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

Final report of the Abuse in Care Inquiry (Whanaketia): Initial Response

Date of Issue: 4 December 2024

These documents have been proactively released:

- Cabinet paper – Final report of the Abuse in Care Inquiry (Whanaketia): Initial Response
- Appendix One: Summary of the 16 Volumes of Whanaketia
- Appendix Two: Summary of the findings of Whanaketia
- Appendix Three: Whanaketia recommendations triage – categories or themes of recommendations
- SOU-24-MIN-0118 Cabinet Social Outcomes Committee Minute of Decision, 30 September 2024; and
- CAB-24-MIN-0380 Cabinet Minute of Decision, 30 September 2024

Summary of redactions:

- Section 9(2)(f)(iv) to enable the confidentiality of advice tendered by Ministers of the Crown and officials:
- Section 9(2)(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions:
- Section 9(2)(h) to maintain legal professional opinion:
- Sections not relevant to the work of the Crown Response to the Abuse in Care Inquiry:
    - CAB-24-MIN-0380 Cabinet Minute of Decision, 30 September 2024
- Appendix Four withheld in full. Refer to progress against recommendations here: Progress against Royal Commission Recommendations .pdf

Office of 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

Cabinet Social Outcomes Committee

Final Report of the Abuse in Care Inquiry (Whanaketia): Initial response

Proposal

1. This paper seeks Cabinet endorsement of an initial approach to respond to *Whanaketia: Through pain and trauma, from darkness to light* (Whanaketia), the final report of the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions (the Royal Commission). It summarises the content of Whanaketia, proposes an approach to respond to its findings, and identifies opportunities for immediate action while further work is done to analyse the more complex and far-reaching recommendations.

2. Opportunities for initial legislative changes are outlined in a companion paper entitled: *Initial Legislative changes in response to the Abuse in Care Royal Commission of Inquiry*.

Relation to Government priorities

3. This paper progresses the Government's response to the Royal Commission.

Executive summary

4. On 25 June 2024, the Royal Commission delivered its final report, Whanaketia, on what happened to children, young people and vulnerable adults in State care and in the care of faith-based institutions in New Zealand between 1950 and 1999. It previously delivered an interim Redress report[1] in December 2021 and two case study reports in 2022 and 2023[2].

5. Whanaketia details widespread and extreme abuse of vulnerable children, young people and adults across a wide range of care settings. It also envisages a more positive future and sets out three broad areas of action to achieve that: addressing the wrongs of the past, ensuring the safety of the current care system, and empowering whānau and communities to look after their own.

6. There are 138 recommendations in Whanaketia. There are also a further 95 recommendations from the interim Redress report delivered in December 2021. These propose significant organisational and system change across all the three areas of action. In addition to the forward-looking recommendations, the reports contain over 500 findings focussed on survivors' experiences of abuse and factors that contributed to that abuse.

[1] *He Purapura Ora He Māra Tipu: From Redress to Puretumu Torowhānui* (the Redress report).
[2] *Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit* (2022) and *Stolen Lives Marked Souls: Inquiry into the Order of the Brothers of St John of God at Marylands School and the Hebron Trust* (2023).

7. The Royal Commission recommends the Government publish a response to its findings in both the final and interim reports within two months (recommendation 130). Requiring officials from multiple agencies to go line by line through over 500 findings to advise on each one individually would use a huge amount of time and resource that could instead be focussed on analysis of the recommendations and ways to create meaningful change for survivors and people currently in care.

8. I therefore propose we partially accept recommendation 130 and *broadly accept* the Royal Commission's overall findings while noting that they have not been tested at an individual level and that further work is required to respond to findings that relate to s9(2)(f)(iv)

9. The recommendations have been broadly grouped into seven themes (redress, justice sector, care safety, monitoring and oversight, community empowerment and prevention, implementation, and faith-based).

10. A total of 113 recommendations are directed at the State. s9(2)(f)(iv) These initiatives could be announced by the Prime Minister at the event to apologise for abuse in care on 12 November 2024.

11. The remainder of the recommendations are more complex and far reaching and will require deeper analysis (including recommendations for complex legislative or machinery of government change and some that may result in a decision not to progress). I propose that officials from the Crown response agencies, led by the Crown Response Unit, will develop a full Response Plan that identifies Lead Ministers and agencies for each recommendation for consideration by joint Ministers s9(2)(f)(iv)

Background to the Royal Commission's final report and early work on the Crown response

12. The Royal Commission was set up in 2018 to investigate historical abuse and neglect in State and faith-based care[3]. Its final report was received on 25 June and was tabled in Parliament on 24 July 2024.

13. The final report describes widespread and extreme abuse of children, young people and vulnerable adults across a wide range of state and faith-based care settings over many years (from the 1950s up to the present day). Estimates provided to the Royal Commission of the number of people abused in care are

[3] Its terms of reference covered abuse in social welfare, disability, mental health, education, and law enforcement settings including direct or indirect (contracted) care which could be community-based or institutional. It included: residences operated by the former Department of Social Welfare (DSW), foster care, adoptions, schools, health camps, psychiatric and psychopaedic hospitals, community disability or mental health care, borstals, police cells and transitional settings, and all forms of faith-based care. It explicitly does not include adult prisons or aged care (persons over 65 years old).

highly variable ranging from 36,000-65,000 to 114,000-256,000. Precise figures are impossible to determine due to data inadequacies and poor record keeping[4].

