ABUSE IN CARE ROYAL COMMISSION OF INQUIRY
STATE INSTITUTIONAL RESPONSE HEARING

Under	The Inquiries Act 2013
In the matter of	The Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions
Royal Commission:	Judge Coral Shaw (Chair) Dr Anaru Erueti Ali'imuamua Sandra Alofivae Paul Gibson Julia Steenson
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Venue:	Level 2 Abuse in Care Royal Commission of Inquiry 414 Khyber Pass Road AUCKLAND
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TRANSCRIPT OF PROCEEDINGS

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[9.04 am]

CHAIR: Tēnā koutou, tēnā koutou, arā tēnā rā tātou katoa. Welcome everybody to today. It's Wednesday and we're on the downward trek in our hearing and the last day of the hearing from our witnesses from Ōranga Tamariki. Just to remind all those witnesses who took the oath on the first day, that you remain, of course on – the affirmation – that you continue to be covered by that affirmation. Tēnā koe, Dr Cooke.

DR COOKE: There we go. Kia ora, everyone. This morning I will need to introduce myself to those who are watching online and I do so –

CHAIR: Can I interrupt this programme and make, yet again, another formal apology for being remiss, sorry everybody. For those who cannot see me, I'm Coral Shaw. I'm the Chair of the Royal Commission. I am an elderly Pākehā woman with white hair to my chin, I'm wearing glasses and today a rather vibrant red jacket with a blue blouse. I'll invite my colleagues to introduce themselves. Julia Steenson.

COMMISSIONER STEENSON: Ata mārie tātou. So I'm Julia Steenson and today I'm wearing a navy blue top, I have brown hair and brown eyes and I'm a Māori woman, kia ora.

CHAIR: Kia ora. Dr Andrew Erueti.

COMMISSIONER ERUETI: Tēnā koutou katoa, e tika ana ki te mihi ki te kaikarakia, Ngāti Whātua, tēnā koe. Me ngā purapura ora i whakauru mai ana e mātakitaki mai ana i te pouaka whakaata e ngā kaiwhakautu, tēnā koutou, nau mai haere mai. I'm Anaru Erueti, I'm wearing a polka dot tie, a pink shirt and a grey suit, kia ora.

CHAIR: Kia ora. Ali'imuamua Sandra Alofivae.

COMMISSIONER ALOFIVAE: Malo le soifua maua ma le lagi e mamā i lenei tacao fou, talofa lava. (Greetings to good health and wellbeing here this morning, welcome). Good morning, talofa lava everybody, I am Ali'imuamua Sandra Alofivae. Today I have on a navy blue dress with a very bright orange cardigan. I am a Pacific of Samoan Chinese descent and I have shoulder length curly black hair.

CHAIR: Kia ora and Paul Gibson.

COMMISSIONER GIBSON: Tēnā koutou, I'm Paul Gibson. I'm a middle aged Pākehā man with greying hair, wearing a dark suit and a light shirt, and I have one headphone over one ear listening to information on the computer, as I am blind with some peripheral vision, kia ora.

CHAIR: Kia ora, now having rectified the error, back to you, Dr Cooke.

QUESTIONING BY DR COOKE: Thank you. Yet again for those who are watching, I am Pākchā, I am elderly, I have grey hair. I'm wearing a black suit with a blue striped shirt, black tie and I'm wearing glasses.

This morning, I'm going to again just bring up some examples of complaints and then going to ask you about some questions relating to complaints and how the process works within Oranga Tamariki and will raise, briefly, one aspect that's of relevance to the foster care inquiry, perhaps in relation to the Care Standards and their implementation.

First of all – so can we bring up, first of all, ORT0000779. This is the Field Officer's Manual Child Welfare Division of 1965 and it's being raised just to, again, show that there were policies in place that were applicable for practice at the time that would be relevant to the work of this Commission and its scope.

CHAIR: And again, just for those watching, those in the audience, you will not see the documents that are coming on the screen. They cannot be redacted safely to protect the privacy of individuals, but counsel will tell us what the document is and will read us the part that he's referring to and he'll read them slowly, won't he, Dr Cooke?

DR COOKE: I will. This is headed "Neglect or Cruelty" and it's H.21 and it says this:

"Whenever there is reason to believe that a child's life is in danger or that he is being subjected to serious neglect or cruelty, the investigation of such complaints must take precedence over all other duties. If the case is sufficiently serious, the officer has not only the right, but also the duty, to make a complaint and obtain and execute a warrant, removing the child to a place of safety until inquiries can be completed and the court can determine what action should be taken.

Investigating complaints of this kind, of course it will be often necessary to depart from the procedural and ethical principles set out earlier in the manual concerning the obtaining of information from third parties moving slowly rather than precipitately and so on. Emergency situations demand emergency measures and in this situation it has to be remembered that we temporarily change our role, ceasing to be case workers and becoming law enforcement and child protection officers. In less serious or urgent cases, investigations may be delayed but never to the extent that a child's interests or welfare is unnecessarily imperilled."

So can we just go back into the document, Zita. Thank you. And you'll see that below that, there are then, it talks of:

"In cases of neglect or cruelty as described above and whether concerning miscellaneous cases or cases where we have official oversight and control, the Police

should be advised unless the DCWO – who, I presume, is the District Child Welfare Officer – has good reason for not wishing to do so, in which case he should consult the Superintendent. Generally speaking, the Police should be advised about every case of cruelty or ill treatment where a child is seriously marked or the DCWO has doubts about the degree of -ill treatment administered. It is a criminal offence to ill-treat, neglect or fail to provide a child with the necessaries of life."

And then it goes on to cite relevant provisions of the Crimes Act. So I'm raising that to again illustrate the point, which I think you will agree with, that there were relevant policies in place within the Department during the period of this Commission's scope. That would have addressed issues of abuse for children both in care and prior to coming into care.

MR TE KANI: Yes.

DR COOKE: Yes. And there would be an expectation, wouldn't there, in every instance where it's sufficiently serious that the Police would be consulted?

MR TE KANI: Um, yes.

DR COOKE: Yes. And would you agree that what the evidence of this Commission has heard, through survivor statements that run over the scope period and beyond, that notwithstanding the fact of there being appropriate policy on many occasions, policies were not acted upon and carried out by those charged with doing so?

MR TE KANI: On the facts that we have seen so far, yes.

DR COOKE: And when you say on the face of what we've seen so far, you're there referring to the totality of evidence that has come before this Commission from a range of survivors and with those survivors having been in State care from 1950 through to 1999, as well as including evidence that goes beyond 1999? That's the case, isn't it?

MR TE KANI: On what we've seen of the survivor testimony presented between 1950 and 1999, yes.

DR COOKE: Yes. And you would accept, as I think you said yesterday, that there are themes of concern, because we covered this yesterday.

MR TE KANI: Yes.

DR COOKE: You would accept there are themes of concern that are still present as of today that reflect the exact matters that we have been canvassing during the scope period?

MR TE KANI: Yes.

DR COOKE: Yes. So you're acknowledging very clearly, there's an admission from you today that there has been a – that the themes of concern of abuse and neglect of children in care have continued from 1950 through to the current day. That's what you're telling us.

MR TE KANI: I'm acknowledging that from the evidence that we've seen thus far, that there are common themes to what we understand of our practice today.

DR COOKE: When you say "acknowledging", are you saying you are telling us that you accept that there are those continuing themes that run from 1950 through to the present day?

MR TE KANI: There are common themes, yes.

DR COOKE: Right. And you're telling us that that's accepted by you because you are acknowledging that to be the case?

MR TE KANI: I'm acknowledging the themes that we've considered from the information provided, yes.

DR COOKE: Right. So again, just to be clear, in saying that you acknowledge that to be the case, you are telling the Commission that that is accepted by you as having occurred?

MR TE KANI: Sorry, what are you – which period are you talking about? Between 1950 and 1999?

DR COOKE: I'm saying to you that during the period from 1950 to 1999, and then you've said in your evidence yesterday, and I think you've said it today, that you accept there are continuing themes that reflect the substantive evidence that we've heard covering the scope period is still existing today?

MS SCHMIDT-McCLEAVE: Madam Chair, I feel that he's been asked this question in a number of different ways. He has accepted, yesterday, that those themes do exist. We also heard evidence yesterday of the change in practice to respond to those instances, so I'm loath to interrupt my friend but it does feel like, given his answer, we're bordering on him being badgered, somewhat.

CHAIR: Close to, but it seems to me – you covered yesterday, Dr Cooke, Mr Te Kani's definition and understanding of what "acknowledgment" meant.

DR COOKE: I did.

CHAIR: I think, in that context, he accepted that that included that he accepted the facts that had been given by the survivors, or something –

MR TE KANI: Yes.

CHAIR: That's right.

MR TE KANI: Yes, Madam Chair.

CHAIR: To that extent, when you say "acknowledging", Mr Te Kani, you mean that you are accepting that the evidence about factual matters as submitted by survivors are correct?

MR TE KANI: Yes.

DR COOKE: But I think I've gone further in getting –

CHAIR: And that includes up to the present day.

DR COOKE: Yes, those themes are running through –

CHAIR: Well just let Mr Te Kani answer, counsel. I think we're all clear about 1950 to 1999. The question is, the themes you accept have continuing – and I think you answered a question, didn't stop at the end of 1999, that the factual background for abuse, neglect has continued through to the present day.

MR TE KANI: Yes.

CHAIR: That's right, and then you've gone on to talk about other ways in which you are responding to that.

MR TE KANI: Indeed, yes.

CHAIR: Does that assist you, Dr Cooke?

DR COOKE: Yes –

CHAIR: Alright, thank you.

DR COOKE: Well as long as it's helpful to the Commission.

CHAIR: I think it is helpful to the Commission, thank you.

MR COOKE: I now want to bring up case studies. The first is ORT0001550_00053. This is a case note file and it's dated March 1986 and it concerns a young female who, at the time, was aged around 16 and I'm going to summarise it. She was in a family home. There had been –she didn't arrive home from school on a Friday night. She was reported missing. The female caregiver had indicated on the Thursday night there had been an argument, that she had "exploded" at this young woman for putting already clean and dried washing back in the machine. It was felt that the young woman had not thought of what she was doing, that she was angry at being told off, but it was not thought that the incident in question was relevant to the issue of her taking off, so that's an important factor here.

What we then, we then see that the young woman telephoned the social worker the following Monday to say that she was okay; she did not ever want to return to that family home. She wasn't prepared to tell the social worker where she was but would meet her the next day as she had a lot to tell her.

We're then told that the family home caregivers telephoned, who were distraught, to say that the young woman in question had telephoned other children within the family

home, had threatened what appear to be two of those children and said that the caregiver father had made a pass at her. This was apparently some five months ago; the same rumour was going around the local college.

The situation was described as getting out of hand. The caregivers of the family home were on the verge of packing up. The social worker would then see this young woman at college to get the full story.

When the social worker met with this young woman, she said she didn't want to be in the family home, she wanted to live with her own family, she thought she wasn't happy at school. She obviously had been – she was upset. She said she had been at Kingslea and Linwood, she felt more comfortable there, so she'd obviously had some previous involvement with the Chief Executive, or with Social Welfare. She then said she would never go back to the family home if she did not want to. She said that uncle had – perhaps you could put that last bit up, Zita?

CHAIR: Just for the timeframe, this is 1986.

DR COOKE: 1986, yes. And here it is, she said:

"Uncle tried to pash her but she had pushed him away. I asked when this had happened. She said last year when she had not been allowed to go to a dance. She had gone up to her room and was angry she had not been allowed to go. He had followed her, tried to put his arm around her and kiss her but she pushed him away. I asked if that was the only time anything had happened like that and she said yes. I asked her if any of the other children were in any danger or at risk of this happening and she said no."

Can we go on to the next page, please:

"The social worker reassured her she would not have to go back to the house. She made it clear she did not want to return to the family home. The social worker asked if she was prepared to meet with the caregivers at a planning meeting and she agreed but not straightaway, perhaps in a week or two. The social worker said she thought the allegation was serious, she believed what she was saying, and she asked the young woman if she'd like her to take it up with the Police, but she said no.

The caregivers were still extremely upset. They insisted on getting things sorted out as soon as possible. They wanted to talk to the young woman because not knowing what was going on was having a detrimental effect on the other children. I said there was no way she would agree to meet with them as yet, but they insisted we all have a meeting the following day at school."

Can you bring up the last paragraph, please? This tells us about the school and the social workers, and the caregivers arrived at school for this meeting. The social worker advises that as soon as – she knew that as soon as the young woman saw the caregiver, she would run a mile. The social worker felt she was very much in the middle of the situation with the foster parents were feeling hurt and angry, wanting the matter cleared up by seeing the young woman, who, for various reasons, did not want to be confronted, least of all by those caregivers. She came into the office. She said she would talk to the social workers but not to the caregivers. When she saw that the caregivers were not going to leave until they had spoken to her, she took off. She'd given the social worker a phone number of where she was staying the day before. She phoned later and there was the visit between the social worker and this young woman.

It goes on to say that she spent an hour with the young woman that afternoon. She was bubbly, happy, talkative mood and said she would be going back to school the following day. She'd like to go and stay with either mum or her aunty. She was still insistent she wouldn't go back to the family home if the caregivers were still there.

Now, there's a lot of information in that, and as I read it, it would appear that we have a social worker who is taking the matter seriously, you would agree?

MR WHITCOMBE: Yes.

DR COOKE: Is there – but it does appear that it's in the context of the Social Welfare dealing with a complaint on a very narrow and specific basis as between what this young woman has said and the foster father, do you accept that?

MR WHITCOMBE: Yes, it is a narrow assessment and, typically, in the present day there would be a range of other things that would occur as a result of a – of a complaint like this.

DR COOKE: Yes, because there doesn't seem to be any suggestion of any wider investigation into the situation of other children in the family home, despite the young woman saying she didn't think anyone else was being harmed.

MR WHITCOMBE: That's absolutely right. In the present day, there'd be a safety assessment for all of the other children in the home.

DR COOKE: Okay. Thank you. I now want to bring up ORT0002659_00206. This is a letter written by a child psychiatrist to the district office in Wellington and it's dated 7 July 1971, and the psychiatrist is reporting on his assessment of a girl – it's described as a girl – who is in her adolescence, as I appreciate it, and she has made an allegation of sexual abuse against the caregiver. And the question – when you read through it, and I'll cite it, go through it, it would appear to raise questions around the extent to which allegations of

sexual abuse are taken as being correct in themselves or whether the possibility of sexual abuse has been, having occurred, is not seen as being upfront.

So here's the statement:

"The question of the alleged interference by the foster parents needs examining. Is this fictional on her part or is she a very affectionate girl who is frightened by her own feelings? She appears to be wanting to get out of the foster home situation and the question is whether she is taxed in a situation where she might feel frightened and, finally, what was the relationship between this girl and the youth found in the flat that she ran away to? Probably in order to answer all of these questions, I would best record the interview as I obtained it from the girl and then comment in later paragraphs on these specific points."

Now, can we go, keep going down, just got to find the right bit, page 3, para 2, please? The psychiatrist says this, and it's a male psychiatrist, whether that makes a difference or not, it may do:

"I wouldn't think this girl is severely disturbed. The foster parents seem to have helped considerably in managing this girl and I guess that some of her behaviours is due to the damage she feels that she's received and there has been a basic restitution process. I hope she is able to face up to this restitution process and see it fairly objectively, rather than use fantasy mechanisms."

Now just pause there. In a situation of a young woman who has made an allegation of sexual abuse and, as you'll see, when we go through this, there have been, there's a history of abuse, it would appear, that the comment that she see it – a restitution process, whatever that is – in an objective way, do you have a comment to make about that?

MS DICKSON: Oh look, it's reflective of the same themes that we discussed yesterday with the starting premise is that the abuse didn't occur, rather than starting with a core belief that the young person is honest in her sharing an experience that has happened to her and that frames, therefore, the way that professionals respond to the issue.

DR COOKE: Yes. This was in 1971 and just from – we know, don't we, that by the early – by around 1960, 1961, when Henry Kempe did his work around child abuse, that the focus towards risks to children from physical harm, sexual harm, etc, became more well-known, didn't it? Are you able to comment on the extent to which, say, by 1971, the then department was across that particular dynamic?

MS DICKSON: I'll make some comments. I couldn't in detail about that time. What I would say is there was certainly an understanding of physical and sexual abuse in a kind of family

context. I think it was much less accepted, understood and recognised the extent to which adults might access positions of trust in order to victimise children.

DR COOKE: Now, can we just move down a bit more. Oh yes, just in that – sorry if you go – it's this bit here, that paragraph, this is on the same page. The psychiatrist talks about:

"In relation to the alleged assault, there seems to be some misconstrued feelings – misconstrued feelings – in this girl, aroused by possible overclose physical contact with this girl, talks about sex education and from other girls and from what other girls told her of the foster parents which may have been fictional. She felt that something was just about to happen and that she could not control herself. She also maintained that she felt extremely guilty, that she felt she was letting the foster mother down and that, in a sense, she felt that the foster father was sexually interested in her, rather than being interested in his wife. She feels under quite a bit – a bit of stress it should be – in the family home at present, feeling embarrassed about what she said about the parents and also feels what the foster father might harm her for what she has said. Whether fiction or fantasy, this girl has been interfered with by the grandfather's son, who was aged 18. She has also had intercourse with one boy at Gisborne following a party. There has been no other sexual relationship since but there has been no sexual relationship involved in the running away incident recently."

So that, again, provides another underlying context, doesn't it, to whatever was happening for this woman and which she was then being, kind of, assessed by the psychiatrist, who's coming from a particular perspective that we would now say was probably not helpful.

MS DICKSON: Yes, and again, the dynamic that I spoke about yesterday of placing responsibility on young people for the, you know, the adult – the inappropriate adult behaviour, and the other thing I would add is not recognising or understanding or appreciating the impact of sexual assault over multiple incidents and multiple perpetrators.

DR COOKE: Can we go down a bit further, please? It's the last paragraph. The psychiatrist notes that he doesn't think she is severely disturbed and that the foster parents seemed to have helped considerably in managing her. It's the highlighted point:

"She will need a fair amount of help in adjusting to her mother. It might be possible to patch up the relationship with the foster parents and to drop the allegations of sexual assault."

You would not agree with the premise that's implicit within that statement, would you?

MS DICKSON: Absolutely not.

DR COOKE: No. And when you, if you think back to even the policies that I referred you to earlier, it would appear that the approach being taken in this case would not be reflective of good application of policy.

MS DICKSON: Certainly noting that this is not the social workers' actions, it's the psychologist's assessment, but in the context behind – what sits behind that, yes.

DR COOKE: Yes. Thank you. Can we go to ORT0049895?

CHAIR: Just before you do – I don't want to stop the flow – this is an example, isn't it, of a professional, a child psychologist, with some mana in the profession, giving advice to social workers? How is a social worker, who has the field manual to go by, the complaints procedure, seeing this, which is quite plainly contrary to the policy – how does a social worker manage that, receiving that "expert advice" from a "person of authority"? Because that must happen a lot and maybe even now.

MS DICKSON: So if I reflect perhaps from a contemporary perspective, certainly there is still that sense of the expert and I think one of the things that I referenced in the shift we're trying to make is to change the balance of knowledge, but I guess, from the social workers' perspective, they would still have to use their own professional skills and judgement and be enabled and supported to do that through what we refer to as professional supervision. So a process whereby engagement between the social worker and their supervisor and other senior staff is used to support the social worker to see that as one piece of information alongside a range of other pieces of information they should be obtaining in a holistic assessment or investigation.

CHAIR: Quite a difficult balancing exercise, isn't it, or difficult navigation of that?

MS DICKSON: Certainly is, and also I would add because it wouldn't just be the social worker who would view that opinion as expert, it would be other parts of the system, for example, courts, who would view that as an expert opinion.

CHAIR: Yes, thank you.

COMMISSIONER STEENSON: Sorry, can I also just ask, so would you see – this is where those who have been through that system's experiences would become quite powerful, in terms of giving input, expert input. Do you agree – do you agree with that?

MS DICKSON: Absolutely agree.

COMMISSIONER STEENSON: Okay. Thank you.

COMMISSIONER ERUETI: Can I just say quickly, counsel, that the manual that you put up originally, it doesn't seem that it would have been informed by – you were saying,

Ms Dickson, about the lack of appreciation of, at the time, of, in the context of foster care, of there being predators who might prey on children, and so the manual itself may have been deficient.

MS DICKSON: Yes, and I think it would have reflected the fact that that was still an emerging kind of common understanding in the field of practice at the time.

COMMISSIONER ERUETI: Still building understanding.

MS DICKSON: Yes, yes.

COMMISSIONER ERUETI: Thank you.

DR COOKE: Just on that, the manual I brought up was dated 1965. Manuals are living documents, aren't they?

MS DICKSON: Yes. Probably easier to be living these days than in the typewritten past but, yes.

DR COOKE: Yes, but back in the days of paper policies and manuals, they were nonetheless still regularly updated so it would be reasonable to assume that by 1971, for example, there would have been some updates of this particular manual?

MS DICKSON: I'm sure that's the case. I would just add simply updating a manual doesn't change workforce mindset and give them the knowledge and development and different ways of thinking about things. That's a much more substantial piece to go along with.

DR COOKE: Yes, okay. So we're now going to this document, which is 1983 and it deals with a 10-year-old girl who has made an allegation of sexual interference by a former foster parent. I want to bring up paragraph 2 and then paragraph 3 or perhaps all together, if that's easiest. It says here in the second part of paragraph 2:

"She claims that both herself and another young woman were interfered with by the foster father. Specifically, she says that he put his hands in their pants on several occasions and fondled them."

The social worker then says, "I acknowledge that she's only 10 years of age", and she's not going to doubt her word. She then says:

"There is no intention by this office to take the situation any further than notify yourselves, and you may wish to discuss the matter with Mr and Mrs [whoever they are] or leave it."

So if we can just go back to the document, that's sent from the, to the director at Tokoroa and would it be appropriate, if we go back to that paragraph 3, "there's no intention to take the matter further but it's really a matter for you", is that an indication that they're seeking advice from a higher authority?

MR WHITCOMBE: Not so much advice; rather, leaving it in that other person's hands to – to make a call.

DR COOKE: So it would suggest that the assistant director is the person who's going to exercise the decision, the discretion as to whether the matter should be taken further?

MR WHITCOMBE: That's what it appears to be, yes.

DR COOKE: Is that a decision that ought to have been taken at the local level?

MR WHITCOMBE: Absolutely, and, as I said earlier, you know, the process of working through that allegation in terms of a caregiver investigation process alongside the safety assessment, ensuring safety, would have to be at the forefront.

DR COOKE: Okay. If that happened today, would there, I assume there would be a mandatory requirement for the case to be investigated and for it to be dealt with by the site office?

MS DICKSON: This would be a case that would meet the child protection protocol, so it would require joint investigation by Oranga Tamariki and Police.

DR COOKE: Okay. And just looking at what we understand of the complaint that was made, it would appear implicit possibly that the child may have been left in that placement.

MR WHITCOMBE: Yeah, it is difficult to see that, but it does seem implicit, and again, the response around that young person and what would they need to work through that situation in terms of the supports.

DR COOKE: Thank you. I now want to go to – this is the last case example, it's CRL0042249_00036 and it's a case that began in 1990 with temporary care agreements and came back to life in 2004.

And this is the summary of findings from the claim that was made.

CHAIR: Again, findings by MSD in relation to a claim for redress.

DR COOKE: By MSD, yes, where the Ministry accepts and so –

MS DICKSON: Sorry, Dr Cooke, can you just remind us what period the practice was?

DR COOKE: The practice – here we're talking of, we're talking of practice here that would have been in 2004. I'm going to go through it, because what you'll see from there are a range of complaints that have been made and a range of practice failures that have been acknowledged. First of all, of course, when this complainant was in his father's care, it says he was not interviewed face-to-face, and the social worker did not investigate allegations of abuse according to policy and practice. There was a placement at home but there was an inadequate home assessment that was performed. There was an absence – further down in paragraph 4, he was placed but there was an absence of a care plan. Just on that, every child in care should have a care plan, shouldn't they?

MS DICKSON: We'd now refer to it as the "All About Me" plan, but, yes, and there should also be caregiver support reflected in the caregiver's own caregiver support plan, yeah.

DR COOKE: Yes. And during the period, say, for example –

MS DICKSON: This would be during the care plan.

DR COOKE: And let's talk about the 1989 Act. One would've expected –

CHAIR: We're going a bit fast here so just slow down everyone.

DR COOKE: Sorry. We would expect for every child in care under the 1989 Act to have a care plan.

MS DICKSON: Yes.

DR COOKE: Yes. There was, if you go to paragraph 8, "CYF failed to respond to the report that he was subject to" what is described as "inappropriate punishment" in the previous paragraph, which was physical labour, kept home from school for two weeks, made to spend all day cutting gorse in his boxer shorts from daylight to dark. Then there's allegations of violence from the caregiver. This is a caregiver who was, in paragraph 10:

"Caregiver not seen as being a suitable caregiver."

And I think we may have covered this case in part earlier. Again, no care plan at paragraph 11. Then there are issues around placement at YouthLink which was unacceptable. Paragraph 15, an allegation of physical assault by a caregiver wasn't investigated or at least there's no evidence of that.

Moving down, again this is still at the other provider's place that he was bullied and assaulted. There was a lack of supervision at that place. Now, if we go down to 23, it says that he's here placed with a couple who were not approved caregivers for the first seven months, contrary to policy. Okay.

And then we know that the female caregiver was also a social worker, and you would be aware of that?

MS DICKSON: Yes.

DR COOKE: Yes. And it also appears as though the female caregiver, who was a social worker, was also the social worker for this young person. We'll come to that in a second.

MS DICKSON: I'm not sure it's clear from what I can read, sorry.

DR COOKE: I'm sorry?

MS DICKSON: I'm not sure I can clearly see that from –

DR COOKE: Oh no I'll come to it. You'll see that in para 24:

"The subsequent approval of this person as a caregiver was contrary to policy, in that it should have been signed off by the regional director since she was a current CYF

social worker. There was a position of conflict as a caregiver, CYF employee and social worker."

And paragraph 25:

"The requirement for the caregivers to be visited every two months by the social worker was not met."

Now the – the failure of practice there is the requirement for the caregivers to be visited. Would it not be the requirement for the child to be visited?

MS DICKSON: There are both requirements for the caregiver and the child to be visited.

DR COOKE: Okay. Can we just move down, Zita? Is there anymore? In that event, can we go to the previous document, which would be ORT0049895. Oh, hang on, yes, I think that's right. I just want to bring up the point where it says that the female caregiver, who was a social worker, was also the social worker for this particular young person.

MS DICKSON: I accept that –

DR COOKE: You accept that –

MS DICKSON: if that's somewhere else. I just can't see it in –

DR COOKE: Well, you accept that to be that case.

MS DICKSON: Yes.

DR COOKE: Okay. No that's fine. I wanted to bring those up to, again, just illustrate points that have been made throughout the course of the evidence and this last one, of course, provides some examples that go beyond this period.

Now, I want to talk now about complaints more generally and I want to bring up the – sorry, yeah – arising out of what we've just heard. When a child or a young person makes a complaint to a social worker, is there any discretion, on the part of that social worker, to not take the complaint further?

MS DICKSON: So "complaint" can be quite broad.

DR COOKE: Yes.

MS DICKSON: So if we're talking about a specific disclosure of abuse then that must be addressed, following the investigation processes that we've referred to earlier. There are other things that children may raise as complaints which should also be addressed and followed up. I just want to distinguish between an allegation and a more general complaint.

DR COOKE: Right. My question – where I was going to is this point, that is there any discretion on the part of a social worker not to decide, to filter out a complaint not to take it further?

MS DICKSON: No.

DR COOKE: No. So if a complaint is made, that has to be investigated?

MS DICKSON: Yes.

DR COOKE: So it would go – would it go from the social worker to his or her supervisor? Where would it go?

MS DICKSON: Again, we're talking about a complaint as opposed to an allegation at this point? So if it's an allegation of abuse, it would be investigated. If it's a – and there's a crossover of both, there are some things that sit in the allegation and complaint process. If it was a – sorry, I know I'm going too fast – complaint process, there's dual pathways for some issues, depending on what –

DR COOKE: I'll try and understand it.

MS DICKSON: Sorry.

DR COOKE: I'm the parent of a child and I come to the local office and I say, "I have a concern that my son has been assaulted in the foster placement".

