



# Whanaketia

Factors

*Ngā haukino o te wā*



THROUGH PAIN AND TRAUMA, FROM DARKNESS TO LIGHT

Presented to the Governor-General by the Royal Commission of Inquiry into  
Historical Abuse in State Care and in the Care of Faith-based Institutions

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# **Whakairihia ki te tihi o Maungārongo**

# He karakia

E tāmara mā, koutou te pūtake o ēnei kōwhiringa, kua horaina nei  
E tohe tonu nei i te ara o te tika  
E ngaki tonu ana i te mārā tipu  
Anei koutou te whakairihia ki te tihi o  
Maungārongo, kia tau te mauri.

Rukuhia te pū o te hinengaro  
kia tāea ko te kukunitanga mai o te whakaaro nui.  
Kia piere ko te ngākau mahora  
kia tūwhera mai he wairua tau.

Koinei ngā pou whakairinga i te tāhuhu  
o te Whare o Tū Te Mauriora.  
Te āhuru mōwai o Te Pae o Rehua,  
kaimuru i te hinapōuri,  
kaitohu i te manawa hā ora,  
kaihohou i te pai.

Nau mai e koutou kua uhia e ngā haukino  
o te wā, kua pēhia e ngā whakawai a ngā tipua nei,  
a te Ringatūkinu rāua ko te Kanohihuna.

Koutou i whītiki i te tātua o te toa,  
i kākahu i te korowai o te pono,  
i whakamau i te tīpare o tō mana motuhake,  
toko ake ki te pūaotanga o te āpōpō e tatari mai nei i tua o te pae,  
nōu te ao e whakaata mai nei.

Kāti rā, ā te tākiritanga mai o te ata,  
ā te huanga ake o te awatea,  
kia tau he māramatanga,  
kia ū ko te pai, kia mau ko te tika.  
Koinei ko te tangi a te ngākau e Rongo,  
tūturu ōwhiti whakamaua  
kia tina, tina!  
Hui e, tāiki e!

– *Waihoroi Paraone Hōterene*

To you upon whom this inquiry has been centered  
Resolute in your pursuit of justice  
Relentless in your belief for life  
You have only our highest regard and respect,  
may your peace of mind be assured.

Look into the deepest recesses of your being  
and discover the seeds of new hope,  
where the temperate heart might find solace,  
and the blithe spirit might rise again.

Let these be the pillars on which the House of Self,  
reconciliation can stand.  
Safe haven of Rehua,  
dispatcher of sorrow,  
restorer of the breath of life,  
purveyor of kindness.

Those of you who have faced the ill winds  
of time and made to suffer,  
at the hands of abusers and the hidden faces of persecutors, draw near.

You who found courage,  
cloaked yourselves with your truth,  
who crowned yourself with dignity,  
a new tomorrow awaits beyond the horizon,  
your future beckons.

And so, as dawn rises, and a new day begins,  
let clarity and understanding reign,  
goodness surrounds you and  
justice prevails.

Rongo god of peace, this the heart desires,  
we beseech you,  
let it be,  
it is done.

– *Waihoroi Paraone Hōterene*

## **Ngā haukino o te wā**

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The title for this Part refers to the fourth verse of the Karakia where there is an acknowledgement of the many abusive and neglectful acts that survivors were subjected to and made to suffer. This title directly translates as 'the ill winds of time'.



### **Pānui whakatūpatō**

Ka nui tā mātou tiaki me te hāpai ake I te mana o ngā purapura ora I māia rawa atua nei ki te whāriki I ā rātou kōrero ki konei. Kei te mōhio mātopu ka oho pea te mauri ētahi wāhanga o ngā kōrero nei e pā ana ki te tūkino, te whakatūroro me te pāmamae, ā, tērā pea ka tākirihia ngā tauwharewarenga o te ngākau tangata I te kaha o te tumeke. Ahakoa kāore pea tēnei urupare e tau pai ki te wairua o te tangata, e pai ana te rongō I te pouri. Heoi, mehemea ka whakataumaha tēnei i ētahi o tō whānau, me whakapā atu ki tō tākuta, ki tō ratongo Hauora rānei. Whakatetia ngā kōrero a ētahi, kia tau te mauri, tiakina te wairua, ā, kia māmā te ngākau.



### **Distressing content warning**

We honour and uphold the dignity of survivors who have so bravely shared their stories here. We acknowledge that some content contains explicit descriptions of tūkino – abuse, harm and trauma – and may evoke strong negative, emotional responses for readers. Although this response may be unpleasant and difficult to tolerate, it is also appropriate to feel upset. However, if you or someone in your close circle needs support, please contact your GP or healthcare provider. Respect others' truths, breathe deeply, take care of your spirit and be gentle with your heart.

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"Taking away a people's political and constitutional power to determine their own destiny breaks the fundamental construct that ensures their independence and thus the authority to make the best decisions for themselves."

**DR MOANA JACKSON**


(Ngāti Kahungunu, Rongomaiwahine,  
Ngāti Porou)

# Ūpoko | Chapter 1

## He whakataki

### Introduction

1. This part of the report explains why abuse and neglect happened to children, young people and adults in the care of the State and faith-based institutions during the Inquiry period, and who was responsible. It identifies the factors which caused or contributed to abuse and neglect in care, the lessons learned and the changes made, as required by clauses 31(b) and 31(e) of the Terms of Reference. It also responds to clause 33 in terms of making findings of fault and whether standards were breached.
2. Chapter 2 talks about survivors, the personal factors that safeguarded them and the factors that contributed to their entry into care and abuse and neglect once they were in care. This chapter also looks at the factors relating to abusers and staff and carers who saw or knew about abuse and neglect.
3. Chapters 3 to 6 set out the factors across State and faith-based care settings that contributed to abuse and neglect. These chapters focus on:
  - > the relevant standards that applied in care settings, and related policies, rules and practices (chapter 3)
  - > the vetting, recruitment, training and development, performance management and supervision of staff and carers (chapter 4)
  - > the complaints processes that were available to people in care, the processes in place for responding to complaints and how effective these were (chapter 5).
  - > the oversight and monitoring of care settings and people in care, and whether it was effective at preventing and responding to abuse and neglect
4. Senior leaders and managers within care settings are brought into focus in these chapters, with a close look at how their individual decisions and actions or inactions contributed to abuse and neglect in care. Their role and responsibilities to manage the people (staff, carers, and people in care), processes and risks is also discussed.
5. Chapter 7 brings together the factors identified in chapters 3 to 6 and concludes why abuse and neglect happened at the institutional level of care.
6. Chapter 8 discusses faith-based institutions and the factors specific to why children, young people and adults in their care experienced abuse and neglect.
7. Chapter 9 describes why the State failed to safeguard people in care and what it should have done when it knew survivors were experiencing abuse and neglect.
8. Chapter 10 explains the role of societal attitudes in abuse and neglect in care.

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9. Chapter 11 sets out the Inquiry's conclusion on why abuse and neglect in State and faith-based care happened during the Inquiry period.
  10. Chapter 12 sets out the Inquiry's key findings on breaches of te Tiriti o Waitangi and its principles, breaches of standards of care, the factors which contributed to abuse and neglect, who was at fault for abuse and neglect, and the lessons learned and changes made during the Inquiry period.



# Ūpoko | Chapter 2

## Te hunga i te pū o ngā mahi tūkinō

### The people at the centre of abuse and neglect

11. During the Inquiry period, many whānau and communities needed support to care for their children, young people and adults at home, at their kāinga or within their community. Without this support, many children, young people and adults were placed in State and / or faith-based care. People placed in care needed support, strong protection and to be safeguarded against abuse and neglect. Instead, many were placed in care facilities with institutional environments and practices that heightened the risk of abuse and neglect.
12. Abusers misused their positions of power and control over people in care to inflict at times extreme and violent abuse, or to neglect people in their care. Abusers sometimes took calculated steps to conceal their actions which allowed them to continue, at times, acting with impunity.
13. Many staff and carers who witnessed abuse and neglect, or were told about it, did nothing. Some bystanders did complain or raise concerns, but often with limited success.

# Ngā tamariki, rangatahi, pakeke kei ngā pūnaha taurima

## Children, young people and adults in care

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### Ngā tamariki, rangatahi, pakeke kei ngā pūnaha taurima e tika kē ana kia tautokona kia tauāraitia

#### Children, young people and adults in care needed support, protective factors and safeguarding

14. Children, young people and adults in State and faith-based care were diverse, with diverse care and support needs. Although each person in care was unique, every person needed support and caring, strong protective factors and safeguarding.
15. Safeguarding is a preventative approach to reduce the risks of abuse and neglect for people. In care settings, safeguarding includes standards of care, appropriate recruitment, adequate staff resourcing, diversity, training and development, and child protection policies and processes. This includes complaints policies that promote and prioritise the safety of those in care, while maintaining their rights and freedoms.<sup>1</sup>
16. Strong 'protective factors' refers to a set of internationally recognised factors that contribute to resilience because they promote healthy development and wellbeing and can reduce the risk of experiencing abuse and neglect.<sup>2</sup> These factors are a combination of personal, parental and environmental factors. People have strong protective factors if they:<sup>3</sup>
  - a. maintain strong connections with family, kainga, whānau, hapū, iwi and community
  - b. have good self-esteem or personal confidence and understand who they are and their place in the world
  - c. for Māori, have full authority over their kāinga (home, residence, village,) to live as Māori, and connection to their whakapapa, whānau, hapū and iwi
  - d. have family cohesion and parental resilience
  - e. have supportive and trustworthy peers and adults in their lives (in addition to their direct carers)
  - f. understand their rights and how they should be treated
  - g. understand appropriate and inappropriate behaviour, personal safety and what they can do in difficult situations.

<sup>1</sup> Independent Inquiry into Child Sexual Abuse (United Kingdom), The Report of the Independent Inquiry into Child Sexual Abuse (2022, pages 199–200).

<sup>2</sup> Australian Institute of Family Studies, Risk and Protective Factors for Child Abuse and Neglect, (May 2017, pages 3, 7–8); Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Volume 2 – Nature and cause (2017, page 18).

<sup>3</sup> Australian Institute of Family Studies, Risk and Protective Factors for Child Abuse and Neglect, (May 2017, pages 3, 7–8); Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Volume 2 – Nature and cause (2017, page 18).

17. Strong protective factors in whānau, children, young people and adults significantly reduces the likelihood of entry into care. In care settings, protective factors can reduce the risk of abuse and neglect and increase a person's resilience to navigate difficult situations.<sup>4</sup>

## **He mōtika i ōatitia i te Tiriti o Waitangi hei tauārai mō ngā tamariki, rangatahi me ngā pakeke Māori**

### **Rights guaranteed in te Tiriti o Waitangi protect tamariki, rangatahi and pakeke Māori**

18. The Inquiry's Terms of Reference required it to be underpinned by te Tiriti o Waitangi and its principles.<sup>5</sup> Part 1 explains that the Inquiry has sought to centre te Tiriti o Waitangi in all its work. It considered the abuse and neglect of tamariki, rangatahi and pakeke Māori in the care of State and faith-based institutions during the Inquiry period through a Tiriti o Waitangi lens. This included using te Tiriti o Waitangi as a standard against which actions or omissions by the Crown and faith-based care institutions must be assessed.
19. In Part 1, the Inquiry described te Tiriti o Waitangi, its principles and how these are relevant to tamariki, rangatahi and pakeke Māori in care and their whanau, hapu and iwi. Through te Tiriti o Waitangi, the Crown made a series of guarantees to Māori including that it would protect the right to exercise tino rangatiratanga.<sup>6</sup> This right included the full authority of Māori over their kāinga, the right to continue to organise and live as Māori, and the right to care for and raise the next generations.<sup>7</sup>
20. The rights guaranteed in te Tiriti o Waitangi reinforce many protective factors. For example, connection to whakapapa, whānau, hapū and iwi are taonga protected by te Tiriti o Waitangi.
21. Dr Moana Jackson (Ngāti Kahungunu, Rongomaiwahine, Ngāti Porou) told the Inquiry that:

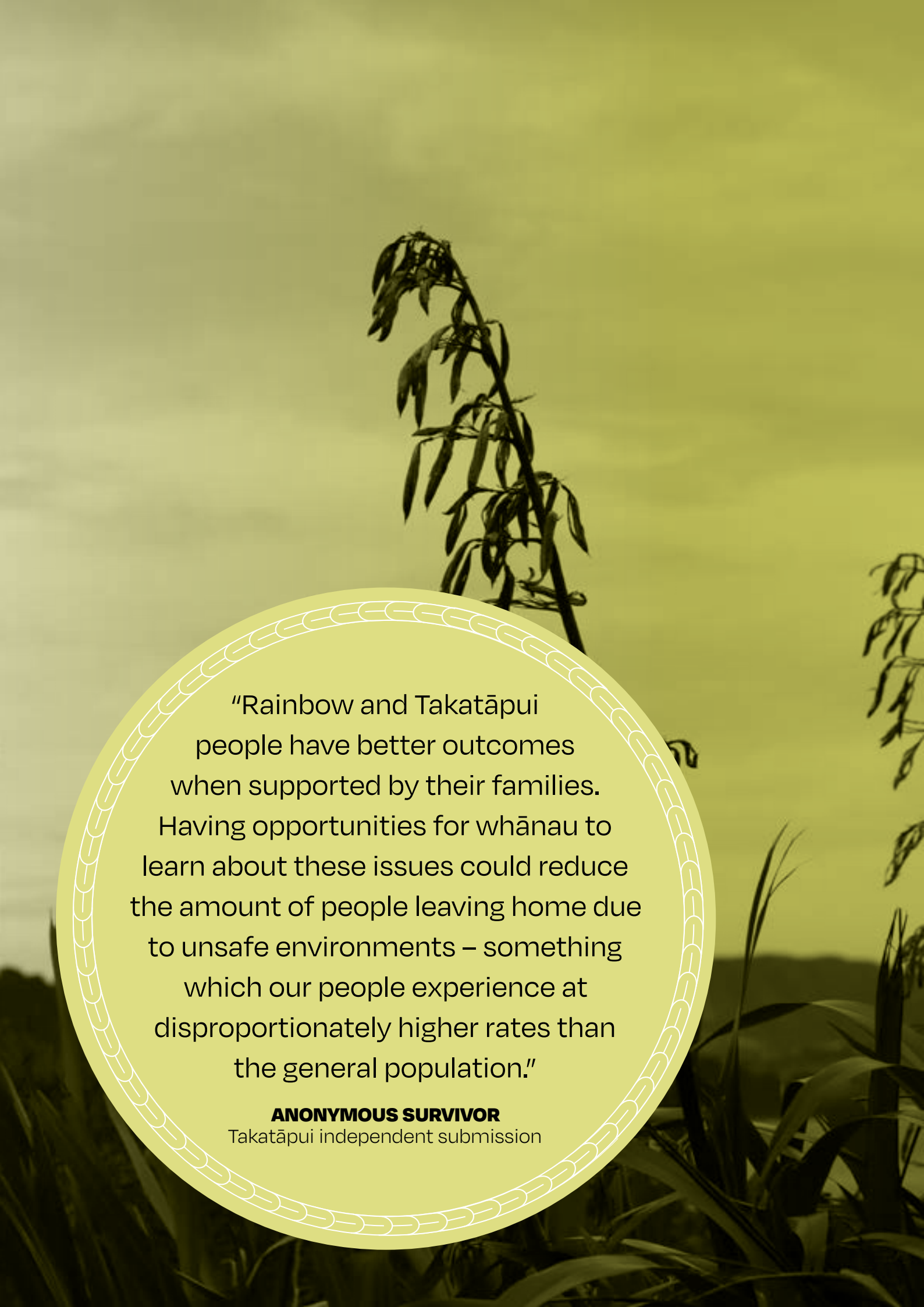
***“Taking away a people’s political and constitutional power to determine their own destiny breaks the fundamental construct that ensures their independence and thus the authority to make the best decisions for themselves”***

4 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Volume 2 – Nature and cause (2017, page 18).

5 Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-Based Institutions, Terms of Reference, clause 6.

6 Waitangi Tribunal, Te Mana Whatu Ahuru: Report on Te Rohe Pōtae Claims Parts I and II, Pre-publication version (2018, page 189).

7 Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkīngā Whāruarua: Oranga Tamariki Urgent Inquiry (2021, page 179).



"Rainbow and Takatāpui people have better outcomes when supported by their families. Having opportunities for whānau to learn about these issues could reduce the amount of people leaving home due to unsafe environments – something which our people experience at disproportionately higher rates than the general population."

**ANONYMOUS SURVIVOR**

Takatāpui independent submission

22. Had these rights been upheld during the Inquiry period – such as the right to tino rangatiratanga over kāinga, and the right to continue to live in accordance with indigenous traditions and worldview guaranteed by te Tiriti o Waitangi principle of options – these would have been amplified protective factors for tamariki, rangatahi and pakeke Māori, reducing entry into care and the risk of abuse and neglect while in care.
23. Parts 3–6 of this report describe how many whānau, hapū, and iwi were not empowered to care for and raise their tamariki, rangatahi or pakeke Māori as guaranteed to them in te Tiriti o Waitangi.<sup>8</sup> When tamariki, rangatahi and pakeke Māori were removed from their whānau, hapū and iwi and placed into care, it removed the ability and power of whānau, hapū and iwi to care for and nurture the next generation, to regulate the lives of their people and to transfer mātauranga Māori.
24. The ongoing, intergenerational effects of colonisation and continuing assimilation policies and urbanisation during the Inquiry period meant that many tamariki, rangatahi and pakeke Māori did not have an understanding of who they were and their place in the world. Some had connections with their whakapapa, whānau, hapū and iwi severed. Many held shame or mamae, rather than pride in their culture.
25. The Crown's failure to uphold these rights during the Inquiry period was a breach of the principles of tino rangatiratanga, kāwanatanga, partnership, active protection and options.

## **He mōtika tangata e tauārai ana i ngā tamariki, rangatahi, pakeke kei ngā pūnaha taurima**


### **Human rights protect children, young people, adults in care**

26. Part 1 sets out the core themes relevant to human rights that the Inquiry used to guide its work, including identifying where the State and faith-based institutions failed to uphold the human rights of children, young people and adults in their care.
27. Human rights recognise that some disadvantaged, minority or Indigenous groups, including whānau and individual mothers or fathers, may need special measures to achieve equity, or eliminate inequity, alongside similar groups.<sup>9</sup> Special measures include targeted financial support or priority access to healthcare, educational, employment or housing services. Special measures also include protections for Indigenous rights. Whānau and mothers or fathers who face the biggest barriers, or who are the most marginalised or vulnerable, should have priority access to these measures.<sup>10</sup>

<sup>8</sup> Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkinga Whāruarua: Oranga Tamariki Urgent Inquiry (2021, pages 11–16).

<sup>9</sup> This understanding informs, for example, the accessibility rights for disabled people affirmed in the United Nations Convention on the Rights of Persons with Disabilities (2007).

<sup>10</sup> United Nations Human Rights Office of the High Commissioner, Human Rights Indicators: A Guide to Measurement and Implementation (United Nations, 2012, pages III and 11).

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28. During the Inquiry period, many whānau, caregivers or individual mothers or fathers were not always supported by the State to care for their children, young people or adults at home. Many struggled with financial hardship, unemployment, housing instability and parental mental distress. Many did not have access to the concrete support or special measures they needed to help build and maintain whānau and /or community cohesion and resilience, and care for their loved ones themselves.
29. Human rights recognise that children, young people, Deaf people, disabled people and people experiencing mental distress are distinct groups that also require special measures (or supports) particularly protective measures.<sup>11</sup> In care settings, this means special protective measures like comprehensive standards of care, as well as special assistance measures for example, non-speaking disabled people in care having access to communication and accommodation supports to assist decision-making.<sup>12</sup>
30. During the Inquiry period, the lack of special protections or measures for people in care were factors that contributed to abuse and neglect. For many Deaf people and disabled people in care, the absence of human rights protections and special measures not only increased their risk of experiencing abuse and neglect, but also prevented them from being able to communicate what was happening to them.

## **Ko ngā take whakauru ki ngā pūnaha taurima i tahuri kē hei take mo te mahi tūkinu**

### **Factors for entry into care became factors for abuse and neglect in care**

31. Many of the circumstances that made it more likely a child, young person or adult would enter care often became the factors for why they were more susceptible to, or at an increased risk of, abuse and neglect in care.
32. These factors included:
- a. being raised in poverty and experiencing deprivation
  - b. being disabled with unmet needs
  - c. being Māori and racially targeted
  - d. being Pacific and racially targeted
  - e. being Deaf with unmet needs
  - f. experiencing mental distress with unmet needs
  - g. being Takatāpui, Rainbow, MVPFAFF+, gender diverse or transgender and being targeted

<sup>11</sup> United Nations Convention on the Rights of the Child (1990); Preamble; United Nations Convention on the Rights of Persons with Disabilities (2006), Preamble (j).

<sup>12</sup> United Nations Convention on the Rights of the Child, Article 3; Oranga Tamariki (Residential Care) Regulations 1996, Regulation 3; Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018, Regulation 3 (1).

33. If a person had experienced significant or multiple adverse childhood events prior to entering in care became the factors for why they were more susceptible to, or at an increased risk of, abuse and neglect in care. Significant adverse childhood events may include:
- a. experiencing violence, abuse, or neglect in private homes or in other care settings
  - b. witnessing violence in private homes, in the community or in other care settings
  - c. having a family member or a peer in a care setting pass away, or attempt or die by suicide
  - d. aspects of a person's environment that undermined their sense of safety, stability and bonding, such as growing up in a private home or in other care settings:
    - i. with parents, caregivers, or peers experiencing substance use problems
    - ii. with parents, caregivers or peers experiencing mental distress
    - iii. where there is instability due to parental separation or household members being incarcerated<sup>13</sup>
    - iv. living in an under-resourced private home or becoming homeless
    - v. experiencing unsupported and weakened family and cultural structures
    - vi. being in families and communities that were unsupported because their needs had not been adequately assessed or met
  - e. having a deferential attitude to people in positions of authority, including faith leaders and medical professionals
  - f. other reasons such as age or gender
34. Experiencing or being any combination of the factors set out above could also make a person susceptible to abuse and neglect in care.
35. These factors were underpinned by societal attitudes, like discrimination based on racism, ableism, disablism, sexism, homophobia, transphobia and negative stereotypes about children and young people, poverty and welfare dependency.
36. Most survivors had or experienced many of these factors, which heightened the risk of abuse and neglect when they were in care. For example, whānau hauā, tāngata whaikaha and tāngata whaiora Māori experienced high rates of abuse and neglect in care and multiple types of abuse, particularly racial and cultural abuse and neglect.
37. The longer someone was in care, the more likely they were to experience abuse and neglect. Many disabled people were placed in institutional care permanently and from a very young age.<sup>14</sup>

<sup>13</sup> Royal Commission of Inquiry into Abuse in Care, A summary of engagements with survivors currently incarcerated (July 2023).

<sup>14</sup> Royal Commission of Inquiry into Abuse in Care, Research report: What we know about the numbers of people in care and the extent of abuse in care (November 2020, pages 31–32).

## Ngā kaitūkinō Abusers

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38. Abusers were male, female, young, old, Pākehā, Māori, Pacific Peoples, people from other ethnic groups, leaders, respected members of communities, unskilled workers, caregivers, volunteers, educated professionals including teachers, social workers, psychologists, psychiatrists and medical staff. They were also religious leaders including bishops, priests, religious sisters, religious brothers, deacons, lay people. Abusers were single, married with children, heterosexual, homosexual and celibate people.
39. There was no single, easily identifiable 'bad apple' abuser,<sup>15</sup> although many held highly skilled or senior positions and some were charismatic leaders.

### I kōtiti kē te whakamahi a ngā kaitūkinō i tō rātou mana whakahaere hei taki mahi tūkinō

#### Abusers misused their positions of power, control to carry out abuse and neglect

40. Most abusers were adults, which gave them inherent power over the children, young people and adults in their care. Many survivors felt afraid to disclose abuse because of the power adults had over them. Māori survivor Mr SN, who was placed into foster care when he was 6 years old, told the Inquiry:
- "I was too scared to tell a staff member what Mr Ansell was doing ... I found it hard to relate to adults, especially when they usually did not believe what I was saying anyway. The staff members who were abusive knew this and so could cover up what they were doing because they knew nobody would believe me or other boys like me."*<sup>16</sup>
41. Abusers were able to misuse the power, control and opportunity that came with their positions to perpetrate abuse and neglect, sometimes going undetected for extended periods of time. The extent of their power, control and the opportunities to abuse, differed from position-to-position. Positions that allowed a high degree of unsupervised contact with, or control over, people in care provided the greatest opportunities for abuse for example, positions in foster homes, boarding schools, institutions and residences.

15 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Improving institutional responding and reporting (2017, page 126); Wortley, R and Smallbone, S, Applying situational principles to sexual offenses against children, Crime Prevention Studies, volume 19 (Lynne Rienner Publishers, 2006, page 30).

16 Witness statement of Mr SN (2021, paras 131–134).



42. Staff and caregivers in institutional facilities and residential settings had almost total power and control over the lives of people in their care.<sup>17</sup> Fran Erikson, a manager at Kingslea Girls' Home in in Ōtautahi Christchurch in 1995, said at the time:
- “What has been reported may only be the tip of the iceberg in that the residential clients are predominately powerless against persons in authority, to all intents and purposes”*<sup>18</sup>
43. Foster parents similarly had almost total power and control over a foster child or young person's life. Abusers who were foster parents were in private family group homes, away from other adults who might intervene, which increased their opportunities to abuse and meant they could operate with enhanced impunity.
44. Staff and volunteers in school hostels or boarding facilities held positions that gave them considerable power and control over the daily routines of those in their care. Abusers were able to use these positions of power and control to carry out abuse and neglect, with high rates of sexual abuse in some settings.
45. Medical professionals and healthcare workers held positions that gave them coercive statutory powers to place people in care (at times without consent), decide their treatment including, at times, using compulsory orders and decide what supports they could access.<sup>19</sup> Some people misused the power and control that came with these positions to inflict certain types of abuse and neglect, such as the extreme medical abuse and neglect demonstrated in the Inquiry's report Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit.<sup>20</sup>
46. Police officers also held positions that gave them coercive statutory powers over a child, young person or adult, including the ability to take someone into custody, and question and charge them with an offence.
47. Child welfare officers, social workers and field officers held positions that gave them power and control to decide whether people in care were safe, to recommend they be moved to and where, and to take people off site.<sup>21</sup>

17 Witness statement of Matthew Frank Whiting (22 November 2021, para 2.29).

18 Fax from Fran Erikson, Manager at Kingslea to Office Solicitor (5 February 1995, page 2).

19 Witness statement of Rachael Umaga (18 May 2021, para 40); Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice Child and Adolescent Unit (2022, page 223); Mirfin-Veitch, B, Tiako, K, Asaka, U, Tuisaula, E, Stace, H, Watene, FR, & Frawley, P, Tell me about you: A life story approach to understanding disabled people's experiences in care 1950–1999 (Donald Beasley Institute, 2022, pages 83–84); Collective Statement of Tāmaki Makaurau Whānau Hauā (September 2022, para 8).

20 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice Child and Adolescent Unit (2022, Chapter Four).

21 Witness statement of Sally Rillstone (14 October 2021, paras 105, 109–114).

48. Within faiths, abusers occupied a wide range of positions. Many of them benefited from the elevated moral authority and / or power attributed to people in religious roles. Examples include the positions of a bishop, pastor, minister, brother, priest, elder or shepherd. It includes positions at faith youth camps, Bible study groups and Sunday schools, and one-on-one pastoral or spiritual direction. Many lay people who volunteered or worked for faith-based entities also enjoyed an assumption of moral authority. Abusers in these positions used their elevated power to carry out abuse and neglect, often within a religious framework or using religious beliefs to justify abuse.
49. Many of those accused of abuse within the Catholic Church were in positions of leadership and authority. Data from the Catholic Church showed that among the diocesan clergy,<sup>22</sup> there were 378 reports of abuse made against 182 individuals, constituting 14 percent of all diocesan clergy during the Inquiry period. Among male members of religious orders,<sup>23</sup> 599 reports of abuse were made against 187 individuals, representing 8 percent of all male members of religious orders during the same period. The remaining 78 percent of perpetrators included female members of religious orders, lay people (staff and volunteers), trainees, other residents, unnamed, unknown and unidentifiable.<sup>24</sup>

**Tērā ngā kaitūkinō i teka, i whakangū i ngā purapura ora,  
ka whakakōtiti i ētahi atu hei karo mō a rātou mahi**  
**Abusers lied, silenced survivors and manipulated others to  
avoid accountability**

50. Many abusers were adept at hiding their abuse or avoiding accountability once concerns had been raised. Some abusers can be adept at hiding their abuse or avoiding accountability for long periods because they:<sup>25</sup>
- occupy respected positions of authority in care settings or are the primary caregiver
  - are highly skilled at manipulating and deceiving people around them, including deceiving care system checks
  - are highly skilled at neutralising, silencing and denying what has happened in an attempt to minimise their wrong-doing<sup>26</sup>
  - appear very successful at work and in their relationships
  - pathologically lie.

22 Includes those clergy incardinated (accepted into or a member) in an Aotearoa New Zealand diocese and present in Aotearoa New Zealand and those on loan from an overseas diocese.

23 Brothers and clergy who are members of congregations under the authority of a congregational leader, rather than clergy who are members of a diocese under a bishop.

24 Te Rōpū Tautoko, Information Gathering Project Fact Sheet (1 February 2022, page 2).

25 Nicol, SJ, Ogilvie, J, Kebbell, MR, Harris, DA, & Phelan, A, Dodging justice: characteristics of men with multiple victims who evade detection for long periods, *Journal of Sexual Aggression* (2022, pages 8–13).

26 Stanley, E, Gibson, Z, & Craddock, I, Performing Ignorance of state violence in Aotearoa New Zealand, *Journal of Criminology* (2024, page 2).

51. Abusers during the Inquiry period would often lie, and many abusers called survivors liars.<sup>27</sup> Abusers would often take steps so that survivors who had disclosed abuse or neglect were not believed.<sup>28</sup>
52. Ross Browne was the chaplain and teacher at Dilworth School (Anglican) in Tāmaki Makaurau Auckland from 1989 until 2006 when the Principal, Donald McLean, and the Board of the School agreed to a “dignified exit” after allegations he had repeatedly sexually abused multiple young boys.<sup>29</sup> In response to clear evidence of his abuse, Ross Browne categorically denied the offending. Ross Browne’s denial of the abuse was described in Hon Rodney Hansen CNZM QC’s report to the Anglican Diocese of Auckland:
- “[Ross Browne] argued that there was no truth or logic to the assertion that he caused or encouraged boys to masturbate in class. He said such an allegation ‘defied common sense’. He maintained that actions he took to control a class containing some unruly individuals were misinterpreted and misrepresented when recalled by class members over ten years later.”***<sup>30</sup>
53. At Ross Browne’s sentencing in 2021, Justice Toogood described the repeated sexual abuse as predatory and pre-meditated and said:
- “The scale and duration of your offending ... indicates that the scale of the actual offending goes much wider than the complainants whose experiences have led to these charges.”***<sup>31</sup>
54. Abusers were often adept at manipulating and deceiving those around them to conceal their abuse and neglect. They would rely on their authority and status, like their skilled position, professional qualifications or being a member of a faith, to convince others they were trustworthy.<sup>32</sup>

27 Witness statement of David Williams (aka John Williams) (15 March 2021, para 121).

28 Royal Commission of Inquiry into Abuse in Care, Beautiful children: Inquiry into the Lake Alice Child and Adolescent Unit (2022, page 223); Witness statements of Mr QL (17 January 2022, para 112) and Sharyn (16 March 2021, paras 132–135).

29 Dilworth Trust Board and School, Documents relating to complaints received regarding professional conduct of Rev Ross Browne, Chaplain (16 February 2006, pages 2–3).

30 Hon Rodney Hansen CNZM QC, Report to the Anglican Diocese of Auckland on matters arising from the ministry appointments of Ross Browne (2022, para 2.14).

31 R v Browne [2021] NZHC 3286 (paras 36 and 51).

32 Witness statements of P. Wilde (23 February 2023, para 4.4) and Mr QL (17 January 2022, para 91).

55. Many abusers developed strong relationships with their colleagues, which worked in their favour when concerns were raised. Rod Morine was a residential social worker at Kingslea Girls' Home in Ōtautahi Christchurch in the 1990s and was "seen to work hard for staff ... and had a reputation for getting people out of trouble."<sup>33</sup> When concerns were raised about him, his colleagues saw them as a management plot against him:

*"... in hindsight we ... were quite intimidated by Rod due to the power he had across campus with staff and within the [Public Service Association]. This may be (my opinion only) why some of the hearsay concerns were never fully followed up on."*<sup>34</sup>

56. Abusers would use their positions to silence or prevent survivors from disclosing abuse or neglect.<sup>35</sup> They would tell survivors that if they disclosed abuse, they would not be believed.<sup>36</sup> Others bullied survivors, threatened further abuse<sup>37</sup> and, in some instances, threatened to kill them<sup>38</sup> or hurt members of their family<sup>39</sup> if they told anyone. Some used their positions to provide incentives to survivors to prevent them from telling someone, such as improved living conditions or rewards.<sup>40</sup>

57. Some abusers found, or put, themselves in positions that enabled them to manipulate complaints processes in their favour. At Gloriavale Christian Community, for example, founder Neville Cooper (Hopeful Christian) dealt with all reports of sexual or physical abuse from its founding in the 1970s until the early 1990s, and was subsequently convicted of sexual offences against a community member.<sup>41</sup>

33 Email re: Rod Morine's files (6 November 1998, page 1); Report to the Minister of Social Welfare, Investigation into allegations against a Kingslea residential social work[er] – Rod Morine (Department of Social Welfare, 29 September 1998).

34 Email re: Rod Morine's files (6 November 1998, page 1).

35 Witness statements of Ms HI (5 November 2011, para 64); Margaret Priest (28 January 2022, para 2.31); Sarah (Sunny) Webster (18 December 2021, para 59) and Mr GR (2021, para 93).

36 Witness statements of Kamahl Tupetagi (3 October 2022, para 56); Mr QL (17 January 2022, para 112) and Ms HA (23 September 2021, para 43).

37 Witness statements of Mr DG (18 May 2021, paras 30–31); Ms KJ (5 April 2022, para 36) and Scott Carr (7 March 2021, para 32).

38 Witness statements of Terry King (10 August 2021, para 36); Sonja Cooper and Sam Benton – relating to the St John of God Order Investigation (8 October 2021, para 215) and Cameron Hore (19 April 2023, para 61).

39 Witness statement of Scott Carr (7 March 2021, para 32).

40 Witness statement of Mr UD (10 March 2021, paras 47–51).

41 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, pages 57–59).

## **Tērā ētahi i tūkinō anō i a rātou i roto i ngā pūnaha taurima**

### **There was peer-on-peer abuse in care**

58. Some survivors were abused by others of a similar age, or those placed in the same care setting, in what is known as 'peer-on-peer' abuse. In care settings, a culture of physical or sexual violence could be established through staff condoning or even encouraging peer-on-peer abuse between residents.<sup>42</sup> Deaf NZ European survivor Mr JS described his experience of sexual abuse after arriving at Van Asch College in Ōtautahi Christchurch 1979:

*"The older boys would often act as a pack and they would target me ... About three times, boarding staff saw this same group of boys target me, take my pants off and try to assault me. Every time, the staff just laughed and did nothing. They found it funny."*<sup>43</sup>

59. The risk of peer-on-peer abuse in a care settings increased when the abuser knew the staff member or carer would not hold them to account. Māori survivor Gina Sammons (Ngāti Kura), who was first placed in foster care with her two sisters when she was 2 years old, told the Inquiry:

*"Tanya was also sexually abused by our oldest foster brother when she was around 6. She confided in the second brother about what had happened, but he told our foster mother, who then told Tanya she was lying and beat Tanya for talking about it. After that, the second brother also began sexually abusing Tanya, and later the adopted brother who raped me also abused her. Tanya didn't tell anyone else after that first time. She had learnt what the consequence was for talking about it."*<sup>44</sup>

## **He maha ngā kaitūkinō kīhai i whakamaua mō a rātou mahi, kātahi ka tohe herekore tonu**

### **Many abusers were rarely held to account and acted with impunity**

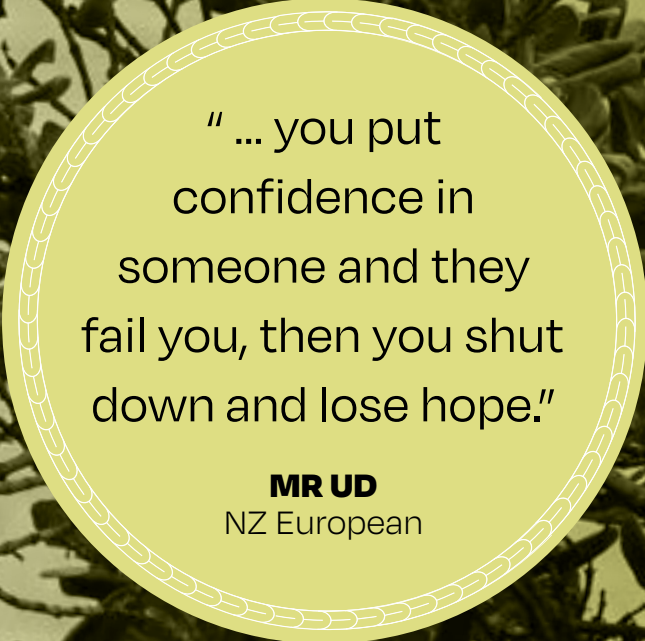
60. Abusers were rarely held to account for their abuse and neglect. Even when concerns were raised or complaints were made, many abusers manipulated those around them to undermine the person making the complaint and the complaint process.<sup>45</sup> Institutional and system failures made it easier for many abusers to conceal their actions, interfere with complaints processes and continue abusing often with a sense of impunity.

<sup>42</sup> Private session transcript of survivor who wishes to remain anonymous (27 November 2019, page 5); Witness statement of Scott Carr (7 March 2021, para 16).

<sup>43</sup> Witness statement of Mr JS (27 May 2022, para 2.66).

<sup>44</sup> Witness statement of Tanya and Gina Sammons (24 February 2020, para 33).

<sup>45</sup> Witness statement of Professor Elizabeth Stanley (11 October 2019, para 31e); Letter to the Human Rights Commissioner, re: promotion and transfer of staff in Residential Social Work (1982); Witness statement of Andrew Meadows (26 March 2021, para 75).



" ... you put  
confidence in  
someone and they  
fail you, then you shut  
down and lose hope."

**MR UD**  
NZ European

## Tērā ētahi i whai pānga mai e tika kē ana kia noho tauārai mō te hunga i ngā pūnaha taurima

### Bystanders had a critical role in safeguarding people in care

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61. Staff, volunteers and carers are a critical part of safeguarding people in care. They can be the first to see signs of abuse and neglect and are often the only adults present who can step in to prevent and respond to it. The Inquiry uses the term 'bystander' in this report to refer to staff, volunteers and carers who observed or witnessed abuse and neglect committed by an abuser of a child, young person or adult in care and had the opportunity to condone, intervene or do nothing. The Inquiry does not consider it appropriate to include children, young people or adults in care in the definition of bystander.
62. Many bystanders during the Inquiry period did try to intervene or report abuse and neglect but were often undermined or bullied by those around them. Some even lost their positions as a result of raising their concerns.
63. The Inquiry heard from many survivors who disclosed abuse and neglect to staff, volunteers, carers and bystanders, but no steps were taken to report the abuse and neglect or stop it happening again.<sup>46</sup> Some staff, volunteers or carers would make excuses for the abuser or dismiss the disclosures as lies.<sup>47</sup> NZ European survivor Mr UD, who was first taken into social welfare care when he was 6 years old, told the Inquiry about his attempts to disclose being sexual abused at Hokio Beach School near Taitoko Levin:
- "When you're a little boy you put confidence in someone and they fail you, then you shut down and you lose hope."<sup>48</sup>*
64. Some survivors told the Inquiry that, even without making a disclosure, staff, volunteers or carers must have been aware of the abuse and neglect and, if they did not know, they should have known.<sup>49</sup> Without disclosure, staff and carers should have noticed or recognised the obvious physical signs or behavioural changes that indicated abuse or neglect in care, like fresh bruising, bleeding, fractures, survivors saying they had abdominal or rectal pains, bloody clothing or bedding, bed wetting, suddenly fearing other staff or carers, malnourishment from lack of food or poor personal hygiene from neglectful care.