14. The Royal Commission's findings and recommendations are the result of 1,630 interviews with survivors, 1,176 sworn statements, over 100 community engagements, wānanga, and fono, 16 public hearings, several commissioned pieces of research, and by reviewing hundreds of thousands of documents provided by government agencies, faith-based institutions and others.

15. Whanaketia comprises 16 documents: a preliminary report, five case study reports, a book of survivor experiences, and nine volumes of the final report itself. These are additional to the Redress report provided in December 2021 and the two case studies from 2022 and 2023 (on the Child and Adolescent Unit at Lake Alice Hospital and the Marylands school and Hebron Trust run by Catholic Order of the Brothers of St John of God).

16. On 26 June 2024, the Cabinet Social Outcomes Committee noted the Lead Coordination Minister for the Government's response to Whanaketia would report back in September 2024 with:

    16.1. a summary and initial assessment of the key findings, themes, and recommendations in the final report;

    16.2. a proposed approach to if and how the Government publicly accepts the findings and recommendations; and

    16.3. a work programme for further work on analysis of the recommendations and/or implementation [SOU-24-MIN-0068 refers].

17. Since then, the Crown Response Unit has been working with 18 Crown response agencies to develop a response to both the overall report and to the findings and recommendations. The agencies are listed in paragraph 61.

18. On 2 September, Cabinet Social Outcomes Committee agreed to establish a Crown Response Office to drive the implementation of the work programme arising from the Royal Commission [CAB-24-MIN-0331 refers]. Until the Crown Response Office is set up, I will continue to refer to the officials co-ordinating this work as the Crown Response Unit.

Despite its focus on the horrors of abuse in care, Whanaketia also sets out recommendations for a better future

19. Whanaketia focusses on the experiences of survivors of abuse and neglect in care, and on what went wrong during the inquiry period. It also aspires to a future care system where whānau and communities are better supported to care for their

[4] These figures are based on a report produced for the Royal Commission by Martin-Jenkins, which used two different methodologies to estimate how many people may have been abused in State or faith-based care: a top-down methodology and a bottom-up methodology. The top-down methodology estimated that between 114,000 and 256,000 people may have been abused in care, based on estimated rates of abuse in similar contexts internationally and in New Zealand. The bottom-up methodology estimated the figures at between 36,000 and 65,000, based on estimated rates of under-reporting for similar crimes in New Zealand. Martin-Jenkins describe the first approach as their main estimate and the second as a supporting estimate.

own, State and faith-based care is safer and better regulated, and any abuse or neglect in care is identified early and those responsible are held accountable.

20. Whanaketia points out that societal factors and negative attitudes towards children, disabled people and Māori contributed to abuse in care. It recognises that the State has made changes to safeguard against abuse and neglect in care from the 1980s onwards, for example finding that "towards the end of the inquiry period the State made many changes, including new legislation, policy and standards". However, it also found that change was slow, and its scale was "smaller than the extent of the abuse and neglect in care".

21. Both the narrative and the recommendations in Whanaketia point to three broad areas of action for the future:

    21.1. **Address the wrongs of the past:** through public apologies, actions to support public understanding and collective recognition and healing, redress for survivors, and investigations and prosecutions of wrongdoers;

    21.2. **Ensure the safety of the current care system:** with a focus on standards, safeguarding, training, accreditation, vetting and screening, complaints processes, data collection, monitoring, reporting and oversight, and providing good staff pay and conditions, and

    21.3. **Empowering whānau and communities to look after their own:** including through social and educational campaigns, programmes for prevention of abuse in care and funding for community services that includes devolution, resource-sharing, partnership and collaboration.

22. The recommendations directed at the State propose significant organisational and system change across all three of the broad areas of action described above.

A proposed approach to responding to the over 500 findings in Whanaketia

23. Whanaketia recommends Government publish a response to its findings in both the final and interim reports within two months (recommendation 130):

> *"The government and faith-based institutions should publish their responses to this report and the Inquiry's interim reports on whether they accept each of the Inquiry's findings in whole or in part, and the reasons for any disagreement. The responses should be published within two months of this report being tabled in the House of Representatives."* (recommendation 130)

24. On 26 June 2024, the Cabinet Social Outcomes Committee noted that officials had been notified that the final report is likely to be over 1,000 pages, and that given [its] size, significance, and complexity … the timeline recommended by the Royal Commission is not feasible…. [SOU-24-MIN-0068 refers].

25. There are over 500 findings in the report (depending on how they are counted as they are not numbered and many are bulleted). The large number of findings reflects the breadth of the Royal Commission, spanning 70 years (though mainly focussed on 1950 – 1999) and describing the experiences of thousands of people across a wide range of health, disability, education, justice and social welfare

settings. By way of contrast, the *Royal Commission of Inquiry into the Terrorist Attacks on the Christchurch Mosques on 15 March 2019* made nine findings. A summary of the findings is provided in Appendix Two.

26. Many findings speak to the overall experiences of abuse and neglect across the care population. They also speak to the failures of state systems and institutions that enabled abuse to occur. These findings are largely descriptive. s9(2)(f)(iv) [redacted]

27. Requiring officials to go line by line through over 500 findings to advise on whether Government accept each individual finding would be hugely resource and time intensive and is unlikely to contribute to meaningful change either for survivors or for people currently in care. Nor would this remove the need to consider evidence on a case-by-case basis during existing 'alternative dispute resolution' processes, noting that decisions around the basis for verifying and assessing claims in future redress processes are still to be determined.

