall question	Decisions	Implications	Ministerial Group initial consideration
	Support services framework: • high-level types and levels of support services to be accessed • how service provision/access is to be prioritised • extent to which the system invests in or guides broader sector capability	Guides key aspect of redress shaping survivor experience Affects processes and overall cost	October
How the detailed processes, systems, structures etc are developed	Detailed design approach: • who does the detailed design work • oversight arrangements – including extent of survivor leadership • core features/principles for the design approach • how diverse survivor perspectives are to be balanced or synthesised • critical milestones and timing	Determines complexity, duration, and cost of detailed design process	October

D. Background to the work – the Royal Commission's redress system recommendations and the Design Group's redress proposals

5. The Royal Commission recommended a new redress system is established that:

   a. is founded on a series of principles, values and concepts founded in te ao Māori;

   b. provides for a process with an independent, government-funded inclusive Māori Collective leading the design of the puretumu scheme, working together with survivors, a government-funded group representing survivors described as the Purapura Ora Collective and with others;

   c. is designed and run in a way that gives effect to te Tiriti o Waitangi;

   d. is established by an Act of Parliament and funded by the Crown, but with contributions from participating institutions is independent of the institutions where the abuse took place;

   e. requires the wind down of current State claims processes and for all government agencies to join and encourages faith-based institutions to join within a reasonable time, although the latter will, if necessary, be required to join;

   f. provides for financial payments that give a meaningful recognition of the harm and trauma suffered;

   g. facilitates oranga services tailored to individual survivors' needs (and, where appropriate, those of their whānau), including help with health, education, employment, secure housing, building and maintaining healthy relationships, counselling and social and cultural connections;

   h. facilitates meaningful apologies;

i. provides a safe, supportive environment for survivors to interact with the system, talk about their abuse and make a claim for redress, and that is open to all survivors, including those who have been through previous processes and those covered by accident compensation legislation;

j. allows family members to continue a claim on behalf of a survivor who dies;

k. gives priority to elderly or seriously ill survivors;

l. covers the full range of physical, sexual, emotional, psychological, racial and cultural abuse, along with neglect;

m. develops and makes public information about the types of support available, eligibility and assessment criteria, and timeframes for making decisions on a claim;

n. allows survivors to choose between making a claim that takes into account abuse and its impact or simply the abuse only, which will have lower standards of proof than applies in the courts;

o. makes belief of a survivor's account the starting point for assessing a claim; and

p. involves survivors in deciding on the form and content of apologies and acknowledgments and choosing the nature and extent of the oranga services they may need.

6. The Design Group proposed:

a. bringing all redress functions into one entity independent of the Crown and non-State care organisations, and under the governance of survivors;

b. ensuring the system's long-term sustainability with a capital investment managed by the entity, using investment earnings to self-fund the operating budget;

c. the Crown would provide the initial capital investment, and then secure contributions from non-State care organisations to recoup an appropriate share of the funding cost;

d. the redress system would have five functions:

i. provide a safe, responsive environment where survivors can share and access support for their experiences;

ii. facilitate acknowledgements and apologies;

iii. provide access to monetary payments and targeted services and supports for survivors to restore their own mana;

iv. monitor, investigate, and advocate for system-level changes to care settings, to help eradicate abuse; and

v. manage investment funds to ensure certainty of funding and maintain a sustainable system for future survivors.

e. have broad coverage in terms of both the types of abuse experienced and the settings the abuse occurred in;

f. operate a high-trust model with significant decision-making about redress pathways resting with individual survivors;

g. a focus on the supports and services survivors needed to move from a traumatised to a flourishing state, including by drawing on and expanding effective existing services, and creation of new services only where there are gaps;

h. the delivery of personal apologies, developed through a guided process underpinned by a set of apology principles that acknowledges the limitations on what can be said so as not to create legal risk;

i. providing access to three forms of monetary payment – with each payment having a different evidentiary requirement reflecting its purpose and monetary level:

   i. a flat-rate welcome (whakatau) payment (of $10,000), that helps a survivor feel valued and minimises immediate financial pressure on a survivor as they engage with the system;

   ii. 'standard' stepped payments (of $30,000–$400,000) reflecting different levels of survivor experience – with suggested monetary amounts for each step which are higher than payments made by existing historic claims services, although with an expectation that the number of survivors at the upper levels of experience would be limited; and

   iii. a flat-rate whānau harm payment (of $10,000) available to those cared for by survivors and impacted by the latter's trauma, to help mitigate further intergenerational harm;

j. the need for strong performance monitoring to support continuous improvement and assurance the system is effectively using its resources to deliver against its purpose;

k. the importance of keeping bureaucracy to a minimum – maximising the proportion of resources that go to survivors rather than to the operation of the system;

l. phased implementation of different aspects of the system, prioritising older survivors, those receiving end of life care, and those living with multiple comorbidities; and

m. that the design and establishment of the system can itself be an opportunity for healing and should be led out by an interim survivor leadership (kaitiaki) group that works closely with the Crown.

Agenda Item Three

Listening, learning, changing
Mā Whakarongo me Ako ka huri te tai
Crown Response to the Abuse in Care Inquiry

High-level structuring of redress functions

For: Ministerial Group – Crown Response to the Abuse in Care Inquiry

Date: 17 July 2024 **Security level:**

Purpose

1. This paper outlines key decisions and issues for consideration about the functions associated with the design and delivery of redress. Those issues concern the way those functions are structured, with a focus on the independence and integration. It seeks Ministerial feedback on the current direction of this work to guide the next stage of developing draft options for Cabinet on these matters in September. An A3 summary of the structuring considerations is provided in Appendix One.

2. Redress is fundamentally the attempt to put right a wrong that has occurred, by acknowledging the wrong and providing some form of remedy or reparation. The Royal Commission has set out redress functions that represent how redress should be applied for abuse in care. There are key questions in how the functions are structured to provide confidence, consistency, and ease of navigation for survivors, and efficiency in how redress operates.

Recommendations

3. It is recommended that the Ministerial Group:

    a. **note** this paper seeks Ministerial endorsement to a set of redress functions and an approach to the structuring of those functions to guide the next stage of work on advice to Cabinet in September 2024;

    b. **endorse** the four redress functions recommended by the Royal Commission, in simplified version as follows:

        i. provide a safe, supportive environment for survivors to share their experiences;

        ii. facilitate acknowledgements and apologies by institutions for abuse, in care;

        iii. facilitate access to support services and financial payments that enable survivors to restore their inherent dignity; and

        iv. share insights on systemic issues relevant to abuse in care and the harms experienced;

    c. **note** there is a wide range of options on the level and type of payments and supports services that could be provided through redress and Cabinet is expected to make decisions on these matters in November;

d. **note** to give effect to these four redress functions, decisions are also required on associated system-level functions, specifically policy and framework setting (including responsibility for any legislation), system governance and oversight, and redress performance;

e. **note** there are two aspects to how these redress functions and the associated system-level functions are structured - the degree of independence (that is, how distant redress is from care provision or the Crown generally) and the degree of integration (that is, how consolidated the different parts of redress are);

f. **note** the Royal Commission and Design Group both recommended a highly integrated redress system but had differing views on the level of independence, with the Royal Commission recommending independence from care agencies and the Design Group recommending independence from the Crown as a whole;

g. **note** the degree of integration has implications for the simplicity of access and consistency of redress received by survivors, and the potential operational and financial efficiencies that can be achieved;

h. **note** we consider that, as a minimum, the redress system should be built around a common set of high-level policy parameters and a consolidated approach to the monitoring of redress provision across those settings, including clear information for all survivors on what redress to expect and how to access it;

i. **note** in addition we are investigating options for how to ensure a seamless experience of redress across different redress services as an alternative to the establishment of a single redress entity, and we will provide further advice on these options at subsequent Ministerial Group meetings;

j. **note** the degree of independence has implications both for survivor trust and confidence in redress and the Crown's ability to discharge its moral duty regarding abuse in care while ensuring appropriate fiscal controls; and

k. **provide feedback** on redress system design with the following features to support independence and accountability:

   i. the Crown retaining accountability for key policy parameters and Crown spending;

   ii. redress policy setting and claims decision-making independent of agencies with current or historic care responsibilities;

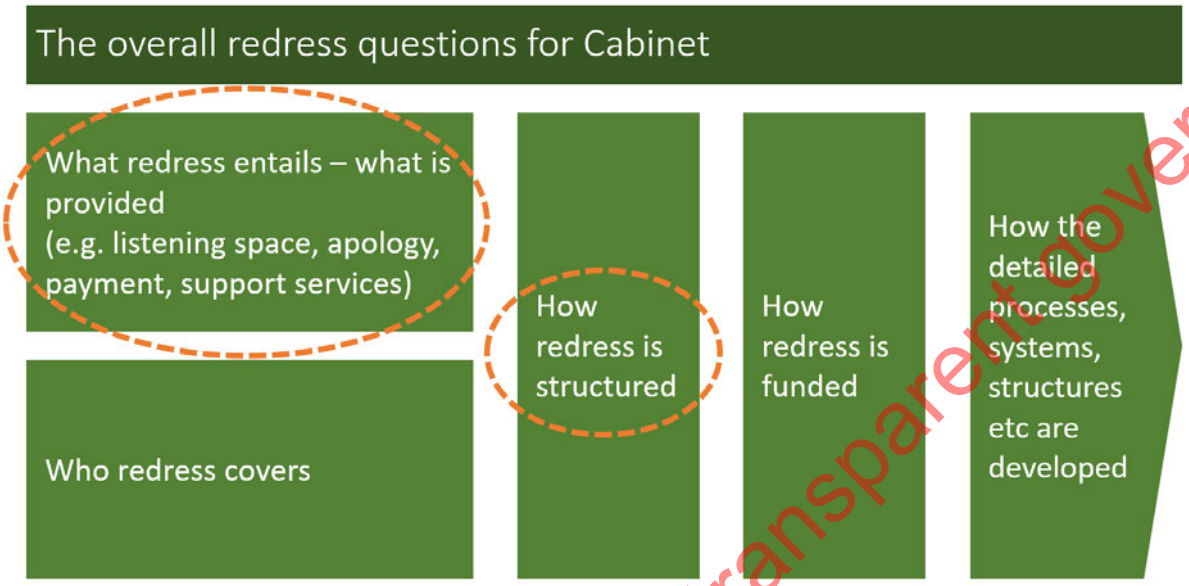
   iii. a statutory redress monitoring role for survivors, that could extend to providing perspectives on policy and service design and delivery based on survivors' needs and aspirations;

   iv. governance that enables survivors to influence the delivery of redress to help meet the needs of diverse survivors; and

   v. mechanisms which support certainty and sufficiency of funding across financial years and different administrations.

A stepped approach is being used to work through the five main areas of redress design for survivors of abuse in care

4. The following figure summarises the overall questions that were agreed to be worked through in stages as part of the recent Crown Response work programme [CBC-24-MIN-0050 refers]. This paper deals with the first area, 'what redress entails', and the third area, 'how redress is structured'.



Part A: Functions

There are four recommended functions that encompass, at a high-level, the different components of redress

The Royal Commission recommended four functions that reflect the core nature of redress

5. The Abuse in Care Royal Commission of Inquiry (the Royal Commission) recommended an integrated redress system with four redress functions, that it:

   a. provides a safe, supportive environment for survivors to share their care experiences;

   b. facilitates acknowledgements and apologies by institutions for tūkino (abuse, harm, and trauma) in care;

   c. facilitates access to support services, financial payments and other measures that enable te mana tāngata (the restoration of a survivor's inherent dignity); and

   d. reports and makes recommendations on systemic issues relevant to abuse in care.

6. The Royal Commission also recommended that the redress system should 'disseminate information about [itself] so as many eligible individuals as possible know about and can access its services'. Awareness and accessibility are important aspects of any system, and so are not proposed as a redress function. Instead they are system functions, as discussed in paragraphs 17–19 below. Effective promotion and information dissemination would be part of the detailed processes to be developed once the high-level redress parameters have been set.

The Design Group endorsed the Royal Commission's recommended functions but proposed some amendments that reflected its views on the way the functions should be delivered

7. The Design Group endorsed the Royal Commission's recommended functions but proposed amendments to three functions:

    a. adding 'survivor-led' to describe the sharing environment to the first function;

    b. noting that survivors restore their own mana in the third function, that it is not something to be 'given' by a redress system; and

    c. expanded the fourth function considerably, from the Royal Commission's focus on identifying systemic issues within the care system to an active monitoring and advocacy function, reflecting the concern that care systems must not perpetuate abuse and produce future survivors.

