



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

# Crown response to the Royal Commission into Historical Abuse in State Care and in the Care of Faith-based institutions

May 2025

**Te Kāwanatanga o Aotearoa**  
New Zealand Government



Photo: Scott Venning

# Contents

To navigate back to this page,  
click on the home icon



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<b>Context</b>	<b>3</b>
<b>How to read this document</b>	<b>4</b>
<b>Overview of the Crown response</b>	<b>7</b>
<b>Objective one: Address the wrongs of the past</b>	<b>11</b>
Provide redress for abuse and neglect in care	12
Acknowledge victim and survivor experiences	24
<b>Objective two: Make the current care system safe</b>	<b>28</b>
Provide care system leadership	29
Monitor, report and provide oversight	38
Ensure safety-focussed policies, processes and places	43
Enable a safe and capable workforce	53
Identify and respond effectively to abuse and neglect	60
<b>Objective three: Empower those in care, their families, whānau and communities</b>	<b>71</b>
Improve recordkeeping and access to records	72
Prevent entry into State care	76
Listen to the voices of those in care	83
<b>Implementation recommendations</b>	<b>89</b>
<b>Abbreviations and definitions</b>	<b>96</b>



# Context

## Background to the Royal Commission

The Royal Commission into Historical Abuse in State Care and in the Care of Faith-based Institutions (the Royal Commission) was established by the Government in 2018. It was set up in response to long-repeated calls from survivors and their advocates for abuse and neglect in care in Aotearoa New Zealand to be appropriately investigated.

The Royal Commission's Terms of Reference directed it to investigate the experiences of children, young people and adults in State and faith-based care between 1950 and 1999. The Royal Commission also heard evidence of abuse and neglect outside this time, including from 1999 to the present. The Royal Commission investigated:

- why people were taken into care
- what abuse and neglect happened in care
- the impacts of the abuse and neglect
- the factors that caused the abuse and neglect in care to occur.

The Royal Commission's reports, information from its hearings, interviews with survivors and others, and documentary evidence provide the basis for the recommendations set out in its:

- 2021 redress report *He Purapura Ora, He Māra Tipu from Redress to Pūretumu Torowhānui (He Purapura Ora)*
- 2024 final report *Whanaketia – Through pain and trauma, from darkness to light Whakairihia ki te tihi o Maungārongo (Whanaketia)*.

He Purapura Ora made 95 recommendations for apologies and for changes to compensation and litigation frameworks, and redress systems and processes for survivors of abuse and neglect in care. Whanaketia made 138 recommendations with a focus on making the care system safe, and empowering and investing in whānau and communities. The recommendations are addressed to the Crown, to faith-based institutions and to other named organisations in the care and justice systems.

## Purpose of the Crown response

This Crown response document details action already undertaken by the Government and government agencies in response to the Royal Commission's recommendations. It sets out the next phases of work to respond to further recommendations. The publication of this response document is designed to support transparency and accountability in how the Crown is responding to each of the Royal Commission's recommendations. Updates will be published annually.



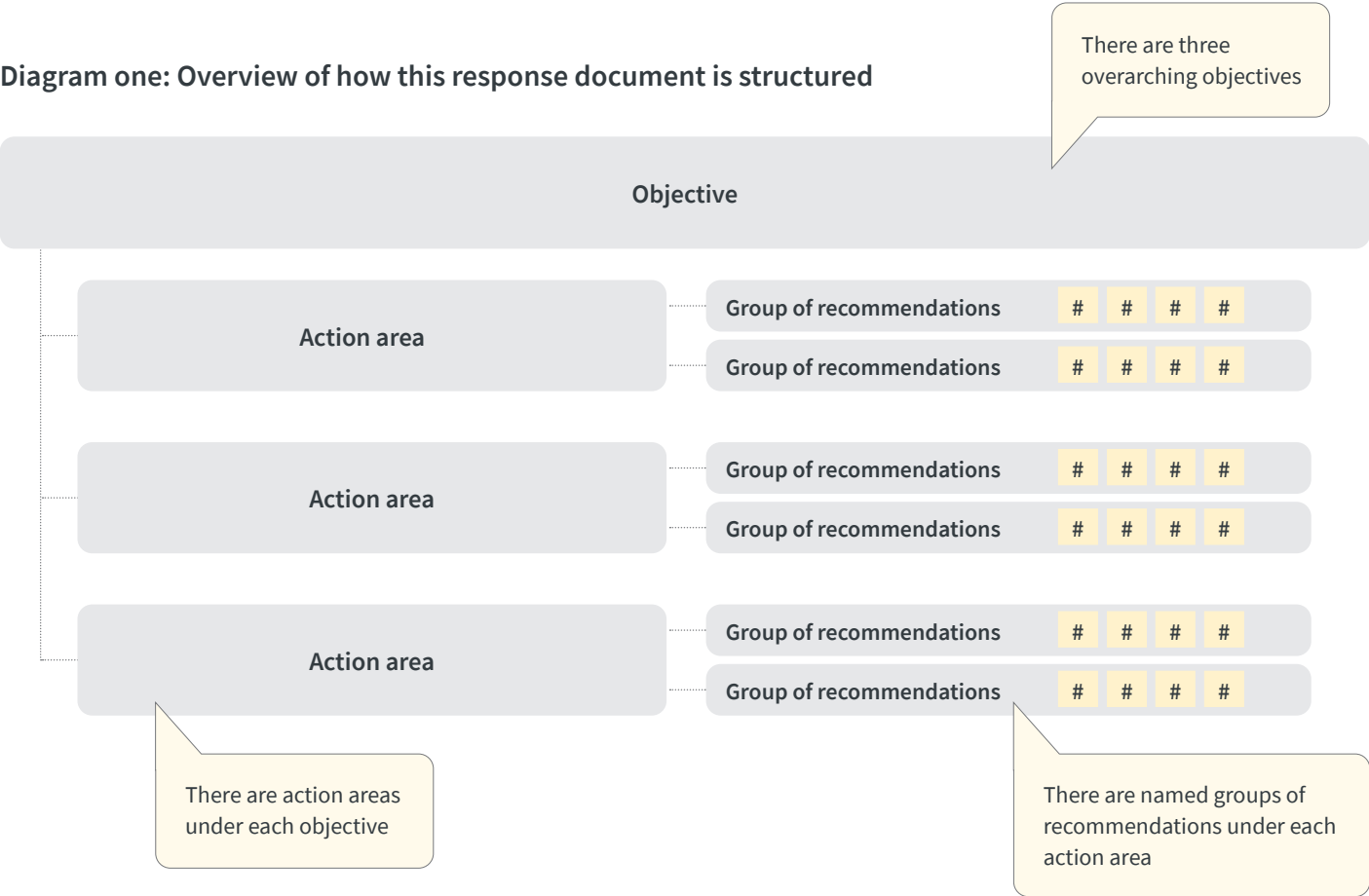
# How to read this document

The detail of the Crown’s response to the Royal Commission is set out below. The recommendations are grouped into action areas under three objectives. The objectives are based on those in Whanaketia and are:

- 1. address the wrongs of the past
- 2. make the current care system safe
- 3. empower those in care, their families, whānau and communities

Diagram one below, *Overview of how this response document is structured*, shows how this response document is structured and the groupings of recommendations work.

Diagram one: Overview of how this response document is structured



## How to read the detailed response under each objective

In the response below, each group of recommendations shows the Ministers and agencies directly involved in the analysis, decision-making and/or implementation work. Several other government agencies will support work across the response. This includes other policy and operational agencies.

The Crown response will be supported by the population agencies: Te Puni Kōkiri, Ministry for Pacific Peoples and Whaikaha – Ministry of Disabled People. These agencies have an important role because of the over-representation of Māori, Pacific Peoples and Deaf and disabled people in the care system.

The current response and status of each recommendation is also shown. For many recommendations, both the response and status will change over time, as the Crown response continues. This will be shown in annual progress reporting. Diagram two below shows what this looks like; *How to read the summary of response table*.

Diagram two: How to read the summary of response tables

Ministers and agencies involved:			
Recommendations included:	Response:	Status:	
He Purapura Ora, he Māra Tipu	The current response will be listed here		
#	● ACCEPT	● COMPLETE	
#	● ACCEPT INTENT	● ONGOING	
#	● PARTIALLY ACCEPT	● UNDER WAY	
#	● NEEDS FURTHER CONSIDERATION	○ NOT STARTED	
#	● DECLINE	–	
Whanaketia		The current status will be listed here	
#			

Where work directly addresses a Royal Commission recommendation, the response will show as “accept”. Where “decline” has been recorded, the reason for the decision is set out. Responses also include “accept intent”, “partially accept” and “further consideration needed”. An explanation of each response and status category is set out in diagram three and four below.

### Diagram three: Definition of the “response”

#### ACCEPT

The recommendation is accepted. It will be implemented as it was set out by the Royal Commission.

#### ACCEPT INTENT

The intent of the recommendation is accepted. It will be implemented in a different way than set out by the Royal Commission.

#### PARTIALLY ACCEPT

One or more sub-parts of the recommendation are accepted as set out by the Royal Commission. The recommendation is not accepted in full.

#### NEEDS FURTHER CONSIDERATION

The recommendation requires further consideration before a response can be determined.

#### DECLINE

Following analysis and a decision-making process, the Crown declines to implement this recommendation.

### Diagram four: Definition of the “status”

#### NOT STARTED

Work on the analysis and/or implementation of the recommendation has not yet started.

#### UNDER WAY

Work has begun on the analysis and/or implementation of the recommendation.

#### COMPLETE

Work on the recommendation has been completed, consistent with the agreed project scope and decision-making process.

#### ONGOING

The work to deliver on the recommendation part of an ongoing programme of work or activity.

The Royal Commission’s recommendations are summarised throughout this document but have not been duplicated, because of their length. The recommendations can be found in full here:

- a. [He Purapura Ora, he Māra Tipu](#)
- b. Whanaketia – [The Future \(Part 9\)](#)





# Overview of the Crown response

## Safeguards in the care system have been strengthened since the period investigated by the Royal Commission and improvements are ongoing

Safeguards in the care system have been strengthened and improved since the period investigated by the Royal Commission; 1950-1999. For example:

- improvements have been made in safety checking and vetting of carers, especially those who work with and care for children and young people, and Cabinet has directed further work on the children's worker safety regime in line with recommendation **58(b)** from Whanaketia
- the use of restrictive practices has been regulated, with pain compliance practices ruled out of use in most care settings, and work has started on mapping current practice against the Royal Commission's recommendations, in line with recommendations **72-74** from Whanaketia
- improvements have been made in the independent monitoring and oversight of the care system, including care providers and individual carers, and work is under way to improve monitoring and oversight in the children's system, in line with recommendation **85** from Whanaketia.

## Thirty-six recommendations have been completed in the first phase of the Crown response, and the response is moving into phase two

The Royal Commission acknowledged some of the improvements in the care system, in Whanaketia. It also said more needs to be done. Across He Purapura Ora and Whanaketia, it made 207 recommendations to the Crown. It also made recommendations to faith-based institutions and other non-governmental organisations.

Thirty-six of the recommendations directed to the Crown have been completed as part of the first phase of the Crown response. The response and status of the recommendations to the Crown are summarised in diagram five below; *Summary of the response and status of recommendation to the Crown*.

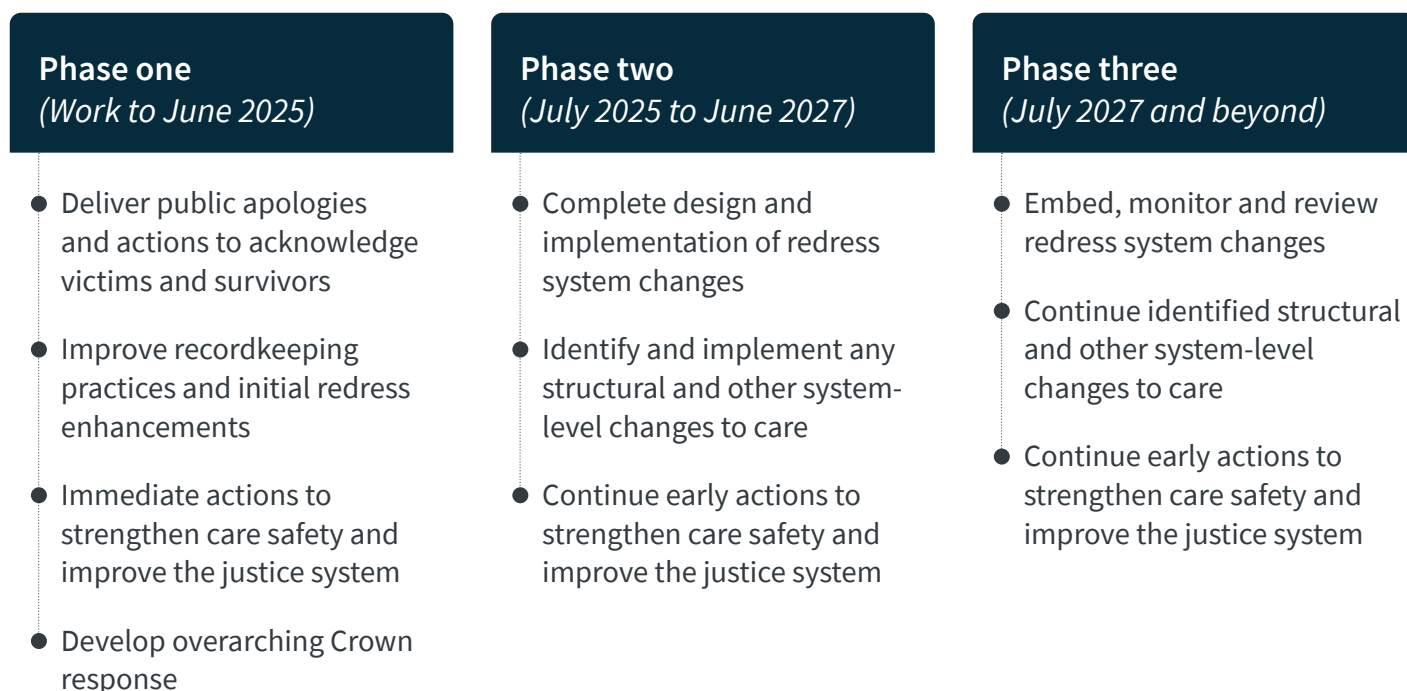
**Diagram five: Summary of the response and status of recommendation to the Crown**

	COMPLETE	UNDER WAY	ONGOING	NOT STARTED
ACCEPTED	3	6	10	–
INTENT ACCEPTED	4	28	6	–
PARTIALLY ACCEPTED	6	13	8	1
NEEDS FURTHER CONSIDERATION	–	38	–	61
DECLINED	23	–	–	–
TOTAL	36	85	24	62



Work on many more recommendations is under way and will be continued over the next phases of work. The current high-level phasing for the work is summarised in diagram six below; *Summary of the phases of the Crown response*

**Diagram six: Summary of the phases of the Crown response**



The multi-year response reflects the number of recommendations made by the Royal Commission, their complexity and the inter-dependencies between many of them.

Work on responding to the recommendations also needs to progress alongside delivering on other priorities for the Government and government agencies. This includes work on the Government's targets to improve health, education, law and order, employment and housing outcomes.

### **Priorities for the next phase of the response are redress, decisions on the structure of the care system and further actions to strengthen care safety**

Redress is a priority for phase two of the response. Decisions on redress services have been made, and implementation is under way. More information is given in *Objective one: Address the wrongs of the past*.

Work is also progressing to enable decisions on whether structural change to the care system will deliver better outcomes and, if so, the degree of change needed and how it will be delivered. This is also a priority for phase two. More information

is given in *Objective two: Make the current care system safe*.

Other work to strengthen safety in the care system and improve the justice system for survivors is also in progress. This includes work in response to the Royal Commission and work that aligns with its intent. It is described throughout this response document. It includes initiatives that are part of existing agency work programmes and new initiatives supported through funding from Budget 2025.

### **Outcomes of decisions on structural and other system-level changes will inform and affect the Crown response to several other recommendations**

Decisions on structural and other system-level changes, including those associated with a new stand-alone Care Safe Agency, a Care Safety Act, a National Care Strategy and a centralised commissioning agency, will substantially affect phase three of the Crown response, planned for July 2027 and beyond. The extent to which the care system, or parts of it, is integrated, aligned or coordinated will affect the approach taken to several other recommendations.