28. s9(2)(h) [redacted]

29. s9(2)(h) [redacted]

30. s9(2)(g)(i) [redacted]

31. For these reasons, I propose we *partially accept* recommendation 130 and:

    31.1. *broadly accept* the Royal Commission's overall findings while noting that these findings have not been tested at an individual level and s9(2)(f)(iv) [redacted]

31.2. s9(2)(f)(iv) [redacted]

32. I also propose we work to ensure the apologies by the Prime Minister and the seven Crown response Chief Executives make clear our commitment for to be held to account for the failings of the past and the actions Government is taking to prevent further abuse and neglect in care.

Initial analysis of the recommendations has grouped them into seven themes: redress, justice sector, care safety, monitoring and oversight, community empowerment, implementation, and faith-based

33. The recommendations have been grouped into seven categories to help focus on the outcomes to be achieved and to help determine which agencies should respond to each recommendation. The categories are redress, justice, care safety, monitoring and oversight, community empowerment and prevention, implementation, and faith-based. These are detailed in Appendix Three.

34. s9(2)(f)(iv) [redacted]

35. s9(2)(f)(iv) [redacted]

Agencies have identified recommendations that could be implemented early and others that will require further consideration

36. From the 113 recommendations in Whanaketia for the State:

36.1. s9(2)(f)(iv) [redacted]

36.2. s9(2)(f)(iv) [redacted]

36.3. s9(2)(f)(iv) [redacted]

36.4. s9(2)(f)(iv) [redacted]

37. s9(2)(f)(iv) [redacted]

37.1. s9(2)(f)(iv) [redacted]

37.2. s9(2)(f)(iv) [redacted]

38. s9(2)(f)(iv) [redacted]

39. s9(2)(f)(iv) [redacted]

40. I propose that our response to these recommendations is summarised through the Prime Minister's public apology and further that we introduce and have the first reading of a small omnibus bill on the day of public apology. This will help reassure survivors, their whānau and supporters of the Government's commitment to survivors, and to a safer care system. These proposals are set out in the parallel Cabinet paper titled: *Initial Legislative changes in response to the Abuse in Care Royal Commission of Inquiry*.

Developing a formal response plan and reporting mechanism

41. Having identified which recommendations we can move early on and which will require more in-depth analysis, the Crown Response Unit will work with relevant agencies to develop a full programme of work for completing advice on all recommendations and implementing those recommendations that are agreed.

42. s9(2)(f)(iv) [redacted]

43. The Royal Commission recommended Government publish responses to each of its recommendations, including full or partial acceptance, and reasons for any disagreement, within four months of Whanaketia being tabled in Parliament (recommendation 131). I recommend that we *partially accept* this recommendation by publishing this and subsequent Crown Response Cabinet papers and the Response Plan.

44. As set out in the paper establishing the new Crown Response Office, individual agencies will be accountable for their actions under the plan. A key role for the

Office will be to enable that accountability by establishing a clear plan and monitoring agencies' progress on their actions and providing strong leadership and coordination across the work programme.

45. To support this, a group of responsible Chief Executives has been established to oversee the work programme. The group will be chaired by a statutory Deputy Public Service Commissioner.

46. I recommend that, consistent with recommendation 133 of the Royal Commission, progress against this plan be reported annually. This reporting can be done by the Crown Response Unit in the short term, s9(2)(f)(iv) [redacted]

Engagement with survivors and their advocates

47. The Royal Commission has recommended agencies move beyond consultation and engagement to a model of co-design with the widest range of communities. This is to ensure that any actions taken reflects the experiences and needs of people in care and are tailored to reach, engage and provide access to all communities (recommendation 127).

48. The Royal Commission has also recommended swift action, setting out its own proposed timeframe for response to its recommendations. This desire for speed is understandable to build confidence among survivors and demonstrate that government is prioritising addressing the issues the Royal Commission raised. However, there will be a tension between the need to respond quickly and the need to respond well - by engaging with survivors and their advocates. In particular, engagement with disabled and hard-to-reach survivors is time consuming to do well and may slow the pace of the work if not carefully managed.

Cost-of-living implications

49. The proposals in this paper do not have cost-of-living implications.

Financial implications

50. s9(2)(f)(iv) [redacted]

51. s9(2)(f)(iv) [redacted]

52. s9(2)(f)(iv) [redacted]

s9(2)(f)(iv) [redacted]

53. The costs associated with the redress system recommendations are potentially significant and s9(2)(f)(iv) [redacted]

54. Some of the more complex and far-reaching recommendations relating to the current care system also have financial implications. Decisions on these are still some way away, and for many significant analysis will be required before they can be made. Funding issues, including reprioritisation or requests for additional funding, will be considered as part of that further analysis, and any further funding required will be sought as part of usual Budget processes.

Legislative implications

55. s9(2)(f)(iv) [redacted] These are contained in the accompanying paper: *Initial Legislative changes in response to the Abuse in Care Royal Commission of Inquiry*. Other than that, there are no legislative implications from the proposals in this paper.