8. The specificity the Design Group added to the way the functions are described highlights the central importance the Group placed on independence and survivor leadership. As the Group itself noted, the amendments speak to the way the functions should be delivered rather than their core substance. The amendments are therefore of more use when considering the structuring of the functions and the detailed design of processes, rather than the fundamental 'what' of redress.

It is proposed that a slightly simplified version of the Royal Commission's recommended functions are endorsed to guide the next stage of work on redress design

9. Redress is fundamentally the attempt to put right a wrong that has occurred, by acknowledging the wrong and providing some form of remedy or reparation. The Royal Commission's recommended functions represent a way of dividing up the core aspects of redress as they apply to abuse in care – allowing survivors to share their experiences, then providing an appropriate apology, payment, and access to services addressing the harm they experienced, to support an improved quality of life.

10. The Royal Commission also considered that the information gathered through a redress system represents a significant source of insights about failures in care. The trends and systemic issues a redress body identified should therefore be shared with relevant care and oversight agencies to assist with ongoing improvements to care.

11. The Design Group's proposals were provided without knowledge of the direction the Royal Commission would take in its final recommendations and findings. We now know the final recommendations include a significant focus on care oversight and monitoring, as well avoiding duplication and confusion within care monitoring. Consideration of monitoring, including any role as part of redress, should be part of the wider response to the Royal Commission's final recommendations and not a specific focus for redress. We therefore propose using a slightly simplified version of the functions as originally set out by the Royal Commission as the guide for what redress entails.

12. Current State claims processes provide each of the four recommended functions to different degrees. All agencies provide apologies and payments, facilitate access to care records, and provide access to limited counselling supports during claim processes. Agencies' listening function is primarily focused on the claim they are making, while seeking to provide a safe space for sharing experiences. Agencies' insight function is generally limited to referring immediate

safety concerns to the police or relevant care body. In many cases, they have built up significant bodies of knowledge about particular historic institutions.

13. The recently established Survivor Experiences Service provides a safe and supportive environment for survivors to share their experiences. It can help facilitate survivors access to claims processes. The Service has been established as an interim approach while the wider redress work is progressed.

14. Four comparable international redress schemes – Australia, Ireland (Republic), Northern Ireland, and Scotland – offer payments and as part of their claims process facilitate access to limited support services delivered by separate organisations. Only the Australian scheme provides direct access to counselling as part of the redress package. The international schemes do not typically provide apologies and have listening functions focused on the claim being made by a survivor. The schemes do produce regular reports on issues and trends as part of a relatively limited insight function.

15. The Royal Commission's recommended functions have a stronger focus on the safe sharing of survivors' experiences and the provision of support services than is generally the current case in domestic processes and international schemes. The recommended breadth, with choices other than a financial settlement, reflects what the Royal Commission learnt from survivors, researchers, and other experts about the ability to design redress in a way that maximises the opportunity for delivering improved outcomes – with survivors better able participate in all aspects of social, cultural, and economic life.

16. There are operational costs associated with each of the four recommended redress functions, but the third function – support services and financial payments – is the major driver of redress cost. How such a function is translated into operating procedures will be critical for the effectiveness and affordability of redress. There is a significant breadth of choices in how payments and services can be arranged and offered to help balance the outcomes they deliver for survivors against the sustainability of redress. Providing a safe space to share and a choice of support services alongside or instead of payments do not in themselves have to be costly but provide survivors with increased self-determination and choice in addressing the harm they experienced. Options for draft payment and support service frameworks are intended to be provided for consideration at the September and October Ministerial Group meetings, to inform draft framework options to be considered by Cabinet in November.

Alongside the redress functions are three system functions needed to support the effective delivery of redress

17. The Royal Commission (and Design Group's) functions focus on what redress is to be delivered. There are also system functions needed to support the effective delivery of the redress functions. These system-level functions are:

    a. policy and framework setting, including responsibility for any legislation;

    b. system governance and stewardship, including accountability for Crown expenditure;

    c. redress performance monitoring; and

    d. overall awareness and accessibility of redress.

18. The Royal Commission and Design Group did not address the first three areas as specific functions but spoke to some aspects of them, for example when noting there needs to be clear performance frameworks and reporting to help provide confidence that the redress delivered fulfils its intended outcomes, and for redress system policies to be developed through collaboration and engagement.

19. When considering redress structuring, it is important for the Crown to have a clear view on the system-level functions as they represent key areas for managing risks around redress and for effectively discharging the Crown's moral and legal duties, including the development and oversight of legislation, and accountability for Crown expenditure. The following discussion of redress function structuring therefore includes relevant consideration of system functions.

Part B: Structuring of the functions

There are two fundamental aspects for structuring redress functions – the degree of independence and the degree of integration

20. When considering how the redress functions could be structured, the following two aspects – degrees of integration and independence – define the range of potential options. The aspects intersect but are outlined separately to be clear about what each means in the context of redress. Decisions around independence and integration will significantly affect survivors' experiences when seeking redress, as well as the role and risks of the Crown and non-state institutions.

Independence

21. Independence in relation to redress refers to the:

    a. separation or distance between redress provision and the care agencies where abuse occurred; and

    b. separation or distance between redress provision and the Crown and non-state care providers in general.

22. The nature of the independence is defined through the:

    a. degree of Ministerial and statutory oversight – what reporting requirements are in place, what scope a Minister or Ministers have to direct the priorities and performance of a body, system, or function;

    b. scope of powers – what ability does a body have to determine its own policies and how a function is discharged;

    c. nature of governance – what form of governance is in place, and who or what does it report to (intersecting with the degree of Ministerial oversight), with what composition and appointment process (intersection with survivor leadership as a factor highlighted by the Design Group); and

    d. funding available – the funding arrangements in place to support the body, system or function (including the security of funding streams), the reporting requirements in place, and the purposes for which the funding can be used (intersecting with the scope of powers).

23. The way in which independence and integration are configured are connected to decisions on the nature of funding models, eligibility, and frameworks covering apologies, payments, and services. Detail for the redress functions will be set out in frameworks covering apologies, payments, and support services – which can include the ability for strong performance oversight, innovation, and risk management. Direction from Ministers on the degree to which independence and integration is enabled will narrow the range of options presented to Cabinet.

Integration

24. Integration in terms of redress refers to:

    a. the degree of consistency in the way each function is discharged;

    b. which functions are grouped together; and

    c. the way in which functions (or groups of functions) are delivered to and experienced by survivors – for example, how many bodies are providing the functions, whether there is a common entry point that provides access to multiple bodies.

25. Integration of functions is a structural choice, separate to the physical centralisation of delivery. Even a highly integrated approach still enables 'hub and spoke' type delivery models, where a single body may be responsible for all functions but facilitates access to contracted services that are delivered locally to survivors. The optimum delivery model will need to be identified through the detailed design process, since it depends on the decisions made by Cabinet on the high-level parameters in this stage of work. Such an approach also allows for engagement with survivors on how redress should be experienced in a tangible way.

The Royal Commission and Design Group recommended a highly integrated redress system, while having different views on how independent the redress system should be – with the Royal Commission focused on independence from care agencies and the Design Group on independence from the Crown

26. In its redress report, the Royal Commission recommended:

    a. The Crown should take an all-of-system approach to responding to abuse in care.

    b. The Crown should set up a fair, effective, accessible and independent puretumu torowhānui scheme.

    c. The puretumu torowhānui scheme should operate independently of the institutions where tūkino (abuse, harm and trauma) took place.

    d. The puretumu torowhānui scheme should encourage the provision of support services locally, while the Crown should properly resource local services, and commissioning new support services where gaps have been identified.

    e. The membership of the governance body for the puretumu torowhānui scheme should give effect to te Tiriti o Waitangi, and reflect the diversity of survivors, including disabled survivors, as well as including people with relevant expertise.

27. In its recommendations and accompanying commentary, the Royal Commission envisaged a single integrated redress system that oversaw all of the proposed functions, although delivery of support services would be highly decentralised.

28. While recommending an independent system, the Royal Commission's view of independence was focused on the boundary between redress and agencies providing care. In the commentary accompanying the recommendation on independence, the Royal Commission noted "The problems with existing redress processes are well-documented. The solution, in our view, is establishing a new puretumu torowhānui scheme that is open to all survivors of abuse in State and faith-based care, including indirect State care, and is independent of the State, indirect State care providers and faith-based institutions. That is, it should be an independent Crown entity, not a departmental public body."

29. The Royal Commission also highlighted the importance of the system being survivor-focused, trauma-informed, and accessible to all survivors.

30. In its high-level design proposals, the Design Group recommended:

    a. An independent, survivor-led central entity with survivor-facing and system-facing functions is established, to deliver monetary payments and personal apologies and acknowledgements, coordinate access to survivor-elected services and supports, and monitor and report on the Survivor-Led Redress System's performance as well as progress towards the eradication of abuse in care.

    b. The Survivor-Led Redress System puts survivors at the centre of its governance and executive.

    c. The Survivor-Led Redress System must be constituted by a flexible range of survivor-focused redress pathways.

    d. The central entity performs and retains the functions necessary to ensure that redress is and remains survivor led.

    e. The central entity sits within, monitors, and facilitates a comprehensive and responsive range of redress experiences.

31. The Design Group's recommendations also envisage a highly integrated single redress system that facilitates access to a decentralised range of support services. The Design Group had a stronger view on redress independence, envisaging an entity removed from the Crown at governance, operating, and funding levels.

New Zealand State and non-State claims processes have very limited independence, are well joined-up internally but limited integration across services, leading to highly variable survivor experiences

32. The four main current State care claims processes – operated by the Ministry of Education, Ministry of Health, Ministry of Social Development (MSD), and Oranga Tamariki – have low levels of independence in terms of the Royal Commission's recommendation being based in agencies that either currently provide care or have historic links with care. Some aspects of the functions delivered by the agencies are independent. For example, the Ministry of Education employs external assessors to review and make decisions on claims, with the independent decision then implemented by the Ministry's Sensitive Claims unit.

33. Considering oversight, scope of powers, governance and funding, the existing claims processes have a low degree of separation from the Crown in general, and minimal separation from care agencies.

34. The Survivor Experiences Service is an interim service that was recently set up to provide a safe and supportive environment in which to share experiences. The Survivor Experiences Service is independent from care agencies and is based within the Department of Internal Affairs, under a Ministerially-appointed Board that is primarily comprised of survivors.

35. Non-State care claims processes have low levels of independence being provided by the organisations that were also generally responsible for providing care. Non-State organisations are highly variable in the processes they operate, with some using independent advisors or panels to consider claims, others having staff directly considering claims, and others using restorative justice type processes.

36. There is limited integration across the existing claims processes within the Crown and no integration between the Crown and non-State claims processes. There is no common entry point for redress available in New Zealand, meaning survivors must go to individual agencies if their care spanned multiple settings. Agencies provide some assistance to such survivors in connecting them with other relevant claims processes, but this is a manual process for agencies. Agencies also refer applicants to other services where available. For example, the Ministry of Health, encourages applicants to its service to connect with the Survivor Experiences Service if they are looking for somewhere to share their experiences in a safe and supportive environment, leaving the Ministry's process to focus on acknowledgment, payments and supports.

37. All State care claims processes operate in line with the Crown Resolution Strategy, which sets out five principles for resolving claims. However, the principles are set at a high level and while agencies fulfil them for their particular circumstances there is limited consistency across the claims processes in terms of payments and supports available (reflecting the individual care setting), and in some situations within the broader settings as well. For example, in health settings, there are significantly different payments available to those who experienced abuse in the Lake Alice Unit, compared to those who experienced abuse in other psychiatric care settings. The teams operating the claims processes collaborate to try and ensure consistency of communications with and information for survivors.

38. The claims agencies are internally integrated with dedicated teams handling three of the four key functions (acknowledgement, payments, and (to a limited degree) supports,) to ensure information flows and approaches internally are as seamless as possible. There is also integration between some agencies based on the care setting they cover. For example, while MSD manages redress for abuse in child welfare settings prior to 2017, child welfare records are held by Oranga Tamariki. There is a robust process in place for the provision of records from Oranga Tamariki to MSD.

The structuring of redress in international schemes is generally more independent, and involves internally integrated single entities

39. Information on the structuring of four comparable international redress schemes – Australia, Ireland (Republic), Northern Ireland, and Scotland – is set out in Appendix Two. All have established a single redress scheme (entity) although it is important to bear in mind the schemes vary in scope and eligibility, as discussed in the previous paper for the Ministerial Group on redress scope. Importantly, only the Australian scheme provides personal apologies as part of an offer of redress.