46 Witness statements of Ms HA (23 September 2021, paras 44–46) and Mr EC (24 February 2022, para 50).

47 Witness statement of Mr UD (10 March 2021, paras 24, 35, 42, 64, 67–68).

48 Witness statement of Mr UD (10 March 2021, para 58).

49 Witness statement of David Williams (aka John Williams) (15 March 2021, para 135).

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65. Many staff, volunteers, carers and bystanders consistently failed to intervene to stop or report abuse and neglect because:
- the people in their care had become dehumanised in their eyes, so they no longer cared what happened to them
  - they gave abusers the benefit of the doubt, due to personal relationships, grooming, and unconscious bias
  - they were reluctant to intervene due to fear of reprisals, or there was an institutional culture that discouraged or suppressed intervention
  - they were not trained to identify signs of abuse and neglect
  - they had become desensitised to abuse and neglect because it was commonplace and normalised in the care setting
  - there was no legal mechanism that required reporting for much of the Inquiry period (voluntary reporting was introduced in 1989 and reporting protocols for agencies and care providers in 1995).<sup>50</sup>

66. Dr John Crawshaw, Ministry of Health's Director of Mental Health and Director of Addiction Services, discussed the effects of institutionalisation on both staff and people within care settings:

***"Quite aside from the issue of abusive people in positions of power within institutions, the institutionalisation of staff and residents led to an environment in which bad practices were not challenged.***

***The institutional environment was a factor as to whether some staff or carers would intervene when they saw signs of abuse or neglect.***<sup>51</sup>

67. The high rates of abuse and neglect during the Inquiry period could have been much lower if all staff, volunteers and carers had been trained to recognise signs of it and had strong and clear incentives or direction to report it, such as mandatory reporting obligations.

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50 Children, Young Persons and their Families Act 1989, section 15; Children, Young Persons and their Families Amendment Act 1994, section 4

51 Brief of Evidence of Dr John Crawshaw on behalf of the Ministry of Health for the Investigation into State abuse in psychiatric care (1 April 2021, para 3.5).



## He akonga i kitea he mea i panonihia Lessons identified and changes made

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68. This section relates to clause 31(e) of the Terms of Reference, which requires the Inquiry to report on the lessons learned and changes made to prevent and respond to abuse and neglect.
69. The lessons identified are stated definitively for clarity, even though it is generally unclear to what extent the State did in fact 'learn the lesson'. In most cases, the changes made reflected aspects of a lesson learned were hindered by implementation issues or were only applied to discrete parts of care settings, which limited their potential to safeguard people in care.
70. The lessons described below relate to:
- lessons identified and changes made for families, whānau and people in care
  - lessons identified and changes made about abusers
  - lessons identified and changes made about reporting abuse.
71. The sections on lessons identified or changes made set out below and throughout this part of the report are not exhaustive.

## He akonga i kitea he mea i panonihia mō ngā whānau iwi kē, Māori mai me te hunga i ngā pūnaha taurima Lessons identified and changes made for families, whānau and people in care

72. The State learned that some families, whānau, mothers and fathers needed special measures to care for their loved ones at home. From the 1970s onwards, the State made changes to legislation to provide some support, including financial, to families in need.
73. The State learned that families, whānau and communities needed to have much greater, direct roles in care. From the 1980s onwards it made legislative changes to most settings to bring families and communities closer to care. For example, in 1989 there were large-scale changes to education and social welfare settings. The Education Act 1989 devolved the State's responsibility for running State and State-integrated schools to Boards of Trustees elected by parents and communities.<sup>52</sup> The Children, Young Persons and Their Families Act 1989 introduced greater participation by whānau, hapū, iwi and extended family in decision-making about children and young people, including family group conferences.<sup>53</sup>

<sup>52</sup> Education Act 1989, Part 9.

<sup>53</sup> Children, Young Persons, and Their Families Act 1989, section 28.

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74. The State learned that it needed to value Māori identity, culture and connections. From the late 1980s onwards, legislation began to include limited references to the principles of te Tiriti o Waitangi<sup>54</sup> and tikanga Māori.<sup>55</sup> However, there was never any explicit legislative protection of or reference to the rights guaranteed in the text of te Tiriti o Waitangi, such as tino rangatiratanga.
75. The State learned that it needed to legislate to protect the rights of people in care. Between 1986 and the early 1990s, the State began to protect the basic legal rights of some people in care, including rights to access to information, rights to an advocate, visits from family and complaints processes. These protections were limited to children, young people and adults in care in State residences or subject to compulsory mental health treatment orders.<sup>56</sup> There was no explicit reference to the human rights of people in care or to the rights guaranteed in the text of te Tiriti o Waitangi in care-specific legislation.
76. There were initiatives in some settings, like education, from the 1980s to help children and young people understand and identify sexual abuse and ways to safely respond to and report abuse.
77. The State started to recognise the need for people in care and their whānau to have access to information about themselves from their time in care, which was reflected in the Official Information Act 1981 and the Adult Information Act 1985.
78. To a lesser degree, faith-based institutions introduced components of safeguarding and protective factors from the late 1980s. These changes tended to be slow and dependent on individual local leaders for introduction and implementation.

## **He akonga i kitea he mea i panonihia e pū ana ki ngā kaitūkinō** **Lessons identified and changes made about abusers**

79. The State learned that safety checks, which include vetting and reference checking, were a critical first step to prevent abusers from entering a care setting, although relevant legislative changes were not made during the Inquiry period.
80. The State also began to learn that other factors, like effective, accessible complaints processes, staff training and accountability were critical to preventing and responding to abuse and neglect. However, changes were piecemeal and did not apply consistently across all settings.

<sup>54</sup> See State-Owned Enterprises Act 1986, section 9; Conservation Act 1987, section 4; Crown Minerals Act 1991, section 4; Resource Management Act 1991, section 8.

<sup>55</sup> See the Resource Management Act 1991, section 2, which refers to kaitiakitanga.

<sup>56</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 6, 64–75; Children and Young Persons (Residential Care) Regulations 1986, sections 6, 13.


## He akonga i kitea he mea i panonihia e pā ana ki ngā kaitūkinu Lessons identified and changes made about reporting abuse

81. The State began to learn that staff and carers need training to know what the signs of abuse and neglect are, and clear policies and processes to follow on what to do when they recognise those signs.
82. From 1995, legislation required the Director-General of Social Welfare to promote awareness of abuse, how to prevent it, how to report it, and to develop, implement and monitor reporting protocols for all care workers.<sup>57</sup>
83. The State made changes to legislation in 1989 to encourage anyone to report abuse or neglect of a child or young person to a social worker or NZ Police and to protect anyone who made such a report.<sup>58</sup> This led to an increase over time in reports of alleged child abuse, neglect and insecurity of care, mainly in relation to private homes.<sup>59</sup> However, the legislation did not make it clear that staff and carers should, or must, report signs of abuse and neglect in care.

57 Children, Young Persons and their Families Amendment Act 1994, section 4.

58 Children, Young Persons, and Their Families Act 1989, section 16; Children, Young Persons, and Their Families Amendment Act 1994, section 5.

59 Waldegrave, S & Coy, F, A differential response model for child protection in New Zealand: Supporting more timely and effective responses to notifications, *Social Policy Journal of New Zealand*, Issue 25 (July 2005, page 33).

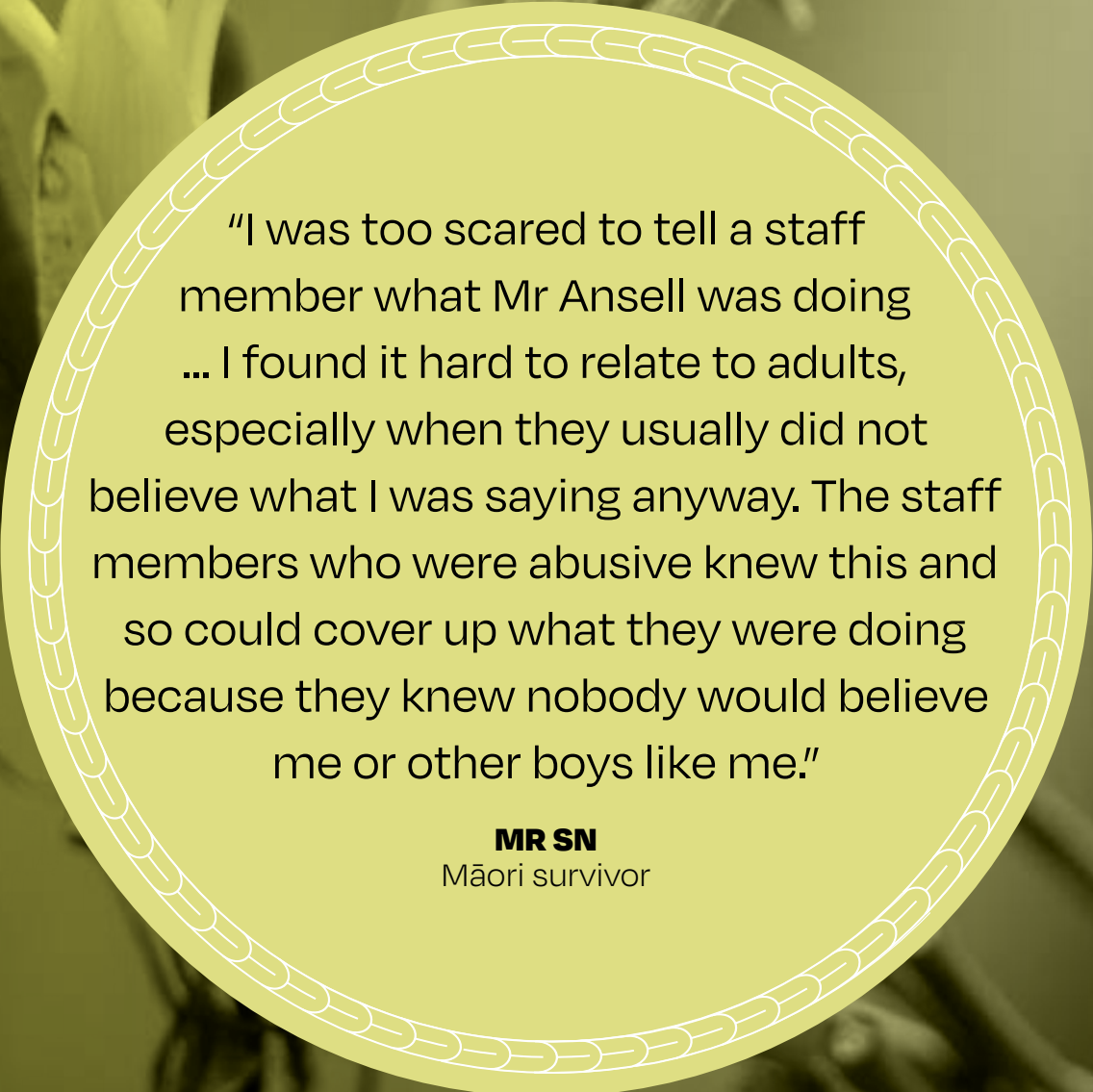


## He kōrero mutunga mō te hunga i te pū o ngā mahi tūkino

### Conclusion on the people at the centre of abuse and neglect


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84. People in care needed support, strong protective factors and safeguarding. Te Tiriti o Waitangi and human rights were an additional layer of protection for children, young people and adults in care and their whānau, hapū and iwi. However, breaches of te Tiriti o Waitangi contributed to many tamariki, rangatahi and pakeke Māori entering care and increased their risk of being abused or neglected in care. Many whānau and people in care did not have the protections and reasonable accommodations they needed and were entitled to as part of their human rights. Many people in care did not have the support, protective factors or safeguarding they were entitled to.
85. People in care relied on the adults around them to care for them, to protect them from abuse and neglect and, if it happened, to intervene and stop it. Some of the adults that people in care relied on to safeguard them were abusers. Many abusers were predatory and misused their positions of power and control to carry out serious and, at times, extreme, extensive and depraved abuse and neglect. Some abusers were peers of those in care. Abusers were rarely held to account. Many abusers acted with impunity and entitlement because of the failures of multiple, interconnected institutional factors.
86. Staff and carers who worked or volunteered in care settings should have intervened to protect people in care when they saw abuse and neglect or signs of it. Many did not. For many staff, volunteers and carers that were bystanders and observed, or witnessed a situation of abuse and neglect, there were negative consequences if they spoke up, such as being bullied by other staff members or losing their jobs. Bystanders often gave the abuser the benefit of the doubt and dismissed those survivors who were brave enough to tell them what was happening. Many staff, volunteers and carers lacked training or were desensitised to abuse and neglect because it had become so normalised. None had an obligation to mandatorily report signs of abuse and neglect in care.



"I was too scared to tell a staff member what Mr Ansell was doing ... I found it hard to relate to adults, especially when they usually did not believe what I was saying anyway. The staff members who were abusive knew this and so could cover up what they were doing because they knew nobody would believe me or other boys like me."

**MR SN**  
Māori survivor



"Nobody wanted  
a broken teenage girl!"

**TANIA KINITA**

Māori (Ngāti Hineuru, Ngāi Tahu,  
Te Arawa, Ngāti Whakaue)

# Tania Kinita

**Hometown:** Hawkes Bay

**Age when entered care:** 14 years old

**Year of birth:** 1971

**Time in care:** 1985-1989

**Type of care facility:** Family homes, foster care

**Ethnicity:** Māori (Ngāti Hineuru, Ngāi Tahu, Te Arawa, Ngāiti Whakaue, Ngāti Tūwharetoa)

**Whānau background:** Tania has one half-brother and four sisters.

**Current:** Tania has five tamariki and two mokopuna.

Ko Titiokura te maunga

Ko Mohaka te awa

Ko Te Haroto te Marae

Ko Mataatua te waka

Ko Ngāti Hineuru te iwi

Ko Te Rangihiroa te tangata

Raua

Ko Kakaramea te maunga

Ko Waikato te awa

Ko Ohaaki te Marae

Ko Puaharangi Manunui

Ko Ngāti Tahu / Ngātii Whaoa te iwi

Ko Te Rama te tangata



**My whānau name was originally Kingita, but the mana of our name was altered when my whānau had to sign for wages and the employers couldn't read or pronounce our name correctly, so the 'g' was removed and our whānau carried Kinita on. There is a deep history surrounding our experiences of land confiscation, wrongful arrest and the imprisonment of my tīpuna over at the Chatham Islands. The theft of my culture and my right to te ao Māori is entrenched in my whakapapa, and this is the ancestral history load that I carry with me, or the muri kawenga that sets the scene for my experiences of abuse.**

My maternal grandfather served in Turkey in WWII, and he suffered post-traumatic stress disorder (PTSD). My mother had a strict upbringing and is a survivor of sexual assault. My father served in the war in Vietnam and suffered undiagnosed PTSD, there is also a history of sexual abuse in his generation. My mother and father parented out of this background of trauma, of mental health issues, of alcohol and drug abuse and intergenerational sexual abuse. When my mother was hapu, she wanted a son because she already had two daughters before me. I had a twin, but my mother miscarried my twin while she was hapu and this is when the disconnection between me and my mother started. This disconnection was the foundation of our relationship.

I was 14 years old when I was made a State ward. I was told that my parents no longer had any rights to me and I belonged to the Crown. This made no sense to me. I am not a piece of land.

We grew up around violence. The violence we experienced and witnessed as kids was almost always connected to alcohol. My dad would sexually abuse me when they were drunk or when my mother was working. My father was very good at instilling a type of wairua of separation between myself and my sisters, and myself and my mum. We never spoke to each other about the abuse we were suffering until eventually I built up the courage to speak to my older sisters about the abuse and tried to create a plan for us to escape. For my dad to sexually abuse us he had to essentially remove aspects of te ao Māori from our life, because he wouldn't be able to abuse us if there was wrap around community support. He tried to put a wedge between my mother and I, so that there was no communication with her about the abuse.

I ran away with my cousin, but Social Welfare caught up with us and asked me to disclose what had happened and why I had run away from home.

I told them that what I said was not to be repeated to my mother as it would rip her to pieces. I had memorised everything about the abuse from my father. The time of day, what he was wearing, where he placed the knife that locked the door, where my mother was. So, it was quite easy to tell them. But they breached my confidentiality and sent my mother the report of everything I had disclosed, without telling me. This completely broke my trust. Reading the report, my mother tried to kill herself and then decided I was a liar.

They took me to hospital to have an internal examination and I was absolutely petrified. I had no trust or confidence in these people, and I was mentally and emotionally exhausted. A few days later they took me to court to emancipate me from my parents. I didn't understand what was happening.



My first placement was Kingsley Family Home, run by a Māori Mormon couple. Most of the children who were placed in Kingsley were put in there because they committed a crime. This was confusing for me because the only crime I committed was running away from home and disclosing the abuse by my father. My first week in Kingsley was frightening, the social workers never explained what was happening or tried to talk to me to see how I was feeling. There was a policy at the time that stated that Māori children needed to be placed in a home that had at least one Māori caregiver. So, when I think back, I think that my placement at Kingsley was intentional. The issue with this practice is that there was nothing at the time that required Social Welfare to look at options within the child's own whānau.

After Kingsley, I was placed with a foster family and they were loving. But my social workers heard that my foster mother had struck up a relationship with my parents, and my dad wasn't allowed access to me, so they moved me. They put me in a car with a black plastic bag filled with all my belongings and took me to my next home. You know you're a foster kid if all your belongings can fit in a black plastic bag.

I was never part of the decision to move me, and I had all these thoughts like; Why was nobody talking to me, why can't I choose where I live, why can't I live with my Aunty, why do I have to live with strangers? When the car pulled up at the next home, my thoughts were racing – I knew the family and I didn't feel safe here. My concerns didn't matter to my social worker, he dropped me off and was on his way.

My foster father's demeanour was imposing and intrusive. The way he sat, the way he looked at me and the way he spoke to me made me uncomfortable as a teenage girl. I remember him saying things like "You're a fox, and you love it, you love the power of knowing that men drop at your feet". This was a whole new language that I didn't understand, and I was confused by comments like this. This was also when I got my first hiding for being "too lippy".

My foster father was extremely violent and abusive. He knocked me out, pummelled my face black and blue, cracked my cheek bones, broke my nose, sprayed my blood up the walls and kicked me senseless. My social worker came to a meeting and all he said to my foster father was, "that's a bit extreme, isn't it?" and sent me home with him again. I completely shut down at this point. No one listened to my voice, and nobody wanted a broken teenage girl.

My foster father constantly made comments with sexual undertones and invited older men to come to the house and spend time with me, bartering prices with these men to marry me. On one occasion a man came to our house and asked me to marry him. He was getting closer and closer in my personal space and I wanted to be left alone. I told him I was only a kid and I did not want to marry him. That night he got drunk and committed suicide. My foster father blamed me for him taking his own life and gave me a hiding.

I felt like I could never win. I was just trying to survive being there. I could never comprehend how Social Welfare could approve those people to be paid caregivers, they were just as bad as some of the parents and homes that most of us came from.

When I turned 17, I left my foster home. I left there a shell of a human. I was dissociative, like a zombie. There was no transition plan for me, and I had no money, no understanding of how to make money or how to apply for a job. Social Welfare had located a relative who was willing to care for me, my Uncle Charlie. Uncle Charlie was heartbroken when he discovered that I had been in care all those years and that they didn't try to locate or notify him about my situation earlier. It broke me to know that he was always waiting and ready to care for me.

I'm aware that my foster father works in an evangelical Christian church and is part of a men's programme. I have no words for how let down I feel, not just for me but for everyone he continues to 'help'.

Today I'm the proud mother of five tamariki, and four pēpi in heaven who I miscarried. I have two beautiful mokopuna too. When I went on to have my own tamariki, I realised I didn't know what a healthy family looked like. I was so used to taking care of everyone else that I didn't know what a good mother looked like, or a good wife. I had to watch other people to see what these qualities were and teach myself.

Once I had my own children, I grew to despise my mother. I couldn't understand how she didn't defend us, as I would die for my tamariki. Today I have no relationship with my parents. Occasionally, I popped in to see my father before he died to see how his health was and whether he was prepared to say sorry. That day never came.


Being made a ward of the State stripped me of all connection to my identity and the opportunity to learn reo. A true apology would be them supporting me to reconnect with my culture and funding my social work degree. This trauma has left me with a huge sense of loss. I am still fighting to decolonise myself today. The work I need to do to reconnect to my cultural identity falls on my shoulders alone.

I don't know if the PTSD ever goes away. I have moments in the day when the monologue is not okay. I'll get a flashback because someone looks similar to somebody. I'm extremely sensitive to noise, and children screaming is a trigger for me. The doctor said I had bipolar and needed to be on medication. Couldn't I just be sad? I'd never given myself permission to cry and grieve. Labelling me and forcing me to take anti-psychotic drugs was not tikanga.

Romiromi healing has been my therapy and balances my wairua and mauri, helping me to recover from the years of trauma I faced. I fight with every ounce of me that I have to heal. At 50 years old I can say that I love the life I have created for myself. I have an inner drive and strength to heal and restore my mana. I will not be another Māori statistic. I don't know where this strength came from, but I don't just want to survive – I want to thrive.<sup>60</sup>

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<sup>60</sup> Witness statements of Tania Kinita (2 August 2021 and 17 September 2022).



"You  
just felt like  
a piece of shit –  
you were treated like  
you were scum, like  
you didn't matter!"

**MR NL**  
Pākehā

# Mr NL

**Hometown:** Palmerston North

**Age when entered care:** 8 years old

**Time in care:** 1995–1997

**Type of care facility:** Gisborne Health Camp

**Ethnicity:** Pākehā

**Whānau background:** Mr NL grew up in Napier. His parents separated when he was young and he has an older sister. Mr NL is dyslexic and suspects he had undiagnosed ADHD as a child.

**Current:** Mr NL lives with his partner and has three sons; each has severe ADHD and one also has Oppositional Defiance Disorder.



**I've been to pretty much every school in Hawke's Bay, because I was an unruly child. I got labelled as a naughty kid, a difficult kid. Nobody seemed to really care why I acted the way I did – I was just naughty and that was it. Even if I didn't do anything wrong, I would still get the blame.**

Mum and Dad used to argue all the time, then they separated on Christmas Eve 1995. After that, there was an incident at school when another kid was giving me a hard time about my dad. Child, Youth and Family Services got involved and I was made to go to a health camp in Gisborne when I was about 7 or 8 years old.

It was a scary place. The dormitories were split, with older kids at the back of the dormitory and the younger kids up at the front of the dormitory. So many of the kids there were bullies, they just used to beat people up for no reason and get away with it.

If you didn't do as you were told, you were forced to stand at attention, feet together, hands by your side, not allowed to move while everybody else was asleep. If that didn't work, the supervisors would get the older kids onto you. I woke up at 5.30am one morning to find a group of three older boys with bars of soap in socks beating the shit out of me.

They had a time out room they used to put me in. It was small, carpeted and soundproofed. I was locked in there multiple times – no toilet, nothing. There was only one window, on the door – it had a slot on it, so then they could open it, look in, then close it. There was one light that was way, way up in the roof that I couldn't get to. When I was in there I didn't know if it was day or night, or even how long I'd been in there. I had to eat my dinner in there and I can't even really remember if I was given anything to drink. The only time I was allowed out was to have a shower at night.

One time I kicked and kicked and kicked on the door until somebody came and I was pleading with them to go to the toilet. They just said, "Too bad, you should have thought about that before".

Once I ended up going toilet in my pants. They pulled me out and paraded me up and down in front of the other boys to show them: "This is what happens if you don't do as you're told."

I just felt like a piece of shit. I was treated like I was scum, like I didn't matter. I'd never allow anybody to do that to my kids. I'd fight tooth and nail to bloody stop that from happening. Rather than help me, it was easier to just send me away somewhere. I've seen it with my own kids, too, "You're unteachable, you're unruly, we can't teach you, we don't want you".

Being in the health camp fucked me up pretty badly. It really taught me not to trust people. I don't have any friends at all. I'm really funny about meeting people and being around people. I used to be a big advocate for standing up for what's right and I'd argue the point if I knew I was in the right, but I won't do that anymore, I just shut down and walk away. Since I was at health camp I feel almost like I've got no emotions. I don't really get that happy or sad, I'm just numb all the time. If you don't show emotion and you don't feel anything, nobody can use it against you – you can't be a target.

I've had problems with drugs and alcohol. I don't drink anymore because I got sick, but drugs have been such a big burden my entire life. I need to stop so the drugs so there's not that hold over me. Instead of spending money on drugs I can take the kids away for a holiday.


If my partner starts getting angry with me, she'll get even more wound up because instead of talking to her I won't talk – I'll just sit there and look at the floor and go quiet. Because that's always been my response since I was in the health camp. I just shut down whenever there's conflict and try and get away from it.

That's why I don't deal with people and that's why I went farming. That's why I'm a tree surgeon, because I don't have to deal with people. I can avoid conflict. I can't hear someone talking to me when I've got a chainsaw going. Cows don't argue. Cows are quite peaceful to be around, lovely animals, and if you treat them right they'll do exactly what you want them to do, whereas to me, most people are just out for themselves and all they can get.

In life, I've never been able to get anywhere because I keep doing the same stuff over and over again. I'm telling my story because it's time to deal with that and hopefully be able to move on.<sup>61</sup>

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61 Royal Commission of Inquiry (Abuse in Care), private session. Mr NL (16 June 2020).



"What has been reported may only be the tip of the iceberg in that the residential clients are predominately powerless against persons in authority!"

**FRAN ERIKSON**

manager at Kingslea Girls' Home in in Ōtautahi  
Christchurch in 1995



# Ūpoko | Chapter 3

## I takahia tonu ngā paerewa i roto i ngā pūnaha taurima

### Standards of care were routinely breached

87. Standards of care set the baseline for how the rights of people in care will be protected and how they will be kept safe from abuse and neglect.<sup>62</sup> They prevent and respond to abuse and neglect because they make it clear to everyone what their rights and obligations are and what is unacceptable.
- People in care know how they will be kept safe, what their rights are and how these will be protected, and their whānau and community know too.
  - Institutions and foster carers know what care they need to deliver based on the standards.
  - Oversight and monitoring bodies know what institutions and foster carers should be doing and when they are failing.
88. Standards of care were routinely breached throughout the Inquiry period. In many institutions, residences, family homes and foster homes, schools, hostels, and transitional and law enforcement settings, breaches of standards of care were serious and unlawful. European survivor Lindsay Roxburgh, who attended Dilworth School in Tāmaki Makaurau Auckland in the 1990s, told the Inquiry:
- “Victims of abuse were everywhere. It was an unspoken existence.”*<sup>63</sup>
89. Breaches of standards of care varied in severity. Many were extremely serious such as unconsented medical treatment and sexual abuse, some appeared minor such as infrequent visits to State wards in care, but all contributed to abuse and neglect, or were themselves abusive and neglectful.
90. The first section of this chapter looks at what standards of care were in place across all care settings. It responds to clauses 31(b) and 10.2(c) of the Terms of Reference. It looks at whether standards were set out in legislation and if they applied consistently to all people in care and all care providers. It also looks at how accessible they were to all staff and carers, people in care, their family, whānau and community. The second section of this chapter looks at breaches of standards of care, in line with clause 33 of the Terms of Reference.

<sup>62</sup> Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Volume 6 – Making institutions child safe (2017, pages 12–14).

<sup>63</sup> Witness statement of Lindsay Roxburgh (3 November 2022, para 18).

# Ngā paerewa i roto i ngā pūnaha taurima i te wā o te Pakirehua

## Standards of care during the Inquiry period

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### Ngā paerewa atawhai e tika kē ana hei aukati mahi tūkinō

#### Common standard of care to prevent abuse and neglect

91. Before and throughout the Inquiry period, disability and mental health, social welfare and parts of education settings had common legal standards to prevent ill-treatment, later called abuse and neglect. These common standards were all similar to this standard for institutional care which had been in place since 1911.

*“Every Superintendent, licensee, officer, nurse, attendant, householder, or other person having the oversight, care, or control of any mentally defective person, or employed in any institution, house, or place in which any such mentally defective person resides, who strikes, wounds, or ill-treats, or wilfully neglects, any such mentally defective person is guilty of an indictable offence.”<sup>64</sup>*

92. Before and throughout the Inquiry period, across all State and faith-based care settings it was a criminal offence to sexually abuse or indecently assault a person in care (consent was not a defence),<sup>65</sup> with special provisions for women and girls, regardless of age, in institutional care.

*“Every person is guilty of an indictable offence who has or attempts to have carnal knowledge of any female who is detained under the provisions of the Act, or is otherwise under oversight, care, or control as mentally defective [consent is no defence].”<sup>66</sup>*

93. Neglect and ill-treatment / abuse were also unlawful in Deaf, disability and mental health settings, social welfare settings and parts of education settings. From 1961, neglect and ill-treatment / abuse were unlawful in all settings including all parts of education and faith-based care settings.

### Kāhore he wāhi mo te Tiriti o Waitangi i roto i ngā paerewa atawhai

#### Te Tiriti o Waitangi was absent from standards of care

94. In Part 6 the Inquiry noted that the Crown’s te Tiriti o Waitangi obligations include ensuring the Crown and, as appropriate other institutions, recognise Māori rights and values and give effect to the Crown’s te Tiriti o Waitangi obligations.

<sup>64</sup> Mental Defectives Act 1911, sections 126–127; Mental Health Act 1969, sections 112–113; Mental Health (Compulsory Assessment and Treatment) Act 1992, section 114; Child Welfare Act 1925, section 24; Child and Young Persons Act 1974, section 103; Children, Young Persons, and Their Families Act 1989, section 453; Children, Young Persons, and Their Families Amendment Act 1994, section 2; Industrial Schools Act 1882, sections 48, 75; Offences of the Person Act 1867.

<sup>65</sup> See Crimes Act 1908 sections 208–219; Crimes Act 1961, section 195.

<sup>66</sup> Mental Defectives Act 1911, section 127; Mental Health Act 1969, section 113.

95. During the Inquiry period, there was no legislative direction that standards of care should give effect to the rights guaranteed to iwi and hapū in te Tiriti o Waitangi or incorporate te Tiriti o Waitangi itself. It was left to government agencies and individual institutions to decide if and how to incorporate te Tiriti o Waitangi into their standards of care. The Inquiry did not see any standards of care that explicitly incorporated te Tiriti o Waitangi or gave effect to the rights of iwi and hapū as expressed in te Tiriti o Waitangi, such as the right to exercise tino rangatiratanga or that explicitly provided for te Tiriti principles of partnership, active protection or equity.
96. Up until the late 1980s the Crown and government agencies developed standards of care without hapū or iwi input, undermining both tino rangatiratanga and te Tiriti o Waitangi principle of partnership. This represented a missed opportunity to incorporate tikanga Māori and Māori models of care into standards that reflected te ao Māori, matauranga Māori, tikanga and te reo Māori, and to ensure connections to culture and to whānau, hapū and iwi were maintained. The Inquiry did not see any evidence of standards of care that sought to achieve equitable outcomes for tamariki, rangatahi and pakeke Māori in care, even though over-representation of Māori in care settings was a known issue from the 1960s and Māori were the majority in social welfare care settings. This was a breach of both the active protection and options principles of te Tiriti o Waitangi, which arise from the guarantee to Māori of both tino rangatiratanga and the rights and privileges of British citizenship under article 3.<sup>67</sup>
97. The Inquiry did observe that from the mid-1980s onwards there were some attempts made to include aspects of te ao Māori, tikanga Māori and te reo Māori in some care settings.

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<sup>67</sup> Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkinga Whāruarua: Oranga Tamariki Urgent Inquiry (2021, page 100–101).



## **Kāhore i tino kitea ngā mōtika tangata i roto i ngā paerewa atawhai**

### **Human rights were largely absent from standards of care**

98. For most of the Inquiry period, standards of care did not refer to or provide for the human rights of children, young people or adults in care.
99. From 1950–1996, in Deaf, disability and mental health settings there was no legislative direction that human rights should be explicitly protected and fulfilled in standards of care. It was left to government agencies and individual institutions to decide whether to incorporate human rights into their standards of care. Some did. From 1996, several human rights obligations were expressly included in the Code of Health and Disability Services Consumers' Rights, such as the right to dignity. There were exclusions for some people in care for example, people under compulsory mental health treatment orders were excluded from the Code's right to give informed consent to treatment.<sup>68</sup>
100. From 1950–1986, in social welfare settings, the Department of Social Welfare's standards of care did not explicitly incorporate or reference the human rights of people in care. From 1986, regulations prohibited humiliating or degrading treatment of children and young people in social welfare residences, but there were no other explicit references to human rights in social welfare settings.<sup>69</sup>
101. During the Inquiry period, standards of care in education, faith-based and transitional and law enforcement settings did not explicitly refer to or incorporate human rights. The Ministry of Education did issue guidelines in 1997 to schools referring to the dignity of children and young people.

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<sup>68</sup> Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996.

<sup>69</sup> Children and Young Persons (Residential Care) Regulations 1986.

## Ngā paerewa atawhai i ngā takinga whaikaha, hauora hinengaro Standards of care in disability and mental health settings

102. Between 1950 to 1992, it was left to government agencies and institutions to decide whether and how they would protect the rights of the children, young people and adults in their care. Some institutions developed their own standards to protect the rights of people in their care with wide ranging approaches. For example, the 1988 Statement of Rights for Residents of Templeton Hospital, a psychopaedic institution in Ōtautahi Christchurch, was entirely patient and human rights focused:

*“All residents ... should have and freely exercise the following rights:*

*1) The right to dignity and respect.*

*2) A right to adequate protection from any physical or mental abuse and exploitation.*

*3) The right to proper daily care. This includes proper exercise, nutrition, sleep, medical attention, dental care and hygiene.”<sup>70</sup>*

103. From November 1992, the basic rights of people subject to compulsory mental health treatment orders were protected in legislation.<sup>71</sup> They had:


- > the right to know their rights while in care and have a copy in writing;
- > the right to an interpreter, including for te reo Māori or to meet their communication needs
- > access to independent legal and psychiatric advice
- > the right to company
- > the right to send and receive mail and make phone calls.

104. A complaints process was also included which provided important protections including the requirement for directors of area mental health services to rectify matters and rights of appeal.<sup>72</sup> There was also a general emphasis on family connections and cultural identity and connections to support protective factors while in care.

<sup>70</sup> Statement of rights for residents of Templeton Hospital and Training School (14 September 1988); Memo regarding adoption of Templeton Hospital and Training School's Philosophy and Statement of Rights (14 September 1988, page 1).

<sup>71</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 64–75.

<sup>72</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 6, 64–75.

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105. From May 1993, for people in the care of other disability and mental health service providers, the Ministry of Health set standards of care through its health service contracts.<sup>73</sup> There was only a legislated requirement in the Health and Disability Services Act 1993 for standards of services (rather than care or preventing and responding to abuse or neglect in the care of a provider), and general objectives to secure the best health, care and greatest independence for people receiving the services. The Department of Health's 1992 Child Abuse Guidelines for Health Services set standards for preventing and responding to abuse.<sup>74</sup>
106. From 1996, most people in the care of health and disability service providers were also entitled to services that met the standards in the Code of Health and Disability Services Consumers' Rights. There were limitations on the right to informed consent for some people who were considered unable to do so or where compulsory mental health treatment was ordered.<sup>75</sup> The standards in the code focused on the rights of people in care, including:
- a. the right to be treated with respect
  - b. the right to be free from discrimination, coercion, harassment, and exploitation
  - c. the right to dignity and independence
  - d. the right to make an informed choice and give informed consent (although people subject to a compulsory order were specifically excluded from this right).<sup>76</sup>

## **Ngā paerewa atawhai i ngā takinga toko i te ora**

### **Standards of care in social welfare settings**

107. From 1957 until 1989, the Department of Education's Field Officers Manual and its later versions (including the Social Workers Manual) acted as default standards of care for social welfare settings.<sup>77</sup> These documents were essentially a complete guide to social work for staff, describing in detail how they should carry out all aspects of their day-to-day work. They also contained guidance on best practice in social welfare settings including residences, family homes and foster homes, including:
- a. a State ward must be medically examined before entering an institution<sup>78</sup>
  - b. State wards should be visited at least once every four months, and in person<sup>79</sup>

73 Health and Disability Services Act 1993, section 8(1)(d).

74 Department of Health, Child abuse guidelines for health services (June 1992, page 5).

75 Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996.

76 Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996, regulation 2.

77 Department of Education, Child Welfare Division Field Officers Manual (1957); Parker, W, Social Welfare Residential Care 1950–1994, Vol 1 (Ministry of Social Development, October 2006, page 6).

78 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, J6.8, J19.2).

79 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, H9.14, J9.35).

- c. State wards were to be seen on the same day where concerns were raised about their safety "within the hour if possible"<sup>80</sup>
  - d. the basic physical requirements for secure units, like the need for the cell to be specially designed for that purpose and provide adequate light, ventilation, warmth and safety for the child detained<sup>81</sup>
  - e. an array of standards for when a State ward was placed in a secure unit, including standards relating to their physical, education and mental and emotional needs<sup>82</sup>
  - f. ill-treatment or neglect of a State ward was unlawful<sup>83</sup>
  - g. if a social worker suspected a person in care was being ill-treated or neglected, investigating this took precedence over all other duties<sup>84</sup>
  - h. if ill-treatment or neglect was suspected, regardless of evidence, the person in care should be examined as soon as possible by a doctor<sup>85</sup>
  - i. NZ Police should be informed of cases of cruelty, ill-treatment or neglect.<sup>86</sup>
108. The various iterations of the manuals made changes to some specific areas over time, for example in relation to corporal punishment. The 1957 manual allowed corporal punishment but discouraged it and said that in every instance it is used it should be reported to the District Child Welfare Officer and recorded on a punishment register.<sup>87</sup> The 1975 manual said corporal punishment could only be used as a last resort by the principal, assistant principal or senior housemaster / housemistress.<sup>88</sup> In 1984, the manual prohibited the use of corporal punishment altogether and this policy remained in following versions.<sup>89</sup>
109. In State-run foster homes and family homes, there were limitations on the use of corporal punishment from 1937, including that it could not be used on girls.<sup>90</sup> However, in 1950, policy stated that punishment administered by a mother in private "with an open hand or a plain light strap" for children under 12 years old was not forbidden, but "should be limited according to the age, physical condition, health and mentality of the child concerned, and preference is to be given to other forms of discipline".<sup>91</sup> In 1990, the Department of Social Welfare explicitly said the use of corporal punishment by foster parents and family home caregivers was unacceptable.<sup>92</sup>

80 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, A14.12).

81 Department of Education, Child Welfare Division Field Officers Manual (1957, J.124(i) and (v)).

82 Department of Education, Child Welfare Division Field Officers Manual (1957, J.124).

83 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, J19.1).

84 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, A4.2, A4.12(d)).

85 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, C2.17).

86 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, H2.8, C2.16).

87 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 21).

88 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 22).

89 Ministry of Education, Legislation and social work guidance over the years (n.d., pages 22–24).

90 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 25).

91 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 25).

92 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 26).

