7 October 2026 OIA 0177

[redacted]

Tēnā koe [redacted]

I refer to your request received on 22 September 2026, which has been considered under the Official Information Act 1982 (OIA). You requested the following information:

> *I write to request that you please supply the following information under the Official Information Act:*
>
> - *Agendas for each Safety in Care System Leadership Group meetings since their establishment*
> - *Briefings for each Safety in Care System Leadership Group meeting since their establishment*
> - *A list of the members of the Safety in Care System Leadership Group*
> - *The Terms of Reference for the Safety in Care System Leadership Group.*

Response to your request

The 'Safety in Care' System Leadership Group (System Leadership Group) was established following Cabinet decisions in December 2025 as part of the Government's response to the Abuse in Care Royal Commission. The System Leadership Group provides system wide leadership across the care system, oversees work to improve care safety, and drives implementation of the Royal Commission's care safety recommendations.

While Cabinet agreed to establish the System Leadership Group in December 2025, a period of establishment work was required to finalise governance arrangements, confirm membership, appoint a chair, and secure ministerial approval of the Terms of Reference. The Terms of Reference were finalised and approved on 16 June 2026, with Paula Tesoriero, Chief Executive of Whaikaha – Ministry of Disabled People, appointed as Chair.

While governance arrangements for the System Leadership Group were being finalised, work to progress care safety improvements continued through the existing Crown Response Chief Executives' Group (Crown Response Group). This was effective due to the significant overlap in membership between the two groups, with the Chief Executives of Oranga Tamariki, Whaikaha, and the Ministries of Education, Health and Social Development participating in both governance arrangements. During the establishment phase, care safety matters were considered through the Crown Response Group, ensuring early decisions and oversight of the care safety work programme were not delayed while the System Leadership Group Terms of Reference, membership and chairing arrangements were finalised.

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Agendas for each Safety in Care System Leadership Group meetings since their establishment

As the System Leadership Group have not had any formal meetings to date, I am refusing this part of your request under section 18(e) of the OIA as the information does not exist.

Briefings for each Safety in Care System Leadership Group meeting since their establishment

I am releasing the briefing titled '*Seeking direction on a cross-system framework for safe care'*, which was addressed to both the Crown Response Group and the System Leadership Group. Some parts of this briefing are withheld in full under section 9(2)(f)(iv) to maintain the confidentiality of advice tendered by or to Ministers and officials.

In making my decision, I have considered the public interest considerations in section 9(1) of the OIA. I do not consider that these considerations outweigh the need to withhold the information.

A list of the members of the Safety in Care System Leadership Group

The System Leadership Group is chaired by Paula Tesoriero, Chief Executive of Whaikaha. Its members are the Chief Executives of Whaikaha, Oranga Tamariki, the Ministry of Health, the Ministry of Social Development, and the Ministry of Education, with additional agencies able to participate where appropriate. The Functional Chief Executive of the Crown Response Office attends meetings of the System Leadership Group as an Ex officio member.

The Terms of Reference for the Safety in Care System Leadership Group

I am releasing the final Terms of Reference for the System Leadership Group in full.

We may publish this OIA response on www.abuseinquiryresponse.govt.nz (with your personal details having been removed). Publishing responses to OIA requests increases the availability of information to the public and is consistent with the purpose of the OIA to enable effective participation in the making and administration of law and policies, and to promote the accountability of Ministers and officials.

You have the right to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available via www.ombudsman.parliament.nz or freephone 0800 802 602.

Nāku noa, nā

John Henderson
General Manager Enabling Services

Published by the Crown Response Office

COVER NOTE

Seeking direction on cross-system framework for safe care

To:	Crown Response to the Abuse in Care Chief Executives' Group/ Safety in Care' System Leadership Group
From:	Crown Response Office
Meeting Date:	13 May 2026
Security level:	

Agenda Item 4: Care System

Purpose

1. This paper seeks your endorsement of the approach to developing advice for Care Ministers in June 2026 and for Cabinet decisions in July 2026.

Recommendations

2. It is recommended the Chief Executives' Group:

   a. **note** Appendix One provides an overview of the approach being taken to develop advice for Cabinet on making the care system safe. This approach includes:

      i. identifying the biggest gaps to fill to support a safe care system;

      ii. potential mechanisms for a cross-system framework to set and fulfil shared expectations and potential scope of settings that framework will cover; and

      iii. next steps (shorter and longer-term) for filling identified gaps and building that cross-system framework;

   b. **agree** to the high-level logic for organising the advice for Ministers (Appendix One);

   c. **note** that early analysis is underway on the response to the Royal Commission's recommendations about independent monitors and duty of care; and

   d. **note** proposed timeframes for next steps.