40. In terms of independence, the international schemes have approached independence in two ways. Australia's redress scheme is similar to current New Zealand State processes as its redress

entity is based within the Australian Department of Social Services. The only element of independence in the Australian scheme are its independent assessors who make decisions on redress applications. Ireland, Northern Ireland, and Scotland all have a version of an independent Crown entity model, although these entities do not provide all redress functions. In these three examples, legally independent public bodies were established with Ministerially appointed board members (or in the case of Northern Ireland, some appointments are made by the judiciary), who make decisions on redress applications. The entities work in partnership with their respective governments, with administrative and operational support provided by government, and the independent entity making decisions on redress awards.

41. Looking at the degree of integration, all four schemes are fully integrated in the sense that they have one single redress scheme operating an integrated framework in each country, although again it should be noted that the Irish and Northern Irish redress schemes are only open to those who were abused in residential schools.

Independence is important for survivors, but the nature of that independence can be delivered in different ways

The intent of the Design Group's proposals and the Royal Commission's recommendations relating to independence and survivor leadership is to help ensure the integrity and effectiveness of redress

42. When considering the nature of the Design Group's proposals, it was envisioned that the eligibility parameters and frameworks guiding the way in which apologies, payments and services are delivered would be established by a survivor-led group and enacted in legislation to deliver a survivor-led redress system. Once established, the system would be funded through a one-off capital investment to enable the establishment of a charitable trust or non-government organisation which has no further dependence on or accountability to the Crown.

43. The Design Group also envisaged that the entity would operate within legislative parameters and highlighted the importance of the entity being held to account against those parameters. The proposals offer little detail on how the entity would be held to account, for example whether this might be through the civil courts by individual or collective survivor action.

44. The Royal Commission's recommendations highlighted that redress would need to be governed and delivered independently from agencies with current or historic care responsibilities and considered a statutory entity the best mechanism to deliver this. The Royal Commission highlighted that having redress decided by agencies which had either perpetrated or failed to prevent abuse represented a significant conflict that undermined survivors trust in and willingness to access redress. The Royal Commission made no recommendations relating to the monitoring of redress provision.

45. In addition to independence the Design Group also highlighted the importance of survivor leadership. Its proposals envisage a significant role for survivors in the provision of redress at all levels, while the Royal Commission recommended a specific role for survivors in redress governance which reflected the diversity of the survivor population. The Royal Commission also highlighted the importance of having appropriate skills and expertise needed for effective governance.

46. The Design Group's proposals intent, as well as the Royal Commission's to some extent, is to avoid the risk of the Crown comprising the integrity and effectiveness of the redress system, by:

    a. failing to consistently prioritise meaningful funding for redress;

b. seeking to design and operate the system to minimise the cost of redress to the Crown;

c. failing to understand and respond to the needs of survivors through decisions around redress design and operation;

d. being too closely associated with the redress system which may risk survivor confidence in the system; and

e. being too risk averse for fear of loss of public confidence and therefore compromising the ability to design and deliver innovative but potentially higher risk supports and services for survivors.

A fine balance needs to be struck between the Crown's accountability for abuse in care and independence and survivor leadership

47. From the Crown's perspective there are two further matters to consider in relation to independence and survivor leadership:

    a. accountability for key policy parameters and spending;

    b. managing fiscal risks to ensure redress sustainability.

48. While there is a strong desire highlighted in the Design Group's proposals to limit the role of the Crown in the design and operation of the redress system, the Crown ultimately remains politically, legally and morally culpable for abuse in care and the Crown, rather than survivors, should therefore be held accountable for ensuring the effective provision of redress for that abuse. The Design Group's proposals envisage the Crown primarily being held to account through funding redress. However, Crown funding for redress imposes responsibilities on the Crown to be accountable for that expenditure. The Royal Commission outlined a stronger role for the Crown working in partnership with survivors, although with significant distance from care agencies.

49. Crown accountability is particularly important given high survivor expectations, the sensitivity and complexity of redress provision and the likely high and uncertain cost of redress and associated fiscal risks. Additionally, decisions around who redress is delivered to and how it is prioritised could be contentious (with potential disagreement on this matter between different survivor communities) meaning the Crown will need to remain close to policy settings to help ensure appropriate fiscal controls and to avoid survivors having to carry responsibility for those contentious choices.

50. Retaining accountability for the Crown for key redress parameters and spending would not align with the Design Group's recommendations. There are, however, other ways in which to strengthen the role of survivors within this framework. In particular, we consider there should be a central role for survivors within redress system monitoring, in particular providing perspectives on how redress could deliver on the needs and aspirations of survivors, how redress is performing in relation to those needs, and providing perspectives into the design and delivery of relevant redress functions.

51. The previous paragraphs highlight the need for Crown accountability for key policy parameters and Crown spending. However, consideration is also needed on how give effect to the Royal Commission's findings that the Crown has consistently failed to adequately resource redress and therefore the intent behind the Design Group's recommendations for sufficient financial

independence from the State. Officials consider mechanisms need to be explored which could enable affordable and sustainable redress provision across financial years and administrations.

Recommended way forward on independence

52. Reflecting the key concerns for the Crown and the ways in which independence can be defined, and survivor concerns, we are seeking Ministers' feedback on a redress system design with the following features to support independence and accountability:

    a. the Crown retaining accountability for key policy parameters and Crown spending;

    b. redress policy setting and claims decision-making independent of agencies with current or historic care responsibilities (consistent with a number of overseas jurisdictions);

    c. a statutory redress monitoring role for survivors, that could extend to providing perspectives on policy and service design and delivery based on survivors' needs and aspirations;

    d. governance that enables survivors to influence the delivery of redress to help meet the needs of diverse survivors; and

    e. mechanisms which support certainty and sufficiency of funding across financial years and different administrations.

53. Subject to Ministerial feedback, draft redress structure options will be prepared for the draft Cabinet paper for consideration in September. To inform these draft options further design work will also be completed with the Public Service Commission and the Treasury.

Integration supports survivors to have a simple, consistent redress experience, and can help drive overall operational efficiency

Survivors have highlighted the inconsistency in the levels of redress offered for similar abuse in different settings by current claims processes, which undermines the accountability and outcomes achieved by survivors

54. In testimony to the Royal Commission, direct engagements, and in the Design Group's high-level proposals, a number of survivors have highlighted the disparate redress (in particular different payments) offered for similar abuse in different care settings, whether State or non-State. This has significantly undermined many survivors trust in the accountability offered by the existing redress processes – different payment levels imply different views on the severity of what a survivor experienced, or else suggest that redress is being treated in a totally arbitrary manner.

55. Different redress offerings are also likely to be affecting the improved outcomes a survivor can experience from the redress they receive. Where payments are being used by survivors to secure support services to address the impacts of abuse on their lives, different payments naturally affect the services they can procure. For survivors that have experienced similar types of abuse to subsequently be able to afford different levels of support only because of where the abuse occurred creates a significant inequity.

56. Claims processes have developed at different times in response to survivors coming forward with allegations of abuse in different settings. These varied development pathways, which have involved different funding mechanisms and legal considerations reflecting different sectors, have led to the current disparate offerings. Previous attempts by the Crown at harmonisation have

focused on the types of engagement survivors have during the claim process. The redress offered by non-State organisations is similarly varied, without the benefit of any overarching body to support even process harmonisation.

57. There is the opportunity to provide consistency of eligibility and the redress to be offered through, at a minimum, consolidated policy setting by the Crown that includes common frameworks to be used by whatever bodies are providing redress. This would be complimented by coordinated performance monitoring that helps to ensure the common policies are all being consistently and appropriately applied.

Survivors of abuse in multiple care settings have highlighted the difficulty in navigating current State and non-State processes, which undermines the outcomes achieved by survivors

58. Survivors of abuse in multiple care settings have highlighted the significant complexity they face in having to identify and apply to multiple agencies when seeking redress for their full experience. This can start with simply understanding which claims process covers which care setting for which time period. Claims agencies can assist survivors with other processes once they have made initial contact, but this does not remove the fundamental need to engage with different processes.

59. Individual State and non-State processes will generally have their own procedural requirements reflecting their different development as noted above. Along with different demand levels on individual agencies, these procedural differences will typically result in varying timeframes for each process and require survivors to provide different supporting materials or evidence. All of which can be retraumatising for some survivors, undermining their wellbeing and the effectiveness of the redress they eventually receive.

60. In a worst case, some highly vulnerable survivors (in particular intellectually disabled survivors) can 'fall through the cracks' by becoming so confused about the different claims processes that exist and which covers their care that they do not engage with redress at all.

61. There is the opportunity to provide to greater clarity on what redress is available and how to access it. At a minimum this would be via a consolidated directory of redress bodies and how to contact them – with clear information on the care settings each covers, the types of redress available, and the process involved with applying for and being considered for redress. Such a list could be promoted through multiple channels and in a wide variety of formats.

62. One step along from consolidated information would be a consolidated entry point. This would be a service that survivors could contact, share basic information with, and then be assisted to engage with the appropriate redress body or bodies. Such a service could be stand alone or provided alongside an existing service such as the Survivor Experience Service. The active nature of an entry point, compared with a passive directory, would allow for more personalised assistance for survivors with particular needs or complex care histories.

Separate to survivors' direct experiences, integration can support operational efficiencies that allow a higher proportion of funding to go to the redress received by survivors

63. Integration can provide operational benefits, that can assist in managing affordability and risks. At more modest levels, such as consistent standards or common redress frameworks, performance management is simpler with a single set of benchmarks that all redress processes or bodies can be assessed against.

64. At higher levels of integration, such as a redress function consolidated in a single body, it should be possible to achieve economies of scale through reduced duplication and greater specialisation of staff and systems. Such economies should lower overall processing costs for that function, either reducing the overall cost of redress or allowing a greater proportion of funding to go to the payments and supports delivered to survivors.

Higher levels of integration can be achieved alongside different approaches to independence for the redress functions

65. Alongside the proposed positions on independence (paragraphs 52) which allow for different degrees of independence for different functions or groups of functions, there is the potential to apply different degrees of integration to those functions or groups of functions. Having independent survivor leadership of some integrated functions could support more innovative approaches in what and how those functions are delivered. In many cases survivors have significant lived and professional experience that can support more flexible, creative and pragmatic solutions or offerings.

66. Table One outlines three different degrees of integration, what each degree would mean for survivors' experience of redress, and the implications for redress efficiency and cost. The major improvements for survivors' overall experiences – greater consistency and simpler navigation – can be achieved through lower degrees of integration. However, the operational efficiencies that could be achieved through higher levels of integration could be experienced by survivors as faster timeframes in the consideration and processing of applications. Operational efficiencies would also have financial benefits.

Table one. Three approaches to integration for redress functions

Approach	Consistency in what survivors get and who is eligible for redress across all settings, co-ordinated monitoring across all settings, plus better information for survivors about where to go and what to expect	Consistency in what survivors get and who is eligible for redress across all settings, co-ordinated monitoring across all settings, plus a more seamless experience of accessing redress through some consolidated redress functions	Consolidation of all redress functions within one body, under one set of policies on who is eligible for redress and what they get, with a fully seamless experience of accessing redress

Description of approach	• Redress would operate under common policies and frameworks (that define the redress survivors should be able to access), and with common redress performance monitoring.
	• There would be consolidated guidance on the range of redress bodies and the care they cover.
	• Redress would be delivered by multiple bodies (reflecting different care settings or groups of settings) under the common policies.
		• Different bodies would each manage a single redress function or group of functions, , operating under common policies and frameworks.
		• Consolidation would be either by the type of function or the care setting. For example:
		  ○ One agency would focus on a safe listening environment and support services, and another would focus on payments and apologies OR
		  ○ One agency would handle all redress functions for State care settings while other bodies would handle non-State care settings.
		• There would be a consolidated common entry point that provides survivors with a connection into the different bodies
			• All redress functions for both State and non-State care settings would be consolidated in one body.
			• There would be a single set of policies and frameworks

Approach	Consistency in what survivors get and who is eligible for redress across all settings, co-ordinated monitoring across all settings, plus better information for survivors about where to go and what to expect	Consistency in what survivors get and who is eligible for redress across all settings, co-ordinated monitoring across all settings, plus a more seamless experience of accessing redress through some consolidated redress functions	Consolidation of all redress functions within one body, under one set of policies on who is eligible for redress and what they get, with a fully seamless experience of accessing redress
Experiences for survivors	• Survivors would receive consistent redress for abuse across care settings. • Survivors would find it easier to navigate redress, though clear and consolidated information on how to access redress and what to expect. • Survivors of abuse across multiple settings would still need to engage with multiple bodies, but the overall experience across each body should be more uniform.	• Survivors would receive consistent redress for abuse across care settings. • Survivors would find it easier to navigate redress through the common entry point and would have consolidated information on what to expect across redress bodies. • If the grouping was based on care settings, then survivors who had only been in State care would engage with a single body. However, survivors who had been in both State and non-State care settings would still need to engage with multiple bodies but would do so through the common entry point. • Some specific challenges could apply under such an approach, particularly where functions were divided between bodies and there would need to be 'hand off' points for survivors between bodies. If not well designed and supported such points could be traumatic for survivors.	• Survivors would have a single pathway to access redress and would receive consistent redress. • Depending how care providers are connected to redress, there is the potential to limit survivors' choice if they wished to engage directly with a care provider to receive redress. Connections would need to be carefully considered through the detailed design process to preserve survivor choice.