MS DICKSON: That would be a disclosure. It would be treated as an investigation.

DR COOKE: The child says to the social worker, "I want to make a complaint because I was hit last night because I didn't eat my dinner".

MS DICKSON: That's an allegation of abuse. That should be treated as an investigation.

DR COOKE: And – the pathways there, are they the same?

MS DICKSON: Yes, it would follow the investigation – the joint investigation – by today's standards, the joint investigation, the child protection protocol – of both the parents –

COMMISSIONER STEENSON: Sorry.

MS DICKSON: Sorry.

COMMISSIONER STEENSON: Sorry, did you want to finish that sentence?

MS DICKSON: No, it's okay.

COMMISSIONER STEENSON: I'm just wondering the difference, what would constitute a complaint that wasn't an allegation of abuse?

MS DICKSON: So a child may complain about certain decisions that a social worker might be making in relation to frequency of contact with whānau, which in itself wouldn't – is a serious issue that should be treated with all seriousness and responded to, but it's not an allegation of abuse that sits within a joint child protection protocol investigation. So that should still be treated as a complaint and the concerns that the child is articulating being taken very seriously and responded to, but it wouldn't generate the same investigation in relation to an allegation of abuse or neglect.

COMMISSIONER STEENSON: Right, thank you.

DR COOKE: What if the child says to the social worker, "I'm being – I'm in this foster family. There are three other children" they may be older, younger, maybe the same age, "I'm being treated differently from them. They got nice clean clothes. I'm having to wear the same knickers every day for a week", something like that, or some other kind of differential treatment which may have a psychological or emotional impact on that child. How would you categorise that kind of concern?

MS DICKSON: So I think, by today's standards, we would treat that still as a report of concern and do an assessment because it is an indication potentially of emotional abuse. We definitely talk in some of our guidance around emotional abuse, about the impact of differentiated care, treatment, love.

DR COOKE: How would it work in practice? I come to you because I'm in care, you're my social worker and I say, "I'm really pissed off because I'm not being treated the same and I'm feeling uncomfortable in this household. I don't feel – I don't belong, and I've been here for eight months".

MS DICKSON: So, from my perspective, that would be sufficient concern to start what we – I know this is, sorry, I do apologise if this is getting technical a little bit, but there are some concerns, allegations, which may not meet the threshold for that joint child protection investigation, but still may meet the threshold for a care concern that should be assessed. So I would think that would still be entered as a report of concern and a social work assessment follow.

DR COOKE: Let's assume that the assessment said – presumably, that assessment would include a conversation with the caregivers?

MS DICKSON: Yes.

DR COOKE: If there was an acknowledgment from them that there were some problems arising of this nature, so it's not physical or sexual abuse, what would be the process of "intervention", in inverted commas, that would then follow?

MS DICKSON: By today's standards?

DR COOKE: Yes, in today.

MS DICKSON: Yes, so that wouldn't the sole determinant in the assessment. It would be a broad view of that, so it would be the child's experience. Certainly, how the caregiver responded to that concern would be a critical consideration. By today's standards, if there was, based on that assessment, a view that it was in the child's best interests to work to address that concern in the care arrangement and that could be done, there would be additional considerations formally identified in the caregiver support plan, things like training, things

like some suggestions and ways of perhaps thinking differently about the situation in the home.

MR WHITCOMBE: I think the critical thing in this situation, because it is – it's a hypothetical situation, but what is the child, what is the young person saying about what they want, what they want to be different and what would make it feel safe and feel comfortable and their voice would be really important in that.

DR COOKE: Let's cut down to the practical, to the site level aspect of it all. You do your assessment. There may be a decision that there needs to be some therapeutic input, parent/child work, that kind of thing. That would – presumably, you would make a referral through to clinical services, possibly?

MS DICKSON: That would be one pathway.

DR COOKE: Possibly? That would be one path? Do you want to tell us what clinical services is?

MS DICKSON: So we have some in-house specialist support which is psychologists, therapists and they do a range of work with children and – which could include assessment but also some direct therapy.

DR COOKE: And that would include work with caregivers, wouldn't it?

MS DICKSON: They would be involved potentially in the direct therapy, yes.

DR COOKE: And how many clinical services sites do you have?

MR WHITCOMBE: We have – I wouldn't be able to say the number, but we have a team here in Tāmaki Makaurau, quite a significant team. We've also got specialist services in Hawke's Bay and in the Canterbury region, but it's not a service that extends right across the country and, in those situations, we utilise wider psychologists contracted privately.

DR COOKE: Okay. And in Auckland I think you've got one at Manukau as well, in South Auckland. Tell me –

MS DICKSON: A team in Manukau, yes.

DR COOKE: Yes. And tell me – are there issues where you have, sorry, if a child and caregiver needs assistance, and it's specifically identified as being capable of being provided by clinical services, what is the timeframe for getting that referral picked up and acted upon?

MS DICKSON: I would have to check their current capacity and timeframe. Sorry, I don't have that.

DR COOKE: Alright. So that could be – because that would be relevant, wouldn't it, to the welfare of the child within that particular environment and whether or not the demands that

are presented – sorry, the parenting demands and capacity can be satisfied and met without putting the placement at risk?

MS DICKSON: It would be one factor. There would be other factors around the suitability of the therapist, you know, things like cultural match, that kind of thing, but certainly availability and capacity to act on the concern in the timeframe required would be one consideration.

DR COOKE: Right. If it was considered imperative, and I appreciate this may be the case more in some more outlying areas, that you have to instruct an external professional, are there any financial restrictions on the local site's ability to do that?

MS DICKSON: If it's assessed as being a need for a child, the – my Chief Executive may want to comment, but the expectation is that that need would be met.

DR COOKE: Is that a decision that is taken at the local level?

MS DICKSON: Yes.

DR COOKE: Does that come out of the site – does the site manager have his or her budget that they then have to account for?

MS DICKSON: There's a mixture of resourcing, so some are directly paid by the site, and some would be through contracted service provision.

DR COOKE: If this case came before a family group conference (FGC) and the social worker – let's assume there's a report, perhaps there's a report from clinical services, which I've seen, as you would appreciate, which says, "The following further interventions are required", and there's a cost to this, and in the family group conference there is agreement to that but the social worker then says, "Well, I can agree to this but it's subject to the approval of the site manager", because of the financial allocation that's involved, is that, and given the obligations that, I think, under the Act you're meant to implement agreements from FGCs, so far as practicable, would you agree with the proposition that having a potential veto from a site manager over an essential service provided to a child solely because of money, would appear to be inappropriate?

MS DICKSON: Not when that veto is governed by that protection around "so far as practicable".

DR COOKE: Because as I understand it, it would be practicable to provide the intervention because, theoretically, money should not be an obstacle to that.

MR WHITCOMBE: I think there's a couple of principles. Absolutely, we should not be walking past need and we should be enabling the right thing to happen for that child, but also for their family in terms of the response and the things that the wider family might need; and we have to do that in accordance with the Public Finance Act and there's principles around stewardship and how we spend money and also utilise the publicly available resources that

exist, you know, through district health boards or through the Ministry of Education and other service providers.

So there is a balance. I would also suggest there's a tension between the two things, between the Oranga Tamariki Act and the obligations that we have and rightly so on both fronts.

DR COOKE: Sure. I was going to ask a question about this the other day and I haven't got my questions with me, but there's a reference in the Brown Report from 2000 where Judge Brown spoke very specifically about the tension between the obligations of the Chief Executive in providing for children and the obligations that the Chief Executive has in terms of the requirements of section 5 of the Public Finance Act.

If Judge Brown, at that stage in 2000, was expressing concerns in that respect, you're telling us today those tensions still exist.

MR TE KANI: Yes, they do.

COMMISSIONER ERUETI: What is section 5 of the Public Finance Act?

DR COOKE: I think it's section 5. Section 5 of the Public Finance Act, I think, in essence, provides that chief executives – you're not allowed to spend money beyond what it has been targeted and appropriated.

MR TE KANI: Appropriated, correct.

DR COOKE: That's basically it, isn't it?

MR TE KANI: That is it yes.

DR COOKE: Presumably if – I don't know, do you call it Vote Oranga Tamariki?

MR TE KANI: Yeah, preferential, yes.

DR COOKE: Yes. If that says you can spend X amount of dollars on whatever, you can't go off and do it somewhere else, so there is that tension, but – yeah, but it's in the Brown Report as one of the recommendations –

CHAIR: And the question is that it was a concern in 1990, it is still a current concern.

MR WHITCOMBE: That's right.

CHAIR: Thank you.

DR COOKE: If a complaint is made – we went down this rabbit hole which was interesting but valuable perhaps – if a – a child has the right to make a complaint, right?

MS DICKSON: Yes.

DR COOKE: If a – what assistance does a child get in making a complaint? You would say you've got a right to go to the Ombudsman. How would you assist that child in making a complaint, for example, to the Ombudsman, if you're that person's social worker?

MS DICKSON: By today's standards?

DR COOKE: Yes, we're talking about now.

MS DICKSON: So depending on the nature of the complaint and the degree of – I'm just thinking about the role that the social worker might have if the concern was actually about the social worker. Obviously, that has some different dynamics but –

DR COOKE: Let's assume it's not about the social worker but about –

MS DICKSON: Right, that would be helpful. So the social worker would need to make sure that children under – even before a complaint arises – need to make sure that children understand they have a right to make a complaint and –

DR COOKE: Let's assume the child knows that and says, "I want to make a complaint of this guy I've heard who's called the Ombudsman. I've heard lots of good stuff about him".

MS DICKSON: Yep, so I believe the social worker's responsibility would be to work alongside that child to have support to access that pathway. Some of that support may not come directly from the social worker themselves. We have VOYCE Whakarongo Mai now as an independent advocacy service and have Kaiwhakamanawa, who may be the more appropriate person to actually walk alongside the child through the complaint process.

DR COOKE: Does every child in care have a relationship with VOYCE?

MS DICKSON: Every child in care should have the opportunity to have that relationship.

DR COOKE: How does a child in care go about ensuring that there is a relationship with VOYCE, given the role and purpose of VOYCE?

MS DICKSON: So I'd like to just double check that my understanding of that is current over the break, if that's okay –

DR COOKE: Alright.

MS DICKSON: – but there is a proactive offer, as opposed to a responsive offer.

DR COOKE: Sure. I'm happy –

MR WHITCOMBE: And within the Care Standards, the rights for children, that is part of the social work responsibility to ensure that the child has access to the complaints process, that they know how they can work through that and they're supported to do that.

MS DICKSON: But we have some agreements with VOYCE and I just want to check the exact nature in terms of the extent to which they proactively connect with children.

DR COOKE: I know that Ms Toohey is going to be asking questions about that and I may come back to it later in the day.

MS DICKSON: Thank you.

DR COOKE: If a complaint is made to the Ombudsman – just moving more generally to the Ombudsman – and he investigates and makes a specific recommendation, does that recommendation go back – does that go to Head Office in Wellington?

MS DICKSON: So the recommendations that the Ombudsman makes, they do come back to a central team, and it's within my area, but it would include recommendations that require – often would include both recommendations that require a local site--based response and likely recommendations for more of a system review of practice guidance kind of response as well.

DR COOKE: Can you tell us how many – to your knowledge, of the recommendations that the Ombudsman has made, and he's giving evidence, I think, later in the week, has Oranga Tamariki adopted each and every of the recommendations that have been made, to your knowledge?

MS DICKSON: I would say we've accepted a vast majority of the recommendations and we have processes that track our actions towards those recommendations.

DR COOKE: With the recommendations that have been accepted and adopted, are they more likely to be matters relating to actual practice down at the site level, or are they more thematic matters that may be the responsibility of Wellington –

MS DICKSON: There will be both.

DR COOKE: Both. The Ombudsman, if the Ombudsman – sorry if a complaint is made to the Ombudsman and he receives it but says, "I'm not going to investigate it but I think there are some worries here, can you go away and look at it", does that occur?

MS DICKSON: So there's a close working relationship between the Oranga Tamariki feedback and complaints team and the Ombudsman's office, so, yes, it's not unusual for the Ombudsman to suggest that the matter be referred and the feedback and complaints team to take the first action in reviewing the concern.

DR COOKE: So in those instances where the Ombudsman comes and says, "Hey, I've got a couple of concerns, maybe you should look at A, B and C", and they're not recommendations, of course, are they taken up in a serious way as being matters that should be addressed?

MS DICKSON: Sorry, can you just clarify, are you talking about an individual complaint, concern or a more general –

DR COOKE: Well a specific complaint has been made to the Ombudsman. He comes back and says, "I'm not investigating it, but I think A, B and C should be looked at".

MS DICKSON: I think we would – well, it's in my team and my responsibility, we would look at it and consider what further action might need to happen.

MR WHITCOMBE: And often, in my experience, the Ombudsman would ask us to report back and let him know what it is that we have done.

DR COOKE: Sure. Okay. Now, we've talked about complaints and there's also, we're also aware that people can make grievances but that's more related to residences, isn't it?

MS DICKSON: Yes.

DR COOKE: What is the distinction, from your perspective, between a grievance and a complaint? And why are they – is there different nomenclature? Why are different names given to them?

MR WHITCOMBE: I'm not sure that I can answer that question in terms of the language. I would certainly see the grievance process as a process that enables and supports young people in residence to make a complaint and it could be a complaint of many different types.

MS DICKSON: It is referred to within regulation, though, isn't it, grievance?

MR WHITCOMBE: The grievance, why it is called that, is absolutely right – it's referred in that way under the regulations.

DR COOKE: That would be the 1996 Regulations?

MR WHITCOMBE: Yes.

DR COOKE: The Residential Care Regulations. Okay. Just on the nature of regulations, do you still have secure care regulations?

MR WHITCOMBE: That's right, the 1996 Care Regulations remain in force alongside the National Care Standards.

DR COOKE: Were there specific regulations pertaining to the use of secure care?

MR WHITCOMBE: Yes, there are.

DR COOKE: And they are still in force?

MR WHITCOMBE: That's correct.

DR COOKE: Okay. I want to briefly cover the Care Standards and this is an –

COMMISSIONER ERUETI: Sorry, Mr Cooke, I'm just trying to understand the difference between – did you say the 1996 Care Regulations which relate to secure in residences?

MR WHITCOMBE: They're the 1996 Residential Care Regulations and they specifically do relate to the Care and Protection and Youth Justice residences. The first part of the regulations really focus on the rights that children have within residences, and they do go

on and speak to the use of secure care, the use of, you know, time spent in bedrooms, the establishment of a community liaison panel and other matters.

COMMISSIONER ERUETI: So there is some overlap between these regs and the care and safety standards?

MR WHITCOMBE: Yes, I think the Care Standards go a lot further in really articulating what it is that children – all children should have in care and get really quite specific.

DR COOKE: Thank you. So we have the Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018 and they, for the first time, present or give us a requirement for good practice over both care and protection in residences. That's right, isn't it?

MR WHITCOMBE: Yeah, and I'll just invite my colleague, Paula Attrill, who is an expert in this area, as one of our witnesses to be able to also speak to the National Care Standards.

DR COOKE: We'll do that in a second. I just wanted to make sure that we understand what the scope of it is. And prior to the implementation of the regulations, you would agree that for residences, there were the Residential Care Regulations, they were in force from 1996, but for Care and Protection, there were no formal regulations at all?

MS DICKSON: No, so it would be what was prescribed in policy or guidance, yes.

DR COOKE: Yes. Okay. Now the Care Standards were prepared in-house, weren't they?

MS DICKSON: They were prepared in, and this is, I would say, that question might be better answered by Paula Attrill, who is actually involved in that piece of work directly.

MS ATTRILL: Mōrena koutou, ko Paula Attrill tōku ingoa. I'm the General Manager of International Case Work and Adoption Services in Oranga Tamariki and today I have a blue shirt on, I have short grey hair and I wear glasses.

So the Care Standards were one of the initiatives that developed from the EAP Report and the basis of the Care Standards is very strongly hinged to the feedback that we received from care experienced young people, caregivers, whānau and our staff in regards to matters relating to how children in care could receive a better service and have their needs met whilst in care.

CHAIR: What does the "EAP" stand for?

MS ATTRILL: That's the Executive Advisory Panel, Judge Shaw.

CHAIR: Yes, thank you.

MS ATTRILL: External.

CHAIR: That's an external report?

MS ATTRILL: It was led by Paula Rebstock.

CHAIR: That's the Rebstock report, thank you.

COMMISSIONER ERUETI: 2015, yeah.

DR COOKE: So there would've been – there was significant work done arising out of that which led to the promulgation of the Care Standards in July 2018.

MS ATTRILL: Yes.

DR COOKE: And that in-house work was done by Oranga Tamariki?

MS ATTRILL: We led the work. Just to be clear, the Care Standards were finalised in 2018 but they came into being, or they were enacted in 2019. There was a period of 12 months whereby the Ministry was responsible for getting prepared for implementation.

DR COOKE: I'm just going to come to that. The Care Standards themselves – and this is on page 1. I can't bring them up, for various reasons, but the Care Standards, the Order in Council is dated Wellington, the 2nd day of July 2018, so that's when the regulations were made.

MS ATTRILL: Yes.

DR COOKE: You agree with that. And if we go over to regulation 2, sub-clause 2, the rest of these regulations – and I'll explain why it says the words "rest of these regulations" – come into force on 1 July 2019.

MS ATTRILL: Yes.

DR COOKE: Yes. So the exceptions are regulations 79 to 81, 83 and 84(1)(a) and they came into force on 31 December 2020. And regulations 79 to 81 in particular refer to the Independent Monitor and that the role of the Independent Monitor, therefore, as regulation 79, must start assessing compliance with the regulations as from that date.

MS ATTRILL: Yes.

DR COOKE: What isn't excluded and what should have been in place as of 1 July 2019 is the obligation under regulation 86 for the Chief Executive to put in place compliance by self-monitoring. That's correct, isn't it?

MS ATTRILL: I'm looking at my colleague, Nicolette, because that's her team's area of responsibility.

DR COOKE: The question that I'm posing to you is that the regulations, including regulation 86, came into force, they were active from 1 July 2019.

MS DICKSON: Yes.

DR COOKE: Which included the Chief Executive monitoring compliance in respect of the Care Standards.

MS DICKSON: Yes.

DR COOKE: Other than those that came into effect as of December 2020, you were expected to be up and ready to go as at July 2019.

MS DICKSON: Yes.

DR COOKE: And you weren't.

MS DICKSON: Yes, we weren't.

DR COOKE: And yet they are your regulations. They are.

MS DICKSON: Yes, they're regulations we are responsible to meet, yes.

DR COOKE: They are regulations that were prepared by Oranga Tamariki, I think Erin Judge who was then the legal officer was involved in the drafting of them, there was consultation with case holders such as the Law Society.

MS DICKSON: Yes.

DR COOKE: The question that I'm putting to you is that the regulations you drafted anticipated them coming into force in July 2019 and with you, Oranga Tamariki, as the responsible agent who had the most children in care being ready to go as at 1 July 2019. That's the expectation, wasn't it?

MS DICKSON: I think it is the expectation. The only thing I would say is that the regulation that you're referring to talks about a continuous improvement towards the meeting of the Care Standards and we acknowledge that we have more work to do, considerably more work to do, in order to be compliant with those regulations. I don't think that diminishes, though, that it is right that those aspirations set a high and appropriate standard for tamariki in care.

DR COOKE: Sure. Let me read the relevant provision of regulation 86, which was in force as of 1 July:

"The Chief Executive must..."

Which is mandatory, isn't it? It's not "may".

MS DICKSON: Yes.

DR COOKE: "...must monitor their own compliance with these regulations (self-monitoring) by (a) having systems in place for continuous improvement that identify and address areas of practice that require improvement."

So it's expected that as at 1 July, you would have a system in place to enable you to carry out the continued improvement. It's not giving you an opportunity over a period of time to put in place processes and systems; they were expected to be in place to monitor your continuous improvement.

MS DICKSON: Yes, and I've acknowledged that they weren't and that's been obviously acknowledged also by the Independent Children's Monitor [ICM].

DR COOKE: Would you accept – the ICM, can we bring that up? And I think my friend, Ms Toohey, may refer to this as well – although i don't know what page I want – we may come back to this, but, in essence, you will be aware of that provision in the ICM's big report that because of your failure to meet the necessary standards, you don't know what, in fact, you're complying with and you don't know to what extent children and young people in your care are, in fact – whether they're safe or not. You recall that provision.

MS DICKSON: Yes, but I would say that there is – I'd like to add some context around the fact that we have elements of the Care Standards that we can monitor, elements of the Care Standards we cannot monitor at a whole of population level, and we do a large amount of case file analysis across all of the Care Standards which is recognised as progressing towards a situation of a fully developed monitoring system.

DR COOKE: It's a work in progress.

MS DICKSON: Yes.

DR COOKE: But if I was to reframe it and put it to you in this way, that Oranga Tamariki has failed to comply with the provisions of the Care Standards because as of 1 July 2019, you were not in a position to meet the obligations set out in regulation 86?

MS DICKSON: We have acknowledged that we are partially compliant.

DR COOKE: To reframe it, you were not in a position as on 1 July 2019 to comply with the Care Standards. That's a simple "yes", isn't it? "We were not compliant".

MS DICKSON: There were still elements where I would say we were partially compliant, but I have acknowledged that, yes, we were not meeting, and neither are we yet fully, the range of monitoring requirements for Care Standards.

DR COOKE: Alright. I want to go back to complaints and complaints from children. And this is referred to at, I think, pages 83 to 84. Here we go. This tells us that over the reporting period, 7,056 tamariki and rangatahi were in Oranga Tamariki care. During the same period, 14 complaints were made. They made up 1% of the people who made complaints. I think it's going to tell us that there were 14,000 – sorry 1,400 complaints made in total. So that's 1% of complaints were made by children.

CHAIR: Just for the record, what was the reporting period on this particular –

DR COOKE: 2020 to 2021.

CHAIR: Thank you.

DR COOKE: You would have a – there would be a concern, wouldn't there, that of the total number of children – sorry, from the total number of children in care, which was over 7,000 at this time, there were 1,400 complaints but only 14 were from children?

MS DICKSON: Yes, I'm deeply concerned about that.

MR WHITCOMBE: I would just want to say that that would not include the grievance process of making a complaint within residences. There's separate reporting that sits around that process.

DR COOKE: Would it suggest that the advice given to children who were in the care of the Chief Executive, about how to make a complaint and/or their understanding of processes about making a complaint are not getting through?

MS DICKSON: It would suggest a range of things potentially about the feedback and complaint system. And what I would add is that in the future direction plan, we've recognised the need to make sure that the feedback and complaints system is one that is fit for purpose and tamariki and whānau friendly.

DR COOKE: Schedule 2 of the Care Standards contains a statement of rights. It says in the schedule:

"This statement is for children and young persons in care to read in order to understand their rights to care and support under these regulations."

And it then describes six things that they should remember, "to help you understand the statement", it tells us. Is that the document that's given to young people?

MS DICKSON: Yes.

DR COOKE: The schedule itself?

MS DICKSON: Yes, that's correct.

MS ATTRILL: What we did in preparation for the Care Standards coming into effect was to develop resources for different age groups in care and different languages and different ability levels in terms of comprehension as well.

DR COOKE: How was that presented to the young person, the child? Is it a pamphlet, is it an A4 folder?

MS ATTRILL: It's a hard copy document. It's a – it's written in a way that's – with the graphics and the presentation of it, it has been developed in a way that resonates with children and we asked children and young people to provide advice and guidance in terms of the product that was eventually developed and approved.

DR COOKE: I understand that. Let's talk about a child who's in care who's – -I'm a three-year-old – I'll give you a number of examples. I'm a three-year-old, I am an eight-year-old, I'm a 14-year-old. As a three-year-old-, what am I given so that I'm able to understand what my rights are on being a child in the care of the State?

CHAIR: Ms Attrill is looking somewhere else – are you going to answer it or –

MS ATTRILL: I'm just wanting to check whether either of our social work – I'm happy to start with a response. So, clearly, how we engage with a child who's aged three in regards to their rights and entitlements is different than how we would engage with a 14-year-old. If I could perhaps start with a 14-year-old, depending on their level of comprehension and development, their language and culture, we would be – social workers are required to have a conversation, sit down, step through the series of rights and obligations against the Chief Executive, help them understand what they can expect in terms of being in care, help them understand who they can go to if they are – if they have concerns or they're wanting to make a complaint or raise issues in regards to what's happening for them in care. They're left with something concrete to take away, oh sorry, they're left with something concrete that they can refer to. So that would be for a 14-year-old-.

For a 10-year-old, the conversations are more nuanced and aimed at that person – that child's stage of development and, clearly, for a three-year-old, the ability to convey information and understanding about rights is much different than for older children. So that raises the importance of those around that three-year-old, the people caring for them, the caregiving whānau understanding what rights that child has and how they play a role in ensuring those rights are upheld.

DR COOKE: If the child – let's take any of those examples and I'll focus on the older ones for present purposes.

CHAIR: Are you going to be progressing further on this?

DR COOKE: I think I'll be 10 minutes – five minutes probably.

CHAIR: Alright. Just checking with our sonographer, are you alright with that?

DR COOKE: Five minutes.

CHAIR: We're just on the brink of our timeframe.

DR COOKE: Yes I know, and then I'm going to finish.

CHAIR: Alright.

DR COOKE: Thank you. Who is it, is it the social worker who has the responsibility of explaining to the child what their rights are under the Care Standards?

MS ATTRILL: Ultimately, the obligation's on the Chief Executive and he exercises that through delegation to social workers, yes.

DR COOKE: So it's the social worker.

MS ATTRILL: Yes.

DR COOKE: Yes. Would it necessarily be the case that a social worker who has responsibility for that task under delegation is going to have the specific attributes that will enable him or

her to deliver the message to that child? And I'm thinking of English as a second language, a child who may be from the Pacific, may have an intellectual disability, may require the assistance of a communication assistant, that kind of nuance, and how would – because we know – how would those children get that assistance?

MS ATTRILL: So we are reliant on the capability of our social work workforce to be able to convey matters relating to the rights of children in care. My colleague, Nicolette, referred earlier to the way that social workers are supervised, the training and development that we provide in recognition of the fact that, you know, our staff at different times are at different levels of ability in terms of their social work practice, new practitioners require more support and assistance than perhaps some of our more experienced practitioners and, equally, there are, you know, opportunities for development for older practitioners that also need to be addressed.

So, I mean, it is very reliant on the way we supervise, train and support social workers to be able to engage with the young people that they are working with and children.

MS DICKSON: And if I could just add, if it was a specific language or communication need, support, specific support, should be accessed.

DR COOKE: What about the situation where you have children – let's assume it's a child with FASD, because we know that sometimes those children are able to present in a way that is well beyond their actual capacity to understand. They can present as being quite articulate and perhaps there's no outward indication that perhaps there's FASD. How does a social worker – because I'm thinking it's all very well having this theoretical context around what we're doing, but if you get down on to the ground where it's all dirty and making sure that kids are, in fact, okay and making sure there isn't a disconnect between up there and down there, how do you know, other than through the ICM, what, in fact, is happening around making sure these kids know their rights and are able to implement them?

MR WHITCOMBE: I think that the issues that you're raising around the development – the developmental age of children is really pertinent. I think that the issues that you're raising around culture and language are also really pertinent to this.

One of the things that we did do in Youth Justice across the youth justice social work workforce and with some of the staff in residences, was support through the use of communication assistance speech and language therapists and provide training right across our workforce for that very reason, are we – we want to be really sure that children and young people understood what was being said to them, particularly around court situations

and big decisions that were being made about them. So I've seen many examples of incredibly creative plans that go to the communication style and way of understanding of young people so that they are really clear.

DR COOKE: Thank you. I've finished.

CHAIR: Thank you. We'll take the morning adjournment. Sorry?

MS CHASE: Kia ora tātou, ngā mihi.

CHAIR: Sorry, Ms Chase. I'm looking wildly around.

MS CHASE: Nga mihi ki a koutou katoa, ko Frana Chase tōku ingoa. I'm Māori, I'm wearing a gold dress. I just wanted to speak to the Care Standards, to give some context around its development, timing and the implementation of the Care Standards.

CHAIR: Can I – we would welcome that, but can I suggest we do it after the break because the health and safety of our signers and recorders is at issue here.

MS CHASE: Ka pai, kia ora.

CHAIR: So you can prepare over the next 15 minutes, and we'll make sure we do that when we come back. Thank you.

MS CHASE: Ka pai.