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Context

3. The Royal Commission's view was that "a national care safety regulatory system is urgently needed to ensure all care settings are safe" (*Whanaketia,* Part 9). It identified a number of components that a care safety system would need, including:

    - a set of Care Safety Principles (recommendation 39, and attached as Appendix Two);
    - an overarching National Care Safety Strategy (recommendation 40);
    - a single Care Safe Agency with 18 specified functions (recommendation 41);
    - new legislation and a duty of care (recommendations 45d, 47); and
    - a set of rules, standards and guidelines that would apply to all agencies providing care (recommendation 47).

4. In December 2025, Cabinet:

    - directed officials to progress a cross-agency work programme to build and strengthen care safety, with one initial focus being on the development of care safety requirements and expectations [CAB-25-MIN-0451-refers]; and
    - agreed that the Lead Coordination Minister would report to Cabinet by August 2026 on the care safety requirements, implementation and delivery options, and timeframes for any legislation.

5. We have since progressed work in response to the Royal Commission's recommendations including:

    - working with agencies, the Ministerial Advisory Group and care experienced people to develop a set of principles based on those put forward by the Royal Commission;
    - engaging with care agencies, the Ministerial Advisory Group and a care workforce reference group to identify functions, from the 18 proposed by the Royal Commission, to guide our understanding of what safe care looks like in practice and identify gaps;
    - engaging with independent monitors to consider the effectiveness of current independent monitoring and oversight arrangements; and
    - considering options to implement a duty of care, including engaging with care and other relevant agencies.

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6. This work and resulting insights will be drawn into options for a care safety framework.

7. The Lead Coordination Minister is planning to discuss these proposals with Care Ministers at their 23 June meeting and report back to the Social Outcomes Committee on 22 July. The draft advice is due to the Lead Coordination Minister by 4 June.

Structuring advice on a care safety framework (Appendix One)

8. Appendix One outlines the structure of advice we intend to provide to Ministers (and subsequently Cabinet), reflecting:

    - that the care safety principles are intended to provide a shared cultural and practice anchor to drive change, 9(2)(f)(iv) [redacted]
    - we have elaborated on functions recommended by the Royal Commission to develop a set of benchmarks as a policy tool to support agencies with a 'shared language' of what safe care looks like.

9. There are a spectrum of mechanisms ranging from 'soft' to 'hard' levers including, for example, potential for: a legislated statutory duty of care, a national care safety strategy and frontline tools such as guidance and checklists. The levers will enable us to create change in these areas:

    i. system leadership and accountability for care safety
    ii. a mandate for agencies to work towards safe care
    iii. how we fill the gaps
    iv. monitoring and reporting
    v. enforcement (dependent on other decisions made above)

10. We note that there are existing mechanisms in place across the spectrum in settings, and so further work would consider whether these could be leveraged or strengthened, alignment requirements or any other implications. Additionally, we are conscious of the potential for phasing – with shorter term pathways leading to a long run horizon.

11. There are some initial actions we can take or are already taking to move closer to what safe care looks like (for example, by strengthening enablers like a capable workforce). Appendix One provides examples of some high-level gaps that have emerged from

[1] 9(2)(f)(iv) [redacted]

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agency workshops assessing existing care functions against the benchmarks, to be confirmed and refined on testing with care agencies.

12. The Lead Coordination Minister has asked for options for early actions that could be potentially funded through a re-prioritisation of remaining funding within the workforce tagged contingency, following decisions regarding the first and second drawdowns. CRO is working with agencies to progress this advice.

13. We will recommend that Cabinet agrees to public consultation (to begin during the pre-election period) on proposals for the care system, to inform a March 2027 report back with recommendations for change. The specific nature of the consultation (whether it is wide or more targeted) will depend on Cabinet's appetite for exploring potential regulatory change. The paper will seek delegation of specific decisions regarding the consultation process (including release of a discussion document, if required) to the Lead Coordination Minister.

Feedback

14. We are seeking your feedback on:

- the overall direction and proposed approach to delivering this advice;
- any other mechanisms or tools we should consider as part of our development of the options that are not included on page 3 of Appendix One; and
- any other considerations to take into account in developing and delivering this advice to joint Ministers.