Diagram seven: Summary of action areas and groups of recommendations

Key:

He Purapura Ora

Whanaketia

Address the wrongs of the past						
Action area	Group of recommendations	Recommendations				
Provide redress for abuse and neglect in care	1. The purpose, functions and scope of a redress system	1	4	12	15-21	42 45
		47-50	52	61-63	82-84	92
		9-10				
	2. Redress system design	5	22-23	25	27	30-31
Provide redress for abuse and neglect in care		41	43	46	51	55-59 64
		68-70	90	8-9	16	
	3. Redress offerings	24	26	28-29	32-40	44
		53-54	65-67	91	93-94	
Provide redress for abuse and neglect in care		17-18	21			
	4. Compensation system	75(c)	76	11		
	5. Public apologies for historic abuse and neglect	10-11	2-3			
	6. Acknowledge victims and survivors of historic abuse and neglect	71-72	5	19-20		
Make the current care system safe						
Action area	Group of recommendations	Recommendations				
Provide care system leadership	7. A functional review of the care system	9	40-41	43	46	116
	8. A Care System Office	44	123	124		
	9. A Care Safety Act and amendments to the Charities Act 2005	45	49(a),(b),(d)			
	10. Safeguarding in the care system	50-51	53-56	63(c)		
	11. The right to be free from abuse and neglect	75(a),(b)	119			
	12. Care Safety Principles	39				
Monitor, report and provide oversight	13. Functions and powers of independent monitoring and oversight bodies	85(a),(b)	86-87			
	14. Human rights-focussed care system performance indicators	52	120			
Ensure safety-focussed policies, processes and places	15. Care standards and duties that are monitored and enforced	77	47	49(c)		
	16. Organisational accreditation	48				
	17. Care facilities, and their design features	75(a),(c)				
	18. Close care and protection residences	70				
	19. Restrictive practices	72-74				
	20. Care placements close to family, whānau and community	75(b),(d)	79-80			
Enable a safe and capable workforce	21. Workforce strategy	61				
	22. Care worker registration, barring and pre-employment vetting	57	58(a),(c)	64		
	23. Children's worker safety checking regime	58(b)				
	24. Employment practices, induction and training	33	59	60	62	
		63(a),(b),(d),(e)-(i)				



Identify and respond effectively to abuse and neglect	25. Mandatory reporting	69
	26. Prosecution guidelines	22 23 24
	27. Criminal and civil justice legislation	78-81 26 27(a)-(c) 28-32 37-38
	28. <i>New Zealand Police Manual</i>	34
	29. Investigations into abuse and neglect, including torture	6-7 35
	30. Judicial-led initiatives	25

## Empower those in care, their families, whānau and communities

Action area	Group of recommendations	Recommendations
Improve recordkeeping and access to records	31. Recordkeeping and access to records	85-89 81-82
Prevent entry into State care	32. Contemporary and community models of care	71 78 115
	33. Social, educational and prevention campaigns and programmes	73-74 111-112 121-122 128
	34. Gloriavale	88
Listen to the voices of those in care	35. Those in care, family and whānau to participate in care decisions	76-77 114
	36. Complaints processes and information sharing	63(j) 65-68 83-84



## OBJECTIVE ONE:

# Address the wrongs of the past

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This objective includes the Royal Commission's recommendations to address the wrongs of the past. It includes its recommendations to provide redress for abuse and neglect in care and to acknowledge and memorialise victim and survivor experiences, including through public apologies.

## Provide redress for abuse and neglect in care

### What the Commission said about survivors' need for redress

The Royal Commission said the existing State and non-State redress systems could be complex, inconsistent, lengthy and difficult to navigate, risking further trauma for survivors. It heard from survivors that redress systems and processes are generally focussed on reaching a financial settlement rather than promoting the restoration of wellbeing in a way that meets their diverse needs and those of their families, whānau and communities.

The Royal Commission recommended a shift from multiple, individual redress systems and processes to one that is integrated and independent. It recommended that the new redress system provide acknowledgements and apologies for abuse and neglect, together with monetary payments and access to wellbeing support and services.

The limits applied to survivors' abilities to seek redress were the subject of recommendations. The Royal Commission wanted to ensure that settlements through existing redress systems did not affect survivors' rights. It wanted survivors to be able to pursue redress to the full extent possible, through all available avenues, including compensation through the Accident Compensation scheme.

The Royal Commission recommended that a document called the Attorney-General's *Values for Crown Civil Litigation* be reviewed. It wanted this document to expressly say the Crown will behave as a model litigant and explain fully what that means.

### Response to recommendations for redress and compensation

This section includes the Royal Commission's recommendations focussed on ensuring the redress system is equipped to support survivors, their families, whānau and communities, along with its recommendations related to compensation.

Aotearoa New Zealand's redress system for survivors has developed over the past decade as an alternative dispute resolution model. Initially shaped through litigation against the Crown in the 1990s, it evolved into an out-of-court process. In 2008, the alternative dispute resolution model was formally established under the Crown Litigation Strategy, which was later revised as the Crown Resolution Strategy. It includes the following:

- Ministry of Health historic abuse claims process for people who were abused in care at the Lake Alice Psychiatric Hospital Child and Adolescent Unit between 1972 and 1977 and who were 17 years old or under at the time, and the Historic Abuse Resolution Service for allegations of abuse in State-run psychiatric facilities or psychopaedic hospitals before 1 July 1993.
- Ministry of Education (Education) sensitive claims process for people who were abused or neglected in specialist, primary or intermediate schools before 1989, or any State school that has since closed, including specialist and health camp schools. Education's process includes a rapid payment process for claimants who attended Waimokoia / Mt Wellington Residential School and a prioritised settlement process for claimants with terminal illnesses.

**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities**

- Ministry of Social Development Historic Claims service for people who experienced abuse or neglect while in the care, custody or guardianship of Child, Youth and Family or its predecessor agencies before 1 April 2017. Survivors can elect an individually assessed claim or a rapid payment process (introduced in late 2022).
- Oranga Tamariki interim approach to redress, which covers child welfare settings since 1 April 2017. The Oranga Tamariki process involves actively engaging with the claimant to understand their needs and wishes. The redress package offered to a claimant is intended to reflect their unique needs and preferences and/or those of their whānau and/or advocate.


























## 1. Purpose, functions and scope of a redress system



















These are the Royal Commission's recommendations relating to the purpose, functions and scope of its proposed new redress system. This includes He Purapura Ora recommendation 21, which is to extend an offer to faith-based institutions and other care providers to join the scheme. A connection exists between these principles, values and concepts and the Care Safety Principles at recommendation 39 from Whanaketia.

The recommendations related to developing a model litigant policy are also included here, because any such policy would likely be principles and values based. Connections exist between these recommendations and those in the criminal and civil justice legislation group, including the recommendations associated with amending the Limitation Act 1950 and Limitation Act 2010.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Crown Response Office | Crown Law Office | Ministry of Justice | Ministry of Social Development | Whaikaha – Ministry of Disabled People | Ministry for Pacific Peoples | Department of Corrections | Te Puni Kōkiri | Ministry of Business, Innovation and Employment (Accident Compensation Policy) | Accident Compensation Corporation | Oranga Tamariki

Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
1	 DECLINE	–
4	 DECLINE	–
12	 DECLINE	–
15	 DECLINE	–
16	 PARTIALLY ACCEPT	 ONGOING
17	 DECLINE	–
18	 PARTIALLY ACCEPT	 ONGOING
19	 PARTIALLY ACCEPT	 ONGOING
20	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
21	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
42	 ACCEPT	 ONGOING
45	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
47	 PARTIALLY ACCEPT	 ONGOING
48	 ACCEPT	 ONGOING



49	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
50	 DECLINE	–
52	 DECLINE	–
61	 DECLINE	–
62	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
63	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
82	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
83	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
84	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
92	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
<b>Whanaketia</b>		
10	 DECLINE	–

## Work under way

Work is progressing to improve the existing State redress system and redress payments to survivors. A single “front door” into the system will be introduced. Cross-agency work will be undertaken to align redress processes and improve consistency in redress offerings. Public monitoring and reporting on the performance of the system will include insights from survivors.

The existing functions of the State redress system will be continued. Most functions align with the functions the Royal Commission recommended for its new redress system, so He Purapura Ora recommendation 16 has been partially accepted. The functions of the existing redress system are to:

- provide a safe, supportive environment for survivors to share their experiences
- facilitate acknowledgements and apologies for abuse in care

- facilitate access to records, support services, legal support and payments
- share insights on abuse and neglect in care and the harm experienced.

Recommendation 18 from He Purapura Ora has been partially accepted because redress will continue to focus on survivors. The family and whānau of survivors will not be able to access redress, as recommended by the Royal Commission, except in the situation where a survivor dies after initiating a claim. A presumption against making redress payments to some serious offenders will also be implemented. This presumption will apply to new claimants who have been convicted of a qualifying offence under Schedule 1AB of the Sentencing Act 2002 and were sentenced to five or more years in prison for that offence.

The types of abuse and neglect covered by the current State redress system will be retained. Redress will not cover cultural, racial and spiritual abuse and neglect as recommended by the Royal Commission. For this reason, recommendation 19 from He Purapura Ora has been partially accepted.

Recommendation 42 from He Purapura Ora, that redress payments should not adversely affect survivors' financial position, has been accepted. State redress payments will continue to be tax-free and not affect an individual's tax liabilities or entitlements. Work is also progressing to correct a regulatory inconsistency relating to redress payments made to Lake Alice Psychiatric Hospital Child and Adolescent Unit survivors. This will ensure any redress provided to that group of survivors remains tax-free in perpetuity.

Settling a claim does not limit a survivor's right to make a complaint but does limit a survivor's ability to take civil proceedings. So, recommendation 47 from He Purapura Ora is partially accepted.

Redress decisions within the existing system have no legal effect on a named person or organisation as per recommendation 48 from He Purapura Ora. This is because they are not the result of an investigation. For this reason, recommendation 48 has been accepted.

### Future work

Further work is under way to consider the eligibility matters in recommendations 20 and 21 from He Purapura Ora. This includes considering whether access to the State redress system will be made available to survivors outside the core State care system. For example, survivors of abuse and neglect in schools not covered by the Ministry of Education's (Education's) process, those in settings that Health New Zealand has responsibility for and survivors of faith-based or other non-governmental institutions. A response to recommendations 62 and 63 from He Purapura Ora on the roles and responsibilities of the Crown and faith-based institutions will follow decisions on these eligibility matters.

Recommendation 45 from He Purapura Ora will be considered as part of the work on potential integration of claims outside the core State care redress system. State redress services will not offer 'common experience payments', as envisioned by the

Royal Commission, but agencies do have the ability to investigate (or recommend an investigation into) systemic abuse at institutions they are responsible for. For example, Education has conducted research into Waimokoia / Mt Wellington Residential School (Waimokoia). As a result, Education made findings about what was happening there while it was open. Survivors of Waimokoia can apply for a rapid payment based on these findings and on when they attended the school. Consideration is being given to the need for a model litigant policy in response to recommendation 82 from He Purapura Ora. A decision on recommendation 82 is contingent on significant policy choices for the Crown in relation to historical abuse litigation. The Crown response to recommendation 83 from He Purapura Ora will follow this.

Recommendation 92 from He Purapura Ora is under consideration. Of note, since the publication of He Purapura Ora, no historical abuse claim has reached that stage of proceedings where the Crown has had to decide whether to rely on the limitation defence at trial.

### Reason for decline

He Purapura Ora recommendations 1, 4, 12, 15, 17, 50 and 52 have been declined because these are the Royal Commission's recommendations associated with the establishment of a new, independent and principles-based redress system. Improving the existing system is a priority.

































Recommendation 61 is declined because redress for survivors of abuse in State care will continue to be delivered by existing agencies. This recommendation would require a new agency to be established.













Recommendation 10 from Whanaketia is declined because access to redress for survivors of abuse in State care will not be backdated. Survivors with settled claims will be able to access a top-up payment that aims to address inequities in previous settlements.

## 2. Redress system design

These are the Royal Commission's recommendations relating to the design of its proposed new redress system and powers of the entity delivering the scheme. It also includes recommendations about how claims should be assessed, redress delivered and how information can be shared on the outcome of a claim.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Crown Response Office | Ministry of Social Development | Whaikaha – Ministry of Disabled People | Crown Law Office | Ministry of Justice | Ministry for Pacific Peoples | Department of Corrections | Te Puni Kōkiri | Ministry of Business, Innovation and Employment (Accident Compensation Policy) | Accident Compensation Corporation | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>He Purapura Ora, he Māra Tipu</b>		
5	 ACCEPT INTENT	 COMPLETE
22	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
23	 ACCEPT	 UNDER WAY
25	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
27	 ACCEPT	 ONGOING
30	 DECLINE	–
31	 DECLINE	–
41	 PARTIALLY ACCEPT	 UNDER WAY
43	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
46	 PARTIALLY ACCEPT	 ONGOING
51	 ACCEPT	 UNDER WAY
55	 ACCEPT	 ONGOING
56	 ACCEPT	 ONGOING
57	 ACCEPT	 UNDER WAY
58	 ACCEPT	 ONGOING
59	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
64	 NEEDS FURTHER CONSIDERATION	 UNDER WAY

68	 DECLINE	–
69	 DECLINE	–
70	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
90	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
<b>Whanaketia</b>		
8	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
9	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
16	 NEEDS FURTHER CONSIDERATION	 UNDER WAY

## Work completed to date

The intent of recommendation **5** from He Purapura Ora, to establish and fund a well-resourced independent Māori collective to help it in responding to the report, has been accepted, and this work is complete. The Redress Design Group was established, with Māori representation. It also included people who could speak about the support and services needed by all survivors, including Pacific Peoples and Deaf and disabled people. The Redress Design Group proposals were publicly released in May 2025.

Existing redress services have been improved since the release of He Purapura Ora. For example:

- all redress services work with the Survivor Experiences Service. This is why recommendation **27** from He Purapura Ora has been accepted
- existing services all provide survivors with a written record of their decision. These records are not available in te reo Māori or New Zealand Sign Language, which is why this recommendation **46** has been partially accepted
- the approach of existing services to confidentiality and redactions is consistent with recommendations **55** and **56** from He Purapura Ora.

## Work under way

The improvements to the redress system that are being implemented align with recommendations **23** and **51** from He Purapura Ora. Recommendation **23** is accepted. Recommendation **51** is accepted as the improvements will seek to ensure a consistent experience for survivors regardless of which agency is responsible for their claim, and an independent review process will be introduced. The review process will allow survivors to challenge redress decisions in an easier and more timely manner.

Other work under way to improve the design of the redress system, consistent with government decisions, includes:

- work towards a consistent offer of support services, regardless of which claims agency is responsible for resolving a survivor's claim (as per recommendation **25** from He Purapura Ora, which is under consideration)
- the introduction of a common payment framework within the overall funding provided through Budget 2025. Recommendation **41** from He Purapura Ora is partially accepted because payments will be increased (with the intention of being more meaningful) but will not cover all of the matters set out by the Royal Commission

- implementation of common referral policies for the core State redress system agencies aligned with recommendation 57 from He Purapura Ora.

Recommendation 22 from He Purapura Ora is under consideration. Risks are involved in extensively promoting State redress services, particularly for those agencies with a significant backlog of claims. New claimants could come forward only to have to wait a long time to receive redress. A response to Whanaketia recommendation 9 is also pending the outcome of decisions on whether non-State redress will be integrated into the State system.

Recommendation 43 from He Purapura Ora is under consideration. Payments are being reviewed for equity between survivors, which aligns with part of this recommendation. No decision has been made, however, on whether payments will be reviewed on an ongoing basis.

He Purapura Ora recommendation 58 has been accepted because no limits are in place on a settled claimant's ability to disclose what redress they receive from a State redress service.

## Reason for decline


































Recommendations 30 and 31 from He Purapura Ora are declined. Prioritisation is being given to building on existing assessment processes used by State redress services, so the introduction of the assessment approach envisioned by the Royal Commission is not possible. The purpose of redress payments will continue to be to acknowledge but not compensate for the harm of abuse and neglect in State care.

Recommendation 68 from He Purapura Ora has been declined because this was outside the scope of work of the Redress Design Group. Recommendation 69 from He Purapura Ora is also declined because this involved responding to the review in recommendation 68, which did not occur.













### 3. Redress offerings

These are the Royal Commission's recommendations associated with the forms of redress that should be offered. This includes payments, support and services, personal apologies, and forms of redress to survivors, their families and whānau.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Crown Response Office | Ministry of Social Development | Whaikaha – Ministry of Disabled People | Crown Law Office | Ministry of Justice | Ministry for Pacific Peoples | Department of Corrections | Te Puni Kōkiri | Ministry of Business, Innovation and Employment (Accident Compensation Policy) | Accident Compensation Corporation | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>He Purapura Ora, he Māra Tipu</b>		
24	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
26	 ACCEPT	 ONGOING
28	 DECLINE	–
29	 DECLINE	–
32	 PARTIALLY ACCEPT	 UNDER WAY
33	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
34	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
35	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
36	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
37	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
38	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
39	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
40	 PARTIALLY ACCEPT	 UNDER WAY
44	 DECLINE	–
53	 ACCEPT INTENT	 UNDER WAY
54	 PARTIALLY ACCEPT	 ONGOING
65	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
66	 NEEDS FURTHER CONSIDERATION	 NOT STARTED



67	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
91	 DECLINE	–
93	 PARTIALLY ACCEPT	 ONGOING
94	 ACCEPT	 COMPLETE
<b>Whanaketia</b>		
17	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
18	 PARTIALLY ACCEPT	 ONGOING
21	 DECLINE	–

## Work under way

On the day of the public apology, the Prime Minister committed to investing \$32 million to increase capacity in existing redress systems while work to improve redress for survivors continues. The additional \$32 million of redress funding is enabling the Ministries of Health, Education and Social Development and Oranga Tamariki to complete an additional 746 claims over two years to 2026.