Adjournment from 10.37 am to 10.56 am

CHAIR: Welcome back, and just before we start with you, Ms Toohey, I think Ms Chase wanted to say something in relation to that last point, so kei a koe, Ms Chase.

MS CHASE: Tēnā koutou. I just wanted to give some context around the development of the Care Standards because I didn't want a sense of belief that we dreamed it all up on our own. There was significant engagement across the country with caregivers, with whānau, with hapū, with iwi, across near 26 regions across the country and significant engagement around the development of each of those standards and which ones that they believed were a priority for them. Also when we talk about the implementation of the Care Standards, and the timeframes, we knew that we would not be able to deliver on them come that date, but what we wanted to do was set the expectations clearly for Oranga Tamariki but also all section 396s around signalling the expectation of their being able to deliver a standard of care, so I just wanted to give a bit of context to that.

CHAIR: Kia ora. Yes, Ms Toohey.

QUESTIONING BY MS TOOHEY: Morena, ko Anne Toohey tōku ingoa. For those who cannot see me today, I'm a middle-aged Pākehā woman with blonde, curly hair wearing a dark jacket.

Kia ora anō.

MR TE KANI: Mōrena.

MS TOOHEY: Mr Chappie, just to begin, I just wanted to recap on some of the evidence from yesterday when yesterday afternoon I asked you for your comment in relation to the apparent prevalence of sexual abuse in State care and I asked you the question, "Do you accept that sexual abuse of children in State care was a systemic problem?" And you answered, "On the basis of the information we've seen, acknowledging it will be under-reported, I think we've established that over the scope period, there is a large number of instances of sexual abuse".

Could you perhaps just clarify again the answer to that question of whether you accept that sexual abuse of children in State care in the scope period is a systemic problem.

MR TE KANI: Yes, it is a systemic problem, yes.

MS TOOHEY: Thank you. Just in relation to today's session, I want to talk to you, just carrying on from Dr Cooke's questions about complaints, just some different aspects in relation to residential care.

MR TE KANI: Okay.

MS TOOHEY: At the start of this hearing, before you were here, the Office of the Children's Commissioner counsel opened for that entity and noted the Children's Commissioner view that an effective complaints system must be mokopuna- and whānau-centred, accessible, independent, respond to mokopuna within their timeframes and subject to robust oversight. Do you agree with that aspirational statement about what a good complaints system should look like?

MR TE KANI: We do agree, yes.

MS TOOHEY: Going back in time to the scope period, one of the issues that the survivors have described in their evidence to the Commission has been a barrier to making a complaint was this culture of what's referred to as "no narking" within the residences. Are you aware generally of that evidence that's been provided?

MR TE KANI: Yes.

MS TOOHEY: I'm just going to give you an example, which I don't need to bring up on the screen, but for reference is EXT0017943, which relates to a Māori person admitted to Epuni Boys' Home in 1969. He said, and this is at paragraph 101:

"During my first days at Epuni, I was a right little yeller, however I got the message about not narking almost straight away. This was because I told one staff member about how another staff member had treated me. The next thing I knew, the first staff member was calling my name over the loud speaker so that all the other boys could hear. He was

saying, 'What's this all about, you little tattle tale?' This gave staff and boys a reason to pick on me and I was beaten by the other boys for being a nark."

That same witness, at paragraph 284, went to Kohitere in 1972 and said:

"It was made clear to me by staff and boys at Kohitere that it was inappropriate to nark. This was standard in all the boys' homes and I knew the outcome of anyone who did nark."

Just so we're all clear, "narking" means reporting abuse by anyone. Is that your general understanding of that?

MR TE KANI: That's our general understanding, yes.

MS TOOHEY: Just make a comment here, a side comment, that a lot of these terms that we've been going through over the last couple of days, not "narking", reference to secure as being "the pound", reference in Social Welfare documents to children being "inmates", is reminiscent of a prison culture, isn't it?

MR TE KANI: There is the overlap, yes.

MR WHITCOMBE: I'll just make the comment also, having been a residential social worker in residences, the language of "narking" certainly does relate to potential abuse, you're right. It also relates to many other things in terms of what might be going on in the residence from other boys, the right or the wrong things that they may be doing. It's a broad statement.

MS TOOHEY: So telling on each other, as well as telling on the staff, is that what you mean?

MR WHITCOMBE: That's right.

MS TOOHEY: Okay. Are you saying that this is a recent phenomenon as well, the narking issue?

MR WHITCOMBE: When I came into residences in 2001, it was language that was still used at that time and we would, on a regular basis, run a range of different programmes but one of the programmes centred on the rights of the young people and it was the role of the staff to push against that kind of language and that kind of culture.

MS TOOHEY: Because what you really want in a residential care facility is more of a call out culture than a no narking culture, isn't it?

MR WHITCOMBE: Absolutely, and the kind of culture that creates the safety for that to occur without any repercussion.

MS TOOHEY: Another example, just taking you to this without bringing it up again, EXT0016039 at paragraph 119, this is quite a lot later between 1987 and 1989 at Kohitere, the witness said:

"There was a culture of extreme violence and no narking which staff reinforced. I had also experienced the no narking culture at Melville, another residence. No action was taken to punish or educate the boys who were hitting and beating me, in fact it was quite the opposite. For instance, I reported the first beating I received in the villa to a staff member who lit into me because I made the report."

He goes on, at paragraph 262, to note that when he reported incidents of violence and sexual abuse to staff:

"This just resulted in me being told not to nark and being beaten and bashed."

I understand from what you're saying that there's no real denial that this was the culture and that those statements are acknowledged in the same way.

MR TE KANI: Yeah, don't deny that at all.

MS TOOHEY: I want to now give you an example of what happened when someone did complain and this is again the Whakapakari incident, one of the same witnesses that I mentioned yesterday, EXT0016043 and this is at paragraph 32:

"When," – and then they name the staff member – "discovered a letter I had written to my mother complaining about the violence another staff member had inflicted on me, he told me to apologise to that other staff member repeatedly until I cried. To stop me crying, the other staff member choked me until I could not breathe. The first staff member then told me to rip up the letter and put it into the fire. Before I did this, he wrote my mother's address and told me he would go there and make her pay if I ever wrote negative things about Whakapakari again. He also told me he would get me or my family if I ever told anyone about the choking."

Now Ms Dickson, you might remember back to the field – I'm not suggesting you were practising in 1965, but from then, it was permissible under the field manuals for Social Welfare to censor mail coming in and out of residences.

MS DICKSON: That's my understanding at the time.

MS TOOHEY: Okay. But this example of Whakapakari is in 1998. Is Oranga Tamariki still censoring mail in and out of the residences?

MR WHITCOMBE: Describe to me what you mean by "censoring"?

MS TOOHEY: Well, my understanding is potentially opening mail and reading it that is incoming or outgoing from residents.

MR WHITCOMBE: It's my understanding that they are not doing that, absolutely.

MS TOOHEY: Okay. And again, that's an example of one of the risks of a 396 provider who has their own – first of all, is on an island, so not accessible to anyone for help, and, secondly,

that that 396 provider was running its own complaints system, or lack of. Do you agree that that's an obvious safeguarding issue from that example?

MR TE KANI: Absolutely, yeah.

MR WHITCOMBE: Can I also just clarify my statement. I know that there are provisions in the regulations around searching of property and there has to be appropriate causal belief established in order for any kind of search to occur and that that might include an incoming package or mail, if there was reason to believe that it could contain something that might put young people at risk. So I did just want to clarify that.

MS TOOHEY: Sure. Does that apply the same, Mr Whitcombe, for Care and Protection and Youth Justice?

MR WHITCOMBE: It applies to both Care and Protection residences and just for the context of everyone, we currently have two Care and Protection residences operating, one at Epuni and one at Puketai and we have five Youth Justice residences operating and the total number of young people at any one time that they're caring for at the moment would be – would fluctuate – but it would be around 130 to 135.

MS TOOHEY: I want to bring up a schedule, I think we looked at this one yesterday, MSC0008283.

COMMISSIONER ALOFIVAE: Ms Toohey, can I just ask Mr Whitcombe, so is that the total number of beds in those residences?

MR WHITCOMBE: The total number of beds in the Care and Protection residences at the moment is I understand to be 19, but I could be corrected on that, so it's a very low number. In the Youth Justice residences, the total number is 171, but we don't operate to that capacity currently.

COMMISSIONER ALOFIVAE: Okay. Thank you.

MS TOOHEY: The reason I'm bringing up this screenshot again is to illustrate, really, the importance of a good complaints system. If we just look at the first name – I won't name this person –

CHAIR: Can you just orient, for the sake of the people who can't see the document, what we're looking at, please?

MS TOOHEY: Yes. Once again, this is a table compiled by the Commission of information provided by MSD in relation to allegations of abuse by staff at residences to their Historic Claims Unit and this one has been filtered per staff member. And you can see at number one the staff member is named, and I think you will recognise that staff member as someone who was a principal of a boys' home. And if you look just first at the bottom left

corner of that table, if we just highlight that, it says 48 of 442 records found. We looked at this with the Ministry of Social Development and established that that number records the number of allegations against that person. So I appreciate you haven't had time to consider that, but if you'll just accept from me that that's what the table is showing.

And then if we – just looking generally at this page, we see that there are allegations of physical and sexual and emotional abuse beginning in 1949. You see that at the top. And if we scroll down to the end, it goes all the way until 1988. So that is a period – and you can see it's all the same home. That staff member worked in that home for 39 years and there are now 48 allegations of historic abuse. In relation to that, do you agree with me that the principal of a residence, as it was called then, or the head of a residence, whatever that job title might be now, would be setting the tone for the culture of that particular residential setting?

MR TE KANI: Yes. Yes, indeed.

MS TOOHEY: And I think you'll agree with me that this is quite a profound example of why the complaints system is so important, because, presumably, if children had felt that they could complain and if there was an adequate response to that complaint, this situation would not have happened.

MR TE KANI: I agree with that, in addition to the importance of how the residences are managed and led.

MS TOOHEY: Sorry, can you just clarify that a little bit?

MR TE KANI: I agree with your proposition about the importance of the complaints feedback for the residences, but also, from my perspective, in addition to that is the importance of the management and leadership of the residences as well.

MS TOOHEY: Yes, because, presumably, if that call out culture is established by the leader, whatever the position is, of that residence, then you could expect that that would filter down and become the culture.

MR TE KANI: Of the residence, yes.

MS TOOHEY: Alright, I just want to go now to the most recent ICM report. I know we looked at this just before the break, this BAR0000720 and page 85. One thing, as we're bringing that up, can you just explain the, I was just slightly confused about the difference between a grievance and a complaint. Is a grievance something that goes to the grievance panel? What's the difference?

MR WHITCOMBE: Yes, that's right. Essentially, the grievance process is the way that a young person can raise anything that they want to. They also should have regular visits from their

social worker who they might want to raise issues with, also with their youth advocate or lawyer for child. And in addition to that, the presence of VOYCE Whakarongo Mai workers within the residence is frequent and they establish relationships within each of the residences across the country.

MS TOOHEY: Alright. So if we just go to paragraph 6 here, looking at that, this is the -- so just to orientate this, this is the ICM's latest report for the period mid 2020 to mid 2021, if I've got that right.

MR TE KANI: Yes.

MS TOOHEY: And they are reporting on, essentially, compliance with those National Care Standards that we were talking about before. And they've noted that Oranga Tamariki says the grievance procedure needs to be safer and you've outlined the current arrangements that tamariki and rangatahi are required to ask staff members for a form to make a grievance. Those are the same staff that manage the day-to-day living of tamariki and rangatahi, including them being able to leave residences, have visitors and make phone calls. Staff also manage the grievance procedure. Although staff who may be the subject of a grievance are not involved in the investigation, Oranga Tamariki accepts that its current grievance procedure does not allow tamariki and rangatahi in residences to make complaints independent of staff.

Is that still currently your position that this needs a bit of work?

MR TE KANI: So our current position it actually needs, in my words, an overhaul, so, which is why we have work already under way, which is called Manaaki Kōrero, working with VOYCE Whakarongo Mai to completely redesign our feedback and complaints process internally. The points made here – sorry, the paragraph that you've described, we would agree would not be optimal for an open and transparent complaint process.

MS DICKSON: And if I could just add, that these specific issues are the ones that have been identified as a priority for action in the work that Mr Te Kani's just described, so there is active work on those issues, having multiple channels, not relying on staff to access the grievance process.

MS TOOHEY: Just another couple of points before we perhaps come back to that, the next paragraph down says:

"An issue also raised is that rangatahi have spoken to Oranga Tamariki staff about not wanting to be narks, which may prevent them from making a grievance. Oranga Tamariki has advised that they are developing a project to make the grievance procedure youth friendly..."

Which I think you've just referred to, Mr Te Kani –

MR TE KANI: Yes.

MS TOOHEY: "...timely and safe to use."

MR TE KANI: Yes. Just to add, Ms Toohey, in the residences already is the opportunity for young persons to make complaints anonymously, to, or at least make complaints in an anonymous box which could then be referred on to VOYCE Whakarongo Mai or their advocates, and that, I know, is clearly communicated and articulated to every young person that enters the residences.

MS TOOHEY: Right. I guess the problem with that, though, is that if it's an anonymous box and it's quite a serious allegation of harm, then you're going to run into that same issue of not being able to investigate it in terms of your employment obligations unless you have a named person who you can then take that complaint to the staff member.

MR TE KANI: That could well happen, yes.

MS TOOHEY: Just so I understand, and I'm sorry to labour this point if it's already been covered, but if a child in a residence wants to make a complaint or an allegation of harm, they must first do that within the residence, have I got that right?

MR WHITCOMBE: In some ways, you know, they're not able to leave the residence and so you're right in that regard. That was also why I wanted, you know, to make it clear that there are other people who interact with the child on a regular basis, and it isn't just those people that I suggested were there, VOYCE Whakarongo Mai and the youth advocate and social worker. Each residence, you know, the young people have really good relationships with the schoolteachers and that's a – they're not run by Oranga Tamariki, they're run by schools, and there's also a health provider at residence every day and a young person can ask at any point to go and meet with the nurse.

So I think what I would want to say and not be defensive, because I agree that the system needs an overhaul and it needs to be youth friendly and transparency in pathways will create that for young people.

MS TOOHEY: Just on that, there's a couple of points here. One is on that no narking culture, does it concern you that the ICM report from June 2021 is still identifying that as a barrier, 71 years on from the beginning of the Commission's scope period as a barrier to making a complaint?

MR WHITCOMBE: Yes, absolutely.

MS TOOHEY: And that's probably a bigger problem for you than the complaints procedure, is the culture.

MR TE KANI: Yes indeed. Acknowledge that, yes.

MS TOOHEY: We might not be able to resolve that one today, but just in terms of VOYCE, I just wanted to bring up something else for your comment and that's at page 75 of the ICM report at paragraph 3. This is referring to Oranga Tamariki's use of VOYCE Whakarongo Mai to inform tamariki and rangatahi in care about advocacy services, but the survey by Oranga Tamariki showed that only 46% of 1,545 tamariki and rangatahi who were surveyed know about VOYCE and only 29% know how to contact the service.

Is that – Ms Dickson, do you want to comment on that?

MS DICKSON: Yes, so I wanted to check some information over the break, so there's both a responsibility for social workers to advise tamariki, rangatahi about VOYCE, but there's also, in keeping with the right of participation, an automatic process where the names and contact details of tamariki in care are provided to VOYCE so they can proactively initiate contact.

What I would say is VOYCE is a growing organisation, so its coverage and capacity has grown over the period that the monitor's reporting and since.

MS TOOHEY: I just want to go to another page here of the ICM report which is page 84 and I just want to be clear about how complaints have arisen. Ms Dickson, you referred yesterday to the safety and harm report and how – and the steps that have been taken with that unit to report on findings of harm. I understand from that report that those findings, that the raising of a concern of harm being inflicted could be raised by a number of people that we've just talked about, by staff or a lawyer for child, a caregiver, but this part of the report reflects that during the reporting period for the ICM, so mid 2020 to mid 2021, of 7,056 tamariki and rangatahi in Oranga Tamariki care, only 14 complaints and one compliment were recorded from tamariki and rangatahi. Can we just contrast that to the numbers of children who the safety unit concluded were harmed, which I think is 486, approximately?

MS DICKSON: Findings against; some children could have more findings.

MS TOOHEY: Yes, and obviously, there are some who will be small who can't complain, themselves, but that figure, I think we'd all agree, is quite alarmingly low.

MS DICKSON: Yes, what I would say, though, is that the 14 complaints don't reflect all of disclosures of abuse or allegations of abuse or concerns about abuse or neglect that were then treated as a report of concern. So it's not an automatic overlap that those matters that go through a child protection investigation would also generate automatically a complaints system review of this nature.

MS TOOHEY: I think they've said at the bottom there in that paragraph that's highlighted at the bottom, that Oranga Tamariki is improving its complaints process, you've talked about that this morning, and that if it's successful, they would expect to see an increase of the number of complaints and compliments recorded:

"We will monitor the rate of engagement."

I don't think this year's report is available yet, is that right?

MS DICKSON: No, so we're in the process of finalising our annual response to the Monitor. They will report on that early in 2023.

MS TOOHEY: Are you in a position to comment yet about whether it's increased, or not?

MS DICKSON: It's certainly not increased to the level that I would consider is indicative of a tamariki responsive complaints system, no.

MS TOOHEY: All right.

COMMISSIONER ERUETI: Do we know if these 14 complaints are from the residences or from foster care?

MS DICKSON: These are more likely to be outside of residences because complaints in the residence space are treated in the grievance pathway. So this would be children and young people who were in a range of other care arrangements, including the whānau care arrangements, the 396, but also potentially young people who have left care or young people who remain in the custody of Oranga Tamariki who have returned home.

COMMISSIONER ERUETI: Okay. We're getting to 396, but I understood before that, in the residence there are two paths, you can make a complaint as well as lodge a grievance with the grievance panel.

MS DICKSON: So a young person, while they're in residence, may also – you know, they might build a trusted relationship with a youth worker in residence and share some things that were of concern to them about their broader social work involvement and so that wouldn't be treated through the grievance process. That would be then addressed through a complaints process outside grievance – outside of the residence, because it would be relating to an issue that wasn't specifically related to the residence.

COMMISSIONER ERUETI: I see. Just to a tamariki, I wonder if that distinction is clear to them about the nature of the complaint, it doesn't really matter, it's just getting their concerns through. If there are two processes, how that can confuse a child.

MS DICKSON: And it shouldn't be for the child or young person to navigate that response. I would accept, I think it is more complicated than is helpful for children and young people at the moment.

COMMISSIONER ERUETI: Kia ora.

MS TOOHEY: Just to finish this subject, I just want to look forward as to the new regime, which seems to have passed its third reading last night with the Oversight Bill. You – as I understand it, under the new regime, the Ombudsman will assume responsibility as an external monitor or external body available to investigate complaints. Is that your understanding as well?

MS DICKSON: They already have the potential to investigate complaints, but they will have an expanded remit.

MS TOOHEY: My understanding is that in the first instance, many of those complaints that might be made to the Ombudsman, and I think you alluded to this before, would be sent back to Oranga Tamariki to investigate first?

MS DICKSON: There would be – my understanding would be that there's an initial triage that the Ombudsman's office would do and if it was felt appropriate that there might be value in Oranga Tamariki utilising its complaints process first, then it would be referred back-, yes.

COMMISSIONER ERUETI: I think you said that, usually, there would – through the triage, it would come back to OT, is that right? They're more common than not?

MS DICKSON: It would depend on the nature, so I think the conversations I've had with the Ombudsman's office, if they felt it was a concern that required quite robust investigation of a set of facts, they would absolutely say it was their responsibility. If they felt that perhaps there were issues that were more easily responded to in a more mediated, restorative way, then that's when they would recommend bringing it back, because there would be more potential for a relational approach and quicker resolution of the concerns, but they are very clear, if it's more of that investigative finding of a set of circumstances and values, they would take that forward to investigate.

COMMISSIONER ERUETI: Yep. But in your experience, do you think many of the cases back to OT?

MS DICKSON: A large number do, a significant number.

MS TOOHEY: Ms Dickson, this is, again, a question for you. This morning, I just mentioned before the Office of the Children's Commission opening to the Commission and just recalling that comment that in that Commissioner's view, in referring to them repeatedly highlighting concerns and their view that a complaints system should be subject to robust oversight, you mentioned this morning that you have a close working relationship with the Ombudsman. That comment raises – might raise a few alarm bells in terms of how robust

the oversight is going to be under this bill, given that the Ombudsman is meant to be the overall monitor of this complaints system. Do you want to comment on that?

MS DICKSON: Sorry, that certainly wasn't my intention to convey any sense that there was an interference in the independence of the role. What I'm meaning to say is that there is regular liaison between the offices so that, as the process that we've just talked about, where there is a referral back of an issue or us reporting back on outcomes of recommendations, that happens in a timely way. So we meet regularly to provide information. There are channels of communication. I did not intend to imply that there was any more extensive nature of the interaction than that.

MR TE KANI: Ms Toohey, if I can add, we've got an agreed protocol between both offices. There's clear processes, even in our interaction, which is quite formal in nature. For the very reason you've identified, the Ombudsman himself is very clear about maintaining the integrity of his office, so given that, the interactions with us is professional but careful to maintain that integrity.

CHAIR: Can you see that notwithstanding what are carefully established protocols, that from a survivor's perspective, that the mere fact that there is a relationship that needs to be managed, could raise some alarm bells? Could raise some suspicion, just on the face of it?

MR TE KANI: No, I acknowledge that. I acknowledge and do have empathy for survivors, you know, with the perception –

CHAIR: That's right.

MR TE KANI: – that that relation could be – could be too close.

CHAIR: Was it ever contemplated how that – because you've obviously tried to address that in your protocols with the Ombudsman, but was there ever any consideration given to another way of operating that would lessen that perception?

MR TE KANI: I think, from speaking on behalf of Oranga Tamariki, and the Ombudsman will no doubt have his own views, our interactions are very transparent in that what we do, how we interact is, for my words, discoverable. So we operate knowing that there's public accountability over the nature of our relationship for the very reason. We're very respectful of each other's boundaries and authority. We're very respectful, of course, of the office of the Ombudsman's powers and duties as well. Ultimately, they have a role to play to keep us accountable and demonstrate that accountability to the public.

The practicality of the working relationship, however, means they have to work with us to access information, as you've understood for the last two days, that we hold. So, at one level, they will of course work closely with those who make complaints, but by

nature of doing a thorough job of the complaints they receive, we, Ms Dickson's team have to work very closely with them in the provision of that information, answering questions.

CHAIR: To a large extent, you are having to work within a framework that you might not necessarily have designed but somebody else has designed a framework and you're having to manage the relationships within that legislative structure, aren't you?

MR TE KANI: Of course, and given, as I've just said, the nature of the information we hold, that they require to discharge their obligations too.

CHAIR: Okay, thank you, we'll leave that at that point. Thank you.

COMMISSIONER ERUETI: On that, it is interesting that a significant number of these complaints are being triaged and filtered out and come back to OT [Oranga Tamariki] so that this independent monitoring function is only for those kind of higher threshold concerns and complaints, suggests that there needs to be some other process that's also independent for these other complaints that are coming back so that they're managed externally to OT?

MS DICKSON: So that's – Mr Te Kani mentioned the work of the man Kaki kōrero work that we're doing with VOYCE Whakarongo Mai, so other than whatever legislative or regulatory processes for monitoring and oversight would be, we're really open minded to the proposal that comes, based on the experiences of tamariki and whānau about the full range of review options, which could include an independent complaint function.

MR TE KANI: If I can add just one more point, ma'am. Some of the nature of what's referred back to Oranga Tamariki is by and large relational. The assessment of the office of the Ombudsman that there's been a relationship break down between a social worker and a tamariki or whānau and on the basis of the information they've received and the triage that they've done, said actually start by referring that back to Oranga Tamariki, they'll maintain an oversight of the handling of it, so we will write back to them formally about how we've responded to it. The office of the Ombudsman will maintain its relationship with the complainant to assess whether we've met their needs and expectations and how we've handled their concerns. So what sits behind it is a process.

MS DICKSON: And I would note, and this is possibly something just to check with the Ombudsman, as I understand it, there would need to be, the complainant would need to be comfortable with the proposed approach of the Ombudsman as well.

MS TOOHEY: Just to finish this subject, to give you the opportunity to comment, the other part of the Children's Commissioner opening last Monday was that a functional mokopuna- and

whānau-centred complaints system has never existed and is urgently needed. You've made some comments acknowledging the scope for improvement.

MR TE KANI: Yes.

MS TOOHEY: Do you see you've still got some way to go in relation to that?

MS DICKSON: Most definitely.

MS TOOHEY: And just finally, from that statement from the Office of the Children's Commissioner, I had the impression that possibly you don't have that same close working relationship, and I don't mean that in a negative sense, but that you don't have that same relationship with the Children's Commissioner's office as you do with the Ombudsman?

MS DICKSON: We do have a similar relationship, a liaison, working arrangements governed by an agreement, regular interaction to make sure that we provide what's required for them to undertake their duties – undertake their role, sorry.

MS TOOHEY: Thank you. I want to now switch to a slightly different subject and that is just the examination of a complaint case study. And this is – I'm just going to bring up a document ORT0072615. I'm going to refer to this person as "Person F", to avoid disclosing who it relates to. This document is a letter from the mid 1980s, from the head of the Dunedin Girls' Home to the Director-General of Social Welfare, reporting on an employment process in relation to a staff member. If we just, if I just call out paragraph 1, it notes the serious and inappropriate behaviour of the staff member, who, if he had not resigned, would have been the subject of charges under the State Services Act which, they are confident, would have led to his dismissal.

And then if we go to paragraph 3 and number 2 there, so you see there that there was "notice of inappropriate behaviour" and it's set out again at paragraph – if we go down to the next subparagraph 2. There was an allegation of sexual abuse by this staff member of two young girls and the whole of the staff had threatened to walk off the job if he came back to work.

And then if we go to the paragraph 4 on the next page, subparagraph 2, this records an interview that was conducted with the staff member. They raised with him the matter of sexual abuse, and if we go to paragraph 3, he was told that staff would not work with him, and then see that he, if you look at paragraph 8 there, admitted kissing, hugging, initiating some group massage with staff. And then if we go down to paragraph 4, if I can just summarise this, he agreed to, "provided little in the way of a defence but elected to resign and did so".

And then if we go all the way down to paragraph 8, you'll see that the sexual abuse was reported to the Police. One of the complainants did not want to cooperate with the Police, but there was obviously more than one, from that letter.

And then going down to paragraph 9:

"Summarising, I believe that this staff member's resignation was a satisfactory conclusion to this bad episode. He must never be allowed to work in the State Services again, especially in social work."

So this is the mid 1980s. And I think you'll agree with me that that's a reasonable response. Setting aside whether the matter was referred to the State Services Commission for charges, that seems like a reasonable response, and it's been dealt with and referred to the Police.

MR TE KANI: Yes.

MS TOOHEY: So, fast forwarding to the early 2000s, I just want to go to document ORT0074838. And this document, when it comes up, is the same staff member, Person F's application for employment at Epuni as a night attendant supervisor in the early 2000s. You'll see there at page 1 he records – if we just call out the box, under "Please tick the appropriate boxes", "Have you ever been employed in DSW?" "Yes, Dunedin Girls' Home", and it's got the years written there.

Can any of you speak to the period in 2001 as to whether somebody's file would be checked if they had indicated that they had worked for Social Welfare before?

MS DICKSON: I can't say for certain. I would expect that it should have been.

MS TOOHEY: Alright. We'll bring up the next document, NZP0018309. And this is a file note from 2011, so a much later review of the file. You'll see this file note has been prepared as part of the historic claims process and it relates to the same staff member, Person F. It's prepared in 2011 and if we just go to the next page, if we see the highlighted part there, the person reviewing this, Person F's file, for the purpose of the historic claim has noted:

"His staff card carries the statement 'Not suitable for re-employment'."

It records that he was offered that position at Epuni, which he took, and if we go down the page, we can see there, without going into huge detail there, you'll note that there were quite a large number of allegations in that period when Person F was employed at Epuni. For privacy reasons, I won't outline all of them, but they generally relate to one-on-one counselling sessions at night and resulted in complaints and then that staff member left Epuni after about a year of employment.

CHAIR: And we're talking here at about 2002, are we?