Next Steps

15. Subject to your feedback on the approach, we will continue to work with agencies (and consult the Ministerial Advisory Group) to develop proposals and refine the narrative for this work. This includes working with the Deputy Chief Executive's group to ensure options are designed to elicit a clear steer from Ministers on their priorities for this work and to endorse the final papers.

16. Broader timeframes for provision and delivery of the advice are as follows:

4 June	Draft advice to Lead Coordination Minister
23 June	Care Ministers meeting and considering relevant proposals
22 July	Lead Coordination Minister report back to the Social Outcomes Committee

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27 July	CAB

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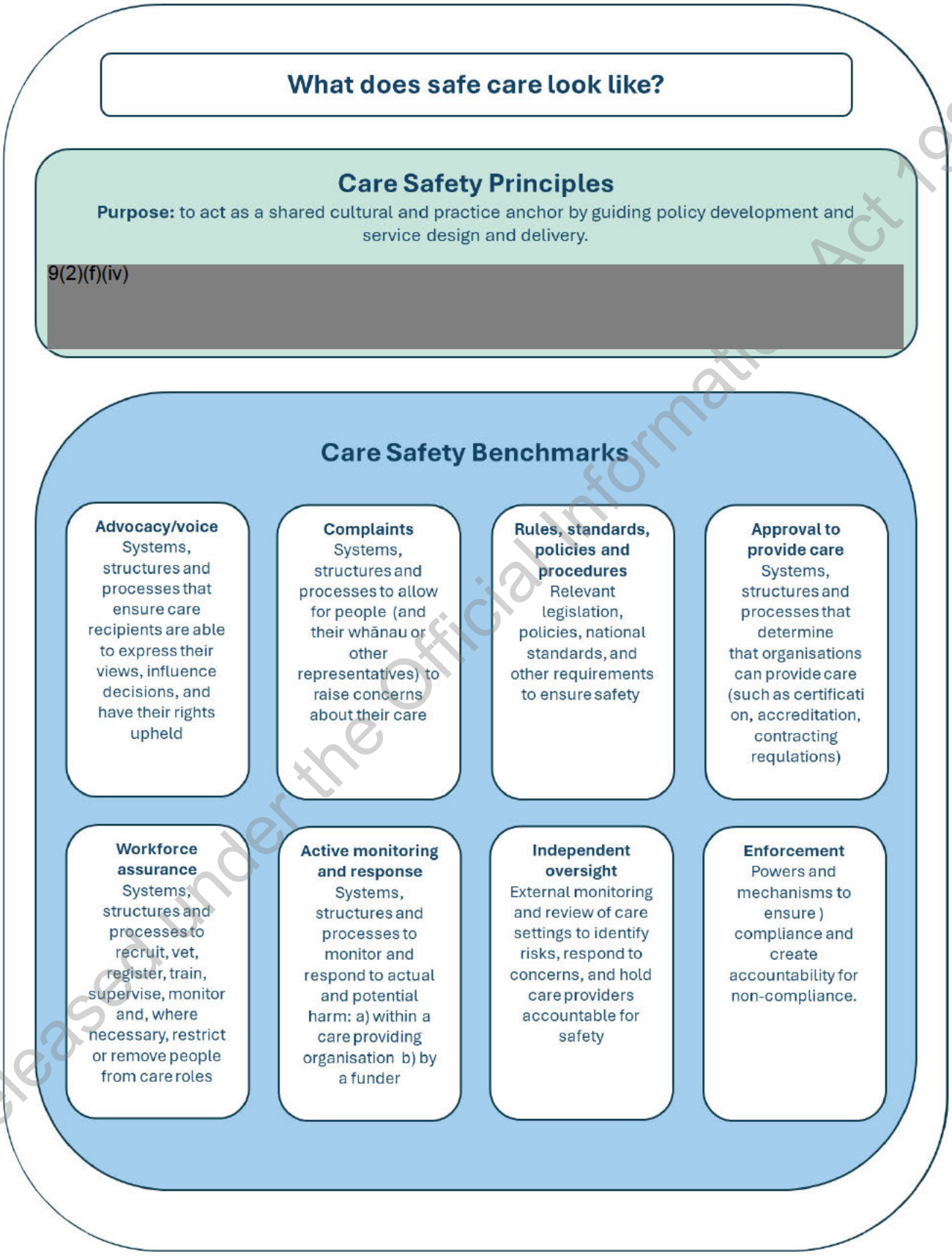
Appendix One: Proposed structure of care safety framework advice (A3)