110. By law, only reasonable use of corporal punishment was allowed under section 59 of the Crimes Act 1961. This was repealed in 2007.<sup>93</sup>
111. There were crucial gaps in the manual and its iterations until the late 1970s:  
*“[there was] no guidance for staff on responding to a child in care alleging sexual abuse; no guidance about what to do if caregivers were alleged to be perpetrators of abuse.”*<sup>94</sup>
112. In the 1980s, the Field Officers Manual was replaced by the Care and Protection and Youth Justice Handbooks. These handbooks typically included significant discussion about family group conferences and legal powers over children and young people. They also set out obligations about standards of care that were similar to the Field Officers Manual, such as:
- when a child or young person was placed in the care of the Director-General of Social Welfare, a social worker should arrange for a general medical check-up as soon as is practicable. As a general rule, parental consent and the consent of the young person (when appropriate) to a medical examination should be obtained<sup>95</sup>
  - children and young people in care should be visited at least every two months, meetings must be face-to-face with the child or young person only<sup>96</sup>
  - all allegations of abuse by caregivers of a child or young person placed in their care by the Director-General must be investigated<sup>97</sup>
  - when abuse is alleged to have occurred in a family home, every child or young person in residence will need to be interviewed<sup>98</sup>
  - when the allegation relates to sexual or serious physical abuse the joint CYPFS / Police Sexual Abuse Team protocol must be followed.<sup>99</sup>
113. These manuals or handbooks were not legally binding on staff, institutions or on foster carers and in practice they were treated as guides.<sup>100</sup> The documents were confidential and people in care had no access to them, neither did their families, whānau and communities.<sup>101</sup> There were no legally binding standards of care until 1986.

93 Crimes Act 1961, section 59; Crimes (Substituted Section 59) Amendment Act 2007, section 5.

94 Witness statement of Michael Doolan (7 May 2007, para 43).

95 Department of Social Welfare, Care and Protection Handbook, Volume 2, Chapter 9 – Care Services (1996, page 45).

96 Department of Social Welfare, Care and Protection Handbook, Volume 2, Chapter 9 – Care Services (1996, page 40).

97 Department of Social Welfare, Care and Protection Handbook, Volume 2, Chapter 9 – Care Services (1996, page 84).

98 Department of Social Welfare, Care and Protection Handbook, Volume 2, Chapter 9 – Care Services (1996, page 86).

99 Department of Social Welfare, Care and Protection Handbook, Volume 2, Chapter 9 – Care Services (1996, page 84).

100 Witness statements of Denis Smith (15 December 2021, para 45) and Michael Doolan (7 May 2007, para 211).

101 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, A1.5).



114. From 1986, legislative standards of care were put in place for all social welfare residences (a residence established under section 364 of the Children, Young Persons and Their Families Act). The standards did not cover foster homes, family homes and third-party care providers although they received State funding.<sup>102</sup> The standards were explicit about the basic rights of people in care, like rights to information about their care and the regulations, rights to personal items, privacy, visits from family and whānau and others, rights to a grievance procedure and rights to education and recreation.
115. The 1986 regulatory standards also clarified what treatments were unacceptable. For example, children and young people could not be degraded or humiliated, corporal punishment / physical violence was prohibited and limits were placed on the use of searches and secure care.<sup>103</sup> These regulatory standards were expanded in 1996.<sup>104</sup>
116. From 1992, the Department of Social Welfare set standards of care for third-party care providers, like Moerangi Treks and Te Whakapakari Youth Programme, through service contracts and its business unit, the New Zealand Community Funding Agency who approved, funded and monitored third-party providers.<sup>105</sup>

102 Children and Young Persons (Residential Care) Regulations 1986.

103 Children and Young Persons (Residential Care) Regulations 1986, regulations 22, 23, 27–36.

104 Children, Young Persons, and Their Families (Residential Care) Regulations 1996.

105 New Zealand Community Funding Agency, Standards for Approval – Level One: Child and Family Support Services (November 1995, pages 5–15).

117. The Department's standards for third party providers were more focused on service delivery and processes than on a shared set of accessible standards of care. The standards were high level, requiring processes be in place relating to a broadly stated standard. For example, these are from the standards for third party providers in 1995:

***"Standard 10: Provision of Care***

***All organisations have procedures which ensure that the care provided for children and young persons meets their individual needs for safety and nurture.***

***Standard 11: Discipline***

***Children and young persons are not physically punished, or disciplined, or treated in a way that is degrading or humiliating or causes unreasonable fear or anxiety. Alternative methods of discipline are employed.***

***Standard 12: Procedure for Complaints***

***All organisations have a policy for dealing with complaints about staff / care-givers, which is written, given and is explained to families and young persons.***<sup>106</sup>

118. From 1995, third party care providers were also required to have in place protocols for reporting child abuse to the Department of Social Welfare and NZ Police.<sup>107</sup>
119. Social worker visits to State wards were meant to be a critical intervention point to prevent and respond to abuse and neglect in care. Minimum visitation standards were set from 1957.<sup>108</sup> Evidence shows that the minimum visitation standard of at least once every four months was commonly breached. Many survivors said they either never received visits from social workers while they were in care, or they were visited much less frequently than once every four months.<sup>109</sup>

106 New Zealand Community Funding Agency, Standards for Approval – Level One: Child and Family Support Services (November 1995, pages 27–29).

107 Children, Young Persons and their Families Amendment Act 1994, section 4; New Zealand Community Funding Agency, Standards for Approval – Level One: Child and Family Support Services (November 1995, page 10).

108 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 7).

109 Witness statements of David Williams (aka John Williams) (15 March 2021, para 74); Kathleen Coster (9 March 2022, para 97); Mereani Harris (17 August 2021, para 20) and Ms HB (9 August 2021, para 28).

120. It was also a requirement for social workers to see State wards personally during their visits.<sup>110</sup> Many survivors said that when visits did occur, they were always in the presence of their caregivers and they were unable to speak to their social workers alone. Māori survivor Gina Sammons (Ngāti Kura), who was first placed in foster care at 2 years old, said she “had to hide under the bed so the social worker wouldn’t see my black eyes”.<sup>111</sup>
121. Breaches of face-to-face visit standards meant children and young people remained in abusive environments without the opportunity to disclose the abuse or neglect they were experiencing to the responsible social worker.
122. The Inquiry heard that some staff cut corners because of caseloads, either reducing the number of visits, or not visiting at all,<sup>112</sup> with some staff recording that they had complied with the Manual’s standard despite not doing so:
- “I would sometimes ring families, rather than do a visit. I would, however, write up the phone calls as if it was a visit ... my understanding is that senior staff ‘turned a blind eye to this practice’ ... I would ring more than half of the foster parents and then visit when issues arose.”<sup>113</sup>*
123. At the Inquiry’s State Institutional Response Hearing, Nicolette Dickson, Deputy Chief Executive of Oranga Tamariki, accepted these breaches of visitation standards were common experiences of survivors in care during the Inquiry period.<sup>114</sup>

110 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 7).

111 Witness statement of Tanya and Gina Sammons (24 February 2020, para 20).

112 Witness statement of Denis Smith (15 December 2021, paras 42 and 47); Confidential Listening and Assistance Service, Some memories never fade: Final report of the Confidential Listening and Assistance Service (Wellington, 2015, pages 25, 28).

113 Witness statement of Denis Smith (15 December 2021, para 42).

114 Transcript of Nicolette Dickson, Deputy Chief Executive, Quality, Practice and Experiences, Oranga Tamariki, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, page 692).

## Ngā paerewa atawhai i ngā takinga mātauranga

### Standards of care in education settings

124. Between 1950 and 1989, there were no legislated standards of care specifically for schools, including special schools for Deaf students. Schools made their own decisions about how they wanted to treat people in their care, including to what extent they wanted to use physical discipline / corporal punishment.<sup>115</sup> Section 59 of the Crimes Act 1961 allowed teachers to use reasonable force to correct behaviour.<sup>116</sup> As explained in the Department of Education's 1964 handbook:

*"What is permissible in a public primary school is determined by the general law, by the bylaws of the local Education Board, and by such directions as may be issued by the Head Teacher to his staff. ... The Head Teacher himself has full responsibility for formulating ... the school's policy on corporal punishment ... the final decision is his."*<sup>117</sup>

125. Corporal punishment was permitted in education settings until 1990. The Department of Education told the Inquiry that it began suggesting to schools that alternative methods of correction be used from the early 1970s but did not advise stopping its use in schools until 1987. Corporal punishment was prohibited under law on 23 July 1990.<sup>118</sup>
126. From 1950 to 1989, blind, Deaf and disabled children generally did not attend mainstream schools.<sup>119</sup> Their parents were responsible for providing them with "efficient and suitable education".<sup>120</sup> If they could not or did not, the State could direct their child to be sent to a special school or a similar institution.<sup>121</sup> Special schools could either be day schools or residential schools with boarding facilities.

<sup>115</sup> Crimes Act 1961, section 59; Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 99).

<sup>116</sup> Crimes Act 1961, section 59.

<sup>117</sup> Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 99).

<sup>118</sup> Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 97); Education Act 1989, section 139A (inserted on 23 July 1990, by section 28(1) of the Education Amendment Act 1990).

<sup>119</sup> Section 127(1) of the Education Act 1914 applied to "blind, Deaf, epileptic and feeble-minded children"; Section 115 (1) of the Education Act 1964 applied to a "child who has attained the age of seven years and is of school age and is suffering from disability of body or mind of such a magnitude as to require special education ... "

<sup>120</sup> Education Act 1914, section 127(2); Education Act 1964, section 115(1).

<sup>121</sup> Education Act 1914, section 127(3); Education Act 1964, section 115(2).

127. For principals of residential schools, there was a 1986 Department of Education Handbook for them to follow.<sup>122</sup> This contained standards including section 2.4.3 which related to 'timeout' procedures. This allowed both exclusion timeout and seclusion timeout and detailed under what circumstances each would be appropriate. It gave permission for children and young people to be physically removed to go to timeout and noted that children should be released from timeout within three to four minutes, as long durations in timeout could be counterproductive.<sup>123</sup>
128. As part of the Education Act 1989, all children and young people who had special education needs had the right to enrol and receive education at State schools.<sup>124</sup> However, if the Secretary for Education was satisfied that a child or young person should receive special education, they could still direct their parents to enrol them at a particular State school, special school, special class or special clinic.<sup>125</sup>
129. After 1989, the board of trustees of a State or State-integrated school controlled the day-to-day management of schools.<sup>126</sup> There were no standards of care in the Education Act 1989, but the Minister could issue national education guidelines, which were a "statement ... of desirable codes or principles of conduct or administration for specified classes or descriptions of person or body".<sup>127</sup> The Minister used this statutory power to issue binding guidelines to boards requiring them to provide a safe physical and emotional environment for students<sup>128</sup> and a duty to operate in a fair and transparent manner.<sup>129</sup> It was then largely left to boards to decide how to implement this standard within their school.
130. After 1989, school hostels, boarding facilities and private schools continued to decide for themselves whether to adopt standards of care or not, although they were not legally required to and there were no penalties or consequences for not doing so.<sup>130</sup> For example, up until 2000, policies at Dilworth School in Tāmaki Makaurau Auckland were kept "confidential to staff" so students and parents were not allowed to see them.<sup>131</sup>

122 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, pages 103–105).

123 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, pages 104–105).

124 Education Act 1989, section 8.

125 Education Act 1989, section 9.

126 Education Act 1964, section 75.

127 Education Act 1989, section 60.

128 Education Review Office, Schools and the law: Reporting to ERO (June 2003, page viii).

129 Education Review Office, Schools and the law: Reporting to ERO (June 2003, page ii).

130 Education Act 1964, section 186 (continued in force after the Education Act 1989 was enacted).

131 Dilworth Independent Inquiry, An independent inquiry into abuse at Dilworth School (September 2023, paras 8.115–8.116).

131. In 1997, the Ministry of Education issued Circular 1997/12 (The Responsibility of Trustees for the Personal Safety of Students in Schools) to principals of State and State integrated schools, chairpersons of boards of trustees of schools and proprietors of private schools. In it, the Ministry set out its views on the responsibilities of principals, boards, and proprietors for the personal safety of children and young people in their care.
132. The Circular emphasised the need for schools to act promptly on complaints of alleged abuse. It also reminded schools they should implement policies to ensure all children and young people were treated with dignity and respect, had their rights and needs met, and that staff were familiar with how to prevent, recognise and respond to abuse.<sup>132</sup>

### **Ngā paerewa atawhai i roto i ngā takinga whakatika, mauhere ā-ture** **Standards of care in transitional and law enforcement settings**

133. Throughout the Inquiry period, NZ Police relied on their General Instructions and related manuals for how they treated people in their care.<sup>133</sup> These Instructions and manuals were similar to the social welfare Field Officer Manuals, in that they were internal best practice guidance for NZ Police on how to do their job.<sup>134</sup>
134. The standards in the manuals were generally not explicit about preventing abuse and neglect of children, young people, or adults in risk in the care of NZ Police. Standards included:
- extreme care was to be taken in interviewing anyone under 17 years of age; a parent or guardian must be present or promptly informed if not<sup>135</sup>
  - a parent, guardian, or teacher must be present when interviewing a child under the age of 14<sup>136</sup>
  - when a young person was arrested, they should not be kept in a lock-up unless safe custody cannot otherwise be provided<sup>137</sup>
  - immediate attention was to be given to a complaint that someone was in need of care, protection or control, with inquiries completed in the shortest time possible.<sup>138</sup>
135. People who were State wards in transitional and law enforcement settings were covered by the standards of care for social welfare settings, and these were referred to in the NZ Police Instructions and manuals.<sup>139</sup>

132 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 468 (7 July 2022, page 27).

133 Brief of Evidence of Thomas Fitzgerald on behalf of NZ Police for the investigation into abuse in State psychiatric care (1 April 2021, pages 1–3); New Zealand Police, Manual of General Instructions (1977); NZ Police Manual of General Instructions (1980).

134 Brief of Evidence of Thomas Fitzgerald on behalf of NZ Police for the investigation into abuse in State psychiatric care (1 April 2021, pages 1–3).

135 NZ Police, Manual of General Instructions (1977, C42(1), (3), (5)).

136 NZ Police, Manual of General Instructions (1977, C42(2)).

137 NZ Police, Manual of General Instructions (1977, C44(2)).

138 NZ Police, Manual of General Instructions (1977, C46(1)).

139 For example, remand residences were dealt with under the Children, Young Persons and their Families Act 1989, section 364.

136. The Instructions and manuals were not a transparent set of standards of care that people in care, their families, whānau or communities were given or could access on request.<sup>140</sup> When Dr Oliver Sutherland asked for copies on behalf of the Auckland Committee on Racism and Discrimination in 1977, he was told by the Minister of Police:

***"I do not consider these suitable material for public dissemination and accordingly your application is declined. However, you have my assurance that the instructions are adequate and should serve to preclude complaints [from people in the care of Police] in these areas."***<sup>141</sup>

137. The Inquiry heard that young survivors, several aged 14 years old, were picked up by NZ Police and questioned without the presence of any parent, guardian, or lawyer.<sup>142</sup> Multiple survivors said that they were interrogated with physical violence and coerced into confessing to crimes, in some cases which they did not commit.<sup>143</sup> Pākehā survivor Lindsay Eddy said:

***"You're dumbfounded as a kid – tired and hungry, in a cell for a day so you just confess to get out. They never told you about your right to have an adult present."***<sup>144</sup>

138. These actions by NZ Police were breaches of the standards in their General Instructions.<sup>145</sup> They were extreme and had serious consequences that shaped the lives of survivors. These actions led to admissions to boys' homes, borstals and adult prisons, which survivors were left to navigate alone.<sup>146</sup>

139. Some survivors reported being kept in NZ Police cells, often overnight or sometimes up to weeks.<sup>147</sup> The NZ Police's General Instructions stated that a young person should not be kept in a lock-up unless safe custody cannot otherwise be provided.<sup>148</sup> The Department of Social Welfare also had an active role to ensure young people were not held in police cells, as set out in their series of manuals. In some instances, child welfare officers did not do anything to assist young people in these situations.<sup>149</sup> In other instances, social workers were unable to find an alternative place for these young people to go.<sup>150</sup> In 1997, one survivor was kept "in police cells for 3 months as there were no beds available in youth detention centres".<sup>151</sup>

140 Letter from Allan McCready (Minister of Police) to Dr Oliver Sutherland (5 December 1977).

141 Letter from Allan McCready (Minister of Police) to Dr Oliver Sutherland (5 December 1977).

142 Witness statements of Grenville Fahey (30 April 2021, paras 4–24); William MacDonald (4 February 2021, paras 54–56) and Lindsay Eddy (24 March 2021, paras 133–135).

143 Witness statements of Grenville Fahey (30 April 2021, paras 14–23); Toni Jarvis (12 April 2021, para 167) and Lindsay Eddy (24 March 2021, paras 133–135).

144 Witness statement of Lindsay Eddy (24 March 2021, para 135).

145 New Zealand Police, Manual of General Instructions (1977, C42(1)-(5)).

146 Witness statements of William MacDonald (4 February 2021, paras 54–58) and Grenville Fahey (30 April 2021, paras 22–31).

147 Witness statements of Mr CA (17 September 2021, paras 73–74); Ms QA (19 October 2022, paras 11.1–11.2); Lindsay Eddy (24 March 2021, paras 133, 135) and Mr U (12 February 2021, para 92).

148 New Zealand Police, Manual of General Instructions (1977, C44(2)).

149 Witness statement of Dr Oliver Sutherland (4 October 2019, paras 9–10).

150 Witness statement of Ms QA (19 October 2022, para 11.2).

151 Confidential Listening and Assistance Service, Police referrals and outcomes (n.d., page 5).

## Ngā paerewa atawhai i roto i ngā takinga pūnaha taurima ā-whakapono

### Standards of care in faith-based care settings

140. Faith-based institutions were required to comply with general standards in law, such as those barring ill-treatment and neglect, sexual assault and corporal punishment, but there were no legislated standards of care specific to faith-based institutions. Care standards, if any, varied between faiths and between regions within faiths, and changed over time.
141. From 1950 to 1999, the Catholic Church did not have a consistent set of safeguarding policies that applied across its institutions. From the early 1990s, the Catholic Church started to implement safeguarding guidelines and protocols, formalising these documents from 2000. However, it was not until 2017 that the Catholic Church implemented a formal, consistent safeguarding policy.<sup>152</sup>
142. From 1950 to 1999, the Anglican Church did not have a nationally consistent approach to safeguarding people in its care. The Anglican Church accepted that it had a “significant systems failure, particularly around the protection of children and vulnerable people”.<sup>153</sup>
143. The Salvation Army did not have a dedicated safeguarding policy in place during the Inquiry period. It adopted an internal Child Protection Policy in November 2015.<sup>154</sup>
144. The Methodist Church did not introduce a national safeguarding policy until 2000,<sup>155</sup> despite operating children’s homes since 1913.<sup>156</sup> The Methodist Church told the Inquiry that the Synod and Conference appointed a board to administer each children’s home that was responsible for admissions and the resident children’s welfare. At the Inquiry’s Faith-based Institutional Response Hearing, Reverend Tara Tautari (on behalf of the Methodist Church of New Zealand) said:

***“The Church did not have safeguarding policies and processes in place, and this led to unimaginable suffering of some children, young people and vulnerable adults.”<sup>157</sup>***

<sup>152</sup> First witness statement of Cardinal John Dew (23 September 2020, page 26).

<sup>153</sup> Transcript of evidence of Most Reverend Donald Tamihere at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 20 October 2022, page 550).

<sup>154</sup> Salvation Army Child Protection Policy (November 2015).

<sup>155</sup> Opening statement of Maria Dew KC on behalf of the Methodist Church and Wesley at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 246).

<sup>156</sup> Auckland Children’s Home (1913 to 1975); Opening Submissions of the Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa, Wesley College Board of Trustees, and Wesley College Trust Board at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 3.10).

<sup>157</sup> Transcript of opening statement of Reverend Tara Tautari on behalf of the Methodist Church of New Zealand at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 250).



145. The Presbyterian Church of Aotearoa New Zealand made certain behavioural expectations more explicit in its adoption of a code of ethics in relation to pastoral care in 1995. However, it has acknowledged that the code of ethics has not been consistently upheld and that breaches are not consistently reported. It accepted it needs to do more to educate members about its codes and to make clear requirements around reporting, and must make more requirements relating to safety binding on every part of the church.<sup>158</sup>
146. As the assemblies are autonomous, the Plymouth Brethren Christian Church does not have or enforce any national policies or procedures on any matters of individual assemblies.<sup>159</sup> The church told the Inquiry that families are responsible for safeguarding their children, young people and adults in care and educating them about abuse. The church does not consider that there are any opportunities for abuse within its pastoral settings and claims there are no barriers to disclosing abuse.<sup>160</sup>
147. The Gloriavale Christian Community leadership told the Inquiry it has had child safeguarding rules and procedures in place from its inception, but these were never formalised into a written policy during the Inquiry period.<sup>161</sup>
148. Faith-based institutions could also be approved to be care providers under section 396 of the Children, Young Persons and their Families Act 1989. As discussed above in relation to the standards of care in social welfare settings, these care providers were assessed against a set of standards for service provision, with annual reviews to ensure the standards were maintained.

## **Ngā aronga atawhai tangata kīhai i āta tuhia, i kaupare rawahia rānei ki te taha Individual care needs were often not recorded or were ignored**

149. Some care settings had record keeping and data management policies regarding individual care needs in place,<sup>162</sup> however the Inquiry heard evidence that these policies were not always followed and did not require the ethnicity or cultural identity of people in care in care to be recorded.


158 Presbyterian Church of Aotearoa New Zealand, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 523 (4 October 2022, page 3, para 1a).

159 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce issued to the Plymouth Brethren Christian Church on 9 September 2020 (23 April 2021, page 3).

160 Royal Commission of Inquiry into Abuse in Care, Internal notes from the inquiry's meeting with representatives of the Plymouth Brethren Christian Church (29 November 2022, page 22–24).

161 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (4 July 2022, page 21).

162 Record Keeping History of the Ministry of Social Development and its Predecessor Agencies: Part One – Agency Structure, Records Systems, and Procedures (n.d., pages 52–54).

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150. Several survivors told the Inquiry that their ethnicity was misidentified, incorrectly recorded or not recorded at all.<sup>163</sup> This primarily affected Māori and Pacific survivors. Some survivors believed this was done intentionally and wondered if social workers did this because they thought they were all the same or thought it would make them easier to be placed with a foster or adoptive family.<sup>164</sup> Research has found evidence of “insufficient, patchy and poor-quality ethnicity data collection across State care institutions”.<sup>165</sup>
151. From the late 1980s, failures to accurately identify and record individual care needs often meant services or funding were not provided to the person in care despite their care needs and eligibility. These failures were compounded for people with undiagnosed disabilities and could result in harm, such as educational neglect, or a lack of an ability to communicate that abuse or neglect was happening.
152. In 1994, the State introduced the Needs Assessment and Service Coordination service. The purpose of this service was to identify the needs of disabled people and people experiencing mental distress and match these to standardised funding and services.<sup>166</sup> The foundational policy for the Needs Assessment and Service Coordination service identified that it should not treat disabled people as being sick, it should be culturally sensitive and be flexible and innovative.<sup>167</sup> However, during the Inquiry period the service was based on a medical approach to treating impairments rather than the holistic the needs of the person and their whānau.
153. While some people were provided with the right supports and care through the Needs Assessment Service Coordination service, some were not which increased their risk of abuse and neglect (for example, by not having the communication supports necessary to report abuse and neglect). Several reports were published in the late 1990s and early 2000s highlighting problems with the service, particularly for Māori and Pacific Peoples.<sup>168</sup> In 2003, the National Advisory Committee on Health and Disability would recommend the service be fundamentally redesigned because of its shortcomings in identifying and meeting the needs of disabled people and people experiencing mental distress.<sup>169</sup>

163 Witness statements of Ms RK (2021, para 11); Mr CE (8 July 2021, para 117) and Rachael Umaga (18 May 2021, paras 21, 51, 64).

164 Private session transcript of survivor who wishes to remain anonymous (5 May 2021, pages 8–9); Witness statement of Ms AF (13 August 2021, paras 3.2–3.4).

165 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, Leonard, J, Hāhā-uri, hāhā-tea: Māori Involvement in State Care 1950–1999 (Ihi Research, 2021, page 373).

166 Te Whatu Ora, Needs Assessment (2023).

167 Shipley, J, & Upton, S, Support for Independence for People with Disabilities – A New Deal (Ministers of Health and Social Welfare, 1992, page 10).

168 Health Funding Authority, Disability Support Services: Strategic work programme: Building on the New Deal (Ministry of Health, 1998); National Advisory Committee on Health and Disability, To Have an ‘Ordinary’ Life Kia Whai Oranga ‘Noa’ (September 2003).

169 National Advisory Committee on Health and Disability, To Have an ‘Ordinary’ Life Kia Whai Oranga ‘Noa’ (September 2003, page 49).

## I takahia e ngā tikanga toko hinonga ngā paerewa Institutional environments and practices breached standards


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154. During the Inquiry period, many children, young people and adults were placed in large-scale psychopaedic and psychiatric institutions. Deaf and disabled people and people experiencing mental distress were also placed in specialist wards in general hospitals and in educational settings such as special schools, residential schools and occupational training centres. Institutional models of care, which included institutional environments and practices, were a feature of these care settings.
155. Institutional environments and practices were also present in other care settings, such as social welfare residences and family homes. Children, young people and adults in care during the Inquiry period had diverse care and support needs. The 1957 Field Officers Manual outlined the need for children to know they were “recognised as an individual, different from others, with a name and story” of their own,<sup>170</sup> alongside standards to support each person in care having their individual needs recorded and met, like individual medical or educational needs.
156. Despite the diversity of people across multiple care settings and their different needs, they experienced a heavily regimented one-size-fits-all model of care with the same form of care applied to everyone regardless of their age, gender, abilities, culture, needs and reasons for being in care.
157. Features of institutional models of care which contributed to abuse and neglect included:
- rigid routines that people in care had little influence or control over
  - identical activities shared by people in care or groups of people in care
  - people in care having limited or no influence over who provided their care
  - a lack of control over day-to-day decisions, for example activities or mealtimes
  - a lack of choice about who they lived with
  - isolation or segregation from the community

In addition, for disabled people in care the key feature of an institutional environment that contributed to abuse and neglect was a disproportionate or high number of disabled people living in the same environment.

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<sup>170</sup> Department of Education, Child Welfare Division, Field Officers Manual (1957, J.88).

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158. In care settings with institutional environments and practices, conformity with rules; and discipline and order were prioritised over the needs of people in care, described as an approach of “rules, power and control”.<sup>171</sup> Conformity was often enforced through harsh and abusive discipline.<sup>172</sup>
159. For some larger institutions, a strict one-size-fits-all routine meant they could rely on smaller staff numbers. The Inquiry heard that smaller staff numbers led to people in care losing their independence and individuality.<sup>173</sup>
160. An emphasis on conformity over individual needs resulted in standards of care being overlooked or ignored and people in care not receiving the level of care they needed, increasing the risk of abuse and neglect. For example, in its report to the Minister of Health in 1986, the Department of Health said:
- “In most psychiatric hospitals in New Zealand the range of treatment options available is inadequate so that patients with very different needs are often treated in the same ward with the same programme ... the lack of individualised assessment, treatment and rehabilitation programmes tends to lead to undue reliance on drug therapy and various forms of custodial care; and to seclusion.”***<sup>174</sup>
161. In that same report, the Minister of Health was told there was a widespread lack of formal recognition of the cultural needs of people in psychiatric institutions, such as access to te reo Māori interpreters, rongoā practitioners or cultural support groups.<sup>175</sup>

171 Witness statement of Helen Porter (26 August 2022, page 5).

172 Witness statements of Mr GV (27 July 2021, paras 56–57, 78) and Jonathon Stevenson (29 March 2022, paras 72–73, 84).

173 Transcript of evidence of Dr John Crawshaw, Director of Mental Health and Addition Services, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, page 212)

174 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 6–7).

175 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 10–11).

## I rarua ngā paerewa i te noho kikī me te hē o ngā wāhi tiaki

### Standards were compromised by overcrowding and unsuitable facilities

162. Overcrowding and unsuitable facilities were another example of institutional environments and practices that compromised basic standards of care and contributed to abuse and neglect.<sup>176</sup> Overcrowding was common in psychiatric institutions, social welfare residences and in family homes.<sup>177</sup>
163. Many institutions had substandard physical environments. Buildings were outdated, poorly designed and inappropriate; with some social welfare residences lacking ground space for recreation and activities.<sup>178</sup> Institutional design that reflected military or prison environments was common at many residences, for example, barbed wire, heavily barred secure cells, high walls and open block sleeping quarters similar to secure cells.<sup>179</sup>
164. Overcrowding often led to compromised daily routines like reduced or absent oversight, lack of individualised care and limited activities. Many people in overcrowded and unsuitable environments suffered abuse and neglect, including:
- sexual abuse
  - a lack of privacy and dignity through open toilet, washing, and sleeping areas
  - compromised personal hygiene and dental and medical care
  - no access to clean personal items like clothes and shoes
  - limited warm clothing and bedding
  - generally unsanitary living conditions.<sup>180</sup>
165. Geographically isolated facilities could increase the risk of abuse and neglect by creating opportunities and cultures of total control with limited outside influence.<sup>181</sup>

176 Carr, A, Duff, H, & Craddock, F, "A systematic review of reviews of the outcome of severe neglect in under resourced childcare institutions", *Trauma, Violence, & Abuse* 21(3) (2020, pages 484–497).

177 Mahony, P, Dowland, J, Helm, A, & Greig, K, *Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals* (Department of Internal Affairs, 2007, page 19); Parker, W, *Social Welfare Residential Care 1950–1994, Vol 1* (Ministry of Social Development, October 2006, page 49); Grant, JW, *Acting Director-General Department of Social Welfare, Circular Memorandum re: Numbers of children and young people in family homes* (Department of Social Welfare, 23 October 1981).

178 Carson, R, *New horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 59).

179 Stanley, E, *The Road to Hell: State violence against children in postwar New Zealand* (Auckland University Press, 2016, page 53); Letter from Mrs HM Pierad to the Minister of Education regarding the construction of a girls' home (13 January 1970, page 11).

180 Mahony, P, Dowland, J, Helm, A, & Greig, K, *Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals* (Department of Internal Affairs, 2007, page 19, 31–32); Witness statement of Te Aroha Knox (16 August 2021, paras 25–31).

181 Beyer, L, Higgins, D, & Bromfield, L, *Understanding organisational risk factors for child maltreatment: A Review of Literature* (Australian Government Department of Families, Community Services and Indigenous Affairs, 2005, pages 46–47).

166. Father Timothy Duckworth, Provincial of the Society of Mary, believed that the militaristic style of schooling at Hato Pāora College near Aorangi Feilding was, like other male boarding schools, intensified by its geographic isolation:
- “Hato Pāora was operated in a militaristic and masculine fashion, which would have emphasised conformity, strength, and toughness. I consider this a ‘macho’ culture. This was not unusual in a boys’ boarding school, but I believe this may have been more pronounced at Hato Pāora due to its small size and isolated location.”*<sup>182</sup>
167. Isolated facilities could also lead to staff focusing on control and surveillance, which contributed to them becoming desensitised to the needs of people in their care.<sup>183</sup> Isolated areas within facilities could become areas where abusers would have unsupervised access to people in care and their abuse hidden from sight.<sup>184</sup> Isolated facilities could also make it difficult for families and whānau to connect with and visit their loved one in care, a critical protective and safeguarding factor.
168. Secure units were an unsuitable physical environment that contributed to the abuse and neglect of children, young people and adults in care. While there were standards in place from 1957 in social welfare settings on the physical environment of secure units, evidence shows these were often not followed. At the Inquiry’s State Institutional Response Hearing, Chappie Te Kani, Chief Executive of Oranga Tamariki, agreed that the history of treatment of children in solitary confinement was “inhumane”.<sup>185</sup> Many institutions used solitary confinement and similar restrictive practices. Secure units were also environments where people in care would experience physical or sexual abuse. These were still in use in 1989, despite being heavily regulated.<sup>186</sup>

182 Evidence from the Provincial of the New Zealand Province of the Society of Mary, Father Timothy Duckworth, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce No 497, (19 July 2022, para 66).

183 Green, L, “Analysing the sexual abuse of children by workers in residential care homes: Characteristics, dynamics and contributory factors”, *Journal of sexual aggression* 7(2) (2008, page 17).

184 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Volume 2 – Nature and cause (2017, pages 177–178); Mathews, B, Child Sexual Abuse in Institutional and Non-Institutional Context, in Mathews, B & Bross, DC (eds) (2019, pages 162–163).

185 Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, page 724).

186 Human Rights Commission, The use of secure care and related issues in Social Welfare institutions (June 1989, page 7).

169. Age mixing was a common feature of social welfare settings including in residential care, family homes and foster care, with younger children routinely placed with much older children or young people. This increased the risk of peer-on-peer violence and sexual abuse. Māori survivor Te Aroha Knox (Ngā Puhī, Tainui) said she was “constantly surrounded by older children” in one family home when she was about 10 years old, and that “they were men really”.<sup>187</sup> One night she was raped by an 18 year old boy and the next night a 16 year old boy attempted to rape her. She said she was “completely unsafe in that family home”.<sup>188</sup> Age mixing also exposed younger children to dangerous behaviours of their older peers, for example violence, crime, drugs and alcohol.
170. In 1969, the principal of Miramar Girls' Home in Te Whanganui-a-Tara Wellington became increasingly concerned at the problems arising from young girls in need of care being cared for in the same facilities as difficult teenage girls who were on remand. The principal recalled three instances where children as young as 4 years old were sexually assaulted by teenage girls. He also worried about the effect on younger children of the “frightening hysterical type behaviour” exhibited by some teenage girls.<sup>189</sup> The Superintendent was made aware of these negative aspects of mixed aged and dual-purpose care and noted that, while the policy was “undesirable”, the Child Welfare Division was “still a long way from rectifying this anomaly”.<sup>190</sup>
171. Gender mixing of children and young people in residences and institutions became more common in the late 1980s when many of the large single sex residences closed. A Department of Social Welfare report from 1986 on sexual abuse in residential institutions showed there were differing views on the risks of sexual abuse in gender mixed residences. The report attached an opinion from Dr Miriam Saphira CNZM supporting single sex facilities but concluded that “sexual abuse occur[s] in heterosexual and mono-sexual institutions”. It noted that “mono-sexual institutions are not necessarily any safer” but recommended “there should be choices for male and female sexual abuse victims” who may wish to be placed in a single sex facility. The report identified that all residential institutions were responsible for safeguarding against sexual abuse.<sup>191</sup> However, evidence indicates that safeguarding against sexual abuse was not adequate.<sup>192</sup>

187 Witness statement of Te Aroha Knox (16 August 2021, para 25).

188 Witness statement of Te Aroha Knox (16 August 2021, paras 25–31).

189 Letter from the Principal of Miramar Girls' Home to the District Child Welfare Officer (Child Welfare Division of the Department of Education) regarding the care of Disturbed Adolescent Girls and shelter care cases in the Girls' Home (28 April 1969, pages 2–3).

190 Letter from DG Reilly for the Superintendent to the District Child Welfare Office, regarding the care of Disturbed Adolescent Girls and shelter care cases in the Girls' Home (10 June 1969, page 6).

191 Vincent, P, Mixed sex residential institutions – implications for sexually abused young people, paper for the Department of Social Welfare Principals' Conference 29 September–3 October 1986 (9 September 1986).

192 Memo from the Manager of Kingslea regarding Investigation outcome into allegations that the clients of the Secure Unit may have had sexual intercourse and possibly ongoing sexual relations (8 April 1999).

172. The mixing of children and young people in social welfare institutions also created an environment where there was heightened risk of abuse and neglect through exposure to violence, criminal behaviours and other influences. The risks were described by the principal of Ōwairaka Boys' Home in Tāmaki Makaurau Auckland in 1967:

*"... the mixed function of the Home creates major difficulties. The home is required to absorb a large number of cases on warrant and remand as well as cases where short term training and residence is required before placement. The result is that neither aspect of the work can be undertaken with success."*<sup>193</sup>

## **Kīhai te taurira mo ngā pūnaha taurima i noho tika me ngā paerewa atawhai**

### **Punitive care model was inconsistent with standards**

173. Institutions that adopted a "punitive model"<sup>194</sup> commonly drew on elements of cultures within the prison system and / or military and frequently involved physical, violent treatment of people in care. Former social worker Mr PY told the Inquiry that the secure units at both Kohitere Boys' Training Centre in Taitoko Levin and Ōwairaka Boys' Home in Tāmaki Makaurau were cell blocks and that:

*"[t]o a young person Ōwairaka would have been seen like a prison. Being placed in the Secure Unit on admission and then potentially later for misbehaviour would only have reinforced this."*<sup>195</sup>

174. New Zealander Mr BY, who was placed in Kohitere Boys' Training Centre in Taitoko Levin when he was 15 years old, told the Inquiry:

*"There should not be a jail mentality in care facilities. It needs to be remembered that a care facility is a children's home. Some of the children may have done stupid things, but they are still children."*<sup>196</sup>

<sup>193</sup> Letter from A Ricketts, Manager of Ōwairaka Boys' Home, to the Department of Child Welfare Office, Auckland regarding Inmate numbers at the Boys Home and the constant need to move boys out for new admissions (20 March 1967, page 3).

<sup>194</sup> Witness statement of Ms PD (23 October 2022, paras 2.19 and 2.21).

<sup>195</sup> Witness statement of Mr PY (6 December 2022, paras 25 and 86).

<sup>196</sup> Witness statement of Mr BY (23 July 2021, para 83).



175. Survivors who spent time in corrective training described it as “military style training”<sup>197</sup> and told the Inquiry that it was designed to “scare the shit out of us for three months and get us back on the straight and narrow except it didn’t really work”.<sup>198</sup> Pākehā New Zealander Mr TL, who was placed in Rangipō Prison Farm corrective training facility near Tūrangi when he was about 17 years old, believes that he and the other trainees were part of a “failed experiment”,<sup>199</sup> explaining that:

***“CT [corrective training] was a three-month youth justice sentence which was introduced in 1985 as a replacement for borstal. It was designed as a type of ‘bootcamp’ for young offenders aged 16 to 19 years. I think it was supposed to ‘scare us straight’. From what I understand the concept of CT was quickly abandoned as the reoffending rates were very high.***

***The focus of CT was entirely on ‘breaking’ trainees using practices such as name calling, swearing, punching, kicking, shouting, physical exercise beyond the point of exhaustion, sleep deprivation, humiliation, setting up bullying between trainees and poor living conditions.”***<sup>200</sup>

176. Mr TL said that “[a]bsolutely no effort” was made to address the reason for the offending which brought young people to corrective training, or to provide skills or support so that they could make positive changes in their lives when they left.<sup>201</sup> This experience was echoed by other survivors,<sup>202</sup> with one survivor noting that the programme “didn’t stop people from going to prison later”.<sup>203</sup>
177. Instead of reforming or rehabilitating them, survivors told the Inquiry that it “made me worse, not better”;<sup>204</sup> that “[a]ll the beatings and bashings only made you harder and angrier”;<sup>205</sup> and that “we learnt how to fight better, how to run more quickly from the police and be fitter, stronger young men.”<sup>206</sup> They also told the Inquiry that corrective training put them and others on a path towards more criminal offending and prison.<sup>207</sup>

197 Witness statement of Mr IA (2 June 2022, para 4.43).

198 Witness statement of Chris Te Moananui (8 April 2022, para 112).

199 Witness statement of Mr TL (5 November 2020, para 3.2.2).

200 Witness statement of Mr TL (5 November 2020, paras 3.2.2–3.2.4).

201 Witness statement of Mr TL (5 November 2020, para 3.2.4).

202 Witness statements of Mr TM (23 December 2021, para 76) and Chris Te Moananui (8 April 2022, paras 117–118 and 120).

203 Witness statement of Mr IA (2 June 2022, para 4.41).

204 Witness statement of Mr GQ (11 February 2021, para 116).

205 Witness statement of Mr IA (2 June 2022, para 4.42).

206 Witness statement of Chris Te Moananui (8 April 2022, para 118).

207 Witness statements of Tani Evan Kata Tekoronga (19 January 2022, para 104) and Chris Te Moananui (8 April 2022, para 119).