MS TOOHEY: Yes. So I think that you'd accept that whatever happened there in 2001 when that staff member was employed, re-employed by Child, Youth and Family, the later iteration of the Department of Social Welfare, was, can be nothing except for a failing, given what was on his staff file.

MR TE KANI: What was on his file, yes.

MR WHITCOMBE: That's right.

MS TOOHEY: I just want to fast forward to the end of this story and I'm going to bring up a document which is publicly available, which is a decision of the Parole Board from June this year. And this relates to Person F. I think you would have seen this.

MR TE KANI: Yes.

MS TOOHEY: Yes. It's been provided, Madam Chair, to the Crown last night. And again, for privacy reasons, I won't go into all of it, but this document, if we just go to the next page, records that this staff member is currently in prison. He was denied parole. He is serving a 13-year sentence of imprisonment for rapes of female children aged 10 to 15, all of whom were in Dunedin Girls' Home in the first half of the 1980s.

There are a few things that I want to ask for your comment about. The first is that, according to this report, the sexual offending by this staff member took place over a six year period at the Dunedin Girls' Home and while we agreed that the investigation we looked at earlier by the girls' home was quite reasonable and resulted in him leaving and the referral to the Police, it's obvious that the complaints were not immediate, that at the time of his departure and this coming to the attention of the home, this had been continuing for six years at the home. Do you have any comment about that in terms of how you feel the complaints procedure performed at that time?

MR TE KANI: I mean, clearly, the actions were criminal in nature, so I think we have to be clear about that and we start there, and it's regrettable that the young girls at that time weren't safe and that his actions led to what we've read. A child-centric, tamariki-centric complaints process, with all the best intentions we would hope would make that transparent and draw that out. One of the effects we know that would come from such a design of a process is it would act as a deterrent for those who are of a predatory nature to want to seek out to work in such an environment, because they'll know they'll be under scrutiny and transparency.

MR WHITCOMBE: I just wanted to – just from a feelings perspective, it makes me feel sick that that was allowed to go on and, yeah, it's appalling, it shouldn't have happened. It is incredibly regrettable and – yeah, I just wanted to put those statements on the table.

MS DICKSON: And I would just simply add I think it's more than a failing of a complaints system, it's a failing of the fundamental safeguarding protections that we've talked about over the last two days, a failure to recognise, respond and take action to prevent abuse.

MS TOOHEY: Because one of the other issues that I wanted to ask you to comment on was that even despite the clearly quite receptive principal at the time who conducted that investigation and was – acted decisively –

MR TE KANI: Yeah.

MS TOOHEY: – obviously, those girls didn't feel that they could disclose to them the full extent of what was going on at the time, because what is recorded in that Parole Board decision is far more extensive, isn't it?

MR TE KANI: Yes.

MS DICKSON: Yes.

MS TOOHEY: And, Ms Dickson, do you have a comment, I know this is your area within Oranga Tamariki, do you see this as a challenge still with that no narking culture, that even if you do complain, maybe you minimise the extent of it because you're still living in that residence or with that caregiver and you maybe want to alert someone to the fact that something's not right but you don't want to risk the consequences of a full disclosure?

MS DICKSON: So what I would say is that what we would now recognise is that if one young person was at risk, the likelihood is that other young people in the same care arrangement were also at risk, so part of the joint protocol that we have with Police, we refer to it as the "mass allegation investigation", which is not the greatest term, but it basically acknowledges the need to consider the potential for multiple victims in a situation, so the onus shifts from a young person overcoming all those pressures, not narking, the threats, the kind of things that would prevent them from disclosing, to providing an active opportunity to share what's occurred to them. So there would be a tailored social work interview with a child to give the opportunity for disclosure, even if there hadn't been an allegation made in respect of them.

MS TOOHEY: I have one more document about this – but it might take a few minutes.

CHAIR: I think we should take the break because of the people, but we'll resume with this when we come back, thank you.

Adjournment from 11.54 to 12.11 pm

CHAIR: Thank you, Ms Toohey.

MS TOOHEY: To finish off this subject, I just want to look at how complaints such as the one against Person F were recorded historically and then look at how they are now. I want to

bring up document [ORT0●0●769]. This is a statement that was provided by Oranga Tamariki in relation to the complaints process at the request of the Commission. And you see there at paragraph 2 it's setting out a historical overview about the complaints process, the expert advisory group and recommendations. So that's the context of this document.

And then at paragraph 5, it sets out:

"For a 6●-year period, 195● to 2●1●, information about allegations of abuse, subsequent investigation and assessment and outcomes is held on individual case files and cannot be reported without reviewing each individual case file."

So my understanding in relation to Person F, who we've just been looking at in the Dunedin Girls' Home, is that there would be no central register of complaints made against that person at the time.

MS DICKSON: That's my understanding.

MS TOOHEY: That in order to see whether there had been a complaint, you'd have to go to the individual's – the staff member's file.

MS DICKSON: Yes.

MS TOOHEY: Right. And just in terms of a general proposition, do you agree with me that it's important to have a central Complaints Register so that if, for example, Person F was employed in the early 1980s at the Dunedin Girls' Home, there was no investigation, some complaints were raised but they didn't result in his losing his employment, in other words, they were not substantiated, and then five years later, in a different home, similar allegations are made, you'd really want to you know, wouldn't you, even if it hadn't been substantiated?

MR TE KANI: Yes, you would. Even if they weren't substantiated, yes, you would.

MS TOOHEY: I just want to turn now to what Ms Nicholls told us, and this was a year or so ago – it was October 2020 that this statement was made, so I just want to go to what she says the current process was at that time and check whether it remains current. So this is at paragraph 14. And Ms Nicholls refers to the expert measurement group's recommendations, which I think you've referred to in evidence already, as to what a good complaints system should look like and I think, Ms Dickson, you've referred to this, about the new measurement approach which reports on all abuse findings in care, which I think is the Safety of Children in Care unit reports.

But the Commission's understanding from this statement is that the central register that now exists of complaints, if you like, of abuse in care only records substantiated findings.

MS DICKSON: So if I could just explain a little bit about how an investigation would be recorded in our case management system, so an allegation would be recorded, and I'm talking about CYRAS, so this is the distinction I made a little bit earlier about complaint versus a child protection investigation.

So a record of the report of concern would be entered and a record of the assessment and finding, whether found or not found, would be entered.

MS TOOHEY: Against what?

MS DICKSON: Against the child.

MS TOOHEY: Right. That's the problem, isn't it, Ms Dickson?

MS DICKSON: It does raise an issue that unless a finding is made of substantiated abuse against a named perpetrator, that – that wouldn't be recorded or searchable per se.

MS TOOHEY: This is a major risk, in terms of safeguarding, that you do not centrally record a register of complaints that are not substantiated, isn't it?

MS DICKSON: The record of non-substantiation would be in each case file.

MS TOOHEY: Isn't that the problem, Ms Dickson? Can you see the problem? So I want to give you another example to illustrate this. Somebody is at a family home. They are, effectively, a foster parent. A child comes forward in, say, 2017 and says, "I was raped by this person who's running the family home". An investigation is held; maybe the person doesn't want to go through with it, they are intimidated by it, maybe the Police don't want to prosecute; there's no finding. So that remains on her file or maybe his file, but isn't registered. Bear with me.

Fast forward. 2020, there's another complaint by another girl who doesn't know the girl from 2017, has nothing to do with her, no possibility of collusion, she makes a complaint of rape. Your safety unit goes to investigate it, sees no substantiated finding against that person and doesn't have all that relevant information to consider. Do you see how the lack of a centralised register of complaints that are not substantiated is so important for safeguarding?

MS DICKSON: Yes, I do agree with that. If I could – I do agree with that.

MR WHITCOMBE: Within our CYRAS system, any allegation – sorry, in CYRAS, I'm referring to our case management system – any allegation does have a name attached to it and so names are searchable within our system, and it doesn't take a substantiation for it to be clear that there has been an allegation made if you do a specific search for a specific person.

CHAIR: A staff member – is it dealt with by a staff member or by the name of the complainant?

MS DICKSON: So both the child and the alleged perpetrator, if known, would be added as what we call participants in an investigation. So you would be able to see that somebody was a participant in an investigation if you searched that file. I still accept the point it's not as comprehensive as – -because it is sensitive to things like incorrect spelling, you know, the extent to which the search is completely done, so I do – I add those – we add those comments by way of context, not to negate, or not to suggest that my comment before that it could be stronger is not correct.

MS TOOHEY: Just to give you the context, the reason that the Commission became aware of this is because we had requested under section 20 data about the numbers of children in care, the numbers of allegations of assault and for the scope period and none of that information could be given because of the way the data was recorded and you can see it's a concern that that remains the issue.

MS DICKSON: It's a very serious concern and we absolutely know the limitations of our current case management system and recording processes.

COMMISSIONER STEENSON: Can I just ask, do you think it would be useful then to have somewhat of an expanded version of that, like a centralised system that would allow sort of a registration of those kinds of details for the purpose of vetting and complaints management across agencies?

MS DICKSON: I think we have an opportunity ahead of us over the next few years where it is planned to fundamentally re-design our case management system to make these kind of safeguarding and vetting practices, a central design consideration in that system.

MS TOOHEY: Because, can I suggest to you also, that the kind of information that you, Mr Te Kani, talked about as a taonga on the first day of giving evidence –

MR TE KANI: Yes.

MS TOOHEY: – to give you information that you can act on, if – for example, in the Christchurch home that's been suspended and about to be closed down, if you had a central register of complaints coming in, and I don't know what that would look like, but if, say, you had a number, a large number of complaints coming in about one or more staff member on one site, that would be important information.

MR TE KANI: Yes, it would be.

MS DICKSON: And if I could just add, it's not just having one register or system, it's having the range of information systems, you know, staff, client, complaint, working in an integrated way so that across all three, there's no gaps, I guess, where information cannot be held, so...

MS TOOHEY: It's about that data being accessible to you isn't it?

MS DICKSON: Yes.

COMMISSIONER ERUETI: Can I ask, I mean, currently you wouldn't be using CYRAS and doing a name search as part of a vetting process for a new staff member in a residence, would you be doing that?

MS DICKSON: Yes.

COMMISSIONER ERUETI: You would be doing that?

MR WHITCOMBE: Yes, we would.

CHAIR: And it raises a bigger question for me as well. At the moment, you're looking at staff members from Oranga Tamariki and its predecessors. I think we've got to be mindful that there are people from other agencies, former – and I'm thinking particularly of, say, school teachers, so teachers who may have been perpetrators in their former life, looking for a new job coming across. Now, Oranga Tamariki wouldn't hold any details of complaints, substantiated or not, from the education sector, would they? Or is there an information sharing ability?

MR WHITCOMBE: What would have happened, were a report of concern would have been made, if there was any allegation of harm to a child, and that person's record would be a part of that, so the vetting information would come through.

CHAIR: So does education hold record, do you know? Does education – just using that as an example, does that hold records of unsubstantiated complaints of the sort that Ms Toohey's referring to? Do we know that?

MR WHITCOMBE: Only so much if we've received a report of concern.

COMMISSIONER ERUETI: If that child is in Care and Protection or –

MR WHITCOMBE: Only so much as if we've been reported to in terms of the concern around that particular teacher.

MS DICKSON: If there's a report of concern for any child and a teacher was identified as the alleged perpetrator, they would be added –

CHAIR: I'm sorry, I haven't explained myself well, I beg your pardon. I'm talking about employing, Oranga Tamariki employing somebody who has been a teacher who has had unsubstantiated allegations against them.

MS DICKSON: There wouldn't be specific checks with teaching, as far as I'm aware; it would be checking CYRAS and convictions.

CHAIR: But are we confident that education has got the central register of substantiated and unsubstantiated complaints?

MR TE KANI: I can't answer that question. We don't have an agreed protocol which shares that information. So to answer your question, if there are a number of unsubstantiated allegations against teachers held in a centralised place by the Ministry or the teacher's discipline tribunal, we wouldn't have access to that as an organisation by right.

MS TOOHEY: That subject of vetting is the next case study that I want to put to you.

COMMISSIONER ERUETI: May I, Ms Toohey, just ask quickly, if we're moving from complaints, are we going to come back to the 396 providers?

MS TOOHEY: Yes, after this example.

COMMISSIONER ERUETI: Will we also look at foster care and complaints process?

MS TOOHEY: I think that Mr Cooke's going to come back to that at the end of the day.

COMMISSIONER ERUETI: Okay, ka pai, thank you.

MS TOOHEY: I want to bring up a document [ORT0132833] – oh sorry, yes no that's correct. So this is a very recent response to the Commission, 19 August, and you'll be aware that this relates to a person who was raised in this hearing on the first day with the Ministry of Social Development.

MR TE KANI: Yes.

MS TOOHEY: And someone we've named "Person A" and, just to give the background of this, this relates to a person who is currently employed by Oranga Tamariki, that the Commission noticed there were also allegations of historic abuse that had been raised with the Ministry of Social Development.

And if we just go to page 3 of this document, being very careful here not to give details, given the sensitivity of the situation, just to summarise the employment history of this person, this person had been employed by the predecessors of Oranga Tamariki and resigned in about 2005 and was re-employed in 2009 and appears to have continuously worked since then for Child, Youth and Family, as it was until 2017, and then Oranga Tamariki.

MS DICKSON: Yes.

MS TOOHEY: Right. And is currently in a role that involves some interaction with children in a residence.

MS DICKSON: Yes.

MS TOOHEY: Can I just go to paragraph 8. I just want to talk specifically about the period when Person A was re-employed in 2009. The response, and this is the response of Oranga Tamariki to the Commission in relation to this issue, that, confirms that when this person

was re-employed at that time, the correct pre-employment checks were processed correctly with no adverse findings.

So I just want to go now to document [ORT0107226], which is a document that had been provided to the Commission as part of the general records that were sought in terms of the Commission's inquiry. You'll see it relates to early 1990s and there is an allegation recorded against Person A of physical assault. And you'll see in the first paragraph, the allegation is that after the child been returned to secure after absconding, which means escaping from the residence, this Person A had entered his cell to give him his inhaler and had punched him in the head just above the eye.

And you'll see there, looking down in the letter, that Person A denied the allegation and there were no other witnesses.

And if we just look at the page 2:

"There is no way that the allegation can be substantiated and I have therefore stated to Person A that the inquiry is at an end and he is entirely cleared but it's vital that there be no residual suspicion attached to Person A because of this allegation and the necessary inquiry."

First, I think you'd agree with me that that's not a satisfactory response, the fact that there was no witness to it in terms of the response – and you're nodding, but can we get –

MS DICKSON: I'm sorry, that was an unsatisfactory response.

MS TOOHEY: But, more importantly, why was this not considered when the Person A came to be re-employed in 2009 when the requisite pre-employment checks were done?

MS DICKSON: I'm not able to answer that.

MS TOOHEY: I just want to go now to what happened next, which is ORT013... sorry, the same document we were on before – actually, we don't need to go to that. I'll just summarise what it said. In the response that we were looking at earlier at paragraph 30, it refers to a staff allegations table. We considered this on the first day of the hearing and that was that in 2006, Cooper Legal, a law firm who will be known to you as acting for a number of claimants, brought to the attention of MSD that there were current staff that their clients had made allegations of abuse against. We heard evidence from MSD, and it's summarised there, that the Ministry identified who those staff were who were current staff.

So we'll just go to that document now, [ORT0l 11834]. Ministry of Social Development confirmed last week that this was the table that's referred to of the staff who were current at that time. And if you just look on the first page there, I'm not going to name all these different staff, but this is about ten staff members who were currently

employed. And just to confirm again, that at this time, 2006, Child, Youth and Family was within the Ministry of Social Development.

MR TE KANI: Yes.

MS TOOHEY: Who were considering historic claims, on the one hand, against these staff and employing the staff, on the other hand.

MS DICKSON: Yes.

MS TOOHEY: You'll see there that the first allegation is – this is not Person A, but physically abusive, would beat up boys in their room. The second allegation relates to a female, she would give boys massages and would have sex with some of them, even though they were underage. The next, one big Pākehā man would hit boys around the head. And if we go to the next page and see the bottom entry there, the allegation is that the staff member forced a boy to rape another boy. And then if we go to page 3, we see that Person A is named.

MS DICKSON: Yes.

MS TOOHEY: And the allegations are that Person A would set up initiation fights and stompings; make boys go over the hill to be beaten; he would beat up boys when they were doing physical training and kick them when they were on the ground; make boys play rugby against him as an excuse to beat them so that he could kick, punch and clothesline boys; he would set up fights between boys and give the boys extra treats, cigarettes and food, if they beat up, stomped or blanketed other boys.

So that's the allegation against Person A. And then if we just go down to look at – I want to highlight another one to you on page 5, you see there that an allegation is forcing boys to perform oral sex on the staff member. So I think you'd agree with me that these allegations against staff who were current in 2006 were quite serious.

MS DICKSON: Yes.

MS TOOHEY: Alright. I just want to go back – sorry to jump around with this, but back to the document we were looking at before, which is the NTP 511. It is 0132833.

CHAIR: I think it's worth pointing out, too, for those who can't see it, that that list of allegations against current staff lists the staff name, where they worked previously, the allegation against them and then their current position as at 2006 within Oranga Tamariki or its predecessor, with full information about where they were and what their job was, just for the record.

MS TOOHEY: Thank you. So if we go back to paragraph 30, this is the response from Oranga Tamariki detailing what happened in 2006. So it says at 31 that – sorry, at 30, that that table that we were just looking at identified the 11 current staff members and then if we just

call out 32 to 36, so there was a further document called "Outline of the plan to inform current staff of allegations against them" prepared in 2006, and the plan was that under employment law, employees have a right to know if allegations have been made against them. The process, at 34, was:

"The allegations were mostly vague and did not constitute serious criminal behaviour. As a result, it was decided not to investigate the allegations further. Unless new information came to light then the staff would not need to be suspended."

And if we go over the page, so at 35:

"The plan was marked 'Draft' and despite searching electronic records, we have been unable to confirm whether the instructions in the plan were completed for each staff member."

The plan was to personally inform each staff member and of the decision not to undertake an investigation. The General Manager was to advise the staff member that there will be supports in place for them – EAP, which is counselling, am I right?

MR TE KANI: Yes.

MS TOOHEY: And a contact to keep them updated and that in preparing the evidence, Oranga Tamariki had reviewed all of their staff files in that table we looked at before and there was no reference to the allegations or any subsequent investigation.

MR TE KANI: Correct.

MS TOOHEY: The upshot of all of that is that once this came to Child, Youth and Family's attention in 2006, at most, you might have offered the staff members counselling and you did nothing about it despite the allegations relating to, I think you'll agree with me, some very serious criminal offending.

MS DICKSON: Yes.

MS TOOHEY: Okay. Just in that same letter at paragraphs 9 and 10, it's outlined that all safety checks under the Children's Act were completed with no concerns raised. Can you explain how it is that the allegations that were made to the Ministry of Social Development as the employer did not feature when you re-employed this person in 2009?

MR TE KANI: We can't answer that question, Ms Toohey.

MS TOOHEY: Alright. I'm just going to go to one final document on this, which is MSD0015421. This is what happened – I just want to take you to what happened after those, after the information was provided by Cooper Legal, the Ministry of Social Development, as they confirmed last week, then started to receive a series of historic claims against Person A directly and this is a table that I think you'll be familiar with –

MR TE KANI: Yes.

MS TOOHEY: – which again details the historic claims made to the Ministry of Social Development in relation to Person A. I think you'll be aware, without me having to take you through this, that effectively there are 24 allegations of physical abuse; two of other kinds of abuse had been discounted as not being able to be proved.

MS DICKSON: Yes.

MR TE KANI: Yes.

MS TOOHEY: And I think we've heard that the Ministry accepted that maybe three or four claims had happened and paid out on a total of 18, and when they said – just to be fair, when they said they accepted they happened, obviously, that's not to a criminal standard or anything of that nature.

MS DICKSON: Yes.

MS TOOHEY: So even later after the Cooper Legal information, even when there are documents, quite detailed analysis of the claims for those findings, while this – while Person A is employed simultaneously by the same organisation doing these claims, there's no information, is there, on Person A's file about these historic allegations?

MS DICKSON: Not until we received some in 2019.

MS TOOHEY: Right. Okay. And my understanding from the evidence is that in 2019, now of course MSD is separate to Oranga Tamariki.

MR TE KANI: Yes.

MS TOOHEY: And had been since April 2017?

MR TE KANI: Yes.

MS TOOHEY: They advised you of, I think, ten of the historic claims?

MS DICKSON: From memory, it was 10. One was found outside of the employment period and a year later we received a further one.

MS TOOHEY: And I think you've also outlined, and we don't need to go back to it, but outlined the process within that document that we were looking at earlier, that following notification of those claims, you satisfied yourself that there were no active safety concerns in relation to this Person A still having contact with children in their day-to-day job.

MS DICKSON: I would just want to qualify that we satisfied ourselves to the extent that we could, because there were limitations on being able to address the allegations with the staff member, which meant we couldn't, in the way that we would normally address it fully with a staff member and discuss the extent of safety concerns with them.

MS TOOHEY: Right. I am going to bring this up, ORT0132833 again, paragraph 16. It just includes the statement, and you'll see it in a moment, that no evidence of any previous employment concerns were identified by speaking with Person A's manager or through reviewing previous personnel files. Did you not look at the 1990 allegation of the punch to the face in the secure unit?

MS DICKSON: My understanding – I can't confirm that. I believe it wasn't looked at.

MS TOOHEY: It's just – we're three years on from you being notified of the information that the Commission has set out here today. Is the issue here some kind of employment process? Is that the issue, in terms of this person still continuing to have contact with children?

MR TE KANI: This person – I can answer this. This person is no longer in a role that's interacting with children.

MS TOOHEY: So that's different to what we've been given on 19 August?

MR TE KANI: I understand there should have been a much more recent update on that.

MS TOOHEY: The Chair asked the question of the Ministry of Social Development last week in relation to their process earlier as to whose interests are taking precedence here. Is it the interests of children in residential care settings, who we've just outlined this morning and agreed are vulnerable, are unlikely to make a complaint, or is it the privacy and employment interests of an employee of Oranga Tamariki?

MR TE KANI: It's a case-by-case situation, but the starting point has to be, first, we have all the relevant information about that person and any allegations; and the second, in my view, we must, if we can, under law, as well as with the agreement from complainants, put those allegations to those people.

MS TOOHEY: Sure.

MS DICKSON: If I could just add, I think it's not so much interests, it's obligations and legislation, and if I could just give context around the High Court ruling, it was one that we raised concern about in terms of, we were very worried about these allegations and our ability to address them fully, but there were restrictions on us being able to put the allegations to Person A because of that High Court ruling.

MS TOOHEY: Alright. So that High Court ruling related to people who had made a claim in court.

MS DICKSON: Yes.

MS TOOHEY: Some of the allegations to the Ministry of Social Development, on the evidence that the Commission received last week, did not relate to people who had made a claim. So you'd accept that that isn't going to create a barrier?

MS DICKSON: So we were still obliged to seek the claimant's consent to put the claims, if we could obtain that, and those were the steps that we were taking.

MS TOOHEY: Alright. First of all, the High Court left open, didn't it, expressly, the position that for vetting purposes, the ruling didn't apply, the safety of children.

MR TE KANI: Yes. That's true, correct.

MS TOOHEY: Second of all, whatever your legal obligations are, I think you'd agree with me that if safety of children is paramount, you would make sure that while you are satisfying your legal obligations to a staff member, that you take them away from children while you're investigating –

MR TE KANI: Yes.

MS TOOHEY: – or sorting out this legal mess.

MR TE KANI: Yes, agree.

MS TOOHEY: And that hasn't happened until this –

MR TE KANI: That has happened now.

MS TOOHEY: Has happened now?

MR TE KANI: Has happened now, yes.

CHAIR: When did it happen?

MR TE KANI: Last Monday.

MS TOOHEY: That was after the Commission asked for information about it.

MR TE KANI: That was, to the Commission, at the point in time I was aware of the issue. This issue was brought to my attention relatively late in the process, which is unsatisfactory. At the point in time, it was brought to my attention, it was very clear to me, on the basis of the information I had seen and read, that actually we had to put the safety of the tamariki first, given the nature of the allegations, whilst we work through this process, bearing in mind out of respect to the process we could only put one allegation to the person, given the number of allegations, and that's the process we're currently embarking on.

MS TOOHEY: And the other nine people named in that 2006 as current staff, where there were some allegations of serious sexual and physical offending, have you satisfied yourselves in relation to those people named?

MR TE KANI: To the extent that we are, as I've stated just now, wanting to assure ourself about the safety of the tamariki for whom they might be working with.

MS TOOHEY: Are any of those other nine still employed by Oranga Tamariki?

MR TE KANI: I can't answer that question.

MS TOOHEY: Alright I want to move now to a different topic before the break and that's just the issue of oversight and I want to go to the latest ICM report, that I know we've looked at it before, which is MSC0008239. Again, this is the first full report of the Monitor which was from the period 1 July 2020 to 30 June 2021. Sorry it's page 32, third paragraph from the bottom, I think. Yes, third from the bottom. You'll see there that this talks about the concept first of self-monitoring.

So my understanding of the way in which monitoring works for Oranga Tamariki is that, first, you self-monitor against the regulations and care standards, and then, secondly, we have now the ICM that provides a measure of external monitoring.

MS DICKSON: Yes.

MS TOOHEY: And we'll come to the 396 in a moment, but just looking at this, and I know we've touched on this already.

MS DICKSON: Yes.

MS TOOHEY: But if we look at that, it's talking about Oranga Tamariki has stated that its self-monitoring is sufficient, but then it says in the third sentence:

"From our data and information request, Oranga Tamariki was able to answer 57% of the questions, but Oranga Tamariki cannot report on tamariki and rangatahi access to health services, and whether they are informed of and understand their rights, or whether caregivers are given appropriate training and information about the tamariki they care for."

Then it continues on in the second to last paragraph:

"Oranga Tamariki can provide data for only 5% of the 199 measures for all children in their care using its database. The remainder of data provided comes from quality practice tools, surveys and manual analysis of case files. Case file analysis is a useful and important component of self-monitoring, however the low level of structured data available limits its ability to assure itself of the standards of care for every tamariki or rangatahi in their care."

I know you talked about this earlier, Ms Dickson, about the CYRAS case sampling, but I think you'd agree that the fact that you can only provide data for 5% of all of the measures as of June last year is a problem.

MS DICKSON: Yes, it's a problem.

MS TOOHEY: Because it then limits the way in which the Independent Monitor can conduct their external monitoring.

MS DICKSON: Yes.

MS TOOHEY: Because you can't measure it and they certainly can't, am I right?

MS DICKSON: Yes.

MS TOOHEY: What about – I just want to touch on the 396 providers, first in relation to their complaints mechanisms. Am I right in understanding that it is for the 396 provider to satisfy you through the accreditation process that they have a good complaints system first internally?

MS DICKSON: Yes.

MS TOOHEY: And that they are required to notify you of any instance, any allegations of harm, is that right?

MS DICKSON: Yes.

MS TOOHEY: But otherwise it's for them to organise their own complaints system?

MS DICKSON: Largely that's my understanding.

MS TOOHEY: And my understanding about the ICM is that they do not go to talk to children who are within 396 provider care.

MS DICKSON: They are exploring engagement with children as part of how they will conduct their monitoring into the future.

MS TOOHEY: So far, though, with the last three reports, they haven't?

MR TE KANI: So far, you're right, yes, correct.

MS TOOHEY: So we know that 396 providers include faith-based organisations and the likes of the historic, now closed down Whakapakari and Moerangi, that's the kind of provider would be included under that?

MS DICKSON: Some faith-based but not all faith-based. Only a small number, actually.

CHAIR: It might be helpful for those watching and listening to have a very brief description of what 396 is all about. It's probably an incomprehensible code.

MS DICKSON: Do you want to... Would you like me to try –

MR WHITCOMBE: Just in a simple way, section 396 refers to a part of the Oranga Tamariki Act and for an organisation to receive funding from Oranga Tamariki, there needs to be accreditation and within that 396 status, I think there are three levels, and the highest level is where you can provide care. So there's three steps of assessment and assurance that are worked through in order to achieve that 396 status.

CHAIR: These are, effectively, contracted by Oranga Tamariki to provide care on its behalf.

MR WHITCOMBE: That's right, yes.

CHAIR: That's all we need to know. Thank you.

MS TOOHEY: Residential care as well.

MS DICKSON: Group home care, yes.

MR WHITCOMBE: Yes, group home care.