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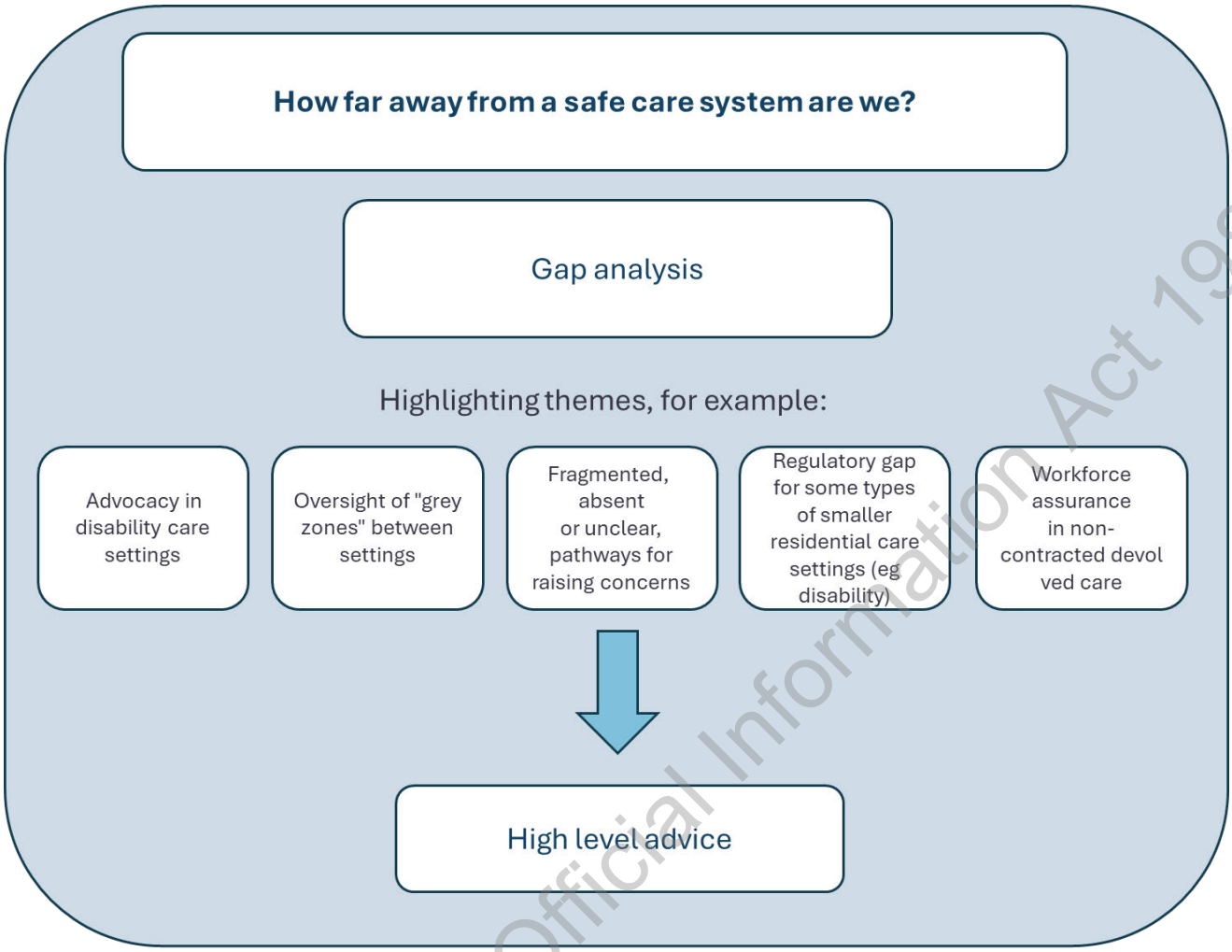

And what settings should be in scope?

- Aged care?
- Non-state funded settings?
- Innovative/future models of care? (e.g. where carers are employed directly by the person in care, through flexible funding, rather than through a government contract)
- Sector specific scope matters

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How to drive implementation of safe care across the system

~~Full Royal Commission Recommendations~~

Mix of legislative, non-legislative, top-down/bottom-up options over varied periods/paces

Looking across tools for...