An end-of-life payment of \$20,000 has been made available for Lake Alice Psychiatric Hospital Child and Adolescent Unit (Lake Alice) survivors who have a terminal illness and six months or less to live. The end-of-life payments to Lake Alice survivors are ex gratia payments. Prioritised payments offered to other survivors of abuse or neglect in State care are full and final settlements. This is why recommendation 93 from He Purapura Ora is partially accepted.

Historic inequities in the reimbursement of legal fees in previous Lake Alice settlements are also being addressed. Recommendation 18 from Whanaketia is recorded as “partially accept” because an independent review of previous settlements was not undertaken as part of implementing this process.

A torture redress scheme for eligible Lake Alice survivors has been established. Redress includes

a payment, a new written apology that explicitly acknowledges torture, and facilitating access to support and rehabilitative services. Eligible Lake Alice survivors can choose an expedited payment of \$150,000 or an individual payment pathway where each claim is independently assessed by an independent arbiter who will determine payment amounts.

The Ministry of Education is undertaking comprehensive research into McKenzie Residential School and Campbell Park School so it can implement rapid payment processes for survivors of abuse at these places. It is also:

- undertaking work to improve the information available on its website, including making this accessible for claimants with disabilities
- streamlining internal processes and policies to speed up the claims process for survivors so they can reach a resolution sooner.

In response to recommendation 94 from He Purapura Ora, the Survivor Experiences Service has been established to support people who were abused in State, faith-based or other forms of care. It offers two services for survivors, their families and whānau: sharing experiences of abuse in care (listening service) and records support (help with access to care records). The Government has confirmed the Survivor Experiences Service will continue to operate

while improvements to redress services are made, so recommendation 26 from He Purapura Ora is accepted.

Decisions on the redress system will address several of the Royal Commission's recommendations regarding redress offerings. This includes:

- an increase in the funding for redress payments to enable all redress payments to be raised and for higher top-end payments for egregious abuse experienced by a small proportion of survivors. The response to recommendation 40 from He Purapura Ora is “partially accept” because payments made by the State redress system do not consider the impact of abuse or neglect in care
- the provision of apologies that take explicit responsibility for what happened to a survivor as per recommendations 32-36 from He Purapura Ora. Work on whether legislative change is needed to allow for more meaningful apologies is under way and recommendation 32 is partially accepted because apologies are made only to survivors themselves and not others affected by abuse in care. Cabinet will consider options for change in July 2025
- a more consistent offer of support services, drawing on He Purapura Ora recommendations 24, 37-39 and 65-67. The response to these recommendations will be advanced through further advice to Ministers in July 2025 and through operational improvements by agencies.

The intent of recommendation 53 from He Purapura Ora is accepted. A new process for the independent review of claims decisions where survivors are dissatisfied with the outcome will be introduced, but this will not directly affect claims outcomes. This new review process is designed to be quicker and easier than going to the Ombudsman, with that remaining as an option if survivors want to pursue a complaint through that route.

Recommendation 54 from He Purapura Ora is partially accepted. Principle 3 of the Crown Resolution Strategy, which guides State redress agencies' approach to resolving claims, says if claimants become aware of additional material information or circumstances that were not considered by the Crown at that time, the Crown may consider that new information and whether any additional response should be made. This does not fully align with the Royal Commission's recommendation because the onus is on claimants to provide additional material and not the redress services.

### Reason for decline

Recommendations 28 and 29 from He Purapura Ora are declined. Survivors accessing the State redress system will have a choice of a “brief” claim (a rapid or expedited assessment) or a “standard” claim (a standard individual assessment). They will not be able to make both a brief and standard claim.

Recommendation 44 from He Purapura Ora is declined because the State redress system will not offer common experience payments as envisioned by the Royal Commission.





Recommendation 91 from He Purapura Ora is declined. Existing State redress agencies have continued to resolve claims while the Royal Commission's redress recommendations are considered. Settlements did not guarantee access to an improved redress system for survivors with settled claims.

Recommendation 21 from Whanaketia is declined. Family and whānau will not be able to access the State redress system therefore the recommended whānau payment will not be offered.

## 4. Compensation systems

The Royal Commission's recommendations on access to compensation through the Accident Compensation Corporation (ACC) or the courts have been grouped here. Recommendation **11** from Whanaketia replaced recommendation **76** from He Purapura Ora. There are connections between these recommendations and those associated with amending the Limitation Act 1950 and Limitation Act 2010 in the group, *Criminal and civil justice legislation*.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Ministry of Justice | Ministry of Social Development | Department of Corrections | Ministry of Business, Innovation and Employment (Accident Compensation Policy) | Accident Compensation Corporation | Oranga Tamariki

Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
75(c)	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
76	(Replaced by Whanaketia 11)	
Whanaketia		
11	 NEEDS FURTHER CONSIDERATION	 UNDER WAY

### Future work

The Ministry of Business, Innovation and Employment – Accident Compensation Policy will provide advice to the Minister for ACC on recommendations **11** and **75(c)** from Whanaketia by the end of Quarter Three 2025.

## Acknowledge victim and survivor experiences

### What the Royal Commission said about acknowledging victim and survivor experiences

The Royal Commission said the lack of acknowledgement or apologies for abuse and neglect created further trauma for survivors. It found that, where acknowledgements or apologies were made, they were often insignificant or made too late. It made a suite of recommendations associated with the making of apologies.

The Royal Commission stated that a useful and public way to acknowledge the experiences of victims and survivors, and raise awareness of abuse and neglect, is memorials. It noted that survivors suggested placing memorials or plaques at the site of the relevant institutions where they were abused or neglected.

In He Purapura Ora, the Royal Commission found evidence of unmarked graves for patients who died in care across Aotearoa New Zealand. It noted that this led “some in the community to describe disability care as ‘from cradle to unmarked grave’”.<sup>1</sup> Graves were located at, or associated with, several psychiatric hospitals, including Porirua, Tokanui and Sunnyside hospitals.

### Response to recommendations to acknowledge victim and survivor experiences









The Royal Commission’s recommendations relating to the making of apologies for abuse and neglect in State care are grouped here, along with recommendations from He Purapura Ora and Whanaketia relating to tangible actions to acknowledge victims and survivors. This includes recommendations to fund memorials, hold ceremonies, establish archives of survivors’ accounts of their abuse and deliver projects to remember and honour survivors. Much of the work to implement these recommendations has been completed or is under way.

<sup>1</sup> He Purapura Ora, page 41.

5. Public apologies for historic abuse and neglect in care

The recommendations for public apologies to survivors of abuse and neglect in care have been grouped here.

**Ministers and agencies involved:** Department of the Prime Minister and Cabinet | Ministry of Health | Ministry of Education | Crown Response Office | Public Service Commission | Crown Law Office | Ministry of Social Development | New Zealand Police | Oranga Tamariki

Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
10	 PARTIALLY ACCEPT	 COMPLETE
11	 PARTIALLY ACCEPT	 COMPLETE
Whanaketia		
2	 PARTIALLY ACCEPT	 COMPLETE
3	 PARTIALLY ACCEPT	 COMPLETE

Work completed to date

The Prime Minister and seven public sector agency leaders formally apologised to survivors of abuse in care on 12 November 2024. In his apology, the Prime Minister acknowledged specifically that torture occurred at Lake Alice. The apologies made can be found online at: [Public apology to survivors of abuse in care](#) | [Crown response to the Abuse in Care Inquiry](#).

The Crown response to the recommendations for public apologies is recorded as “partially accept”. This is because the apologies did not meet the specific detail of every recommendation and their sub-parts.



6. Acknowledge victims and survivors of historic abuse and neglect

The Royal Commission’s recommendations for actions to acknowledge and memorialise victims and survivors have been grouped here. This includes the recommendation to investigate potential unmarked graves and urupā (burial sites). This is because these sites should be acknowledged and those who rest in them remembered.

The Commission also recommended reviewing the appropriateness of any streets, public amenities, public honours or memorials named after, depicting, recognising or celebrating a proven perpetrator. Reminders of perpetrators are retraumatising for survivors.

**Ministers and agencies involved:** Ministry of Health | Health New Zealand | Ministry of Education | Crown Response Office | Ministry of Justice | Ministry of Social Development | Ministry of Culture and Heritage | New Zealand Police | Department of Corrections | Department of Internal Affairs | Oranga Tamariki

Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
71	ACCEPT INTENT	UNDER WAY
72	ACCEPT INTENT	UNDER WAY
Whanaketia		
5	ACCEPT INTENT	UNDER WAY
19	NEEDS FURTHER CONSIDERATION	UNDER WAY
20	PARTIALLY ACCEPT	UNDER WAY

Work completed to date

Sculpture and poetry taonga (treasures) were commissioned as a memorial to victims and survivors. They were designed and created by survivors themselves. Waiata (chant), poi karakia (incantation) and karanga (call of welcome) were composed by Te Ātiawa and Taranaki whānui, and informed by survivor insights. All taonga were completed and delivered at the Dawn Ceremony on 11 November 2024 and the public apology on 12 November 2024.

Communications and advice were sent to relevant government agencies, to raise awareness of

recommendations 5, 19 and 20 from Whanaketia and encourage their review of the appropriateness of any streets, public amenities, public honours or memorials within their jurisdictions. Advice has also been sent to all Local Authorities. The Ministry of Justice, Ministry for Culture and Heritage, New Zealand Police and Department of Corrections have completed their reviews.

A survivor-focussed fund has been established for non-governmental initiatives that support survivors. It also supports projects for local councils to care for or memorialise unmarked graves. The Government has also announced an annual day of reflection on the one-year anniversary of the public apology to survivors of abuse and neglect in care.



## Work under way

Work is under way to confirm an interim resting place for the taonga, to establish a Kaitiaki Rōpū (caretaker collective) to look after the taonga for the long term and to determine the role of the taonga as part of the National Day of Reflection in November 2025.

Government agencies, including the Ministry of Health, Ministry of Social Development, Health New Zealand and Oranga Tamariki, are undertaking a review to identify memorials to proven perpetrators within their jurisdictions. The Ministry of Education is developing information for the education sector to support its response.

The Crown Response Office has begun work on the planned National Day of Reflection in November 2025. This includes possible approaches to the design and delivery of the day.

## OBJECTIVE TWO:

# Make the current care system safe

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This objective includes the Royal Commission's recommendations to make the current care system safe. It includes recommendations for care system leadership, to monitor, report and provide oversight of the care system, and ensure:

- the care system has safeguards against abuse and neglect in care, and safety-focussed policies, procedures and places
- the care system has a workforce that is appropriately regulated and has the right capacity and capability
- that contemporary abuse and neglect in care are responded to appropriately.

## Provide care system leadership

### What the Royal Commission said about the need for care system leadership

The Royal Commission noted, “during the inquiry period there was no nationwide strategic approach to preventing or responding to abuse and neglect in care”.<sup>2</sup> It was concerned too many Ministers and agencies were involved in developing strategies and policies for the care system, and systems were numerous, disconnected and inconsistent. It said these systems ultimately failed to provide a safe environment for children, young people and adults in care.

During the Inquiry period, the Royal Commission said no legislated care standards were in place for disability, mental health or faith-based care. It considered the standards in place in other care settings were inconsistently enforced, if enforced at all. It stated te Tiriti o Waitangi (the Treaty of Waitangi) and human rights were not at the forefront of the provision of care.

The Royal Commission said many care agencies and providers had no, inadequate or poorly implemented safeguarding policies and procedures. It said this made it easier for perpetrators to abuse those in care and to get away with abuse. It made safeguarding recommendations directed at leaders and detailed active steps they should take to create a proactive safeguarding culture.

The Royal Commission wanted all care providers and individual care workers to be bound by care standards and regulated. It wanted to clarify roles and responsibilities for setting standards and ensuring they were complied with, and for dealing with complaints and investigations, leveraging the Charities Act 2025.

### Response to recommendations for care system leadership

This section of the response includes the Royal Commission’s recommendations for a new stand-alone Care Safe Agency, a Care Safety Act, a National Care Strategy and a centralised commissioning agency. Decisions on these recommendations are a priority for this phase of the response. This is because the extent to which the care system, or parts of it, is integrated, aligned or coordinated will affect the approach to many other recommendations.

Before decisions on the care system leadership recommendations are taken, care agencies will continue to work within their existing legislation, strategies, frameworks and principles. Many are already aligned with the care principles the Royal Commission set out in recommendation 39 from Whanaketia. These include the:

- Pae Ora (Healthy Futures) Act 2022, the suite of guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 and Ngā Paerewa Health and Disability Services Standard NZS 8134:2021. The Mental Health Bill progressing through Parliament will result in further alignment with the care principles
- *Code of Health and Disability Consumers’ Rights*, which establishes the rights of consumers and the obligations and duties of care providers. It is a regulation under the Health and Disability Commissioner Act 1994 and aims to uphold the dignity, rights and wellbeing of people receiving care
- Children’s Act 2014 requirements that central agencies take a leadership role in aspects of child safeguarding and that prescribed State service providers and their contractors must have a child protection policy

<sup>2</sup> Whanaketia – The Future, para 277, page 155.



OBJECTIVE ONE:

Address the wrongs of the past

OBJECTIVE TWO:

Make the current care system safe

OBJECTIVE THREE:

Empower those in care, their families, whānau and communities

- obligations of school boards under the Education and Training Act 2020, the education workforce training competencies, and the outcomes sought through *Ka Hikitia – Ka Hāpaitia – The Māori Education Strategy* and the *Action Plan for Pacific Education 2020–2030*
- Oranga Tamariki practice approach, which is grounded by te Tiriti o Waitangi and based on a mana-enhancing paradigm. It draws from the te ao Māori (the Māori worldview) principle of oranga (wellbeing). Oranga Tamariki also has a Pacific strategy and the *Oranga Tamariki Disability Strategy*.



OBJECTIVE ONE:  
Address the wrongs of the past

OBJECTIVE TWO:  
Make the current care system safe

OBJECTIVE THREE:  
Empower those in care, their families,  
whānau and communities

## 7. Functional review of the care system

These recommendations are grouped to understand more about the current care system and identify gaps, overlaps or inconsistencies that could be addressed through system-wide integration, alignment or coordination or other change. For this reason, the grouping includes the recommendation made by Commissioners Erueti and Gibson that a single centralised commissioning agency be part of a new, unified care system.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Crown Response Office | Ministry of Social Development | Public Service Commission | Ministry for Pacific Peoples | Whaikaha – Ministry of Disabled People | Te Puni Kōkiri | New Zealand Police | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>He Purapura Ora, he Māra Tipu</b>		
9	● NEEDS FURTHER CONSIDERATION	◐ UNDER WAY
<b>Whanaketia</b>		
40	● NEEDS FURTHER CONSIDERATION	◐ UNDER WAY
41	● NEEDS FURTHER CONSIDERATION	◐ UNDER WAY
43	● NEEDS FURTHER CONSIDERATION	◐ UNDER WAY
46	● NEEDS FURTHER CONSIDERATION	◐ UNDER WAY
116	● NEEDS FURTHER CONSIDERATION	○ NOT STARTED

### Work under way

A functional analysis of care agencies' roles and responsibilities has begun. It is referencing the list of functions proposed for the Care Safe Agency at recommendation 41 from Whanaketia and the legislative measures proposed for a new Care Safety Act at recommendation 45 from Whanaketia.

### Future work







Findings from the functional analysis will be used to develop advice for Ministers about how to respond to the Royal Commission's recommendations for structural change to the care system. It will also be used to help prioritise the next phase of the response.



## 8. Care System Office

The Royal Commission recommended the establishment of a new Care System Office in recommendation **44** from Whanaketia. Recommendations **123** and **124** from Whanaketia provide further guidance on the intent for the office. This is why these recommendations have been grouped.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Crown Response Office | Ministry of Social Development | Public Service Commission | Ministry for Pacific Peoples | Whaikaha – Ministry of Disabled People | Te Puni Kōkiri | New Zealand Police | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>Whanaketia</b>		
<b>44</b>	 PARTIALLY ACCEPT	 UNDER WAY
<b>123</b>	 PARTIALLY ACCEPT	 UNDER WAY
<b>124</b>	 PARTIALLY ACCEPT	 UNDER WAY

### Work completed to date

A Crown Response Office, led by a functional chief executive, has been established. It reports to the Lead Coordination Minister and sits in the Public Service Commission. The Crown Response Office is supported by a cross-agency Chief Executives' Group.

### Work under way

The current response to recommendation **123(a)** and **123(b)** from Whanaketia, that the Government establish a Care System Office later to become the Ministry of Care System, is “partially accept” and “under way”. This is because the review of the care system needs to be completed before further decisions on the establishment of a Care System Office can be made.

### Future work

Advice will be given to Ministers and Cabinet, considering decisions arising from the functional review of the care system.

### Reason for decline

Recommendation **123(c)** from Whanaketia, that the Care System Office does not employ senior officials or middle management who have been involved in the care system, has been declined. This is because to provide quality, credible advice, the Crown Response Office and care agencies need knowledge and understanding of the existing system, including the history of what changes have been tried, what has and has not worked and why.