Impact analysis

56. Regulatory Impact Statement not required.

Population implications

57. Māori, Pacific people, disabled people, children and young people, and sexually and gender diverse people have all been negatively affected by the care system, and Whanaketia highlights the impacts of racism, ableism and homophobia. The recommendations have been informed by these experiences with the aspiration that efforts to improve state care, and to provide redress for those harmed, will result in systems that better meet the needs of all these groups. A summary table of potential impacts on these different population groups is below:

Population group	How the proposal may affect this group
Māori	Māori were over-represented in some state care settings throughout the inquiry period, particularly in social welfare care. Thus, Māori are likely to be over-represented among those seeking redress, and among those who would benefit from a safer care system.
Pacific people	It is likely that Pacific people were also overrepresented in some state care settings (particularly social welfare settings), and therefore will also be over-represented among those who would benefit from a better redress system and from a safer care system.
Disabled people	Disabled people in the past were routinely placed in institutions from early childhood, often well into their adult years. This means many disabled people may be eligible for redress. As some disabled people still rely on out of home care they will also benefit from a safer system. Quality

Population group	How the proposal may affect this group
	engagement with the large and diverse disabled population must include accessible information in alternate formats and accessible forums.
Children and young people	State care includes education settings, therefore all children in New Zealand (currently or in the future) will benefit from safer care settings.
LGBTQI+	The care system in the past often targeted LGBTQI people for conversion therapy, and other forms of mis-treatment, particularly in psychiatric care. LGBTQI people were also sometimes targeted for abuse in the wider care system because of their sexual orientation.

Treaty of Waitangi - te Tiriti Implications

58. As well as the findings in the final report relating to potential Treaty of Waitangi - te Tiriti breaches, there are a number of recommendations in Whanaketia that discuss partnering with Māori, working with Māori whānau, hāpu and iwi and Māori communities and/or giving effect to Te Tiriti o Waitangi (for example, recommendations: 14, 39, 117, 126,127 and 129). It is proposed that further analysis of these findings and recommendations will be completed as the more complex recommendations are worked through over the coming months.

Human rights Implications

59. Whanaketia recommends that human rights be embedded in the new redress scheme in accordance with various United Nations conventions and declarations (recommendation 15), that performance indicators based on these should be established and reported against annually (recommendations 16 and 17), and that a review of the New Zealand Human Rights Framework should be undertaken (recommendation 119). These recommendations are complex and will need to be considered as part of further analysis undertaken as the more complex recommendations are worked through over the coming months.

Use of external resources

60. No external resources such as contractors or consultants were engaged to provide a material contribution to the preparation of the advice in this paper.

Consultation

61. All the agencies involved in the Crown response were consulted during the development of this paper, including in the preparatory work. This includes: the Treasury, the Ministries of Health, Education, Social Development, and Justice, Oranga Tamariki, Whaikaha (the Ministry of Disabled People), the NZ Police, Crown Law, the Department of Corrections, Archives New Zealand, the Ministry of Business, Innovation and Employment (ACC Policy), ACC, Te Puni Kōkiri, the Ministry for Pacific Peoples, the Independent Children's Monitor, the Education Review Office, and the Public Service Commission.

62. The Department of Prime Minister and Cabinet has also been informed.

Communications

63. The Royal Commission emphasised the importance of communications in its recommendations, including: widespread dissemination of the report (113), and publishing a response to the findings (130) and recommendations (131). The Crown Response Unit will identify opportunities to communicate decisions as they are made in response to the Royal Commission.

Proactive release

64. This paper will be proactively released and published on the Crown Response Unit website as soon as practicable after the Prime Minister's apology.

Recommendations

The Lead Coordination Minister for the Crown Response to the Abuse in Care Inquiry recommends that the Cabinet Social Outcomes Committee:

1. **note** *Whanaketia: Through pain and trauma from darkness to light* (Whanaketia) the final report of the *Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions* was tabled in Parliament on 24 July 2024;

2. **note** that the overall shifts pointed to in Whanaketia focus on addressing the wrongs of the past for survivors of abuse in care, making the care system safe for children, young people and adults, and empowering whānau and communities to care for their own where possible and to prevent abuse and neglect in state care;

3. **note** the Royal Commission recommended the Government publish responses to each of its over 500 findings, including full or partial acceptance, and reasons for any disagreement, within two months of Whanaketia being tabled in Parliament (recommendation 130);

4. **agree** to *partially accept* recommendation 130 by *broadly accepting* the Royal Commission's overall findings while noting that these findings have not been tested at an individual level and that s9(2)(f)(iv) [redacted]

5. s9(2)(f)(iv) [redacted]

6. **note** inter-agency work to respond to the 113 of the 138 recommendations directed at the Crown has identified:

    6.1. s9(2)(f)(iv) [redacted]

6.2. s9(2)(f)(iv) [redacted]

6.3. s9(2)(f)(iv) [redacted]

7. **note** these s9(2)(f)(iv) [redacted] and will form the basis of the actions that could announced in the Prime Minister's public apology on 12 November 2024, subject to separate Cabinet decisions as required;

8. **note** the Royal Commission recommended Government publish responses to each of its recommendations, including full or partial acceptance, and reasons for any disagreement, within four months of Whanaketia being tabled in Parliament (recommendation 131);

9. **agree** to *partially accept* recommendation 131 by publishing this and subsequent Crown Response Cabinet papers and the Response Plan detailed in recommendation 15;

10. **note** that this paper is not seeking funding for, or agreement to, the recommendations referred to in recommendation 6 and that some of these will be subject to Cabinet decisions, and some will require funding, including:

10.1. s9(2)(f)(iv) [redacted]

10.2. s9(2)(f)(iv) [redacted]

11. s9(2)(f)(iv) [redacted]

12. s9(2)(f)(iv) [redacted]

13. s9(2)(f)(iv) [redacted]

14. **direct** officials from the Crown response agencies, led by the Crown Response Unit, to develop a full Response Plan which identifies Lead Ministers and agencies for each recommendation for consideration by joint Ministers s9(2)(f)(iv)

15. **invite** the Lead Coordination Minister responsible for the Crown Response to the Abuse in Care Inquiry to report this Response Plan to the Cabinet Social Outcomes Committee s9(2)(f)(iv) and

16. **agree** to report progress against the Response Plan on an annual basis and confirm the period over which reporting will be completed as part of the report back outlined in recommendation 15.