178. Between 1957 and 1965, 67 percent of all borstal trainees were reconvicted within two years of their release.<sup>208</sup> In 1980 the Minister for Justice publicly acknowledged that these rehabilitative programmes had not fulfilled their objective. The Minister also accepted that reoffending rates showed these had not succeeded in reducing reoffending.<sup>209</sup>
179. Tamariki and rangatahi Māori made up the majority of people in borstals or corrective training facilities during the Inquiry period.<sup>210</sup>
180. In 1981, the Penal Policy Review Committee noted that detention centre training had not worked and had a reoffending rate of over 70 percent.<sup>211</sup> Their report highlighted concerns that the hard physical training programme was completely inappropriate for many young people being sent there, and that:
- "[F]or the underprivileged, inadequate youth who can barely cope, this sentence may infringe the United Nations prohibition of cruel and inhumane treatment."***<sup>212</sup>
181. Studies on boot camp programmes that became popular as a juvenile correctional sanction throughout the United States in the 1980s found boot camps alone "do not have an effect on participants' odds of recidivism".<sup>213</sup> Critics have argued "that the structure and process of boot camps are ideologically inconsistent with rehabilitative treatment". Reasons for this include that boot camps do not "target the causes of delinquency", may "impede rehabilitation by relying solely upon negative reinforcement", and their structure is one where "adult bullies are given unfettered power over vulnerable charges", which can encourage physical abuse and neglect.<sup>214</sup>
182. Professor Elizabeth Stanley told the Inquiry that:
- "State workers used a host of violent punishments, isolation techniques and damaging medical treatments to make children comply with their demands. Wrapping it up in the language of rescue, treatment or discipline, we somehow give this violence legitimacy."***<sup>215</sup>

208 Williams, D, The abolition of borstal training: A penal policy reform or a failure to reform penal policy? (The University of Auckland, 1984, page 81).

209 Williams, D, The abolition of borstal training: A penal policy reform or a failure to reform penal policy? (The University of Auckland, 1984, page 80).

210 Williams, D, The abolition of borstal training: A penal policy reform or a failure to reform penal policy? (The University of Auckland, 1984, page 82).

211 Report of the Penal Policy Review Committee 1981 (Hasselberg, Wellington, 1983, pages 80–81).

212 Report of the Penal Policy Review Committee 1981 (Hasselberg, Wellington, 1983, pages 80–81).

213 Meade, B and Steiner, B, "The total effects of boot camps that house juveniles: A systematic review of the evidence", *Journal of Criminal Justice* 38(5) (2010, pages 841 and 845); Bottcher, J and Ezell, ME, "Examining the effectiveness of boot camps: a randomized experiment with a long-term follow up", *Journal of Research and Delinquency* 42(3) (2005, pages 321, 327–328).

214 Meade, B, and Steiner, B, "The total effects of boot camps that house juveniles: A systematic review of the evidence", *Journal of Criminal Justice* 38(5) (2010, page 842).

215 Stanley, E, *The Road to Hell: State violence against children in post-war New Zealand* (Auckland University Press, 2016, page 8).

## I takahia tonu ngā paerewa atawhai

### Standards of care were routinely breached

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183. Standards of care were routinely breached throughout the Inquiry period. In many institutions, residences, family homes and foster homes, schools, hostels, and transitional and law enforcement settings, breaches of standards of care were serious and unlawful. For example, the Inquiry has found abuse and neglect occurred across all care settings throughout the Inquiry period despite being unlawful. Despite sexual abuse being unlawful in all settings throughout the Inquiry period, the Inquiry found sexual abuse was a common form of abuse in care, with children aged 10 to 14 years old enduring high levels of sexual and physical abuse. Some further key examples of departures from standards are discussed below.

### I hē te whakanoho tāhanga, weherua, te tiaki ā- here hei tikanga whiu

#### Solitary confinement, seclusion and secure care wrongfully used as punishment

184. Some settings had standards that limited the use of solitary confinement, seclusion or secure care. For example, under the Mental Health (Compulsory Assessment and Treatment) Act 1992 it was only to be used if necessary, where necessary, and for as long as it was necessary, for the care or treatment of the patient or the protection of other patients.<sup>216</sup>
185. Under Department of Social Welfare standards from 1957, it was generally only to be used as an emergency procedure. Under the Children and Young Persons (Residential Care) Regulations 1986, it was not to be used for punishment.<sup>217</sup> The Department of Education set guidelines on the use of timeout in residential schools in 1986, including that it should not be used for longer than a matter of minutes.<sup>218</sup> In addition, the Crimes Act 1961 still sat across every care setting and could come into effect if its use amounted to neglect endangering the life of a person or permanent health of a person.<sup>219</sup>
186. Despite these limits on the use of solitary confinement, seclusion and secure care, the Inquiry found survivors commonly reported the misuse of solitary confinement or seclusion, that there was over-use of seclusion in residential care, and wrongful use of solitary confinement in psychiatric facilities.

<sup>216</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992, section 71.

<sup>217</sup> Ministry of Social Development, Legislation and social work guidance over the years (n.d, pages 19–20).

<sup>218</sup> Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, pages 103–105).

<sup>219</sup> Crimes Act 1961, section 151.

## I takahia tonu ngā paerewa rongoā, i ētahi wā he takahi hoki i te ture

### Medical standards were frequently breached, at times unlawfully

187. Despite a range of medical standards being in place, the Inquiry found some children, young people and adults in care experienced over-medicalisation, lobotomies, sterilisation, invasive genital examinations, experimental psychiatric treatments without informed consent, electric shocks and injections of paraldehyde as punishment, which exposed some patients to unreasonable medical risks.

188. Medical certificates were required for all State wards before admission to a social welfare residence to ensure their medical needs were known to staff and carers,<sup>220</sup> "but this system frequently fell down".<sup>221</sup>

189. Many people in care were medicated for long periods without the necessary medical reviews:<sup>222</sup>

*"Significant numbers of patients continue to be given drugs for lengthy periods without review. Such lack of review of individual treatments is of particular concern as many of the drugs, if given over prolonged periods, are capable of producing serious side effects."*<sup>223</sup>

190. Survivors from St Mary's Home for Unwed Mothers in Tāmaki Makaurau Auckland experienced inadequate support during pregnancy and medical neglect during childbirth.<sup>224</sup>

191. Breaches of health care standards were sometimes outside the control of the institution. Institutions could go for long periods with no visits at all from doctors or health specialists when they were not available. For example, Campbell Park School in Waitaki had no visits for seven months in 1971, Hokio Beach School near Taitoko Levin had no visits for two years from 1973 to 1975, Holdsworth School near Whanganui had no visits in 1980 and Epuni Boys Home in Te Awa Kairangi ki Tai Lower Hutt had no visits in 1981.<sup>225</sup>

220 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, J6.8, J19.2).

221 Parker, W, Social welfare residential care 1950–1994, Vol 1 (Ministry of Social Development, October 2006, page 55).

222 Parker, W, Social welfare residential care 1950–1994, Vol 1 (Ministry of Social Development, October 2006, page 55); Mahony, P, Dowland, J, Helm, A, & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 29); Witness statement of David Newman (31 May 2022, page 8).

223 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, page 7).

224 Witness statements of Nancy (Sally) Levy (16 December 2021, paras 38–43) and Margaret Wilkinson (17 September 2020, paras 47, 58 and 61).

225 Parker, W, Social welfare residential care 1950–1994, Vol 1 (Ministry of Social Development, October 2006, page 55).

## He pūputu tonu te kino o ngā whiu patu me te wepu tangata Physical, corporal punishment was often severe

192. Between 1950 and 1990, standards on corporal punishment varied across settings and was unlawful in all care settings from 1990. In Department of Social Welfare institutions, corporal punishment was discouraged from 1957 and prohibited in 1984.<sup>226</sup> In foster homes, its use was limited from 1937 but the Department did not ban it in policy until 1990 and under law it was not banned in the home environment until 2007.<sup>227</sup>
193. In education settings, corporal punishment was prohibited under law in from 1990 but began to be phased out in policy before this time.<sup>228</sup> The Inquiry heard that some faith-based schools kept their own policies allowing the use of corporal punishment after 1990.<sup>229</sup>
194. Before any setting prohibited corporal punishment, standards made it clear that it was only to be used in reasonable circumstances, without weapons and as a last resort. This was not the experience of most survivors. Teachers, foster parents, principals, supervisors and staff members used physical force that went well beyond what could be justified under the standards of the time, whether or not it was explicitly prohibited.

## Ko ngā kōtiti kētanga i roto i ngā tari Kāwanatanga te pūtakenga mai o te takahi i ngā paerewa

### Government agency confusion led to serious breaches of standards

195. Evidence before the Inquiry highlights that government agency confusion led to serious breaches of standards. At times, confusion amongst government agencies about the extent of their statutory powers and how these overlapped with the powers of other agencies resulted in serious breaches of standards.
196. In most cases, the confusion was between Department of Social Welfare staff and other government agencies or NZ Police.<sup>230</sup> In one example, this resulted in a 15 year old boy being unlawfully placed in Lake Alice Hospital and subjected to unconsented medical treatment, including electric shocks.<sup>231</sup>

<sup>226</sup> Ministry of Social Development, Legislation and social work guidance over the years (n.d., pages 21–24).

<sup>227</sup> Ministry of Social Development, Legislation and social work guidance over the years (n.d., pages 25–26); Crimes Act 1961, section 59.

<sup>228</sup> Education Act 1989, section 139A.

<sup>229</sup> Education Review Office, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 449, – Appendix One (June 2021, pages 10–16).

<sup>230</sup> Human Rights Commission, The use of secure care and related issues in Social Welfare institutions (June 1989, pages 79–80).

<sup>231</sup> Office of the Ombudsman, Summary of a report compiled upon an investigation into a complaint against the Department of Health and the Department of Social Welfare (5 April 1977, paras 27–30).

197. In 1987, the Department of Social Welfare realised it had been using secure units unlawfully as a result of "a defect" in their empowering legislation, which had come into effect in 1983.<sup>232</sup> Before 1983 there had been no specific legislative provision for the Department to operate secure units and confine children and young persons in secure care despite them having been used for over 20 years by that point.<sup>233</sup> However, this was subsequently clarified by another law change in 1996, prescribing when secure care could be used for children and young people in residences.<sup>234</sup>

## **He akonga i kitea he mea i panonihia i roto i ngā paerewa atawhai**

### **Lessons identified and changes made to standards of care**

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198. It is difficult to say that the State learned that some practices were harmful during the Inquiry period. For example, from the outset of the Inquiry period, the State knew abuse and neglect were unlawful. The State also knew early on during the Inquiry period that excessive corporal punishment was wrong, and it was aware that alternative forms of punishment were in some cases preferable.<sup>235</sup> However, it took until 1990 for the State to legislate to abolish corporal punishment.
199. The State was slow to make legislative changes to prohibit practices that harmed children, young people and adults in care, and slow to act when it knew harmful or unlawful practices were happening.
200. From 1957, the State demonstrated it knew what components of good standards and practice could look like through the Field Officers Manual and subsequent versions. However, these standards were located in staff manuals for most of the Inquiry period; were generally inaccessible to people in care, their families, and whanau; were process-driven (rather than rights or person-driven); and lacked any references to te Tiriti o Waitangi or the human rights of those in care. They were also inconsistently applied between individual staff, foster carers and institutions, and people were rarely accountable for failing to follow the standards.

<sup>232</sup> Children and Young Persons Amendment Act 1983, section 43A, 49AA; Department of Social Welfare, Circular Memorandum 1987/14 – Secure Care in Institutions: Limitations on Use (23 February 1987, para 1).

<sup>233</sup> Department of Social Welfare, Circular Memorandum 1987/14 – Secure Care in Institutions: Limitations on Use (23 February 1987, paras 2–3).

<sup>234</sup> Children, Young Persons and Their Families Act 1989, section 367; Children, Young Persons and their Families (Residential Care) Regulations 1996, Part 5.


<sup>235</sup> Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, pages 97–101).

201. Standards of care were rarely provided for in legislation or regulations and, when they were, they were only applied to certain parts of care settings (like social welfare residences having regulated standards, compared to faith-based private schools that had none). This meant people in care experienced differing levels of standards and care providers had differing obligations to those in their care.
202. For most of the Inquiry period, there was also little evidence of effective collaboration with families, whānau and people with lived experience of care in the development of standards of care.
203. From about 1986 onwards, the State made changes to reflect it had learned that institutions needed legislative direction from the State on standards of care. The State introduced comprehensive legislative standards in 1986 for children and young people in State social welfare residences,<sup>236</sup> although these standards did not apply to children and young people in foster care or social welfare facilities run by third party providers. Standards did not apply to children, young people or adults in care in other settings.
204. The State did not legislate to give effect to te Tiriti o Waitangi as part of standards of care, even though those rights were directly relevant to tamariki, rangatahi and pakeke Māori in care.
205. The State did not progressively introduce human rights protections into care-specific legislation, even though the Crown had progressively increased its international human rights commitments over the Inquiry period.
206. In 1992, the State introduced the Mental Health (Compulsory Assessment and Treatment) Act to establish basic standards of care for patients who were assessed and treated under compulsory mental health orders.<sup>237</sup>
207. Faith settings learned of the harm of abuse and neglect but generally failed or were slow to implement standards to safeguard against it. Some faith-based schools learned of the harm of corporal punishment but maintained standards that allowed for its use, even following its legislative abolition.

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<sup>236</sup> Children and Young Persons (Residential Care) Regulations 1986.

<sup>237</sup> Mental Health (Compulsory Assessment and Treatment) Act 1992.



"She terrorised  
us, but she was held  
up as a beacon of  
compassion."

**RENÉE HABLUETZEL**  
Pākehā



# Renée Habluetzel

**Hometown:** Ōtautahi Christchurch

**Age when entered care:** 6 months old

**Year of birth:** 1961

**Type of care facility:** Foster care; adopted into a family that ran a children's home

**Ethnicity:** Pākehā

**Whānau background:** Renée went into care at six months old and was adopted just before she turned 5 years old. She reconnected with her birth mother when she was 17 and describes the relationship as difficult. Her mother has passed away. Renée also discovered the identity of her father as an adult.

**Currently:** Renée has two children, a son and a daughter. She is still close with her foster brother Paul, after reconnecting about 12 years ago.



**I was adopted before I turned 5 years old by a woman who ran Little Acres Children's Home for disabled children in Christchurch, Mrs Miles. She was probably the most evil person I have ever met, and will ever meet in my whole life. She was so cruel to the most vulnerable people – not just me but hundreds of children.**

Mrs Miles told me she adopted me because my birth mother was crazy and didn't want me. She said all our mothers were prostitutes and bad people. I believed her at first – then I realised, how can they all be prostitutes? I think my mother was probably mentally unwell – she'd had a rough life herself and no family support. From what I've pieced together, Mrs Miles manipulated my birth mother into signing the adoption papers. Although I didn't have the best relationship with my birth mother, I never doubted that she tried to do her best for me.

I used to joke that Mrs Miles didn't need to go to the gym because she got a full body workout beating the crap out of us. I remember regular beatings for being 'naughty', although in retrospect, nobody really was. She would punch us, thump us, kick us to the ground and hit us in the head. She would make me put my hand out and smack me over the back of the hand with a wooden hearth broom and then send me to school. I couldn't write for hours. Once I got away with putting my left hand out so I could still write, but she figured that out and she was furious.

It always amazed me that we didn't have bruises. I think she was tactful about where she hit us so that it didn't show. She would whack all the kids across the head. Once, when I was 12, I got such a severe beating that I was off school for a whole week – I had bruises all up my legs and my back.

She had a particular dislike for anybody who wet the bed. She would pull me out of bed at 10pm to check if I'd done it yet. If I had, then she'd beat the crap out of me. Then I'd have to get back into my wet bed – she wouldn't change the sheets. The nature of beatings was such that I was absolutely terrorised. I think she enjoyed it. When she started on us, her husband would just take off and do something else – get out of the house. A few times she tried to get him to hit us and he would just walk away.

She would make me wear the singlet I had worn to bed to school the next day so that I would stink. I'd try to get the singlet off and stick it in my bag so no one could tell, but I'd still smell, and I got a really hard time from other kids.

When I was about nine or 10, she broke my tooth by smacking me against the bar frame of the bath. I still hate looking at that now. She was washing my hair and said I was wriggling too much, so she got me by my hair and just smashed me against the bath. After that my tooth was really sharp and I kept getting a cut lip and cut tongue because of it. If I complained about it, she would just hit me around the head.

After she beat us up, she would make us all hug and kiss her. I wouldn't do it, I didn't want to hug someone after they'd thumped me.

From a young age I didn't think I was a person, and I didn't think the rest of us were, either. We weren't treated like people – we were just things. She used to tell me that she saved me from the gutter, and that I was there because no one loved me, so I owed her.

One of my early memories is scrubbing a floor with about five of us in a line. The girls just worked all the time. My job was to do the dishes at night. I'd help all the kids go to bed, then Mrs Miles would have us knitting clothes for everybody before bed.

It was also my job to get Mrs Miles up in the mornings. I would bring her some toast with jam on it and a cup of tea. Then I would get her a hot cloth to wipe under her armpits, help her put her bra on, get her clothes out and help dress her. Then I'd have to empty her urine potty from under the bed.

Another child sexually abused me. He was about 10 years older than me. I know he started abusing me before I was five, when I got adopted, because I remember being in court for my adoption and knowing that I was already being regularly abused by him. I think Mrs Miles knew what was going on because she caught him red-handed touching other children at least twice, but she didn't care. At night he would go along and tap us in bed with a hockey stick, which was a signal to get out of bed and go into the bathroom, where he'd abuse us.

Social workers used to come at least once a month and Mrs Miles hated it. They were becoming younger and more educated, and she did what she could to keep them away – they were onto her and she knew it. She became more in favour of non-verbal kids.

Most parents wanted to visit their children at the home and Mrs Miles would tell them awful lies. She did a good job of convincing them never to visit, saying things like, "They get upset when you come to see them. That one, your son, screamed and screamed for days after you came to see him. It's best you don't come back."

I remember six instances of children dying in care – four who died at the home and two who were dropped off to die. I remember thinking I could die, because it was kind of normal for kids to die, and there were a lot of very sick kids.

When I met my birth mother she told me Mrs Miles promised when she adopted me that I would get an education, have music lessons and do ballet, and I'd have my teeth straightened. My mother gave Mrs Miles a lot of money to do all of those things – my grandmother remembers it too. Mrs Miles's children mocked me for not doing ballet and I never understood it. Her grandchildren would say "we're off to do ballet" and laugh at me. If I got presents from my biological family they'd be taken off me and given to her grandchildren. I'd go to visit their house and see all my presents there.

When I met my birth mother it destroyed her to learn what had happened to me – she thought she'd done the right thing by leaving me there.

I escaped at 17 years old. I'd been told I was going to be put into psychiatric care, she was going to organise that next, and I got out before she could do that.

She shut down Little Acres within six months of me leaving. I saw a newspaper article and I rang Social Welfare to raise my concerns. They just ignored me. I feel so angry at the State.

A documentary about the children's home and Mrs Miles' "selfless" work was made in about 1973. It was filmed when I was about 13 years old. Mrs Miles named it Four in the Morning, because that was the time she was supposedly up looking after the kids. She wasn't. I know she's dead now, but I still worry.

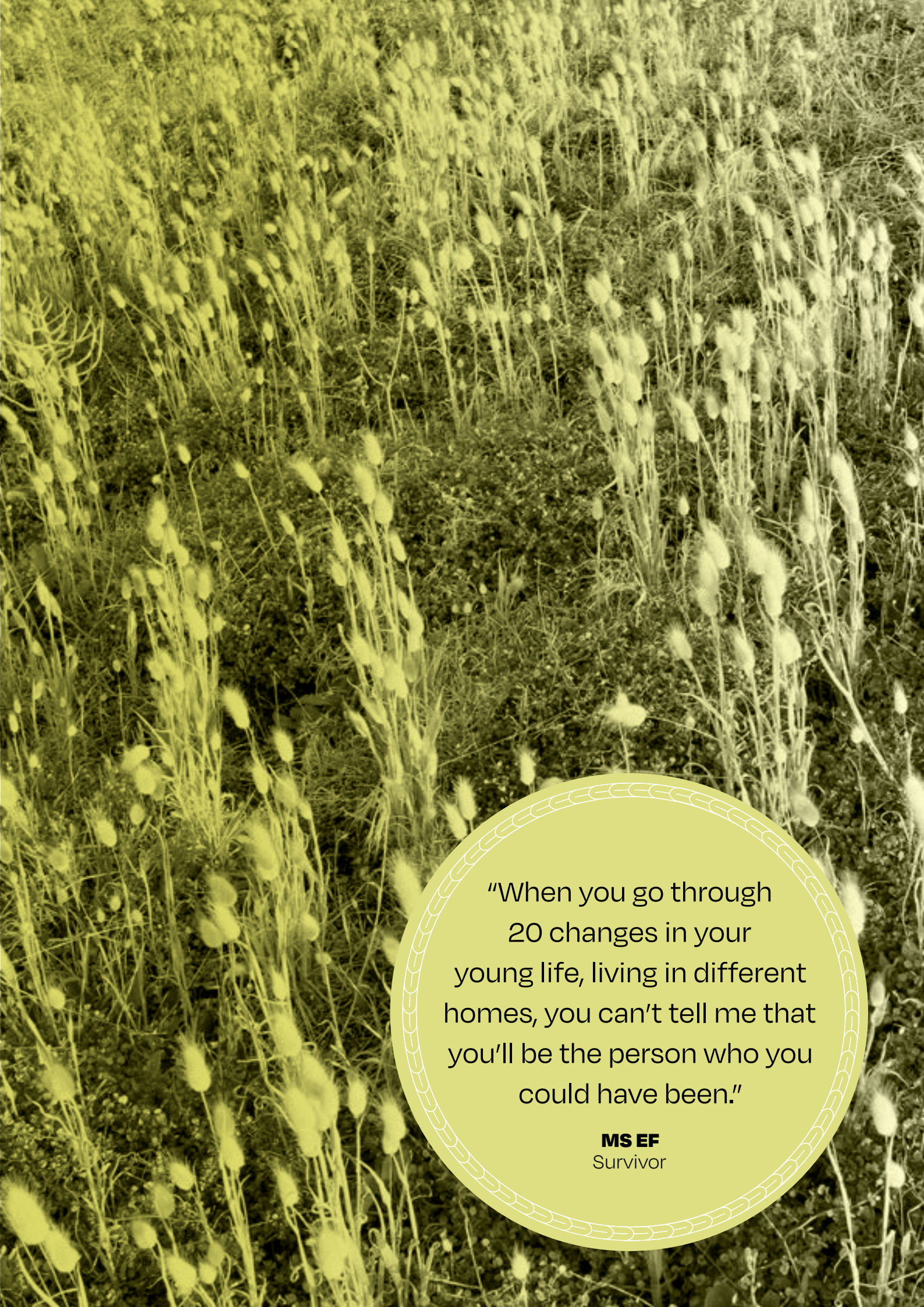
Mrs Miles was also given a British Empire Medal for her services to the intellectually disabled in Christchurch, in 1969. She is forever held up as this beacon of compassion, and I would like to see that medal taken off her. What I want more than anything now is for the people who adopted me to acknowledge that they let me and my future descendants down. I'd like them to offer me and my kids some redress for what they did. I'd also like to be un-adopted. I would like no one on my birth certificate, except for perhaps my birth mother.

Disabled children are so vulnerable, and the fact I'm the only person to come forward from the place I grew up isn't surprising, because Mrs Miles got people she could shut up.<sup>238</sup>

*The Inquiry notes that Presbyterian Support South Island commissioned an independent investigation into the allegations made between 2005 and 2007 but they were unable to be corroborated. The matter was also referred to the NZ Police and no charges were laid.*


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<sup>238</sup> Witness statement, Renée Habluetzel, WITN1007001 (10 August 2022).



"When you go through  
20 changes in your  
young life, living in different  
homes, you can't tell me that  
you'll be the person who you  
could have been."

**MS EF**  
Survivor



"I was taken out of  
a good home and put  
into places where I lost  
my identity and suffered  
horrific abuse"

**MR VV**

Niuean, Māori (Ngāpuhi)

# Mr VV

**Hometown:** Tāmaki Makaurau Auckland

**Age when entered care:** 12 years old

**Year of birth:** 1959

**Type of care facility:** Boys' homes – Ōwairaka Boys' Home, Hokio Beach School, Holdsworth School, Kohitere Boys' Training Centre

**Ethnicity:** Niuean, Māori (Ngāpuhi)

**Whānau background:** Mr VV's father was Niuean-Tahitian and his mum was Māori. He can trace his whakapapa to Rahiri, a famous tūpuna of Ngāpuhi. He has three younger siblings and two older siblings, who all grew up together in Pakuranga.

**Current:** Mr VV is serving a sentence of preventive detention and has spent eight years in prison. He is the father of 13 children.



**Child Welfare got involved with my family because I wasn't going to school. My records say that I first came to the attention of Child Welfare in February 1971 because of some offending.**

I was sent to Ōwairaka Boys' Home on a Child Welfare warrant. The police took me to Ōwairaka the first time. I was only there for a few weeks, but was taken straight to the secure unit, where I was locked in my cell for 23 hours a day. When I was allowed out of my cell, I had to do harsh physical training as punishment. I didn't go to school, and I didn't get any books or anything else to do. I only had a shower every few days and ate my meals in my cells. I strongly recall not being allowed to do anything during the day, not even look out the window, which only looked out onto a concrete wall anyway. I remember the ceiling of my cell was made out of Perspex plastic, which meant I had no natural light. I didn't get a lot of food in secure, because it was sometimes withheld as punishment. Sometimes we were only given corn on the cob to eat, and I was so hungry that I would eat the cob as well.

There is only one record which suggests my social worker looked for alternative care for me. There's a note in my file that talks about Māori foster families not wanting a part-Niuean boy, and Niuean foster parents saying they did not want to care for a part-Māori boy. I was not aware of this. I don't think my social worker ever looked for a foster placement for me. I didn't even know I had a social worker. The social worker also said my extended family didn't want to care for me. But nobody in my family ever mentioned being asked by a social worker to help care for me. I had a lot of paternal cousins close by, as well as my mum's sisters, who also lived close by. The two sides of the family often got together and there were no problems. There were lots of options for my social worker but those were never explored.

Later on I was transferred from Ōwairaka to Hokio Beach School, just out of Levin. I got an initiation beating from the other boys. I was punched, kicked and stomped on until I started crying. For my first few months at Hokio, I got beaten up almost every day by older boys.

I experienced horrific abuse at Hokio. There was a staff member at Hokio, a Māori man who was pretty fit and had large, bulging eyes. The first time he abused me, he came into my room at night while I was sleeping. He sat on my bed and fondled me in an aggressive way, while asking me if I was going to run away. Then he jumped on me, and dry humped me. He forcibly kissed me and put his tongue in my mouth. I tried to scream, so he stopped. I told a staff member about it, he said to me, "Well, did he hurt you?" When I said, "No", he said not to worry about it.

My abuser would watch me have a shower, which I found really difficult, then offer me a cigarette and tell me to come down to the shower block to smoke it. When we'd get there, he'd rape me. This happened multiple times. After the first time, I would try to fight him off. He would beat me up to stop me fighting back and hold me down by my neck with a hand over my mouth. He made me perform oral sex on him once as well. To keep me quiet, he would hit me around the back of my head with an open palm and kick me in the backside. I would get a sore head and bruising, and bleed from the rapes.

I never talked about what happened with anyone, but I remember the boys had a kind of code language they talked in. Everyone knew he was doing something bad to boys.

Later I was transferred to Holdsworth School, where there was physical violence among the boys and sexual abuse from staff. One staff member came into my room very late at night and woke me up. He rolled me onto my side and forced me to perform oral sex on him. I cried and begged but he wouldn't let my head go. I really struggled at Holdsworth because of the abuse, and I ran away at least once and spent a night in police custody.



I was in and out of different places for a while after that. In 1973 I was admitted to Kohitere Training Centre. By this time, I was really institutionalised. I was the one dishing out the violence, because I had learned what to do at all the other institutions. That was all I knew. I was put in the secure unit at Kohitere a few times – my records confirm that I spent three weeks in secure in September 1973, because of my “poor performance and disruptive behaviour”. The notes also say that I hadn’t been very productive as a member of the work group, and suggested that I could return to the Islands, “where his present way of life could be acceptable”. It’s pretty hurtful to read things like that in my records. It sounds very racist to me.

I went back to live with my parents and was sent to live with some family in Niue. I spent almost two years there. When I got back home, I got a job with my dad and did a stint at borstal.

I joined the Black Power when I was about 17 years old. A lot of us had been in the boys’ homes and the gang gave me a sense of belonging and identity. I’m still affiliated now, but I would call myself an ‘elder statesman’ rather than an active member.


I wasn’t taught anything about my culture or identity in the boys’ homes. I never had te reo lessons or learned anything about tikanga or my whakapapa. Most of what I’ve learned, I learned in my 30s. I have a Diploma in Māori Studies, and I’ve completed 13 of 21 papers of a Bachelor’s degree at Te Whare Wananga o Awanuiarangi. I advise on matters of tikanga and help other people. I’m fluent in te reo Māori.

The Child Welfare staff didn’t even say my name properly for the entire time I was a State ward. I was taken out of a good home and put into places where I lost my identity and suffered horrific abuse. So many of the records from my time in State care describe me as an adept and clever burglar. I was only 12 years old when they wrote those things about me. I often owned up to burglaries, rather than getting caught. It feels like those notes were written to justify my placement in those hell holes.

The time in the boys’ homes made me who I am today, and I think it resulted in me being subjected to long-term imprisonment.<sup>239</sup>

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<sup>239</sup> Witness statement of Mr VV (17 February 2021).



"The Church carries the primary responsibility for ensuring the protection and wellbeing of those in its care. We failed in this sacred duty and are determined to make amends."

**REVEREND TARA TAUTARI**

on behalf of the Methodist Church of  
New Zealand at the Inquiry's Faith-based  
Institutional Response Hearing

# Ūpoko | Chapter 4

## Nā ngā kaupapa me ngā tikanga ngoikore i hua ai te mahi tūkino

### Poor employment policies, practices contributed to abuse and neglect

208. Many staff and carers in State and faith-based institutions genuinely approached their position to do the best they could for those in their care. While many did, poor employment policies combined with poor senior leadership and management practices could undermine or make it harder for individual staff and carers to safeguard people in care.<sup>240</sup>
209. Generally, employment policies and practices were left to each setting to decide what was needed from 1950 through to the late 1980s. Some departments would set broad, process-based requirements through service contracts.<sup>241</sup> From the late 1980s, different settings had different legal obligations. For example, from 1989 the Director-General of Social Welfare had a legal duty to ensure that people delivering social services received adequate training and complied with appropriate standards.<sup>242</sup>
210. This chapter focuses on vetting, recruitment, training and development, and supervision of staff and carers. It relates to clauses 31(b) and 10.2(a) of the Terms of Reference.

<sup>240</sup> Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 2, Nature and Cause (2017, pages 158–159, 166–172); Historical Institutional Abuse Inquiry (Northern Ireland), Report of the Historical Institutional Abuse Inquiry (2017, pages 25–27); Independent Inquiry into Child Sexual Abuse (United Kingdom), The Report of the Independent Inquiry into Child Sexual Abuse (2022, page 124).

<sup>241</sup> New Zealand Community Funding Agency, Standards for Approval Level One: Child and Family Support Services (November 1995, Standards 13–16, pages 31–34).

<sup>242</sup> Children, Young Persons, and their Families Act 1989, section 7(f).

# Ngā wherawheranga kaimahi i te wā o te Pakirehua

## Vetting during the Inquiry period

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### Kāhore he ture tohe i te wherawheranga kaimahi, kaiatawhai hoki

#### No statutory requirement to vet staff and carers

211. Throughout the Inquiry period, there was no statutory requirement to vet prospective staff or carers, paid or voluntary, in any State or faith-based care setting. In the absence of legal direction, settings followed the State Services Commission's policies, designed their own, or had no policies in place. From the 1980s onwards, vetting requirements were part of service contract requirements in social welfare and Deaf, disability and mental health settings.
212. NZ Police had no statutory framework for responding to vetting requests. Up until 1978, NZ Police had a practice of only allowing limited enquiries of someone's background and only in relation to certain categories of requests.<sup>243</sup> These categories included examples where NZ Police considered that doing so was in the public interest or where they deemed the organisation could not do it themselves.
213. In 1978, two years after the creation of a centralised and searchable database of criminal convictions, NZ Police developed internal guidelines for responding to vetting requests.<sup>244</sup> Those guidelines were that vetting requests would only be carried out for listed organisations, initially limited to prospective foster and adoptive parents in social welfare settings (the only listed organisations relevant to this Inquiry).<sup>245</sup>
214. From 1950 to the late 1970s, with no formal vetting arrangements in place, most care settings who wanted to vet applicants were generally reliant on the honesty of applicants to declare any prior convictions on job applications, with no formal means to verify their responses.<sup>246</sup>

<sup>243</sup> NZ Police, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 421 (9 June 2022, para 9.5).

<sup>244</sup> NZ Police, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 421 (9 June 2022, paras 9.2–9.3).

<sup>245</sup> NZ Police, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 421 (9 June 2022, para 9.3).

<sup>246</sup> Witness statement of Michael Doolan (December 2022, para 43).

## Ngā kaupapa wherawhera i roto i ngā takinga whaikaha, hauora hinengaro Vetting policies in disability and mental health settings

215. In disability and mental health settings, there were no mandatory vetting requirements or policies. At times there was a deference to membership of professional bodies like the New Zealand Medical Council, the regulatory body for doctors.
216. The Medical Council could not register people who had been convicted of any offence punishable by imprisonment of two years or more or who were “otherwise not of good fame or character”.<sup>247</sup>
217. The Medical Practitioners Act 1995 tightened restrictions on registration. Doctors who had been convicted of any offence punishable by imprisonment for a term of three months or longer had to satisfy the Medical Council that the offence would “not reflect adversely on his or her fitness to practice medicine”.<sup>248</sup> The Medical Council could also decline registration if an individual was “not fit to practice medicine by reason of any mental or physical condition”,<sup>249</sup> if they had been the subject of professional disciplinary proceedings,<sup>250</sup> or were otherwise “not fit to practice medicine”.<sup>251</sup>
218. However, as the Medical Council acknowledged at the Inquiry’s Lake Alice Child and Adolescent Unit Hearing in June 2021, it did not always act to ensure that people in care were safe from doctors who should not have been practicing.<sup>252</sup> They also acknowledged that due to the length of time that had passed and the incompleteness of records available to the current Council, it was not able to provide reasons for decisions that were made in the past in relation to complaints of abuse or in relation to Dr Selwyn Leeks.<sup>253</sup> The Medical Council told the Inquiry that if Dr Leeks’ conduct occurred today and it was notified of his conduct, “there is no way Dr Leeks would be practicing”.<sup>254</sup>
219. The Nursing Council of New Zealand decided who could become a registered nurse. Throughout most of the Inquiry period the only restrictions outlined in the governing legislation were that the nurse had to be a certain age and “of good character and reputation”.<sup>255</sup>

<sup>247</sup> Medical Practitioners Act 1950, section 16; Medical Practitioners Act 1968, section 22.

<sup>248</sup> Medical Practitioners Act 1995, section 13 (b).

<sup>249</sup> Medical Practitioners Act 1995, section 13 (c).

<sup>250</sup> Medical Practitioners Act 1995, section 13 (d).

<sup>251</sup> Medical Practitioners Act 1995, section 13 (g).

<sup>252</sup> Transcript of evidence of Aleyna Hall and David Dunbar, New Zealand Medical Council, at the Inquiry’s Lake Alice Child and Adolescent Unit Hearing (Royal Commission of Inquiry into Abuse in Care, 23 June 2021, page 652).

<sup>253</sup> Transcript of evidence of Aleyna Hall and David Dunbar, New Zealand Medical Council, at the Inquiry’s Lake Alice Child and Adolescent Unit Hearing (Royal Commission of Inquiry into Abuse in Care, 23 June 2021, page 630).

<sup>254</sup> Transcript of evidence of Aleyna Hall and David Dunbar, New Zealand Medical Council, at the Inquiry’s Lake Alice Child and Adolescent Unit Hearing (Royal Commission of Inquiry into Abuse in Care, 23 June 2021, page 652).

<sup>255</sup> Nurses and Midwives Act 1945, section 16; Nurses Act 1971, section 19; Nurses Act 1977, section 19.

## **Ngā kaupapa wherawhera i roto i ngā takinga toko i te ora**

### **Vetting policies in social welfare settings**

220. In social welfare settings, vetting of foster parents was discretionary between 1950 and 1970. Between 1970 and 1980, vetting of foster parents was required as part of best practice policy.<sup>256</sup>
221. It is unclear when vetting requirements for social workers and staff at social welfare residences and institutions became part of formal recruitment policy.<sup>257</sup>

## **Ngā kaupapa wherawhera i roto i ngā takinga mātauranga**

### **Vetting policies in education settings**

222. In education settings, including special schools for Deaf students, there was no mandatory vetting requirement or policies for teachers or education staff and carers during the Inquiry period.<sup>258</sup> Between 1950 and 1989, regional education boards were responsible for their own policies for vetting. From 1989, this responsibility shifted to boards of trustees. Several schools did not vet new staff.<sup>259</sup>
223. Up until 1989, the Department of Education registered teachers, with a focus on skills and good character. There was no requirement to vet teachers before they worked in education settings. From 1989, the Teaching Council took over this role.
224. There was no requirement to vet individuals who wanted to register and open a private school.<sup>260</sup> Anyone could open a private school so long as the school met the criteria of "efficiency". Even if vetting was carried out and it revealed criminal convictions, it was not a ground to decline registration of the school.<sup>261</sup>

<sup>256</sup> Oranga Tamariki, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 418 (June 2022, para 7.18).

<sup>257</sup> Oranga Tamariki, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 418 (10 June 2022, para 7.16).

<sup>258</sup> Brief of Evidence of Iona Holsted, Secretary for Education and Chief Executive of the Ministry of Education, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 8 August 2022, pages 134, 137–138).

<sup>259</sup> Witness statements of Ms KF (20 December 2021, para 4.4) and Mr KL (6 April 2023, para 22).

<sup>260</sup> New Zealand Law Commission, Private schools and the law (Wellington, 2008, page 48).

<sup>261</sup> New Zealand Law Commission, Private schools and the law (Wellington, 2008, page 48).

## Ngā kaupapa wherawhera i roto i ngā takinga pūnaha taurima ā-whakapono Vetting policies in faith-based care settings

225. Across all faith-based care settings, the State did not legislate for any mandatory vetting requirements or policies throughout the Inquiry period. There were varying approaches to vetting across faiths, but most were inadequate and ineffective.
226. Catholic institutions lacked adequate procedures for the selection and vetting of potential clergy, religious (members of religious orders) and lay staff. This led to the appointment in some cases of inappropriate and unqualified staff, which increased the risk of abuse.
227. The Methodist Church did not have mandatory vetting requirements or policies during the Inquiry period. Vetting processes were managed by individual childrens' homes. The Methodist Church explained that their vetting processes were "at best ad-hoc and depended on knowledge in the public domain and disclosures by the person concerned".<sup>262</sup>
228. The Anglican Church did not have consistent, mandatory vetting requirements or policies.
229. The Inquiry heard that elder appointments in the Plymouth Brethren Christian Church were based on their standing within the community and there were no formal vetting processes for those appointed to leadership roles.<sup>263</sup>
230. Presbyterian Support Otago acknowledged that "individuals who were married, part of a church or involved with community objectives were believed to be upstanding and suitable to be involved in the care of children", and did not need vetting, which was "naive".<sup>264</sup>
231. In the Salvation Army, staff shortages meant that little was done at times to screen the suitability of lay staff. However, Salvation Army officers were subject to more reference checks and training.<sup>265</sup>
232. Gloriavale told the Inquiry that their leadership were not NZ Police vetted, except for those who work in the school or early childhood centres.<sup>266</sup>

262 Methodist Church of New Zealand, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 452, Questions 2–7 (24 May 2022, page 7).