Approach	Consistency in what survivors get and who is eligible for redress across all settings, co-ordinated monitoring across all settings, plus better information for survivors about where to go and what to expect	Consistency in what survivors get and who is eligible for redress across all settings, co-ordinated monitoring across all settings, plus a more seamless experience of accessing redress through some consolidated redress functions	Consolidation of all redress functions within one body, under one set of policies on who is eligible for redress and what they get, with a fully seamless experience of accessing redress
Implications for operation	• Having multiple bodies would not reduce duplication and therefore there would be limited opportunities to reduce operational costs. However, there would be a clearer system-level view of the cost drivers and performance expectations for each body.	• Bodies providing a function would be able to develop more specialist skillsets to provide survivors with higher levels of assistance related to that function. • Along with a clearer view of cost drivers, there would be some potential for reduced duplication and efficiencies of scale for consolidated functions, thereby providing some financial returns. • A common entry point would assist in being able to tailor information available to different groups of survivors that provide clear, accessible messages on coverage, and what to expect from the process and redress available. • A common entry point could add to the complexity of 'back office' operation since it would involve connection with multiple bodies, but would remove the need for individual redress bodies to have a role in connecting survivors with other bodies.	• This approach would avoid duplication and provide the greatest opportunity for finding efficiencies of scale, thereby potentially leaving a higher proportion of funding to be spent on survivor redress. • Care would need to be taken through well-defined frameworks and strong performance monitoring to avoid body scope creep.

Recommended way forward on integration

67. Reflecting the issues set out by survivors regarding inconsistency and complexity of navigation with current claims processes, we are seeking Ministers' feedback on a redress system design with the following features in terms of integration:

    a. at a minimum, a set of common policies and frameworks that set out redress to be provided for abuse in State care, and potentially for abuse in non-State care (subject to options for redress scope);

    b. at a minimum, there is a common entry point or entry guidance for redress that helps ensure survivors have a simple pathway for being connected with redress processes (however those processes are structured 'behind the scenes'), and which assists in tailored, accessible information for specific survivor populations; and

    c. the ability to move towards higher levels of integration over time, both in terms of State and non-State care and redress functions, to help secure operational and funding efficiencies alongside improved redress consistency and navigation for survivors.

68. Subject to Ministerial feedback, draft redress structure options will be prepared for the draft Cabinet paper for consideration in September. To inform these draft options further design work will also be completed with the Public Service Commission and the Treasury.

Redress function structuring touches on other parameters that are yet to be considered by the Ministerial Group

69. The degree of integration and independence can be assisted by the way in which redress is funded. Funding model options are intended to be discussed at the August Ministers Group meeting. Structural options can use a variety of funding models, so the two components can be considered separately without limiting choice in either case. In addition, the feedback sought at this time on structuring can be reviewed in light of subsequent discussion on funding models and adjusted accordingly.

70. Detail for the redress functions will be set out in frameworks covering apologies, payments, and support services – which can include the ability for strong performance oversight, innovation, and risk management. Options for the frameworks are part of the second tranche of intended Cabinet decisions (covering frameworks and the detailed design process), for November 2024. Subject to the Ministerial Group's feedback on the functions, discussion papers will be provided on the frameworks for the September and October Ministerial Group meetings.

71. Function structuring will also have implications for the detailed design process, particularly in terms of the groups that will need to be engaged with and the types of testing. Options for the detailed design process are intended to be part of the Ministerial Group's discussion at its October meeting.

Part C. Next steps

72. Based on the discussion of the decisions and key considerations set out in this paper, draft options for the structuring of redress functions will be prepared. Further advice will be provided at the 21 August Ministerial Group meeting on the remaining decisions on eligibility parameters and redress funding options.

73. A set of draft functions, eligibility, structure, and funding options will then be set out in a paper seeking Social Outcome Committee endorsement in September to engage with the former Design Group and non-State care representatives on the draft options and analysis. Feedback from these groups will then allow for options to be finalised and considered by Cabinet.

74. A draft of the paper will be provided for Ministerial Group review outside the meeting sequence, to support the intended timetable.

Appendix One: Summary of consideration of high-level structuring of redress functions

Key aspects for considering the high-level structuring of functions

Functions

Key considerations:

- The Royal Commission recommended four functions that describe core aspects of redress, along with a recognition that information gathered through redress represents a significant source of insights about failures in care.
- The redress functions reflect what the Royal Commission learnt from survivors, researchers, and other experts about what redress should offer to maximise the opportunity for delivering improved outcomes to survivors.
- Current New Zealand and international redress schemes demonstrate all four redress functions to varying degrees.
- Alongside the redress functions are system functions that speak to the effective delivery of any system, and which the Crown needs to consider for the design of redress.

Redress functions:

- provide a safe, supportive environment for survivors to share their experiences
- facilitate acknowledgements and apologies by institutions for abuse, in care
- facilitate access to support services and financial payments that enable survivor to restore their inherent dignity
- share insights on systemic issues relevant to abuse in care

System functions:

- policy and framework setting (including responsibility for any legislation)
- system governance and stewardship (including accountability for Crown expenditure)
- redress performance monitoring
- overall awareness and accessibility of redress

Independence

Key considerations:

- Independence refers to the degree of distance between redress and care providers or the Crown generally. Current claims processes generally have low levels of independence from current or historic care providers.
- The Royal Commission recommended redress be delivered by an independent Crown entity, while the Design Group recommended redress be fully independent from the Crown. Both considered independence important to survivor confidence in redress and to help ensure the integrity and effectiveness of redress for the longer term.
- The Crown ultimately remains politically, legally and morally culpable for abuse in care and the Crown, rather than survivors, should therefore be held accountable for ensuring the effective provision of redress. Crown funding for redress also imposes responsibilities on the Crown to be accountable for that public expenditure.

Proposed overall position:
Having a level of independence in monitoring, governance, and redress decision-making that supports survivor confidence in the integrity of redress, while maintaining an appropriate level of Crown involvement to discharge its moral culpability and oversight of public financial accountability.

Policy and framework setting
- Crown retains accountability for key policy parameters
- Redress policy setting independent of agencies with current or historic care responsibilities

Redress performance monitoring
- Statutory redress monitoring role for survivors, that could extend to providing perspectives on policy and service design and delivery based on survivors' needs and aspirations

System governance and stewardship
- Crown retains accountability for Crown expenditure
- Mechanisms support certainty and sufficiency of funding across financial years and different administrations
- Governance enables survivors to influence the delivery of redress to help meet the needs of diverse survivors

Redress function delivery
- Claims decision-making independent of agencies with current or historic care responsibilities

Integration

Key considerations:

- Integration refers to the degree of consistency in the way each function is discharged, and the way in which functions are grouped together to be delivered to and experienced by survivors. Current claims processes are generally highly integrated in themselves but have limited integration across each other.
- The Royal Commission and Design Group both recommended a single highly integrated redress system.
- Improved integration would address inconsistency in redress offered for similar abuse in different settings, and the difficulties survivors of abuse in multiple care settings face in navigating multiple processes – both of which undermine confidence in redress and the accountability and outcomes achieved.
- Improved integration could also support operational efficiencies that could support faster process timeframes or provide financial benefits.

Proposed overall position:
Integration that at minimum ensures survivors have a consistent redress experience with clear navigation. 'Back office' integration to be explored as part of the detailed design process with a focus on operational efficiency that helps deliver financial benefit and prompt, effective delivery of redress.

Policy and framework setting
- One Crown agency or body responsible for integrated policy and framework setting

Redress performance monitoring
- Single body discharging statutory redress monitoring role

Redress access
- Common entry point, providing integrated access to redress bodies

Redress function delivery

Spectrum of choices based on different levels of integration:
- Multiple State and non-State bodies delivering redress for different care settings
- One body covering State care settings and multiple bodies covering non-State care settings
- A body covering each redress function for both State and non-State care
- Single redress body covering State and non-State care settings

Appendix Two: Structuring of functions in four international redress schemes

Scheme	Independence	Integration
Australia – National Redress Scheme (current) Scheme functions: *Safe-listening space* Apologies Payments and supports Insights	Scheme entity established through legislation. This followed an agreement signed between federal and state or territory governments in Australia which conferred relevant powers from state-level to federal government. The redress entity is part of the Department for Social Services. *Governance* The Minister of Social Services has overall responsibility for the scheme. Governance, policy direction and minor changes to the scheme are made by the Minister's Redress Governance Board. This is chaired by the federal minister and includes the relevant ministers from each participating state and territory. Voting procedures are spelled out in the agreement between the federal and state governments. Depending on the nature of a change to the scheme, the legislation establishing it may need to be amended. *Operation* The director of the scheme entity, known as the Operator, is responsible for operation of the scheme. They are employed by the Department for Social Services. Decisions on applications for redress are made by independent assessors, employed by the Operator. All other functions are delivered by government departments – the Department of Social Services and Services Australia, with the latter making payments and providing other residual services to the scheme entity.	Fully integrated/one redress entity. The scheme has its own support service which can assist people in making applications. They can also speak with the scheme on behalf of applicants. The scheme has a free legal service ('knowmore' Legal Services) provided by the scheme to assist people in considering their options before applying, and after they receive a decision. The scheme also has a free financial service to assist applicants with the process of receiving a potentially large lump sum payment. Support offered through scheme as part of a redress package is provided at state or territory level with some slight variation in how it is provided depending on location. Support consists emotional and psychological support (counselling) with the amount depending on the severity of abuse which the scheme is acknowledging. Apologies are referred to in the scheme as a 'direct personal response' (DPR). The process for delivering these depends on applicant preference and the scheme will facilitate the creation of a DPR from each responsible institution if the applicant wants them.

Scheme	Independence	Integration
Ireland – Residential Institutions Redress Board (closed) Scheme functions: *Safe-listening space* Payments and supports Insights	Scheme entity established through legislation. *Governance* The RIRB was set up as an independent body. It consisted of a chairperson and ordinary members who were appointed by the Minister for Education and Science. A separate Residential Institutions Redress Review Committee was also set up to conduct reviews of redress awards requested by applicants, whose members were also appointed by the Minister for Education and Science. *Operation* Administrative functions are delivered by government employees. The RIRB and the Review Committee had the ability to hire staff with the approval of the Minister of Education and Science, with consent of the Minister for Finance of the RIRB and the Review Committee. Remuneration for staff was determined by the Minister for Finance. The RIRB convened panels to make decisions on redress applications and also had responsibility for promoting the redress scheme. If applications were successful, the RIRB instructed the relevant parties to make payments. The Department of Education and Science made initial payments (up to € 10,000), and then any remaining balance was paid through the High Court by the Accountant's Office.	Fully integrated/one redress entity. Government-funded support services were available to applicants and were provided by separate organisations. This consisted of access to either a national counselling service or financial advice. The Irish scheme did not provide personal apologies.

Scheme	Independence	Integration
Northern Ireland – Historical Institutional Abuse Redress Board (current) Scheme functions: *Safe-listening space* Payments and supports Insights	Scheme entity established through legislation. *Governance* Applications for redress (the scheme refers to this as compensation) are considered by the Historical Institutional Abuse (HIA) Redress Board, which is an independent "body corporate" which works under a partnership arrangement with the Northern Ireland (NI) Government. The Redress Board is led by President who is appointed by the Chief Justice in NI. The Chief Justice is also in charge of appointing other judicial members of the Board. The NI Government (the Executive Office) is responsible for appointing lay members of the Board. *Operation* Applications for redress are considered by a panel appointed by the President of the HIA Redress Board. Panels consist of a "judicial" member, who chairs the panel, and two other lay members who are not "judicial" - usually from a health and social care background. The panel determines whether and how much compensation to award. Administrative functions are provided by the NI Government, who designated the Department of Justice as the department responsible.	Fully integrated/one redress entity. Support available to applicants is provided by separate organisations. The primary organisation is the Victims and Survivors Support Service, which is a trauma-network established to address other historical traumas, such as the Troubles or the Magdalene Laundries. The Inquiry into Historical Institutional Abuse also recommended the establishment of a commissioner to advocate for and support victims. The commissioner can provide general advice and information about applying to the Board and survivors are encouraged to talk to the commissioner's office prior to applying. The commissioner has a duty to encourage the provision and co-ordination of relevant health and welfare services and must also monitor facilities currently available in NI that provide victims and survivors with services such as health, housing, education, employment, or social security and health services. The Northern Irish scheme does not provide personal apologies.