Authorised for lodgement.

Hon Erica Stanford

Lead Coordination Minister for the Crown Response to the Abuse in Care Inquiry

Appendix One: Summary of the 16 Volumes of Whanaketia

#	Title	Content
00	Preliminaries	Executive summary, summary of findings and consolidated recommendations (164 pages)
01	Purpose and process	How the Royal Commission was set up and the methodologies it used to gather and analyse information (180 pages)
02	Background and context	The social, historical, and environmental factors that led to the expansion of the care system in the twentieth century (230 pages)
03	Circumstances	The various pathways for entry into different care settings, including social welfare care, faith-based care, deaf and disability settings and psychiatric care (190 pages)
04	Nature and extent	The second largest volume describes the range of different types of abuse and neglect and the range of different settings in which it occurred in some detail (352 pages)
05	Impacts	The individual and collective impacts of abuse in care on survivors lives and on their families, whānau and communities (164 pages)
06	Te Tiriti o Waitangi and Human Rights	A relatively short volume on breaches of Te Tiriti o Waitangi and human rights violations (64 pages)
07	Factors	A large volume outlining the factors that the Royal Commission considers led to abuse in care up to 1999 (336 pages)
08	Puretumu Torowhanui, Holistic Redress	Reviews the progress to date to implement the Royal Commission's December 2021 redress recommendations (86 pages)
09	The Future	The largest document discusses survivor experiences after 1999, describes how a future care system could be structured, and introduces all the recommendations (360 pages)
10	Case study: Out of Sight, Out of Mind	A case study of the Kimberley Centre in Levin, an institution for people with learning disabilities run by the Department of Health and closed in the early 2000s (100 pages)
11	Case study: Our Hands were tied	A case study of the Van Asch and Kelston schools for the deaf (which remain open under Ko Taku Reo) (90 pages)
12	Case study: Cauldron of Violence	A case study of Hokio Beach School and Kohitere Boys Training Centre, two national Department of Social Welfare residences in Levin that closed in the late 1980s (102 pages)
13	Case study: Boot camp	Whakapakari, a Department of Social Welfare funded youth programme on Great Barrier Island (110 pages)
14	Case study: Jehovah's Witnesses	A case study of experiences of abuse in the Jehovah's Witness church (53 pages)
15	Survivor Experiences	Describes the individual experiences of 82 survivors of abuse in a range of different care settings, illustrated with professional portraits of each named individual (348 pages)

Earlier (interim) reports:

Title of report	Received
He Purapura Ora He Māra Tipu: From Redress to Puretumu Torowhanui	December 2021
Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit	December 2022
Stolen Lives Marked Souls: Inquiry into the Order of the Brothers of St John of God at Marylands School and the Hebron Trust	July 2023

Appendix Two: Summary of the findings of Whanaketia

The full set of findings from the Royal Commission are set out in four volumes ("parts") of its 16-volume final report, as well as in its five new case studies, two previous case studies (on Lake Alice Hospital and Marylands school/Hebron Trust) and the previous interim report on redress.

The findings from the main report are drawn together in the final report's Preliminaries volume, which includes a 27-page summary of the key findings.

This document draws on the Preliminaries volume summary, in four sections:

We have also appended a document that sets out the full findings text, including the additional findings from the five new case studies and the previous two case studies.

Circumstances that led to people being placed into care

Key findings - summary

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

Māori and Pacific

- Māori were more likely to be placed in State care, due to colonisation, urbanisation, breakdown of social structures and racism.
- Tamariki and rangatahi Māori made up the majority in social welfare care and were over-represented in other care settings. They were more likely to be sent to harsher institutions such as borstals.
- The State almost always failed to recognise Māori or Pacific world views when removing or placing Māori and Pacific.
- The State did not typically consider in-home whānau, hāpu, iwi or community care placements.
- Between the 1950s and 1980s, Māori and Pacific peoples experienced heightened surveillance and targeting by Police and other State agencies for running away, staying out or behaving in ways perceived as promiscuous.

Deaf, disabled and mentally distressed

- Deaf, disabled and mentally distressed people were often denied or restricted from involvement in decisions about their own lives.
- Decision-making was often influenced by ableist or disablist attitudes, which led to segregation and social exclusion.
- Institutional care was over-used. For many, formal State care was the only option provided, often for their entire lives.
- They were often denied involvement in decisions about their own lives.

Unmarried mothers and adoptions

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

Nature and Extent of abuse and neglect in care

Key findings - summary

- Best available estimates indicated that up to 200,000 people were abused in care between 1950 and 2019. Precise figures are impossible due to data inaccuracies and poor records. The total number may be higher than this estimate.
- Forms of abuse and neglect included: entry into care, psychological and emotional, physical, sexual, racial and cultural, spiritual and religious, medical, solitary confinement, financial and forced labour, and educational.
- Sexual, physical and emotional abuse were the most common forms.