263 Notes of meeting with representatives of Plymouth Brethren Christian Church (Royal Commission of Inquiry into Abuse in Care, 29 November 2022, page 13).

264 Presbyterian Support Otago, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 518 (5 October 2022, page 3).

265 Expert opinion of Peter Lineham (4 April 2024, page 25).

266 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (8 July 2022, page 30).

## Kīhai i āta wherahia te tū wātea o te hunga i ngā pūnaha taurima i te kaitūkino

### Absence of vetting exposed people in care to abusers

233. Across all settings, absent, inadequate or poor implementation of vetting policies increased the risk of people in care being exposed to abusers.<sup>267</sup> At times, this risk resulted in serious sexual abuse.

## Nā te kore o te kaupapa wherawhera i āhei ai te whai mahi a te kaitōkai tamariki

### Absent vetting led to serious child sexual abusers being employed

234. There were several examples of social welfare residences and institutions where staff who had histories of child sexual abuse allegations and convictions were unknowingly employed through absent vetting.<sup>268</sup> Michael Ansell, who went on to sexually abuse multiple boys while employed at Hokio Beach School near Taitoko Levin, was hired in 1973 despite being convicted in 1969 for sexually abusing a 14 year old boy.<sup>269</sup> The Assistant Principal of Hokio Beach School from that time later explained:

*“given the systems in place at the time, in particular the absence of any comprehensive vetting system for criminal activity, [Hokio Beach School Manager] Keith North simply had no way of knowing.”<sup>270</sup>*

267 Ministry of Social Development, Case assessment (30 July 2013, page 4); Ministry of Social Development, Case assessment (2 October 2013, page 18); Ministry of Social Development, Memo re: Legal advice on possible payment (3 December 2014, page 2); Ministry of Social Development, Memo re: Approval of settlement payment (9 March 2015, page 4); Transcript of evidence of Nicolette Dickson, Deputy Chief Executive, Quality, Practice and Experiences, Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, pages 682–683); Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 283–284); Witness statement of Mark Benjamin (5 October 2022, paras 2.25–2.26); Transcript of evidence of Father Timothy Duckworth for the Catholic Church at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 October 2022, page 122).

268 Witness statement of Ken Cutforth (3 October 2022, para 52); NZ Police, Supplementary Criminal Offence Report, Michael Ansell (27 October 1976); NZ Police, Record of conviction re: Michael James Ansell (24 August 2020); Witness statement of Michael Doolan (in the High Court of New Zealand) (7 May 2007, para 261); Sunday Star Times, “‘No way’ to check on boys’ home offender” (4 May 1986).

269 Supplementary Criminal Offence Report, Michael James Ansell (27 October 1976); NZ Police, Record of conviction re: Michael James Ansell (24 August 2020); Witness statement of Michael Doolan (in the High Court of New Zealand) (7 May 2007, para 261).

270 Witness statement of Michael Doolan (in the High Court of New Zealand) (7 May 2007, para 264).



235. The same problems with vetting were happening more than a decade later. For example, in 1986, the Department of Social Welfare said that they had no way of knowing that a staff member was a convicted sex offender when they employed him. He had been convicted of sexually assaulting a young person in 1964 and was employed by the Department in 1983, where he worked at two Auckland boys' homes until he was once again arrested and convicted of sexually assaulting a different boy. The Department said he had indicated in his job application that he had no convictions, but they had no access to NZ Police's vetting system to verify his response.<sup>271</sup>
236. The systemic failures of employing a carer with 24 allegations of abuse was noted as "we didn't do our best work at that time"<sup>272</sup> by the Ministry of Social Development's chief executive Debbie Power at the Inquiry's State Institutional Response Hearing.

**Kīhai i wherawheratia ētahi tāngata nā te whakapono he hunga tōtika rātou  
People were sometimes not vetted because they were assumed to be trustworthy**

237. In some cases, vetting policies or practices were not followed because of an assumed high trust in the applicant.<sup>273</sup>
238. At the Inquiry's Faith-based Institutional Response Hearing and in response to the example of Methodist Minister Reverend Albert Grundy, who repeatedly abused a survivor in his care, General Secretary of the Methodist Church Reverend Tara Tautari acknowledged that this was:

*"a prime example of where we took it for granted that this person was good because the person was known. And so therefore due diligence is put to the side because of so-called personal knowledge and also a deference to their standing and status."<sup>274</sup>*

271 Transcript of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki, and Peter Whitcombe, Chief Social Worker, Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, page 743); Sunday Star Times, "No way to check on boys' home offender" (4 May 1986).

272 Transcript of evidence of Debbie Power, Chief Executive, Ministry of Social Development, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 15 August 2022, page 43).

273 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 283–284).

274 Transcript of evidence of Reverend Tara Tautari for the Methodist Church and Wesley College at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 267).

**Tērā ētahi kaitaki, kaiwhakahaere matua i āta tohi kaimahi me te ārai i  
aau kaitōkai**

**Senior leaders and managers sometimes knowingly employed and protected  
sexual abusers**

239. In both State and faith-based care settings, some senior leaders or managers appointed an abuser into a position despite knowing they had former criminal convictions for child sexual abuse.
240. Standards and Monitoring Services Chief Executive Officer Mark Benjamin told the Inquiry how a staff member at a Christchurch disability group home was convicted of sexually abusing at least one of the residents.<sup>275</sup> Several years later, Standards and Monitoring Services discovered the same staff member had been re-employed at the same home.<sup>276</sup> When questioned about their decision, Mr Benjamin recalled them saying that they felt the perpetrator has “paid [his] price and deserved a second chance”.<sup>277</sup>
241. The Department of Social Welfare also re-employed staff who had previous allegations of abuse against them. In the 1980s, Edward Anand was reported by a fellow staff member for sexually abusing girls while working at Dunedin Girls’ Home in Ōtepoti Dunedin. He denied the allegations but admitted to engaging in group massage with the girls, and to hugging and kissing them but believed this was no different to how other staff engaged with the girls.<sup>278</sup> He resigned before a complaint was referred to NZ Police. The Head of the home wrote to the Director-General of Social Welfare advising that Mr Anand “must never be allowed to work in the State Services again”.<sup>279</sup> He was later hired at Epuni Boys’ Home in Te Awa Kairangi ki Tai Lower Hutt, despite Mr Anand disclosing that he had previously worked at Dunedin Girls’ Home and his staff card reading “not suitable for re-employment”.<sup>280</sup> Edward Anand was later convicted of sexually abusing eight girls at the home, aged between 10 and 15 years old.<sup>281</sup>

275 Witness statement of Mark Benjamin (5 October 2022, paras 2.25–2.26).

276 Witness statement of Mark Benjamin (5 October 2022, paras 2.25–2.26).

277 Witness statement of Mark Benjamin (5 October 2022, para 2.27).

278 Cadogan, MJ (Director), General Notes of Interview with Edward Anand (27 February 1986, page 2).

279 Transcript of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki and Nicolette Dickson, Deputy Chief Executive, Quality, Practice and Experiences, Oranga Tamariki, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 24 August 2022, pages 819–820); Letter from Director to the Director-General, re: Staff – Dunedin Girls’ Home, Assistant Residential Social Worker (20 March 1986, page 3).

280 Transcript of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki and Nicolette Dickson, Deputy Chief Executive, Quality, Practice and Experiences, Oranga Tamariki, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 24 August 2022, page 820); Ministry of Social Development, File note – Information from staff files, Care, Claims and Resolution Team (18 October 2011).

281 Transcript of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki and Peter Whitcombe, Chief Social Worker, Oranga Tamariki at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 24 August 2022, page 821).

242. In 1979 Father Alan Woodcock was convicted of indecently assaulting a 17 year old male. In 1982, Provincial Father Bliss appointed him to a teaching position at St Patrick's College (Catholic) in Te Awa Kairangi ki Uta Upper Hutt, knowing he had a criminal conviction.<sup>282</sup> Within a year, there was a report of abuse against Father Alan Woodcock.<sup>283</sup> He was later convicted again for serious sexual offending against 11 boys.
243. The Salvation Army offered Raymond Vince a position in 1997 despite receiving reports of sexual abuse in 1992. On hearing the Salvation Army had offered him this position, some members of his family objected and threatened the Salvation Army that they would go to NZ Police "on the grounds they felt others could be unsafe".<sup>284</sup>
244. Raymond Vince resigned and went on to work as a drug and alcohol counsellor. In 2008, he was jailed for nine charges of indecent assault of girls under the age of 12 years old, and one charge of rape of a girl between the age of 12 and 16 years old. These charges related to his time at the Salvation Army's Bramwell Booth Home in Temuka between 1977 and 1981.
245. Hopeful Christian was able to return to Gloriavale when he was released on parole after he served a prison sentence for indecently assaulting a young girl in the community. NZ European survivor Rosanna Overcomer, survivor and Gloriavale Leaver's Trust representative, told the Inquiry that:

***"he was allowed back into our community, the community where I, a child, lived. The people that should have cared for the children and vulnerable allowed a sex offender not only into a close-knit community with inadequate living quarters but back into the senior position of leadership as the Shepherd of the church."***<sup>285</sup>

282 Transcript of evidence of Father Timothy Duckworth for the Catholic Church at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 October 2022, page 122).

283 Transcript of evidence of Father Timothy Duckworth for the Catholic Church at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 October 2022, page 124).

284 NZ Police, Extract from resignation register (31 January 1997).

285 Transcript of opening statement for Gloriavale Leaver's Trust at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 27).

# Nā te ngoikore me te paku o ngā rawa tautoko i hua ai te mahi tūkinō

## Inadequate recruitment and under resourcing contributed to abuse and neglect

### Kāhore i hāngai rawa ngā kaimahi me ngā kaiatawhai ki te hunga i ngā pūnaha taurima

#### Staff and carers were not representative of the people in care

246. An absence or lack of respect for staff and carer diversity increased the risk of abuse or neglect.<sup>286</sup> Some staff or carers abused or neglected those in their care who were different to them, linked to underlying societal attitudes like racism or ableism. Other staff or carers, who themselves had been victimised, intimidated or bullied for their diversity by their colleagues, found it harder to raise or report concerns about abuse or neglect. It also impacted whether a person in care felt they could safely disclose abuse. Māori survivor Reverend Dinah Lambert (Ngā Rauru Kītahi, Ngāti Porou, Ngāti Kahungunu), who was at Abbotsford Home (Anglican) in Waipawa, Te Matau-a-Māui Hawkes Bay in the 1960s, told the Inquiry how she would approach disclosing her abuse now:

*“if I was that child, I would just run to the nearest Māori family. That’s who I would go to because I’d go to my own ... because I would feel more safe in doing that as a child then.”<sup>287</sup>*

247. Māori survivors described a lack of Māori staff at care institutions despite being over-represented in these settings.<sup>288</sup> Reviews of social welfare homes in the 1970s and 1980s found that Māori culture and values were absent and sometimes resisted by non-Māori staff.<sup>289</sup> This was despite Māori making up the majority of tamariki and rangatahi in these settings.<sup>290</sup> Tā Kim Workman said when he visited Kohitere Boys’ Training Centre in Taitoko Levin as a Youth Aid Officer in the early 1970s, there were very few Māori staff and a total absence of any cultural input into the lives of young Māori people.<sup>291</sup> This lack of representation was in part a result of Pākehā focused recruitment processes.<sup>292</sup>

286 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Volume 2 – Nature and cause (2017, pages 165–166).

287 Transcript of evidence of Reverend Dinah Lambert at the Inquiry’s Tō muri te pō roa, tērā a Pokopoko Whiti-te-rā (Māori Experiences) Hearing (Royal Commission of Inquiry into Abuse in Care, 15 March 2022, page 485).

288 Witness statements of Mr TH (7 June 2021, para 105) and Vincent Hogg (15 December 2021, para 87).

289 Human Rights Commission, Report of the Human Rights Commission on representations by the Auckland Committee on Racism and Discrimination, Children and young persons homes, Administered by The Department of Social Welfare (1982, pages 4–46); Johnston, Archbishop AH, Report of Committee to Report to the Minister of Social Welfare on the current practices and procedures followed in institutions of the Department of Social Welfare in Auckland (29 October 1982, page 50).

290 Human Rights Commission, Report of the Human Rights Commission on representations by the Auckland Committee on Racism and Discrimination, Children and young persons homes, Administered by The Department of Social Welfare (1982, pages 41–46); Johnston, Archbishop AH, Report of Committee to Report to the Minister of Social Welfare on the current practices and procedures followed in institutions of the Department of Social Welfare in Auckland (29 October 1982, page 50).

291 Witness statement of Tā Kim Workman (5 October 2019, para 21).

292 The Maori Perspective Advisory Committee, Puao-te-ata-tu (day break): The Report of the Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare (September 1988, page 38); Berridge, D, Cowan, L, Cumberland, T, Davys, A, McDowell, H, Morgan, J, and Wallis, P, Institutional racism in the Department of Social Welfare, Tāmaki Makaurau (November 1984, page 24); Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 278).

248. Most staff and carers in all settings were Pākehā, while most people in care were not.<sup>293</sup> This stark contrast was recognised as early as the 1970s.<sup>294</sup> The 1979 report of the Auckland Committee on Racism and Discrimination into children’s residential homes concluded that addressing the monocultural and “mono-racial” staffing “would be the first measure necessary to help eradicate the inherent racism within the homes”.<sup>295</sup>
249. A 1985 report by the Department of Social Welfare reported that, in residences in Tāmaki Makaurau Auckland:
- a. 62 percent of residents were Māori compared to 22 percent of staff
  - b. 16 percent of residents were Pacific Peoples compared to 5 percent of staff
  - c. 22 percent of residents were Pākehā compared to 71 percent of staff.<sup>296</sup>
250. A 1988 study into the experiences of foster children and their foster families found that over 75 percent of foster parents were Pākehā at a time when 45 percent of children and young people in foster care in Tāmaki Makaurau Auckland and Ōtautahi Christchurch were Māori.<sup>297</sup>
251. The Inquiry saw limited evidence about the number and proportion of staff and caregivers who were Deaf or disabled beyond what survivors told the Inquiry, which was that most staff were non-disabled and not representative of those in care. Information on whether staff and carers were disabled, Deaf or blind, and the proportion of these staff and carers to people in care, was not regularly collected by government agencies or the faiths.
252. The Inquiry heard that a lack of Deaf staff contributed to the neglect of Deaf culture and a failure to provide adequate education to Deaf children.<sup>298</sup> This was compounded by the State policy banning sign language until 1969, with oralism being standard practice at all Deaf schools for much of the Inquiry period. For example, at St Dominic’s School for the Deaf (Catholic) in Aorangi Feilding there were no Deaf teachers and children were not taught to sign. Instead, the focus was on addressing their perceived impairment through oralism and speech therapy.<sup>299</sup>

293 Maori Perspective Advisory Committee, Puao-te-ata-tu (day break): The Report of the Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare (September 1988, page 38).

294 Auckland Committee on Racism and Discrimination, Ngā Tamatoa, Arohanui Inc, Social Welfare children’s homes: Report on an Inquiry held on June 11 1978 (1979, Appendix, page 2).


295 Auckland Committee on Racism and Discrimination, Ngā Tamatoa, Arohanui Inc, Social Welfare Children’s homes: Report on an Inquiry held on June 11 1978 (1979, Appendix, page 2).

296 Berridge, D, Cowan, L, Cumberland, T, Davys, A, McDowell, H, Morgan, J, and Wallis, P, Institutional racism in the Department of Social Welfare, Tāmaki Makaurau (November 1984, page 17).

297 Whitney, L, Walker, B, & von Dadelszen J, Experiencing foster care: The views of children, natural family and foster parents (Department of Social Welfare, Research Division, 1988, page 5).

298 Witness statement of Jarrod Burrell (9 August 2021, para 3.4)

299 Witness statement of Jarrod Burrell (9 August 2021, paras 3.5 and 3.7).

The background of the entire page is a close-up photograph of numerous green leaves, likely from a tree or shrub, with prominent veins. The leaves are layered and fill the frame. Overlaid on this background is a white, rounded rectangular text box containing a quote and the name of the speaker.

" ... there was insufficient recognition of the need for more resources in the residential field. There were insufficient staff and they were not well trained."

**ROBIN WILSON**

Former Director-General of Social Welfare

## I parea tonu ngā kaimahi me ngā kaiatawhai i te paku tonu o ngā rawa tautoko Staff and carers were often compromised by under resourcing

253. Understaffing contributed to abuse and neglect in care through staff being overworked, tired and under pressure which affected their ability to provide individualised care, and led to emotional, physical, and educational neglect of people in care. It also contributed to abuse and neglect through inadequate oversight or supervision of staff which provided abusers with opportunities to abuse or neglect people in their care.<sup>300</sup>
254. Robin Wilson, former Director-General of Social Welfare told the Inquiry:  
*"... there was insufficient recognition of the need for more resources in the residential field. There were insufficient staff and they were not well trained."*<sup>301</sup>
255. Understaffing in institutions was a common problem, including at psychopaedic and psychiatric institutions,<sup>302</sup> community mental health settings,<sup>303</sup> residential homes<sup>304</sup> and some faith-based boarding schools.<sup>305</sup>
256. Many staff said they felt overworked, under pressure and tired due to understaffing.<sup>306</sup> A 1977 Ministerial inquiry into faith-run care services reported "dangerously low staffing levels" in children's residential facilities and noted "two recent examples of experienced, dedicated, and normally highly reliable and competent staff breaking down under the pressure placed on them".<sup>307</sup> When Anthea Raven joined the Department of Social Welfare in the 1980s, most social workers "had around 60 active files and some of those may have involved a number of children from one family."<sup>308</sup> In 1983 it was reported that a social worker's "caseload should be limited to eight at any time".<sup>309</sup>

300 Witness statements of Johnny Nepe (10 December 2021, page 16) and Mr HN (7 May 2022, page 6).

301 Witness statement of Robin Wilson (25 November 2022, para 24).

302 Prebble, K, Ordinary men and uncommon women: A history of psychiatric nursing in New Zealand public mental hospitals 1939–1972 (The University of Auckland, 2007, pages 58, 99, 240); Witness statement of Mr EI (20 February 2021, page 4); Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 11–12).

303 Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley, (May 1996, page 87).

304 Carson, R, New horizons: A review of the residential services of the Department of Social Welfare. (Department of Social Welfare, 1982, page 51); Memorandum to the Superintendent: Request for additional housemaster at Hokio (8 April 1959, page 1); Witness statement of Robin Wilson (20 November 2022, page 6); Cahill, T, Mitchell, A, Nixon, A, Sherry, B, & Wetterstrom, J, Church Social Services: A report of an inquiry into child care services (Department of Social Welfare, 1977, page 6).

305 Transcript of evidence of Christopher Johnston, General Secretary of the Wesley College Trust Board, at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, pages 277, 293).

306 Ministry of Social Development Historic Claims Team, Transcript of interview with former CYFS supervisor (2 March 2015, pages 3–4); Prebble, K, Ordinary Men and Uncommon Women: A History of Psychiatric Nursing in New Zealand Public Mental Hospitals 1939–1972 (The University of Auckland, 2007, page 58); Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley (May 1996, pages 120–121); Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 11–12).

307 Cahill, T, Mitchell, A, Nixon, A, Sherry, B, & Wetterstrom, J, Church Social Services: A report of an inquiry into child care services (Department of Social Welfare, 1977, pages 13–14).

308 Witness statement of Anthea Raven (17 October 2022, para 23).

309 Department of Social Welfare, Minutes of the Third Intensive Foster Care Scheme Annual Review (28 October 1982, page 1).

257. A 1986 review of psychiatric and psychopaedic hospitals made a direct link between understaffing and neglect of patients, noting that insufficient staff numbers led to “deficiencies in dignity and in the basic elements of appropriate care”.<sup>310</sup> The review also found that:
- “Staff shortages and low morale seriously affect patient care and ... lead to lack of awareness and general acceptance of substandard conditions ... staff often appear defeated and convey an air of resignation.”***<sup>311</sup>
258. Some staff from psychiatric institutions told the Confidential Forum for former in-patients of psychiatric hospitals about having “a lack of time for kindness”.<sup>312</sup> The 1996 second Mason inquiry into mental health services in found that “multi-disciplinary staff shortages have resulted in lower standards of care.”<sup>313</sup>
259. Some survivors were sexually or physically abused at night when staffing levels were low, with only one staff member on duty.<sup>314</sup>
260. Some staff expressed concern of the safety risk of low staffing levels and inadequate supervision.<sup>315</sup> A 1999 review found night staff were working alone at Kingslea Residential Centre in Ōtautahi Christchurch despite this being against policy at the time.<sup>316</sup>
261. The Kohitere Boys’ Training Centre Annual Report 1964 noted that teacher shortages at the school “meant that little work could be done with boys who were assessed as ‘backward readers’ or otherwise having educational problems”.<sup>317</sup> Former social workers said understaffing often meant that they did not have enough time to work with whānau and sometimes ended up “cutting corners”, such as visiting children in care less frequently than they were supposed to.<sup>318</sup>

310 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, page 8).

311 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, page 12).

312 Mahony, P, Dowland, J, Helm, A, & Greig, K, Te Āiotanga: Report of the Confidential Forum for former in-patients of psychiatric hospitals (Department of Internal Affairs, 2007, page 32).

313 Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley (May 1996, page 123).

314 Witness statements of Mr FI (27 July 2021, paras 48–49); Mr GQ (1 February 2021, paras 71–72); Tony Lewis (21 August 2021, para 27); Toni Jarvis (12 April 2021, para 72); Mr MX (17 December 2021, para 38); Mr TH (7 June 2021, paras 96–97); William Wilson (6 July 2021, page 10) and Nellie Boynton (24 November 2020, para 114).

315 Letter from Kohitere Principal to the Director-General: Night Cover/Kohitere (4 May 1977); Letter from Night Attendant to the Principal Kingslea: The Welfare and Security of the Pedder Units at Night (2 May 1985); Memorandum to the Superintendent: Request for additional housemaster at Hokio (8 April 1959, page 1).

316 Reeves, C, Lang, N, & Direen, A, Management review of operational care practice at Kingslea Residential Centre (Children, Young Persons and their Families Agency, July 1999, pages 5, 8).

317 Parker, W, Social welfare residential care 1950–1994 vol. II: National institutions (Ministry of Social Development, 2006, page 64).

318 Witness statements of Denis Smith (26 April 2022, paras 37–46 and 15 December 2021, para 42); witness statement of Jamie Gratton Gilbertson (11 October 2022, paras 23, 26, 50–55).



262. Up until the 1990s, boarding students at Wesley College (Methodist) school hostel in Pukekohe had inadequate adult supervision overnight and prefects / senior students were responsible for supervision and discipline of junior students.<sup>319</sup> The dormitory prefects and senior students in the hostels were responsible for much of the abuse that occurred at Wesley College, usually initiated as a punishment or a way to maintain obedience from the junior students.
263. Senior students and prefects at Wesley College should never have been placed in a position where they were responsible for supervising and disciplining the younger students. These senior students and prefects were not adequately trained or supervised to be in positions of authority. Some adults at the college were aware of the hierarchical culture causing harm to students and did not do enough to stop it. These factors contributed to the school's culture of violence and led to the tradition of the "Wesley Way".
264. At the Inquiry's Faith-based Institutional Response Hearing when General Secretary of the Wesley College Board Chris Johnston was asked about what led to inadequate supervision, he said:
- "I can speculate that it was due to finance. I know pre-integration, and integration for Wesley was in 1976, that the reason for integration was that Wesley College could not afford to maintain as a private school. That's my speculation, you know, affording the additional staff."***<sup>320</sup>
265. Reverend Faulkner also told the Inquiry that when he was a student at Wesley, "most of the outside of school time and during the weekends there was one adult in place for 200 students."<sup>321</sup>
266. Throughout the Inquiry period care work was not valued by society. This inadequate recognition contributed to conditions where staff and care workers were not appropriate or appropriately trained, were underpaid, experienced poor working conditions, and were otherwise not supported to provide safe and therapeutic care. These factors contributed to environments in which abuse was more likely to occur.

319 Joint witness statement of Wesley College Principal, Chair of Wesley College School Board of Trustees, Chair of Wesley College Trust Board and General Secretary of Wesley College Trust Board, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 454 (8 July 2022, para 122(2)).

320 Transcript of evidence of the Methodist Church of New Zealand and Wesley College at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 293).

321 Transcript of evidence of the Methodist Church of New Zealand and Wesley College at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 277).

**Kō rātou o te ao whakarato me ngā ope taua te momo i tohia hei kaitoko atawhai**

**Staff with service and military backgrounds were recruited to deliver care**

267. Some care facilities actively recruited staff with service backgrounds. For example, in 1978 the New Zealand Herald featured an advertisement for an assistant housemaster to work at Ōwairaka Boys' Home in Tāmaki Makaurau Auckland, stating that a person "with a service background or work with young people would be most suitable" and no academic qualifications mentioned.<sup>322</sup> That same year, the Auckland Committee on Racism and Discrimination showed that eight of fifteen of the staff employed at Ōwairaka had an armed services background, with nine staff having no high school or other academic qualifications:
- "... we are staggered by the emphasis on military background compared with that on educational qualifications."*<sup>323</sup>
268. Robin Wilson, who was the Director-General of Social Welfare in 1992,<sup>324</sup> told the Inquiry that people with military backgrounds were hired to work in institutions because they were available and they understood discipline. In his view:
- "it wasn't altogether negative, there were some very, very good people, but people that come from the military have the adage of discipline and requiring respect and all that kind of thing. When faced with a great mob [of residents], they didn't know quite what to do [with] them."*<sup>325</sup>
269. He explained that at Ōwairaka, several staff "were ex-military and that was the way they actually operated" which he acknowledged was "terribly bad social work practice".<sup>326</sup>
270. Having a service background did not mean that staff were inherently abusive. Survivors of social welfare care settings with a high proportion of ex-service staff told the Inquiry there was an "army mentality"<sup>327</sup> with strict regimes and excessive punishments in facilities including Epuni Boys' Home in Te Awa Kairangi ki Tai Lower Hutt,<sup>328</sup> Kohitere Boys' Training Centre in Taitoko Levin,<sup>329</sup> Ōwairaka Boys' Home in Tāmaki Makaurau Auckland,<sup>330</sup> Waikeria Borstal near Te Awamutu,<sup>331</sup> and Rangipo Prison Farm corrective training facility near Tūrangi.<sup>332</sup>

322 Letter from Oliver Sutherland (for Auckland Committee on Racism and Discrimination) to Mr Walker (Minister of Social Welfare, re: Qualifications of Staff (17 April 1978, page 1).

323 Letter from Oliver Sutherland (for Auckland Committee on Racism and Discrimination) to Mr Walker (Minister of Social Welfare, re: Qualifications of Staff (17 April 1978, page 2).

324 Witness statement of Robin Wilson (25 November 2022, para 1).

325 Private session transcript of Robin Wilson (7 July 2022, Annexure B, page 43).

326 Private session transcript of Robin Wilson (7 July 2022, page 26).

327 Witness statement of Michael Rush (16 July 2021, para 108).

328 Witness statements of Brian Moody (4 February 2021, para 38) and William MacDonald (4 February 2021, paras 86, 91-95 and 232).

329 Witness statements of William MacDonald (4 February 2021, paras 199, 232) and Michael Rush (4 February 2021, paras 108, 146).

330 Witness statement of Michael Rush (4 February 2021, para 82).

331 Witness statements of Mr GV (27 July 2021, para 115) and Jonathon Stevenson (29 March 2022, paras 71-73).

332 Witness statement of Chris Te Moananui (8 April 2022, paras 110-112).

271. Māori and Pākehā survivor Jonathon Stevenson (Kāti Māmoe, Kāi Tahu) said that most of the staff in the youth unit at Waikeria Borstal near Te Awamutu were “Vietnam veterans and crazy sadists who wanted to hurt us”.<sup>333</sup>
272. Former residential staff member, Ken Cutforth, described the principal of Ōwairaka Boys’ Home, Arthur Ricketts, as a “military man” who took the approach of “line up and do as you’re told, don’t answer back”. Ricketts ran staff training seminars, which resulted in his regimented leadership methods spreading to other institutions, like Epuni Boys’ Home and Hamilton Boys’ Home. Ken Cutforth said that Ricketts “became an exemplar to follow for some principals”.<sup>334</sup>

## He ngoikore nō ngā mahi ako, whakawhanake mahi tokonga atawhai

### Inadequate training and development to deliver care

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#### I poto tonu te ako me te whakawhanake kaimahi, kaiatawhai ki te mahi atawhai ake

#### Staff and carers lacked training and development specific to care

273. Many staff and carers did not have the training and development needed for their roles and the demands they faced in care settings, particularly in overcrowded and under-resourced facilities.
274. For regulated care professions like medical professionals and teachers, training, development and vetting could form part of their registration requirements.
275. Most staff and carers (including volunteers) were unregulated. Until the late 1980s, employment policies and practices were generally left to each care setting to decide what was needed. Some departments would set broad, process-based requirements through service contracts.<sup>335</sup> From the late 1980s, different settings had different legal obligations. For example, from 1989 the Director-General of Social Welfare had a legal duty to ensure that people delivering social services received adequate training and complied with appropriate standards.<sup>336</sup>

<sup>333</sup> Witness statement of Jonathon Stevenson (29 March 2022, para 73).

<sup>334</sup> Witness statement of Ken Cutforth (3 October 2022, para 45).

<sup>335</sup> New Zealand Community Funding Agency, Standards for Approval Level one: Child and Family Support Services (November 1995, Standards 13–16, pages 31–34).

<sup>336</sup> Children, Young Persons, and their Families Act 1989, section 7(f).

276. In disability and mental health settings, and in Deaf settings, there were numerous reports of a lack of training of both clinical and non-clinical staff and concerns about how that affected children, young people and adults in care.<sup>337</sup> The second Mason inquiry into mental health services in 1996 found a lack of trained staff, particularly in child and adolescent mental health.<sup>338</sup> training was provided, it sometimes taught techniques that were not appropriate for a supportive care environment.<sup>339</sup>
277. Referring to the recommendations on patient rights in the 1983 Gallen Inquiry, the Mason Inquiry said the changes in the Mental Health (Compulsory Assessment and Treatment) Act 1992 that provided better protection for patients and should have reduced inpatient admissions, required significant staff training and resourcing to be effective. That training and resourcing had not happened. The necessary community-based services had not been set up and as a result hospital admissions were still seen as the mainstay of crisis response.<sup>340</sup>
278. In social welfare settings, staff were often appointed from entirely unrelated backgrounds because of a lack of applicants.<sup>341</sup> Few staff had formal qualifications or were well trained to do the job.<sup>342</sup> Training was often “on the job” and from the 1960s, the Department of Social Welfare began to develop training courses for residential staff. From the 1970s these courses were made compulsory for all new staff, although some of these were short, which limited what could be taught and could not cater for all newly recruited staff.<sup>343</sup>

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337 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, pages 12–13); Behrens, MJ, Report on Inquiry pursuant to section 58 (1) of the Mental Health Act 1969 (4 October 1983, page 43)

338 Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley, (May 1996, page 133).

339 Witness statement of Caroline Arrell (21 March 2022, para 2.10–2.14).

340 Ministry of Health, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley (May 1996, page 22).

341 For example, Recommendation for appointment to advertised vacancy number 1986/9309 ro4 Ōwairaka Boys Home (15 December 1986, pages 6–7).

342 Witness statement of Robin Wilson (20 November 2022, page 6); Transcript of evidence of Peter Whitcombe, Chief Social Worker, Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, page 707).

343 Witness statement of Michael Doolan for the White Trial (Crown Law Office, 7 May 2007, paras 195–196); Department of Social Welfare, Introducing the Residential Social Work: Induction Training Programme (1985, pages 3–6).

279. A 1981 study on social work, prompted by a concern that “the standards of training for social service workers were not adequate for the tasks social service workers were required to undertake,”<sup>344</sup> reported that 78 percent of social workers had no professional qualifications.<sup>345</sup> The situation had improved slightly by mid-1990s, when 44 percent of frontline staff and 55 percent of new recruits had the minimum qualification to apply for registration as a social worker.<sup>346</sup> Former Chief Social Worker Michael Doolan told the Inquiry that:

***“The absence of training opportunities meant that the managers or principals of [social welfare] institutions in the early to mid 1970s almost always had significant numbers of staff who had little or no training.”***<sup>347</sup>

280. The situation was similar for family home carers, who were not always given adequate information on the children and young people they were caring for or enough guidance on their role.<sup>348</sup> The Inquiry was told by carers that what training they did receive only came about six weeks after they started caring and that they did not receive any more training over the years they were foster and / or family home carers.<sup>349</sup>

281. A lack of appropriately selected and trained staff sometimes led to the overuse of restrictive practices and physical violence.<sup>350</sup>

282. Former social worker Mr PY told the Inquiry that, in the 1970s and 1980s, “[n]obody had any training on how to restrain that I was aware of.”<sup>351</sup> He said that at Kingslea Girls’ Home in Ōtautahi Christchurch in the mid-1980s, girls were physically restrained at times and “sometimes that was more physical than it possibly needed to be”.<sup>352</sup> A 1985 report to the Minister of Health found that with proper training and enough staff, seclusion in psychiatric and psychopaedic hospitals would be unnecessary.<sup>353</sup>

344 Rochford, M, & Robb, M, People in the social services. A New Zealand survey (Wellington: Social Work Training Council, 1981, page 5), as cited in Staniforth, B, Counselling in social work in Aotearoa New Zealand – Social workers’ perspectives and practice, Aotearoa New Zealand Social Work, Issue 22(3) (2010, page 17).

345 Rochford, M, & Robb, M, People in the social services. A New Zealand survey (Wellington: Social Work Training Council, 1981, page 18), as cited in Pilalis, J, Social work education in New Zealand: Ideological bases of current debates, Aotearoa New Zealand Social Work, Issue 2 (2008, page 49).

346 Brown, M, Care and protection is about adult behaviour: Ministerial Review of the Department of Child, Youth and Family Services Report to the Minister of Social Services and Employment (2000, page 53).

347 Witness statement of Michael Doolan (December 2022, para 44).

348 Witness statement of Leo and Carla van de Geer (3 May 2022, para 28); Transcript of evidence of Nicolette Dickson for Oranga Tamariki, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, page 690).

349 Witness statement of Leo and Carla van de Geer (3 May 2022, paras 30–31)

350 Witness statement of Mr NO (1 March 2021, paras 32–33); Matthews, M, The medicalisation, use of psychotropic medications and seclusion and restraint for people with a learning disability and/or autism spectrum disorder: An expert opinion provided to the Royal Commission into Abuse in State Care (2022, para 3.4).

351 Witness statement of Mr PY (6 December 2022, para 50).

352 Witness statement of Mr PY (6 December 2022, para 165).

353 Department of Health, Report to the Minister of Health: Review of psychiatric hospitals and hospitals for the intellectually handicapped (1986, page 7).

## **Te ako me te whakawhanake i ngā takinga pūnaha taurima ā-whakapono** **Training and development in faith-based care settings**

283. Across all faiths investigated, there was a lack of training or ongoing development for those in leadership positions.
284. Inadequate resourcing and a lack of training contributed to the abuse and neglect of children and young people in Catholic institutions such as Sunnybank Boys' Home near Whakatū Nelson and St Joseph's Orphanage in Te Awa Kairangi ki Uta Upper Hutt. The Inquiry heard from many survivors that staff would use restrictive and violent practices to manage the behaviour of children and young people.<sup>354</sup> Sister Sue France stated that a lack of resourcing and training contributed to abuse within the Catholic Church:

*"the lack of resources, of people being put in positions where they should not have been put in positions of care of children, or in situations where they were ill-trained for the work that they were doing."*<sup>355</sup>

285. Cardinal John Dew acknowledged the failure to provide training for those preparing for certain aspects of religious life or priesthood:

*"Historically, there was no training on the importance of boundaries and training regarding appropriate behaviour for those preparing for the religious life or priesthood. Nor was there the safeguarding training, or safeguarding policies that are now a key part of our church."*<sup>356</sup>

286. Cardinal John Dew also accepted that the lack of training to prepare clergy and religious (members of religious orders) for what the isolating and demanding role has contributed to the abuse within the Catholic Church:

*"I believe that historically many individuals within the Church may have been ill equipped to deal with mental health issues and loneliness which may have contributed to their actions in harming others."*<sup>357</sup>

<sup>354</sup> Witness statements of Mr NO (1 March 2021, paras 9–38) and Dion Martin (21 June 2021, para 11).

<sup>355</sup> Transcript of evidence of Cardinal John Dew, Dr Paul Flanagan and Sister Susan France at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 October 2022, page 229).

<sup>356</sup> Witness statement of Cardinal John Dew (4 October 2022, para 15).

<sup>357</sup> Witness statement of Cardinal John Dew (4 October 2022, para 16).

287. During the Inquiry's Faith-based Redress Hearing in March 2021, Anglican Bishop of Christchurch, Reverend Dr Peter Carrell, acknowledged the failure by the Anglican Church to implement boundary training for its clergy:<sup>358</sup>

*"I became the Ministry Educator in 2001 in the Diocese for Nelson. My memory is that we did not have a systematic programme for regular boundaries training. In hindsight that was a mistake. We should have had that. ... I think there was a complacency that we were basically a set of good people, good clergy, not so much that we didn't need boundaries training but that it wasn't an urgent priority as we were seeking to offer other forms of—I mean other things that were also important in training our clergy."*<sup>359</sup>

288. Colonel Gerry Walker told the Inquiry that the Salvation Army had a "Safe to Serve" document from around 2010 that "captured the training that was required, it captured the signs [of abuse] to look for, the training needed, who needed training, the monitoring ... [and] auditing of that". He said he did "not recall that there was anything as clearly documented as that" before 2010.<sup>360</sup>

289. In 1959, the Methodist Church appointed a Commission to examine the Church's practice of care of children and delivered a report to the Methodist Conference in 1961. The recommendations to the Conference included ensuring that those providing care for children were adequately trained and resourced. The Methodist Church failed to implement the recommendations consistently across all churches, which meant it missed an opportunity to implement and strengthen its safeguarding practices and the way it cared for children.<sup>361</sup>

290. Plymouth Brethren Christian Church told the Inquiry that Elders are not required to undergo any specific training and are not subject to any formal supervision or oversight. They are, however, expected to be familiar with the scriptures and the ministries of current and former senior leaders of the Church.<sup>362</sup>

358 Transcript of Bishop Peter Carrell at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 19 March 2021, page 365).

359 Transcript of Bishop Peter Carrell at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 19 March 2021, page 365).

360 Transcript of evidence of Colonel Gerry Walker for the Salvation Army at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 15 March 2021, page 46).

361 Opening Submissions of the Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa, Wesley College Board of Trustees, and Wesley College Trust Board at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 3.21).

362 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1, Appendix 1: Overview of the PBCC (23 April 2021, page 2, para 10).