9. Care Safety Act and amendments to the Charities Act 2005

The Royal Commission recommended a new Care Safety Act be enacted. It also recommended changes to the Charities Act 2005, to ensure alignment with the new Care Safety Act. This is why these recommendations have been grouped.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Crown Response Office | Ministry of Social Development | Public Service Commission | Ministry for Pacific Peoples | Whaikaha – Ministry of Disabled People | Te Puni Kōkiri | New Zealand Police | Oranga Tamariki

Recommendations included:	Response:	Status:
Whanaketia		
45	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
49(a),(b),(d)	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED

Work under way

The functional review of the care system needs to be completed before further decisions on these recommendations can be made.

Future work

Advice will be given to Ministers and Cabinet on these recommendations, after decisions arising from the functional review of the care system have been made.

## 10. Safeguarding in the care system

These are the Royal Commission's recommendations relating to safeguarding to protect the health, wellbeing and human rights of those in care. They are included in this group because the Royal Commission stated that effective leadership is critical both for creating an organisational culture where safeguarding is embedded at all levels and a care system where children, young people and adults in care are valued.

Ministers and agencies involved: Ministry of Health | Ministry of Education | Ministry of Social Development | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>Whanaketia</b>		
50	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
51	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
53	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
54	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
55	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
56	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
63(c)	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED

### Work completed to date

Work has been completed that aligns with the Royal Commission's recommendations for safeguarding across the care system. "Assisting Change" is a new trial programme commissioned by the Ministry of Social Development | Disability Support Services (MSD | DSS). The programme is helping disability providers, including those providing residential care, to improve the quality of their support to the Deaf and disabled communities.

Oranga Tamariki has established the Child Protection Investigation Unit, which has a safeguarding objective. Its goal is to identify systemic failures in the organisation's care of children, to ensure systems, process and practices improve safety.

### Work under way

MSD | DSS has safeguarding initiatives under way aligned with the Royal Commission's safeguarding recommendations. MSD | DSS:

- contracted the *Disability Abuse and Prevention Response*, which is an approach to safeguarding the rights of disabled people and responding to situations of violence, abuse and neglect against Deaf and disabled people.
- is reviewing and strengthening contractual levers and processes for safeguarding in the disability support sector. This includes reviewing accreditation standards for care providers and considering targeted use of the standards by additional providers.

OBJECTIVE ONE:

Address the wrongs of the past

OBJECTIVE TWO:

Make the current care system safe

OBJECTIVE THREE:

Empower those in care, their families, whānau and communities

MSD | DSS providers began participating in the National Quality Forum in March 2025. The Forum is intended to enable providers to share insights and information to improve the quality of care, including safeguarding.

### Future work

Work on the recommendations for safeguarding will be initiated in a future phase of the response. The approach to analysing the recommendations, and decisions on next steps, will be directly influenced by decisions made in response to the functional review of the care system.



11. Right to be free from abuse and neglect in care

These are the recommendations from He Purapura Ora and Whanaketia about the right to be free from abuse in care and the need to strengthen the human rights protections for those in care. They are included in this care system leadership section because they would provide a strategic foundation for the delivery of care, along with the recommended Care Safety Principles.

Ministers and agencies involved: Ministry of Justice   Te Puni Kōkiri   Whaikaha – Ministry of Disabled People		
Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
75(a),(b)	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED
Whanaketia		
119	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> UNDER WAY

Work under way

Work has begun on analysing recommendation **119(a)** from Whanaketia to introduce a stand-alone right to security of the person in the New Zealand Bill of Rights Act 1990.

Future work

These recommendations are connected to the functional review of the care system, the Care Safety Principles and work on care standards and duties, in particular Whanaketia recommendation **47**, which also requires further consideration. Further work to respond to them will be initiated in a future phase of the response as priorities allow.

12. Care Safety Principles

These are the Royal Commission’s recommendations that all care system participants should be guided by their recommended care safety principles for preventing and responding to abuse and neglect in care. They are included in this care system leadership section because they would provide a strategic foundation for the delivery of care.

Ministers and agencies involved: Ministry of Health   Ministry of Education   Ministry of Social Development   Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
39	<div>NEEDS FURTHER CONSIDERATION</div>	<div>NOT STARTED</div>

Work under way

The Mental Health Bill progressing through Parliament includes new principles to ensure care is supportive and responsive to the needs of the person and is guided by their will and preferences. It also includes duties to encourage and help people to participate in decisions being made about them, as well as more robust family and whānau involvement in critical processes. The principles in the Mental Health Bill are well aligned with those proposed by the Royal Commission.

Future work

Implementation planning for the Mental Health Bill is progressing alongside the Parliamentary process. This will include work across various areas including guidelines, training and implementing the new supported decision-making roles. The Bill has a commencement date of 1 July 2027.

The Care Safety Principles recommended by the Royal Commission are expected to be considered as part of the work on the functional review of the care system.

## Monitor, report and provide oversight

### What the Commission said about monitoring, reporting and oversight

The Royal Commission said that, during the Inquiry period, the State failed to ensure robust, independent oversight and monitoring of care providers. It noted that, although new oversight and monitoring mechanisms were put in place over the Inquiry period, the Ombudsman, as an Officer of Parliament, remains the only entity completely independent of the Government. It expressed concern about the resourcing of oversight and monitoring bodies, and their ability to monitor and report at a system level alongside focussing on those at risk.

In Whanaketia, the Royal Commission considered and rejected recommending a single new body be created. Instead, it recommended work to ensure no duplication, gaps or inconsistencies occur across current oversight and monitoring entities. It considered that:

- all care providers should collect adequate data on abuse and neglect in care, and regularly report on these matters
- the Government should establish system-level, human rights-based performance indicators to help prevent abuse and neglect.

### Response to recommendations for monitoring, reporting and oversight

This section of the response includes the Royal Commission's recommendations relating to independent oversight, and the independent bodies that hold care system participants to account. These bodies are important for ensuring:

- providers comply with applicable legislation, regulations and standards

- places of care are safe and fit for purpose
- the voices of those in care, their families, whānau and community are heard
- complaints and allegations can be escalated appropriately
- independent monitoring and reporting is undertaken on the care system.

The oversight bodies that exist within the current care system and fall within the scope of these recommendations are set out below:

- Tari o te Kaitaki Mana Tangata | Office of the Ombudsman
- Te Kāhui Tika Tangata | Human Rights Commission
- Te Mana Mātāpono Matatapu | Office of the Privacy Commissioner
- Te Hoihau Hauora, Hauātanga | Health and Disability Commissioner
- HealthCERT
- Te Tāhū Hauora | Health Quality and Safety Commission
- Te Hiringa Mahara | Mental Health and Wellbeing Commission
- Te Tari Arotake Mātauranga | Education Review Office
- Mana Whanonga Pirihimana Motuhake | Independent Police Conduct Authority
- Mana Mokopuna | Children and Young People's Commission
- Aroturuki Tamariki | Independent Children's Monitor.

Aotearoa New Zealand is party to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT seeks to prevent torture and other forms of ill-treatment through the establishment of a system of regular visits to places of detention carried out by independent international and national bodies.

Domestic oversight bodies conducting these visits include the Ombudsman (for prisons and health and disability settings) and Mana Mokopuna – Children and Young People’s Commission (for places used to care for children and young people). OPCAT monitoring entities regularly report on their findings and make recommendations for improvements to responsible government agencies.

This section includes the recommendations for improved performance indicators and the collection and consideration of data to improve safeguarding. The recommendations will build on the monitoring and reporting already in place. This includes:

- the Ministry of Health’s (Health’s) public information and statistics relating to the use of mental health compulsory assessment and treatment legislation. Health’s reporting obligations will be enhanced with the passage of the Mental Health Bill before Parliament
- Health New Zealand’s data on health service providers and the outcomes they are achieving for people receiving mental health and wellbeing services. This information enables better quality service planning and decision-making at local, regional and national levels
- the Ministry of Education’s data relating to attendance, achievement and learner wellbeing and safety, such as traumatic incidents, and incidents and complaints in the education sector
- the Ministry of Social Development | Disability Support Services’ regular reporting and monitoring of complaints and critical incidents, and performance returns received from service providers

- monitoring and reporting by Oranga Tamariki, including the *Safety of Children in Care Annual Report* that measures the findings of harm for children and tamariki Māori and young people and rangatahi Māori in care.



13. Functions and powers of independent monitoring and oversight entities

These are the Royal Commission’s recommendations for independent oversight of redress systems, and the care system. The Royal Commission specifically recommended in 85(b) that the existing care and protection and youth justice oversight and monitoring agencies should be consolidated into a single agency. This is why recommendation 85 has been broken into two sub-parts.

Ministers and agencies involved: Ministry of Health   Ministry of Education   Ministry of Justice   Ministry of Social Development   Public Service Commission   New Zealand Police   Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
85(a)	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED
85(b)	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> UNDER WAY
86	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED
87	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED

Work completed to date

An independent review of the Oversight of Oranga Tamariki System Act 2022 and Children and Young People’s Commission Act 2022 was undertaken in 2024. The review found that the objectives of the Acts were being met, and the entities’ roles and responsibilities are clear.

Work under way

The Oversight of Oranga Tamariki System Legislation Amendment Bill was introduced in 2024. It seeks to make the Independent Children’s Monitor an independent Crown entity, which would increase its independence from the Government.

## Future work

The Oversight of Oranga Tamariki System Legislation Amendment Bill includes a provision for an independent review of the two Acts it amends to be undertaken every five years. At that time, additional changes could be considered to further strengthen oversight of the children's system in the context of any changes made in response to the Royal Commission's recommendations, in particular recommendation **85(b)** from Whanaketia.

The Ministry of Health is initiating a programme of work to increase the capacity of oversight bodies and the expertise of those in statutory oversight roles, to ensure greater independent oversight and compliance of compulsory mental health, addiction and intellectual disability care. This programme of work will be well aligned with the Royal Commission's recommendation **86** from Whanaketia.

The care system functional review needs to be completed before further decisions on the role and responsibilities of the monitoring and oversight agencies can be made.

## 14. Human rights-focussed care system performance indicators

The Royal Commission's recommendations associated with data and performance indicators have been grouped, because it makes sense to consider them as a package.

Ministry of Health | Ministry of Education | Ministry of Social Development | Te Puni Kōkiri | Whaikaha – Ministry of Disabled People | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>Whanaketia</b>		
52	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
120	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED

### Work under way

Oranga Tamariki is enhancing its data and reporting capabilities through the delivery of strategies and undertaking system changes. A main area of work is to collect standardised disability information for children and young people in care or youth justice residences. 'Pacific Narratives, Evidence, Data and Insights' is one of five strategic objectives in its Pacific strategy. This will support future work in response to the Royal Commission's recommendations related to human rights-focussed care system performance indicators.

### Future work

The care system functional review needs to be completed before further decisions about work on these recommendations can be made.

## Ensure safety-focussed policies, processes and places

### What the Royal Commission said about policies, procedures and places

The Royal Commission said that, during the Inquiry period, legislated care duties and standards were lacking in some sectors. It was concerned about duplication, inconsistencies, and gaps in duties and standards in other sectors.

The Royal Commission recommended a duty of care be instituted. It considered that a system of accreditation would ensure consistent standards of care were met by all care system providers. It considered that registered charities should lose their registration status for non-compliance.

Many survivors told the Royal Commission that care providers would use restrictive and violent practices to manage the behaviour of children, young people and adults in care. It was concerned about unnecessary and inappropriate use of restrictive practices, in particular, solitary confinement.

The Royal Commission said that, during the Inquiry period, the physical design of some care places failed to provide residents with their rights to privacy, dignity and respect. It commented that places in which care services were delivered need to be designed to prioritise safeguarding.

### Response to recommendations for safety-focussed policies, procedures and places

This section of the response includes the Royal Commission's recommendations focussed on safe policies, procedures and places for the delivery of State care. It includes recommendations to have duties and standards in place for the organisations and individuals providing care services.

#### Standards for provision of care

Standards for providing care and care placements have changed since the Inquiry period. As noted

above, the health sector has the Pae Ora (Healthy Futures) Act 2022, a suite of guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) and the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (Ngā Paerewa). The Mental Health Act contains several offences including for the “neglect or ill-treatment of proposed patients and patients” that will be improved by the Mental Health Bill before Parliament.

Independent District Inspectors are required under the Mental Health Act to inspect facilities where people are compulsorily detained under mental health legislation. They are required to report monthly to the Director of Mental Health in the Ministry of Health on the activities of facilities, including alleged breaches of rights. The Mental Health Bill contains strengthened requirements for reporting on the operation of legislation to the Director of Mental Health and Director-General of Health.

Meeting the relevant criteria of Ngā Paerewa is required as part of health care providers' certification under the Health and Disability Services (Safety) Act 2001. If the auditors find a criterion is not being met by a service provider, they will issue a notice of correction that the service provider must action.

Schools, early learning services and school hostels have obligations related to learner safety under the Education and Training Act 2020, the Children's Act 2014 and associated regulations and rules. Specific offences are identified in the Crimes Act 1961 for ill-treatment or neglect of a child or vulnerable adult by someone with care of them (section 195) and failure to protect a child or vulnerable adult (section 195A).

The Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018 set out the standard of care for children and young people, and the support that caregivers can expect to receive. Organisations that have legal custody of children or young people under section 396 of the Oranga Tamariki Act 1989 are responsible for meeting the *National Care Standards*.



**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities**

Te Kāhui Kāhu, the social services accreditation agency, now assesses some social service providers against the *Social Sector Accreditation Standards*, helping to ensure that the services delivered are safe. Accreditation is carried out on behalf of six government agencies: the Ministries of Housing and Urban Development, Justice, Social Development and Pacific Peoples, and the Department of Corrections and Oranga Tamariki.

### Care placements

Health New Zealand aims to place individuals in inpatient or residential facilities close to their homes or within their regions. Services are typically coordinated locally, to ensure patients maintain connections with family and whānau, friends and community, as well as with the staff of the services they are engaging with. A person may be placed outside their region due to lack of availability of appropriate care, the urgency of care needed or need for specialised care requirements. For example, specialised inpatient eating disorder units are not available in all regions.

Oranga Tamariki strongly preferences care placements with family, whānau and community wherever possible, provided those placements meet the essential needs of children and young people in care. This is required by law and is embedded in Oranga Tamariki policies, practice, guidance and training.

### Restrictive practices

The use of restrictive practices has been regulated or ruled out of practice since the Inquiry period. The Education and Training Act 2020 prohibits the use of seclusion in schools and early learning services. Its use in health and disability facilities is only permitted if a person is subject to one of two statutory systems: the Mental Health (Compulsory Assessment and Treatment) Act 1992 or the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

In 2023, the Ministry of Health issued revised guidance on the use of seclusion and restraint under the Mental Health (Compulsory Assessment and

Treatment) Act 1992. The guidelines now include a stronger emphasis on person-centred and culturally appropriate approaches.

Within Oranga Tamariki, children and young people can only be admitted to secure care under section 368(1)(a) and (b) of the Oranga Tamariki Act 1989 and with the approval of a team leader or staff member on the Senior Duty Roster.

Health New Zealand has implemented the *Restraint Elimination and Safe Practice Policy* that aims to provide a restraint free environment to preserve the dignity and mana for people receiving its health services. Its national training course *Safe Practice Effective Communication* supports the best and least-restrictive practice in mental health inpatient units. The course does not support the use of pain compliance techniques. It teaches alternative ways of working to minimise use of restraint. All mental health and hospital-level intellectual disability services ward staff are required to complete the training.

The use of physical restraint in schools is regulated by the Education and Training Act 2020, the Education (Physical Restraint) Rules 2024 (the Restraint Rules) and the *Aramai He Tētēkura | Arise our Future Generations guidelines* which include physical restraint guidelines. The Restraint Rules require that teachers who are assessed as being highly likely to need to use physical restraint, and any non-teaching staff authorised to use physical restraint, must be trained in appropriate physical holds by accredited physical restraint practitioners. The physical restraint guidelines advise that restraints that involve “immobilising through pressure points and pain holds” are unsafe, cause harm and must not be used.







Under the Oranga Tamariki (Residential Care) Regulations 1996, the use of physical force or holds while dealing with children or young people in its residences can only be used in extreme circumstances. Staff must have reasonable grounds for believing that the use of physical force is necessary.



## 15. Care standards and duties that are monitored and enforced

These are the Royal Commission's recommendations that speak to the need for consistent care standards and duties that are monitored and enforced through an effective penalty regime. It includes the recommendation for the penalty regime to be aligned with the Charities Act 2004.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Ministry of Justice | Ministry of Social Development | Whaikaha – Ministry of Disabled People | Ministry of Business, Innovation and Employment (Health and Safety Policy) | WorkSafe New Zealand | Department of Internal Affairs | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>He Purapura Ora, he Māra Tipu</b>		
77	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
<b>Whanaketia</b>		
47	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
49(c)	 NEEDS FURTHER CONSIDERATION	 NOT STARTED

### Work under way

The Mental Health (Compulsory Assessment and Treatment) Act 1992 includes offences and penalties for abuse and neglect. This aligns with the Royal Commission's recommendations. The Mental Health Bill carries over and updates the offences. The penalty for the offence of neglect or ill-treatment will raise from two years' to five years' imprisonment.

The Mental Health Bill also contains greater safeguards and protections of a person's rights. These include new independent support and advocacy roles, improved rights and complaints processes, more opportunities for a person to exit the legislation if compulsion is no longer required, and the ability to appeal decisions made.