Scheme	Independence	Integration
Scotland – Redress Scotland (current) Scheme functions: *Safe-listening space* Payments and supports Insights	Scheme entity established through legislation. *Governance* Redress Scotland has statutory independence from the Scottish Government. It is called a "non-departmental public body" in the Scottish system. Legally, Redress Scotland consists of a chair and at least five other members, all of whom are to be appointed by the Scottish Government. It is an "un-regulated" appointment process due the specialist nature of the work. *Operation* Decisions on redress applications (or reviews of decisions) are made by panels convened by Redress Scotland. Secretariat services to support the decision-making processes can be appointed by Redress Scotland itself. The Scottish Government is legally required to provide Redress Scotland with additional administrative support necessary to deliver on its purpose/function. Administrative services necessary to support other aspects of the process (primarily receiving and processing applications, payments and facilitating access to support) are provided by the Children and Families Directorate of the Scottish Government.	Fully integrated/one redress entity. Support available to applicants is provided by separate organisations. As applicants apply for redress to the Scottish Government, all applicants are assigned a case worker who can help them access support entitlements (in addition to facilitating Redress Scotland's assessment of their claim). The entity itself has a support service called the "Emotional Support Helpline" which applicants can call when they are thinking of applying. if applicants require more support, then case workers can refer them to the Redress Support Service which is provided by the In-Care Survivors Alliance. This service has a team of "link workers" who are recruited by the Alliance and trained to support applicants. The Alliance partners with trauma-informed and other relevant organisations/charities to provide these services. This is funded by the Scottish Government. The Scottish scheme does not provide personal apologies.

Agenda Item Four

Redress for Lake Alice Unit survivors who experienced torture and a separate matter relating to inequities in previous settlements

For: Ministerial Group – Crown Response to the Abuse in Care Inquiry

Date: 17 July 2024 **Security level:**

Purpose

1. This paper provides the Ministerial Group with advice on matters related to possible redress for survivors who experienced torture at the Lake Alice Psychiatric Hospital Child and Adolescent Unit (the Lake Alice Unit).

2. It also provides advice on a related Royal Commission recommendation that all Lake Alice settlements be reviewed for parity.

Recommendations

3. It is recommended that you:

   a) **note** Cabinet has agreed Government formally acknowledge that some survivors of the Lake Alice Unit experienced torture [SOU-24-MIN-0072 refers];

   b) **endorse** seeking Cabinet decisions in September on redress for torture at the Lake Alice Unit before wider work on the re-design of redress for survivors of abuse in care is completed;

   c) **endorse** that redress for torture should consist of a new apology which explicitly acknowledges torture, a one-off payment, and access to appropriate support and assistance services, which would align with recommendations from the UN Committee Against Torture (UNCAT);

   d) **provide feedback** on the options for the size of a one-off payment, noting how they would combine with previous average and highest end payments as follows:

      i. $30,000 payment for torture = $100,000 total (average), $150,000 total (highest)

      ii. $50,000 payment for torture = $120,000 total (average), $170,000 total (highest)

      iii. $80,000 payment for torture = $150,000 total (average), $200,000 total (highest)

      iv. $100,000 payment for torture = $170,000 total (average), $220,000 total (highest)

   e) **note** that providing access to support and assistance services needs to be considered in light of what may have already been provided or is currently available to individual survivors, particularly through ACC;

   f) **provide feedback** on the options for resolving the potential complexities with access to appropriate support services for survivors of torture:

i. using the one-off payment for torture as both a payment recognising the experience of torture and funds to access support services; or

ii. facilitating survivors of torture to access existing support entitlements and providing additional support grants to survivors who are unable to do so;

g) **endorse** seeking funding for new redress for torture through a bid for between Budget contingency;

h) **endorse** implementing new redress for torture for the Lake Alice Unit through the existing Ministry of Health historic claims process, with support from the Crown Response Unit (CRU), including to conduct targeted engagement with Lake Alice survivors and advocates as part of the process;

i) **provide feedback** on your preferred approach to resolving the matter of legal fees that were deducted (by their lawyers) from payments to individual survivors who settled with the Crown in the first round of Lake Alice settlements (with subsequent settlements not affected by the same issue):

i. either to endorse resolving this matter now by seeking between Budget contingency funding to reimburse legal fees deducted from round one claimants (recommended);

ii. or to defer decisions on parity in Lake Alice settlements and/or to appoint an independent reviewer as per a Royal Commission recommendation.

Legal privilege

4. This paper includes references to legal advice and should be reviewed for legal privilege before it is publicly released.

The Crown has formally accepted that some survivors of the Lake Alice Unit experienced torture and Cabinet now needs to decide whether to proceed with or defer decisions on new redress for survivors of torture

5. As recently agreed by Cabinet [SOU-24-MIN-0072 refers], the Crown has formally accepted that some survivors of the Lake Alice Unit were tortured, as per the criteria set out in the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (the Convention). The criteria for torture in the Convention are included in Appendix One.

6. This decision is being communicated directly to key survivors in confidence and will be set out in the speech the Lead Coordination Minister for the Government's response to the Royal Commission makes at the time of the tabling of the Royal Commission's final report.

7. Cabinet now needs to make decisions on if and what specific new redress should be provided to survivors of the Lake Alice Unit who experienced torture and when it wants to make those decisions. The finding of torture represents a new material circumstance meaning that while some survivors have already received redress for their experiences in Lake Alice (see Appendix One for an overview the previous and ongoing settlement process), a new, specific response is required in order to acknowledge all that occurred. Such a response should be offered to those who experienced torture, even if they have had a settlement under the existing terms.

8. While the previous settlements and ongoing claims process do recognise the abuse experienced by Lake Alice survivors, including the abuse which meets the definition of torture, the process does not explicitly acknowledge torture or directly provide access to rehabilitative support services. Lacking these two components was central to the findings against New Zealand by the UNCAT, in its rulings on the individual complaints made by two Lake Alice survivors, Paul Zentveld in 2020 and Malcolm Richards in 2022. The other findings related to failures to conduct prompt and impartial investigations into the individual's complaints.

9. The two broad options for when to make and implement decisions on torture-specific redress are:

   a) as soon as practicable, with redress ideally offered inside of the 2024 calendar year; or

   b) as part of wider work to redesign redress for survivors of abuse in care, with this likely to be finalised through Budget 2025 or 2026 and subject to wider decisions considered by Cabinet.

10. Advice on the timing of decisions on redress for torture was provided to the Lead Coordination Minister for the Government's Response to the Royal Commission as part of the development of the Cabinet paper acknowledging torture. It was noted that there are risks with each of the timing options.

11. The primary risk associated with making and giving effect to decisions on redress for torture now is that decisions on torture-specific redress would be decided independent of decisions on what redress might be available for other survivors through an improved redress system. The result of this could be that torture-specific redress is ultimately out-of-line with subsequent decisions. Additionally, survivors who are currently accessing redress through other agencies claims processes (and other health settings covered through the Ministry of Health process) could have a sense of unfairness that Lake Alice survivors, who have already received higher payments on average, are receiving further payments and support.

12. The primary risk associated with deferring decisions on specific redress for torture is potential further harm to Lake Alice torture survivors who are increasingly aged and unwell. Survivors have also been awaiting decisions on redress for several years – the UNCAT findings in the case of Paul Zentveld were issued in January 2020 and the Royal Commission's report on the Lake Alice Unit was published in December 2022. There are also reputational risks that would result from the Crown's treatment of survivors who experienced torture and with New Zealand's international standing similarly impacted through ongoing criticism from UNCAT, with the potential for new or further complaints to UNCAT if the matter is not resolved. This could impact on survivor confidence in the Government's commitment and ability to deliver an effective overall response to the Royal Commission, which could adversely impact the wider redress redesign process.

13. We recommend the Ministerial Group endorse seeking Cabinet decisions on redress for torture as soon as practicable. Recognising that there are risks associated with each option, the likely harm to Lake Alice Unit torture survivors and the reputational risks to the Crown, and the small and highly specific nature of this cohort of survivors, suggest prioritising decision redress for torture presents the least overall risk to the Crown. This timing presents an opportunity to respond to a matter of long-standing concern, distress and advocacy. It also provides an opportunity to demonstrate decisive action by this

administration following the several years survivors have been waiting since the initial UNCAT recommendation.

14. Prior to the receipt of the final report from the Royal Commission, there was also some concern around whether the costs of providing torture-specific redress might be higher than anticipated if the Commission surfaced more instances of torture. Crown Response officials have reviewed the final report and it does not contain any specific findings of torture akin to what happened at Lake Alice. The Crown will also continue to review historical claims presenting to existing services to identify any allegations of torture. Nonetheless, any redress for torture agreed for Lake Alice survivors would set a precedent for acknowledging torture in other settings, whether delivered as a standalone process or as part of wider changes to redress.

If Cabinet wishes to proceed with making decisions now on torture-specific redress, this package should consist of a new apology, a one-off payment, and access to appropriate support services

15. Drawing on material on reparations under the Convention and Royal Commission recommendations on redress, an offering of redress for torture should consist of: an apology or acknowledgement, a payment, and access to appropriate support and/or rehabilitative services. Individual survivors would then be able to determine which components of such an offering they wished to receive.

A new apology to survivors that explicitly acknowledges torture

16. Previous apologies provided to Lake Alice Unit survivors (signed by the Prime Minister and Minister of Health at the time of settlement) describe experiences at the institution in very general terms, consistent with the approach previously agreed by the government (working with the lawyers for the survivors) in 2001. Describing matters in a general way has left some survivors feeling that the apology did not adequately acknowledge their experiences. A copy of the text of the current apology is included in Appendix One.

17. The first component of a torture-specific redress offering should therefore be a new apology that explicitly addresses torture and acknowledges experiences at the Lake Alice Unit at a greater level of detail, drawing on Royal Commission's findings. The apology would still need to describe experiences at a collective rather than individual level, and careful balancing would be required between recognising the testimony of survivors while avoiding definitive statements about former staff in the absence of any successful prosecutions, particularly since most former senior staff (including the Lake Alice Unit's head, Dr Selwyn Leeks) are deceased or unfit to respond to allegations. A new apology to the survivors who made complaints to UNCAT, Paul Zentveld and Malcolm Richards, should also acknowledge their unique circumstances and role in this matter.

18. Subject to Ministerial feedback on an overall redress offering, the CRU can produce a draft text, working closely with Crown Law and other relevant agencies, for consideration by the offices of the signing Ministers and the Attorney-General (who has responsibility for matters relating to torture). Following initial Ministerial review, the draft text would need to be tested with some Lake Alice Unit survivors or their representatives to ensure it is not re-traumatising and speaks to the nature of their experiences.

19. If the Government agrees to a new apology, following the approach taken to the previous apology, we recommend it is signed by the Prime Minister, Minister of Health, and Lead Coordination Minister.

20. While the new apology described here would be provided individually to survivors who experienced torture, it is anticipated that the planned public apology by the Crown for abuse in care will speak directly to the experiences in the Lake Alice Unit, which will facilitate wider dissemination of the Crown's regret on this matter.

A one-off payment that recognises torture

21. The second component of a new redress offering should be a one-off payment that, alongside the apology, acknowledges torture. The payment ultimately serves two purposes. Firstly, it explicitly acknowledges those survivors who experienced abuse that has since been classified as an act of torture. Secondly, it expresses the Crown's regret that, due to the failure to conduct prompt and effective investigations, no successful prosecutions were achieved in relation to torture at Lake Alice meaning survivors never saw the accountability that can be provided through a judicial process.

22. 9(2)(h) [redacted] However, there have been no previous payments for torture in New Zealand and there are no directly comparable international cases that could serve as a precedent. Determining what the appropriate value is for a one-off payment recognising torture is inevitably a fraught and somewhat arbitrary process. A new one-off payment would also be in addition to the payment made for the overall experiences of abuse that are recognised through the previous settlements or those available to new claimants under the current claims process operated by the Ministry of Health, which adds further complexity to determining payment levels in this situation.