291. Presbyterian Support Central acknowledged that, as identified from the available records, there did not appear to have been robust recruitment and vetting processes while its Berhampore Home in Te Whanganui-a-Tara Wellington was operating and there is not evidence of training for staff about safeguarding. The organisation told the Inquiry that, had there been oversight, safeguarding, supervision and appropriate training, some of the abuse could have been prevented.<sup>363</sup>
292. When Gloriavale Christian Community was asked whether its leaders were required to undergo training such as boundaries training, they said that they have recently applied for leaders and managers to attend training programmes for company directors and trustees. This suggests there was no training and development specific to care during the Inquiry period.<sup>364</sup>

### **He kūiti kāhore rawa atu rānei akonga e mōhiotia ai ngā tohu o te mahi tūkinō i ngā pūnaha taurima**

#### **Limited or no training to identify signs of abuse and neglect in care**

293. Before the 1980s, there was limited training and development of staff and care workers to identify signs of abuse and neglect in care.<sup>365</sup> From the 1980s onwards, most care settings began developing their own guidance and training, initially focusing on sexual abuse.
294. Social workers started to receive formal training on sexual abuse in the 1980s. A 1983 circular issued by the Department of Social Welfare noted that “in recent years the Department has actively encouraged staff, both formally through staff training and in particular through a series of seminars on child abuse, and informally through discussion between H.O. [head office] and district staff, to facilitate and participate in multi-disciplinary case conferences on child abuse cases.”<sup>366</sup>
295. The Residential Social Work Induction Training Programme, which began in 1984, included brief definitions of physical abuse and neglect and sexual abuse at the back of its fourth module, Understanding Human Needs and Development.<sup>367</sup> Its guidance on identifying and preventing sexual abuse is limited to noting that “often it is difficult to detect sexual abuse ... [t]he best indicators are, short of the child telling someone, a sudden change in behaviour, signs of emotional disturbance, unexplained sudden crying and excessive nervousness.”<sup>368</sup>

363 Transcript of evidence of Presbyterian Support Otago and Presbyterian Support Central at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 256–257).

364 Gloriavale Christian Community, Response to Care Notice to Produce 460 (8 July 2022, page 30).

365 Daly, K, Redress for historical institutional abuse of children, in Deckert, A & Sarre, R (eds), *The Palgrave Handbook of Australian and New Zealand Criminology, Crime, and Justice* (2017, page 7); Witness statements of Denis Smith (15 December 2021, para 19) and Patricia Williams (12 July 2022, paras 12, 29); Ministry of Social Development, Practice review for [survivor] (April 2011, para 41).

366 Department of Social Welfare, Circular Memorandum 1983, A multidisciplinary approach to child abuse (SWK 11/13/-) (May 1983, page 1).

367 Department of Social Welfare, *Introducing the Residential Social Work Induction Training Programme – Module Four: Human Needs and Development* (1985, page 67).

368 Department of Social Welfare, *Introducing the Residential Social Work Induction Training Programme – Module Four: Human Needs and Development* (1985, page 67).



296. In 1984, the Department of Education issued guidelines on how to deal with “cases of suspected sexual abuse of pupils” and how to investigate and report allegations of abuse.<sup>369</sup> Updated guidance was issued in 1989.<sup>370</sup> In 1997 the Ministry of Education issued a circular reminding school boards of trustees that they had to implement policies and procedures to ensure that “staff were familiar with ways to prevent, recognise and respond to abuse”.<sup>371</sup>
297. The Department of Health issued Child Abuse Guidelines for Health Services in 1992 to supplement area health boards’ own policies and processes on identifying and responding to signs of abuse and neglect:
- “The safety of the child is paramount. Health service providers must therefore ensure that staff are provided with a basic knowledge and understanding of the indicators of child abuse, and the appropriate reporting procedures to follow.”***<sup>372</sup>
298. From 1995, the Director-General of Social Welfare had a statutory duty to promote, by education and publicity, professional and occupational awareness of child abuse, ways to prevent it and to report it.<sup>373</sup>

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369 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, pages 129–130).

370 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, pages 130–131).

371 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 131).

372 Department of Health, Child abuse guidelines for health services (June 1992, page 14).

373 Children, Young Persons, and Their Families Amendment Act 1994, section 4.

A coastal landscape with a beach, ocean, and a large tree in the foreground, overlaid with a white text box. The scene is bathed in a warm, golden light, suggesting a sunset or sunrise. The tree in the foreground has dark, silhouetted branches and leaves. The beach is sandy and stretches towards the water. The ocean is calm, and a distant landmass is visible on the horizon under a cloudy sky.

"The structural racism that exists in the care and protection system reflects broader society!"

**CHAPPIE TE KANI**

Chief Executive, Oranga Tamariki

# Ko te hunga i ngā pūnaha taurima i tukia tonu e te ngoikore o ngā tikanga arataki i ngā kaimahi me ngā kaiatawhai

## People in care often bore the brunt of poor supervision of staff and carers

299. Poor supervision or performance management contributed to abuse and neglect because it became accepted and staff and carers were not held to account for abuse or neglect.
300. A culture of using physical violence against children, young people and adults in care was so normalised in some care settings that staff found it difficult to intervene when they witnessed abuse or were ostracised if they complained.<sup>374</sup> Tā Kim Workman told the Inquiry about his experience of visiting Kohitere Boys' Training Centre in Taitoko Levin as a Youth Aid Officer in the 1970s:
- "In later years, I thought about why I didn't do more to address the situation; to 'blow the whistle'; report on what I knew and call for an investigation. If it did occur to me, I would have put the idea quickly out of contention. The culture was such that I would not have been supported. Moreover, I would have been branded a 'stirrer' and secured my place as an 'outlier' within the police organisation."<sup>375</sup>*
301. When staff did not agree with normalised violence or derogatory treatment of people in care, they felt under pressure to either conform or leave.<sup>376</sup> This meant that the staff who did remain could become increasingly desensitised to abuse and neglect because no one had been able to stop it.<sup>377</sup>
302. Neglect and physical and emotional abuse was so common in some institutions that it became invisible to staff. Paul Milner, who visited the Kimberley Centre near Taitoko Levin, a psychopaedic hospital for children with learning disabilities, for around three years in his role as a disability researcher, told the Inquiry:
- "In the culture that I witnessed, it was next to impossible for anybody to do anything more than walk away. That is the nature of an institution. The things that I was completely affronted by and recognised immediately as abuse, I no longer saw."<sup>378</sup>*

374 Witness statements of Allison Campbell (15 February 2022, paras 2.48, 3.15); Caroline Arrell (21 March 2022, para 2.61); Ken Bragan (19 February 2022, para 21) and Enid Wardle (3 October 2021, para 3.25).

375 Witness statement of Tā Kim Workman (5 October 2019, para 29).

376 Ōwairaka Boys' Home report: Transcript of interview with Bruce Pollard (12 April 1978); Auckland Committee on Racism and Discrimination, Interview with Martin Tolich, Assistant Housemaster in Secure Block (Owairaka) (n.d.); Report from Cheryl Ash, My Placement at Allendale Girls' Home (24 May 1980); Letter from PP Heath, senior teacher at Fareham House School to IW Hanna, District Senior Inspector of Primary Schools (20 June 1977).

377 Witness statement of Paul Milner (1 June 2022, paras 2.47 and 2.49).

378 Witness statement of Paul Milner (1 June 2022, paras 2.47 and 2.49).

## Kāhore te Tiriti o Waitangi i kitea i ngā kaupapa me ngā tikanga hautū mahi

### Te Tiriti o Waitangi was absent in employment policies and practices

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303. During the Inquiry period, there was no legislative direction that employment policies or practices should incorporate te Tiriti o Waitangi or give effect to the rights guaranteed to iwi and hapū in te Tiriti o Waitangi. It was left to government agencies and individual institutions to decide whether and how to incorporate te Tiriti o Waitangi into their employment policies and practices regarding vetting, recruitment, training and development of staff and other carers.
304. The Inquiry notes that section 56(2) of the State Sector Act 1988 included an obligation for a chief executive of a department to operate a personnel policy. That policy needed to contain provisions “generally accepted as necessary for the fair and proper treatment of employees”. Section 56(2)(d) said the policy should recognise:
- “(i) the aims and aspirations of the Maori people; and*
  - (ii) the employment requirements of the Maori people; and*
  - (iii) the need for greater involvement of the Maori people in the Public Service.”<sup>379</sup>*
305. The Inquiry did not see any employment policies or practices that explicitly incorporated te Tiriti o Waitangi. The State was aware from at least 1982 that there was a lack of diversity in the public service, and that recruitment and training programmes were needed to increase diversity and appoint people directly into positions of seniority and responsibility.<sup>380</sup> That this was not effectively addressed represents a missed opportunity to benefit from the Māori thinking, approaches and values that greater involvement of Māori employees in care settings and policy agencies would have bought. This was contrary to te Tiriti o Waitangi principles of tino rangatiratanga, partnership, active protection, good government and options as set out in Part 1.<sup>381</sup>

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<sup>379</sup> State Sector Act 1988 section 56(2)(d).

<sup>380</sup> State Services Commission, Public Service in a Multicultural Society: Waahi conference 1982 (1983, page 14).


<sup>381</sup> Waitangi Tribunal, Tino Rangatiratanga me te Kāwanatanga: Te Paparahi o Te Raki Inquiry Stage 2 Report Part I (2023, page 69).

## He akonga i kitea he mea i panonihia e pā ana ki ngā tikanga hautū mahi

### Lessons identified and changes made to employment practices

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306. The State learned that it needed to regulate the recruitment and training of staff and carers in care settings. It began to take steps to do this from the late 1970s, primarily through internal policies in social welfare and education settings.
307. However, there were no legislative changes during the Inquiry period to make staff vetting mandatory in all care settings, to direct NZ Police on how to respond to vetting requests, or to create serious sanctions for those senior leaders and managers in care settings who knowingly gave abusers with criminal convictions positions in care settings.
308. The State did not make any legislative changes during the Inquiry period to bring a consistent approach across all care settings to recruiting diverse staff and carers, baselines for what constitutes adequate resourcing to prevent or respond to abuse and neglect in care, or training and development requirements to deliver care or recognise the signs of abuse and neglect in care.



"They put me  
in a straitjacket  
and raped me"

**CHRISTINA RAMAGE**  
New Zealand European

# Christina Ramage

**Hometown:** Tāmaki Makaurau Auckland

**Age when entered care:** 15 years old

**Year of birth:** 1956

**Time in care:** 1971–1976

**Type of care facility:** Psychiatric hospitals – Ward 10, Auckland Hospital;  
Carrington Hospital

**Ethnicity:** New Zealand European

**Whānau background:** Christina has a younger brother and a younger sister.

**Currently:** Christina lives in Auckland and says her counsellor is a lifeline for her.



**I was 15 years old and a friend and I went out to celebrate passing School Certificate. That night, I was raped by five young men. They were at a bus stop and threatened me, dragged me around the back, then raped me. I remember bits and pieces of what happened, but other parts are blank. I kept it to myself, but soon afterwards I started cutting myself because I was so stressed.**

I was also sexually abused by my father from when I was a pre-schooler until I was 13 years old. A lot of what I remember from this time is being in darkness. I was afraid most of the time because I didn't know what was going to happen. I became more and more stressed and ended up having seizures.

I was 15 years old when I was admitted to psychiatric care, first at Auckland Hospital. A doctor there gave me something he described as a "truth drug", then I went before a three-person panel and they decided I was a danger to myself and to the public. I was committed to Carrington Hospital as an involuntary patient. The doctor had said I would be told the results, including what I had said, but that never happened. It makes me angry, because it seems like they decided to commit me because of what I'd said, but they wouldn't tell me what I had said.

I was sent to Carrington Hospital in 1972, at 16 years old. I was taken to a dark and smelly room and told to get on the bed. They gave me electric shocks without anaesthetic. Then I was admitted to an unlocked ward for women, but later moved to a locked ward called Park House.

My sister told me the entrance to Carrington was nice and welcoming, with a picture of Jesus on the wall. But that wasn't the case with the wards – they were terrible, overcrowded and understaffed, and I was treated as a lesser human being. The bedrooms had bars on the windows. The reception and entrance were a facade.

I was given a lot of drugs but never told what they were or how I might react to them.

It was a known thing that the male nurses at Carrington were university students working for wages in the semester break, so a lot of them were totally untrained. In the female ward, women were there to be used for sex or assault. People seemed to think it was easy to look after a lot of 'loonies'. These untrained nurses had direct access to straitjackets and were allowed to use them on us without having to give any reason.

One day I was walking down a corridor when two young male nurses grabbed me, took me into an area behind doors where the straitjackets were kept, and put one on me hurriedly and roughly. I was confused and afraid; I didn't know what I'd done wrong, and I was terrified of whatever was going to happen.

They laughed and joked. "Nobody can see us here," one said. They pushed me onto the ground, and I thought, "This is it". I realised what was about to happen, and it terrified and panicked me. I struggled uselessly to get out of the straitjacket even though I knew I couldn't. I closed my eyes, I was overwhelmed and despairing.

As one raped me, the other would say, "Hurry up, hurry up". I was raped by both of them. I could feel my body above my waist, but not below at all. I screamed out even though I knew it was no good – my cries couldn't be heard through the thick and solid doors that hid the three of us.



After the rape, the two of them sat on the steps and laughed at me for what seemed like forever. "She's no good, scum, rotten to the core," one said. They took the straitjacket off and I straightened my nightgown. I didn't say anything – after all, who would believe a mental patient who had previously been abused and raped and was currently in a mental asylum? They'd probably say I was asking for it, or I was lying. I knew if I said something, I'd be locked up.

I was sexually abused by a psychiatrist while I was at Park House. A nurse took me to a very small room and the psychiatrist locked the door. He asked me a few questions. One of them was, "Do you like sex?". I thought he'd find something wrong with me if I said no, so I said yes. The nurse took me to the examination bed and left the room, and the psychiatrist took my underwear down and raped me.

A few months after the psychiatrist had raped me, a nurse took me to a room that was usually always locked. The room had lots of shiny things. They told me to get on the bed, and suddenly everything went dark. The next thing I knew, I was awake. "It's okay, you haven't got a baby anymore," a nurse said. I realised I had been given an abortion following the rape by the psychiatrist.

I think this is one of the most criminal aspects of my time at Carrington. It still haunts me today.

I was also sexually abused by other patients. Three young women assaulted me, two of them on either side fondling my breasts while the other one pushed a finger up my vagina.

I also saw other people being abused or neglected in the same way that I was, and it created an atmosphere of abuse and neglect that was thick. A female patient once got hold of some matches and went to her room during the day and set fire to herself on the mattress. I never saw her again. The incident really troubled me because she was in quite a helpless situation – she had been 'dumped at the door' at birth as she was disabled.

I became wary of what was going on around me, and I trusted no one. All-encompassing fear was everywhere and hung really heavily. The feeling was palpable all the time.

I was given 10 rounds of electric shocks, six shocks per round. I wasn't told how this would be done, what might happen to me afterwards as a result, or why I was being given the shocks. I wasn't given a sedative or anaesthetic on any of these occasions, and wasn't even told that this was a possibility. ECT was often given as a form of punishment.

I had to get onto the bed and the nurses would put a cloth in my mouth while they held me down. The doctor would say, 'are you ready' and flick the switch on the grey ECT box. After ECT, I was always sore in my private parts, and I realised I must have been raped or sexually assaulted.

You got one bath per week, as the sole female nurse came in only once a week. She would watch you having a bath. The baths were made of rough concrete and the water only covered the bottom half of your body as you laid down.

The wards had padded cells and you were thrown into them as punishment if you played up. I was thrown in there for making a noise scraping my chair as I got up in the dining room. The reasons for locking us up were many, and petty.

I was generally unable to express myself, so when I did, it was in the form of fighting. The male nurses would throw me into a room and take apart the three-piece bed, leaving only the mattress. They'd pull my pants down and roughly inject me with a knockout drug, and leave me in there for a long time. It was usually dark when I went in and daylight when I came out, except for the occasions when I was left in there for longer than a day.

Going into psychiatric care was the end of any education I received. I didn't get any schooling, although a few people did, if they were considered 'well enough'. Sometimes an occupational therapist would come in, but there was no entertainment and nothing to do.

I was 20 years old when I was discharged from Carrington. My hopes and dreams were shattered. I was angry, bitter, sad, and I felt alone. It was like being in a straitjacket all the time.

It is encouraging that, after 37 years in my case, a Royal Commission of Inquiry has finally taken steps to seek to uncover the harrowing stories of many individuals who were in care. It's long overdue.

I've spoken out for the people who are currently in psychiatric wards, and for those in the future. My experience shows that there is always hope.<sup>382</sup>

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<sup>382</sup> Witness statement of Christina Ramage (27 July 2021).

# Ūpoko | Chapter 5

## Kāhore i kitea ngā kaupapa taki kōamuamu, e ngāwari noa rānei te karo

### Complaints processes were absent or easily undermined

309. Effective complaints processes need to be designed for children, young people and adults in State and faith-based care and be easily accessible.<sup>383</sup> Complaints policies should clearly cover how to make a complaint, responding to a complaint, investigating a complaint, support and assistance for complainants, and how to achieve system-level improvements in light of a complaint.<sup>384</sup> Record-keeping requirements are also critical for the effective administration of complaints processes and for providing oversight of decisions made.<sup>385</sup>
310. Absent, inaccessible or poorly implemented complaints processes can perpetuate abuse.<sup>386</sup> Institutional behaviour that undermines complaints processes and contributes to abuse and neglect in care include:
- use of internal or closed processes that avoid external scrutiny<sup>387</sup>
  - prioritising the reputation of the care facility over the wellbeing and safety of people in care<sup>388</sup>
  - prioritising the abuser's reputation and /or rights as an employee or member of a union over the wellbeing and safety of people in care<sup>389</sup>
  - failing to refer complaints to appropriate authorities.<sup>390</sup>

383 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 7, Improving Institutional Responding and Reporting (2017, page 23 and section 3.4).

384 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 7, Improving Institutional Responding and Reporting (2017, pages 23 and section 3.5).

385 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 7, Improving Institutional Responding and Reporting (2017, pages 17, 33, 139–141 and 157–158).


386 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 2, Nature and Cause (2017, page 173); Sullivan, J & Beech, A, "Professional perpetrators: Sex offenders who use their employment to target and sexually abuse children with whom they work", Child Abuse Review 11 (2002, page 162).

387 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 2, Nature and Cause (2017, page 163).

388 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 2, Nature and Cause (2017, pages 162 and 173); Independent Inquiry into Child Sexual Abuse (United Kingdom), The Report of the Independent Inquiry into Child Sexual Abuse (2022, page 155).

389 Independent Inquiry into Child Sexual Abuse (United Kingdom), The Report of the Independent Inquiry into Child Sexual Abuse (2022, page 124).

390 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Volume 2, Nature and Cause (2017, page 163).

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311. The first section of this chapter looks at what complaints processes were available to children, young people and adults in care to raise concerns or make complaints about abuse or neglect during the Inquiry period. It relates to clauses 31(b) and 10.2(b) of the Terms of Reference.
312. The second section of this chapter looks at what processes were in place across all care settings to respond to concerns or complaints of abuse or neglect, and how effective these were, including internal investigations into the concern or complaint and referrals for disciplinary or criminal action. It also covers barriers experienced by people in care to raising concerns or making complaints as part of looking at how effective institutional responses to complaints were. This section relates to clauses 31(b) and 10.2(d) of the Terms of Reference.

## **Ngā kaupapa kōamuamu i te wā o te Pakirehua**

### **Complaints processes during the Inquiry period**

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313. From 1950 to 1986, there were no legislated rights to a complaints process for children, young people and adults in care in any State or faith-based care setting. It was left to individual care facilities to decide whether to provide people in their care with access to a complaints process.
314. From 1986, the law required social welfare residences to have complaints processes accessible for people in their care. From 1992, the law required people subject to compulsory mental health treatment assessments or orders to have access to complaints processes. All other people in State or faith-based care were reliant on either government agencies or individual care facilities to provide them with access to a complaints process.
315. Like standards of care, complaints processes varied so widely during the Inquiry period that access to an adequate complaints process depended on when someone was in care, where, and whether they were disabled or not.

## Ngā kaupapa kōamuamu takinga whaikaha, hauora hinengaro

### Complaints processes in disability and mental health settings

316. Until the 1990s, the primary mechanism for children, young people and adults in care in mental health settings to raise concerns or make complaints was through district inspectors and official visitors.<sup>391</sup> District inspectors were required to have medical qualifications, or from 1969 legal qualifications as either a barrister or solicitor, and reported to the Director of Mental Health as independent watchdogs of mental health services.<sup>392</sup>
317. Unlike district inspectors, official visitors did not need to be highly qualified but needed to have “impartiality, respectability and social concern”.<sup>393</sup> Official visitors’ main purpose was to act as an advocate or friend for people in psychiatric hospitals. They could escalate issues they observed or concerns that were raised by people in care.<sup>394</sup> Official visitors also reviewed how complaints were managed and made recommendations to hospital management to improve processes.<sup>395</sup>
318. There were initially not enough district inspectors across the country – there were only two in the 1960s, increasing to 27 by 1997.<sup>396</sup> Their role was poorly defined and many people in mental health care settings were not aware of them or how to speak to them. The official visitor role was retained under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Official visitors were appointed in 1993 but were not reappointed in 1996. In 2014, official visitors had still not been re-appointed.<sup>397</sup>
319. After 1992, there was a legislated complaints process for people in care who were subject to compulsory mental health assessments and treatment orders.<sup>398</sup> This was limited to complaints about breaches of their statutory rights. The complaints process ensured that people subject to compulsory orders had access to advocacy, and that all complaints would be independently investigated by either the district inspector or official visitor.<sup>399</sup> If a complaint was substantiated, it had to be referred to the Director of Area Mental Health Services, along with any recommendations. The Director had a legal duty to take all steps needed to fix the complaint.<sup>400</sup> There was also a right of appeal if the complainant was unhappy with the outcome.<sup>401</sup>

391 Mental Defectives Act 1911, sections 70–78, Mental Health Act 1969, sections 5, 56–65.

392 Prebble, K, Gooder, C & Thom, K, New Zealand’s Mental Health District Inspector in historical context: “the impartial scrutiny of a citizen of standing”, the Journal of Law, Medicine & Ethics 22(2) (2014, page 415); Mental Defectives Act 1911, section 41; Mental Health Act 1969, section 5.

393 Prebble, K, Gooder, C & Thom, K, New Zealand’s Mental Health District Inspector in historical context: “the impartial scrutiny of a citizen of standing”, the Journal of Law, Medicine & Ethics 22(2) (2014, page 417).

394 Letter from Basil James, Director of Mental Health to Chief Executives of Hospital Boards, Information for Official Visitors and District Inspectors, Circular Letter (Hosp) No 1984/9 (18 January 1984).

395 Letter from HH Wilson, Official Visitor, to the Medical Superintendent, Palmerston North Hospital attaching Official Visitor’s Report on a complaint made by a Patient on Tuesday 30th June 1987 (22 July 1987).

396 Professor Michael Taggart, Report to the Ministry of Health on District Inspectors (20 May 1997, pages 3, 11).

397 Prebble, K, Gooder, C & Thom, K, New Zealand’s Mental Health District Inspector in historical context: “The impartial scrutiny of a citizen of standing”, the Journal of Law, Medicine & Ethics 22(2) (2014, page 424).

398 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 75.

399 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 75(1).

400 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 75(2).

401 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 75(4).

320. From 1996, the Code of Health and Disability Services Consumers' Rights made it clear that anyone in the care of a health and /or disability service provider had the right to complain.<sup>402</sup> Providers were obligated to facilitate the fair, simple, speedy and efficient resolution of complaints. There were clear time-limited procedural steps that providers were required to follow to ensure the complaint was dealt with and complainants were kept informed throughout, including about their rights of appeal.

## **Ngā kaupapa kōamuamu takinga toko i te ora**

### **Complaints processes in social welfare settings**

321. From 1957 to 1986, complaints processes for social welfare settings were contained in the Field Officers Manual and its later versions (including the Social Workers Manual). Like the standards of care set out in these manuals, complaints processes were not accessible to children and young people in care, their family or whānau.
322. In this period, visits from a child welfare officer or social worker were considered the primary way that children and young people in care could raise concerns or complaints. This was reflected in the guidance in the staff manuals, which included best practice guidance on the minimum number of face-to-face visits required. The manuals also set out that concerns or complaints of abuse or neglect should be promptly dealt with and prioritised and that, if the concerns or complaints were considered serious, NZ Police should be contacted.
323. From 1984, it was the principal's responsibility to develop a formal grievance procedure for complaints processes in social welfare residences.<sup>403</sup> This requirement did not cover foster homes and third-party care providers. The principal had discretion regarding what to include in the grievance procedure.<sup>404</sup> In 1986 it became a requirement for the principal of the residence to inform children and young people in care about the grievance procedure and how they could lodge a complaint.<sup>405</sup> The 1989 Care and Protection Handbook and Youth Justice Handbook did not include information on complaints processes.<sup>406</sup>
324. In 1989, the Human Rights Commission conducted a review of secure care in social welfare residences and found that very few had formal complaints or grievance procedures in place, despite being legally required.<sup>407</sup>

402 Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996, regulation 2, right 10.

403 Department of Social Welfare, Social Work Manual, volume II (1984, Q5.3.3).

404 Department of Social Welfare, Social Work Manual, volume II (1984, Q5.3.3).

405 Children and Young Persons (Residential Care) Regulations 1986, regulation 6.

406 Department of Social Welfare, Care and Protection Handbook (July 1989); Department of Social Welfare, Youth Justice Handbook (October 1989).

407 Human Rights Commission, The use of secure care and related issues in Social Welfare institutions (June 1989, page 75).

325. The 1996 updated Residential Care Regulations gave every child or young person in a residence the right to access the grievance procedure<sup>408</sup> and introduced the right to an independent advocate when making a complaint.<sup>409</sup> The Regulations also established grievance panels and made it compulsory for every residence to have one.<sup>410</sup> The key functions of a grievance panel were to monitor compliance with the grievance procedure and review decisions made by the manager about complaints and any punishment or sanction imposed on a resident.<sup>411</sup>
326. Third party providers had to have a written policy for dealing with complaints, which had to be given to and explained to children and young people in care and their families.<sup>412</sup>
327. The Care and Protection Manual 1996 set out details of the Commissioner for Children's complaints service, which was established so that the public could bring issues of concern relating to either individual children or groups of children to the Commissioner's attention. When reviewing complaints, the Commissioner could give opinions on whether the complaint was justified or make recommendations, but did not have the power to enforce these.<sup>413</sup> Child, Youth and Family had an agreed protocol for the management of complaints received by the Commissioner for Children.<sup>414</sup>

408 Children Young Persons and Their Families (Residential Care) Regulations 1996, regulation 15.

409 Children Young Persons and Their Families (Residential Care) Regulations 1996, regulation 16.

410 Children Young Persons and Their Families (Residential Care) Regulations 1996, regulations 29–31.

411 Children Young Persons and Their Families (Residential Care) Regulations 1996, regulation 31(1).

412 See New Zealand Community Funding Agency, Standards for Approval Level one: Child and Family Support Services (November 1995, standard 12).

413 Children and Young Persons Service, Care and Protection Manual – Volume 1 (1996, Chapter 1, page 31).

414 Children and Young Persons Service, Care and Protection Manual – Volume 1 (1996, Chapter 1, page 1 and Chapter 4, pages 26–27).

## Ngā kaupapa kōamuamu takinga mātauranga

### Complaints processes in education settings

328. From 1950 to 1989, there were no legislated requirements for children and young people in education settings, including special schools for Deaf students, to have access to a complaints process.<sup>415</sup> Like standards of care, it was left to schools to decide whether to provide a complaints process. From 1989, it was left to a State or State-integrated school's board of trustees to decide whether to have a complaints process, taking into consideration any guidance from the Ministry of Education.<sup>416</sup> For private schools, school hostels and boarding houses, there was also no specific legislative direction on complaints processes for children and young people in their care.<sup>417</sup>
329. For Deaf students in special schools or classes, there were no legislated requirements for access to a complaints process. The Inquiry saw no evidence of a documented complaints process at either Van Asch College in Ōtautahi Christchurch or Kelston School for the Deaf in Tāmaki Makaurau Auckland until 1994.<sup>418</sup> There was no reference to complaints or complaints policies in any of their annual reports to the Department of Education, nor any indication of Departmental oversight of complaints.
330. From 1994, Kelston School for the Deaf had a general complaints policy that covered complaints made against staff, although it was focused more on protecting staff than people in care. The policy had nine stated purposes, of which the first two were "to ensure minor concerns are not blown out of proportion putting the staff member under undue stress" and "to ensure individual staff members are not unfairly harassed or unreasonably impeded from carrying out their allotted tasks".<sup>419</sup>

## Ngā kaupapa kōamuamu takinga whakatika, mauhere ā-ture

### Complaints processes in transitional and law enforcement settings

331. From 1950 to 1999, there were no legislated requirements for people in transitional and law enforcement settings to have access to a complaints process. NZ Police's General Instructions were silent on complaints processes for children, young people and adults in their care.<sup>420</sup>

415 Education Act 1914; Education Act 1964.

416 Education Act 1989.

417 Education Act 1989.

418 Kelston Deaf Education Centre, Complaints against staff members, (14 July 1994).

419 Kelston Deaf Education Centre, Complaints against staff members (14 July 1994, page 1).

420 NZ Police, Manual of General Instructions (1977); NZ Police, Manual of General Instructions (1980).



## Ngā kaupapa kōamuamu takinga pūnaha taurima ā-whakapono

### Complaints processes in faith-based care settings

332. From 1950 to 1999, there were no legislated requirements for children, young people and adults in faith-based care to have access to a complaints process. Each faith-based institution decided whether to provide a complaints process, and what that would consist of.
333. Survivors of Gloriavale Christian Community were actively prevented from reporting their abuse. Overseeing Shepherd of Gloriavale Howard Temple conceded at the Inquiry's Faith-based Institutional Response Hearing that the community's policy documents prevented reporting of crimes to secular agencies, including to NZ Police, and that everyone in the community was aware of this policy.<sup>421</sup> The policy limited contact with the outside world,<sup>422</sup> including State agencies, and reduced opportunities for oversight and the disclosure of abuse. It was in place from 1989 to 2002.<sup>423</sup>
334. The Salvation Army's Orders and Regulations provided a procedure for improper conduct, but this focused on the discipline of staff rather than on being an accessible complaints process for people in its care.<sup>424</sup> In 1989, the Salvation Army established the Officer Review Board, which assisted the Territorial Commander with disciplinary matters and required that certain complaints must be investigated. In 1991, the Salvation Army leadership in Aotearoa New Zealand implemented an Official Minute that provided guidelines on some situations including child abuse. The Official Minute provided that a report with recommended action be submitted to Territorial Headquarters to ensure disciplinary consistency across the Territory.
335. The Salvation Army introduced the Sexual Misconduct: Policies & Complaints Procedures Manual in 1999. The manual details the processes for complaints and investigations of sexual misconduct. All criminal sexual behaviour must be reported to the Secretary for Personnel and the complainant is also advised to report their complaint to NZ Police.<sup>425</sup>

421 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 47).  
Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 48).

422 Gloriavale Christian Community, *What we believe – Basic beliefs* (2015, pages 39, 124).

423 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 48).

424 Witness statement of Colonel Gerry Walker on behalf of the Salvation Army (29 January 2021, para 4.4); *Orders and Regulations for Corps Officers of the Salvation Army* (The Salvation Army, 1937).

425 Witness statement of Colonel Gerry Walker on behalf of the Salvation Army (18 September 2020, para 5.3).

# I te nuinga o ngā wāhi mahi kāhore he kaupapa whakautu kōamuamu

## Most settings did not have processes in place to respond to complaints

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### Te whakautu kōamuamu takinga whaikaha, hauora hinengaro

#### Response to complaints in disability and mental health settings

336. In disability and mental health settings, there was little evidence of internal processes for investigating and responding to reports of abuse and neglect in care before the 1980s, although there were external processes in place (such as district inspectors, official visitors, and the Health and Disability Commission).

### Te whakautu kōamuamu takinga toko i te ora

#### Response to complaints in social welfare settings

337. In social welfare settings, the process for responding to concerns or complaints was generally set out in the Field Officers Manual, and subsequent versions, including handbooks, with clear guidance on what to do when the concern or complaint was serious:

*“Whenever there is any 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 ...”*<sup>426</sup>

338. The 1957 Field Officers Manual reminded Child Welfare Officers of the importance of contacting NZ Police, as it was “a criminal offence to ill-treat, neglect or fail to provide a child with the necessaries of life”.<sup>427</sup>

339. From 1996, processes for responding to complaints in social welfare residences were set out in the Children, Young Persons, and their Families (Residential Care) Regulations.

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<sup>426</sup> Department of Education, Child Welfare Division Field Officers Manual, Part 1 (1957, H21 page 10).

<sup>427</sup> Department of Education, Child Welfare Division Field Officers Manual, Part 1 (1957, page 10).

## **Te whakautu kōamuamu takinga mātauranga**

### **Responses to complaints in education settings**

340. In education settings, including special schools for Deaf students, formal processes for investigating and responding to reports of abuse were generally not in place until the mid-1980s. These were generally left to individual schools to develop, with no specific requirement or direction in legislation.

## **Te whakautu kōamuamu takinga whakatika, mauhere ā-ture**

### **Responses to complaints in transitional and law enforcement settings**

341. Between 1950 and 1989, there were no clear processes in place in transitional and law enforcement settings to respond to concerns or complaints about children, young people and adults in their care. From 1989, the Independent Police Complaints Authority could receive complaints alleging any misconduct or neglect of duty by any NZ Police employee, regarding any practice, policy, or procedure of the NZ Police affecting the person making the complaint.<sup>428</sup>

## **Te whakautu kōamuamu takinga pūnaha taurima ā-whakapono**

### **Responses to complaints in faith-based care settings**

342. Most faith-based institutions began establishing processes for investigating and responding to reports of abuse and neglect in their care towards the end of the Inquiry period in the 1980s.<sup>429</sup> The Inquiry saw limited evidence of formal investigative processes within faith-based institutions during the Inquiry period.

<sup>428</sup> Independent Police Conduct Authority Act 1988, section 12 (1)(a)(i) & (ii).

<sup>429</sup> Witness statement of Murray Houston on behalf of the Salvation Army (18 September 2020, para 4.5); Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Pūretumu Torowhānui Volume 1 (2021, page 191).

343. Before the 1990s, formal processes for responding to reports of abuse had not been established within the Catholic Church.<sup>430</sup> Some church leaders perceived the abuse of children, young people and adults as a canonical crime and a moral failing, not a criminal offence that should be reported to NZ Police. From 1987, leaders within the Catholic Church in Aotearoa New Zealand, the New Zealand Catholic Bishops' Conference and the Congregation Leaders Conference of Aotearoa New Zealand began to develop processes relating to responding to reports of abuse.<sup>431</sup>
- a. In 1987, the New Zealand Catholic Bishops' Conference released a pastoral letter to priests about sexual misconduct.
  - b. From 1990 to 1992, the New Zealand Catholic Bishops' Conference sought advice about a national protocol for responding to complaints of sexual abuse and sexual misconduct, and a "provisional protocol" was established in 1993.
  - c. In 1995, the Congregation Leaders Conference of Aotearoa New Zealand developed congregational guidelines for cases involving sexual abuse.
  - d. Te Houhanga Rongo – A Path to Healing was formally adopted as a national protocol in 1998. Although the current and previous versions of Te Houhanga Rongo – A Path to Healing state that the protocol was first "adopted" in 1993, there is no evidence dioceses or religious institutes collectively agreed to any national policy before Te Houhanga Rongo – A Path to Healing in 1998.<sup>432</sup>
344. The Catholic Church provided the Inquiry with various complaints policies it had in existence. This included guidelines on sexual misconduct by clerics, religious and church employees (first issued in 1993 and sometimes referred to as the "provisional protocol"),<sup>433</sup> a 1996 document for congregational leaders detailing the suggested procedures in cases of allegations of sexual abuse by a religious,<sup>434</sup> and St John of God draft guidelines for complaints against brothers 1997.<sup>435</sup> Disciplinary processes in response to clergy and religious who are abusers are discussed in the Inquiry's interim report, He Purapura Ora, he Māra Tipu: from Redress to Puretumu Torowhānui.<sup>436</sup>

430 Witness statement of Cardinal John Dew (4 October 2022, para 23).

431 Synopsis of oral closing submissions – Filed on behalf of the Bishops and Congregational Leaders of the Catholic Church in Aotearoa New Zealand at the Inquiry's Faith-based Redress Inquiry Hearing (Royal Commission of Inquiry into Abuse in Care, 29 March 2021, para 27).

432 Transcript of evidence of Cardinal John Dew for the Catholic Church at the Inquiry's Faith-based Redress Inquiry Hearing (Royal Commission of Inquiry into Abuse in Care, 26 March 2021, page 803).

433 Catholic Church guidelines on sexual misconduct by clerics, religious and church employees (1 January 1994).

434 Catholic Church suggested procedures in cases of allegations of sexual abuse by a religious, (8 March 1996).

435 Guidelines for Brothers or St John of God in Australia, New Zealand and Papua New Guinea in implementation of "Towards Healing", policies & procedures of the Province Professional Standards Committee (4 September 1997).

436 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui Volume 1 (2021, pages 180–183).

345. As described in He Purapura Ora, he Māra Tipu: from Redress to Puretumu Torowhānui, the Anglican Church does not have a national policy document to provide guidance to bishops responding to reports of abuse. Bishops instead rely on part of the church's code of canons, Title D. Title D sets out the standards of conduct for clergy and others associated with the church as well as the disciplinary process for alleged abusers. However, the focus of this process is on the discipline of clergy and their suitability to continue as a priest rather than the needs of the complainant.<sup>437</sup>

346. The lack of a national policy document led to a lack of consistency and transparency across different Anglican Church care settings. Until the late 1990s, the bishop of the relevant diocese was responsible for dealing with any reports of abuse, but there were no guidelines in place to assist them. The Anglican Church has acknowledged that:

*"Responses to reports of abuse historically lacked objectivity and distance. Leaving it up to each Diocese and Bishop to handle its own complaints has led to a lack of consistency and transparency across the Church in this space.*

*The lack of overarching Church policy or procedure to guide the handling of complaints of abuse is a mistake that we have previously identified. Regretfully, the focus of the Church has been on issues of discipline rather than on survivors."*<sup>438</sup>

347. The Methodist Church had no formal policy for responding to complaints. It described its approach as a traditional legal approach, requiring survivors to first report to NZ Police before it would conduct its own investigation.<sup>439</sup>

348. The Presbyterian Church has accepted that while healing is a part of their complaints process, it is primarily a disciplinary process. The church accepted that the process is not survivor focused, but told the Inquiry that complaints were considered "sincerely and with great care".<sup>440</sup> At the Inquiry's Faith-based Institutional Response Hearing, Reverend Wayne Matheson, the Assembly Executive Secretary of the Presbyterian Church of Aotearoa New Zealand, explained that the church's complaints process is:

*"... primarily aimed at disciplining the person if the charge is proved, rather than anything else."*<sup>441</sup>

437 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui Volume 1 (2021, pages 184–190).

438 Joint witness statement of The Most Reverend Philip Richardson and The Most Reverend Donald Steven Tamihere (5 October 2022, paras 17–18).

439 Opening Submissions of the Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa, Wesley College Board of Trustees, and Wesley College Trust Board at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 9).

440 Transcript of evidence of Reverend Wayne Matheson on behalf of the Presbyterian Church of Aotearoa New Zealand at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 317).

441 Transcript of evidence of Reverend Wayne Matheson on behalf of the Presbyterian Church of Aotearoa New Zealand at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 317).

349. The Salvation Army did not have any standardised processes in place to respond to complaints made by those within their care. It addressed complaints case by case.<sup>442</sup>
350. The Gloriavale Christian Community had no formal or consistent processes regarding the disclosure of abuse.
351. The Plymouth Brethren Christian Church provided evidence to the Inquiry about how it responds to reports of abuse, stating that the Church “does not have any policies (written or otherwise) relating to claims [reports of abuse] or redress processes at either a national or assembly level”.<sup>443</sup> However, based on a survey of assemblies, the Church provided the Inquiry with a summary of how “any allegations of abuse in any context ... have been or would be expected to be managed and addressed”.<sup>444</sup> The Church explained how it responds to “unacceptable conduct”, which was geared towards forgiveness and reconciliation, as its mechanisms for responding to abuse allegations were based on religious doctrine. For example:

***“When a member engages in behaviour that is inconsistent with Christian principles according to the holy scriptures, elders and other members work to help them to address that behaviour and its underlying causes and support them to overcome it and remain in the church (Galatians 6 v 1).”***<sup>445</sup>

352. Plymouth Brethren Christian Church told the Inquiry that if a member’s problematic behaviour is ongoing and poses a risk to the spiritual, psychological and /or physical wellbeing and safety of themselves or other members, he or she may be “confined” for a period while elders investigate and take steps to address the situation. While confined, a member remains in the fellowship of the church, but is asked not to attend church meetings and not to have unnecessary contact with other church members. Depending on how serious the allegations are and whether they are substantiated, a perpetrator may be withdrawn from.<sup>446</sup> In the majority of cases, the issues are resolved and the confined member is restored to full fellowship after a short period.<sup>447</sup>

442 Transcript of evidence of Colonel Gerry Walker for the Salvation Army at the Inquiry’s Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 15 March 2021, page 62); Witness statement of Murray Houston on behalf of the Salvation Army (18 September 2020, para 4.5); He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui Volume 1 (2021, page 191).