MS TOOHEY: How do you know, yourselves, that their complaint system is working in the way that you require when you provide accreditation?

MS DICKSON: It's part of the review process to, but it is – as you've explained, it's to look at the processes, how they're described in policies and in guidance in the organisation. There may be, on some occasions, a look at actual files or case files as part of a review, but largely it's assuring the process, as you described earlier.

MS TOOHEY: Are any of the current section 396 providers operating in remote or isolated areas?

MS DICKSON: So we checked that yesterday and, no, they're not there. Might be some who are – they're all in environments that can be accessed relatively easily by road and are visited.

MS TOOHEY: Okay. Do you go in and talk to the children to check and audit that that complaints process is working, or is it a paper-based review of whether the process is working?

MS DICKSON: So I don't want to be overly complicated, but there would still be a social worker for each child, so that social worker would still be responsible for aspects of the care standards that relate to the child's plan. In terms of going in – sorry, can you just repeat that?

MS TOOHEY: I'm just wondering who's talking to the children to check that they do feel that they can complain. Rather than just relying on what the organisation is telling you they're doing, how do you know for sure?

MS DICKSON: So the expectation that was described this morning in the care standards about making sure children know their rights, know about the complaints process, is still incumbent on the social worker even though the care is being provided by a provider and that provider has their own complaints process. I'm not suggesting that's perfect. I'm just saying that that is still an expectation that the social worker –

MR TE KANI: I think Ms Chase wants to answer.

MS CHASE: Kia ora, I just wanted also add that it was also the role of Counsel for Child around being the independent visitor, not just a social worker but also Counsel for Child should be seeing that child as well.

COMMISSIONER ALOFIVAE: Can I just ask a question in response to that, Ms Chase. So if Counsel for Child then puts it in their report that the child is making a complaint or an allegation, what then happens to that? Because those reports are filed in court and they're sent to Oranga Tamariki, the social worker, and also to your legal counsel.

MS CHASE: I'll probably refer back that back to Nicolette.

MS DICKSON: So it speaks to the comments I made earlier that it would depend on the nature of the concerns, so if it met the threshold for an allegation to be investigated under the joint child protection protocol, that's the process it would follow. If there were more general concerns that didn't meet the threshold for that investigation, it would still be recorded as a report of concern for assessment. If it was a more generalised service issue, that would then be addressed through a complaints process.

COMMISSIONER ALOFIVAE: And how do you close the loop then for those children that are making complaints, because like you said, Mr Whitcombe, it's another independent avenue for complaints to be made and often, presumably, they would also be mentioned in the courtroom when files are being reviewed. How – is there an assurance around those complaints actually then being registered and then you go down your different tracks, but the – how do you close that loop with the child?

MS DICKSON: So depending on the age of the child and the most appropriate way, the social worker would have responsibilities. If it had been raised by a lawyer for child, the social worker should also be advising the lawyer for child of the outcome so that that can be an additional protection.

MS CHASE: There probably is one gap, though, and that, from an Oranga Tamariki perspective, and that is that some section 396 providers have their own social workers, so their delegation is wider than ours.

MS DICKSON: That's for a small number of agencies and children, so they are the two that I think you referred to earlier.

MR TE KANI: Open Home Foundation and Barnardos, yes.

MS TOOHEY: Do you know how many children are within the 396 providers in total, or could you get that?

MS DICKSON: I could get that.

MR WHITCOMBE: And just approximations, there are about 3,300 in foster care, but there would be a further 1,400, approximate, in other types of care settings.

MS DICKSON: But to note that would also include children who had returned home or remained home, but Oranga Tamariki retained custody of them.

MS TOOHEY: Just one last point in relation to this 396, this time monitoring, if Oranga Tamariki doesn't have the data for its own self-monitoring against the 199 measures for children in their care, how can you be sure that the – that you can monitor the section 396 providers? How do you know that they are meeting the care standards?

MS DICKSON: So, again, I'd just say that some of those care standards relate to obligations Oranga Tamariki social workers still hold in terms of the child's plan and others are held by the 396 provider. I would say, in response to your question, we are not in a position where we can adequately assure.

MR WHITCOMBE: One of the things that we have done is set up specific roles through Māori partnerships and communities, which is the commissioning arm of the organisation, to support 396 providers to come together as communities of practice and the specific focus of that is to support the establishment of the National Care Standards into their policies and practise and help them, you know, obviously, have relationships and learn from each other, so there's a support mechanism in there to help them grow the care standards into their practice.

MS DICKSON: And if I could just add, when I say we can't, it's at that whole of population individual child level, so we can't say for every child every standard has been met. There are, however, sources of information that enable us to give a picture of certain perspectives and that's what's referred to in the case file analysis surveys and other things.

MS TOOHEY: Just stepping back, just very quickly, Madam Chair, but there isn't much mention in the ICM about the 396 providers who aren't at the Barnardos kind of level. It appeared to me, and can you comment, that they are reliant on Oranga Tamariki and your accreditation process to conduct first instance monitoring of those 396 providers? Have I got that right?

MS DICKSON: Yes.

MR TE KANI: So there's the accreditation process, that's number one, and then there's the actual obligations on those providers who are providing care to then operate within the National Care Standards, so they have that dual, that dual accountability.

MS TOOHEY: Sure, but in terms of monitoring that they are, is it for Oranga Tamariki in the first instance?

MR TE KANI: Yes, yes.

MS DICKSON: So the Monitor doesn't have a direct monitoring role for providers that don't have that sole care responsibility.

MS TOOHEY: Right, so that's why it doesn't appear in their report because that's for you?

MS DICKSON: Yes, although they have made it clear that there's – that we improve the information we provide about that and we are providing further information in this year's response.

MS TOOHEY: Are you really sure that there are no 396 operators operating in a way that we've seen not that historically with Whakapakari out there at the moment, given that you're not able to monitor your own compliance with the care standards?

MS DICKSON: I'm confident that there is a much more robust set of oversights than were in place for those two providers that we've talked about in this hearing.

MS TOOHEY: That doesn't, that doesn't really – with respect to you, Ms Dickson, that doesn't really answer the point. Are you confident that there are none operating in the same manner?

MS DICKSON: To the extent that we can be, we're confident.

COMMISSIONER STEENSON: Can I just clarify, is that through your social workers?

MS DICKSON: Yes, sorry, so that is a combination of the oversight mechanisms for 396 providers and the accountabilities that sit with the social worker, in terms of visiting, in terms of monitoring the plan, understanding their needs, responding to concerns, so all of the things that we've talked about still would apply equally to a child in a 396-care provider than in a whānau or foster care arrangement.

COMMISSIONER STEENSON: Right. And so can I just ask, how many children would a social worker be looking after at any one time, approximately?

MR WHITCOMBE: I think the average at the moment is around 19 to 20.

COMMISSIONER STEENSON: Okay, and so that's – that's quite a demanding load.

COMMISSIONER ERUETI: I think we're going to explore that, aren't we, social work practice and things like recruitment and so forth; but it does seem that you rely heavily on the social worker relationship with a child to meet these monitoring and allow access to complaint and so forth, Ms Dickson, or Mr Te Kani?

MS DICKSON: I think there is a primary responsibility on a social worker, but the social worker should be working in a collegial way with a range of other trusted people in the life of a child, so we've talked about lawyers for children. There are often other community partners involved in supporting children in care as well, so you would be expecting that, those relationships to offer a safety net, but what I wouldn't want to say is that that absolves the primary responsibility on the social worker.

COMMISSIONER ERUETI: Okay, thank you.

MR TE KANI: Just sorry – just to come back to your primary point, Ms Toohey, can and should there be improvements to how there's monitoring of 396 providers who are providing care for tamariki? Absolutely. And do we need a process that provides greater clarity and assurance over that? I would agree with that, yeah.

CHAIR: Seems like a note to end on before we take lunch. Shall we return at two or 10 past two? It's up to you.

MS TOOHEY: I regret to say that our confidence about time is sort of evaporating.

CHAIR: It's diminishing? Let's come back at two o'clock. Thank you.

Lunch adjournment from 1.07 pm to 2.02 pm

CHAIR: Welcome back everybody, and good afternoon, Mr McCarthy. Welcome back to the podium.

QUESTIONING BY MR McCARTHY: Tēnā koutou e ngā rangatira o te pae, tēnā koe Mr Te Kani, Mr Whitcombe and Ms Dickson. My name is Winston McCarthy. I am one of the lawyers assisting the Commission. I am quite tall. I am of Māori and Samoan descent, and I am wearing a charcoal suit and a blue shirt today.

MR TE KANI: Kia ora.

CHAIR: I want to correct that – he's very tall.

MR McCARTHY: Sorry, I don't want to mislead the Commission. So during this session, we're going to be talking about oversight and monitoring and Ms Toohey sort of set me up to lead this discussion. Mr Te Kani, in your brief, you note in your acknowledgment section that oversight and monitoring did not ensure children were kept safe from harm during our scope period. Do you recall that?

MR TE KANI: Yes, I do.

MR McCARTHY: And at a general level, do you agree that poor oversight and monitoring practices enables abuse to persist, especially with what we've heard over the last two days?

MR TE KANI: I would acknowledge that, yes.

MR McCARTHY: So you would agree that it's one of the strongest safeguards that the State has to ensure the safety of children in their care?

MR TE KANI: One of a number of safeguards, yes.

MR McCARTHY: Now, just before we get into the meat of my sort of questions, last night I was going through your future directions document and that was published in September of last year; is that correct?

MR TE KANI: Correct.

MR McCARTHY: And one of the stated goals over the next 12 to 24 months, so I guess – or 12 months from now, so by the end of next year, I guess, it says that a goal is to place the voices of tamariki and rangatahi at the centre of decision-making. Do you recall that?

MR TE KANI: Yes.

MR McCARTHY: While we're going through our discussion, it's a touchstone that we're going to come back to, so if we could keep that in the forefront of our minds.

MR TE KANI: Ka pai.

MR McCARTHY: So we're going to begin at the coal face. Just to orientate you, we're going to start with the on the ground monitoring and then we're going to look at the organisational monitoring and then we're going to have a brief discussion about the role of media and your responses to the monitoring that they do.

Now Ms Dickson, you noted at the end of the last session about the importance of social workers and the monitoring process, is that right?

MS DICKSON: Yes.

MR McCARTHY: What I propose to do is to take you through a few historical documents, a few survivor voice documents, that outlines what happened historically. I'm not going to take you to a document unless you'd like to. I was just hoping to read it out, if it's okay.

CHAIR: Just a wee note on speed please, just keep slow.

MR McCARTHY: Sorry. So the first example is from a survivor who was in Ōwairaka from 1971 to 1974 and he suffered significant physical, sexual and emotional abuse within the residence and, for the record, his witness statement is EXT0016024. And he said at the beginning of paragraph 74:

"Social workers would say they come and see you, but they didn't. I went from one place to another and none of us had social workers. Records say we did, but the social workers never came to see us. I never met a social worker. They didn't do anything. They came to see other people, but not me. This is what I can't understand. How can people like social workers write things like they did in my file when they didn't even see me? They tore a child's life apart."

Now, the second example is from later on in our scope period. It was from a survivor who was placed at Whakapakari in 1998. He suffered significant abuse while at the section 396 provider and also we've had a brief discussion about that, and we'll go into that further on. For the record, his witness statement is EXT0016043. And I will note just quickly that I have replaced the names of the people with their job title at the provider.

So starting at paragraph 46, he said:

"I also never saw my social worker after he dropped me off at Whakapakari. He called once on 19 October 1998 and spoke to the supervisor, who told my social worker that I was doing well and fitting into the programme."

So, Ms Dickson, clearly these are instances where the social workers weren't monitoring the children and young people in their care, would you agree with that?

MS DICKSON: I would agree with that.

MR McCARTHY: And the evidence we've received is that these aren't isolated examples, that it was widespread – social workers not visiting or visiting infrequently the survivors in care, would you accept that?

MS DICKSON: In the context of the period?

MR McCARTHY: Yes, in the scope period.

MS DICKSON: Yes.

MR McCARTHY: Looking forward to today, in your response to written questions posed before this hearing, what we call a notice to respond, or an NTP – this is just jargon; we'll probably refer to it later on – you state that the frequency of social work visits should be based on the needs of tamaiti. That's correct, isn't it?

MS DICKSON: Yes.

MR McCARTHY: I'd like to take you to the latest report of the ICM for the period 1 July 2020 to 30 June 2021. The document number, for the record, is MSC0008239. I'll read it out, but do you see the highlighted section there?

MS DICKSON: I do.

MR McCARTHY: So it says there:

"60% of assessments (195 out of 323) do not cover how often tamariki should be visited by a social worker. 62% of tamariki (434 out of 700) were not visited by a social worker at the frequency detailed in their plan. Of those 62%, 54% were visited, on average, every eight weeks."

Would you agree that this data demonstrates that there is currently inadequate visitation by at least some social workers within Oranga Tamariki?

MS DICKSON: Yes, I would note there has been subsequent case assessment – case file analysis since this period, but I'm not debating these results and I wouldn't suggest that they have completely improved but there has been some improvement in the period since the report.

MR McCARTHY: But we don't have that report in front of us, do we?

MS DICKSON: No.

MR McCARTHY: Are there any consequences for social workers who fail to meet the required number of visits in the All About Me plans?

MS DICKSON: Well, the first thing would be that this would be an issue identified between the social worker and their supervisor and, in the first instance, the reasons and support needs

that might be needed to ensure that the social worker was doing as is required was addressed first.

MR McCARTHY: Do you find it concerning that this issue began at the start of our scope period from 1950 and still seems to be an issue in 2020(sic) today?

MS DICKSON: I am still concerned by the frequency of visiting. It's the most – arguably the most important part of the social workers' response to children in care. I would say, though, that the majority of children would be visited more frequently than the examples that you provided historically – not necessarily up to the standard we would expect today, but more frequently than in the past.

MR McCARTHY: Well, perhaps we'll see what the children have to say. So at page 51 of the same report – and I can take you there, if you like or I can just read it out – this is what the ICM said:

"Tamariki and rangatahi told us that when their relationship with their social worker isn't working well, it has an impact on them getting the things they need. In some cases, it has a negative impact on their emotional wellbeing. They say the cause of poor relationships is often a social worker not visiting or communicating with them, a social worker letting them down numerous times, or having multiple social workers who they don't know and, therefore, don't trust. Some tamariki say they don't know what a social worker is or that their social worker does not ask them questions, or they lose every bit of information and never listen. One rangatahi said their social worker's poor communication has made them feel pathetic and down in the dumps."

Do you have any comment on those reflections, that qualitative data?

MS DICKSON: I accept that that is the relationship that those young people have described with their social worker and that that's not adequate. I would say we have other sources of insights from young people who would say that there are young people who enjoy a very different relationship with their social worker than these experiences reflect.

CHAIR: The point about this quote, though, is not the numbers, because you've already accepted that the numbers of visits aren't as good as they could be, this is about what happens to children when they don't have a good relationship and that seems to be driven by the fact that they're not being visited. So I think the question is, do you accept that not visiting, it's not just compliance with a rule, it's about making children feel safe and trusting.

MS DICKSON: It's the most fundamental way to ensure children can raise when things are not okay and for action to be taken.

CHAIR: That's right, and a pipeline into a complaints system, for example.

MS DICKSON: Yes.

CHAIR: Sorry to interrupt.

MR McCARTHY: No, that's fine. That was my point. When you have these types of relationships and you don't have a high trust, sort of, relationship, would you agree that it's less likely for the child or youth to disclose abuse to their social worker?

MS DICKSON: I would agree.

MR McCARTHY: Okay. Another form of coal face oversight, for lack of a better term, is that provided by whānau. Now, Ms Coates covered the connection to whānau during her session. There was a couple of questions that I wanted to put to you. There's the cultural neglect aspect and do you accept that that's a form of abuse?

MS DICKSON: It's not – cultural neglect as an abuse type isn't described in the Act but it is absolutely a feature of other abuse types. So, for example, the Act talks about deprivation, it talks about impact on development, it talks about emotional abuse and, within that, cultural abuse, I think, is very much part of the paradigm.

MR McCARTHY: I was interested in your discussion with, I believe it was Dr Cooke, and you discussed general complaints and one of the complaints that you mentioned as an example was a child or youth not being able to communicate with their family. At some point, that would rise to the level of being cultural neglect, wouldn't it?

MS DICKSON: At some point, it would be more than just a service issue or a decision, it would be something that was having a detrimental impact on the wellbeing of a child, yes, I'd agree. Having said that, that has to be balanced with the safety considerations that are sometimes required to be considered in engagement with whānau members.

MR McCARTHY: Perhaps we'll talk about the role of whānau in terms of oversight. So the same ICM report, and it's at page 84 but I don't propose to take you there, if you take my word for it, it says that 79% of complaints received by Oranga Tamariki were made by whānau. Does that sound about right?

MS DICKSON: 79%? Yes.

MR McCARTHY: You'd agree that connecting whānau, hapū and iwi with tamariki in care provides an important level of oversight and opportunity for young people to express concerns and confide in someone that they trust?

MS DICKSON: Yes, and additionally, it's a right and need of tamariki, but absolutely to your point.

MR McCARTHY: The Commission has heard, historically, whānau visits or communication were limited and treated as a privilege. Would you accept that?

MS DICKSON: In the scope period, yes.

MR McCARTHY: In the scope period. The Commission has also heard that where interactions with whānau did occur, it would often be monitored, for example, care workers reading an e-mail, and that wouldn't be acceptable today, would it?

MS DICKSON: No. I think we addressed that this morning. The only caveat I would say is that there are sometimes restrictions around keeping children safe from unsafe adults within their whānau. Even then, you would be trying to make engagement as natural but safe as possible.

MR McCARTHY: Sure. I wanted to take you to page 67 of the same ICM report that we've been discussing, just the top of the page. It says there, for the people listening at home:

"Most tamariki and rangatahi told us that they don't regularly get to spend time with their parents, siblings and whānau, including their grandparents, aunties, uncles and cousins. The main reasons they gave us are that their social worker does not follow through with arranged or supervised visits, or whānau are still dealing with trauma that prevents them from visiting their tamariki. Some tamariki and rangatahi want more time with their whānau. Others feel completely disconnected from their parents and whānau. One rangatahi said, "They never gave me visits with my parents [Oranga Tamariki said they would]. This has impacted my relationship with my parents now."

So this qualitative data, this voice that we're hearing through the ICM report, it seems to suggest that whānau visits are not occurring often enough to maintain strong relationships. Would you accept that?

MS DICKSON: These experiences certainly indicate that.

MR McCARTHY: Just at the beginning, it says "most tamariki and rangatahi", doesn't it? At the beginning of the paragraph.

MS DICKSON: That they spoke to, is my understanding, so they didn't speak to all children in care. So we have 4,300, approximately, at the moment children in care, so just – I'm not dismissing or discounting this experience at all, I just want to maintain the context that there are other experiences that other children –

MR McCARTHY: Sure.

MS DICKSON: – and young people have and experiences that they have told us are different to this experience and that's to be expected, we have a range of experiences.

MR WHITCOMBE: And also just to add that more children than not are placed with wider whānau, so there is a natural relationship within the context of their placement that is occurring as well, so the number does fluctuate, but it's about 64%.

MR McCARTHY: So you don't accept what is being said here or...?

MS DICKSON: It's not that we don't accept what's being said here. I absolutely accept that this is the experience that these tamariki and rangatahi shared and that it's not an acceptable experience. I just want to contextualise that we hear from – there are a range of experiences and I wouldn't want –

MR McCARTHY: I will stop you. We are going to come to how you hear VOYCE later on and I'm really interested to explore that with you.

MS DICKSON: Sure.

MR McCARTHY: Okay If we accept this at face value, though –

COMMISSIONER STEENSON: Sorry, can I just clarify, are you saying that you don't agree with the methodologies that the ICM uses –

MS DICKSON: Not at all.

COMMISSIONER STEENSON: – to get these results?

MS DICKSON: Not at all. I think that what I'm just simply saying is that they spoke to a group of rangatahi and I'm just wanting to represent that there are other experiences that we've heard through surveys and other sources of information, and I just want to balance that there are experiences for tamariki and rangatahi which would be different to the ones described here. I'm not discounting the methodology.

COMMISSIONER STEENSON: Okay. Thank you, because at the bottom, they do say that some tamariki and rangatahi say they see their parents and whānau during planned visits arranged by their social worker, so I think they have acknowledged that.

MS DICKSON: Yes.

COMMISSIONER STEENSON: Thank you.

MR McCARTHY: With the people that they spoke to, would you agree, if they're not speaking to their whānau, that would limit the opportunities for them to discuss experiences they might be having in the care, including abuse? Would you agree with that?

MS DICKSON: Yes, I would.

MR McCARTHY: Okay. Turning now to look at the oversight, the organisational oversight we spoke of before, we're going to look at residences from an historical perspective first. I'm going to bring up a document, it is ORT000255_00002. This document, as it comes up, I'll just describe it. This is a letter from the principal of Kohitere, one of the residences, to the DirectorGeneral of the Department of Social Welfare, dated 27 August 1980. In the letter, the principal is critiquing the new format for providing annual reports and suggesting the

need for regular inspections. Would you be okay if I read the extracts to you? If I don't have to take you to the document?

MS DICKSON: Sure. That's fine.

MR McCARTHY: So the first extract says:

"You will be aware that some years ago in many institutions, the writing of an annual report became almost the major task of the year. Beautifully presented annual reports were the order of the day. The fact that they often bore little resemblance to what actually went on in these institutions was immaterial. It was often the time of the great white lie. Quite rightly, this major task was seen to be stupid and of little real value."

So it appears that this principal saw annual reports as performative, as opposed to being an actual monitoring measure. Would you accept that?

MS DICKSON: Based on that articulation, it's not something I have a lot of historical knowledge about, but, yes.

MR McCARTHY: Further down, the principal says:

"There is much ado if office procedures are not followed to the letter, but nobody seems terribly worried or interested in the programmes and procedures I adopt with young people."

MS SCHMIDT-McCLEAVE: Madam Chair, we're not seeing that document and I'm wondering, it is quite hard for the witness, I think, to comment on it with it not coming up.

CHAIR: I think there might have been a problem with it coming up.

MR McCARTHY: It's just coming up now, sorry.

MS SCHMIDT-McCLEAVE: Just while I'm on my feet, I'll just note, too, for my friend that the EXT references that we're getting from him, we don't have. We have WIT witnesses, so you could just perhaps bear that in mind if you have two numbers. I understand you might have a different number.

MR McCARTHY: Okay, thank you.

CHAIR: That all sounds very complicated, all right, but it's given time for the document to come up. This is the letter from the principal to the Director-General in 1980 that you've been referring to, Mr McCarthy?

MR McCARTHY: Yes. If we go to page 2? So the second highlighted paragraph, do you see that?

MS DICKSON: Yes.

MR McCARTHY: I'm not sure where I was. I think I had just finished reading the quote.

MS DICKSON: Yes.

MR McCARTHY: Would you accept that paragraph, that it appears that monitoring appeared to be about compliance instead of measuring quality?

MS DICKSON: I would accept that that's the case.

MR McCARTHY: And that's a theme that came through our scope period, that monitoring often was more about compliance than quality. During the hearing, have you heard that come through?

MS DICKSON: It's not a theme I've heard the most strongly but, yes, I'd accept that that's the evidence that the Commission's heard.

MR McCARTHY: If we can read that last paragraph, it says:

"I hope before I retire to see a system of inspection emerge that will make me accountable for the overall programme I initiate with the young people in residence. Such a system would be welcome by me and infinitely preferable to an annual report that has in the past sometimes proved to be a figment of a controlling officer's imagination."

So it's clear, isn't it, from those extracts that we read, the annual reports weren't an effective monitoring mechanism for residences?

MS DICKSON: That would seem to be certainly the view of this person who was –

MR McCARTHY: The principal.

MS DICKSON: – running the residence, yes, and...

MR McCARTHY: Turning to today, and this is for Mr Te Kani, in paragraph 205 of your brief, it says that the future directions plan, which was published in September 2021, makes it clear that the current Care and Protection residences are not a part of Oranga Tamariki's future.

Now, when I was going through that document, the timeframe for achieving that was six to 12 months. Does that sound about right?

MR TE KANI: It's an indicative timeframe of six to 12 months, yes.

MR McCARTHY: I guess that's what I was hoping to get clarity on.

MR TE KANI: Okay.

MR McCARTHY: So it's been almost 12 months. Can you give a timeframe on when these residences will shut?

MR TE KANI: So, I can't give an actual timeframe and the reason for that is the importance of making that transition safely and I don't want to unnecessarily rush it. But what I can say is the timeframe that was provided in the future direction plan was an indicative timeframe for Oranga Tamariki to be very clear about what the process will be for the closure of the Care and Protection residences.

MR McCARTHY: So, you could provide a timeframe when the document was published but what you're saying is now it would be unfair to –

MR TE KANI: And there's, there's some specific reasons for that. Obviously, there's some legal considerations we have to think about for the closure of the Care and Protection residences. We have to close them in accordance with particular legal obligations, which we of course can't put a timeframe on. Alongside all of that, the importance about closing the Care and Protection residences, as we've discussed over the last three days, is the importance of being really clear about what the model of care will be for the tamariki, who, understandably so, will come to Oranga Tamariki with high complex requirements that we have to meet.

MR McCARTHY: I guess that brings me to my next question. I was watching yesterday, and it wasn't clear from the discussion, brief discussion you had about this, what the model of care looked like. Would it be smaller homes?

MR WHITCOMBE: Yeah, so I can comment briefly, and it may be that Frana Chase will comment further, who's leading that particular work, but, yes, that is right, and those homes, so they would be smaller, and they would be established absolutely in partnership with iwi and Māori organisations.

MR McCARTHY: So, would they – it sounds like they'd be section 396; is that the sort of intended plan?

MR WHITCOMBE: Yes, they would need to be approved through section 396.

MR McCARTHY: I'm going to briefly turn to issues that have arisen in section 396 settings or – just to clarify, to begin with, when I was going through the website, there was a reference to 396 settings and care partners. Are care partners, is that another name for 396 settings?

MR TE KANI: Frana will respond to that.

MS CHASE: Kia ora. So the exiting out of residences is to look at the 19 current beds across five of our existing residences, although Te Oranga is not operational currently, and the build of the new builds programme and also the responses that come from the section 396 partners will accommodate for 19 tamariki that may need an alternative to home, but we'll also be looking at where is the best place for tamariki to be where they're supported well by their whānau, so it's not about creating new little institutions or mini homes for tamariki. We've got family homes, if we're going to do that. This is about engaging with whānau, hapū and iwi so that they have their tamariki within their own rohe and they're able to almost triage or provide a wraparound response and that we have assurance that we're giving the right support to tamariki and their whānau first. So that's the plan for how we do that, but like

Mr Te Kani described, we have to work through the legal requirements, HR, etc, etc, around the residences, but that shouldn't mean that tamariki need to stay in residential care longer than required.

COMMISSIONER ERUETI: Ms Frana, are you able to just – do you have a pilot or just explain how, I'm wondering how this might work, say, in Tāmaki with Ngāpuhi numbers and –

MS CHASE: So we have – and Tāmaki Makaurau will be one of the first new builds and I've described yesterday that is at 15 Claude Road. It hasn't been opened yet because, as we've been building, we also have had to be engaging and building up our iwi and Māori partners to become accredited to become a section 396, so that doesn't happen overnight. It takes them time to meet all those standards that are required, develop their policies so that there is an assurance that once the whare is built, that they will be able to operate them.

So that's the process that we're working through now, is around there may be a transitional process where we operate to their operating model as they build their capacity and share our resources and kaimahi, but that will be alongside them to do that.

COMMISSIONER ERUETI: Would that – so that model, that is actually a building, right, so, and who would be the whānau providing the care there?

MS CHASE: So that will be a decision that will be made with our section 396 partners, with urban Māori, with mana whenua, and with the collective of Tamaki Makaurau, so they will make that decision, and similar too – we have in other locations, Ōtākou, for example, we currently are building on Middleton Road, which is a facility, an existing whenua that we already own as an organisation, so we've started a build there with the consent of Ngāi Tahu section 396 approved partner, who is Ōtākou Health Limited, and we're also just in the process of purchasing whenua on Bluestone Road, which is further out – which is a closer cultural connection to them, so they've built their cultural narratives, they've got whenua. Waihopai is another example, that's in Invercargill, so that whare will be built on their marae there. So there's six in total that we're currently building to.