23. 9(2)(h) [redacted]

24. Other payments in the current domestic context can also be looked to. The maximum payment provided to date by the Ministry of Social Development (MSD) Historic Claims process is approximately $90,000 and the maximum lump sum payment available through ACC is approximately $173,180, although neither of these schemes acknowledge torture. MSD Historic Claims offers one-off payments to acknowledge breaches of the Bill of Rights Act. The main breach relevant to the historic claims context relates to the deprivation of liberty and applies to young people who were detained in secure confinement while in care. Payments of $4,000 or $8,000 are available depending on the care setting.

25. Looking to overseas redress schemes, the highest payment in the Australian redress scheme for institutional sexual abuse is AU$150,000 (NZ$165,000). While not addressing torture, the highest payment recognises cruel sexual abuse with a number of compounding factors. The Northern Irish redress scheme for abuse in residential schools, which pays a

fixed amount of £20,000 (NZ$42,000) to any survivor who had been deported to Australia as part of the so-called 'Child Migrant Programme'. This £20k payment is provided in addition to the scheme's stepped payments which recognise the severity of abuse in care (which range from £10,000 to £80,000); so, a survivor in Northern Ireland who experienced abuse which qualifies for the highest payment and who was sent to Australia under the Child Migrant Programme is entitled to a payment of £100,000 (NZ$209,000).

26. As there is an unavoidable, public-facing dimension in deciding the level of a payment acknowledging torture, in addition to the suggested $30,000, we include three more generous payment levels for consideration by Ministers. A $50,000 payment would see the redress payments for survivors of torture align more closely with the highest payment in the Australian redress scheme. An $80,000 payment would see payments align more closely with the highest payment in the Northern Irish (and Scottish) redress scheme for abuse in care. A $100,000 payment would represent an exemplary figure that goes beyond comparable examples here or overseas.

27. Combining these three one-off payment options with the average and highest Lake Alice payments ($70,000 and $120,000) helps to give a sense of what the total redress payment to a survivor of torture at Lake Alice might look like:

    a) $30,000 payment for torture = $100,000 total (average), $150,000 total (highest)

    b) $50,000 payment for torture = $120,000 total (average), $170,000 total (highest)

    c) $80,000 payment for torture = $150,000 total (average), $200,000 total (highest)

    d) $100,000 payment for torture = $170,000 total (average), $220,000 total (highest)

28. We ask the Ministerial Group to endorse the inclusion of a one-off payment in any new redress offered to recognise torture. We also ask Ministers to provide a steer on which payment options you would like further analysis on – whether the four options included here or different options you would like considered.

Access to appropriate therapeutic and assistance services for the experience of torture

29. The third component of a redress offering for torture should be providing access to appropriate support services. In material published by the UNCAT to assist in the application of the Convention it noted that redress for torture should include rehabilitation. The Royal Commission also recommended that any offer of redress for abuse in care should include providing survivors of abuse with access to a range of support services.

30. Examples of appropriate support services that survivors of torture at the Lake Alice Unit might need (or want) access to include:

    a) medical costs associated with conditions arising from the abusive use of ECT and paraldehyde injections, such as a urological examination and/or surgery, or neurological examination and cognitive therapy;

    b) dental costs to address oral health issues or operations such as hip-replacements, that would lead to significantly improved quality of life and which potentially address physical conditions that have their roots in the abuse and ill treatment experienced at the Lake Alice Unit; and/or

    c) home modifications to help address accessibility issues arising from chronic health conditions or impairments.

31. Decisions around supports for torture survivors need to be made in light of what support is available, through ACC in particular but also other health and disability services. As Ministers are aware, ACC is a scheme which provides financial compensation and/or support services to people who have suffered an eligible physical or mental injury (or injuries) caused by certain events. The most obvious 'event' covered by ACC is an 'accident', such as a fall or an incident at work. ACC has a sensitive claims process which covers mental injuries sustained from sexual assault (such as PTSD). ACC also covers injuries caused by medical treatment[1] if the injury is not an ordinary consequence of the treatment.[2]

32. A key driver of the uncertainty about what Lake Alice survivors might have received up to this point, or might be entitled to in future, is that this would always depend on a survivor's needs and eligibility. Moreover, a fundamental feature of ACC is that it is a no-fault scheme. As such, it requires evidence to show that a claim meets the cover criteria but does not require further information beyond that. The practical implication of this is that the data held by ACC does not necessarily identify where a claim relates to Lake Alice.

33. We have anecdotal information from some Lake Alice survivors that they are accessing ACC, although as referenced above, in at least one case this required court action to confirm eligibility. We are also aware of some survivors who due to the ongoing trauma from their experiences struggle to engage with services such as ACC and Work and Income. Speaking generally, survivors of Lake Alice, and particularly those who experienced improper use of ECT or paraldehyde injections, could be able to access a range of potential support services (and potentially financial entitlements), depending on need and eligibility criteria. Given the data limitations described above, this means the only way to know for sure what Lake Alice survivors themselves have received from ACC would be to ask the individuals themselves.

34. This suggests that the support component of redress for torture at the Lake Alice Unit could be more a question of facilitating access to existing support entitlements (through ACC or other systems), rather than directly funding or providing (new) support services through a redress process. It is nonetheless important that any new redress agreed for survivors who experienced torture at the Lake Alice Unit resolves issues around access to appropriate support services. As noted previously, failing to provide the two survivors who made complaints to UNCAT with access to rehabilitation was central to the findings against New Zealand in both cases.

35. We therefore recommend that the Ministerial Group endorse that redress for torture should include access to appropriate support services, including rehabilitation, to ensure that a new redress package agreed for survivors of torture aligns with our domestic and international obligations. However, because survivors' entitlement to existing support services through ACC is uncertain and will vary depending on individual circumstances, we ask the Ministerial Group to provide feedback on the preferred way to proceed in light of this complexity.

[1] Injuries caused by torture at Lake Alice would not be classified as medical injuries in the ACC system because the use of ECT or paraldehyde was not done for legitimate medical purposes.

[2] As clarified in a recent court case, injuries caused by torture at Lake Alice are not classified through the ACC system as unexpected medical injuries, because the use of ECT or paraldehyde was not done for legitimate medical purposes.

36. One approach would be to opt for a higher one-off payment for torture and to describe it as both a payment recognising the experience of torture and funds to access support services. This approach would be easier to implement in terms of administration, as the claims process would not need to have a support 'function'. But this approach could result in (unintended) equity issues: for example, a survivor who was unable to access funded support services would need to use more of their one-off payment to pay for this than a survivor who was able to access all they needed through ACC.

37. An alternative approach would be to assist survivors who come forward to make a claim for torture-specific redress to connect with independent navigation services like 'Way Finders', which are designed to help individuals quickly identify what they might be entitled to under ACC. A support grant could then be provided to survivors who can demonstrate they are unable to access the services they need through an independent navigation service. This approach would mitigate against any unintended equity issues in using the one-off payment to pay for support access. It would be important to emphasise that a support grant would be only available in exceptional circumstances. Decisions would also be needed on the size of the grant and how it would be funded.

There is uncertainty around how many survivors of the Lake Alice Unit were tortured, so two possible scenarios are used to indicate potential costs

38. The Royal Commission has identified 362 children and young people who spent time at the Lake Alice Unit. This total includes children and young people who only spent short periods in the unit, as well as others who spent much longer. As previously noted, 203 survivors have had settlements from the Crown and four claims are currently being considered (the Ministry of Health holds names of all survivors that have received settlements or have a current claim under consideration). Due to the limited nature of information set out in medical records, it is not definitively known which of the children and young people who spent longer periods at the Lake Alice Unit received ECT or paraldehyde injections as punishment.

39. In its report on the Lake Alice Unit, the Royal Commission discussed three groups of survivors, one of 15 individuals who had ECT administered to genitals and breasts, one of 16 individuals who had ECT administered to their arms, hands, shoulders, thighs, legs and feet, and an unspecified number of children and young people that received paraldehyde injections as punishment. The degree of overlap between the three groups was not discussed. Taking the two ECT groups as separate victims and assuming that a similar number (approximately 15-20 survivors) may have been separate victims of paraldehyde injections would give a conversative minimum of 50 survivors potentially eligible for redress for torture.

40. For an upper number, we have suggested using 100 possible claimants. This figure represents just under half of the settled claimants so far and therefore those who would likely have experienced more serious abuse than the 'average' under the payment framework developed in the early 2000s. In addition to public statements made about any new redress offering, the tabling of the final report in Parliament, campaigning by advocacy groups such as the Citizen Commission on Human Rights, and the networks between Lake Alice survivors all suggest it is worth planning for a higher-than-expected demand scenario.

41. However, as the Cabinet paper on acknowledging torture noted, many survivors who spent time at Lake Alice have died or may be incapable of coming forward. Some survivors who

settled with the Crown in the early 2000s may also have chosen to put this part of their life behind them and may not wish to come forward, even if a new offer of redress is made. Any offer of redress to survivors would need to encourage them to come forward about their experiences.

42. The following section on funding for potential redress for torture therefore uses two estimates – 50 and 100 survivors – for costing purposes.

Providing new redress for torture would require new funding to be sought from the between Budget contingency or as a pre-commitment against Budget 2025

43. Potential costs involved with providing new redress for torture would not be able to be met from existing baselines, except for the costs associated with creating and delivering a new apology to survivors who were tortured. The Ministry of Health has budgeted to pay up to five new Lake Alice settlements from its Legal Services budget for 2024/25 ($350,000) and the CRU has no funding for making redress payments.

44. If Ministers agree to torture-specific redress, then funding could be sought from the between Budget contingency for 2024/2025 or as a pre-commitment against Budget 2025.[3] We recommend the Ministerial Group endorse seeking funding from the between Budget contingency.

45. New funding would need to be sought for Vote Health to allow for any new payments and, depending on further work to better understand existing entitlements, access to support services. A new redress process for survivors of torture could be delivered alongside the existing Lake Alice claim process, but the Ministry of Health have advised that this would also require additional resourcing. The existing service operates with very minimal staffing levels and does not currently have a 'support' function. Key considerations on how any new redress could be delivered are discussed in the next section of the paper.

46. Drawing on the potential redress components outlined above, Ministers could agree an overall funding level per survivor. Table One shows the potential cost of payments using the two demand estimates and per survivor costs informed by the payment examples set out earlier. Note that the figures below do not factor cost of any new support offered to survivors of torture or administration costs, as that is still to be worked through.

Table One: Potential overall cost of providing redress for torture at the Lake Alice Unit

Per survivor cost	Number of claimants	Overall cost
$30,000	50	**$1,500,000**
	100	**$3,000,000**
$50,000	50	**$2,500,000**
	100	**$5,000,000**

[3] Seeking funding from the between Budget contingency involves writing a letter to the Minister of Finance with a funding request template (similar to that used in the Budget process). Requests for funding from the between Budget contingency must demonstrate that the request is of high value, urgent, and cannot be met from within baselines. Seeking a pre-commitment against Budget 2025 would require a Budget funding case to be completed, with funding then approved for the 2024/25 year.

Per survivor cost	Number of claimants	Overall cost
$80,000	50	**$4,000,000**
	100	**$8,000,000**
$100,000	50	**$5,000,000**
	100	**$10,000,000**

Proactive engagement with Lake Alice survivors could support the design and implementation of any new redress within parameters agreed by Cabinet

47. If Ministers agree to specific redress for torture, we recommend that redress for the affected Lake Alice Unit survivors is delivered through the Ministry of Health's existing claims process, with support from the CRU in designing the new redress offering, to help ensure it meets the Crown's core objectives for redress [CBC-24-MIN-0050 refers]. Ahead of Cabinet's consideration of redress for torture, work would need to identify what additional administrative and support resources the Ministry of Health would require in order to offer any new redress. The CRU would be able to utilise existing relationships with some Lake Alice Unit survivors, advocates, and relevant experts, to help manage the time and cost associated with engagement, including absorbing a level of cost within baseline.

48. We also recommend the Crown engage with survivors on the detailed process for delivering such redress. Engaging with survivors on the specific composition and delivery approach for redress could help the Crown avoid being seen to be overly prescriptive. Moreover, as survivors and the Crown may have highly variable expectations on what meaningful redress looks like, this reinforces the benefit of close working with survivors and their advocates, as it presents opportunities to work through different considerations as part of the process.

Separate to the matter of redress for torture, the Royal Commission recommended a review into previous Lake Alice settlements for parity

49. In its final report, the Royal Commission recommended that the government should:

    a) appoint an independent person to promptly review all Lake Alice settlements and advise whether any further payments to claimants who have previously settled are necessary to ensure parity in light of the District Court decision in 2005 regarding the deduction of money from second round claimants for legal costs

    b) ensure that any payments to claimants who have not yet settled are, as a minimum, equitable in light of the review.