- System leadership approach
- System-wide mandate for working towards shared expectations
- Coordinating and driving action to fill identified gaps
- Monitoring and reporting
- Possible enforcement (reliant on other mechanisms)

For example

- Non-regulatory tools for culture change (guidance, checklists, training)
- CE driven accountability through performance agreements, letters of expectation
- Cabinet/Ministerial directives
- An overarching national care safety strategy and long-term vision
- Specific performance measures in the reporting framework
- Sector-by-sector regulatory change
- Bespoke overarching legislation with a cross-system duty of care

What early actions can be taken?

- Actions to improve workforce enablers?
- Immediate actions to improve agency coordination?
- Work to develop a monitoring and reporting framework?
- Guidance?
- Other agency-specific actions?

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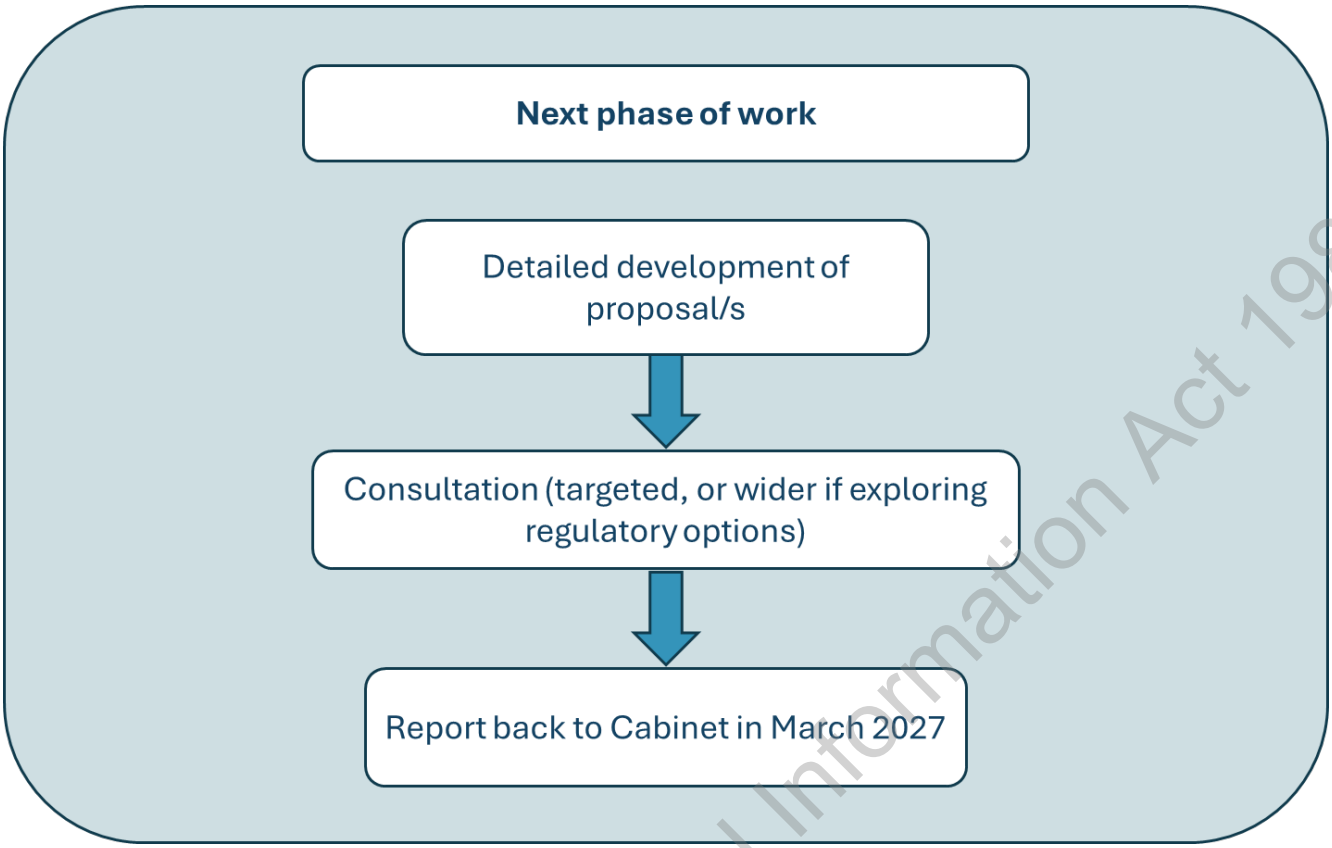

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Appendix Two: The Royal Commission's proposed care safety principles

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

Care Safety Principle 1: The care system should recognise, uphold and enhance the mana and mauri of every person in care:

i. each person in care lives free from abuse and neglect and their overall oranga (wellbeing) is supported in a holistic way

ii. care providers understand and provide for each person and their unique strengths, needs and circumstances

iii. the importance of whānau and friendships is recognized and support from family, support networks and peers is encouraged to enable people in care to be less isolated and connected to their community

iv. people in care are celebrated and nurtured.