443 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Schedule B, para 5).

444 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Schedule B, para 8).

445 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Appendix 1: Overview of the PBCC, para 11).

446 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Schedule B, para 8(j)).

447 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Appendix 1: Overview of the PBCC, para 12).

## I tūtakina te hunga i ngā pūnaha taurima e te mahi a te pouārai i hiahiatia ai te tautoko ā-whānau iwi kē, Māori mai, reo kaikōkiri hoki

### People in care faced barriers and needed family, whānau, or advocacy support

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353. For many children, young people and adults in State and faith-based care, the absence of an accessible complaints process and clarity on how their complaint would be responded to was a significant barrier to raising concerns or making a complaint about the abuse or neglect they were experiencing.
354. Without a known, clear and accessible complaints process, people in care were reliant on others, particularly those in positions of power, to intervene on their behalf and raise concerns with senior staff and managers. For many people in care this could have been a trusted member of their family, whānau or community, or access to an independent advocate.
355. However, children, young people and adults in care were often prevented from seeing their families, either through not being allowed visits or being allowed only short and infrequent visits.<sup>448</sup> In many psychiatric and psychopaedic institutions, families were actively discouraged from visiting their loved ones in care and other forms of family contact were restricted.<sup>449</sup> Connections between siblings in care, who may have been able to speak up for each other, were at times deliberately suppressed by staff and carers.<sup>450</sup>
356. A lack of access to an advocate was a barrier for many people in care.<sup>451</sup> In 1989, the Human Rights Commission recommended that independent advocates be appointed for each social welfare institution, to ensure people in care knew about their rights to complain, and to make complaints on their behalf.<sup>452</sup> However, this did not become a requirement until the Regulations were updated in 1996.<sup>453</sup>

448 Private session transcript of survivor who wishes to remain anonymous (18 February 2020, pages 13, 16–17).

449 Mirfin-Vietch, B & Conder, J, Institutions are places of abuse: The experiences of disabled children and adults in state care (Donald Beasley Institute, 2017, page 40).

450 Witness statements of Reverend Dinah Lambert (1 December 2021, page 8); Victoria Marie Rutter Taylor (18 February 2022, page 2) and June Lovett (14 December 2021, para 42).

451 Transcript of evidence of Irene and Margaret Priest at the Inquiry's Ūhia te māramatanga Disability, Deaf, and Mental Health Hearing (Royal Commission of Inquiry into Abuse in Care, 11 July 2022, page 26).

452 Human Rights Commission, The use of secure care and related issues in Social Welfare institutions, (June 1989, pages 75, 87–88).

453 Children Young Persons and Their Families (Residential Care) Regulations 1996, regulation 16.

357. Care facilities where people in care do not have access to a trusted adult carry a higher risk of abuse, including sexual abuse.<sup>454</sup> Without access to a trusted adult, people in care who were being abused or neglected often felt isolated and were unsure who to tell what was happening to them. This was exacerbated when staff and carers deliberately prevented people in care from having strong connections with family, whānau, communities, or independent advocates, or minimised their contact with them. In some religious communities, like Gloriavale, access to adults or advocates outside the community was actively discouraged, limiting survivors' ability to disclose what had happened to them.
358. Many people in care were not aware of their rights and of what to do if they felt these were being breached, even when the institution was required to tell them about their rights.<sup>455</sup> When complaints mechanisms were available, some people in care were not made aware of them. Māori and Pākehā survivor Jonathon Stevenson (Kāti Māmoe, Kāi Tahu), who was sent to Waikeria Borstal near Te Awamutu in the late 1980s when he was 15 years old, told the Inquiry:<sup>456</sup>

***“There was no-one for us to complain to. They didn’t tell us about the Office of the Ombudsman or about the prison inspector. It was illegal not to inform us about our rights.”<sup>457</sup>***

359. For Deaf and disabled survivors, barriers to making complaints were exacerbated by a lack of support for communication needs.<sup>458</sup> This was an issue in psychopaedic institutions where many residents needed additional communication support and some had no speech at all.<sup>459</sup> The lack of sign language in Deaf schools and the predominance of hearing staff meant that Deaf survivors were limited in their ability to share their experiences of abuse. NZ European survivor Mr JS, who attended Van Asch College in Ōtautahi Christchurch in the late 1970s and early 1980s, told the Inquiry:

***“There were so many times that we tried to complain and tell people what happened to us ... Most of the time the same thing would happen. You would be in the room with two hearing adults and you could see that they were talking to each other but you could not understand what they were saying.”<sup>460</sup>***

454 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final report: Volume 2 – Nature and cause (2017, page 18).

455 Human Rights Commission, The use of secure care and related issues in Social Welfare institutions, (June 1989, page 87).

456 Letter from the Director of Mental Health to the Chief Executives of Hospital Boards regarding official visitors (7 November 1985, page 1).

457 Witness statement of Jonathon Stevenson (29 March 2022, para 113).

458 Witness statement of Robert Shannon (9 June 2021, page 15).

459 Witness statement of Sheree Briggs (24 January 2022, page 6).

460 Witness statement of Mr JS (27 May 2022, para 2.86).



360. Tāngata Turi Māori had no access to trilingual interpreters who could communicate in English, te reo Māori and New Zealand Sign Language to help them with their complaints.
361. For tamariki and rangatahi Māori in State and faith-based care, racism acted as an additional barrier to reporting abuse.<sup>461</sup>
362. For some Pacific Peoples in care, additional barriers to reporting abuse included having to consider the impact of doing so on their family's relationships and community support networks.<sup>462</sup> Shame and the risk to a family's reputation were strong barriers to disclosing abuse among Pacific survivors.<sup>463</sup> For example, making a complaint would challenge the Samoan concept of fa'aaloalo, or respect for carers, elders and authority figures, and bring "shame and hostility to the [survivor's] family".<sup>464</sup> The lack of a culturally appropriate process contributed to barriers to reporting abuse.<sup>465</sup> The Inquiry also heard evidence that complaint processes are hard to navigate and there are language barriers.<sup>466</sup>
363. Part 5 of this report described the fear that prevented many children, young people and adults in State and faith-based care from raising concerns or making a complaint. This included a fear of severe punishment for 'narking' or speaking up,<sup>467</sup> a fear of not being believed,<sup>468</sup> and a fear of excommunication from faith communities.<sup>469</sup> Survivors of faith-based boarding schools for boys told the Inquiry that the 'no narking' rule went hand in hand with the culture of violence and was a significant barrier to reporting abuse or neglect.<sup>470</sup> The Inquiry heard that there was no point in complaining to staff because the culture was one of 'stand up and be a man', and that students had no choice but to take the beatings and tolerate the abuse – if they showed any weakness they would be further picked on.<sup>471</sup>
364. In all care settings, whakamā or shame was a barrier.<sup>472</sup>

461 Witness statements of Margurite Cassidy (15 December 2022, para 2.38) and Ellen Hiini (August 2021, para 41).

462 Witness statement of Ms CU (10 June 2021, page 27–28); Tamasese, T, Parsons, T, King, P, & Waldegrave, C, A qualitative investigation into Pacific families, communities and organisations social and economic contribution to Pacific migrant settlement outcomes in New Zealand (Family Centre Pacific section and the Family Centre Social Policy Research Unit, n.d, pages 68–69).

463 Expert witness statement of Folasāitu Dr Apaula Julia Ioane (21 July 2021, page 16).

464 Witness statement of Frances Tagaloa (2 October 2020, page 12); Expert witness statement of Folasāitu Dr Apaula Julia Ioane (21 July 2021, page 16).

465 Expert witness statement of Folasāitu Dr Apaula Julia Ioane (21 July 2021, page 14); Royal Commission Inquiry into Abuse in Care, Record of health and disability workers fono (28 March 2022, page 8).

466 Royal Commission Inquiry into Abuse in Care, Record of health and disability workers fono (28 March 2022, page 8).

467 Witness statements of Steven Long (15 October 2021, paras 34, 37); Glenda Maihi (3 August 2021, paras 25, 27); Sharyn (16 March 2021, para 77); Alan Nixon (8 October 2021, page 6); Mr SN (30 April 2021, para 109) and Toni Jarvis (12 April 2021, paras 68, 72, 80); Transcript of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki and Peter Whitcombe, Chief Social Worker, Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 24 August 2022, pages 813–814).


468 Witness statements of Rūpene Amato (16 July 2021, para 61); Sonja Cooper & Sam Benton of Cooper Legal – relating to the St John of God Order Investigation (8 October 2021, page 37) and Reverend Dinah Lambert (1 December 2021, para 182).

469 Witness statement of Neville McCallum (19 July 2022, paras 4.19, 5.7, 9.7).

470 Witness statements of Mr KL (6 April 2023, para 23); Hone Tipene (22 September 2021, para 40) and Kamahl Tupetagi (3 October 2021, paras 77–78).

471 Witness statement of Mr ST (17 September 2021, page 3).

472 Witness statement of Mr KL (6 April 2023, para 25).

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365. Faith-based settings had unique barriers to reporting abuse or making complaints.<sup>473</sup> There was a strong preference for secrecy and silence, which created additional barriers to making complaints because survivors had little hope that any disclosure of abuse would be dealt with appropriately or lead to those responsible being held to account.<sup>474</sup> Within the Plymouth Brethren Christian Church, people who did make complaints told the Inquiry they were often disbelieved, punished or ostracised.<sup>475</sup>
366. In some faith-based settings, religious doctrine or documents created a barrier. Howard Temple, the current Overseeing Shepherd at Gloriavale, acknowledged that the Gloriavale Doctrine of Unity made it very difficult for members to raise concerns because if they were in conflict with a person, they could not be in unity with that person.<sup>476</sup> It was also accepted that the Doctrine of Submission may have prevented children from raising allegations of abuse.<sup>477</sup>
367. By the end of the Inquiry period, most care and protection and youth justice residences had a grievance procedure in place, and concerns shifted to their effectiveness in practice. A 1999 review of operational care practice at Kingslea Residential Centre in Ōtautahi Christchurch found there were numerous difficulties with how the grievance procedure operated. This included staff deliberately delaying providing the grievance form to the resident, residents having to ask staff members for complaint forms, delays in investigating grievances, and the lack of an external system for randomly checking that residents were able to access the grievance procedure.<sup>478</sup>

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473 Palmer, D, Final report: The role of organisational culture in child sexual abuse in institutional contexts, (Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), 2016, page 46); Hamilton, M., Religious practices that have contributed to a culture of secrecy regarding child sex abuse in five religious organizations (Child USA: The National Think Tank for Child Protection, 2020, page 3).

474 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui Volume 1 (2021, pages 172–173); Submission of Dr Thomas Doyle (9 March 2021, para 274).

475 Witness statements of Mr TW (23 June 2022, paras 84–86); Stephen Simmons (24 July 2022, page 3) and Ms KX (14 September 2022, para 42).

476 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 51).

477 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 52).

478 Reeves, C, Lang, N, & Direen, A, Management review of operational care practice at Kingslea Residential Centre (Children, Young Persons and Their Families Agency, March 1999, page 29).

## I te nuinga o te wā kīhai ngā purapura ora i whakaponohia mo te whāki mahi tūkinō

### Survivors were generally not believed if they reported abuse and neglect

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368. The failure to believe survivors who reported abuse and neglect was a common theme across all State and faith-based care settings. Expert witness Denis Smith told the Inquiry:

*“ ... I would often be told by some of my superiors that children were liars. Within that background, it was difficult to take steps to protect children under our care who complained about their treatment ... ”*<sup>479</sup>

369. Another common theme was calling people who made complaints liars or troublemakers.<sup>480</sup> Several survivors said staff and carers “did not listen,”<sup>481</sup> dismissed their complaint<sup>482</sup> or appeared annoyed<sup>483</sup> when they tried to report abuse.

370. The Inquiry also heard from most survivors that made complaints that they were not believed.<sup>484</sup> Māori Survivor Mr HZ from Marylands School told the Inquiry he had complained many times about abuse but was always disbelieved:

*“I told ... my teacher at Marylands, that the Brothers had been sexually abusing the boys. She didn’t believe me though. She told me that Brothers don’t do things like that and that I must stop lying. ...I also told three social workers from the Department of Social Welfare that I was being abused but they didn’t believe me.”*<sup>485</sup>

371. Australian and New Zealand Survivor Leonie Jackson told the Inquiry that:

*“I have told so many priests about the abuse I have suffered in confession and have only received penance in return. No one ever told me it was a crime or gave me advice, so I believed it was my sin to carry.”*<sup>486</sup>

479 Witness statement of Denis Smith (15 December 2021, para 35).

480 Witness statements of Ms EM (28 May 2021, paras 19–20) and Denis Smith (15 December 2021, para 35).

481 Witness statement of Mr FP (10 March 2022, para 64).

482 Witness statement of Ms MT (9 August 2021, page 2).

483 Witness statements of Ms MT (9 August 2021, page 2) and Alison Pascoe (29 April 2022, page 17).

484 Witness statements of Chris Finan (9 August 2021, para 2.46), Debbie Morris-Jenkins (21 June 2022, para 83) and Susan Kenny (15 July 2021, para 31); Written account of Mr RZ (n.d., page 10); Private session transcript of Mr NM (20 January 2022, page 40).

485 Second witness statement of Mr HZ (14 May 2021, paras 52 and 55).

486 Witness Statement of Leonie Jackson (21 September 2020, pages 7-8).

372. Complaints of abuse by Deaf and disabled people were often minimised or dismissed, underpinned by societal attitudes of ableism and disablism.<sup>487</sup> Staff did not always believe or denied complaints from Deaf or disabled people in care.<sup>488</sup> For example, NZ European survivor Mr JS tried numerous times to raise concerns about serious sexual abuse at Van Asch College in Ōtautahi Christchurch, where all of the staff were hearing, but he was not believed:

***"We tried so hard to always tell the truth but no one ever believed us."***<sup>489</sup>

373. In 1988, a social worker raised concerns about the Department of Social Welfare's approach to allegations of sexual abuse in foster care:

***"... [people in foster care] are often already labelled as a delinquent and it is very easy to dismiss what they are saying. In my client's case there was an onslaught upon her credibility. I was told by a number of my colleagues that she was a liar, untrustworthy, that she was 'no innocent' and given to sexual fantasising."***<sup>490</sup>

374. Complaints of sexual abuse where the abuser was the same gender were sometimes characterised as a "homosexual experience" or "homosexual relationship" rather than as abuse, even where it was clear that the survivor could not legally consent or where the abuser was in a position of power.<sup>491</sup> These attitudes meant that survivors were less likely to be believed if they disclosed abuse or neglect, and likely to consider that what happened to them was not abuse.

375. Survivors of faith-based care told the Inquiry that many people did not believe that a person with religious status could commit abuse.<sup>492</sup>

376. Cardinal John Dew accepted that failures were made by the Catholic Church when responding to reports of abuse before 1985:

***"I also acknowledge that in that period cases weren't handled well, that sometimes they were denied and I said in that apology people weren't believed ... And that was a terrible time and it should never ever have happened like that."***<sup>493</sup>

487 Royal Commission of Inquiry into Abuse in Care, *Stolen Lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (2023, pages 44, 49–50).

488 Witness statement of Mr JS (27 May 2022, pages 11–12); Roguski, M, *The hidden abuse of disabled people residing in the community: An exploratory study* (Tairāwhiti Community Voice, 2013); Llewellyn, G, Wayland, S, & Hindmarsh, G, *Disability and Child Sexual Abuse in Institutional Contexts: Research report for Royal Commission into Institutional Responses to Child Sexual Abuse* (University of Sydney, 2016); Witness statement of Catherine Hickey (2 August 2021, page 10).

489 Witness statement of Mr JS (27 May 2022, page 11).

490 Letter from J Gillanders (Social Worker) to Paul Muir (Senior Social Worker) and Kevin McCarthy (Operations Manager), *Child Sexual Abuse Allegations in Foster Care* (4 November 1988, page 3).

491 Letter from D M Burrows (Social Worker) to the Director, Palmerston North District Office, Department of Social Welfare, *Recommendation for continued involvement* (14 June 1976, pages 6–7); Letter from C A Havill (Social Worker) to the Area Welfare Office, Tokoroa District Office, Department of Social Welfare, *Recommendation for discharge* (12 May 1982, page 2).

492 Witness statements of Rūpene Amato (16 July 2021, page 9) and Ms NI (28 April 2022, paras 67–68); Private session transcript of survivor who wishes to remain anonymous (17 September 2019, page 8).

493 Transcript of evidence of Cardinal John Dew for the Catholic Church at the Inquiry's Faith-based Redress Inquiry Hearing (Royal Commission of Inquiry into Abuse in Care, 26 March 2021, page 803).

377. European survivor Dr Christopher Longhurst, who made several sexual abuse complaints to the Catholic Church's National Office for Professional Standards, expressed his view that "character assassination of a victim is not unusual in the Catholic hierarchy after a victim has been abused and even before any disclosure of that abuse is made".<sup>494</sup> In his role as the leader of the Survivors Network of those Abused by Priests (SNAP), he reported that several members told him that the Catholic Church's response "demonstrated denial, disbelief, concealment, cover up, justifying, lying, diverting, stalling, masking culpability by offering partial or weak apologies [and the] protection of perpetrators".<sup>495</sup>
378. From 1982 to 1983, when Brother Richard Dunleavy was Vice-Provincial of the Marist Brothers, he received a complaint about Brother Giles Waters (Kevin Waters) discussing "sexual matters with his primary school class" at Xavier College in Ōtautahi Christchurch.<sup>496</sup> Brother Richard decided the appropriate response was to send Brother Giles to a Marist Renewal Course for Older Brothers in Rome. When Brother Giles returned from Rome in 1985, he was appointed to teach a Form 1 and 2 class in Gisborne.<sup>497</sup> In 1986, Brother Giles was sent to Sacred Heart College in Tāmaki Makaurau Auckland to assist with administrative work, where he remained until 2004. In 1998, a serious complaint of sexual abuse was received by the Marist Brothers concerning Brother Giles.<sup>498</sup> Further complaints of sexual abuse were received from 2004.
379. Presbyterian Support Central acknowledged its past leadership was historically defensive in its approach to complaints. In the early 2000s, complainants were often encouraged to take the issue to court.<sup>499</sup> There were also occasions where the organisation questioned the credibility of the complainants.<sup>500</sup> Presbyterian Support Otago acknowledged that, in the past, it responded initially to complaints with hesitation or disbelief.<sup>501</sup> While its intent was to "do the right thing", Jo O'Neill (CEO of Presbyterian Support Otago) accepted that "historically people struggled to believe that anyone given authority to assist in this endeavour was capable of abuse".<sup>502</sup> Presbyterian Support Otago considers this contributed to the way complaints were poorly handled.<sup>503</sup>

494 Witness statement of Dr Christopher Longhurst (24 May 2023, para 190).

495 Witness statement of Dr Christopher Longhurst (24 May 2023, para 238).

496 Email from Brother Peter Horide to Pat Coady (21 November 2019, page 2).

497 Notes from Richard Dunleavy to the Royal Commission of Inquiry into Abuse in Care (n.d.).

498 Notes from Richard Dunleavy to the Royal Commission of Inquiry into Abuse in Care (n.d.).

499 Transcript of evidence of Mr Asghar and Mr Waite on behalf of Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 260).

500 Transcript of evidence of Mr Asghar and Mr Waite on behalf of Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 260).

501 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 284).

502 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 284).

503 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 284).

380. The Methodist Church acknowledged “its past and more recent failings in addressing complaints and redress”, noting that “[i]t has not always accepted and acted appropriately on reports of abuse and complaints”.<sup>504</sup> The church also acknowledged that it caused additional harm to survivors when it initially refused to believe them, sought to contest their concerns or looked to refer the complaint elsewhere; and failed to recognise that the church also needed to address the complaint.<sup>505</sup>
381. Survivors who reported abuse in Gloriavale were often disbelieved, blamed for their abuse and subjected to intimidation and shaming by leaders. The treatment of sexual abuse as a sin, rather than a crime, and a focus on forgiveness resulted in the perpetrators’ interests being prioritised over the wellbeing of survivors. It also may have enabled perpetrators to reoffend.<sup>506</sup>

## **Tērā ngā kaimahi matua i aro kē ki te mana o ngā hinonga me ngā kaitūkinō i runga atu i tērā o te hunga i ngā pūnaha taurima**

### **Senior leaders prioritised the reputations of institutions and abusers over people in care**

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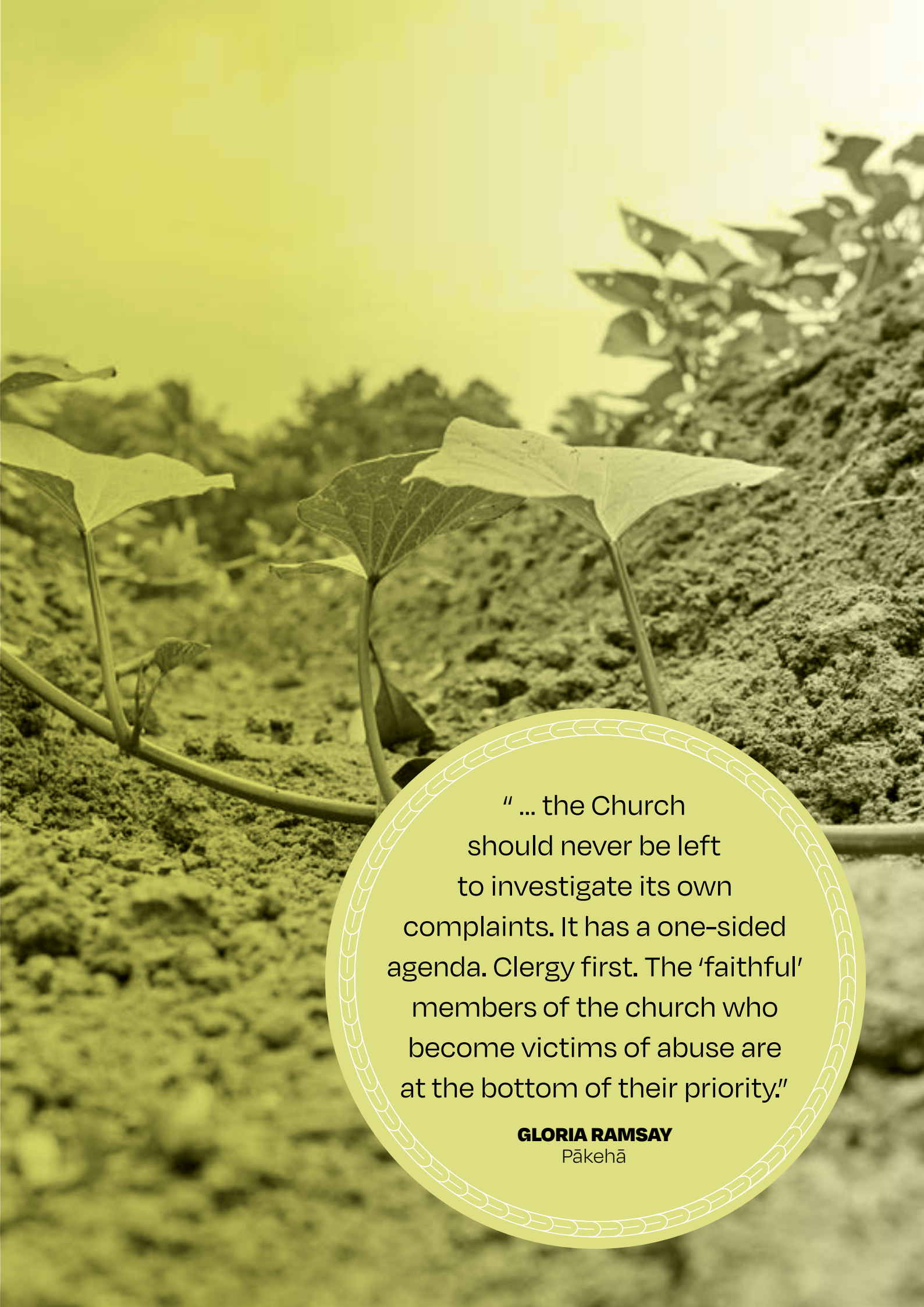
382. In the absence of any legal direction, it was unclear how senior leaders and managers in State and faith-based institutions should handle complaints of abuse or neglect when these intersected with employment processes, professional disciplinary processes, or NZ Police investigations.
383. In practice, many senior leaders and managers made decisions that had the effect of protecting or prioritising their institution’s reputation, or the reputation of the abuser, over investigating the complaint, ensuring the safety of people in care, and holding the abuser to account.
384. In several cases, a senior leader or manager was conflicted by their relationship with the abuser. This conflict of interest contributed to the complaint being handled in a way that effectively protected the abuser rather than the person making the complaint.
385. Pākehā survivor Gloria Ramsay, told the Inquiry:
- “...the Church should never be left to investigate its own complaints. It has a one-sided agenda. Clergy first. The ‘faithful’ members of the church who become victims of abuse are at the bottom of their priority.”<sup>507</sup>***

504 Opening Submissions of the Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa, Wesley College Board of Trustees, and Wesley College Trust Board at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 3.24).

505 Transcript of evidence of Reverend Tautari for the Methodist Church and Wesley College at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 251).

506 Witness statement of Louise Taylor (15 September 2022, paras 6.5–6.6).

507 Witness statement of Gloria Ramsay (15 September 2020, para 4.12).

A photograph of young plants growing in a field, overlaid with a circular graphic containing text. The background is a soft-focus image of a field with young plants and soil. A large, light green circle with a white decorative border is positioned in the lower right quadrant. Inside the circle, there is a quote in black text.

" ... the Church should never be left to investigate its own complaints. It has a one-sided agenda. Clergy first. The 'faithful' members of the church who become victims of abuse are at the bottom of their priority!"

**GLORIA RAMSAY**

Pākehā

## I tirohia ngā kōamuamu anō nei he rarunga kaimahi, wāhi mahi rānei

### Complaints were often dealt with as employment issues or workplace incidents

386. The Ministry of Education advised school boards in 1997 that in cases of alleged abuse by a staff member:

*“The Board must ensure the staff member is treated fairly, according to the terms and conditions of the relevant employment contract, and that the principles of natural justice are adhered to. Close contact should be kept with the Children, Young Persons and their Families Service, and the Police, so the school does not inadvertently undermine or frustrate investigations.”<sup>508</sup>*

387. The deference to other processes being followed sometimes had the effect of prioritising the rights and interests of the abuser over those making the complaint. For some survivors, the use of employment processes to deal with complaints felt like abuse was being “tolerated, covered up and /or minimised”.<sup>509</sup>

388. Reliance on employment law generally resulted in senior leaders and managers taking widely different approaches to responding to complaints. There were examples of complaints of abuse being framed as workplace incidents requiring “performance improvement strategies”.<sup>510</sup>

389. There were numerous instances of abusers remaining in their position as part of the employment law process, and in many cases continuing to abuse. There were examples of the State Services Commission sanctioning institutional staff for abuse but allowing them to continue to work, with some staff going on to abuse more people in care.<sup>511</sup>

508 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 132).

509 Witness statement of Mark Benjamin (5 October 2022, page 7).

510 Meeting with a staff member Kaniere 26 March (MidCentral District Health Board, 1998, page 1); Expert evidence of Dr Patsie Frawley (April 2022, page 16).

511 Ministry of Social Development, Report to Hon Anne Tolley, re: TV3 The Nation's story about historic staff misconduct in Social Welfare residences (21 September 2017, page 13); Letter from DG Reilly to the State Services Commission regarding B Zygadlo, Principal, Girls' Home: Palmerston North (31 May 1972, page 2); Letter from LJV Ganon for the Director of DSW to the Director, Christchurch (13 February 1979); Ministry of Social Development, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 345, paragraph 4: Table of allegations relating to staff named in Schedule B (n.d.); Report to Director-General by SJ Stanton, Regional Manager (2 February 1979); Statement of DK Hamill (2 February 1979); Statement from E Dawes, Assistant Residential Social Worker to the Principal Bollard Girls Home (2 February 1979); Letter from R Hooker, Solicitor for the Director-General to the Secretary of the State Services Commission (5 September 1979).



**He maha ngā kaimahi matua, kaiwhakahaere i tautoko i te rihaina, te hūnuku rānei o ngā kaitūkinu ki wāhi kē**

**Many senior leaders and managers supported abusers to resign or move to a new location**

390. There were numerous examples of senior leaders and managers encouraging or allowing abusers to resign, which avoided both responding to the complaint and following employment processes. At the Inquiry's Faith-Based Redress Hearing in March 2021, Anglican Bishop of Christchurch Peter Carrell told the Inquiry.<sup>512</sup>

*" ... to resign would be, on the facts then known, an appropriate response by him and would mean that we would not, if you like, force a determination ... we would also have been taking care not to construct his dismissal with the potential legal complications that would then ensue. So it would be preferable, if you like, on both counts that he faced up to the situation via his resignation."*

391. Sometimes, senior leaders or managers would simply shift the abuser to another location and used this as reasoning not to investigate the complaint further, called "geographical cure" in faith-based settings.<sup>513</sup> The ability to shift or relocate an abuser required a high level of seniority or authority within an institution or government agency. Sometimes this shift happened without the new institution being told about the risk the abuser posed to children, young people and adults in their care.

512 Transcript of evidence of Bishop Peter Carrell at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 19 March 2021, page 359); Hon Rodney Hansen CNZM QC, Report to the Anglican Diocese of Auckland on matters arising from the ministry appointments of Ross Browne (2022, page 4).

513 Witness statements of Mr F (21 September 2020, para 4.41); Anne-Marie Shelley (6 August 2020, paras 3.19, 3.21); Robert Donaldson (24 August 2020, paras 2.10–2.11); Gloria Ramsay (15 August 2020, para 2.47) and Brother Peter Horide (12 February 2020, page 28); Transcript of evidence of Dr Murray Wilton at the Inquiry's Faith-based Institutions Hearing (Royal Care Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 352–353).

392. At times, care was taken to ensure the abuser's reputation was protected. In 1972, in response to allegations of historical and "current misconduct and offensive behaviour" against Brian Zygadlo, Principal of Margaret Street Girls' Home in Te Papaioea Palmerston North, Acting Assistant Director of Social Welfare J Kidd decided to transfer him to another social welfare residence:

*"Mr Zygadlo has accepted the decision that he must transfer ... But Mr Zygadlo (not without justification) feels that the feasibility of such an arrangement [a relieving housemaster role] would be devoid of the credibility his transfer must be seen to have if he is not to be severely personally disadvantaged.*

*I have today discussed ... the possibility of Mr Zygadlo's request that he should go to Hokio [Beach School] rather than to Kohitere [Boys' Training Centre]. We agree this would be much more practicable, both in terms of the apparent need there ... and in terms of it not being inconsistent with a move that he could have made anyway without disadvantage to his career."<sup>514</sup>*

393. Brian Zygadlo went on to sexually abuse multiple children at Hokio Beach School near Taitoko Levin and has been accused of sexually abusing children at Epuni Boys' Home in Te Awa Kairangi ki Tai Lower Hutt and Stanmore Road Boys' Home in Ōtautahi Christchurch.<sup>515</sup>

394. The Department of Social Welfare's practice of shifting abusers led Ken Cutforth, who was a former staff member of the Department of Social Welfare, to write to the Human Rights Commission:

*"What concerns me in these situations is the method whereby the Department, particularly Head Office personnel, appear to 'cover up' some situations by transferring the accused staff member to another position (no appeals can be heard on such occasions). The person remains in this new position until the incident is well in the past and the facts about the incident and obscured in people's memory, and then the staff are afforded promotion to positions where they in turn can select staff."<sup>516</sup>*

<sup>514</sup> Letter from JW Kidd (Acting Assistant Director) to the Director-General Social Welfare regarding Brian Zygadlo (28 May 1972, page 2).

<sup>515</sup> Witness statement of David Williams (aka John Williams) (15 March 2021, para 89); Transcript of evidence of Chappie Te Kani, Chief Executive Oranga Tamariki at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, page 742).

<sup>516</sup> Letter from Ken Cutforth to the Human Rights Commission re: promotion and transfer of staff in Residential Social Work (n.d., page 3).

395. Ken Cutforth gave four examples of residential staff being transferred to another residence following allegations of abuse against them:<sup>517</sup>
- a. Brian Zygadlo: transferred from his role as Principal, Margaret Street Girls' Home in Te Papaioea Palmerston North to Hokio Beach School near Taitoko Levin, and then to Principal, Stanmore Road Boys' Home in Ōtautahi Christchurch
  - b. Aiden McLean: transferred from his role as Principal, Bollard Girls' Home in Tāmaki Makaurau Auckland to Assistant Principal (later promoted to Principal), Holdsworth School in Whanganui
  - c. Derek Tucker: transferred from his role as Senior Residential Social Worker, Bollard Girls' Home in Tāmaki Makaurau Auckland to a similar position at Ōwairaka Boys' Home in Tāmaki Makaurau Auckland
  - d. Joe Bartle: transferred from his role as Senior Housemaster, Epuni Boys' Home in Te Awa Kairangi ki Tai Lower Hutt to Assistant Principal, Beck House in Eskdale, Te Matau-a-Māui Hawkes Bay.
396. In relation to the Marist Brothers, Brother Peter Horide acknowledged how the practice of simply shifting abusers contributed to abuse:
- "To our deep regret and shame, we now realise that this system was vulnerable to exploitation by abusers and those who sought to cover up their abuse. The system of moving Brothers regularly around the country meant that it was not unusual for Brothers to spend as few as two or three years in any location. This system would allow an abuser to move around Aotearoa New Zealand undetected, continuing their abuse and avoiding their actions being reported. It also allowed members of the Brothers' leadership to move a Brother subject to complaints rather than deal with the conduct. This meant that abusers were not stopped when they should have been and people were abused when this abuse was avoidable."***<sup>518</sup>
397. Cardinal John Dew conceded that the Catholic Church in Aotearoa New Zealand transferred perpetrators in response to abuse allegations. He reported that complaints of sexual abuse and sexual misconduct were not well handled from the 1950s to the 1980s and that complaints may have been 'solved' by the transfer of the respondent.<sup>519</sup> He said the Catholic Church believed perpetrators if they said offending would not happen again.<sup>520</sup> He acknowledged that sometimes this meant they reoffended in the new place they were transferred to and this should never have happened.<sup>521</sup>

517 Letter from Ken Cutforth to the Human Rights Commission re: promotion and transfer of staff in Residential Social Work (n.d., pages 2–4).

518 Witness statement of Brother Peter Horide (12 February 2020, page 28).

519 First witness statement of Cardinal John Dew (23 September 2020, page 12).

520 Transcript of evidence of Cardinal John Dew for the Catholic Church at the Inquiry's Faith-based Redress Inquiry Hearing (Royal Commission of Inquiry into Abuse in Care, 26 March 2021, page 803).

521 Transcript of evidence of Cardinal John Dew for the Catholic Church at the Inquiry's Faith-based Redress Inquiry Hearing (Royal Commission of Inquiry into Abuse in Care, 26 March 2021, page 803).

398. Reverend Peter Taylor abused children at Dilworth School (Anglican) in Tāmaki Makaurau Auckland<sup>522</sup> and went on to hold a full licence and a Permission to Officiate between 1979 and 1987.<sup>523</sup> The Archbishop Philip Richardson told the Inquiry that there were incidents or overtures of sexual abuse while Peter Taylor was licensed in parishes after he taught at Dilworth School.<sup>524</sup> In a joint witness statement to the Inquiry, the Reverend Philip Richardson and the Reverend Donald Tamihere said:

***“The way that the Church handled Peter Taylor’s offending is an example of the failures of the Church when responding to reports of abuse. Despite knowing of the abuse, he committed at Dilworth he was not subject to a disciplinary process nor reported to the Police. Indeed, he was later given other positions. No attempt was made, either, to investigate if he had offended in the positions he held before Dilworth.”***<sup>525</sup>

399. Dilworth accepted that had there been adequate investigations at the time, further harm could have been prevented. Dr Murray Wilton, former Headmaster of Dilworth, told the Inquiry that he accepts:

***“that had the complaints about McIntosh, Wynyard, Cave, [name redacted] and Wilson been fully investigated by appropriate experts, their other abuse may well have been revealed then. And possibly the abuse perpetrated by Harlow and Browne may also have come to light as a result of investigations into abuse by these other staff.”***<sup>526</sup>

400. Leonard Cave was forced to resign from his role as a teacher at Dilworth School following allegations of sexual abuse and was provided with a positive reference when he applied for a teaching position at St Paul’s Collegiate School (Anglican) in Kirikiriroa Hamilton.<sup>527</sup> He went on to perpetrate abuse at St Paul’s.<sup>528</sup>

401. The Inquiry also heard that there were instances where the Salvation Army moved alleged abusers between posts<sup>529</sup> or later rehired previously dismissed officers who went on to offend against others.<sup>530</sup>

522 Witness statements of Stephen Frawley (21 May 2021, paras 120–123); Mr QN (25 May 2021, paras 119–123); Mr TV (7 June 2022, paras 20–30) and Steven Gray (8 March 2022, paras 23–27).

523 Witness statement of Reverend Philip Richardson, Archbishop of Tikanga Pakeha of the Anglican Church (12 December 2021, para 200).

524 Witness statement of Reverend Philip Richardson, Archbishop of Tikanga Pakeha of the Anglican Church (12 December 2021, para 217).

525 Joint witness statement of The Most Reverend Philip Richardson and The Most Reverend Donald Steven Tamihere (5 October 2022, para 19).

526 Transcript of evidence of Dr Murray Wilton at the Inquiry’s Faith-based Institutional Response hearing, (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 341).

527 Transcript of evidence of Dr Murray Wilton at the Inquiry’s Faith based Institutional Response Hearing, (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 340).

528 Transcript of evidence of Dr Murray Wilton at the Inquiry’s Faith based Institutional Response Hearing, (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 340).

529 Letter from Chief Secretary of The Salvation Army to Divisional Commander (8 March 1991).

530 The Salvation Army, Interview with [survivor] (n.d, pages 3, 5); Statement of John Callagher, former Salvation Army staff member (26 February 2003, pages 2–3).

**Te tuku, te whakateka, te whakaiti rānei i te pāmamae, i horahia hei pare kōamuamu, i hua tonu ai te mahi tūkinu**

**Deferral, denial or harm minimisation was also used to avoid responding to complaints, which contributed to abuse**


402. Sometimes senior leaders or managers would defer dealing with a complaint until NZ Police had completed their investigation. This approach was sometimes out of caution to not interfere with a NZ Police investigation.
403. At times, the Methodist Church responded to complaints with what it describes as a “traditional legal approach”, requiring survivors to report their abuse to NZ Police before the Church would conduct its own inquiries.<sup>531</sup>
404. Presbyterian Support Central accepts that historically it was defensive in its approach to complaints.<sup>532</sup>
405. In 2002, Dr George Barton QC was appointed by Presbyterian Support Central and survivors to investigate complaints of abuse at Berhampore Home in Te Whanganui-a-Tara Wellington. Dr Barton had assured survivors involved in the investigation that he would do his best to minimise the strain and stress for them.<sup>533</sup> Presbyterian Support Central accept that the way Dr Barton actually conducted the investigation was legalistic and resulted in further harm and trauma being suffered by survivors.<sup>534</sup>

531 Opening Submissions of the Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa, Wesley College Board of Trustees, and Wesley College Trust Board at the Inquiry's Faith-based Institutional Response Hearing (18 October 2022, para 3.26).