### Future work

Once the Mental Health Bill passes, more detailed implementation work will be progressed to support effective implementation of the changes noted above. The Mental Health Bill has a commencement date of 1 July 2027.

The Ministry of Business, Innovation and Employment – Health and Safety Policy will provide advice to the Minister for Workplace Relations and Safety on recommendation **77** from He Purapura Ora by the end of Quarter Four 2025.

Oranga Tamariki will initiate a programme of work to better understand the risks that may trigger the abuse of children and young people in residential care, and by their individual carers. This will enable improved training and support for care workers, and improved monitoring and reporting on the provision of care. The work will align with multiple Royal Commission recommendations associated with care standards and duties.

OBJECTIVE ONE:

**Address the wrongs of the past**

OBJECTIVE TWO:

**Make the current care system safe**

OBJECTIVE THREE:

**Empower those in care, their families, whānau and communities**

Further work on care standards and duties, and decisions on next steps, will be directly influenced by decisions made in response to the functional review of the care system and the approach decided to the proposed Care Safety Act.





16. Organisational accreditation

This is the Royal Commission’s recommendation that an accreditation system should be created for all care providers to ensure a consistent standard of care. It envisaged the proposed Care Safe Agency would be responsible for the accreditation scheme

Ministers and agencies involved: Ministry of Health   Ministry of Education   Ministry of Social Development   Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
48	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED

Work completed to date

The *Social Sector Accreditation Standards* cover many of the areas of organisational accreditation that were a concern for the Royal Commission. Since the release of Whanaketia, Te Kāhui Kāhu has completed work to:

- map the recommendations of the Royal Commission to the relevant *Social Sector Accreditation Standards*
- form a high-level view of how current accreditation requirements align with the recommendations
- identify what changes could be made to current accreditation requirements to better align them with the Royal Commission’s intent.

Work under way

Te Kāhui Kāhu is working to update accreditation guidance for providers, with reference to the Royal Commission’s recommendations. This is being done to ensure accreditation requirements better support the delivery of safe, quality care services.

Future work

Further decisions on the scope of organisational accreditation will be initiated at a later phase of the response. The approach is dependent on decisions made in response to the functional review of the care system.

OBJECTIVE ONE:  
Address the wrongs of the past

OBJECTIVE TWO:  
Make the current care system safe

OBJECTIVE THREE:  
Empower those in care, their families,  
whānau and communities

## 17. Care facilities and their design features

These are the Royal Commission's recommendations about care facilities and their design features. The Royal Commission wanted all care providers to review their physical buildings and make changes to improve safety.

Ministers and agencies involved: Ministry of Health | Ministry of Education | Ministry of Social Development | Oranga Tamariki

Recommendations included:

Response:

Status:

Whanaketia

75(a),(c)



NEEDS FURTHER CONSIDERATION



NOT STARTED

### Work under way

Health New Zealand is delivering the *Mental Health Infrastructure Programme*. Public and private funding totalling \$997.3 million has been allocated across 16 projects to build modern, fit-for-purpose mental health facilities. The design of the new facilities reflects input from service users and communities. It will support the delivery of contemporary models of mental health care that emphasise privacy, dignity, wellbeing and the safety of patients and staff. This programme aligns with the Royal Commission's recommendations about care facilities and their design features.

Oranga Tamariki is working to review the way residential care is regulated, both to support a strategic shift in how residential care is provided and to update some regulations that are now 25-plus years old. This includes reviewing the powers, rights and protections that apply in all types of residential care, covering all care arrangements that do not involve care by wider family or foster caregivers.

Oranga Tamariki is working to improve safety in its residences and enhance the quality of residential practice through a work programme that includes addressing the recommendations of the 2023 *Secure residences and community homes review*. This work is well aligned with recommendations 75(a) and (c)

from Whanaketia and their focus on physical buildings and their design features. The intended outcomes of this work programme include:

- improving capability and capacity, and creating the safest possible environment to provide tailored care in youth justice or care and protection residences or homes
- improving support for workers in residences and homes so they are clear in their purpose and have the skills, tools and systems needed.

### Future work

The Ministry of Health is initiating a programme of work to assess and improve mental health inpatient units, to ensure they are safer and more responsive to people's needs than they are at present. This programme of work aligns with the Royal Commission's recommendations for care facilities.

Further work on the detail of these recommendations will be considered for future phases of the response, based on decisions made on the structure of the care system and the priorities of agencies, Ministers and Cabinet.



18. Close care and protection residences

This is the Royal Commission’s specific recommendation to close Oranga Tamariki care and protection residences. It is aligned with the Royal Commission’s intent that the Government work towards the deinstitutionalisation of all residential care. It acknowledged that changes in this area would take time.

Ministers and agencies involved: Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
70	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED

Future work

Work to consider the closure of care and protection residences was initiated in response to the 2021 *Oranga Tamariki Future Direction Action Plan*. This plan has since been replaced.

An ongoing need exists for residences in some form, because some children require more intensive support and care than can be provided within existing community-based care arrangements. As a result, Oranga Tamariki is focussing on improving the safety of its residences.

19. Restrictive practices

These are the Royal Commission’s recommendations on the use of pain compliance techniques, restrictive practices and solitary confinement to manage the behaviour of those in care.

Ministers and agencies involved: Ministry of Health   Ministry of Education   Ministry of Social Development   Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
72	● NEEDS FURTHER CONSIDERATION	◐ UNDER WAY
73	● NEEDS FURTHER CONSIDERATION	◐ UNDER WAY
74	● NEEDS FURTHER CONSIDERATION	◐ UNDER WAY

Work under way

A range of work is under way that is well aligned with the Royal Commission’s recommendations relating to the use of restrictive practices in the provision of care.

The Mental Health Bill takes a stronger position to reducing and eliminating seclusion, including through duties on services and the ability to further limit or prohibit the use of seclusion through regulations, once the system is ready. The Mental Health Bill itself does not prohibit seclusion. It does, however, prohibit the use of seclusion for under 18-year-olds.

The *Restraint Elimination and Safe Practice Policy* is being rolled out across Health New Zealand. This policy aims for a restraint-free environment, to preserve the dignity and mana of people receiving health services. This policy is underpinned by the criteria provided in Section 6 – Here Taratahi Restraint and Seclusion from the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021.

The Health Quality and Safety Commission mental health and addiction quality improvement programme is a national initiative working with health board districts to ensure that people who experience mental health and addiction issues, and their family and whānau, receive high-quality care. This includes the *Aukatia te noho punanga: Noho haumanu, tū rangatira mō te tokomaha | Zero seclusion: Safety and dignity for all* project. This project aims to reduce seclusion rates in mental health and addiction adult unit inpatient placements to less than three percent by 1 June 2025, working towards the goal of health equity and ultimately zero seclusion.

On 7 February 2025, schools became responsible for supporting their staff to understand students’ stress triggers and respond to unmet needs. To support schools with this responsibility, the Ministry of Education has published training resources on identifying stress triggers, understanding unmet needs, and preventing, minimising and responding to student distress without using physical restraint.

OBJECTIVE ONE:

Address the wrongs of the past

OBJECTIVE TWO:

Make the current care system safe

OBJECTIVE THREE:

Empower those in care, their families, whānau and communities

## Future work

Care agencies are working to identify legislation, regulations and rules that govern the use of restrictive practices in their sectors and map requirements and practice against the Royal Commission's recommendations. Further work and planning for delivering advice to Ministers and Cabinet will be considered for future phases of the response. This will be based on decisions made on the structure of the care system and the priorities of agencies, Ministers and Cabinet.



## 20. Care placements close to family, whānau and community

These are the Royal Commission's recommendations associated with care placements, including the involuntary placement of children, young people or adults away from their families, whānau and communities in geographically isolated places.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Ministry of Social Development | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>Whanaketia</b>		
75(b),(d)	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
79	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
80	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED

### Work under way

Work is under way in Oranga Tamariki to make caregiving more attractive and to empower caregivers with greater autonomy to make everyday decisions regarding the children in their care. Oranga Tamariki is developing a national care system action plan that includes actions to better support caregivers and enable a shift to a more devolved caregiver workforce. Oranga Tamariki is also working on the establishment of a caregiver panel to gather regular feedback and drive ongoing improvements for caregivers. This work aligns with the Royal Commission's recommendations related to care placements.

## Enable a safe and capable workforce

### What the Royal Commission said about the care workforce

The Royal Commission said that, during the Inquiry period, poor employment practices, induction and training, and poor working conditions and remuneration contributed to the poor quality of care. It wanted to see a shift to care work being recognised as the skilled, professional work that it is.

The Royal Commission noted that, during the Inquiry period, a lack of diversity and lived experience in the care workforce contributed to a lack of understanding of those needing care. It considered that this contributed to discrimination in the care system. It saw a need to establish pathways for people with lived experience to play a role in the care system at all levels, including governance and leadership.

The Royal Commission recommended all care workers be registered and that a comprehensive pre-employment vetting regime be established and consistently applied. The regime would be one where prospective employees could be matched against a centralised list of people who were barred from working in the care system. It defined the care workforce broadly, including any person working or volunteering for a care provider or in a care facility.

### Response to recommendations about the care workforce

This section of the response includes the Royal Commission's recommendations for ensuring the care workforce reflects the diversity of those in care and workers have the right skills and experience to provide appropriate care. This includes that the workforce is appropriately regulated and vetted, and workers receive the training needed.

Across the systems that deliver care, there are a range of strategies and approaches that support building a qualified and skilled care workforce. For example, the:

- Ministry of Health has developed the *Health Workforce Strategic Framework* to ensure Aotearoa New Zealand has a sustainable, representative and responsive health workforce.
- Ministry of Education has Te Pou Ohumahi Mātauranga | Education Workforce. This business group is responsible for sector workforce strategy, teacher supply and employment relations.

Various workforce standards and registration requirements are in place across the health, education, disability and children's care workforces. One example is the Health Practitioners Competence Assurance Act 2003 (HPCA Act), which ensures health practitioners are competent and defines their scopes of practice.

Health professionals covered by the HPCA Act require registration with the relevant associated professional board or council. They also require a current New Zealand practising certificate. Other registration requirements include those for:

- teachers, who must be registered and hold a current practising certificate and are subject to the *Ngā Tikanga Matatika – Code of Professional Responsibility*
- social workers, who are required to be registered with the Social Workers Registration Board.



The Public Service *Workforce assurance model standards*, introduced in August 2020, require enhanced reference checking and disclosure of disciplinary issues for all individuals seeking employment in the public service. They complement the employment practices, including vetting, that care agencies undertake.

Part 3 of the Children's Act 2014 (the Children's Act) requires people working for State services or State-funded organisations who have regular or overnight contact with children (children's workers) to be safety checked. Safety checking requirements include confirming the person's identity, obtaining a New Zealand Police vetting report and assessing whether the person poses any risk to the safety of children. The Education and Training Act 2020 also includes vetting requirements.

The Children's Act contains a workforce restriction that makes it unlawful for a person to be employed as a core children's worker if they have been convicted for a specified offence, unless they have an exemption. The exemption process is independently facilitated by Te Kāhui Kāhu.

In addition to vetting care workers and caregivers, Oranga Tamariki carries out an assessment to determine each prospective caregiver's suitability to provide care. Their capability and capacity are matched against the unique needs of the child or young person requiring care. It uses a framework made up of six core attributes: safety, attachment, resilience, identity, integrity and support.

A contingency fund has been established through Budget 2025 to enable the Ministries of Health, Education and Social Development and Oranga Tamariki to scope, establish and deliver initiatives that respond to the Royal Commission's recommendations relating to enabling a safe and capable workforce. Funded initiatives will be included in the annual updates to this response document.

21. Workforce strategy

The Royal Commission recommended that the Care Safe Agency, once established, develop a workforce strategy to help address the issues the Royal Commission identified for the care workforce. This included ensuring enough people are available with the right skills, experiences and values to meet the needs of people in care. Delivering against this recommendation will be a sizeable task, which is why it is the only recommendation in this group.

Ministers and agencies involved: Ministry of Health | Ministry of Education | Ministry of Social Development | Oranga Tamariki

Recommendations included:	Response:	Status:
Whanaketia		
61	<div> <div></div> NEEDS FURTHER CONSIDERATION </div>	<div> <div></div> NOT STARTED </div>

Work under way

Several workforce strategies are in place that align with the Royal Commission’s recommendation 61 from Whanaketia. They include the:

- *Health Workforce Plan 2024*, which includes programmes to grow the numbers and diversity of the health workforce, including the percentage of Māori, Pacific and Deaf and disabled people as part of the workforce. It intends to address critical workforce gaps as identified by the workforce taskforce
- *Mental Health and Addiction Workforce Plan 2024–2027*, which includes growing opportunities for the consumer, peer support and lived experience (CPSLE) workforce. It includes an initiative to initially fund 200 CPSLE in entry-level roles and support them to obtain qualifications and then an additional 90 CPSLE workers per year

- *Social Work and Professional Workforce Strategy 2024–2027*, which will provide a single and consistent vision for the growth and development of the practice workforce to meet the strategic vision of Oranga Tamariki, recognising that it delivers this work in collaboration with partners.

Future work

The functional review of the care system needs to be completed before further decisions are made on the approach to a workforce strategy for the care system.

## 22. Care worker registration, barring and pre-employment vetting

These are the Royal Commission's recommendations related to individual care worker and volunteer registration, barring and pre-employment vetting. These recommendations are focussed on *individuals* rather than *organisations*.

Ministers and agencies involved: Ministry of Health | Ministry of Education | Ministry of Social Development | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>Whanaketia</b>		
57	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
58(a),(c)	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
64	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED

### Work under way

The Ministry of Health has work under way that aligns with the Royal Commission's recommendations for worker registration. It is considering options to improve regulatory settings for New Zealand's health workforce, including changes to the current Health Practitioners Competence Assurance Act 2003. The current review of regulatory settings includes consideration of an alternative form of regulation that would be suitable for lower-risk services.

A Health New Zealand-wide volunteer policy is being developed, harmonising the approach to volunteers across the organisation. This will include an appropriate approach to vetting, eligibility, recruitment and training, as well as monitoring of volunteer status. This work is aligned with the Royal Commission's recommendations for worker registration, barring and vetting.

### Future work

The functional review of the care system needs to be completed before further decisions are made on registration and vetting across the care workforce.

## 23. Children's worker safety checking regime

The Royal Commission made a specific sub-recommendation that the Government ensure the regime for children's worker safety checking remains fit for purpose. Based on the language used in Whanaketia, this is understood to be the workforce safety regime in the Children's Act 2014.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Ministry of Social Development | Oranga Tamariki

**Recommendations included:**

**Response:**

**Status:**

**Whanaketia**

58(b)

 ACCEPT

 UNDER WAY

### Work completed to date

The Responding to Abuse in Care Legislation Amendment Bill includes amendments to expand the workforce restriction in the Children's Act 2014. The intention is to prevent workers with convictions for certain offences under the Prostitution Reform Act 2003 and certain overseas convictions from being core children's workers unless exempt.

### Work under way

Cabinet has directed officials to do further work on options for improved safety checking requirements. This includes enabling employers to better identify prospective core workers who have criminal convictions from overseas jurisdictions.

### Future work

The Ministry of Education will update and publicise guidance on how to comply with the amended Children's Act 2014 when the Responding to Abuse in Care Legislation Amendment Bill comes into force. This will be done with the care agencies whose care providers have safety checking responsibilities, and with Te Kāhui Kāhu, which facilitates the core worker exemption process.











Ongoing work on recommendation **58(b)** from Whanaketia may affect work within the worker registration, barring and pre-employment checking response. It may also contribute to the recommendation on employment practices.

## 24. Employment practices, induction and training

These are the Royal Commission's recommendations associated with employment practices, induction and training for care system participants. It includes the recommendation that those working in the Justice sector should be better trained to work with Deaf and disabled people, those who are neurodivergent, and those who are survivors of abuse and neglect.

Recommendation **63(c)** from Whanaketia has been split from the other sub-part of recommendation **63** and included in the safeguarding grouping under system leadership. This is because it is a recommendation specifically about safeguarding.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Ministry of Justice | Ministry of Social Development | New Zealand Police | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>Whanaketia</b>		
33	 ACCEPT INTENT	 UNDER WAY
59	 ACCEPT	 ONGOING
60	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
62	 ACCEPT	 ONGOING
63(a),(b),(d),(e)-(i)	 NEEDS FURTHER CONSIDERATION	 NOT STARTED

### Work completed to date

Recruiting for, and supporting, a diverse workforce is existing policy for care agencies, consistent with the requirements of the Public Service Act 2020. The Act places requirements on leaders to promote diversity and inclusiveness within the workforce and workplaces. It is an ongoing requirement that addresses the Royal Commission's recommendation **62** from Whanaketia.

Care agencies also ensure all prospective staff, volunteers and other people have a satisfactory report from any applicable vetting regime and up-to-date registration status where this is required, as per recommendation **59** from Whanaketia. These legal requirements are ongoing and were in place prior to the Royal Commission making its recommendations.

### Work under way

Several New Zealand Police (Police) initiatives have supported its response to recommendation **33** from Whanaketia. It has completed a disability stocktake and is implementing a Disability Roadmap developed with leaders of the disability community and staff. As a result, Police has:

- employed a Community Inclusion and Senior Prevention Partnership Advisor
- initiated training that incorporates lived experience from disabled people
- initiated a Disability Advisory Group that meets quarterly.