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

Case study – Lake Alice Child and Adolescent Unit, near Marton

- Electric shocks and paraldehyde injections were used as punishment, administered to various parts of the body including the head, torso, legs and genitals.
- Solitary confinement was misused.
- People were exposed to unreasonable medical risks.

Case study – Marylands School and Hebron Trust, Christchurch

- Sexual abuse was pervasive. Abuse and neglect was extensive and extreme.
- Some survivors lived in perpetual fear.
- Abuse was used to punish and intimidate.

Case study – Te Whakapakari Youth Programme on Aotea/Great Barrier Island

- Abuse and neglect was extreme.

- There was severe physical violence, isolation on a small island for days at a time, and death threats through mock executions.

Case study – Kimberley Centre (for disabled people), Levin

- Normalised physical abuse, reflected by the “Kimberley cringe”, where people would cower to protect their head if approached quickly.
- Poor nutrition, with people not fed for long periods, or feeding tubes used unnecessarily.
- Absence of purposeful activities for 80% of the time.

Case study – Kelston School for the Deaf, Auckland, and Van Asch College, Christchurch

- Regular sexual, physical, verbal and psychological abuse.
- Linguistic abuse and language suppression.
- Punishment for using Sign Language, no support for Deaf culture and identity.

Case study – Hokio Beach and Kohitere Boys’ Training Centre, near Levin

- Normalised and pervasive violence, including severe corporal punishment involving weapons.
- Staff condoning peer-on-peer violence through a “kingpin” system.
- Pervasive sexual abuse.
- Misuse of solitary confinement.
- Normalised racism and cultural abuse.
- Punishment with extreme physical training and inhumane tasks.

Impacts of abuse in care

Key findings

- Many survivors have gone on to lead fulfilling lives, and some have worked courageously to improve the future for people in care.
- Some people who were abused in care took their own lives or died because of their experiences.
- There is evidence of unmarked graves for patients who died at some psychiatric hospitals, particularly at Porirua, Tokanui and Sunnyside hospitals.
- Most survivors suffered harm and have not been able to live their lives to their full potential.
- Impacts have included: Difficulty with maintaining intimate and family relationships; damaged physical, mental and emotional health and wellbeing; lack of education and reduced employment opportunities; increased financial insecurity; periods of homelessness and reduced trust in authority.

- For some, their experiences became pathways to addiction, sex work, criminality and prison, gangs, entrapment in institutional care, and struggles with sexuality and gender identity.
- Māori and Pacific survivors also experienced family and cultural disconnection, loss of identity, and resulting loss of confidence.
- More than 30% of children and young people from Social Welfare institutions went on to serve prison sentences.
- Abuse and neglect had inter-generational impacts.
- Often, reintegration was difficult, and sometimes never achieved, for people in care returning home.
- Deaf, disabled and mentally distressed survivors experienced ongoing discrimination which limited their ability to leave care.
- The lack of acknowledgement or apology from those in power creates further trauma for survivors.
- Abuse and neglect, and inter-generational harm, have contributed to social inequities.
- The average lifetime cost to the survivor of the loss of enjoyment of things that New Zealanders consider are normal day-to-day activities is estimated to be approximately $857,000. *[Martin Jenkins report, "Economic Costs of Abuse in Care", prepared for the Royal Commission]*.
- The estimated total loss of enjoyment cost is between $96 billion and $217 billion. Of this, $46.7 billion is borne by taxpayers, and $172 billion by survivors. *[Martin Jenkins report].*

Factors which caused or contributed to abuse in care

Crown breaches of Te Tiriti o Waitangi

The following were breaches of the principle of active protection in Te Tiriti:

- Depriving whānau, hāpu and iwi of tino rangatiratanga over their kāinga
- Failure to address ongoing effects of colonisation, which contributed to Māori being placed in care
- Failure to appropriately address trauma caused by abuse and neglect in care.

Other Te Tiriti breaches: Māori

- Stripping Māori of their cultural identity through structural racism, breaching the guarantee of tino rangatiratanga and principles of kāwanatanga, partnership, active protection and equity.
- Excluding Māori from decision making and developing policies for the care of Māori, breaching the guarantee of tino rangatiratanga and principles of partnership and active protection.
- Failing to provide appropriate redress for abuse and neglect.

Breaches of care standards

- People in care had rights to care standards that should have prevented abuse and neglect during the Inquiry period. But in some settings, especially disability, mental health and education, government failed to set adequate or overarching care standards.
- In Social Welfare settings, social workers and foster parents breached standards set out in relevant manuals.
- Police breached standards set out in their General Instructions by interrogating young people with violence and without another adult present, and by holding them in Police cells.
- Standards were routinely breached, with daily breaches in many institutions and foster care places, due to lack of resourcing, poor training, and confusion about statutory powers and roles.
- Breaches varied in severity. Some breaches were abuse in themselves, others allowed abuse to happen. They included the failure of some social workers to visit State wards in care.
- Breaches of care standards included: Neglect and abuse, wrongful use of seclusion and solitary confinement, frequent use of corporal punishment, frequent breaches of healthcare standards (at times unlawfully), failure of social workers to visit State wards in care, and serious breaches of transitional and law enforcement standards.