50. As noted previously, Lake Alice survivors who settled with the Crown in the first round had approximately 40 per cent deducted from the total settlement by their lawyers Grant Cameron & Associates, and therefore their individual payments, for legal costs. While the same approach was initially followed for the round two settlement process, this was subject to successful legal challenge and resulted in a decision by the Crown to repay legal fees deducted from round two claimants.

51. There are two options to resolve the matter of parity in previous settlements. Our recommended approach is for Ministers to agree that the equivalent value of the legal costs deducted from round one payments be put in a contingency fund. Round one

claimants could then be invited to come forward and make a claim for reimbursement. The original settlement totalled $6.8 million and so the 40 per cent deduction would therefore require $2.6 million in total to cover the legal fees for the full 95 claimants, although as discussed below, it is very unlikely that all of this would be needed. Funding to reimburse the legal fees would need to be sought from the between Budget contingency or as a Budget 2025 pre-commitment.

52. We cannot say with certainty how many survivors from the first settlement round are still alive or might come forward to make a claim for repayment, however, it will be fewer than 95. Using mortality rates for people in the same age group would suggest around 70 might still be alive, although this does not consider the additional factors at play with the Lake Alice cohort (such as having long-term medical conditions or impairments), meaning the number of potential claimants is highly likely to be lower still. When the Crown was seeking to repay round two claimants their legal fees, the Ministry of Health was unable to locate around 25 per cent of the round two claimants despite the offer of repayment and the use of a private investigator. The process for locating round two claimants also took place only a few years after settlement, whereas it is now approaching 24 years since the first round of settlements were made.

53. We also do not propose that an offer of legal fees repayment is extended to the families or estates of deceased survivors in the situation where a survivor from round one has passed away. A new offer to round one claimants would essentially mirror the process that took place for round two claimants, which only offered repayments directly to the individuals who settled in the second round.

54. This option supports an approach which aims to resolve all outstanding matters regarding the Lake Alice Unit at the same time. It is likely that any independent review of Lake Alice settlements, given the facts of the matter, would suggest additional payments are necessary to ensure parity across the settlement groups and the review itself would also require funding. Resolving this now would address a longstanding equity issue for those survivors and there would be challenges with delaying decisions on the legal fees matter if the decision is made to proceed with redress for torture as soon as practicable. In any engagement with round one claimants, it is very likely they would raise the matter of legal fees, especially given the recommendation from the Royal Commission in its final report.

55. On the other hand, Ministers could defer decisions on this matter for now, particularly if the preferred way forward is to appoint an independent reviewer. Despite other claimants not being subjected to the same legal costs deduction, it is possible that paying the top-up to round one claimants could result in other claimants feeling they have missed out.

Next steps

56. Subject to the views of the Ministerial Group, Crown Response officials can undertake the necessary work and analysis required to prepare a Cabinet paper which seeks agreement on an approach to redress for torture at the Lake Alice Unit.

Appendix One: Background material on the Lake Alice Unit

The three elements of torture in the Convention

1. The three elements of torture in the Convention Against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment are:

   a) any act causing severe pain or suffering, whether physical or mental;

   b) intentionally inflicted for such purposes as:

      i. obtaining from the victim or a third person information or a confession;

      ii. punishing them for an act they or a third person has committed or is suspected of having committed;

      iii. intimidating or coercing them or a third person; or

      iv. for any reason based on discrimination of any kind; and

   c) the pain or suffering is inflicted by or at the instigation of or with the acquiescence of a public official or person acting in an official capacity.

2. Cases were taken to the UN Committee Against Torture (CAT) by Paul Zentveld and Malcolm Richards and resulted in findings against New Zealand. The CAT determined (in reports issued in 2019 and 2022) that in the two cases New Zealand had breached Articles 12, 13, and 14 of the Convention for each survivor. Articles 12 and 13 require states to have complaint processes and to conduct prompt and impartial investigations by competent authorities. Article 14 requires states to provide redress with a right to fair and adequate compensation.

Previous and current Lake Alice Unit settlement processes

3. The Crown has engaged in two rounds of settlements for Lake Alice survivors to date, the first in 2001 and the second in 2002/3. The Ministry of Health maintains a process for assessing and settling any new claims that arise, in accordance with a 2009 Cabinet decision [CAB Min (09) 41/4 refers].

A. Round one settlement
In 1999, 88 former Lake Alice Unit patients, represented by Grant Cameron & Associates, filed a joint statement of claim in the High Court. The claim had four causes of action: breach of fiduciary duty, unlawful confinement/false imprisonment, assault and battery, and negligence. The causes of action related to allegations of the use of electroconvulsive therapy and paraldehyde injections as punishments, sexual and physical abuse by staff, staff permitting sexual and physical abuse by other patients, unlawful confinement, administration of medical treatments without consent, and perpetrating and maintaining an environment of extreme fear. In early 2000, the Government determined it would compensate and apologise to former Lake Alice Unit patients rather than defend the claim in the High Court. In October 2000, $6.5 million was approved for settlement with 95 claimants (the 88 former patients that had filed and seven other former patients that had since come forward). The Crown appointed retired High Court judge Sir Rodney Gallen to determine how the settlement monies should be divided among the claimants.

Sir Rodney considered the claimants' described experiences to determine how the settlement funds might be distributed. He produced a report about his assessment, which provided general comment on the experiences and the methodology he had used to allocate the settlement monies. Grant Cameron & Associates deducted approximately 40 per cent of the settlement amount in legal costs. The amounts paid out to individuals was strictly confidential and the Crown does not have specific details of individual amounts paid to claimants.

Following the settlement, the then Prime Minister and Minister of Health wrote to each claimant and apologised on behalf of the Government for their treatment in the Lake Alice Unit (see below for the text of round one apology letter).

B. Round two settlement

The Government decided in 2001 to take steps to settle any outstanding or potential claims by former patients of the Lake Alice Unit. The process was to involve an apology and a confidential settlement process broadly similar to the round one settlement of the class action.

Sir Rodney was again instructed by the Crown to consider claimants' experiences and make a determination on the payment amount to be made in line with the principles and criteria he established for the round one process. Sir Rodney was instructed to take into account the absence of substantial legal costs to new applicants.

The round two settlement saw 98 former Lake Alice Unit patients collectively receive $6.3 million in compensation up until 2008. The average settlement was approx. $70,000.

Mr Zentveld filed proceedings in 2005 challenging the instruction to take into account the legal costs deducted from the round one settlement when considering the payments to be made under the round two process. The District Court found for the complainant, which resulted in the reduction applied to the round two payments being reworked. Round two claimants were then being paid an additional approximately 30 per cent on their initial settlement amounts.

C. Individual claims

The Ministry of Health maintains an ongoing process for any new Lake Alice Unit claims that come forward. There have been 9 further settlements since round two was completed in 2008 – an average of one new Lake Alice Unit claim per year.

Claims are assessed against the principles and criteria established for the round two settlements, with the payment determined by the Ministry of Health's Chief Legal Advisor. The average settlement is $68,000. The payment is accompanied by a written apology from the Prime Minister and Minister of Health.

Lake Alice settlement funding has been exhausted and costs for the ongoing claims process are currently met from the Ministry of Health's Legal Services budget on the estimate of two settlements per year maximum.

The Ministry currently has five outstanding new claims under consideration.

Example of an apology letter provided to a Lake Alice Unit survivor

Dear [survivor name]

We are writing to you personally on behalf of the Government of New Zealand to apologise for the treatment you received and may have witnessed in the Child and Adolescent Unit of Lake

Alice Hospital during the 1970s. We are apologising to all those who were mistreated. We believe it is important to take this step, to enable us to move on from shameful practices in mental health care in New Zealand.

You may be aware that the events at the Child and Adolescent Unit of Lake Alice Hospital have been the subject of investigation. As a government we have been determined to acknowledge what happened and to take what steps we can to put things right. We have publicly stated that, whatever the legal rights and wrongs of the matter, and whatever the state of medical practice at the time, what happened there was unacceptable. On behalf of the Government of New Zealand we sincerely apologise to you as a person fundamentally affected by what occurred in the Lake Alice

We hope that this apology will affirm to you that the incidents and events that you experienced and may have witnessed at the Child and Adolescent Unit at Lake Alice Hospital were not only inappropriate, even if judged by the standards of the day, but were also terribly unfortunate. They should not have happened. We very much regret that they did.

We know that this apology cannot change the past, but we do hope it will go some way towards enabling you to move on from your past experiences. In the same spirit we hope that the ex gratia payment the Government has made to you will be of some tangible help.

We wish you all the very best for a positive future.

Yours sincerely

Rt Hon Helen Clark — Prime Minister of New Zealand

Hon Annette King — Minister of Health

Agenda Item Five

Listening, learning, changing
Mā Whakarongo me Ako ka huri te tai
Crown Response to the Abuse in Care Inquiry

Treaty of Waitangi considerations in the public apology

For: Ministerial Group – Crown Response to the Abuse in Care Inquiry

Date: 17 July 2024 **Security level:**

Purpose

1. This paper responds to questions raised at the Ministerial Group for the Crown Response to the Abuse in Care Inquiry (the Ministerial Group) meeting of 29 May 2024, regarding:
    - whether concessions or acknowledgements of Treaty breach should be included within the public apology to be made by the Prime Minister in the House on 6 November 2024; and
    - what liability implications might arise from the apology in general.

Recommendations

2. It is recommended the Ministerial Group:
    a. **note** the final report and the findings and recommendations of the Royal Commission have now been received and they contain multiple findings of Treaty breach;[1]
    b. 9(2)(h) [redacted]
    c. [redacted]
    d. **note** inclusion of a concession of Treaty breach in the public apology presents an opportunity to acknowledge the historical context that helps to explain why disproportionate numbers of Māori were placed in care. The Royal Commission's final report sets out what it considers is the connection between this disproportionality and the Crown's historical role in eroding the ability of Māori whānau and communities to care for and protect tamariki and rangatahi so that they were not in need of state intervention in the first place;

[1] Excerpts and a summary of the Royal Commission's Treaty findings are attached as an appendix.

e. **direct that** either:

- drawing on the provisional work undertaken to date by Crown Law and Te Arawhiti, work is progressed at pace to determine what factual findings related to the Treaty the Crown agrees with in order to enable consideration of concessions of Treaty breach as part of the public apology (recommended by the Crown Response Unit);

Or

- the response to the Royal Commission's findings of Treaty breach should be developed as part of the wider response to the final report, noting this work would not likely be completed in time to allow consideration of the inclusion of Treaty findings in the public apology;

f. 9(2)(h)

g. 

At the Ministerial Group meeting on 29 May, Ministers raised questions around anticipated commentary on Treaty breaches in the Royal Commission's final report

3. At the Ministerial Group meeting on 29 May, there was an initial discussion of anticipated commentary by the Royal Commission on Treaty of Waitangi breaches relating to abuse of Māori while in care.
4. Crown Law and Te Arawhiti have had work underway on this matter since 2023, in response to:
   a. findings in the Royal Commission's interim reports of possible Treaty of Waitangi breaches from abuse in care; and
   b. feedback from some survivors who are close to the work of the Royal Commission and who the Crown Response Unit (the CRU) has engaged with that the public apology should acknowledge a Treaty breach.
5. One of the aspects of this work was if and what could potentially be reflected on this matter in the public apology scheduled for November.

6. At the Ministerial Group meeting, Ministers raised questions around the role of the Royal Commission in relation to findings of Treaty of Waitangi breaches and the possible implications of making a Treaty breach concession. This included identifying any legal risks associated with a concession of Treaty breach made outside of a Treaty settlement or Waitangi Tribunal process, and whether a Treaty breach concession would enable iwi and hapū access to redress for abuse in care.

7. 9(2)(h)

8. 

This briefing outlines advice in response to these questions, including setting out the findings of Treaty breach made in the Royal Commission's final report

9. Since Ministerial Group discussion on this, the final report of the Royal Commission has been provided. It includes a series of findings of Treaty breach. In setting out their findings, the Royal Commission first states that, under their Terms of Reference, they were directed 'to apply te Tiriti and its principles' to its work. This is particularly as 'tamariki, rangatahi and pakeke [adult] Māori are taonga' and 'te Tiriti o Waitangi o Waitangi colours all legislation dealing with the status, future and control of tamariki, rangatahi and pakeke Māori.'[2] Further, their view is that the experiences of so many Māori in care meant they had no option but to make extensive findings of Treaty breach.

10. This includes questioning whether the scale of Treaty breach could be said to add up to cultural genocide. They note that equivalent Royal Commissions or Commissions of inquiry in Canada and Australia have made findings of cultural genocide targeted at indigenous peoples, and they do not consider conditions in New Zealand to be very different from the settings and experiences that led to those findings in Canada and Australia.