**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities**

Police has also introduced a new feature in its information technology system that enables Deaf and disabled people to voluntarily provide any operational information they think is relevant to Police. This will help Police on the frontline when engaging with that person in the future. Police will promote this feature over 2025.

The Oranga Tamariki Enabling Our Practice Systems project has been focussing on areas of improvement for social work practitioners, in alignment with recommendation 33 from Whanaketia and including:

- staff being supported, enabled and empowered to provide consistent, holistic, quality social work practice
- staff being able to support and work with children, young people and their families and whānau in a relational, inclusive, restorative way.

## Future work

The Ministries of Health, Education and Social Development and Oranga Tamariki have been working across their agencies and sectors to gather more information about existing pre-employment practices, with a focus on the relevant sub-parts of recommendation 63 from Whanaketia. The next steps will be influenced by the functional review of the care system, because these decisions will affect what approach is taken.



## Identify and respond effectively to abuse and neglect

### What the Royal Commission said about the response to abuse and neglect

The Royal Commission said that, during the Inquiry period, clear reporting requirements for abuse and neglect were lacking. This meant bystanders did not have the guidance they needed to report matters of concern they had witnessed. The Royal Commission said bystanders frequently failed to report abuse and neglect.

The Royal Commission considered that a lack of mandatory reporting of abuse and neglect resulted in abusers being able to avoid accountability. This allowed them to continue to abuse children, young people and adults while working for different care providers or in different places of care. It noted the different reporting obligations on participants within the care system, and that anyone can voluntarily report abuse and neglect to Oranga Tamariki or the New Zealand Police.

The Royal Commission wanted better oversight and consistency of investigations into abuse and neglect, and better consistency in charging decisions and how charges are prosecuted. Its recommendations sought to ensure that perpetrators of abuse and neglect, and the organisations they work for, are held to account.

The Royal Commission said changes were needed in the justice sector to support victims to make complaints about abuse and neglect and to have their voices heard. It said changes were needed for victims to safely participate in investigation processes and prosecutions. It heard from some survivors who attempted to seek justice that their interactions with the justice system resulted in additional harm or trauma.

The Royal Commission considered that the impacts of abuse and neglect in care mean it is much more likely that survivors will commit offences themselves. It commissioned the *Care to Custody: Incarceration Rates* report, which found one-in-three State care-experienced children and young people went on to serve a prison sentence later in life.

The Royal Commission stated its support for approaches taken in specialist and solution-focussed courts that are designed to help defendants (many of whom are survivors) to address the causes and break the cycle of their offending. It recommended the Government continues to support and invest in these initiatives.

### Response to recommendations for responding to abuse and neglect

This section of the response includes the Royal Commission's recommendations focussed on ensuring a safe and effective legal and policy framework is in place for investigating complaints and allegations when they are made, and for prosecuting those involved in abuse and neglect. This includes recommendations associated with supporting those in care to participate in investigations and prosecutions in a way that does not further traumatise or re-traumatise them.

The Royal Commission's view that the consequences of any mandatory reporting regime would need to be carefully considered is supported. Any decision made on mandatory reporting will have flow-on effects for work on other recommendations. This includes those associated with the Royal Commission's recommended workforce strategy, organisational accreditation, worker registration, complaints processes and information sharing.

25. Mandatory reporting

The Royal Commission has a single recommendation for a limited mandatory reporting regime with obligations on participants in the care system. It noted debate has been ongoing on this matter with no consensus reached.

Ministers and agencies involved: Ministry of Health   Ministry of Education   Ministry of Social Development   New Zealand Police   Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
69	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED

Future work

Dame Karen Poutasi recommended Aotearoa New Zealand introduce mandatory reporting in her report *Ensuring strong and effective safety nets to prevent abuse of children*, which reviewed the murder of Malachi Subecz. Agencies, including the Ministries of Health, Education and Social Development, New Zealand Police and Oranga Tamariki, are working together to prepare advice on mandatory reporting to seek a decision from Ministers and Cabinet in response to the Dame Poutasi recommendation.











Insights from the work on the Dame Poutasi recommendation can be applied when considering the Royal Commission’s recommendation for mandatory reporting. However, further work and analysis is required, given the Royal Commission’s focus on abuse in care, including abuse of adults and abuse in faith-based care settings. Consideration of recommendation 69 from Whanaketia will be undertaken by agencies as priorities allow.



## 26. Prosecution guidelines

These are the Royal Commission's recommendations to amend the *Solicitor-General's Prosecution Guidelines* (SG Guidelines) and ensure that prosecutors are trained in their use. Included are recommendations associated with better enabling access to justice for Deaf and disabled people and people experiencing mental distress.

Ministers and agencies involved: Crown Law Office | Ministry of Justice | New Zealand Police

Recommendations included:	Response:	Status:
<b>Whanaketia</b>		
22(a)	 ACCEPT INTENT	 COMPLETE
22(b),(d)	 ACCEPT	 COMPLETE
22(c),(e)	 PARTIALLY ACCEPT	 COMPLETE
23	 ACCEPT	 COMPLETE
24	 ACCEPT	 UNDER WAY

### Work completed to date

The scheduled review of the SG Guidelines has been completed by the Crown Law Office. The SG Guidelines support prosecutors to make decisions that are fair, detached and objective, while considering all the relevant circumstances of each case. The review of the SG Guidelines included consultation with various people who work in or experience the criminal justice system.

The SG Guidelines are drafted to support prosecutors' compliance with the law, including all relevant human rights law, and include guidance on processes that facilitate unbiased decision-making. They:

- include consideration of the personal characteristics and circumstances of the suspect (such as whether the suspect has any disability or is experiencing any significant mental health issues)

- provide general guidance about how victims' circumstances should be taken into account (including providing guidance relevant to disabled people and victims who have experienced trauma).

The SG Guidelines are drafted to support prosecutors' compliance with the law, including all relevant human rights law. They do not specify compliance with New Zealand's international human rights obligations and other relevant international law obligations in the way recommended by the Royal Commission. This is why recommendation **22(a)** from Whanaketia is recorded as "accept intent".

Recommended **22(c)** is partially met because the public interest test is not explicit that harm in State care weighs in favour of prosecution. Instead, it provides general guidance about how victims' circumstances should be taken into account. The vulnerability of a victim in State care and the harm caused to them will be relevant.

Recommendation 22(e) has six specific sub-parts. This recommendation is partially met. The SG Guidelines provide a detailed process for reviewing decisions in cases involving sexual violation. For all other offences in Part 7 and Part 8 of the Crimes Act 1961, the SG Guidelines do not expressly require a review process. They do, however, have a general requirement for a clear explanation for a decision not to prosecute, and they recognise that prosecuting agencies may review prosecution decisions in certain circumstances.

### Work under way

New Zealand Police is working to have all prosecutors and frontline staff trained on the revised SG Guidelines in advance of them coming into effect on 1 January 2026. For this reason, recommendation 24 remains “under way”.

OBJECTIVE ONE:  
Address the wrongs of the past



























OBJECTIVE TWO:  
Make the current care system safe

OBJECTIVE THREE:  
Empower those in care, their families,  
whānau and communities

## 27. Criminal and civil justice legislation

These are the Royal Commission's recommendations to amend several pieces of legislation, the: Crimes Act 1961, Oranga Tamariki Act 1989, Sentencing Act 2002, Criminal Records (Clean Slate) Act 2004, Evidence Act 2006 and Legal Services Act 2011. This includes the Royal Commission's recommendations associated with amending the Limitation Act 1950 and Limitation Act 2010, with retrospective effect, to be inclusive of survivors whose claims were, or may be, subject to a limitation defence under the Acts.

**Ministers and agencies involved:** Ministry of Justice | Ministry of Business, Innovation and Employment (Accident Compensation Policy) | Oranga Tamariki

Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
78	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
79	 DECLINE	–
80	 ACCEPT INTENT	 COMPLETE
81	(replaced by Whanaketia 31 and 33)	
Whanaketia		
26	 ACCEPT	 UNDER WAY
27(a)	 ACCEPT INTENT	 COMPLETE
27(b)	 ACCEPT	 COMPLETE
27(c)	 DECLINE	–
28	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
29	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
30	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
31	 ACCEPT	 UNDER WAY
32	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
37	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
38	 NEEDS FURTHER CONSIDERATION	 NOT STARTED



**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities****Work completed to date**

Changes were made to legal aid through Budget 2022 that address recommendation **80** from He Purapura Ora, to review and consider raising the legal aid lawyer rates available for abuse in care work.

A 12 percent increase in hourly rates came into effect on 1 July 2022. In addition, an increase in eligibility rates, increase in debt repayment thresholds, removal of interest and removal of the \$50 user charge came into effect for people accessing legal aid on 1 January 2023.

The legal aid changes applied across civil proceedings, not solely to abuse in care work. To reflect the complexity of some cases, including abuse in care cases, legal aid providers may request funding for additional hours. The Legal Services Commissioner also has the discretion to increase the hourly rate for legal aid providers in complex cases where a special set of skills or experience is required.

Two amendments have been made to existing aggravating factors in the Sentencing Act 2002. These changes reflect the vulnerability of victims of offending in State or Faith-based care and the vulnerability of victims of violence or neglect who are under 18 years old.

The amendments to the Sentencing Act 2002 were incorporated into the Sentencing (Reform) Amendment Bill, which was passed on 26 March 2025. This addresses recommendations **27(a)** and **(b)** from Whanaketia. Recommendation **27(a)** is recorded as “accept intent” because, instead of adding a new aggravating factor as recommended by the Royal Commission, an amendment was made to an existing aggravating factor.

**Work under way**

Remuneration for legal aid providers will be considered as part of the Ministry of Justice (Justice) triennial review of the legal aid scheme, which began in January 2025. Work is also being led by Justice to establish a list of lawyers available to provide legal advice on abuse in care cases.

An amendment to the Crimes Act 1961 to explicitly include a reference to disability in the definition of vulnerable adult has been introduced to Parliament in the Responding to Abuse in Care Legislation Amendment Bill. It has been reported back by the Social Services and Community Select Committee. This addresses Whanaketia recommendation **26**.

Work to consider recommendation **37** from Whanaketia proposing amendments to the Legal Services Act 2011 is progressing as part of the triennial review of the legal aid scheme, which began in January 2025. Justice has also started work to consider recommendation **78** from He Purapura Ora, which proposes amendments to the Limitation Act 1950 and Limitation Act 2010.

**Future work**

Consideration of recommendation **29** from Whanaketia, proposing an amendment to the Criminal Records (Clean Slate) Act 2004, is on the Ministry of Justice’s long term work programme to be considered as priorities allow. Recommendation **38** from Whanaketia, proposing an amendment to the Evidence Act 2006, will be considered as part of Justice’s ongoing regulatory stewardship work and any future review of the Act.

Consideration of recommendation **30** from Whanaketia, proposing an amendment to the Victims’ Rights Act 2002, will be incorporated into a future Justice review of that Act. Consideration of recommendation **28** from Whanaketia will be undertaken by Oranga Tamariki as priorities allow.



## Reason for decline

Recommendation 79 from He Purapura Ora will not be progressed. The Ministry of Justice is progressing work to address obstacles to civil litigation identified by the Royal Commission in He Purapura Ora and Whanaketia. At this time, resources will not be dedicated to identifying additional obstacles.

Recommendation 27(c) from Whanaketia has been declined. This is because consideration of offenders' backgrounds, including the circumstances of any previous convictions, is already adequately provided for under several provisions in the Sentencing Act 2002. In addition, concerns were raised about the workability of implementing recommendation 27(c) within the existing sentencing framework.

OBJECTIVE ONE:  
Address the wrongs of the past

OBJECTIVE TWO:  
Make the current care system safe

OBJECTIVE THREE:  
Empower those in care, their families,  
whānau and communities

## 28. New Zealand Police Manual

This is the Royal Commission's recommendation to review the New Zealand Police Manual (the Police Manual), to ensure it reflects and refers to Aotearoa New Zealand's international obligations. This is to make sure Police are trained in those obligations and consider them during criminal investigations.

Ministers and agencies involved: New Zealand Police

Recommendations included:

Response:

Status:

Whanaketia

34

 ACCEPT

 UNDER WAY

### Work under way

The Police Manual sets out the policies of the Police. A triage process to prioritise the (600-plus) Police Manual chapters has been completed, and next steps in the review have been planned. The triage prioritised chapters that already cover the Human Rights Act 1993, Bill of Rights Act 1990, te Tiriti o Waitangi (the Treaty of Waitangi), and any United Nations conventions. It then identified broader topics, such as age, gender, disabilities, freedoms of expression, iwi, Māori, and te Tiriti o Waitangi principles. The anticipated timeframe for the complete review is three to five years.



29. Investigations into abuse and neglect, including torture

These are the Royal Commission’s recommendations relating to investigations into allegations of abuse and neglect, including allegations of torture. These recommendations are for all care system participants and any agency that may receive such allegations.

The response to recommendation 6 from Whanaketia has been recorded as “accept intent” because New Zealand Police (Police) investigations cannot be initiated without a complaint or allegation being made. Capacity constraints and current investigative demands mean Police will generally not be reopening previous investigations proactively.

Care system agencies and the Police accept the intent of recommendation 7 from Whanaketia, noting it has multiple, specific sub-parts. Any agency response to allegations of torture, cruel, inhumane or degrading treatment will be thorough and robust, but may not occur consistently with the specific sub-parts.

Police accepts the intent of recommendation 35 from Whanaketia and is confident it is meeting this intent through its current approach.

Ministers and agencies involved: Ministry of Health   Ministry of Education   Ministry of Justice   Ministry of Social Development   New Zealand Police   Department of Corrections   Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
6	● ACCEPT INTENT	🕒 UNDER WAY
7	● ACCEPT INTENT	🕒 UNDER WAY
35	● ACCEPT INTENT	🕒 UNDER WAY

Work under way

The National Criminal Investigations Group is re-designing the training programme for investigators at all levels. In addition to the training which occurs in the first two years of an investigator’s career, there will be an advanced investigators course and other specialist courses all which form part of a professional development programme for investigators. Recognising and responding to torture will be included in this programme and the first advanced investigators course is due to be delivered in the second half of 2025.

NZ Police accepts and is confident it is meeting the intent of the recommendation 35 through its current approach. Rather than establishing a specialist unit, NZ Police will continue to utilise its existing specialist investigative teams around the country, which have significantly improved since the period the Royal Commission examined.

Police has work under way in response to the Royal Commission’s report *Stolen Lives, Marked Souls* on the abuse and neglect of children and young people of the Catholic Order of the Brothers of St John of God at Marylands School and Hebron Trust in Ōtautahi Christchurch.

OBJECTIVE ONE:

Address the wrongs of the past

OBJECTIVE TWO:

Make the current care system safe

OBJECTIVE THREE:

Empower those in care, their families, whānau and communities

## Future work

Training of all existing Police investigators and new recruits to recognise and respond to abuse and neglect, including torture, will be achieved over time. The training will become compulsory for all constabulary staff.





30. Judicial-led initiatives

The Royal Commission has a single recommendation to the Government in support of judicial-led initiatives such as *Te Ao Mārama – Enhancing Justice for All*.

Ministers and agencies involved: Ministry of Justice		
Recommendations included:	Response:	Status:
Whanaketia		
25	<div></div> ACCEPT	<div></div> ONGOING

Work under way

The Government is supporting and investing in the *Te Ao Mārama – Enhancing Justice for All* initiative that seeks to address the causes of offending and improve access to justice. The Ministry of Justice is partnering with communities and iwi in eight District Court locations to develop and implement locally led solutions that meet the needs of the community. This will improve the District Court system and the outcomes for all who participate within it. The initiative is led by the judiciary.

## OBJECTIVE THREE:

# Empower those in care, their families, whānau and communities

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This objective includes the Royal Commission's recommendations to support and empower those in care, their families, whānau and communities. It includes recommendations to improve recordkeeping and access to records, prevent entry into State care, and to listen to the voices of those in care, their families, whānau and communities.

## Improve recordkeeping and access to records

### What the Commission said about recordkeeping and access to records

The Royal Commission identified low levels of information management maturity and compliance across care agencies, along with issues with record creation, storage and maintenance. It said this led to records not being available when required.

The Royal Commission heard from survivors of abuse and neglect who said that, because they were not believed, no records were created of their complaints and allegations of abuse and neglect. It said poor recordkeeping and data practices led to a lack of accountability and external scrutiny. Opportunities were missed for detecting abuse and neglect, and this contributed to abuse and neglect continuing.

### Response to recommendations for recordkeeping and access to records

Considerable work has already been completed to address the Royal Commission's recommendations to improve:

- **recordkeeping** because having accurate and up-to-date records is critical to understanding and meeting the individual needs of those in care
- **access to records** because this is essential to enabling those in care to understand their care experience and connect with family, whānau and community.

31. Recordkeeping and access to records

These are the Royal Commission’s recommendations to improve recordkeeping systems and processes, record access requests, and survivors’ experiences and outcomes when requesting their personal records.