COMMISSIONER ERUETI: Okay. Can I just ask quickly, too, a brief description of the legal challenges?

MR TE KANI: Yeah, so there's employment challenges, of course, because of the number of staff that are directly recruited and hired to the residences, but as Ms Chase says, that's a process we just have to work through in the normal course of events. We've also got, of course, regulatory challenges we have to work through. With the closure of any of the residences, we have to work through any existing legal arrangements we have already for the care of the tamariki in each of the residences, some of whom might well have specific needs that

have to be met under the Health Act, for example, so it's quite a considered process and when we talk about the future of the model of care, in each of those examples that Ms Chase has provided, it's broader than just talking about infrastructure. It's much more about the wraparound support services that will be provided around the whenua for the tamariki that will be going into care. So I just want to say publicly, it's – any notion that this is a commercial arrangement, I just want to put that to bed because it's fundamentally about how we work with partners on a transitional – what we call a transitional care arrangement to make sure those supports are there and to meet the vision and aspirations that our partners are putting to us about what they believe to be the model of care that they want to deliver for tamariki in their rohe.

COMMISSIONER ERUETI: That six to 12 months seemed pretty ambitious, by the sounds of things. Do you have a ballpark for when, say, that pilot in South Auckland might be ready?

MR TE KANI: Yeah, so for the pilot, as I said, the easiest part is building the building. The part we don't want to rush, we'll go as fast as we need to go, is everything that needs to be wrapped around that. That's separate to the process we need to run to close the residences and part of that will be how we think about the transition and safety plans for each of the tamariki currently in the Care and Protection residences. I've got legal obligations I have to meet about the care and protection of tamariki, so I can't overnight close residences because that puts myself and the organisation at quite legal risk when actually there could well be decisions from the court that requires us to take tamariki into a Care and Protection residence, in some exceptional circumstances nonetheless.

COMMISSIONER ALOFIVAE: Mr Te Kani, can I just ask a follow-up question to that – sorry, Mr McCarthy – and I'm not sure if it's yourself or Ms Chase, so the whare in Claude Road in Manurewa, so when you describe the 7AA strategic partners, but you actually mentioned also a couple of other partners, is the intention of that particular site, is that an urban site, or is it iwi -based? Just wanting, you know, for a point of clarity.

MS CHASE: So mana whenua Waikato Tainui or Tainui, but relationship, the collective of Tāmaki Makaurau.

COMMISSIONER ALOFIVAE: And just another question that really came out of your response, Mr Te Kani, so when you're talking about the wraparound services to the whenua, is that the operationalising of the Oranga Tamariki action plan, where you've got all of your services being quite focused on this particular little cohort?

MR TE KANI: That's a way to articulate it. You know, I mean, in a real practical way, you would have access to health services, you know, bespoke education services, particularly

depending on the needs and requirements of some of the tamariki, so that could absolutely be a way of expressing, you know, the Oranga Tamariki plan of action, yes.

MR WHITCOMBE: And if I could just make a comment, in the conversations that I have with social workers and the feedback that others get, one of the biggest worries that we do have is the need for, at the high needs end of the care continuum, is placement availability and making sure we do have safe and appropriate placements where the unique needs can be met that are often quite significant. And part of my responsibility, when the Oranga Tamariki residence was announced to be closed, was the work undertaken to safely transition the young people that were in that residence to their future placement, and that process at that time took three months and that was very intensive work to move them to where they needed to be, and we wanted to make sure that it was the right next step for them.

COMMISSIONER ERUETI: This sounds like a five-year plan or maybe a 10-year plan?

MR TE KANI: We wouldn't want to put a timeframe on it, but I think we all accept, from what we've heard in terms of the nature of the residences, that these are – that they're not, they're just not the future for Care and Protection, yeah.

CHAIR: Let Mr McCarthy get on because I know we're short of time.

MR McCARTHY: So, we're going to turn now to look at section 396 providers and we discussed that during the last session. Ms Dickson, do you have much historical knowledge of the Whakapakari programme?

MS DICKSON: I started in my employment – I was aware of it at the end of its time, but I haven't referred any young people, haven't had any direct involvement.

MR McCARTHY: Just for your information, Whakapakari started in the 1970s.

MS DICKSON: Yes.

MR McCARTHY: It received a level 1 approval from the Community Funding Agency in 1994 and continued to operate until 2004. Does that sound about right to you?

MS DICKSON: Yes.

MR McCARTHY: And it was closed due to multiple allegations of abuse. That's correct, isn't it?

MS DICKSON: Yes.

MR McCARTHY: We have heard from survivors that there was a large range of abuse that happened at Whakapakari. One of the key aspects that I wanted to focus on today was the use of Alcatraz. So Alcatraz was an off-shore island that boys were sent to as punishment with very little or no supplies or supervision. Looking back to what happened in the past,

do you accept that significant harm was caused to the boys and potentially girls who experienced this?

MS DICKSON: Yes, certainly.

MR McCARTHY: If I could take you to document number CRL0022609_00002. Now, you'll see at the top of that document the date – it's pretty hard to see, I'll just call it out. That's 19 July 1989. Do you see that?

MS DICKSON: Yes.

MR McCARTHY: This is a letter from a Department of Social Welfare official to the Assistant Director-General of the South and West Auckland region reporting on an incident that occurred on Whakapakari in 1989. So, if we can just call out that highlighted section, so I'll just read it out:

"Further to this, from my own perspective, I cannot allow this department to allow youths attending camps to be subjected to Whakapakari justice as it is dispensed by way of banishment to the island called Alcatraz."

So you'll be aware that – you will all agree, I should say, that the Department of Social Welfare had knowledge that Alcatraz was being used in 1989, 15 years before its closure?

MS DICKSON: Yes.

MR McCARTHY: Now, if I can take you to document number CRL0021316. I'll describe the document while we're waiting. The document you will see it's an annual approval report, so the Community Funding Agency, which was responsible for the approval process, they did annual reviews of the various programmes.

CHAIR: What date was it, did you say?

MR McCARTHY: Sorry?

CHAIR: What date did you say it was?

MR McCARTHY: I didn't say the date –

CHAIR: Oh, you didn't.

MR McCARTHY: – but it was – I was going to wait for it to come up, but it was 2 March 1998.

CHAIR: '98.

MR McCARTHY: I might give it 30 seconds and we'll move on if we can't get it up on the screen.

CHAIR: I think that must be the worst job in the room at the moment. You have my sympathies.

MR McCARTHY: Perhaps we can move on to how these settings are monitored today and we can come back if we have time.

MR TE KANI: Ka pai.

MR McCARTHY: I guess the general proposition is, what we've heard during the Commission is that significant amount of abuse happened at the end of our scope period, so in the '90s, in these section 396 settings. Do you accept that?

MS DICKSON: In the two programmes that have been talked about frequently. I wouldn't want to characterise that as in all 396 providers.

MR McCARTHY: Okay, okay. That's fine, but you'd agree that the abuse you heard was quite substantial?

MS DICKSON: It was horrific.

MR McCARTHY: I wanted to talk about how section 396 settings are monitored today. And I'm going to go back to my original question, and I'm a bit hesitant because it sort of set off a longer discussion, but I was on your website and it talked about care partners. So care partners, they need to go through the accreditation process with Te Kahui Kahu, is that right?

MS DICKSON: Yes. I will defer to Ms Chase on this.

MS CHASE: Yes.

MR McCARTHY: And then they need to be approved by – they need to go through the section 396 approval process, which is an Oranga Tamariki-run process, is that right?

MS CHASE: Yes.

MR McCARTHY: Are there any care partners that aren't section 396 approved?

MS CHASE: Not to – there wouldn't be any that are section 396 approved that could provide care for tamariki, no.

MR McCARTHY: And there's around – sorry, there's around 60 care partners; does that sound about right to you?

MS CHASE: I'd be guessing.

MR McCARTHY: I'm just going off the website. Does it sound familiar?

MS CHASE: It sounds about right.

MS DICKSON: If it's on the website, it would be correct.

MR McCARTHY: Just a question I had, do you know how many of the care partners or section 396 organisations are faith-based care partners?

CHAIR: Was the answer "no"? I didn't hear the answer.

MR TE KANI: No, we can get you that information.

CHAIR: It would be good to know how many.

MS DICKSON: I'm just hesitating because it's very few, if any, remaining, but we will come back and confirm that.

MR McCARTHY: Okay. And when you do that, could you possibly let us know what level of funding it receives as well?

MS DICKSON: Funding?

MR McCARTHY: Yeah.

MR TE KANI: Sure.

MR McCARTHY: Now in your response to our notice to produce that we discussed before, at paragraph 15.9, you've said that, currently, around 20% of all care arrangements are led by community-based organisations, is that right?

MS DICKSON: That would be correct.

MR McCARTHY: Would you expect that to increase in the future, given the discussion Ms Coates had with Mr Te Kani?

MS DICKSON: Yes.

MR TE KANI: Yes.

MR McCARTHY: So I guess the oversight of these organisations, care partners or section 396 providers will become more and more important as time goes on, do you agree with that?

MR TE KANI: Yes.

MS DICKSON: I would agree with that. I would just also add the comments that were made yesterday, that there are other whanaungatanga and whakapapa connections that also offer safety in particularly the care partnerships with iwi Māori.

MR McCARTHY: Now, in the same paragraph of your NTP – I won't take you there, because I'm not sure if I can take you there, but you note that a significant part of those in care in community--based organisations are considered "high needs". Is that correct?

MS DICKSON: That's certainly a proportion of the young people who are in a number of the 396 providers, different providers, though, I would say – I would just want to clarify then some of the care partnerships with iwi Māori.

MR McCARTHY: Sure, and the rationale you provided in your notice to produce is that community-based organisations bring specialist skills and experience to meet the needs of those tamariki; is that right?

MS DICKSON: Yes.

MR McCARTHY: Just so the Commission and I'm clear, I was just wondering, I understand that "high needs" has a specific meaning. Could you explain how tamariki are classified as "high needs", what the factors are that go into it?

MS DICKSON: Perhaps Mr Whitcombe might be better to answer that.

MR WHITCOMBE: Yeah, so we haven't had a really, I guess, scientific way of assessing that and that is one of the things that part of the professional practice group that Nicolette oversees is doing at the moment, so that we can really clearly articulate what is it that we would describe as the "high needs" cohort. And part of what we found, when we did some analysis, was that actually some of the tamariki that were in wider whānau care placements, actually when you looked at their range of needs and the significance of the behaviour, that some of those tamariki were placed with whānau.

So it becomes important for us to have a strong evidence base around making sure that we're matching the kinds of supports and services to the needs of the tamariki in the right way.

MR McCARTHY: Sure. The question was there's high needs. Are there other levels that you assign to different tamariki?

MR WHITCOMBE: No, not in a formal way. We certainly do go through a process of – when we have got placement difficulty, when there has been significant placement instability, that we've got a specialist high needs team within the organisation and they've got a range of relationships with various care providers and they help establish the right kind of care arrangement to meet those needs that have proved over time difficult to respond to within traditional care settings.

MS DICKSON: And if I could add just rather than – sorry – by way of description rather than definition, tamariki, rangatahi, who we would identify as having "high needs" would be largely those where the usual service responses from the main agencies like health and education aren't sufficient to meet the needs of rangatahi, so there's a more bespoke level of support required than is either available within our agency responses or general responses.

MR McCARTHY: Okay.

MR WHITCOMBE: I want to be clear because you referenced levels, that that language just came out of a way of doing some analysis across the care cohort where we were thinking about needs in different way and level four being a very high needs group. So it wouldn't be a label that we would assign to a particular child, but it was a description at a point in time that we were using to help analyse a population.

CHAIR: I'm going to just raise something here, and I wouldn't mind betting some survivors are quaking in their boots about this, and I just refer back to evidence that you may have not heard about Lake Alice Hospital, where maybe with the best intention in the world on behalf of practitioners, Social Welfare then, doctors and the like, children were assessed as

being, in that day and age, having "behavioural issues" – I forget the – there was a type, but they were classed in this particular way and what we've learned in hindsight, horrific hindsight, is that some of these children were victims of abuse, some of these children had learning difficulties, and they were a whole range of different things all lumped under one label and treated the same way. So I'm not suggesting you're doing it here but I'm pointing the danger and learning lessons from what happened in the past by classifying children into this bracket or not that bracket, and I think that's why Mr McCarthy wants to know what it is that identifies it and it's good to hear that you are looking into it, but I think it's an urgent need.

MS DICKSON: So, if I can just say it's less about the characterisation of the young person and more about the characterisation of whether they have needs that have been identified that can't be met, and I absolutely recognise the caution you call out about the labelling of behavioural concerns. Unfortunately, that's a practice that persisted much longer than it should have.

CHAIR: Yeah, alright. Thank you. That was just a little shot over everybody's bows, just to remember the past. Thanks, Mr McCarthy.

COMMISSIONER GIBSON: Can I just ask in the professional practice group, what's the mix of disciplines as well as backgrounds and lived experience of people that would contribute to that piece of work?

MS DICKSON: So the professional practice group has now moved into the broader group quality practice experience that I'm part of. A big proportion of it is a social work group, so qualified registered social workers who have practised. I would say quite clearly that we don't have – I wouldn't want to say no representation, because I wouldn't want to assume people's backgrounds, but I couldn't say we have lived experience represented in our workforce. We certainly have lived experience represented in the insights we draw into our work. We do have specialist Māori practice advice, Pacific practice advice, disability practice advice within that group.

CHAIR: Thank you.

MR McCARTHY: So the Commission has heard historically that there was a lack of appropriate placements for children and young people perceived to be high need, and children and young people would often be placed within care partners or section 396 providers even if it was not in their best interests. I'm going to try and call up a document. It's ORT0112365. Sorry, could I try that again, CRL0044485. This document, it's an undated transcript of a Crown Law interview with a Department of Social Welfare official and if we could go to

page 25? Can we go done one more page? Sorry, I'm going to have to move on with my question. It's not the right page. Perhaps we can explore your current quality assurance process. So I understand that you took over the approval process from Te Kahui Kahu in the middle of last year; is that correct?

MS DICKSON: Yes.

MR McCARTHY: And you've developed some guidance for that process and that document is a quality assurance for partnered care guidance, which are publicly available, and it was originally published in September 2021 or June 2021 and it was updated in January 2022. So if we could bring that up. We're going to go to page 6 of that document. I'm just going to describe the diagram for people who are at home. It is publicly available but for people who can't see.

So there's a green inner circle and that describes the annual cycle for regionally-led quality assurance. We have a purple circle, which is a two-yearly cycle nationally led, and then we have a blue circle around both the purple and green circles, which describes the communities and practice that we've discussed briefly in the last session.

Now I wanted to talk initially about the green circle and keep it in mind the discussion that we've had so far – we've discussed that social workers don't always enable rangatahi and tamariki to express concerns; we've discussed whānau, rangatahi and tamariki aren't always able to talk to their whānau to discuss concerns; and now we have the quality assurance cycle. The first circle there is a partnership touch point and I understand that those occur during the course of the year on an informal basis, is that right?

MS DICKSON: Yes.

MR McCARTHY: Is there any requirement for the regionally-led group to talk to tamariki and rangatahi within those section 396 providers?

MS DICKSON: My understanding is not currently, but it is being considered as a future improvement on the quality assurance process.

MR McCARTHY: Okay. And you see there there is an annual care partner reflection? Do you see that?

MS DICKSON: Yes.

MR McCARTHY: Are children – is it required for the quality assurance employees to talk to rangatahi and tamariki during that process?

MS DICKSON: No, the answer would be the same.

MR McCARTHY: I wasn't quite sure about the two-yearly cycle; has that been developed yet?

MS DICKSON: It would be an iteration of an existing process of review, so there have been, in the past, review processes.

MR McCARTHY: So are you saying that you imported the quality assurance process from Te Kahui Kahu? Is that what you're saying?

MS DICKSON: So ongoing monitoring after approval was already part of Oranga Tamariki's role. This approach has been developed more collaboratively with providers, but it reflects some features that would have been already in place.

MR McCARTHY: Sure. You mentioned that this was developed in accordance with care partners and do you recall our discussion at the outset about tamariki and rangatahi being at the centre of decision-making? Was any thought given to including them in the design of the quality assurance process?

MS DICKSON: I couldn't answer that directly but what I would want to say is that there is a large body of insights from tamariki and whānau experiences which all sorts of aspects of the work under way within Oranga Tamariki draws from, as well as, in some cases, also ongoing design work with rangatahi. I couldn't say specifically for this piece.

MR McCARTHY: Do you think that they should be involved in the design of this process?

MS DICKSON: I think that those who have experienced care, are in care should be as involved as we can enable them to be in all processes that relate to them.

MR McCARTHY: So there is an existing two-yearly cycle. Do you know if rangatahi and tamariki are spoken to during that process?

MS DICKSON: I believe not, but I would have to confirm that.

MR McCARTHY: Okay. If we can scroll down to page 11.

MS DICKSON: I might just check if any of my colleagues know? No?

MS CHASE: From a section 396 perspective, we have whānau, hapū and iwi who whakapapa to the tamariki in care, so the partnerships and engagement with them, they have designed and commissioned their whole process all the way through, so their engagement around, and tamariki be involved in all of that process has come from them as a whānau and then representing their voices and rangatahi being involved in that, but when we talk to the whole of a section 396, I don't want to confuse that, so kind of think there's two responses, almost.

MR McCARTHY: I guess maybe it would be clarified if we look at this document. So this is, this is on the screen now? So if we look at the tamariki and whānau section, you can see there – actually, we'll begin at the beginning – the Partnering for Outcomes regional team,

it seems to have a well-developed role. It says "manage relationships with partners as first point of contact, co-lead partnership touch point engagements", I won't read it all out.

MS DICKSON: Yes.

MR McCARTHY: You see there's a care partner. The care partner's role is to share insights and information at partnership touch points and annual care partner reflections, co-lead partnership touch point engagements. When we go and look at tamariki and whānau, have their voices and experiences heard throughout the cycle, then it says:

"Detail of role within quality assurance cycle: Still in development/to be determined."

And then if we look at iwi Māori, there's the same italicised comment:

"Detail of role within quality assurance cycle: Still in development/to be determined."

So again going back to our original discussion, do you think it's acceptable that the voices of tamariki and whānau and iwi Māori appear to be tacked on to this quality assurance process instead of being centred in the decision-making, like we spoke of at the outset?

MS DICKSON: So if I could just echo Ms Chase's comments that as a subset of care providers, I don't think that those comments are as accurate a reflection of the engagement that's happening with iwi and Māori care partners, but, yes, on balance, I think that there is significantly more work that needs to be done and those perspectives should lead, not lag, in quality assurance.

MR McCARTHY: Thank you. I'm rapidly running out of time, but I've got a couple more questions. We didn't have time to discuss fully the Whakapakari example but one of the issues that arose and seems to be a consistent theme in the section 396 providers is in our period, is that they weren't funded appropriately and that affected the quality of the care. That's a natural consequence, isn't it, if they weren't funded?

MS DICKSON: I might ask the Chief Executive if he wants to...

MR TE KANI: Yeah. It would be a natural consequence. In my evidence, I make it clear that if we start – if we do move to a locally -led model, what comes with that is the ability to well resource those who are going to be delivering those services and I think what we've seen, and what – I won't use, lack of funding as an excuse though. What we've seen over the last two days is horrendous and no lack of funding is an excuse for what we've seen.

But, as we move forward, we do have to be mindful of the need to adequately resource the services that we devolve.

MR McCARTHY: Thank you, Mr Te Kani. I guess that brings me to my next question, how do you monitor these providers who are receiving an appropriate level of resource?

MR TE KANI: Yeah it's – so we do monitor that on a regular basis and if I can just make some points about it. When Oranga Tamariki was established, it received significant investment in 2019 and, to contextualise it, we had an operating budget of around $394 million and then, literally, overnight went to $1.4 billion. If you can hold that scale of investment in your head for a minute, it's quite a sizable increase over a short period of time. And what then flowed from that is a subsequent – a significant investment in our partnership and our partner approach from 2019 onwards. The focus for 2019/20, 20/21 was to support our partners to deliver the work that they needed to do, therefore, the focus there was on monitoring the expenditure of their resource.

Today, for 21/22, we're moving to a much more outcomes-based model understanding the return of that funding for the delivery of the benefits for our tamariki, so it's quite a shift.

MR McCARTHY: Right. I just wanted to finish with a final series of questions and it's about oversight provided by the media. Yesterday you discussed with my colleague, Ms Toohey, about the incident at Te Oranga, the residence in Christchurch. There was significant media coverage of the Hawke's Bay uplifts. You'd agree with that?

MR TE KANI: Acknowledge that, yes.

MR McCARTHY: You might not be aware of this, but during our contextual hearing, we heard from Dr Oliver Sutherland, and he was, I guess, the director of ACORD, which brought media scrutiny in the 1970s and that led to a number of quite immediate reforms. Now, the question I have for is you that we discussed before about it requiring a long time for Care and Protection residences to shut, but it seems that if there is media attention brought to bear on an aspect of the system, that change can happen quite rapidly. Would you agree with that?

MR TE KANI: Not necessarily. The signalling to closing the residences has been well signalled over many reports, so the expert advisory panel recommended that, the Ministerial Advisory Board recommended that, too, and that's independent of any what I would call sentinel events driven by the media.

MR McCARTHY: But you would agree that the sentinel event around Te Oranga, the result was that it shut, and it remained shut?

MR TE KANI: I would absolutely acknowledge that, you know, but for that media article, we then acted on what we saw to assure ourselves of the safety of tamariki, yes.

MR McCARTHY: I think that's another aspect that's quite troubling, is that you had a whistle-blower in the example of Te Oranga who felt it was more appropriate to go to the media than to bring their concerns – or have more faith in going to the media than going to, I guess, for lack of a better term, higherups within their organisation to effect change. Does that concern you at all?

MR TE KANI: It does, and that reflects understandably how that staff member feels but also the culture that they were operating within. What's really important for me, for us as a leadership team, is that we create the safe, transparent and open channels for our kaimahi to bring their concerns to me directly, or any number of leaders directly, without fear of repercussion. And, in that specific example, without getting into the details for privacy reasons, of course, for those staff members, it's fair to say those actions were a result of feeling that they couldn't bring those issues to the attention of their senior managers.

MR McCARTHY: And just taking that a step further, obviously, it was the right decision to shut that residence down, but you just said that it was important to develop a culture of bringing issues to bear to the senior managers.

MR TE KANI: Yes.

MR McCARTHY: I guess an unintended consequence of the result of Te Oranga, instead of training and so forth, is that it might actually have a chilling effect on complaints being brought, given that the residents and the employees in those residences appear to not be employed any more.

MR TE KANI: I think you've made a fair point about the chilling effect and if I can speak to that for a minute, and this isn't an excuse, but that's an acknowledgment that staff in that particular residence wasn't well supported, did require support for training and health and safety and were often making those concerns known about what they required. Again, that doesn't excuse their behaviour, but my substantive point is without supporting those staff and the mahi that they do, an unintended consequence could well be the harm that we saw inflicted in those videos. So when we think about the reasons behind closing the residences, in addition to keeping our tamariki safe, was also to do with our view of, actually, the need to support our staff to keep them safe as well.

MR McCARTHY: And, just a final question, you've agreed that the level of support and training was important and there are still Care and Protection residences. I'm assuming that there was a significant uplevel in training for the remaining staff at the other residences? Would that be correct?

MR TE KANI: What I would say is there was a focus on safety and a focus on support of staff. Of course, we can always do better, and I've acknowledged that. However, to be transparent and open, we still have work to do to improve the support we provide for our staff in both our Care and Protection residences and our Youth Justice residences.

MR WHITCOMBE: And there's quite a bit of work that has happened over the course of the last year and a half to establish a core curriculum for all of our residential staff and it's role specific. There's different aspects of the curriculum for different roles, whether you are a team leader or a case worker or a youth worker. The curriculum does include aspects of neurodiversity, training of trauma-informed practice and there's an initial three-week period of training and then other modules of learning are added to that over the next two to three months that have to be completed by that time and then within six months. The establishment of much stronger supervision practice is also part of the response.

MR McCARTHY: So we've heard that high needs individuals go into these settings, and you've said that there's training, ongoing training. Were any specialist staff with specialist skills brought in?

MR WHITCOMBE: Yeah, I mean, an example of that, we received a report that was tabled yesterday from Dr Enys, who has been a part of some training at Epuni, for example, and some of the training is delivered internally.

MR McCARTHY: Sorry, I think you misunderstood my question. I guess what I'm saying is not the trainers but the employees themselves, the day-to-day care of the residential staff, were staff brought in to supplement the current labour force while they were going through their ongoing training.

MR WHITCOMBE: So the initial training curriculum is delivered for those staff as they come in and there's certain things that they have to do before they start working directly with young people and it is a – what you're alluding to is the balancing act of needing to have staff caring at the same time as delivering training and creating the time and space for that training to occur. And that remains a challenge, but it also remains something that we're constantly looking at and have quite a number of staff having worked through the curriculum.

MR McCARTHY: Those are my questions.

CHAIR: Thank you, Mr McCarthy. Are we moving on to a new topic now?

MR McCARTHY: Yes.

CHAIR: I'm just wondering if Commissioners have any questions arising out of that particular section. I sense one coming from my right.

COMMISSIONER ALOFIVAE: Thank you, Mr McCarthy, for leading us through that. Mr Te Kani, can I just ask just a couple of systems questions, if I may.

MR TE KANI: Sure.

COMMISSIONER ALOFIVAE: We've heard a lot about the monitoring and oversight internally but also your section 396 providers and the acknowledgments that there's still a lot of work to go and you're working on it, but is one of the issues the IT systems, the fact that you're all on different IT systems and if it's not interoperable, if they can't talk to each other, you're always going to have quite a big margin for error not picking things up, not knowing what you don't know, which will always put Oranga Tamariki on the back foot?

MR TE KANI: I understand the question. Now I've got to team that will answer this. I need to shake them because they can speak about this for a very long time, so go for it, Nicolette.

MS DICKSON: So, yes, so one of the areas of the future direction plan is exactly that point, that we have a range of datasets that don't speak to each other and, to be honest, are outdated. We've talked a lot about CYRAS already. So there's two – there's three, actually, improvements that have already been made and more planned, so one is a tool called Whiti. I think we've referred to it in the notice. That is intended to create greater visibility for social workers around core activities day-to-day, any managers and supervisors to have real visibility about, you know, core expectations around visiting and whether that's actually occurred, so it's a tool to help real-time management of social work priorities.

There's work progressing between providers around a data exchange where information is able to be shared and one of the purposes of that is to create greater surety around the way care standards are collectively met by our efforts, our social work efforts and provider efforts, and the last example I just give, which is an internal one around our Oranga Tamariki approved caregivers, is a new case management system called the caregiver information system, which has been redesigned with both, for usability and to be able to tell a more connected story about caregivers and the care they provide to children, but also to extract more quality information. So, for example, in our next annual response to the ICM, we will be able to provide more structured information around caregiver support. So all of those things are – some of them are well advanced, others have a lot more work to do. The big one is our case management system and I'll just be honest, that's probably the hardest, biggest investment, longest challenge.

COMMISSIONER ALOFIVAE: And the most expensive to invest in.

MS DICKSON: Absolutely.

COMMISSIONER ALOFIVAE: A follow-up question from that, which is around your workforce development and thank you, Mr Whitcombe, you've made lots of comments around the increase in supervision and the things that have to be covered. I'm thinking broader across your child protection ecosystem and we've heard a lot of evidence from survivors at our different hearings and our private sessions, fono, hui, wananga around, it takes – that when abuse occurs, they don't always report it straightaway, and I think it would be naive for any system to assume, so I'll use a worst-case scenario, multiple rape today, reported tomorrow, and that it takes time because sometimes – and we've heard this a lot, sometimes a young person didn't even know that it was wrong or what was happening, what was actually happening with them, and research has shown us, on average, 20 years to report something quite significant. Can you just, if you're able to, give us a snapshot of what any workforce development plans or strategies that you actually have to be able to address that?

MR WHITCOMBE: We have a programme of work at the moment which is called our workforce strategy and it – you talked about the ecosystem and that's the right way to think about it. Social workers are a core part of the response to tamariki and whānau but they're not the only part of that ecosystem at all, there's caregivers, there's youth workers, there's a range of professions. So it's fair to say that that project is well under way, but what – but that it hasn't landed yet.

I've come into the role about four months ago and I see it as integral in terms of working, not just internally within Oranga Tamariki but beyond, in driving a workforce strategy and lifting the voice of social work but lifting the professionalisation and quality of practice across the system.