People at the centre of abuse and neglect

- Many of the circumstances leading to people being placed in care made them more susceptible to abuse and neglect.
- Abusers misused their positions of power and control. They were often predatory, exploited vulnerability, acted with impunity, concealed their actions, and avoided accountability. Some abusers were peers.
- Many bystanders – staff, volunteers and carers – failed to stop or report abuse.

Institutional factors

- Inadequate, inconsistent and inaccessible care standards.
- Inaccurate identification or assessment of individual care needs were.
- Poor employment practices, including lack of vetting, sometimes knowingly appointing convicted sexual abusers, and poor training and development.
- Variable, absent or poorly implemented complaints processes, including: Barriers to raising complaints, consistent failures to believe people in care who reported abuse and neglect, leaders prioritising reputations over the safety of people in care, consistent failures to report complaints to Police, ineffective oversight and monitoring, failures of accountability that allowed abuse and neglect to continue.

Systemic failures

- There should have been legislation specific to the care system to protect Te Tiriti and human rights, measures to support home care and minimise institutionalised care, and a national care safety framework.
- People in care, and their families and communities, had limited input into State decisions about care.
- Discriminatory legal and policy settings, underpinned by societal attitudes like racism, ableism and disablism, sexism, homophobia and transphobia, children viewed as delinquent, and negative views on poverty.
- The rights of people in care were generally ignored.
- The State lacked diversity and lived experience of care in its leadership.
- People in care were not safeguarded from abuse and neglect, and there was lack of State accountability.
- The State did not take the steps it should have when it saw signs of system failure, such as legislation, support for care at home, steps to minimise institutional care, a care safety framework, best practice training and development, and independent monitoring and oversight.

Societal factors

- Discriminatory social attitudes contributed to survivors entering care and suffering abuse and neglect (as listed in "systemic failures" above).

Findings of fault (against the State)

- ***Social Welfare:*** Ministers and heads of the Child Welfare Division, then the Department of Social Welfare and its successors, were at fault for matters including: Not consistently supporting whānau to prevent people from entering care; often ignoring Māori perspectives and solutions; failing to properly train, support and monitor caregivers; failing to consistently believe or follow up reports of harm.
- ***Health and Mental Health:*** Ministers and Directors-General were at fault for matters including: Implementing institutionalisation from the 1950s to the 1970s leading to abuse and neglect (despite warnings by World Health Organisation and the 1959 Burns Report); ignoring disabled people's perspectives and solutions; inadequate support for families and lack of emphasis on non-institutional care options; overrepresentation in care negatively affecting Māori, Pacific Peoples, Deaf disabled and mentally distressed individuals; inappropriate use of practices like seclusion and restraint.
- ***Education:*** Ministers, Secretaries and Chief Executives were at fault for matters including: Failing to provide education fit for blind, Deaf, disabled children and young people; failing to support NZ Sign Language and Deaf cultural needs; having less oversight of private schools; and failing to keep children safe in some schools and boarding facilities.
- ***NZ Police*****:** Successive Commissioners of were at fault for: Failing to address disproportionate representation of Māori in criminal justice; negative experiences of Pacific peoples with policing; insufficient policy and procedure to

support Deaf, disabled and mentally distressed people; not consistently following policies related to children and young people such as improper questioning of minors; using Police cells to detain children and young people; negative bias against victims of abuse and neglect; and failures to investigate abuse and neglect allegations against people in care.

- ***Governments*** were at fault for matters including: Racism and ableism in legislation, policies and systems; alienation of Māori, Pacific peoples and Deaf peoples from their families, communities and cultures; allowing abuse and neglect of people in care, failure to ensure people in care were safe; inconsistently addressing disclosed abuse and neglect; and gaps in and loss of records.
- ***State or Public Service Commissioners*** were at fault for: Failing to hold Chief Executives to account for matters including: not addressing the public service role in being responsible for abuse and neglect in care; not appropriately responding to abuse and neglect complaints; not providing holistic redress for survivors; not addressing public servants not following successive codes of conduct; lack of coherent safeguarding of people in care; no framework for ensuring a diverse and inclusive care workforce.

Lessons identified and changes made

- The State made discrete changes to safeguard against abuse and neglect in care during the Inquiry period, generally from the late 1980s.
- The State was slow to learn and act on critical lessons. Well-intentioned changes were made to prevent and respond to abuse and neglect, but these were not always realised.
- Changes to address over-representation of Māori were not made until the late 1980s.
- Changes were inconsistent across care settings and were generally smaller than the scale of abuse in care.
- Changes were slow and few in Deaf, disabled and mental health.
- There were some efforts to eliminate discriminatory institutional policies and practices.

Appendix Three: Whanaketia recommendations triage - categories or themes of recommendations

The recommendations have been grouped into the seven broad themes or categories below to help focus on the outcomes to be achieved and to help determine which agencies should respond to each recommendation.