Ministers and agencies involved: Ministry of Health   Health New Zealand   Ministry of Education   Crown Response Office   Ministry of Justice   Ministry of Social Development   New Zealand Police   Department of Corrections   Department of Internal Affairs   Archives New Zealand   Oranga Tamariki		
Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
85	ACCEPT INTENT	ONGOING
86	ACCEPT INTENT	ONGOING
87	ACCEPT INTENT	COMPLETE
88	ACCEPT INTENT	COMPLETE
89	ACCEPT INTENT	ONGOING
Whanaketia		
81	ACCEPT INTENT	UNDER WAY
82	ACCEPT INTENT	UNDER WAY

Work completed to date

A range of work has been undertaken to support improvements in recordkeeping practices and access to records, in response to He Purapura Ora recommendations 85-89.

Records redaction guidance, to help improve consistency of practice across State and non-State record holders, was published on the Crown Response Office website in April 2023. Supporting information for survivors was also published.

Archives New Zealand (Archives) developed and published a definition of “care records”. This was used by the Chief Archivist in April 2024 to issue a

*Temporary care records protection instruction.* This instruction has been used to protect care records of value to survivors since the Royal Commission’s moratorium ended and while Archives works with agencies to update their records disposal authorities.

Agencies worked with the Survivor Experiences Service to establish a records support function. It is designed to make requesting care records safer and easier for survivors. This was launched in August 2024 and will continue, following renewed funding announced in May 2025.

Agencies worked with the Citizens Advice Bureau to develop a one-stop-shop website to help survivors and other care-experienced people understand and navigate the care records landscape. It was

launched in February 2025. Funding to maintain the independent records website was confirmed as part of the Government's improvements to redress announced in May 2025.

In February 2025, Chief Executives endorsed *The Care Records Framework*. It is designed to support care record holders to improve their practice of creating, managing and providing access to care records.

Health New Zealand has issued guidance for the lifecycle management of care records, consistent with its obligations to keep clear and well-documented records under the Health Information Privacy Code 2020, the Health (Retention of Health Information) Regulations 1996, the Health Information Governance Guidelines and Health Information Security Framework.

New Zealand Police (Police) has established a process for better supporting access to the care records it holds. Where requests for information are identified as relating to time in care, they are forwarded to the Police Inquiry Support team to manage.

Archives has worked to better catalogue and index the care records it holds. This is to make requests for records held in government archives quicker to complete and more fulsome in content for survivors.

### Work under way

Archives is reviewing all disposal authorities to identify and protect care records created within the care system and all other areas of central government. It is working with care agencies to improve compliance with the Public Records Act 2005 for care records created by contracted care providers.

The Ministry of Education (Education) is reviewing the record retention and disposal requirements for the education sector. It is cataloguing its own information stores to understand the information it holds that will be of interest to survivors. Work is also under way with Archives to understand how the care records definition will apply to records held by Education and

in the sector, such as in early learning services and schools.

Police have drafted guidance for how the care records definition applies in a Police context. Work is ongoing to identify which records held by Police may fall within the definition.

The Department of Internal Affairs and Archives are supporting the Responding to Abuse in Care Legislation Amendment Bill, which contains amendments to the Public Records Act 2005. These amendments will enable the Chief Archivist to more effectively identify problems with creating and maintaining records, encourage improved recordkeeping and ensure an appropriate response where poor practice is identified.

### Future work

The Care Records Framework will be implemented across government agencies. A phased approach will be taken to manage the scope and size of the changes.

Education will scope what changes are required recordkeeping system and processes within the Ministry of Education and the education sector, to be able to identify relevant current and future care records. It will develop a phased implementation plan for identified changes required.

Education and the Ministry of Social Development | Disability Support Services will work together, and with Archives to:

- develop training resources and guidance tailored to the specific needs of schools and disability service providers
- ensure the schools and disability service providers are aware of their responsibility for secure storage of care records
- assess need, facilitate, and if feasible offer support for, secure storage for care records, for the targeted group of smaller providers only.

**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities**

This will be targeted initially at those with higher needs for expert input and resource support, or who have been identified as at higher risk. This includes specialist schools, schools with a higher equity index number, schools and kura in isolated areas, and smaller disability service providers without the infrastructure to develop the required guidance to support recordkeeping processes.

Archives will implement the new powers in the Public Records Act 2005 that will be made available with the passage of the Responding to Abuse in Care Legislation Amendment Bill.

Archives will also host a central advisory service to provide expert advice to agencies, reducing the need for each agency to invest separately. The service will advise and support agencies as they respond to queries from providers about care records.



## Prevent entry into State care

### What the Royal Commission said about preventing entry into State care

The Royal Commission said it was critical that children, young people and adults do not experience the kinds of institutional environments and practices that led to historic abuse and neglect in care. To support this, it recommended the care system move towards more contemporary and community-based models of care.

The Royal Commission said that, throughout the Inquiry period, discriminatory attitudes shaped decisions about who needed care, the treatment of people in care and the places in which care was provided. It also said society lacks an understanding of the effects of being care experienced on those who were in care, their families, whānau and communities.

The Royal Commission expressed concern that abuse and neglect were still occurring. It saw the need for increased investment in abuse prevention programmes. It also saw a need for people to better understand abuse and neglect and how to protect themselves from it.

### Response to recommendations for preventing entry into State care

This section of the response includes the Royal Commission's recommendations on contemporary and community-based models of care. It includes its recommendations for the provision of care that responds to the needs and vulnerabilities of those in care and protects and enhances the mana and mauri of Māori.

Since the time investigated by the Royal Commission, improvements have been made across the care system to prevent entry into care, and support more contemporary and community-based models of care. Improvements include new approaches, such

as Whānau Ora, which supports whānau, hapū and iwi, and te ao Māori-led programmes and projects to improve outcomes for all Aotearoa New Zealand. Examples of these programmes include the:

- *Whānau Centred Facilitation Initiative* to eliminate family violence and sexual violence through early intervention and prevention support. The initiative uses a codesign approach with 13 providers within Māori communities. It has been running since 2017 and will be completed by the end of June 2025
- *Ngā Tini Whetū* whānau-centred early intervention initiative for whānau Māori with tamariki where early signs of risk have been identified. Ngā Tini Whetū is shifting focus from early intervention to preventing entry into care, through targeted and intensive support for pēpi (babies) and whānau in the first 1,000 days of the child's life. It will continue until 30 June 2027.

Several cross-government strategies are now also in place to support families, whānau and communities. These include the *Child, Youth and Wellbeing Strategy 2024-2027* and *Oranga Tamariki Action Plan* that stems from it, along with the *Te Aorerekura – the National Strategy to Eliminate Family Violence and Sexual Violence*. Various other cross-government and individual agency programmes and projects also support family, whānau and community.

As part of Budget 2025, contingency funding has been allocated to the Social Investment Agency to invest in initiatives that prevent children, young people and adults from entering care. Work to understand which initiatives could be invested in is under way. Agreed initiatives will be included in updates to the Crown response.

32. Contemporary and community models of care

These are the Royal Commission’s recommendations for the provision of care that responds to the needs and vulnerabilities of those in care, and protects and enhances the mana and mauri of Māori in care. This includes recommendations on contemporary care practices, including deinstitutionalisation and devolving care to communities.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Ministry of Social Development | Whaikaha – Ministry of Disabled People | Te Puni Kōkiri | Oranga Tamariki

Recommendations included:	Response:	Status:
Whanaketia		
71	ACCEPT INTENT	ONGOING
78	ACCEPT INTENT	ONGOING
115	NEEDS FURTHER CONSIDERATION	NOT STARTED

Work under way

The intent of the Royal Commission’s recommendations 71 and 78 from Whanaketia is accepted, and work is progressing to ensure the institutional environments and practices that led to the abuse and neglect identified by the Royal Commission are not perpetuated.

The Mental Health Bill will introduce new principles that compulsory care should reflect and be responsive to the needs, including cultural needs, of the person. The Bill includes new care planning requirements that involve a holistic assessment of a person’s needs, including transition planning when a person is ready to exit compulsory care. People must also have a rōpū whaiora (a collaborative care team) in place. This will include care practitioners with expertise that reflects the needs of the person, including cultural and lived experience expertise.

Decentralising the functions and powers of Oranga Tamariki is a commitment set out in the report *Oranga Tamariki Strategic Intentions 2024/25–2029/30*. Oranga Tamariki has two approaches

supporting decentralisation under the banner of “Enabling Communities”:

- prototypes towards long-term transformation
- business-as-usual approaches based on a partnered response.

Ten Enabling Communities prototypes are at varying stages of design and implementation. Nine are led by iwi and Māori organisations. They are developing a work programme with Oranga Tamariki to support and care for their tamariki (children), rangatahi (young people) and whānau. A Pacific prototype is also in the early design phase.

Oranga Tamariki is reinstituting and refreshing its commissioning cycle for the provision of support and care services. The work involves the development of clear timelines and guidance for contracting and commissioning processes, development of new outcomes-based performance measures for contracts incorporating the voices of children, and improved stakeholder management. Oranga Tamariki also is initiating new organisational governance and oversight for its commissioning functions.



**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities**

Oranga Tamariki is improving how care services are funded through anticipating the needs of children and young people, and is drafting new contracts with an appropriate funding model. Once an approach to contracting these services has been finalised, it will run competitive procurement processes to secure new services to meet needs.

**Future work**

The Ministry of Social Development | Disability Support Services is planning to consult on guidelines for the flexible funding of disability support services, as part of the work programme to stabilise disability support services. The work includes improving assurances that flexible funding is being used appropriately and safely. It could also include criteria that ensure flexible funding is safe and appropriate for individual disabled people.



### 33. Social, educational and prevention campaigns and programmes

These are the Royal Commission's recommendations for various social and educational campaigns, including those to:

- address discriminatory attitudes and behaviour, and enable people to better understand, recognise and respond to abuse and neglect
- help Aotearoa New Zealand better understand the impact of abuse and neglect on survivors, to minimise shame, because they were not at fault.

The Royal Commission's recommendations for prevention programmes, and specialist support for those people who exhibit harmful behaviour and may be at risk of abusing others, are included here. Also included is the recommendation for independent Aotearoa New Zealand-specific research on the effects and causes of abuse in care. Links exist between these recommendations and those for human rights-focussed care system performance indicators.

**Ministers and agencies involved:** Ministry of Health | Ministry of Education | Ministry of Justice | Ministry of Social Development | New Zealand Police | Accident Compensation Corporation | Oranga Tamariki

Recommendations included:	Response:	Status:
<b>He Purapura Ora, he Māra Tipu</b>		
73	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
74	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
<b>Whanaketia</b>		
111	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
112	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
121	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
122	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
128	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED

**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities****Work under way**

The Accident Compensation Corporation has two main communication initiatives that align with the intent of these recommendations. These aim to promote wellbeing and prevent harm, challenge the normality and inevitability of violence, promote healthy relationships and oranga whakapapa (mana-enhancing tapu-enriched relationships) and to model oranga whakapapa behaviour:

- “Hono” is a te ao Māori-led behaviour change initiative that focusses on sexual violence awareness and improving how sexual violence is spoken about in the media
- “This is Aotearoa” will involve sharing stories about everyday actions that strengthen whānau and communities, with each story showcasing protective factors in action.

“Hikitia! For Our Future” (Hikitia!) is a community-led, systems-focussed prevention initiative beginning in five regions. Hikitia! providers work to address the underlying causes or drivers of sexual and family violence (including child sexual abuse) through communities.

**Future work**

Dame Karen Poutasi’s report, *Ensuring strong and effective safety nets to prevent abuse of children*, recommended there be public awareness campaigns about abuse and neglect. Work to develop such campaigns is being considered by agencies.



34. Gloriavale

This is the Royal Commission’s recommendation that the Government take all practical steps to ensure the ongoing safety of children, young people and adults in care at Gloriavale.

**Ministers and agencies involved:** Ministry of Health | Health New Zealand, | Ministry of Education | Ministry of Social Development | New Zealand Police | Ministry of Business, Innovation and Employment (Labour Inspectorate) | Department of Internal Affairs (Charities Services) | WorkSafe New Zealand | Oranga Tamariki

Recommendations included:	Response:	Status:
Whanaketia		
88	<div> <div></div> ACCEPT INTENT </div>	<div> <div></div> ONGOING </div>

Work completed to date

Various regulatory agencies have worked in the Gloriavale community for many years. An Employment Court decision in 2022 disclosed significant new information about the community, which enabled some agencies to take an increasingly active stance. From mid-2022 until the end of 2023, a formal structure existed to coordinate agencies’ activities and report on their outcomes. As detailed below, operational activities are ongoing, with inter-agency cooperation and information sharing continuing, where appropriate.

New Zealand Police (Police) conducted several significant criminal investigations into complaints relating to Gloriavale. In addition, in 2021, the West Coast Police Community Prevention team organised several policing activities at Gloriavale. The aim was to increase trust in the Police within the community.

Work under way

The intent of the Royal Commission’s recommendation for Gloriavale is accepted, and cross-government work is ongoing to support safety in the community. Regional operational leads from Health New Zealand, the Ministries of Education, Social Development, and Business, Innovation and Employment (Labour Inspectorate), along with the New Zealand Police, Department of Internal Affairs (Charities Services), WorkSafe New Zealand and Oranga Tamariki, meet monthly. These meetings are for information sharing on the work agencies are doing in relation to the community at Gloriavale. Regional leaders from these agencies meet with the Regional Public Service Commissioner on a six-weekly basis.

The Ministry of Social Development ensures residents of Gloriavale can access social welfare benefits, if they qualify. It provides welfare and employment-related support and housing assistance to individuals who wish to leave the community.

Following a 2023 Education Review Office special review of Gloriavale Christian School, the Ministry of Education meets monthly with the school to monitor progress in addressing the review findings. The school provides fortnightly reports to the Ministry

**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities**

of Education on progress. These reports include curriculum, learning and wellbeing improvement strategies.

Police has a dedicated investigator overseeing all Police involvement with Gloriavale, who works in collaboration with Oranga Tamariki, and other agencies where the need arises. It has ongoing investigations relating to Gloriavale.

In the Ministry of Business, Innovation and Employment, the Labour Inspectorate continues to assess compliance with employment standards at Gloriavale. It is awaiting the outcome of the Court of Appeal hearing of Gloriavale's appeal in the Pilgrim case set for October 2025. The Labour Inspectorate has also filed a request for a compensation order in the Employment Court on behalf of the Courage and Pilgrim plaintiffs.

Oranga Tamariki has established a national oversight group made up of representatives of its Legal, Professional Practice and Operations staff. This group meets weekly with regional staff, to provide advice and support and ensure a line of sight across all issues associated with Gloriavale. Oranga Tamariki also holds a weekly practice-focussed meeting to discuss any specific case practice issues and provide practice advice and support.



## Listen to the voices of those in care

### What the Royal Commission found about listening to the voices of those in care

Many of the Royal Commission's findings emphasised the disempowered position of people in care, particularly those whose rights, including under te Tiriti o Waitangi (the Treaty of Waitangi), were overridden or denied. The Royal Commission said children and young people, especially tamariki and rangatahi Māori (Māori children and young people), and disabled children and young people, including tamariki and rangatahi hauā (disabled Māori children and young people), were undervalued and had no voice in the care system.

The Royal Commission said those suffering from abuse and neglect were often not understood or believed. It found that many people in the care system had no advocate to support them and were not supported to effectively participate in decisions about their care.

During the Inquiry period, the Commission found that decision-makers generally had limited involvement in or connection with the people and communities about which they were making decisions. This included connection with Māori, Pacific Peoples, Deaf and disabled people and those experiencing mental distress.

The Royal Commission noted that the State continues to hold significant legislative power to intervene and make compulsory decisions about people's lives, including removal and placement in out-of-family and whānau care. It considered that work is needed to bring people closer to the decisions that affect them.

### Response to recommendations for listening to the voices of those in care

This section of the response includes the Royal Commission's recommendations to ensure those in care, their families, whānau and communities have a say about care standards, policies and procedures, and the places in which care is provided. It includes recommendations related to complaints processes.

Significant change has occurred in complaints processes across the care system to improve how the voices of those in care are heard when they raise issues and make allegations.

- Health New Zealand and its providers manage complaints in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights. The HDC promotes and protects people's rights. Complaints can be made by the person who received the care, a friend or family member of that person, a service provider, or any other concerned person.
- District Inspectors are appointed by the Minister of Health to independently inspect places where people are receiving compulsory treatment or care under the Mental Health (Compulsory Assessment and Treatment) Act 1992, Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and Substance Addiction (Compulsory Assessment and Treatment) Act 2017. They can investigate complaints and can exercise powers of inquiry.
- A nationwide Health and Disability Advocacy Service is available for free, to help people understand their rights when using health or disability services, get questions answered or to make a complaint. It operates independently from all government agencies, health and disability service providers and from the HDC.







**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities**

- Serious wrongdoing by or in an organisation delivering education services can be reported through a protected disclosure to the Ministry of Education. Employers and former employers of registered teachers have legal obligations to report to the Teaching Council in certain circumstances. The Teaching Council's Complaints Assessment Committee may refer the matter to a disciplinary tribunal independent of the Teaching Council.
- Oranga Tamariki has processes in place to ensure responses to feedback and complaints are appropriate. If an allegation of abuse or harm is raised, it will investigate and take all necessary steps to ensure the safety of the child. This would include consultation with New Zealand Police to determine if a joint investigation may be required.