I just also want to say something about your comments in terms of safety and the time that it takes. We have a long way to go, as a country, around safety being an expectation. It has to be an expectation, not an assumption and – so there's something in moving away from assumed safety and the responsibilities on all of us, wherever we are within the system, to increase the eyes and ears and responsibilities on all of us around safety.

So that's – that I call out because I see that as part of a workforce strategy approach as well.

MS DICKSON: The only thing, if I could add, just as some of the partnership work that has started, is – still more is needed with tertiary providers, so in terms of the wananga, in particular we've got two examples. We've talked a little bit about Tu Maia, which is our

cultural capability programme. We've also got a bicultural supervision programme – I mean, the professional supervision of social workers – and we are engaging with the Social Workers Registration Board and have plans to engage with social work schools, we have existing relationships, but to think more about what is it in that core social work education that prepares people to come out in whatever field of practice they choose to be with that sort of child lens, the lens on child well-being, child safety.

COMMISSIONER ERUETI: Just briefly, this has emerged from the questions, is the – I am trying to get my head around the distinction between the 396 providers and delegated authority under the Act. It seems that for 396, that a provider could provide group home care or even contract to caregivers in homes to look after tamariki, but with the delegated function, they seem to be powers that are prior and more the sort of stuff that you would decide in the Head Office, I assume, about, you know, where to place a tamariki and whether you fund a provider, or even if you might recognise that an iwi could provide a Care and Protection residence service. Is that a distinction, a fair distinction?

MS DICKSON: I'm not sure if this is answering your question, so apologies if it's not, but I think the delegation opportunity is to look across the breadth of functions in the Oranga Tamariki Act and create deliberate opportunities for iwi and Māori community to take on more of those functions. So a very brief example would be iwi-led FGCs, so there a number of iwi who have a delegated function for FGCs and we know, through some evaluation work, the impact that has on experiences. I'm not sure that answers the question, which I think was more about who decides how that's delegated?

COMMISSIONER ERUETI: The impression I have is that for the providers, a lot of that work is really in the 396 space but they're not exercising these type of delegated functions that you're talking about, which are controlling an FGC, as an example, or deciding where a child should be placed. They seem to be more in the Oranga Tamariki – you know, we talked about the power resides in the centre, I think Mr Te Kani talked about, and those delegated functions still remain in the centre, rather than being devolved to Māori or non-Māori organisations.

MS DICKSON: By and large, so within sites. I mean, it's still locally, as opposed to nationally, so it would be within the site social work and management function, but there is provision and opportunities which can be leveraged more than is currently.

MS CHASE: Kia ora, I just wanted to speak to Te Atatū and enabling communities and the work that our Chief Executive talked about earlier on, Mr Te Kani, and that is about a new way of working with whānau, hapū and iwi so that we have assurance that whānau decision-

making happens across all points of our operating model, so not just preventing tamariki from coming into care, but from every single point – at a report of concern, what is whānau hapū decision-making or process that's happening there. If there's a whānau hui, what is that happening? We've also broken it down, FGCs, care when there's a decision about care and transitioning out of care. So we're doing across our operating model. At the moment, and we can provide it, we've done a stocktake of – for every single site across the country and it is one where they self-report, the site managers, whether they can say right now that whānau decision-making happens at those points. So some of them, for example, as Nicolette touched on, are able to report that they have delegated iwi-led FGC positions that we've delegated over, so that – and a piece of work that I'm responsible for is about designing and shrinking those components to our iwi Māori partners in the regions.

CHAIR: Yes, I think we discussed that the other day and I think this is where we reached a delicate point of to what extent the statute or the legislation allows this to happen.

MR TE KANI: Yes.

CHAIR: And we had a discussion about whether there was need. I think at that moment, it might be time for a cup of tea.

COMMISSIONER STEENSON: Can I ask a couple of questions or can I do that when we come back?

CHAIR: I think we should do that when we come back because we're running over time. So following break, what happens next, just so that we know?

MS TOOHEY: We just have the – a session on impacts, which I think we can do succinctly, and Mr Cooke has a short session which he is comfortable if it doesn't happen, but I think that the Commissioners had some issues that they – you communicated to him wanted to hear from –

CHAIR: That's right, and there are some other questions from other people, too.

MS TOOHEY: Yes, and he has that prepared, so I think the idea is I would be about half an hour, and he will as well.

CHAIR: Well, let's make it a short cup of tea. We will make it 10 minutes, so we don't waste any more time. Thank you.

Adjournment from 3.33 pm to 3.45 pm

CHAIR: Thank you, Ms Toohey.

MS TOOHEY: Thank you. Ata mārie(sic). This session, which I hope not to make too long, relates to the impacts of being in State care on the survivors.

CHAIR: I beg your pardon, Julia Steenson had a couple of questions she was going to ask.

MS TOOHEY: I'm sorry. I do apologise, I'm sorry.

COMMISSIONER STEENSON: Thank you. I shouldn't be too long. My questions are for either Mr Te Kani or Ms Chase in relation to the new plan with partnering with Māori iwi and communities. And just – I just wanted to understand things like, because, earlier, you mentioned that you'll be working for consensus in those spaces for mana whenua, and we know that areas like Tāmaki Makaurau, where there's 19 iwi, and it's very difficult to ever get consensus in those spaces and so how that might work in terms of a hard stop, who makes the decisions ultimately and the timing on those, because they can drag on for years.

MS CHASE: Yes, I'm well aware of our internal iwi Māori politics, and it won't be for us, as Oranga Tamariki, to make those decisions or develop those relationships. It will be about them being able to discuss what that looks like.

MR TE KANI: Just to follow up on that, Commissioner. From my perspective, the starting point is our whānau, because, ultimately, that's where the first point of connect is with our tamariki into whatever the system is. So where we want to get to, in my view, in working with whoever is iwi or hapū groups or Māori providers, are those entities, or institutions, if you want to call it that word, who have the ability to have that relationship as close to the whānau as possible. Because, ultimately, what we want to do is not create, as we discussed earlier, a brown bureaucracy. The best results we've seen or the best outcomes we've seen is the ability to get those services and supports as close to whānau as quickly as possible. So whatever models we develop and whatever we do, whether it's with iwi or hapū, that's how we're thinking about design. Is it possible to have a Tāmaki Makaurau-wide agreement about how we might approach child policy, child welfare, the care of tamariki in Oranga Tamariki's care? Possibly, if there's a process that we work through, not picking on Tāmaki Makaurau but work through with the 19 or so groups here towards a shared vision of what their future might look like, I'm optimistic about that. It won't be fast but, equally, it doesn't need to be, before we make that shift or continue to do the work we need to on a day-to-day basis, if that makes any sense. So we won't – the work won't stop whilst we do what we need to do with our partners, with Māori, towards that shared vision; it will take as fast as it takes.

The models will be different, they will be different depending on the visions and aspirations and, to be honest, and I know some will be watching, the level of comfort some will want to take towards some of the services that they might wish to provide. Recognising there's so many services in the suite of the mahi that we do in Oranga

Tamariki, then you add into that all the other social sector entities that have a relationship with whānau and tamariki and then it starts to scale out and get quite big.

What I'm encouraged by, though, is that there are already – and I think Frana's made this point – a number of entities, whether we call them Māori providers or urban authority groups or commissioning agencies, that are already doing work in the social sector space. So at one level, we're not starting from a blank piece of paper. We just have to go at the pace we want to go to and work our way forward.

The real principle, sorry, for us is – we're not going with a solution as Oranga Tamariki. We're not going in with, "Here's the whizz bang thing that needs to – that we want you to do". It's starting from their perspective and working our way backwards.

COMMISSIONER STEENSON: I understand that. I guess I'm just trying to say in five, 10 years, if there's no agreement, does that mean we come back and we still don't have what we need for these tamariki?

MR TE KANI: So if there is no agreement five or 10 years, what it will pragmatically mean is that Oranga Tamariki will continue to operate the way it does, if that makes any sense.

COMMISSIONER STEENSON: Okay.

MS CHASE: If I can just – in terms of the problem that we're trying to solve around the care of tamariki Māori being cared for by their own whānau, hapū and iwi, we are looking at the section 396 through the eyes of the whakapapa of the tamariki. So we know, based on all the mapping that we've done and that's what's built up a particular iwi for being able to be responsive to their own tamariki, is that in Tāmaki Makaurau there are 1,400 tamariki Māori that reside here. Of those 1,400, their natural whakapapa links, 50% of them whakapapa elsewhere, and so with the other partners will be the responsiveness around how they're supported in the whare they live in here, if they're remaining in Tāmaki, which tamariki are living in Tāmaki Makaurau that might be in a motel right now or, like, in a not good place and how quickly can we connect them back to their own people who will care for them.

COMMISSIONER STEENSON: That helps me, actually, Ms Chase, with my following question, which is around tamariki who don't whakapapa to the rohe that they live in, and also urban Māori who don't have any connection to who their iwi even is and how that would be envisaged as being managed.

MS CHASE: Yes, so the whole purpose of standing up each section 396 iwi partner within their own tribal rohe was them to understand and be able to – the state of their tamariki around them, build their model up and cater and care for the kids within their rohe and then as we

stood up each partner across who was doing the same, they would be able to connect to each other so that then, and we have actually – apart from Covid, the things that we have been doing, and you'll see some media footage, if you look, is that we have a whanaungatanga hui where all of those iwi come together and we strategically plan together a wananga process once every six months exactly what our approach will be, where we're at and what our aspirations are for design. So there's been a lot of thought and already engagement, there has been tamariki that have been kind of – come from out of Tāmaki Makaurau and a solution in Taranaki, Ngāti Ruanui has happened almost overnight by those connections.

COMMISSIONER STEENSON: Okay, so just step me through it so I understand a little bit better. For a tamariki who is based with their whānau in, say, I'm making this up, of course – Tāmaki, but they whakapapa to, say, Taranaki, how would that work?

MS CHASE: So currently, right now if they whakapapa to Taranaki, there will be a section 396 which would be – in Taranaki, the only one at the moment is Ngāti Ruanui, I don't mean "only" like that.

COMMISSIONER STEENSON: Kei te pai.

MS CHASE: So, currently, those tamariki would be supported by Oranga Tamariki, so Oranga Tamariki is providing it currently, but in the future we want to be able to have the support mechanism come from Ngāti Ruanui themselves if they whakapapa to them, and the relationships between each of those iwi would be the relationship between those that – they would get extended support of all, so they would support all.

COMMISSIONER STEENSON: Within their rohe as kaitiaki, manaakitanga.

MS CHASE: Yeah, but they would ensure like urban Māori so, and, of course with urban –

COMMISSIONER STEENSON: So the tamariki would stay in that rohe near their whānau but be supported by their iwi?

MS CHASE: So the support would come by the connection to culture and identity, so the day-to-day support, like making sure that the whānau's house is warm, the kids have got what they need and that they're being supported, that would happen locally by the section 396 within that rohe, but there would be a connection so that each tamariki and their whānau have an opportunity to – their feet touch their whenua, they know who they are, they don't leave care not knowing who they are, where they're from –

COMMISSIONER STEENSON: Thank you. That's helped me significantly understand where you're going with that model.

MS DICKSON: Could I just add another layer to that, so alongside the 396 network of whakapapa connection across the motu, we also have a range of roles, some of which are roles of iwi staff based in Oranga Tamariki sites and their specific role is to address exactly that point as well, to help do the identification and connection through whakapapa, recognising that that social workers should have a core skill around identifying whānau and extended whānau, but knowledge around whakapapa is a taonga, it's not appropriate necessarily for the Crown to be in that space, but these roles are also offering a secondary, sorry, an additional network of connection alongside the 396 providers.

COMMISSIONER STEENSON: How many of your social workers would have that cultural competency to do that?

MS DICKSON: So it's not social workers, so most sites it's – sorry, I didn't explain it very well. Most sites will have a – we call them Kaiaranga-a-whānau, and that role is a role that would be either from iwi or mana whenua would have a role in identifying the person or the capabilities or someone who had those skills who could work alongside or within Oranga Tamariki to help facilitate some of those connections for individual tamariki.

COMMISSIONER STEENSON: And there's one for each rohe?

MS DICKSON: Broadly there's one – largely, most sites now have one.

MR WHITCOMBE: There's 62 across the country.

COMMISSIONER STEENSON: Thank you very much, kia ora.

CHAIR: Thank you. Yes, Ms Toohey.

MS TOOHEY: I want to begin by just summarising some of the evidence of the impacts of being in State care has had on some of the survivors. The evidence the Commission has received is that those impacts include a trajectory to prison, a trajectory to gang involvement, a trajectory to suicide and, in many cases, a lack of education. And without going through all of the survivor voice on this, I think that you'll be aware of some of the stories that have been discussed in evidence with some of the other agencies. For example, the witness who, when we questioned the Ministry of Education, was exempted from the legal requirement to attend school because that suited the residence when he wasn't consulted about it. And I think you'd accept, Mr Te Kani, that the overall picture of education in State residential care throughout the scope period was inadequate.

MR TE KANI: On the basis of the testimony we've seen, yes.

MS TOOHEY: The Chief Executive – oh sorry, the Secretary for Education, Ms Iona Holsted, gave evidence to the Commission last week of the negative impact on children who fail to receive an education. And I think you'd agree with her evidence about that, that without it,

you have very limited opportunities to have a vocation, a trade or a profession and, with that, your income earning potential is also lower.

MR TE KANI: I agree with that, yes.

MS TOOHEY: We talked before about Dr Delmage, and I don't think I need to bring this up, but I'll just summarise part of his evidence, which is MSC0008159. And this is an expert opinion provided to the Commission. And at page 11, he addresses the impact of trauma. And I think you'd agree with me that in the scope period and now, children coming into State residential care will have experienced some form of trauma in terms of their journey to get there?

MR TE KANI: Yes.

MS TOOHEY: And in terms of the evidence that we've been going through the last couple of days, in terms of the scope period and the trauma that children suffered from abuse in State care, that's another form of trauma that occurred for those tamariki?

MR TE KANI: Yes.

MS TOOHEY: This is what he said:

"Brain structure abnormalities have been reported in those experiencing childhood trauma, extremely common as part of the background history of tamariki children in both Care and Protection and Youth Justice residential settings, as well as functional differences, which are themselves linked to violent crime, with some studies showing an 11-fold increase in the likelihood of being arrested for an aggressive offence for young people traumatised in early life. Mistreatment is also associated with psychological problems and with changes in the hypothalamic pituitary adrenal axes. Overactivity of this hormonal axis can result in an increase in impulsive aggression, whilst underactivity can result in non-responsiveness to punishment and increased instrumental aggression."

In other words, the impact of trauma on children can be extremely significant, I think you'd agree with my summary there?

MR TE KANI: We agree with that, yes.

MS TOOHEY: I want to very briefly outline how some of our survivors ended up on a trajectory to prison. One of our survivors, one I referred to yesterday, and this is WITN0080030, at page 2, observed:

"Once you are in it" – talking about residential State care – "there were huge obstacles to success. The vast majority of people who went through that institution have seen prison time. Many would never have been to prison if their culture hadn't existed. We became products of an environment overseen by the staff."

I'm going to give you an opportunity comment shortly on these, I just want to run through some examples.

MR TE KANI: Okay.

MS TOOHEY: Another witness – this is WITN0245001 – who was in care and discharged in 1990, says at paragraph 227:

"Since my discharge from Social Welfare care in 1990, I have basically been in and out of prison. I have spent about 18 years in prison, all up, on and off over my life. All the violence and beatings that I was subjected to have made me extremely violent and battle-hardened, which I have taken out on other people. I learned early on that no one would help me. When I reported incidents of violence, beatings and sexual abuse to staff members, this just resulted in me being told not nark and being beaten and bashed."

He goes on:

"I am the only person in my family to do extensive prison time. My father and his brothers went to prison once. I have been repeating this for over 34 years."

Then just going on to, there's another survivor who – this is WITN0342001 – who explains that, at paragraph 54, that he escaped from Borstal and stole guns but was caught not long after by the Armed Offenders Squad:

"I got sentenced to four years and was sent to Kaitoke Prison but they didn't want me so I got sent to D Block, maximum security at Paremoremo. I was really young, only about 17. I did two years and got out when I was 19. For me, the rest of the 1980s was a revolving cycle of crime, jail, escape or release and then reimprisonment."

That witness goes on to explain that he spent a total of 30 years in prison. Now I want to come to another witness, WITN1232001. You might recall that yesterday I raised with you, early on, a child who was truant from school because and was – because he was bored – and got taken into Epuni and I mentioned to you that he spent 40 years in prison. And he talks about how that journey into custodial care began. He says at paragraph 8:

"None of my family have ever been involved with the state child care system, criminal justice system or Police except for me."

At 46:

"I remember starting to steal stuff when I ran away."

He's talking about running away from care:

"This is when I think my resistance to being bad and committing crime was broken down. I started stealing money from milk bottles and clothes from backyards. It just

became normal. Crime and violence was normalised when before it was actually totally alien to me. I'd never seen violence in my family home."

And he says, he goes on to explain that he "spent a total of 18 months in Epuni over three stints and went from someone who thought wagging school must be a serious crime to burglary and car conversion committed in the course of running away from Epuni when I was not kept in a secure block. I formed associations and friendships with some of those who were to become the most notorious and serious criminals in the land. I was educated in the ways of crime."

Now, I will give you an opportunity to comment on those, but, first, I want to raise with you the care to custody report, which I now ask is brought up, MSC0008257, and if we go to page 4. This was a study prepared by an independent research company at the request of the Commission and involved a study of just over 35,000 names. Those names were provided by Oranga Tamariki. We talked before about some of the difficulties and the way that the data was recorded.

MR TE KANI: Yeah.

MS TOOHEY: I'm not suggesting that's your fault, given the historic nature of the scope period. Just so you're aware of the context, those names were provided as transcribed handwritten entries from the registers of State residential care homes in the scope period, as well as Whakapakari and Moerangi Treks. So again, by no means a full picture, I think you'd agree, of those in State residential care, but still, I think you'd also agree quite a significant sample of children.

MR TE KANI: Indeed, yeah.

MS TOOHEY: Those in the dataset, those names included those born between 1940 and 1989, so people who are now aged between 33 and 82. And as you will see on this page, Synergia, the research company, matched the Oranga Tamariki dataset of people who had been in State care with people in the Integrated Data Infrastructure, which I think you will be aware is the combined database of government records managed by Stats NZ.

If we go to page 8, you will see – I'm just summarising here, sorry one more page down, thank you – that Synergia grouped people in the dataset by five-year groups to try and get an accurate picture of what was happening per five years. They also matched the people who'd been in care to a comparison cohort of the general population by age, gender or sex and ethnicity. If we just highlight the top half of that page 8, and for those who cannot read it, this is the conclusion that the study reached as to the people who'd been in State residential care – the research showed that between 20% and 33% of people in State

residential care went to prison. Compared to the matched cohort by gender, ethnicity and age of people who weren't in State residential care, that was 1.6% and 7.7% of the general population.

I think you'll agree with me, Mr Te Kani, that those statistics are quite shocking.

MR TE KANI: They are indeed, yes.

MS TOOHEY: I want to now go to the next page. This demonstrates – if we can bring up 5.2, I'll just call that out. Now this is a graph, I'm going to attempt to summarise it for those who cannot see the screen. This is separating out those overall figures to look at the percentage, the estimated incarceration rate for Māori as opposed to non--Māori. And if we look first on the left-hand graph, you can see that there's a graph with a line at the bottom that represents the matched cohort, by year of birth again, sex and ethnicity, and that lower matched cohort, people who weren't in State care who are Māori, reflects that between 4.5% and 12.6% of the general population went to prison.

The upper graph reflects that for those Māori, same birth year, same gender who went to State care, that there was between 30% and 42% ended up in prison, so, again, reflecting an extremely high rate.

MR TE KANI: Yeah.

MS TOOHEY: And also reflecting an underlying high rate of incarceration generally for Māori. And then if we look on the right-hand side at the non--Māori estimated incarceration rate, for non-Māori, it's between 0.8% and 2.4% of the population who are incarcerated, but for non-Māori, between 15% and 30% who went – who were in State care were incarcerated.

I want to go now to the key findings at page 11. The summary, as prepared by Synergia, the research company, is that over the different five-year groups:

"People who had been in State residential care were usually about five to nine times more likely to be incarcerated than people who had not been in State residential care. Māori who had been in State care were usually around four to seven times more likely to receive a custodial sentence than the matched cohort, and non--Māori who had been in State care tended to be around 15 to 24 times more likely to receive a custodial sentence than the matched cohort."

Mr Te Kani, on Monday you said in evidence that information and data is a taonga and without data, there is no way to learn. Is Oranga Tamariki prepared to accept the data reflected in that study to help it make informed decisions about how to care for tamariki in State care?

MR TE KANI: Yes.

MS TOOHEY: Do you agree generally, Mr Te Kani, that these findings reflect a trajectory from the State residential care system, in the scope period, into prison?

MR TE KANI: Yes, I do.

MS TOOHEY: Do you have any overall comment on the findings?

MR WHITCOMBE: Yeah, I will just make a couple of comments. You know, those findings are really impactful, and I agree in terms of the taonga of that information, and how we drive, firstly, to enable tamariki to be with their families safely and have the supports there, how we drive towards not enabling them to come into a residential care facility, we know that that is not the best place for them. We sometimes refer to it as a fully funded failure model and, in terms of the response that we would want to have around tamariki.

And so I wanted to make those comments. I also really want to make a comment about how it is an all of system response that is needed in terms of responding. One of the biggest in here and now, one of the biggest correlating factors for entry into a residence is around disconnection from school and how the importance of that school relationship and learning becomes in terms of their future into a residential care setting. So that's just one – but one point that I'd like to make. We have – yeah, I'll leave it there, kia ora.

MS TOOHEY: As well as the Enys Delmage evidence, you've also referred to the expert advisory group report in 2015 and that outlines, doesn't it, generally that the importance of treating trauma in children, whether that's from abuse previously, the trauma of coming into care, or trauma from potentially abuse in care, is absolutely critical.

MR TE KANI: Yes. Yes, it is.

MR WHITCOMBE: This does not have to be an inevitability.

MS TOOHEY: Yes. Mr Te Kani, you said in your brief of evidence at paragraph 205, you referred to the future direction plan and you referred to the future direction being more culturally responsive and providing therapeutic and trauma-informed care, and certainly, Mr Whitcombe, you spoke to some of those initiatives in the training for trauma-informed. But I want to suggest to you that what's required for the therapeutic aspect of treating this kind of significant trauma that tamariki have coming into State care or who are in State care, is really professional help.

MR TE KANI: Yes, it is.

MS TOOHEY: A clinical psychologist or a psychiatrist, someone trained specifically to deal with the impact of trauma. Do you agree about that?

MR TE KANI: So on – it's definitely our view that we need to think, in terms of workforce strategy, having a real clear approach to having a trauma-informed skilled staff, not just

inside the Oranga Tamariki agency, but across those agencies, and I think my colleagues will agree with me on that, the importance of having teachers who are trauma-informed and skilled.

On therapeutic, yes, that is important, Ms Toohey, but as important or equally important is also cultural models of well-being and cultural models of care as well.

MS TOOHEY: Yes, absolutely. In the response, the NTP 418 that's been referred to – this is ORT0112365, we don't need to bring it up, but it just noted at paragraph 2.38 that the current need for psychological services for children in care is such that the child and adolescent mental health services cannot meet current demand. And you mention increasing your own psychological services. Do you consider that Oranga Tamariki has sufficient resources or do you see this as a whole of government issue in order to really provide the kind of specialist mental health care that is required here?

MR TE KANI: Yeah, so I'll – just briefly, if I can just speak to the Oranga Tamariki action plan, because I think that's really important to ground how we think about this response, Ms Toohey, because what's really clear is how, as a collective of agencies, we're clear about the requisite investments and capability required to support our tamariki and our whānau. Now, it doesn't rest all on the shoulders of Oranga Tamariki. I think we all accept and know that.

What is the next step with Oranga Tamariki action plan is the importance of all of the chief executives coming together to focus in on this. On Friday, you'll be seeing the Public Service Commissioner and I just want to make a quick point about that, because critical to our success going forward is the platform of Public Service reform that is now in place with the Public Service Act and what's important about that, and there's many aspects to it, is really putting at the heart of the Public Service a public sector Public Service ethos reconnecting the Public Service to our communities, to our whānau, to those people who we have to deliver services to, and Oranga Tamariki action plan, picking up on the question raised by Ms Toohey, is a platform of a number in the Public Service towards how we be better joined up and focusing in on our tamariki and our whānau.

MS TOOHEY: Just on that subject, under the Public Service Act, and I think you've done this with respect to family violence and sexual violence –

MR TE KANI: Yes.

MS TOOHEY: – there's been a joint venture –

MR TE KANI: Correct.

MS TOOHEY: – which I think is an actual legislated for plan.

MR TE KANI: Yes.

MS TOOHEY: And I think, with respect to that, there was a costing done of the – an actual figure, mathematical figure, I think was it $5 billion –

MR TE KANI: I can't quite recall the number.

MS TOOHEY: – something like that assigned to the social and economic cost of sexual violence and family violence.

MR TE KANI: Sexual and family violence, family harm, yes.

MS TOOHEY: Is the action plan that you talked about that's across agencies, the Social Wellbeing Board, at that level of a joint venture or is it something short of that?

MR TE KANI: It's a mirror of that, yeah, so our approach to how we work together is virtually the same, in terms of our accountabilities, in terms of the way we do work. There's different models; of course, the joint venture is a particular model. The Social Wellbeing Board, again, is a different model. There's a number of models under the Public Service Act that can be brought to bear, but the purpose of it is about joining up and focusing on how we deliver those services better to our communities.

MS TOOHEY: Alright.

MS DICKSON: Can I just make an additional point? I think the investment is also about recognising, so each of the survivor stories, the incarceration stories that we've talked about, they're not just individuals, they're within a whānau context and so I think it would be wrong not to just make the point that, actually, the investment needs to be in responses to the needs of tamariki, but in the contact of their whānau if this isn't going to continue, if the impacts that we've described today isn't going to continue into future generations.

MS TOOHEY: Yes. Do you mean – I think we would probably all agree in this room that investment into a whānau early and putting the equivalent amount of money as 40 years in prison, whatever astronomical cost that must be, would be far better front footed right at the start with whānau.

MR TE KANI: Of course.

MS TOOHEY: Do you think the action plan goes that far, Mr Te Kani?

MR TE KANI: It doesn't go that far just yet. The work we're doing around the assessments for those particular areas, so each area, housing assessment, health assessment, education assessment, we will get to as understanding in both a qualitative and quantitative way the cost of what we need for the services that need to be provided, and then we'll you know, to get to your point, where our focus is best placed to, if at all possible, support our whānaus early as possible in the process to avoid them coming into care.

CHAIR: Can I just ask on that, you talked about the social costs of violence; I think you were talking about family violence, sexual violence.

MR TE KANI: Family violence, sexual violence.

CHAIR: This sounds horrible but it's true, the actual dollar cost of those things has been assessed; is that right?

MR TE KANI: There was an economic analysis impact of that, yes.

CHAIR: There was one done a long time ago by Suzanne Snively, wasn't there? That was in the '90s, I think.

MR TE KANI: We can get it for you, Madam Chair. There's a more recent one in cost and impact for all of the Te Aorerekura strategy, which was the most recent family violence strategy.

CHAIR: So you've done it for that. Are you anticipating that that should be done for the cost of abuse in care?

MR TE KANI: We haven't done it for family violence. That was done by the joint venture –

CHAIR: Sorry, it's been done?

MR TE KANI: Yes, it has been done, yes.

CHAIR: Do you know if such an initiative is planned to cover the question of abuse in care?

MR TE KANI: No, I don't, sorry.

CHAIR: Do you think it might be something that's worth thinking about, to justify the investment that's only obviously going to be needed here?

MR TE KANI: No, absolutely, yes.

COMMISSIONER ALOFIVAE: Can I just ask a couple of follow-up questions to that, because we see very clearly you keep referring to a number of assessments that have to be done, so there are different levels that you outline in your future directions – there's your national level, then your regional levels, then, of course, you can break it down even more locally to your providers and whānau that you're working with.

We've heard a lot of evidence that that's all that ever happens is people get assessed and so there's a lot of information already available on whānau that is accessible to you right now and so is there an acceleration of how you do that?

MR TE KANI: Yes.