Grouping	Description	Recommendation numbers	Total
Redress recommendations	These mainly apply to the proposed new redress scheme and either reiterate or build on the recommendations from the 2021 Interim Redress report. Note that key decisions on the interim report are yet to be made but will be coming to Cabinet in the next few months.	1-3, 5, 8-9, 10-11, 14-21, 81-84.	20
Justice Sector recommendations	Nearly half of these involve legislative change – either to improve care safety settings and/or improve the rights of vulnerable people. Others concern training reporting and reviewing manuals and guidelines.	6-7, 22-38, 119, 120.	21
Care Safety recommendations	Most of these recommendations are more complex and require further work (including significant organisational and system change). They require cross-agency analysis and advice and Ministerial decisions on whether to pursue (sometimes) large scale structural change such as a new Care Safe Agency and legislation, or to focus on gaps and consistency of existing standards and practices across sectors.	39-75, 88	38
Monitoring and oversight	These ask for a review of oversight bodies for the mental health, child protection, education and disability care sectors.	85-87	3
Prevention and community empowerment	These include providing advocates for those in care, working more closely with whānau, Iwi and communities, social campaigns, prevention programmes and one significant proposed system change.	76—80, 111-118, 121-122.	15
Implementation recommendations	These include the establishment of a Care System Office in a central agency, community engagement and publication and reporting on decisions made and implementation progress.	123-138	16
Sub-total (State-care focussed recommendations)			**113**
Recommendations for faith-based organisations	Recommendations for action only from faith-groups (noting that the "care safety" group mostly apply to both State and faith groups).	4, 12-13, 89-110	25
Total			**138**

Cabinet Social Outcomes Committee

Minute of Decision

Final Report of the Abuse in Care Inquiry (Whanaketia): Initial Response

Portfolio **Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions**

On 25 September 2024, the Cabinet Social Outcomes Committee:

1 **noted** that *Whanaketia: Through pain and trauma from darkness to light* (Whanaketia) the final report of the Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions (the Royal Commission), was tabled in Parliament on 24 July 2024;

2 **noted** that the overall shifts pointed to in Whanaketia focus on addressing the wrongs of the past for survivors of abuse in care, making the care system safe for children, young people and adults, and empowering whānau and communities to care for their own where possible and to prevent abuse and neglect in state care;

3 **noted** that the Royal Commission recommended that the Government publish responses to each of its over 500 findings, including full or partial acceptance, and reasons for any disagreement, within two months of Whanaketia being tabled in Parliament (recommendation 130);

4 **agreed** to partially accept recommendation 130 by broadly accepting the Royal Commission's overall findings, while noting that these findings have not been tested at an individual level and that further work is required to respond to the findings that are legal in nature;

5 s9(2)(f)(iv)

6 **noted** that inter-agency work to respond to the 113 of the 138 recommendations directed at the Crown has identified:

6.1 s9(2)(f)(iv)

6.2 s9(2)(f)(iv)

7 **noted** that the recommendations in paragraph 6 could form the basis of the actions that could be announced in the Prime Minister's public apology on 12 November 2024, subject to separate Cabinet decisions in October 2024;

8 **noted** that the Royal Commission recommended that the Government publish responses to each of its recommendations, including full or partial acceptance, and reasons for any disagreement, within four months of Whanaketia being tabled in Parliament (recommendation 131);

9 **agreed** to partially accept recommendation 131 by publishing the paper under SOU-24-SUB-0118 and subsequent Crown Response Cabinet papers, with any appropriate withholdings under the Official Information Act 1992, and the Response Plan referred to in paragraph 15;

10 **noted** that the paper under SOU-24-SUB-0118 is not seeking funding for, or agreement to, the recommendations referred to in paragraph 6, but that some will require funding, including:

10.1 s9(2)(f)(iv)

10.2 s9(2)(f)(iv)

11 s9(2)(f)(iv)

12

13 s9(2)(f)(iv)

14 **directed** officials from the Crown response agencies, led by the Crown Response Unit, to develop a full Response Plan which identifies Lead Ministers and agencies for each recommendation for consideration by joint Ministers s9(2)(f)(iv)

15 **invited** 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 to report back to the Cabinet Social Outcomes Committee with the Response Plan s9(2)(f)(iv)

16 **agreed** to report progress against the Response Plan on an annual basis and confirm the period over which reporting will be completed as part of the report back outlined in paragraph 15.

Jenny Vickers
Committee Secretary

Present:
Rt Hon Christopher Luxon
Hon David Seymour
Hon Nicola Willis (Chair)
Hon Chris Bishop
Hon Erica Stanford
Hon Louise Upston
Hon Tama Potaka
Hon Matt Doocey
Hon Nicole McKee
Hon Casey Costello
Hon Melissa Lee
Hon Nicola Grigg
Hon Karen Chhour

Officials present from:
Office of the Prime Minister
Officials Committee for SOU
Office of the Minister for Infrastructure
Office of 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
Crown Response Unit
Crown Law
Department of Internal Affairs
Ministry of Justice
Oranga Tamariki – Ministry for Children

Cabinet

Minute of Decision

Report of the Cabinet Social Outcomes Committee: Period Ended 27 September 2024

On 30 September 2024, Cabinet made the following decisions on the work of the Cabinet Social Outcomes Committee for the period ended 27 September 2024:

[redacted] Withheld as not part of Crown Response to the Royal Commission of Inquiry into Abuse in Care

SOU-24-MIN-0118	**Final Report of the Abuse in Care Inquiry (Whanaketia): Initial Response** Portfolio: Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions	CONFIRMED
SOU-24-MIN-0119	**Initial Legislative Changes in Response to the Abuse in Care Royal Commission of Inquiry** Portfolio: Government's Response to the Royal Commission's Report into Historical Abuse in State Care and in the Care of Faith-based Institutions	CONFIRMED

[redacted] Withheld as not part of Crown Response to the Royal Commission of Inquiry into Abuse in Care

Rachel Hayward
Secretary of the Cabinet