11. Having posed this question, they do not make a specific finding of cultural genocide, while setting out that they consider there is '[s]trong evidence of numerous breaches of te Tiriti and its principles'. These breaches caused significant detriment to many

[2] *Whanaketia* Part 6, *Te Tiriti o Waitangi and Human Rights, Te ture i raurangi rā* para 8(b)

Māori in care, and to their whānau and to next generations. They state that 'The Inquiry is profoundly concerned about this conclusion.'

12. Specifically, in part 6 of its report, *Te Tiriti o Waitangi and Human Rights, Te ture i raurangi rā*,[3] the Royal Commission finds:

    a. There 'is a grave breach' of the Crown's obligations of active protection.

    b. Significant neglect of the Treaty in the design, development and implementation of the care systems. They find this breaches the principles of tino rangatiratanga, kāwanatanga, partnership, active protection, options, equity, equal treatment, good government and redress.

    c. Breach of how the Crown should have legitimately exercised kāwanatanga, requiring the Crown to foster rangatiratanga and ensure laws and policies were just, fair and equitable.

    d. Breach of the principle of options; this includes through the lack of kaupapa Māori options as part of the care systems. This is particularly where the Royal Commission consider there is 'a serious question whether aspects of the care system contained elements of cultural genocide… the laws and practices of removing tamariki, rangatahi and pakeke [adult] Māori involved elements of both systemic racial discrimination and cultural genocide'.

    e. Breach of the principle of equity and equal treatment, evidenced by disparities in abuse and the disproportional impact on Māori and the effect of racism.

    f. Breach of the principle of good government, considering the Crown was 'or should have been aware of the abuse and neglect suffered by Māori while in care'.

    g. That the Crown stripped Māori of their cultural identity through structural racism, and this breached the guarantee of tino rangatiratanga and the principles of kāwanatanga, partnership, active protection and equity.

    h. Failure to uphold the principle of redress, including through ongoing failures to provide consistent redress processes and to address breaches in respect of the care system more broadly.

    i. More broadly, the Royal Commission finds that 'it is clear the Crown has acted in excess of its kāwanatanga powers and breached te Tiriti in a number of ways. The Crown failed to transform the care system in a manner that would uphold rangatiratanga and reflect a true partnership'.

    j. These breaches, the Royal Commission finds, 'transcend' from the individual level to mean trauma has been 'intergenerational and collective', transferred from survivors to their tamariki, mokopuna, whānau, hapū, and iwi. It further comments this is manifested in many ways, including a large range of social problems and indicating clear breaches of the principle of active protection.

[3] *Whanaketia* Part 6, *Te Tiriti o Waitangi and Human Rights, Te ture i raurangi rā* paras 11-42

Crown Law advice on the Royal Commission's findings and whether concessions of Treaty breach should be included in the public apology

13. 9(2)(h)

14.

15.

The inclusion of a concession of Treaty breach in the public apology presents an opportunity to acknowledge the disproportionate numbers of Māori who were placed in care

16. With the public apology, the Crown has an opportunity to acknowledge the historical context that helps to explain why disproportionate numbers of Māori were placed in care. The Royal Commission's final report sets out what it considers is the connection between this disproportionality and the Crown's historical role in eroding the ability of Māori whānau and communities to care for and protect tamariki and rangatahi so that they were not in need of state intervention in the first place.

17. More specifically, based on the engagement that the CRU has done with survivors, the CRU anticipates that a number of Māori, as well as other, survivors:

    a. would see a recognition of Treaty breach as an important part of a sincere Government response and that will help to build trust that the Crown accepts and understands the full depth of abuse experienced;

    b. are likely to be disappointed if they do not hear a specific acknowledgement of or apology for Treaty breach;

    c. would expect any acknowledgement of Treaty breach to focus primarily on their individual experiences, rather than for Māori collectives.

Liability that could arise from the apology, both in terms of the Treaty and more generally

18. 9(2)(h)

19.

20.

21.

We seek Ministerial Group indication of whether the apology text should continue to explore consideration of Treaty breach concession

22. To enable preparation of the draft apology text to continue at the speed needed for an apology delivery in November, we seek an indication from Ministers as to whether you want to prioritise work on factual findings relating to potential Treaty breaches. Specifically, we seek an indication of your direction that either:

- drawing on the provisional work undertaken to date by Crown Law and Te Arawhiti, work is progressed at pace to determine what factual findings related to the Treaty the Crown agrees with in order to enable consideration of concessions of Treaty breach as part of the public apology;

Or

[4] Noting also Recommendation 14 of the Royal Commission's final recommendations is that 'the government should ensure that the puretumu torowhānui system and scheme is designed and operated in a manner that gives effect to te Tiriti o Waitangi and its principles'.

- the response to the Royal Commission's findings of Treaty breach should be developed as part of the wider response to the final report, noting this work would not likely be completed in time to allow consideration of the inclusion of Treaty findings in the public apology.

23. The CRU recommends the first option as it keeps the door open to Ministers deciding to include a Treaty breach concession in the public apology if the outcome of the analysis is that the Treaty was indeed breached.

Next steps

24. Work will continue to confirm the approach to assessing and responding to the Commission's Treaty findings as part of the broader Crown response to the Royal Commission's final report. Timing of the pace of this work will depend on Ministerial preferences in response to the option outlined above.

25. In parallel with this, work will also continue to advance the draft apology text as a whole. This will include working with Crown Law and other agencies to ensure that the substance included in the apology text does not get ahead of decisions by Cabinet on redress and other matters that are still to be decided.

26. An update of progress with the draft apology text, together with an outline of progress with the logistical planning for the public apology event, will be provided at the 21 August 2024 meeting of the Ministerial Group.

Appendix – Excerpts of the Royal Commission's Treaty findings

27. This section directly quotes from the *Summary of Key Findings* section of the *Preliminaries* part of the final report, specifically from *Wāhanga 5: Ngā haukino o te wā, Part 7:* Factors. It is followed by excerpts from *Part 6 'Te Tiriti o Waitangi and Human Rights, Te ture i raurangi rā'*, with its specific focus on Te Tiriti.

28. *The Preliminaries Part of the report, at section/ Wāhanga 5: Ngā haukino o te wā Part 7: Factors, includes these findings*[5] *of 'Breaches of te Tiriti o Waitangi:*

    a. The Crown deprived whānau, hāpu and iwi of exercising tino rangatiratanga over their kāinga (home), to care and nurture the next generation and regulate the lives of their people, and that this breached the principle of active protection in te Tiriti o Waitangi.

    b. The Crown's failure to address the on-going effects of colonisation contributed to tamariki, rangatahi and pakeke Māori being placed in care and breached the guarantee of tino rangatiratanga and the principle of active protection in te Tiriti o Waitangi.

    c. Through failing to appropriately address trauma caused by abuse and neglect in care the Crown failed to prevent inter-generational impacts on Māori, whānau, hapū, and iwi. This breached the principle of active protection in te Tiriti o Waitangi.

    d. The Crown stripped Māori of their cultural identity through structural racism. This breached the guarantee of tino rangatiratanga and the principles of kāwanatanga, partnership, active protection, and equity in te Tiriti o Waitangi.

    e. The Crown excluded Māori from decision-making, developing and implementing policies that directly impacted the care of tamariki, rangatahi, and pakeke Māori. This breached the guarantee of tino rangatiratanga and the principles of partnership and active protection in te Tiriti o Waitangi.

    f. The Crown failed to provide appropriate redress for those who suffered abuse and neglect.'

29. The remaining summary is drawn from the fuller discussion of te Tiriti o Waitangi, at *Part 6 of Whanaketia, Te Tiriti o Waitangi and Human Rights, Te ture i raurangi rā*. In this section of Part 6, the Royal Commission makes a series of specific findings of Treat breach.[6] These include that:

[5] *Wāhanga 5: Ngā haukino o te wā Part 7: Factors*, para 78 onwards

[6] The following paragraphs are excerpts quoted or paraphrased from Part 6, paras 11 through 42

a. ‘Tamariki, rangatahi and pakeke Māori in care are taonga. While assuming ultimate care and responsibility or an oversight role for these taonga, the Crown failed to protect or prevent the abuse that many suffered. This is a grave breach of the Crown’s obligation under te Tiriti o Waitangi to actively protect Māori as well as those institutions who have te Tiriti o Waitangi obligations.’

b. ‘Te Tiriti and its principles were significantly neglected in the design, development and implementation of the care systems and this disregard of te Tiriti went to the heart of the abuse and neglect experienced by many Māori survivors and their whānau. In particular, the overlapping principles of tino rangatiratanga, kāwanatanga, partnership, active protection, options, equity, equal treatment, good government and redress were infringed’.

c. The Crown breached its duties to recognise rangatiratanga and actively protect Māori, including through ‘the failure to address the broader underlying issues that create the circumstances in which Māori are disproportionately taken into the care of State and faith-based institutions was.’

d. The Royal Commission further states ‘the taking of Māori into care was an intrusion into the tino rangatiratanga sphere and undermined the ability of Māori to exercise their right to care for their own supported and enabled by hapū, iwi and communities more broadly. It was also a breach of the legitimate exercise of kāwanatanga (which requires the Crown to foster rangatiratanga and ensure laws and policies were just, fair and equitable) and the principles of partnership and active protection.’

e. There were breaches of te Tiriti partnership and the Crown’s duty of active protection, including through the absence of Māori thought, input, autonomy and influence within the State and faith-based care systems. ‘This resulted in Māori being unable to intervene and protect their own from entry into care and from suffering abuse and neglect while in care. It resulted in the safety of Māori not being met.’

f. There was a breach of the principle of options that follows on from the principles of partnership, active protection, and equity, including through the lack of kaupapa Māori options as part of the care systems. This gives rise, the Royal Commission says, to ‘a serious question whether aspects of the care system contained elements of cultural genocide… [noting that similar Commissions in Australia and Canada found so] … the laws and practices of removing tamariki, rangatahi and pakeke Māori involved elements of both systemic racial discrimination and cultural genocide. The denigration and stripping away of Māori cultural identity as part of a broader system of assimilation was inconsistent with the principles of tino rangatiratanga, kāwanatanga, partnership, active protection and equity.’

g. This is also considering: ‘…Māori have long made up the majority of those in placed in social welfare and youth justice care settings. The number of Māori abused in

care is therefore likely to have been pervasive and disproportionate. Further, being Māori was likely to make the impact of the abuse and neglect worse for survivors'.

h. Disparities in abuse and the disproportional impact on Māori and the effect of racism 'is also a breach of the principle of equity and equal treatment. Further, the Crown was or should have been aware of the abuse and neglect suffered by Māori while in care. This raises concerns that the Crown has breached the principle of good government particularly by failing to adequately care for Māori or obtain and maintain adequate information or knowledge of any abuse or neglect suffered by Māori while in care, or hold abusers to account.'

i. Failures to provide consistent redress process for abuse and neglect in care 'and the ongoing failure of the Crown to address its breaches in respect of the care system more broadly (which leads to abuse and neglect) is a failure to uphold the principle of redress'.

j. 'More broadly than the shortcomings in the redress process, it is clear the Crown has acted in excess of its kāwanatanga powers and breached te Tiriti in a number of ways. The Crown failed to transform the care system in a manner that would uphold rangatiratanga and reflect a true partnership.'

30. The Royal Commission also finds that the breaches it had identified 'transcends the individual' [paras 38-39]:

> 'The trauma of the abuse suffered by those in care was intergenerational and collective. That is, it transferred from survivors to their tamariki, mokopuna, whānau, hapū, and iwi. This can manifest itself in many ways. That includes a number of social problems such as inequitable health and education outcomes, higher incarceration rates, gang formation, intimate partner violence and family and whānau violence, unemployment, homelessness, mental distress, substance misuse and abuse, an overall narrowing number of life opportunities, and suicide… This category of harm also breaches the te Tiriti principle of active protection.'

31. The focus on te Tiriti within Part 6 ends with an overall statement that the Royal Commission considers there is 'Strong evidence of numerous breaches of te Tiriti and its principles' [Part 6, paras 99-100]. They say that Parts 3 to 5 of their report:

> 'provide[s] strong evidence that there have been numerous infringements of te Tiriti o Waitangi principles that apply in relation to the care of tamariki Māori, rangatahi Māori and pakeke Māori across multiple settings. There is strong evidence that te Tiriti o Waitangi and its principles were not taken into account in many care settings, to the significant detriment of tamariki Māori, rangatahi Māori and pakeke Māori in care, and this had a significant inter-related impact on whānau, hapū and iwi, and caused intergenerational harm. The Inquiry is profoundly concerned about this conclusion.'