Care Safety Principle 2: People in care should participate in and make decisions affecting them to the maximum extent possible and be taken seriously:

i. people in care can participate in decisions that affect their lives, with the assistance of decision-making supports and/or an independent advocate they have chosen, where required

ii. people in care can access abuse and/or neglect prevention programmes and information

iii. staff and care workers are aware of signs of abuse and/or neglect and facilitate ways for people in care to raise concerns

iv. people who are currently or have previously been in care can participate in decision-making and policy-making about the care system.

Care Safety Principle 3: Whānau and support networks should be involved in decision-making processes wherever possible and appropriate:

i. connections between people in care and their whānau and support networks are actively supported, and whānau and support networks can participate in decisions affecting the person in care wherever possible and appropriate

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ii. care providers engage in open communication with whānau and support networks about their abuse and neglect prevention approach

iii. whānau and support networks are informed about and can have a say in organizational and system-level policy

iv. whānau, hapū, iwi and Māori can participate in decision-making processes about their mokopuna and uri.

Care Safety Principle 4: The State, faith-based entities (including indirect care providers) and others involved in the care system should give effect to te Tiriti o Waitangi and enable Māori to exercise tino rangatiratanga:

i. whānau, hapū, iwi and Māori exercise the right to tino rangatiratanga over kāinga and are empowered to care for their tamariki, rangatahi, pakeke Māori and whānau according to their tikanga and mātauranga

ii. the Crown actively devolves to Māori policy and investment decisions about the care system, design and delivery of supports and services for, and specific care decisions about tamariki, rangatahi and pakeke Māori

iii. until the realisation of principle 4 (ii), Māori and the Crown should collaborate on policy and investment decision about the care system, the design and delivery supports and services for, and specific care decisions about tamariki, rangatahi and pakeke Māori

iv. tamariki, rangatahi and pakeke Māori who need care live as Māori and are connected to their whānau, hapū, iwi, whakapapa, whenua, reo and tikanga

v. wellbeing for tamariki, rangatahi and pakeke Māori is understood and supported through an ao Māori worldview, encompassing tapu, mana, mauri and wairua.

Care Safety Principle 5: Abuse and neglect prevention should be embedded in the leadership, governance and culture of all State and faith-based entities (and indirect care providers) involved in the care system, including government agencies, faith leaders, care providers, and staff and care workers:

i. leaders across the care system champion the prevention of abuse and neglect in care

ii. prevention of abuse and neglect is a shared responsibility at all levels of the care system

iii. governance arrangements in agencies and entities ensure implementation of measures to prevent abuse and neglect in care and accountabilities and obligations are set at all levels

iv. risk management strategies focus on abuse and neglect prevention

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v. codes of conduct set clear behavioural expectations of all staff and care workers.

Care Safety Principle 6: Care providers should recognise, uphold and implement human rights standards and obligations and the Enabling Good Lives principles, and recognize and provide for diverse needs including the needs of Deaf, disabled people, and people experiencing mental distress:

i. people in care are supported and provided accessible information so they can understand their rights

ii. care providers have human rights standards embedded in their policies and practice

iii. care providers understand people's diverse circumstances and respond effectively to people at increased risk of experiencing abuse and/or neglect

iv. Enabling Good Lives principles underpin all support for disabled people, including culturally appropriate support as determined by whānau hauā, tāngata whaikaha and tāngata whaiora, to enable and empower disabled people to live well, participate in their community without segregation or institutionalisation, and make decisions about their lives.

Care Safety Principle 7: Staff and care workers should be suitable and supported:

i. all stages of recruitment, including advertising and screening, emphasise the values of caring for people in care, the safety of people in care and the prevention of abuse and neglect

ii. staff and care workers have regularly updated safety checks

iii. staff and care workers receive appropriate induction and training and are aware of their responsibilities to prevent abuse and neglect, including reporting obligations

iv. staff and care workers receive appropriate training to ensure they have cultural competency

v. education programmes for staff and care workers include units focused on understanding and preventing abuse and neglect in care

vi. supervision and people management include a focus on preventing abuse and neglect.