35. Those in care, family and whānau to participate in care decisions

These are the Royal Commission’s recommendations for those in care to have advocates, and for a pathway to being an advocate for those with care experience. It includes the Commission’s recommendation to accelerate work to enable those in care to participate in decisions about them.

Ministers and agencies involved: Ministry of Health   Ministry of Education   Ministry of Justice   Ministry of Social Development   Whaikaha – Ministry of Disabled People   Te Puni Kōkiri   Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
76	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
77	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
114	 ACCEPT INTENT	 UNDER WAY

Work under way

The importance of work to enable those in care, their families and whānau to have a greater voice in decisions that affect them is acknowledged. This is why the intent of recommendation 114 from Whanaketia has been accepted and is under way.

The Mental Health Bill progressing through Parliament will introduce the roles of independent support people and advocates, to support the decision-making of those in care. It will include participation duties, to ensure people in care are encouraged and helped to participate in decisions being made about them. It will also provide for more robust family and whānau involvement, including through the introduction of hui whaiora (wellbeing meetings), which will, among other things, enable whānau to be part of decisions about a person’s care.

The Minister of Justice has asked the Law Commission to carry out a review of adult decision-making capacity law. The review will focus on the Protection of Personal and Property Rights Act 1988, which is the primary piece of legislation relating to decision-making capacity. This provides several

decision-making arrangements for people who do not have decision-making capacity, such as welfare guardians, property managers and enduring powers of attorney. The Law Commission is due to provide its final report to the Minister of Justice in mid-2025.

“People for Us” is a new peer-visiting initiative established by the Ministry of Social Development | Disability Support Services. Disabled adults who live in residential services will be visited and provided with help to resolve concerns they may have with the provision of their care. It is focussed initially on people at higher risk of abuse or neglect, for example, those without family, whānau and friends to support and advocate for them. Three providers have been contracted, with visiting due to begin in May 2025, once staff have been recruited and trained.

The Ministry of Disabled People – Whaikaha is working, in collaboration with an advisory group, on creating a hosted website with resources about supported decision-making. The website will include practical resources to support disabled people and others requiring support to make their own decisions in key areas of their lives including health and wellbeing, housing, education and employment. The website covers what supported decision-making



is, why it is important and ways to assist. It includes videos, case studies, images, and posters, with links and references to a range of other resources. The website is expected to be launched in mid-2025.

Oranga Tamariki is supported by advisory groups that provide critical advice, perspectives and assurance to the Chief Executive. A Rainbow Advisory Group is being established. The advisory groups help ensure the unique voices of a range of communities and population groups are heard. Current advisory groups include the following:

- Youth Advisory Group
- Disability Advisory Group
- Pacific Panel.

Oranga Tamariki supports and works closely with VOYCE Whakarongo Mai (VOYCE). VOYCE is an independent organisation that provides advocacy and connection services for children and young people in care. Manaaki Kōrero is a programme of work in which Oranga Tamariki has partnered with VOYCE to collaboratively design and deliver improved processes for feedback, complaints, grievances, information, advice and assistance. Manaaki Kōrero aims to create an environment that ensures tamariki, rangatahi and their whānau:

- can access the information, advice and support they need
- have confidence in the feedback, complaint and resolution process
- are able to raise their concerns safely.

Integrated Voices is a project built from Manaaki Kōrero. It aims to improve how Oranga Tamariki manages and uses tamariki, rangatahi, whānau and community voices to inform decision-making and actions. This is working towards a system that provides information, channels, support and advocacy, with a culture that welcomes and proactively encourages tamariki, rangatahi, whānau and caregivers to provide feedback and raise concerns.

## Future work

Further work on these recommendations will be considered for future phases of the response. It will be based on decisions made in response to the functional review of the care system, and the priorities of agencies, Ministers and Cabinet.

36. Complaints processes and information sharing

These are the Royal Commission’s recommendations associated with complaint processes and information sharing in response to complaints and allegations. The Commission’s recommendation 65 from Whanaketia detailed what it expects a complaint process to deliver. It also outlined a pathway for escalating complaints and allegations, and monitoring and reporting on them.

Ministers and agencies involved: Public Service Commission   Ministry of Health   Ministry of Education   Ministry of Social Development   Department of Corrections   Te Puni Kōkiri   Oranga Tamariki		
Recommendations included:	Response:	Status:
Whanaketia		
63(j)	<div></div> ACCEPT	<div></div> COMPLETE
65	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED
66	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED
67	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED
68	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED
83	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED
84	<div></div> NEEDS FURTHER CONSIDERATION	<div></div> NOT STARTED

Work completed to date

The Protected Disclosures (Protection of Whistleblowers) Act 2022 covers protection of disclosures of serious wrongdoing in a person’s workplace. Staff who raise complaints and allegations of abuse and neglect in care have their identities protected and are also protected from retaliation under employment and human rights law. Although this was implemented before Whanaketia, it addresses the issues raised by recommendation 63(j).

Other work that aligns with the Royal Commission’s recommendations for complaint processes completed in recent years includes the following:

- Guidance for complaints about Ministry of Social Development | Disability Support Services (MSD | DSS) funded providers was updated in July 2024, following seven consultation workshops with providers, Deaf and disabled people and their family and whānau. MSD | DSS completed an internal review of its complaints process in October 2024. The results of the review are informing work to improve the complaints process.

**OBJECTIVE ONE:****Address the wrongs of the past****OBJECTIVE TWO:****Make the current care system safe****OBJECTIVE THREE:****Empower those in care, their families, whānau and communities**

- The MSD Historic Claims safety check process is used when an allegation of sexual abuse or moderate to serious physical abuse is made against a named individual at any stage during MSD's historical claim process. The focus and purpose of this process is to ensure the safety of children or vulnerable people in care. Part of this involves sharing details of allegations with relevant agencies (including Oranga Tamariki) to determine if an individual is currently a staff member or a caregiver for that agency, to enable an appropriate response.

**Work under way**

The Mental Health Bill will help strengthen existing complaints processes for people subject to the legislation as well as voluntary patients receiving mental health care in inpatient settings. This will include through District Inspectors being guided by new principles to improve accessibility, timeliness and transparency of the complaints process.

Under the new Mental Health Bill, the Director of Mental Health will be empowered to direct health service providers to publicly set out how they will address the recommendations of a District Inspector who has investigated a complaint, where those recommendations have not yet been satisfactorily resolved. These changes are aligned with the Royal Commission's recommendations.

**Future work**

The Public Service Commission is scoping a programme of work regarding complaints processes and handling across the public service. The work will be informed by the Royal Commission's findings and recommendations.

Work on the functional review of the care system, together with decisions on the establishment of a Care Safe Agency, will influence roles and responsibilities of agencies in complaint processes (as per recommendations 65, 66, 67 and 68 from Whanaketia). Further work on complaints processes and information sharing will follow these decisions.

MSD will initiate work to deliver new software that will enable the capture and analysis of critical incidents and complaints across MSD | DSS. It will create better visibility of trends across incident and provider types, allowing appropriate targeting of quality initiatives.



# Implementation recommendations

The Royal Commission made several recommendations about “how” the Crown response should be delivered and reported on. These implementation recommendations have been grouped into themes that cover:

- implementing all the recommendations, with cross-party agreement
- partnering with Māori and giving effect to te Tiriti o Waitangi (the Treaty of Waitangi)
- co-designing the response with participants in the care system
- giving effect to human rights
- publishing and reporting on the Crown response.

The current “response” and “status” recorded against these implementation recommendations will be updated over time. This is because the Crown response to He Purapura Ora and Whanaketia requires a multi-year, multi-agency work programme.










## Implement all recommendations, with cross party agreement

The recommendations in this group all relate to accepting and implementing the Royal Commission's recommendations.

The Royal Commission recommended cross-party agreement should be sought to implement the recommendations (recommendation **132** from Whanaketia). This recommendation is partially accepted. It may not be practical to engage across parties on every matter associated with the Crown response, given its complexity and size. Case-by-case decisions will be made. It is noted that each party will form its own view on the recommendations and the work to respond to them.

Because the response requires a multi-year, multi-agency programme of work, the implementation timeframe set out by the Royal Commission (at recommendation **135** from Whanaketia) has been declined. The Royal Commission itself noted, "[t]he changes needed to ensure care in Aotearoa New Zealand is safe are significant and will take time to be effectively implemented".<sup>3</sup>











Recommendations included:	Response:	Status:
Whanaketia		
1	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
125	 NEEDS FURTHER CONSIDERATION	 UNDER WAY
132	 PARTIALLY ACCEPT	 UNDER WAY
135	 DECLINE	–

<sup>3</sup> Whanaketia – The Future, para 727, page 325.



## Partner with Māori and give effect to te Tiriti o Waitangi

These recommendations all relate to the response being delivered in partnership with Māori and consistently with te Tiriti o Waitangi. The intent of these recommendations has been accepted, as the Crown's commitment to te Tiriti o Waitangi will not be delivered in the specific ways detailed in the recommendations.

Recommendations included:	Response:	Status:
<b>He Purapura Ora, he Māra Tipu</b>		
2	 ACCEPT INTENT	 UNDER WAY
13	 ACCEPT INTENT	 UNDER WAY
<b>Whanaketia</b>		
14	 ACCEPT INTENT	 UNDER WAY
117	 ACCEPT INTENT	 UNDER WAY
126	 ACCEPT INTENT	 UNDER WAY















## Co-design the response with care system participants and stakeholders

These recommendations are about co-designing the response, or parts of it, with survivors, Deaf and disabled, Pacific Peoples, other experts, young people, the rainbow community, faith-based institutions, interested parties and the public.

The Crown is committed to engaging on the response, for example, the Redress Design Group was supported by an advisory group with a careful gender balance and diverse membership, including Māori, Pacific Peoples, Deaf and disabled people, rainbow people, young people and State- and faith-based care survivors. However, engagement with survivors and others may not always occur in the

specific ways detailed across the recommendations. This is why the responses to recommendations **6-8** and **14** from He Purapura Ora, and recommendation **127** from Whanaketia are recorded as “accept intent”.

Recommendation **14** from He Purapura Ora and **129** from Whanaketia are for any appointments to governance and advisory roles to appropriately reflect the survivor experience and diversity of those in care, and the need to give effect to te Tiriti o Waitangi. The intent of these recommendations are accepted.

Recommendations included:	Response:	Status:
<b>He Purapura Ora, he Māra Tipu</b>		
<b>6</b>	 ACCEPT INTENT	 UNDER WAY
<b>7</b>	 ACCEPT INTENT	 UNDER WAY
<b>8</b>	 ACCEPT INTENT	 UNDER WAY
<b>14</b>	 ACCEPT INTENT	 UNDER WAY
<b>Whanaketia</b>		
<b>127</b>	 ACCEPT INTENT	 UNDER WAY
<b>129</b>	 ACCEPT INTENT	 UNDER WAY









## Give effect to human rights

These are the Royal Commission’s recommendations to implement the Crown response consistent with national and international human rights obligations.

The Crown is committed to meeting its human rights obligations. This commitment is made in the context of continuing work to deliver Ministerial and Cabinet priorities in the care and justice

systems, some of which will be in tension with these recommendations.

Established processes are in place for considering Aotearoa New Zealand’s human rights obligations when making decisions about legislation, regulations and policy, and in delivering government services. This enables decisions about compliance to occur on a case-by-case basis.

Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
3	 ACCEPT INTENT	 UNDER WAY
Whanaketia		
15	 ACCEPT INTENT	 UNDER WAY
118	 ACCEPT INTENT	 UNDER WAY





## Publish the Crown response and report on it annually

These are the Royal Commission's recommendations associated with responding and reporting on the Crown response. They include publishing:














- responses to the findings and recommendations within four months, as per recommendation **95** from He Purapura Ora and **131** from Whanaketia
- an implementation report annually for nine years, as per recommendations **133** and **137** from Whanaketia.

The Crown has accepted the findings in Whanaketia and is committed to publishing a response to the Royal Commission's findings and each recommendation. However, given the complexity of the recommendations and the need to give them due consideration, the timeframes set by the Royal Commission have not been met. This is why recommendation **95** from He Purapura Ora has been declined, and recommendations **130** and **131** from Whanaketia are partially accepted.

A commitment to annual public reporting has been made. Given that public reporting will occur, implementation reports will not be tabled in the House of Representatives. For this reason, recommendations **130** and **133** from Whanaketia have been partially accepted, but recommendations **134** and **137** from Whanaketia have been declined.

It is expected that all agencies contributing to the Crown response will be able to answer questions from the relevant Select Committee, if asked, during scrutiny week. It is not the intent, at this stage, for the planned public reports to be referred to Select Committees (as per recommendations **134** and **137** from Whanaketia which are declined).

The Royal Commission also recommended that progress reports be referred to the Care Safe Agency (recommendation **42** from Whanaketia). Decisions on the establishment of the Care Safe Agency are needed before the Crown can respond to all the recommendations linked to it, which is why this work is prioritised.

Recommendations included:	Response:	Status:
<b>He Purapura Ora, he Māra Tipu</b>		
<b>95</b>	 DECLINE	–
<b>Whanaketia</b>		
<b>42</b>	 NEEDS FURTHER CONSIDERATION	 NOT STARTED
<b>113</b>	 ACCEPT	 COMPLETE
<b>130</b>	 PARTIALLY ACCEPT	 UNDER WAY
<b>131</b>	 PARTIALLY ACCEPT	 UNDER WAY
<b>133</b>	 PARTIALLY ACCEPT	 UNDER WAY
<b>134</b>	 DECLINE	–
<b>137</b>	 DECLINE	–



Undertake an independent review of the response

The Royal Commission made several recommendations relating to independent reviews of the Crown response. This included that all aspects of the redress scheme’s operations should be reviewed after it has been running for two years and thereafter at periodic intervals. It also recommended that an independent review of the response to its Whanaketia recommendations be initiated nine years after the tabling of its report.

As part of the redress system improvements announced in May 2025, an independent review of the impact of the changes will be undertaken

by October 2027. The review will inform future advice about whether further system changes are needed, and future advice on matters of integration, independence and capacity. Cabinet will agree Terms of Reference for the review by March 2027.

At this stage of the response, a decision cannot be made on whether the other reviews and their timeframes proposed by the Royal Commission would be appropriate. The Crown will continue to consider these recommendations as the response progresses and as part of annual reporting.

Ministers and agencies involved: Crown Response Office		
Recommendations included:	Response:	Status:
He Purapura Ora, he Māra Tipu		
60	<input checked="" type="radio"/> PARTIALLY ACCEPT	<input type="radio"/> NOT STARTED
Whanaketia		
136	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED
138	<input checked="" type="radio"/> NEEDS FURTHER CONSIDERATION	<input type="radio"/> NOT STARTED

# Abbreviations and definitions

Word or abbreviation	Meaning
ACC	Accident Compensation Corporation
Children's Act	Children's Act 2014
children's workers	people working for State services or State-funded organisations who have regular or overnight contact with children
CPSLE	consumer, peer support and lived experience
Education	Ministry of Education
hapū	sub-tribe
HDC	Health and Disability Commissioner
He Purapura Ora	<i>He Purapura Ora, He Māra Tipu from Redress to Puretumu Torowhānui</i>
Health	Ministry of Health
Hikitia!	"Hikitia! For Our Future" is a community-led, systems-focussed prevention initiative
HPCA Act	Health Practitioners Competence Assurance Act 2003
hui whaiora	well-being meetings
iwi	tribe
Justice	Ministry of Justice
Kaitiaki Rōpū	caretaker collective
kura	school
Lake Alice	Lake Alice Psychiatric Hospital Child and Adolescent Unit
mana	prestige
mauri	life force
Mental Health (Compulsory Assessment and Treatment) Act 1992	Mental Health Act
MSD   DSS	Ministry of Social Development   Disability Support Services
Ngā Paerewa	Ngā Paerewa Health and Disability Services Standard NZS 8134:2021



Word or abbreviation	Meaning
OPCAT	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
Oranga	wellbeing
oranga whakapapa	mana-enhancing and tapu-enriched relationships
pēpi	babies
Police	New Zealand Police
Police Manual	New Zealand Police Manual
rangatahi	youth
Restraint Rules	Education (Physical Restraint) Rules 2024
rōpū whaiora	care collaborative team
Royal Commission	Royal Commission into Historical Abuse in State Care and in the Care of Faith-based Institutions
SG Guidelines	Solicitor-General's Prosecution Guidelines
tamariki	child
tamariki and rangatahi hauā	disabled children and young people
taonga	treasures
tapu	sacredness
te ao Māori	the Māori worldview
te Tiriti o Waitangi	the Treaty of Waitangi
Te Aorerekura Action Plan	<i>Te Aorerekura – the National Strategy to Eliminate Family Violence and Sexual Violence</i>
the Royal Commission	The Royal Commission into Historical Abuse in State Care and in the Care of Faith-based Institutions
urupā	burial sites
VOYCE	VOYCE Whakarongo Mai
waiata	song
Whanaketia	<i>Whanaketia – Through pain and trauma, from darkness to light Whakairihia ki te tihi o Maungārongo</i>