COMMISSIONER ALOFIVAE: It's one thing to do it at your national level, but at your regional levels, there would be a lot of information already available. So, I guess the question is, are we just repeating something that's already been done, so we're very good at describing the problem, it's how do you fix the problem?

MR TE KANI: Indeed.

MS DICKSON: I'd just reflect back to a comment I think I made on the first day, that government agencies have traditionally worked vertically in their own policy and assessment channels. I think the difference about the needs assessment work envisaged through the Oranga Tamariki action plan is not necessarily to go repeat a whole lot of assessment, but actually to bring that vertically held set of insights together in an integrated way. I think that is quite different for government. I think in the family violence space, we have some good examples to draw from. So I think that's the significance of the needs assessment in the Oranga Tamariki action plan.

COMMISSIONER ERUETI: We keep hearing about the need for early intervention and that intervention isn't early enough and that OT is waiting for things to escalate to the point where things are pretty poor by the time there is intervention. So I'm wondering, so here, like, Mr Te Kani, you said the next step is to look at where to prioritise where the attention should be, whether it should be prevention, early intervention, it seems that that has been a core kaupapa since 2015.

MR TE KANI: And earlier, yes.

COMMISSIONER ERUETI: And earlier, yeah.

MR TE KANI: Yeah, so for – if I could talk about prevention for a minute. When we talk about prevention, it is quite a complex child policy space, because it requires the collaboration of working across a number of agencies, of course, and I think we all know and understand that, and on that front, what the Oranga Tamariki action plan that agencies have all signed up to do is to really help us all collectively come to a shared view about actually where is these needs.

If I can just give you a real practical example, so, as we know, all agencies are struggling, for example, with housing and the increasing need for housing for our particular populations that we're currently working with, what the Oranga Tamariki action plan does for our particular cohort and our tamariki is get all those agencies together having a shared view of actually what do we do to support – what do we do collectively to then meet what we understand those needs are for our whānau and tamariki in those circumstances. That is just a practical example of how we will work in practice.

MS DICKSON: If I could also add, one of the things through Te Kahu Aroha and the future direction plan is a real clarity around a dual role for Oranga Tamariki moving forward and we've heard – we've talked a little bit about that, both as an enabler of community leadership and prevention, and as a high performing, highly trusted statutory service.

The experience you describe of things getting worse before help comes, I think sits where there's a gap between those two responses, so for me, what's important alongside our agencies is how we don't see those as two disconnected parallel transmitter, an integrated network of safety and support around tamariki and whānau who need it.

MS TOOHEY: I actually just had a couple of follow-up questions. I don't need much more.

CHAIR: Yes, indeed.

MS TOOHEY: Just in relation – I don't know who's best to answer this question of you three, but when you have the action plan coming into place, as you said, Mr Te Kani, there might be someone who has a housing issue, is there priority accorded as a result of the action plan to these families who are at risk of a child is going to have to be removed if the situation can't be resolved? In other words, can they jump the queue?

MR TE KANI: It's not as universal as that. What the Oranga Tamariki action plan does in its current form, recognising that it's quite focused in particular areas in particular agencies and some of the functions that they do, is more than just a commitment, it's saying, "This is what we're going to do collectively for this particular cohort in these particular circumstances". It doesn't mean, at this point in time, it's panacea to solve all the problems and I don't think it can be.

But as time goes on and we start to evolve and get better at working through the Oranga Tamariki action plan, we'll start moving on to other areas, if that makes any sense.

MS TOOHEY: Just contrasting it again to the joint venture, I might have this wrong, but I understood that the joint venture looked at the total economic cost, as awful as that is, and then allocated funding across all of the agencies to resolve it. Is it the same – or, first, do I have that right, and, secondly, if it is, is there funding for the action plan across all the agencies?

MR TE KANI: I can't speak to the funding allocation for the joint venture for Te Aorerekura, but what I can speak to is the expectation with this current administration of the Oranga Tamariki action plan is that the needs, responses are already what agencies are doing.

MS TOOHEY: So there's no additional funding.

MR TE KANI: There's no additional investment because what we're saying is, actually, this is all our core jobs, and we can do better collectively for a plan in this platform by bringing some of these things together.

MR WHITCOMBE: If I could add to that, and this is with my Chief Social Worker's hat on in terms of the advocacy role that I play, you know, our children need a disproportionate investment. We talk about disproportionality; we need a disproportionate investment in

their early years and in their families. I had a read of the Children's Act last night, 2014 Act, so that I could look at the extent of the – you know, the must -do or the may-do type language, and it is my view that the Commission could explore further accountabilities that would put onus across the system. As Oranga Tamariki has onus on it to respond and do the right thing, if we are true to the system response, then we need to explore stronger accountabilities.

MS TOOHEY: And stronger funding potentially for this group.

MR WHITCOMBE: And I think that we've heard as well, and I made some opening comments on the first day about implementation and different directions and different reports, absolutely the investment does need to follow. There needs to be leadership, there need to be a runway for implementation and there needs to be enduring accountability for things to be hardwired into the system, not on influence, not on – not just purely on influence or relationship but it needs hard wiring.

MR TE KANI: Just to add to the investment question you raised, Ms Toohey, this was clearly established by the Expert Advisory Panel's report, the criticality of investing in the child system adequately, and it was one of their core findings from their work, the underinvestment in the system, which then came into the establishment of Oranga Tamariki and its subsequent investment.

MS TOOHEY: I'll finish there, Madam Chair. I think Mr Cooke has some questions.

CHAIR: Thank you, Ms Toohey. Dr Cooke. Your last stand.

DR COOKE: Just as a matter of housekeeping, I'm advised that there's been discussions between Ms Spelman and the Crown about the start time tomorrow, which – and I could be corrected – I believe to be 9 am.

CHAIR: That would sound right because that's what we've done for the last almost two weeks.

DR COOKE: Just to make sure, to make clear our understanding about that. I would hope to be finished by five, or thereabouts.

CHAIR: We'll hold you to that.

QUESTIONING BY DR COOKE: Yes. The first thing I'm going to focus on – there's one matter that I need to raise which came out of the foster care report, I'm going to look at some training and supervision matters, but I first just want to raise, put on to the record a document that would be relevant to the discussion that occurred this morning in relation to training and manuals and sexual abuse and that is a document in the bundle at NZP0046581, which is an MSD report which was on allegations of abuse that occurred in a particular family home. I would refer everyone to pages 13 to 16, where there is a

discussion from a senior manager as to appropriate – as to policies that were applied at the time and where the understanding was about developing policies relating to sexual abuse.

Now, my first question comes out of the foster care hearing, and it concerned statements that were made by two of our experts and one survivor. The experts were Dr Calvert and Dr Cargo, and I asked this question of Dr Cargo:

"Sometimes we understand perhaps that caregivers are told, 'You're only a short-term caregiver, you're only going to have this pēpi for seven days or this infant, two-year-old or three-year-old for six weeks so hold back'."

We were talking about that in the context of attachment, because the feedback from some of the survivors was that they felt that they were placed in environments that were not warm, were not nurturing, okay?

And Dr Cargo answered: "Yes, they don't get attached." And I said: "And that occurs in the context, of course, of a child having been removed and having suffered that trauma." Dr Cargo answered: "And what does that child want? Attachment, relationship."

And there was an acceptance – well she went on to say that:

"Longer term caregivers who have been in it for a while don't necessarily ascribe to that, but what we know is that if you've been removed from anybody and it doesn't matter – and Dr Calvert mentioned that as well – it doesn't matter what kind of relationship, it's still loss and grief. Then you put somewhere for, depending on how old the child is, as far as they know their parents are dead, that's what it feels like, then there's no one to hold and comfort you and say, 'Hey, it's going to be okay. It's going to take some time but it's going to be okay'."

So the theme, what I want to put to you is that that evidence was coming from foster – sorry, from survivors and their experience, and confirmed by the experience and knowledge of Drs Calvert and Cargo – that some caregivers may have had a message that they shouldn't be as outwardly nurturing and loving towards children who came into their care because the children were not going to be there for very long and, therefore, it was a danger, both to them and the child, should they form an attachment.

Do you want to comment on that, as to whether that may have been a message that was conveyed by social workers to caregivers?

MS DICKSON: I think it may have been a message that was conveyed. I think it speaks to the very skilled nature of care provided, that needs to be provided particularly by caregivers who are not whānau to find that balance to be able to show genuine love, warmth, affection, care, but recognise that that may be as part of a child's journey to their own whānau, and if

I could, I wonder if this is – yesterday, we were trying to explore the stability of placement issue and we do have the data that talks a little bit about numbers of placement changes, if this was a helpful place to share that. Otherwise, we can provide it in writing.

DR COOKE: It otherwise would be, but time is not going to allow us but if that could be provided to the Commission?

MS DICKSON: That's alright, we'll provide that.

DR COOKE: And the other side of the coin is some caregivers who may have thought, "We are in a position to commit ourselves to this child", but only to discover soon after or later that that wasn't the case, and the child is then removed, very likely for good reasons, returned to whānau, etc, and, of course, there is then that corresponding feeling of disappointment and loss. Do you accept that is also another part of the dynamic?

MS DICKSON: Yes, I do.

DR COOKE: Okay. Now I want to bring up MSC●●●8●84. This is the – there we are, it's up already – Kahu Aroha Report. I want to use this document and some of the comments in it and I'm going to ask if Zita can bring up page 12 to – and this is about working collaboratively with Māori and other organisations, and it says that the purpose of Oranga Tamariki must be clarified. I suppose you are as I understand it, Oranga Tamariki accepts the thrust of this report; is that correct?

MS DICKSON: Fully, and it's been the foundation of the future direction plan.

DR COOKE: Okay. I want to focus particularly on two things. One is A, and I'm going to address this in a minute with Mr Whitcombe, it's the role of the Chief Social Worker shall be restored as a central role within Oranga Tamariki, and then B, which is the question of training, but I'm more interested in the question of supervision at the moment. So that will be the focus.

And if we could then turn to paragraph 64 and if we could bring that up. This is telling us that part of the issue identified in that report is the devaluing of the social work voice within Oranga Tamariki, resulting in a shift away from professional social work as a core work. There's been a diminishment of the influence of the office of the Chief Social Worker under the 2●17 OT model and just being one of at least 11 voices at Deputy Chief Executive level and that was a contrast to the situation at the time of establishment when the Chief Social Worker was a core role in the leadership team.

And what I want to draw out from that is the proposition that this identifies a failure on the part of the organisation to hold to its heart the fact that it's a social welfare/social worker driven organisation. Mr Whitcombe, would you accept that to be the case?

MR WHITCOMBE: Yes, I would.

DR COOKE: Can you tell us briefly why there was, at a policy level, a diminishing of the influence of the office of the Chief Social Worker, and because I want to put that in the context of your role, which, as I understand it, you would be the – or the person who holds that position, as being the leader of social work direction, in terms of good practice throughout the organisation, both at a policy -driven level and at the application of social work practice at regions and sites. Is that correct?

MR WHITCOMBE: Yes, that is correct.

DR COOKE: And if there has been a diminishment of that influence for a period of time, then that would mean that the application of good social work practice would also diminish at the sites and at ground level in dealing with whānau who come into contact with Oranga Tamariki. Would that be a correct inference?

MR WHITCOMBE: I think the Te Kahu Aroha report articulates it in the reduction over time of investment into a frontline in terms of professional supervision, in terms of learning and development opportunities, and that has fluctuated at different times, but it certainly speaks to that diminishment.

DR COOKE: Can we go to paragraph 66 and just bring that up? There's the recommendation:

"There's a need to reclaim the primary role of the Chief Social Worker as the leader of the profession. This role must work in close partnership with the Chief Executive and be responsible for the re-professionalisation of Oranga Tamariki."

And I see you're sitting next to your Chief Executive. I don't know whether that's for appearances sake or whether it is a reflection of the fact that you are now working at the leadership table.

MR WHITCOMBE: I would be really clear that it's not for appearance's sake. It's – every experience that I've had in the months that I've been in the role has been around enabling that voice. Alongside myself, Nicolette Dickson, as a DCE (Deputy Chief Executive), is a registered social worker and one of our other DCEs is also a registered social worker and that's been intentional.

DR COOKE: I take it you are a registered social worker?

MR TE KANI: I am.

DR COOKE: Yes and do I understand – are you able to say and reassure the Commission today that in terms of the recommendations coming out of this report and the failures that have been identified, that there is a reassurance that can be given as to the priority that should be accorded to the social work voice at all levels within the organisation?

MR WHITCOMBE: Absolutely, and which is why I feel at times I have pushed the envelope, in terms of the role of advocacy as a social work leader, and social work, as a profession, is intended to be an anti-oppressive profession. It is intended not just to exist in the relationship between a practitioner and a whānau, but it's intended to exist in the systems and structures that either enable and support or oppress, and that's why I've made some of the comments in the course of the Commission.

DR COOKE: I don't have time to go through either this report in detail, and I note also the ICM report which referred to the intake of new social workers and the fall-off in totality of numbers of senior practitioners and people at that level.

MR WHITCOMBE: Yeah.

DR COOKE: And there's a concern coming out of this report as to the quality of training that's provided to social workers. There used to be a learning and development training system. Is that still in place?

MS DICKSON: Yes, and if I could just preface my response to that very briefly by describing, very quickly, the relationship between my role and the Chief Social Worker. So we have the vision setting and the direction setting from the Chief Social Worker and then the role, largely my role is to then work closely with the Chief Social Worker to change that into action. So that speaks to the work that we currently have under way within my group again around resetting, really, both of our core programmes around practice induction and our leadership, practice leadership programmes which will both be refreshed as accredited programmes in the new year.

DR COOKE: Would it be would it be reasonable to expect that at the time of the next ICM report, we would be able to read that the pressures on social workers have diminished, in terms of – because of the increased quality of training that they're getting, increased supervision that they're getting, all of those improvements that you've been referring to?

MR WHITCOMBE: I think those things are incredibly important, supervision, training. I also would simply say, a lot of the survivor stories that we've heard have often been in a context of not having a good relationship with their social worker, sometimes that relationship being non-existent, and I would say that good social work practice – and I think we all know that it's very obvious – it sits in a context of a trusted relationship. And a trusted relationship takes time with tamariki, it takes time with families, and if we are to achieve that, if we are to move from a light-touch social work model to a deep and sustained approach where we support the family structures, then that takes depth and time, and we need to enable that.

MS DICKSON: And if I can just add, I would expect to see some improvements. I just would want to comment that we have lot of underinvestment, years of underinvestment in the professional capability to address.

DR COOKE: Okay. This is now a question to Mr Te Kani, initially at least.

MR TE KANI: Yes.

DR COOKE: Under section 72 of the Act and your duties, you are to ensure that social workers receive appropriate training and supervision to carry out their statutory duties.

MR TE KANI: I am aware of that, yes.

DR COOKE: Then there are related obligations from the Social Workers Registration Act covering social workers.

MR TE KANI: Yes.

DR COOKE: And, presumably, there are health and safety issues as well.

MR TE KANI: Yes.

DR COOKE: The question of supervision and of registration is in the context of social workers, as that's defined in the act, isn't it, and a social worker means a person employed in the Department as a social worker; correct?

MR TE KANI: Correct, yes.

DR COOKE: Presumably, then it doesn't cover people who are youth workers, wouldn't cover transporters; that would be correct, wouldn't it? Because they're not social workers, as defined, and, therefore, the obligations that you have do not extend to them.

MR WHITCOMBE: Yeah, they're not as strongly articulated through, you know, the likes of the social work registration board, however, we have obligations to them as part of our kaimahi team who are working in environments that have quite a degree of intensity and they certainly should be having that same level of supervision. The supervision work programme that we have under way does include the broader base of our frontline workforce.

MS DICKSON: And the Social Work Registration Board's code of practice would also include social workers who are in – who are registered social workers who might not be doing a specific narrow social work role.

MR TE KANI: But in terms of your broader question about the broader workforce and obligations there, those reside in our employment agreements and collective agreements with our staff.

DR COOKE: Just to be clear, it would not include, at least at a formal level, those who are categorised as youth workers, for example? That would be correct, wouldn't it?

MS DICKSON: Not unless they were registered social workers.

DR COOKE: No. I'm just mindful of, I think, the cross-examination from Ms Toohey of the incident that occurred down in the residents in Christchurch, where a young person was assaulted and I believe that was by a youth, well it involved a youth worker, as opposed to a social worker.

MR TE KANI: I can't comment on that for privacy reasons, but I can confirm it wasn't a youth worker.

DR COOKE: It wasn't a youth worker. Okay. I now want to – back to Mr Te Kani –

MS DICKSON: Can I say that youth workers also have some particular professional capabilities and skills which is an increasingly strengthened field of practice as well, so I wouldn't want to diminish the contribution of youth workers and I know that that's not intended.

DR COOKE: That's certainly not intended, but it's understanding that within the organisation, there are these different roles.

CHAIR: And responsibilities. I think the short point, really short, is that you, as the Chief Executive, Mr Te Kani, are obliged, have obligations towards social workers.

MR TE KANI: Yes.

CHAIR: You have assumed obligations towards others, but they're not in the statute, so I think that's really the short point, that if it's to be – somebody used the word before – hardwired, that could possibly be something that might be looked at.

MR TE KANI: Indeed. In terms of broader workforce, of course, my obligations to them under the Health and Safety Act.

CHAIR: Of course, they are. We won't push that any further.

DR COOKE: Thank you. I now wanted, just in relation to your statutory obligations that we've just spoken about, the operation of section 7AA would add an extra layer in terms of the obligation that is owed to Māori social workers. Would that be correct?

MR TE KANI: I wouldn't say it adds an extra layer of obligation. That section AA adds considerable obligations on the Chief Executive.

DR COOKE: I have a document here which was taken from your website. It's headed "Māori-Centred Supervision":

> "Under Te Tiriti, there is an obligation that identifies a need for Māori centred supervision and directly links to Oranga Tamariki core practice framework principle working effectively with Māori."
>
> Then it identifies three aspects of Māori-centred supervision: tangata whenua, where participants, the supervisor and the supervisee are Māori; tangata whenua cross

cultural, Māori working with other cultures; and tauiwi, bicultural, those who are not Māori who are working with Māori. And then it goes on to talk about other cultures supervision and there's the example of Samoans working with Samoans, for example.

But I'm mindful of the time, so what I wanted to ask you was, is there provision within Oranga Tamariki for each and every Māori supervisor – sorry, each and every social worker to have supervision from a Māori social worker that occurs within an appropriate Māori framework? I'm thinking, in particular having read it just overnight, an article by Emma Webber-Dreadon, who's Ngāti Kahungunu, entitled "Kaitiakitanga: A transformation of supervision", which I'm sure you're familiar with and which makes a recommendation or suggestions that all Māori social workers should – that the existing supervision system is Eurocentric in its design and does not meet the needs of Māori social workers or their clients, and what I'm wanting to know is, are your social workers, Māori social workers, being given the opportunity of having that very appropriate and Te Tiriti-based social work supervision?

MR TE KANI: I understand.

MS DICKSON: So I would not say that all tangata whenua social workers have access to that yet. What I would say is that there are – and there's not enough time to go into the various strands of work that we have under way to address that issue but I'm very happy to provide more detail on that. What I would say is your point is well made, that the obligation is not just to the social worker; it is to the experiences and outcome of the tamariki and whānau they work with.

DR COOKE: Right, now just in relation to supervision, is there a requirement that those who carry out supervisory roles and the term, in effect, of giving supervision to social workers and supervisors themselves receiving supervision, and whoever provides supervision to the person who provides the supervision – that's almost like is the world standing on a whole row of turtles, isn't it – is there a requirement that those people have professional qualifications in supervision and, if not, why not?

MS DICKSON: So there isn't currently that requirement. I'm probably one of the last generations who did have – come from a time when that was universal for all supervisors. What has been provided is the in-house supervision training. I think what I would say is that we have partnered with, and I think I mentioned this already, we partnered with wānanga around the kaitiakitanga supervision programme and we're increasing that into next year. I think the question of qualifications and requirements for supervision is a critical one as part of the work that we have under way.

DR COOKE: When you're telling us that you were one of the last at a time when it was required, as I understand you saying –

MS DICKSON: Well, it was made universally available to supervisors at that time.

DR COOKE: Right. So, does that mean that since then, there has been a diminishment in the professional capacity of the organisation to provide appropriate supervision to those at the frontline, for example, and to supervisors, because, of course, we know that those people are confronted with the realities of a Care and Protection world.

MS DICKSON: Yes, and we've recently surveyed our social workers and they've confirmed that point.

DR COOKE: Thank you. Now, it's 5.

CHAIR: Don't panic, Dr Cooke. It's important that we get it done and in time. The only thing is how long, because if we're going to go too much longer, we need to take a break.

DR COOKE: No, my plan now was to address – sorry, I had a couple of other areas, but I'm not sure that they are significant for present purposes. It was going to be a question about the Family Court, but that can wait. But there were some questions that Mr Stone wanted asked and questions as well from Mr Ferriss, which will take me just a couple of minutes.

CHAIR: Well, I'm going to really, and I know it's putting an imposition on you, Katherine, but if it takes no more than five minutes – would that be all?

DR COOKE: Yes. The questions from Mr Stone, and I think one of them was almost asked yesterday, was, do you think there is benefit to you, as Oranga Tamariki, in bringing survivors to the table and listening to their experiences of having been through the system and learning from them?

MR TE KANI: Yes.

MR WHITCOMBE: Yes, I do.

DR COOKE: And that reflects the fact of living experience having much to offer; you would accept that?

MR TE KANI: Yes, it does. The point I do want to make, though, is we have been engaging with survivors at different levels and in different ways, so I just don't want to leave an impression that we haven't been.

DR COOKE: Okay. The second question – the other related question, again which it has to be relevant to what's occurring, is given, this covers, just comes to the care to custody discussion you had with Ms Toohey, is whether or not you perceive value in working with gangs because of that, their involvement – often gang members will have previous

involvement with Oranga Tamariki and have gone into the prison system, and do you see any benefit in beginning to engage with the gangs that are present throughout the motu?

MR TE KANI: So the Ministerial Advisory Board have started a dialogue with gang and whānau, so we'll take our steer from the work they do there.

DR COOKE: Thank you. The next questions are from Mr Ferriss. He's given me a number, but I don't think – from my discussions this morning with Ms Toohey, some of those relate to areas that are still under inquiry and it may be premature for me to place those before you, but I think there are then two questions that would be appropriate for me to ask. The first is, is there protection for whistle-blowers if they're employed by OT in a caregiving role or social workers and/or youth workers?

MR TE KANI: Yes, there is. There's the Protected Disclosures Act and also there's also processes internally to Oranga Tamariki now for them to raise issues of concern directly.

DR COOKE: Thank you. The next question relates to girls who are in Care and Protection and refers to a file review that was undertaken in 2012, which was subsequently documented in the 26 MSD paper called "Care and Protection secure residences: a report on the international evidence to best practice and service delivery". Now, the analysis apparently revealed how 43% of girls in Youth Justice and Care and Protection in secure engaged in prostitution. The question that he asks is, do you have any record of how many girls in State care have been involved in prostitution and, if not, why not?

MR WHITCOMBE: That would take a case file analysis. It wouldn't be able to be pulled directly from a data source.

DR COOKE: Thank you. That brings me to an end, although I see my friend is standing.

MS SCHMIDT-McCLEAVE: Madam Chair, just an indulgence for two more minutes. Ms Attrill would like to make a statement around the question of adoption, with the Commissioners' leave.

CHAIR: We are stretching the chewing gum to its very limits. And I'm just going to check with my colleagues whether they have any final questions, because if they do then we might take a break.

COMMISSIONER STEENSON: No, I don't have anything further other than to say "Thank you".

CHAIR: Alright, so Commissioners, after a slightly beady look – no, no, we've all agreed we won't ask any further questions. So, Ms Attrill, if you can keep it as short as possible and you can always put in a statement later on, if you want to add to that.

MS ATTRILL: Thank you, Judge Shaw. I appreciate time's running very tight and we're at end of a very long day, but I just wanted to acknowledge the experience of harm that many people who have been subject to an adoption or adoption proceedings have had. Their experience has not been unlike those in the care system, except that they have had to face the additional effects of the adoption legislation and, for some, the horrific impact that's had on their lives.

I'd particularly like to acknowledge the experience of birth mothers who experienced their babies being forcibly being removed or their being coerced into relinquishing them or those birth mothers who felt they had no choice in decisions being made about their babies.

Adopted people who had their whakapapa severed by law, the harm that they experienced at the hands of adoptive parents and also the life changing impact of living in the context of closed adoptions and learning later in life that their life story was not – was a fallacy, it wasn't based on the true birth experience.

And then the last group I just wanted to acknowledge is wider family, who, even these days, are searching for connections to put together the pieces of whakapapa for relatives who were adopted themselves and the limitations of the legislation in terms of enabling them access to critically important information.

The impact of the adoption legislation on the lives of survivors warrants a full day's hearing and discussions, in my view, and the last thing I would say is just to recognise that the Ministry of Justice are leading extensive reforms of our adoption legislation, which will address the issues that survivors have rightfully raised. And I just thought it was proper and right to mention their experience, as distinct from children in care today.

COMMISSIONER ERUETI: Kia ora.

CHAIR: It is absolutely proper and right and just – we do acknowledge adoptees and families of adopted people, as you have said, and just to let everybody know, that it's a subject that we have been dealing with. It's not been able to be fitted into our public hearing, but we are certainly consulting, talking, reading and watching the new legislation with much interest, so, but thank you so much for raiding that.

COMMISSIONER ERUETI: We had evidence in our first evidential hearing.

CHAIR: Very first hearing we dealt with it, but of course, just to let you know that we just didn't pick up the ball and drop it and we have continued with it. That brings us to the end. We have people in the room who have been here now for three days under close watch, not only of the Commission but of the world who has been watching. I just want to thank you,

each one of you, sincerely on behalf of the Commission for enduring these three days. I know it's been long and hard, and I can't tell you how valuable it's been to us. We are immensely appreciative of your stamina in coming.

We must also note the very hard work put into the preparation of your briefs of evidence and, in particular, the responses. And we can see, as recently as a couple of days ago, to the peppering of section 20 notices that we've given to you and would you, please, on behalf of us, thank your teams because we know you haven't all done it personally, we know there are hard-working people behind the scenes.

So, on that note I wish you all well and thank you very much for your evidence and it's time, matua, that you brought your korowai aroha to us please.

KAUMATUA HAURAKI: Kia ora, i mua i te karakiatanga mai i a mātou o Oranga Tamariki kei te mihi atu ki a rātou katoa, e mātaki mai ana i runga i te ipurangi rārangi. Ko rātou anō hoki ko tae mai ā-kanohi i maukinohia rātou i roto i ngā momo whare o ngā momo kāwanatanga, kei te mihi atu ki a rātou. Kei te mihi anō ki a koe te Heamana o te Kōmihana, e mihi nei ki a mātou me te whakahoki pēnei ake, ahakoa he taumaha nā rātou kua pahemo ake nei, he poto tēnā i te wā i maukinohia e whanga nei ngā kaihanga, ngā kaitono kia ea ai ō rātou wawata. Nā reira, kei te tino mihi atu ki a rātou. Anā, ko tāku mihi whakaotinga ki ngā rōia, ki ngā rōia i akiaki mai i a mātou, me ngā kaimahi katoa. Tae ana hoki koe, ki a koe tā mātou kaumatua, Ngāti Whātua. Kāre e mutu ngā mihi ki a koutou katoa. Anā kei a koe te wā.

CHAIR: E mihi ana ki a koe matua.

KAUMATUA NGĀTI WHĀTUA: Tēnā koe e te rangatira. Kei te mihi ana ki a koe, tae mai nei ki tēnei wā o tātou te mihi ana o tātou i tēnei rā. Engari, tēnei rā mō ō tātou poroporoaki, poroporoaki ō, mō ō koutou whānau hoki. Your Honour, at this time - Your Honours, can I say at this time, I just want to bring a point of kōrero for Ngāti Whātua. When we have done a mihimihi to Oranga Tamariki and as they now prepare to go home, we are now in the state of poroporoaki for them, so I would like to now, and he's passed on his mihi to us, and what I'd like him to do now is to whakakapi to say our final prayer while you are here after we sing our waiata te aroha te whakapono, te rangimarie. (Waiata Te Aroha).

KAUMATUA HAURAKI: (Karakia whakamutunga).

Hearing adjourned at 5.14 pm to Thursday, 24 August 2022 at 9 am