Care Safety Principle 8: Staff and care workers should be equipped with the knowledge, skills and awareness to keep people in care safe through continuous education and training:

i. staff and care workers receive training on the nature and signs of abuse and neglect in care

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[redacted]

ii. staff and care workers receive training on organisational and national abuse and neglect prevention policies and practices

iii. staff and care workers are supported to develop practical skills in safeguarding children, young people and adults in care

iv. staff and care workers have appropriate cultural knowledge.

Care Safety Principle 9: Processes to respond to complaints of abuse and neglect should respond appropriately to the person (e.g., child-focused or young person-focused or adult in care-focused) in a timely manner:

i. everyone in care and their whānau and support networks have access to information and decision-making supports to help them engage in complaints processes

ii. care providers have complaint handling policies that are appropriate for the people in care and that clearly outline roles and responsibilities, approaches for responding to complaints and obligations to act and report

iii. effective complaints processes are understood by people in care, staff and volunteers, and whānau and support networks and are culturally appropriate

iv. complaints are taken seriously, responded to promptly and thoroughly, and reporting, privacy and employment law obligations are met.

Care Safety Principle 10: Physical and online environments should minimise the opportunity for abuse and neglect to occur:

i. risks in online and physical environments are mitigated while upholding the right to privacy and ensuring the wellbeing of people in care

ii. online environments are used in accordance with codes of conduct.

Care Safety Principle 11: Standards, policy and practice should be continuously reviewed, including from time to time independently reviewed, and improved:

i. care providers regularly review standards, policy and practice to prevent and improve responses to abuse and neglect in care

ii. complaints and concerns are analysed to identify systemic issues, both within organisations and within the care system as a whole

iii. people who are currently or have previously been in care are enabled to participate in reviews of standards, policy and practice.

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Care Safety Principle 12: Policies and procedures should document how each care provider will ensure that people in care are safe:

i. safeguarding practice is prioritised and integrated throughout organisations

ii. policies and procedures embed safeguarding and abuse and neglect prevention measures

iii. policies and procedures are accessible and easy to understand

iv. stakeholder consultation informs the development of policies and procedures

v. leaders champion and model compliance with policies and procedures

vi. staff and care workers understand and implement the policies and procedures

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14

Pages 15-16 withheld in full under s 9(2)(f)(iv).

'Safety in Care' System Leadership Group - Terms of Reference

Purpose and scope

1. The Royal Commission into Historical Abuse in State Care and in the Care of Faith-based Institutions (the Royal Commission) made 207 recommendations to the Crown across two reports. These included 95 recommendations in the redress report, *He Purapura Ora, He Māra Tipu from Redress to Puretumu Torowhānui*, and 112 in the final report *Whanaketia - Through pain and trauma, from darkness to light Whakairihia ki te tihi o Maungārongo*.
2. The recommendations relate to:
    a. addressing the wrongs of the past;
    b. making the current care system safe;
    c. empowering those in care, their families, whānau and communities; and
    d. ways to implement the Royal Commission's recommendations.
3. Cabinet[1] has mandated the establishment of a 'Safety in Care' System Leadership Group (SCS Leadership Group). The purpose of the SCS Leadership Group is to provide system-wide leadership to make care safe by overseeing and driving the response to the Royal Commission's care safety recommendations.
4. Work relating to wider matters related to care quality will not fall in scope of the SCS Leadership Group.

Role and Functions

5. The role of the SCS Leadership Group is to:
    a. provide system leadership through collective decision making that feeds into and is given effect via Chief Executive's individual accountabilities;
    b. drive and implement changes to make care safe, including the allocation of their resources to effect change; and
    c. oversee and drive the work programme to analyse and respond to the Royal Commission's 'care safety' related recommendations.
6. The SCS Leadership Group will provide system-wide:
    a. leadership and strategic direction and priorities for making care safe;
    b. policy advice about care safety to the Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions (the Lead Coordination Minister) and responsible Care Ministers[2]; and
    c. performance measurement and reporting.

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[1] [SOU-25-MIN-0173 Refers]

[2] The Ministers of Education, Social Development and Employment, the Minister for Children and the Associate Minister of Health (with delegations from the Minister of Health for the *Response to the Royal Commission into Historical Abuse in State Care and in the Care of Faith-based Institutions*

7. Independent input will be sought from the Abuse Inquiry Response Ministerial Advisory Group, survivors, and people with care experiences, as required.

Membership

8. The initial membership of the SCS Leadership Group consists of the Chief Executives of:
    a. Whaikaha – the Ministry of Disabled People (Chair)
    b. the Ministry of Health;
    c. the Ministry of Social Development;
    d. the Ministry of Education;
    e. Oranga Tamariki – the Ministry for Children; and
9. The SCS Leadership Group, through its Chair, may agree to invite others to join either permanently or for specific items. These may include operational organisations such as Health New Zealand.
10. The Chair will regularly review the membership, in consultation with the Lead Coordination Minister, as the work programme evolves.

Ex-officio member

11. The Functional Chief Executive of the Crown Response Office (or their delegate) will attend the SCS Leadership Group meetings as an ex-officio member but will not have a decision-making role.
12. The Functional Chief Executive of the Crown Response Office needs to have an overview of the work and decisions of the SCS Leadership Group and will provide support to the SCS Leadership Group, including information, insights and monitoring of progress on the work programme in relation to the Crown's response to the Royal Commission's 'care safety' related recommendations.

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Members' Roles and Responsibilities

Role	Responsibilities
Chair	• Finalise agendas, review supporting materials, and ensure meeting summaries and decisions are clearly recorded and communicated. • Provide leadership and facilitate respectful, focused discussions that encourage broad participation and allow for genuine disagreement • Guide the SCS Leadership Group toward consensus and, if consensus is not reached, lead the process to determine next steps including seeking further advice if needed. • Promote and model collaborative working across agencies to support the Leadership Group's objectives.
Members	• Engage thoughtfully and respectfully in preparation and discussions, maintain a whole-of-system perspective over individual agency interests, and seek alignment and common ground. • Focus decisions on achieving the best outcomes for people in State care, even if they differ from agency preferences. • Aim for consensus and, when not possible, commit to finding a constructive way forward, including seeking further advice if needed. • Model and promote collaborative working, embodying the desired culture and fulfilling assigned responsibilities.
Secretariat support	Support will be provided from the Crown Response Office. This will include: • support to develop, implement and monitor the SCS Leadership Group's work programme; • support and coordination to develop system level policy advice and advice on system level strategic priorities; • support and coordination for engagement and communications with key stakeholders as required, noting that many key relationships will continue to be held at an individual agency level; • oversight and co-ordination of meetings including administrative support, scheduling meetings, collating papers, preparing agendas, recording, and distributing minutes, and tracking the completion of action points as

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	required; and • attendance at meetings by the Functional Chief Executive of the Crown Response Office.

Ways of working

13. Members will work together as leaders, governors, and stewards to build and strengthen a Care Safety System, rather than as individual agency Chief Executives, to deliver change.

14. The SCS Leadership Group will determine its own procedure for decision-making. The responsibilities of the SCS Leadership Group membership and collective SCS Leadership Group decisions do not override the accountability of SCS Leadership Group members (or any other Chief Executives) to their respective Ministers.

Meetings and Committee Operations

15. The quorum for decision-making is half plus one, one of whom must be the Chair.

16. SCS Leadership Group members may delegate meeting attendance to an Acting Chief Executive or a Deputy Chief Executive (or equivalent) if they cannot attend. Delegates will have the full decision-making powers of a member and are counted for quorum. However, there is a Ministerial expectation that the Chief Executives will generally attend, and the use of delegates is by exception only.

17. The SCS Leadership Group will meet every two months. Most business will be conducted during meetings; however, the Leadership Group may also discuss or approve matters via email when necessary.

18. Additional meetings may be scheduled at the request of member(s) or if urgent decisions are required. As much notice will be given as is possible and members are expected to make every effort to attend.

19. The agenda and relevant papers will be distributed to attendees 5 working days before the meeting or in exceptional circumstances, presented at the meeting. If urgent decisions are required, the Secretariat may distribute out-of-cycle papers to the SCS Leadership Group for their feedback and/or endorsement.

20. The Secretariat will distribute meeting minutes within 5 working days of the meeting.

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Term of the Leadership Group

21. The SCS Leadership Group will operate at least until the end of June 2027, when decisions on system leadership will be reviewed.

Updates to the Terms of Reference

22. The Chair of the SCS Leadership Group, in consultation with the SCS Leadership Group and the Lead Coordination Minister, will update the terms of reference as required including following an annual review.

Endorsed by Hon Erica Stanford, Lead Coordination Minister for the Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions on 16 June 2026[3]

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[3] Briefing *Crown Response Governance Refresh*, CRACI 26/048