532 Transcript of evidence of Naseem (Joe) Asghar and Patrick Waite on behalf of Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 260).

533 Transcript of evidence of Naseem (Joe) Asghar and Patrick Waite on behalf of Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 262).

534 Transcript of evidence of Naseem (Joe) Asghar and Patrick Waite on behalf of the Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 260, 263–264).

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406. In other cases, senior leaders would minimise allegations, even when they involved unlawful sexual abuse, to avoid taking any steps to respond to complaints. John Gainsford was a manager at Bramwell Booth Home, a Salvation Army Children's Home in Temuka from 1973 to 1975. In 1972, while Gainsford was serving as an officer in Gisborne, a Salvation Army Major (who was the National Social Services Secretary) met with NZ Police to discuss three incidents involving nudity and three different children. NZ Police left the complaints with the Salvation Army to deal with as it saw fit. The Social Services Secretary Army Major subsequently decided the incidents were just "foolish" behaviour by Gainsford and recommended he receive counselling.<sup>535</sup> The Salvation Army ultimately received 26 complaints of historical abuse by John Gainsford, most of which it advised were received after 2003.<sup>536</sup>
407. John Gainsford was subsequently convicted of 26 counts of sexual offending against children, including rape, between 1973 and 1974 at Bramwell Booth Home. Had the Salvation Army taken appropriate action in 1972, and in response to subsequent complaints, later prolific sexual offending by John Gainsford could have been prevented.
408. The Salvation Army was made aware of numerous allegations of abuse from the 1950s through to the early 2000s that related to the same group of eight alleged perpetrators.<sup>537</sup>
409. The Gloriavale Christian Community's leadership routinely failed to respond to reports of abuse or failed to respond adequately. From its founding until the mid-1990s, all reports of sexual or physical abuse were dealt with by founder and then-Overseeing Shepherd, Neville Cooper (Hopeful Christian), who was subsequently convicted of sexual offences, including against young people.<sup>538</sup>

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535 Police interview regarding conduct of Officer John Gainsford (6 November 1972); Transcript of evidence of Colonel Gerald (Gerry) Francis Walker for the Salvation Army at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 15 March 2021, pages 63–65).

536 Transcript of evidence of Colonel Gerald (Gerry) Francis Walker for the Salvation Army at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 15 March 2021, page 63); Police interview regarding conduct of Officer John Gainsford (6 November 1972, page 1); Letter from Social Worker to Colonel (unnamed) The Salvation Army (5 November 1993).

537 Transcript of evidence of Colonel Gerald (Gerry) Francis Walker for the Salvation Army at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 15 March 2021, pages 61–63).

538 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, pages 57–59).

410. In 1989, in response to historical allegations of a Methodist minister sexually abusing a young girl he was fostering, another Methodist minister, Reverend David Ansell, told his superior they did not have a legal obligation to report the abuse to NZ Police:

*“Thinking over the possible legal ramifications of the church ‘knowing and not telling’, I doubt there would be any. If this girl is having counselling (for whatever reason) then I think they will work out whether there is anything to tell, and I don’t think for one moment that the church bears any responsibility to do this.”<sup>539</sup>*

411. The Methodist minister continued to foster children despite having complaints of sexual abuse against him. At the Inquiry’s Faith-based Institutional Response Hearing, Reverend Tara Tautari agreed that the prevailing attitude “was all about protecting the reputation of the [Methodist] Church and also of powerful people in the Church, powerful people being Clergy”.<sup>540</sup> Reverend Tautari considered that the failure of the church to act in 1989 in response to the allegations meant that:

*“... the Church was complicit in enabling this abuse to continue, that it sent a message that Clergy could behave in this way and get away with it. And that it sent a message to women that they were not safe, even in our most sacred spaces.”<sup>541</sup>*

## **Ko te whakautu kōamuamu a ētahi kaimahi matua me ngā kaiwhakahaere he tohi whakatau noho tapu**

### **Some senior leaders and managers responded to complaints with confidential settlements**

412. Sometimes confidential settlements were reached, which in some cases bound the person who had made the complaint.<sup>542</sup> Sister Susan France, Congregational Leader of the Sisters of Mercy New Zealand, said she was aware of some parts of the Catholic Church that were “protective of its reputation and as such made efforts to keep allegations of abuse quiet.”<sup>543</sup>

539 Extract of letter from Reverend Ian Ramage to Reverend David Ansell, Superintendent Waikato District (11 October 1989, page 2); Letter from GH Peak (legal advisor) to Reverend SJ West, Re: Criminal responsibility (11 October 1989).

540 Transcript of evidence of Reverend Tara Taurari on behalf of the Methodist Church at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 259).

541 Transcript of evidence of Reverend Tara Taurari on behalf of the Methodist Church at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 259).

542 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui Volume 1 (2021, page 218).

543 Witness statement of Sister Susan France Congregational Leader, Nga Whaea Atawhai o Aotearoa Sisters of Mercy of New Zealand (4 October 2022, para 36).

## **Tērā ngā kaimahi matua, kaiwhakahaere, ngā kaimahi me ngā kaiatawhai kīhai i whāki kōamuamu**

### **Senior leaders, managers, staff and carers failed to report complaints**

413. Throughout the Inquiry period many forms of abuse and neglect were against the law. However, there was no legal or mandatory direction for leaders, managers, staff and carers in State and faith-based care settings to report to NZ Police if they suspected or knew of this unlawful behaviour happening to a person in care.
414. Without government direction on reporting unlawful behaviour, abuse and neglect to NZ Police, it was left to each State or faith-based care setting to develop its own policies and practices on reporting. In 1989, the Children, Young Persons, and Their Families Act provided in law that a person may report child abuse or suspected child abuse to a social worker or police officer and that if the disclosure was provided in good faith they would be protected from civil, criminal, or disciplinary proceedings.<sup>544</sup>
415. Across all State and faith-based settings, there were failures to consistently report crimes against children, young people and adults in care to NZ Police.

### **Kīhai i whāki kōamuamui ngā takinga whaikaha, hauora hinengaro Failure to report complaints in disability and mental health settings**

416. In disability and mental health settings, it was left to each institution to develop its own policies on reporting to NZ Police. The Inquiry heard evidence that across multiple institutions there was a reluctance by staff to involve NZ Police in complaints of abuse and neglect. For example, the Palmerston North Hospital Board Staff Dismissal Committee met in 1985 after a student nurse had struck a patient four times on the buttocks with a lavatory brush at the Kimberley Centre, a psychopaedic hospital for children with learning disabilities, near Taitoko Levin. The Committee discussed the situation with the mental health district inspector, but rather than reporting the abuse to NZ Police, it resolved that the nurse “be disciplined but not dismissed or charged with assault”.<sup>545</sup>

<sup>544</sup> Children, Young Persons, and Their Families Act 1989, sections 15 and 16.

<sup>545</sup> Minutes of a meeting of the Palmerston North Hospital Board Staff Dismissal Committee (11 September 1985, page 1).



417. Pākehā survivor Alison Pascoe, who was in Kingseat Psychiatric Hospital in Karaka, reported that she was sexually assaulted by a male patient when she was 12 years old, around 1954. After she disclosed the incident to staff, there were some repercussions for the patient, but there was no police involvement. Alison told the Inquiry that staff:

*"... should have called the Police. I don't know why they didn't. Patients had no rights."*<sup>546</sup>

## **Kīhai i whāki kōamuamu i ngā takinga toko i te ora**

### **Failure to report complaints in social welfare settings**

418. In social welfare settings, the 1970 Social Workers Manual included a reporting policy that reminded staff that it was a criminal offence to ill-treat or neglect a child or to fail to provide them with the necessities of life. The manual said that, generally speaking, NZ Police should be advised in these cases.<sup>547</sup> In the 1984 manual, this wording was changed to strengthen this direction, from saying "the police **should be** advised" to saying "police **to be** advised"<sup>548</sup>.

419. From 1995, an amendment to the Children, Young Persons, and their Families Act 1989 placed a new statutory duty on the Director-General to "develop and implement protocols for agencies (both governmental and non-governmental) and professional and occupational groups in relation to the reporting of child abuse and monitor the effectiveness of such protocols".<sup>549</sup>

420. Despite having these policies in social welfare settings, staff did not always follow them. Often, survivors were not believed when they disclosed abuse, and no action was taken. In other cases, sometimes social workers believed the allegations but chose not to take it any further. Former social worker Marjory van Standuleen said that as far as she was aware, "nothing was done by the department in terms of treating the abuse as an offence".<sup>550</sup>

421. There were serious failures by the State to internally investigate, and refer to NZ Police, allegations of sexual abuse against a foster parent and subsequent family home caregiver who cared for at least 100 children from 1978 to 1997.<sup>551</sup>

546 Witness statement of Alison Pascoe (29 April 2022, paras 2.69–2.73).

547 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 7).

548 Ministry of Social Development, Legislation and social work guidance over the years (n.d., page 7).

549 Children, Young Persons and their Families Amendment Act 1994, section 4(1).

550 Witness statement of Marjory van Staalduin (29 August 2022, para 51).

551 Police Statement of Ernest Young (n.d., page 5).

422. NZ European survivor Andrea Richmond told the Inquiry she was raped by this male caregiver several times while placed with him in 1980. At the time she did not disclose the abuse because she did not know it was wrong,<sup>552</sup> but later in 1988 she advised her social worker that she had been sexually abused by this caregiver when she was placed with him.<sup>553</sup> This conversation was recorded. However, it was decided that no subsequent action should be taken to investigate the complaint or refer it to NZ Police, as the foster family were not fostering at the time. The Ministry of Social Development acknowledged that the failure to report this to NZ Police was a serious practice failure.<sup>554</sup>
423. The caregivers continued to foster children until 1992, when they were appointed caregivers of a family home until 1997. Over this time multiple other girls were sexually abused.<sup>555</sup> At least one of these girls also reported the abuse to her social workers at the time but was not believed.<sup>556</sup> In 1997, the caregivers were investigated for serious allegations of neglect, and following the investigation they voluntarily resigned with no consequences. The male caregiver continued to sexually abuse girls, including his adopted daughter and granddaughter, before being later convicted of sexual offending.<sup>557</sup>
424. A former principal of Epuni Boys' Home in Te Awa Kairangi ki Tai Lower Hutt said that when he found out about a night supervisor sexually abusing a boy in the early 1970s, he immediately dismissed the night supervisor. However, he did not report it to NZ Police because there were no other witnesses, despite the staff member not denying the allegation and him finding the survivor "very truthful".<sup>558</sup>
425. In 1983, a social worker wrote a letter to another office, stating that a foster girl in their area had complained of repeated abuse from her foster father. The social worker said that while she was "aware of no reason to doubt her word" there was "no intention by this office to take the situation any further than to notify [the Assistant Director]".<sup>559</sup>

## **Kīhai i whāki kōamuamu i ngā takinga mātauranga**

### **Failure to report complaints in education settings**

426. As discussed above, there were no national complaints policies during the Inquiry period for education settings, including special schools for Deaf students. It was up to individual schools whether they developed their own policies or not.

552 Witness statement of Andrea Richmond (3 March 2022, paras 36–39).

553 Witness statements of Andrea Richmond (3 March 2022, paras 36–39 and 11 May 2022, pages 1–2).

554 Ministry of Social Development, Practice review for [survivor] (2011, para 70).

555 Witness statements of Ms EM (28 May 2021, paras 16–22) and Mrs EJ (13 May 2022, paras 33–35); Police victim impact statement [survivor] (n.d., pages 2–5).

556 Witness statement of Ms EM (28 May 2021, paras 18–19).

557 Police statement of Ernest Garth Young (n.d., page 10); Ministry of Social Development, Practice review for [survivor] (2011, paras 5, 67); Police victim impact report of [survivor] (21 November 2010).

558 Ministry of Social Development, Interview of meeting with former Epuni principal (22 November 2006, pages 23–24).

559 Letter to Assistant Director, Social Work, from Social Worker (4 May 1983).

427. The Inquiry did not locate any policies from the Inquiry period on referring complaints of abuse in education settings to NZ Police. NZ European survivor Mr JS, who attended Van Asch College in Ōtautahi Christchurch, told the Inquiry he could not believe that an incident of him being stabbed and needing several stitches in about 1982 was not reported to NZ Police.<sup>560</sup>
428. The Ministry of Education now places a responsibility on schools to report complaints or reports of concern to NZ Police in some cases.<sup>561</sup>

### **Kīhai i whāki i ngā takinga pūnaha taurima ā-whakapono** **Failure to report complaints in Faith-based care settings**

429. In faith-based care settings, protocols for reporting complaints or concerns to NZ Police were generally not developed during the Inquiry period.
430. The Anglican Church had no national policy on reporting abuse to secular agencies such as NZ Police and Oranga Tamariki.<sup>562</sup> The Right Reverend Te Kitohi Wiremu Pikaahu (Te Pihopa o Te Tai Tokerau) said that with regard to Queen Victoria School (Anglican) for Māori girls in Tāmaki Makaurau Auckland, “upon review of the material disclosed to the Royal Commission, it does not appear that any reports of abuse were referred to the NZ Police or other state agencies”.<sup>563</sup> The position was the same at Te Aute College (Anglican) in Te Matau-a-Māui Hawkes Bay. The Most Reverend Donald Tamihere acknowledged that he had “not seen any material to suggest that any instances of abuse were referred to the Police or other State agencies”.<sup>564</sup>

560 Witness statement of Mr JS (27 May 2022, para 2.57).

561 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 114).

562 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Pūretumu Torowhānui Volume 1 (2021, page 188).

563 Witness statement of the Right Reverend Te Kitohi Wiremu Pikaahu (Te Pihopa o Te Tai Tokerau) (18 July 2022, page 12).

564 Witness statement of the Most Reverend Donald Steven Tamihere (Archbishop of Tikanga Māori of the Anglican Church and Te Pihopatanga o Te Tairāwhiti) (20 July 2022, para 32).

431. Gloriavale's current leader, Howard Temple, acknowledged that the doctrinal text "What We Believe" has historically included information that amounted to a policy that prevented its members from reporting crimes outside its community.<sup>565</sup> All disclosures of abuse were to be dealt with in-house by the Gloriavale leadership<sup>566</sup> and within the families involved.<sup>567</sup> Up until the mid-1990s, then-leader Neville Cooper (Hopeful Christian) dealt with the internal discipline of abusers "in the way he thought best".<sup>568</sup> Current leader Howard Temple acknowledged that as recently as 2017, the Gloriavale leadership still wanted to keep sexual offending reports in-house unless the person re-offended.<sup>569</sup>
432. Examples of failures by Catholic Church leaders to respond to abuse include evidence regarding the internal investigations of the Catholic Church, which found that former Bishop of Dunedin John Kavanagh should have investigated a complaint of abuse against Father Freek Schokker in 1963 but failed to do so.<sup>570</sup> In another case, in 1977 Brother Brian O'Donnell, the Provincial of the Order of St John of God, destroyed two anonymous letters that alleged abuse by the Prior, Brother Roger Moloney and Brother Bernard McGrath at Marylands School in Ōtautahi Christchurch, "because of the harm [they] could do".<sup>571</sup>
433. The Inquiry found no evidence that the Methodist Church had adequate policies on referring criminal matters to NZ Police until 2003.<sup>572</sup>
434. The Salvation Army did not have policies on referring criminal matters to NZ Police, as the obligation to report abuse was placed on the complainant.<sup>573</sup>

565 Transcript of evidence of Howard Temple on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, pages 46–47).

566 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, pages 46–47).

567 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (July 2022, page 27).

568 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (4 July 2022, page 15).

569 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 73).

570 National Office for Professional Standards, Letter from Complaints Assessment Committee to Cardinal John Dew: Re: Investigation into allegation that Bishop Kavanagh as the Bishop of the Dunedin Diocese failed to act on complaints of sexual abuse (15 December 2021, page 2).

571 Royal Commission of Inquiry into Abuse in Care, *Stolen Lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (2023, page 243, para 115).

572 Methodist Church of New Zealand, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (1 April 2021, pages 6–7).

573 The Salvation Army, *Sexual Misconduct: Policies & Complaints Procedures Manual* (1999, page 7); Transcript of evidence of Colonel Gerry Walker for the Salvation Army at the Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 15 March 2021, page 55).

## He ruarua nei ngā tuhinga kōamuamu mahi tūkinō Few records were kept of complaints of abuse and neglect

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435. There were many limitations on data during the Inquiry period, particularly concerning complaints. In cases where no formal documentation exists it can take longer for abuse and neglect to be exposed and for perpetrators to be held to account. Ineffective record management could result in prior complaints of abuse and / or neglect being overlooked.
436. Education, social welfare, transitional and law enforcement and health settings were subject to the record keeping requirements of the Archives Act 1957, which are detailed in Part 2.

### He ruarua nei ngā tuhinga kōamuamu mahi tūkinō i ngā takinga ā-Turi, whaikaha, hauora hinengaro Deaf, disability and mental health settings

437. Few records were kept of complaints of abuse and neglect in Deaf, disability and mental health settings. Before 1992, complaints were routinely not recorded in Deaf settings, nor were they routinely recorded in disability or mental health settings. When recorded, they were often not reflective of what had happened, and were dismissive of the abuse and / or neglect reported. There are limited records regarding complaints made to relevant professional bodies.<sup>574</sup>
438. The New Zealand Medical Council provided the Inquiry with several documents relating to investigations into complaints about Dr Selwyn Leeks' abuse at the Lake Alice Child and Adolescent Unit. The Council acknowledged that though some of the other documents requested by the Inquiry did exist at some stage, they could not be found:

*"There is no obvious explanation as to why these documents could not be located, and it is assumed that these documents were not retained once they were no longer current."*<sup>575</sup>

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574 Affidavit on behalf of the Medical Council of New Zealand for Notice to Produce No1 (10 June 2020, pages 3–5); Affidavit of Associate Professor John Allan on behalf of the Royal Australian and NZ College of Psychiatrists, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce No 1 (11 December 2020, pages 3–5).

575 Affidavit on behalf of the Medical Council of New Zealand, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce No1 (June 2020, page 4, para 16).

439. The 1983 Gallen Inquiry found that incidents and allegations of ill treatment at Oakley Hospital in Tāmaki Makaurau Auckland were not recorded on patient files. Instead, an incident book was used to record altercations on the ward, including between patients and staff. The Gallen Inquiry indicated that this was done out of a desire to protect staff from any disciplinary action that might result from an allegation of mistreatment.<sup>576</sup>
440. The Gallen Inquiry noted that the proper process was for complaints and violent incidents to be recorded on patient files and properly investigated, including referring matters to the official visitor as soon as possible after they occurred.<sup>577</sup>

## Ngā takinga toko i te ora

### Social welfare settings

441. Limited information on complaints was often recorded and only on individual personal files. For most of the Inquiry period, the manuals were the primary source of instruction on recording information, including complaints. In 1989, they were superseded by the Care and Protection Handbooks.
442. Though the manuals and handbooks had very detailed and thorough instructions for records management,<sup>578</sup> the level of detail recorded in the paper files was largely dependent on the individual social worker. There were limited case reviews and quality checks until the 1984 manual introduced a review panel. The purpose of the panel was to complete an independent review and monitor progress.<sup>579</sup>
443. Oranga Tamariki told the Inquiry that “[f]or a 60-year period, 1950 to 2010, 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.”<sup>580</sup> This made it difficult to identify patterns of abuse or prolific abusers and resulted in abusive staff being rehired and children and young people being placed with abusive foster parents.<sup>581</sup>

576 Gallen, R, Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, (January 1983, page 87).

577 Gallen, R, Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, (January 1983, pages 97–98).

578 Department of Education, Child Welfare Division Field Officers Manual (1957, N.21); Department of Education, Child Welfare Division Field Officers Manual (1970–1984, N.13, pages 4–9); Department of Social Welfare, Care and Protection Handbook (1989, page 90); Child, Youth and Family, Care and Protection Handbook 1996 – Volume Two (1996, sections 9.91–9.92).

579 Department of Social Welfare, Social Work Manual Volume 2 (September 1984, page 26, M3.1).

580 Statement of Andrea Nichols for Oranga Tamariki for Notice to Produce No 14 (23 October 2020, para 5).

581 Information Sheet written by J Wallout (Social Worker) (18 September 1988, page 3); Police Statement of Ernest Garth Young (n.d., page 11); Ministry of Social Development, Practice Review (April 2011, para 70); Witness statement of Andrew Meadows (26 March 2021, paras 67–68, 73).

444. Before the introduction of electronic systems, individual paper files meant it was difficult to track complaints if the individual file was transferred to another district, because no records remained in the current district. In 1980, a letter addressed to the Director-General of Social Welfare from a social worker discusses an allegation of abuse by a foster child against his foster father:

***“Unfortunately I have to report that there have been two incidents where similar allegations have been made against this person by European youths with whom they were fostering ... Unfortunately, both of these youth’s files have been transferred to other districts and I have no means of checking on any notes made at the time of the allegations.”***<sup>582</sup>

445. The earliest electronic case management system was the Children and Young Persons Service computer information system that operated between 1990 and 1994.<sup>583</sup> Different versions of this electronic case management system were used until replaced with CYRAS (the current electronic case management system) in 2000.

446. At the Inquiry’s State Institutional Response Hearing, Nicolette Dickson, the Deputy Chief Executive, Quality, Practices and Experiences at Oranga Tamariki, was questioned about the possibility of records of complaints being overlooked when transferring files between districts during the Inquiry period. She replied that before the centralised case management system (CYRAS), it was “a very real risk”.<sup>584</sup>

447. In the foster care context, the lack of adequate record keeping resulted in earlier allegations of abuse being overlooked, and children and young people being placed with unsafe caregivers. The department recognised the risk of this as early as 1971, when it issued an internal memorandum to all District Child Welfare Officers stating that:

***“From time to time a case arises where children are placed in a foster home which has proved in the past to be unsatisfactory. This may come about either because the home has not been clearly recorded as unsatisfactory or because no check was made of the records.”***<sup>585</sup>

582 Letter from senior social worker to Director-General re: Allegations made against foster parents (21 October 1980, page 3).

583 Robertson, JP & Maxwell, GM, A study of notification for care and protection to the Children and Young Persons Service, Occasional Paper No. 5 (Office of the Commissioner, for Children, 1996) as cited in Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 103).

584 Transcript of evidence of Nicolette Dickson for Oranga Tamariki at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 23 August 2022, page 771).

585 Child Welfare Division, Circular Memorandum from Superintendent to all D.C.W.Os Principals etc.: Unsatisfactory Foster and Adoptive Parents (29 October 1971).

## Ngā takinga mātauranga

### Education settings

448. The Ministry of Education told the Inquiry that documentation on the record keeping practices of the Department of Education and Education Boards was not available.<sup>586</sup> During the Inquiry's State Institutional Response Hearing, Secretary for Education Iona Holsted acknowledged "that record-keeping issues, including the loss of some records has caused pain to many because their full story could not be told".<sup>587</sup> She said one of the reasons that she made that acknowledgement was because "individual case notes are often not available" and when accountability for schools shifted in 1989 from school boards to the Ministry, the "transfer of records was not well done".<sup>588</sup>

## Ngā takinga whakatika, mauhere ā-ture

### Transitional and law enforcement settings

449. The Inquiry saw evidence where survivors' complaints and statements to NZ Police were not located because they had not been recorded, because they had been destroyed, or because they were lost or thought to had been lost.<sup>589</sup>

450. NZ Police told the Inquiry that they have had "a progression of policies and practices related to the disposal and archiving of its public records".<sup>590</sup> NZ Police's archived records fall under over 300 agencies because each NZ Police station is allocated its own agency code.<sup>591</sup> Archives New Zealand's records show that NZ Police have had a schedule of categories of records for destruction and retention since at least 1961. Documents of "historical interest" had to be stored at Archives New Zealand and it was up to the officer in charge of the district to determine what met this threshold.<sup>592</sup>

451. NZ Police guidance on the destruction of files from 1976 (D115) did not identify any classes of offence files that should be retained, apart from files of "historical interest". In 1984, NZ Police Schedule 8 was introduced, which referred to specific offence codes for the first time.<sup>593</sup> For example, it contained instructions on the disposal of documents relating to complaints against NZ Police; these had to be "transferred to National Archives in all cases where complaints result in proceedings being heard by either the Police Tribunal or District or High Courts".<sup>594</sup>

<sup>586</sup> Affidavit of Stephen Metherell for the Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 6, (7 August 2020, para 12).

<sup>587</sup> Transcript of evidence of Secretary for Education Iona Holsted at the Inquiry's State Institutional Response Hearing, (Royal Commission of Inquiry into Abuse in Care, 18 August 2022, page 334).

<sup>588</sup> Transcript of evidence of Secretary for Education Iona Holsted at the Inquiry's State Institutional Response Hearing, (Royal Commission of Inquiry into Abuse in Care, 18 August 2022, page 388).

<sup>589</sup> Confidential Listening and Assistance Service, Police referrals and outcomes (26 November 2019, pages 1–8); NZ Police, Court Cross-Examination (4 June 2009, pages 26–27).

<sup>590</sup> Affidavit of Michael Webb for NZ Police, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 6 (21 August 2020, para 7).

<sup>591</sup> Affidavit of Michael Webb for NZ Police, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 6 (21 August 2020, para 6).

<sup>592</sup> Affidavit of Michael Webb for NZ Police, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 6 (21 August 2020, para 7).

<sup>593</sup> Affidavit of Michael Webb for NZ Police, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 6 (21 August 2020, para 8).

<sup>594</sup> NZ Police Schedule No 8: Police District Offices Instructions for Disposal of Records (Received by National Archives on 27 July 1984, page 72).



## Ngā takinga pūnaha taurima ā-whakapono

### Faith-based care settings

452. Many survivors tried to get copies of their records of complaints from their time in faith-based care settings, only to find they had been lost or destroyed or were sparse.
453. Before this Inquiry, the Catholic dioceses and religious institutions did not centrally hold information about abuse that has been reported to Catholic Church authorities or records of decision-making about any redress provided to survivors.<sup>595</sup> Without adequate formal reporting processes within Catholic institutions, and because individual reports of abuse were not believed, leaders within the Catholic Church had no understanding of the scale of abuse that was occurring.<sup>596</sup>
454. Some Catholic institutions, such as the Order of the Brothers of St John of God, appear to have had a practice of not making or keeping records of reports of abuse and neglect that it received about brothers or more generally. This has also meant limited records were kept regarding ethnicity and disability.<sup>597</sup>
455. When questioned about an investigation into a complaint of sexual abuse at Dilworth School (Anglican) in Tāmaki Makaurau Auckland, Derek Firth, a former Chair and trustee of the Dilworth School Trust Board, accepted that there are no records of the investigation because they were destroyed during a “cleanout” in 1992 or 1993.<sup>598</sup> Mr Firth acknowledged that the Dilworth Trust Board did not have a document retention policy in those days, and decisions about record keeping were at the discretion of the general manager.<sup>599</sup>
456. The Anglican Church conceded that its failures to implement record keeping policies led to inconsistent responses to abuse and neglect within the Church.<sup>600</sup>
457. In relation to the several records of abuse and neglect at Te Aute College in Te Matau-a-Māui Hawkes Bay, the Most Reverend Donald Tamihere noted that “there is little information available on the disciplinary action, recording and reporting carried out because of the limited material available”.<sup>601</sup>

595 Witness statement of Cardinal John Dew (4 October 2022, paras 23–24).

596 Witness statement of Cardinal John Dew (4 October 2022, para 21).

597 Royal Commission of Inquiry into Abuse in Care, *Stolen Lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (2023, page 47).

598 Transcript of evidence of Derek Firth at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 20 October 2022, pages 491–492).

599 Transcript of evidence of Derek Firth at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 20 October 2022, pages 491–492).

600 Joint witness statement of The Most Reverend Philip Richardson and The Most Reverend Donald Steven Tamihere (5 October 2022, para 60).

601 Witness statement of the Most Reverend Donald Steven Tamihere (20 July 2022, para 31).

458. The Most Reverend Philip Richardson and the Most Reverend Donald Tamihere told the Inquiry:

***“Abuse occurred which was systematic and involved significant complicity and cover-up by key staff members of some institutions. Better controls should have been in place to protect children and vulnerable people”.***<sup>602</sup>

459. Because it was not seen as a priority, the Methodist Church had not digitised its Methodist Children’s Homes records, resulting in many documents being destroyed in the sequence of Canterbury earthquakes that started on 4 September 2010.<sup>603</sup> The loss of records caused pain to survivors, who rely on these to form the basis of their identity.<sup>604</sup>

460. The Methodist Church accepted that due to its failure to implement record keeping policies for reports of abuse and neglect, it does not have full information about all the reports and complaints that are likely to have been made to the Church.<sup>605</sup>

461. In relation to The Salvation Army, there is one reported instance where it was noted that records of a meeting in 1974 between The Salvation Army leadership and John Gainsford, later a convicted child abuser, were missing.<sup>606</sup> On a second occasion, an independent investigator reported that a complainant said that certain records may have been removed, but it was never confirmed.<sup>607</sup> Colonel Gerald Walker said he accepted there had been “gaps” in its documentation, but did not know how some of these had happened, noting that current retention policies did not exist earlier.<sup>608</sup>

462. In relation to one Presbyterian Support entity, Presbyterian Support Otago, all records were destroyed in 2017 and 2018, except for registers of names and dates. The first report of abuse had been made to Presbyterian Support Otago several years earlier in 2004, and so it was aware there had been reports of abuse and neglect at the time the decision was made to destroy the records.<sup>609</sup>

602 Joint witness statement of The Most Reverend Philip Richardson and The Most Reverend Donald Steven Tamihere (5 October 2022, para 16).

603 Transcript of evidence of Reverend Tara Taurari on behalf of the Methodist Church at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 261).

604 Transcript of evidence of Reverend Tara Taurari on behalf of the Methodist Church at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 262).

605 Opening Statement of Reverend Tara Tautari on Behalf of the Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 46).

606 The Timaru Herald, Salvation Army documents go missing (17 October 2006).

607 Report from Rob Veale, investigator, to Lieutenant Colonel Andy Westrup, The Salvation Army, Interim report arising from allegations of sexual misconduct (24 December 2013).

608 Transcript of evidence of Colonel Gerald Walker for The Salvation Army at the Inquiry’s Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 16 March 2021, page 124).

609 Transcript of evidence of Joanne O’Neill on behalf of Presbyterian Support Otago at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 282).

463. The Plymouth Brethren Christian Church told the Inquiry that it does not record the ethnicity of members, therefore it does not record the ethnicity of anyone who reported abuse and / or neglect. The same applies for disabled people.<sup>610</sup>
464. When asked by the Inquiry what issues have been identified in its record keeping policies and practice relating to reports of abuse, Gloriavale Christian Community responded that record keeping policies will be reviewed shortly.<sup>611</sup>

## **Kāhore te Tiriti o Waitangi i kitea i ngā kaupapa me ngā tikanga hautū mahi**

### **Te Tiriti o Waitangi was absent in complaints processes**

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465. From 1950 to 1999, there was no legislated direction that complaints processes should give effect to the rights guaranteed to hapū and iwi in te Tiriti o Waitangi. Despite the disproportionate numbers of tamariki, rangatahi and pakeke Māori in care, complaints processes during the Inquiry period were not developed in partnership with whānau, hapū or iwi to embed tikanga and te ao Māori into complaints processes for tamariki, rangatahi and pakeke Māori.
466. The lack of culturally appropriate complaints processes for tamariki, rangatahi and pakeke Māori throughout the Inquiry period demonstrates a lack of concern for, and a failure of the State to actively protect, Māori in care.

## **He akonga i kitea he mea i panonihia e pā ana ki ngā tikanga hautū mahi**


### **Lessons identified and changes made to complaints processes**

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467. The State learned that State and faith-based care settings needed detailed direction on processes for raising and responding to concerns or complaints and for record-keeping. The State introduced changes for children and young people in the care of social welfare residences in 1986, and for people subject to compulsory mental health assessment or treatment orders in 1996. All other settings were generally left to develop their own approaches to complaints processes.

<sup>610</sup> Royal Commission of Inquiry into Abuse in Care, Internal notes from the Inquiry's meeting with representatives of the Plymouth Brethren Christian Church (29 November 2022, page 24).

<sup>611</sup> Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 521 (29 September 2022, page 7).



"The system needs  
to be based around  
tikanga Māori"

**MS FT**

Cook Islands whakapapa

# Ms FT

**Hometown:** Ōtara, Te Tonga o Tāmaki Makaurau South Auckland

**Age when entered care:** 15 years old

**Year of birth:** 1980

**Time in care:** 1995

**Type of care facility:** Youth justice facilities – Weymouth in Te Tonga o Tāmaki Makaurau South Auckland, Epuni Boys' Home in Te Awa Kairangi ki Tai Lower Hutt.

**Ethnicity:** Ms FT has Cook Islands whakapapa and a strong affinity with Māori culture.

**Whānau background:** Ms FT has two brothers and two sisters. Ms FT and her brothers were raised by their grandparents. Her sisters were raised by her birth mother.

**Currently:** Ms FT has six children and five mokopuna. She is currently incarcerated in Auckland Women's Prison.



**Growing up in Otara, it felt like we were one big family. I used to stay at the neighbours' houses as everyone knew everyone. My biological mother came around now and then, but it was my nan and grandfather who raised me and my siblings.**

Though he had Cook Islands and German heritage, my grandfather was big on Māori culture. I looked up to him and took so much pride in what he taught me. He was a man of great mana and I always tried to please him.

Between the ages of around four and seven years old, I was molested at home. It wasn't a family member – it was some prick who stayed with us who was an in-law.

I started fighting a lot. At primary school, most kids scratched or pulled hair. I punched the person I was fighting until they bled. I also whacked staff as well, usually when they were trying to restrain me. When they touched me, I felt this need to lash out. I was always distracted in school and couldn't really listen.

My grandparents always talked to me and tried to help me. My uncle, who was a well-known medical figure in the Pasifika community, told my grandparents that I was hyperactive. He said he could give me some medication, but my grandfather said no. Instead, my grandparents tried to tire me out – I got up early and was given a lot of chores.

I could drive an automatic by eight and a manual by nine. I was hanging out with thugs, trying to be cool. If someone tried to break into a car but couldn't, I would do it just to show people I could. I got pregnant when I was 13 and my son's father was 18.

There was a specific event when I was 15 that led to me going into care. After I stood with my brother when he was jumped by a number of men, he took his friend's side in an argument. I saw that as a betrayal. My grandfather had told me if any of his children betrayed another, they would be cut off from our family. I took his words too literally and felt like he needed to be physically cut off and needed to die. I used a kitchen knife and stabbed him once in the back. I missed his heart by about six inches.

When I arrived at Weymouth, I was forced to strip in front of male guards who were behind the glass. I don't think I had any type of psychiatric assessment or anything like that. I was put in secure, which was very isolating. It was very similar to the pound we have here in Christchurch Prison.

I was transferred to Epuni. I didn't understand what was going on – no social worker visited while I was at Weymouth and no-one told me shit. I thought I was at Weymouth for two weeks, I found out recently that it was actually a couple days. It felt like forever.

When I arrived at Epuni it was the same deal – I stripped down and was placed in secure for about a week. I had two cousins and one brother from Auckland in their own secure cells, so there were familiar faces. We were allowed "out" for one hour a day but only in the hallway – we didn't get fresh air or a chance to exercise.

I remember the principal and a guard who acted like her attack dog – he looked at us like we were scum and never treated us like human beings. The kingpin resident was always talking to them. The first time I was at the table tennis table, she threw the bat at me. She was trying to bully me to get off the table, trying to staunch me out. I threw the bat at her, then I grabbed the chair and whacked it at her. I then started punching her but I got pulled off. I think they made her do it to see how I would react. I definitely reacted – I got the chair and smashed it on her and then started hoeing into her.

The guard watched for a bit but as soon as the principal came, he pulled me by my top and tried to choke me out. I punched him in the face, it made his nose bleed. He kicked me to the ground, and then he lifted me by my hair, put me in a headlock and carried me into secure. In another incident I started swearing at the lady called Nan, which was a mistake. She then got the same guard as before to come. He slammed me to the ground and just started putting knees into me. Knee, knee, knee. The principal watched him giving me a hiding.

After that, I played up all the time. They were trying to make me submissive and I am not that person. One time, when a black eye I got from the guard was healing up, he punched me to make it go black again. Another time I gave him a bloody nose and he really went in – I was bruised all over. He booted us, choked us, everything.

I also got into fights with other youths. One boy, who was in Black Power, threw a knife at me when I was eating so I threw a hot jug of water over him. Gangs played a big role at Epuni. People were either Black Power or Mongrel Mob. Me and the cousins were Crips from Auckland but that meant nothing to them.

Sometime after, I asked the boy why he threw the knife and he told me that he had to. The facilitators of Epuni were instigating the violence – they were making us react violently and use violence to achieve things.

There was another staff member who was a sexual predator and worked night shift. He tried to come into my room, but I told him to fuck off. You could hear him rooting girls in other rooms though. They said he pretty much raped them at the beginning, but they realised they could get stuff out of it, like money into their canteen and other favours like that.

We couldn't really complain to anyone. I did try to raise the paedophile with another staff member who was pretty solid, but he didn't want to make a formal complaint because it would jeopardise his job.

The school work wasn't challenging at all. I played the dumb card because I didn't want to show that I was quite intelligent. The main thing I learnt was that I didn't want any of my children to experience what it was like to be in these types of institutions.

After six months, I went back to my mum's care. I had to see a psychiatrist as part of the conditions of my release. I tried to attack her when she kept pushing me to talk about my mum not being around when I was a kid. Her style made me angry – she was a stranger asking me all these things and I told the court I would rather just get thrown back in Epuni than answer them.

Now I know that I didn't have the tools to process what I had been through. No-one had ever thought to help with that while I was in care. I got no help or support getting back to normal life after Epuni. My only support was my mum, and our relationship was up and down.

Dealing drugs was the only way we could get money. It's sad because it felt hypocritical contributing to the problem just to make a better life for my whānau. These are the challenges and trade-offs that we have to make that government and the system don't see. I had five more kids to my partner, who I am still with today.

After a history of fraud, dishonesty and driving while disqualified, I was charged with grievous bodily harm in 2003. I went down as the instigator and my partner went down as the principal. At the time, I was in denial about my involvement because I hadn't physically carried out the attack. It wasn't until I did a therapeutic course at Auckland Women's Prison that I understood my role.

I got pregnant while I was released on bail for the trial. I went into Mount Eden Women's Prison on remand and was not pregnant at the time. When I arrived, I was strip-searched and internally checked to see if I was hiding anything. It felt so violating, but I thought it was normal. When I was sentenced and sent back to Mount Eden I was five and a half months pregnant. I was strip searched but not internally examined. When I transferred to Arohata Women's Prison on remand, I was told that strip searches like that don't happen. I never complained about my experience at Mount Eden because I felt ashamed.

I had my baby for three days after I gave birth and then I had to watch my mum come in and take her. I transferred to Arohata because the "baby bonding" each day was putting a strain on my baby. She would just get used to me and my smell and then be taken away. My daughter was 3, turning 4 years old when I finally got her back and she called me "aunty" at first. That was hard.

Wanting to live a legit life, we moved to Wellington for five and half years. A recruiting company said I had awesome qualifications but declined my application because of my fraud history. I couldn't get around these hurdles. In the end, I got a job doing cleaning and administration for my partner's boss.

I also decided to go to Victoria University to study. I wanted to be someone who came into prisons to help the women see a better life. When my moko was sick, I transferred to Auckland University. I was in Auckland for three months before I was charged in 2016 for the offence that I am now in prison for.



At Auckland Women's Prison, I had a positive attitude. I knew that the experience was what we made it and I wanted to help bring the best out of every wahine – for them to know that our prison experience doesn't define who we are. Staff could see that I was influencing and empowering other women, so they moved me to another unit. They didn't want us to feel empowered in prison.

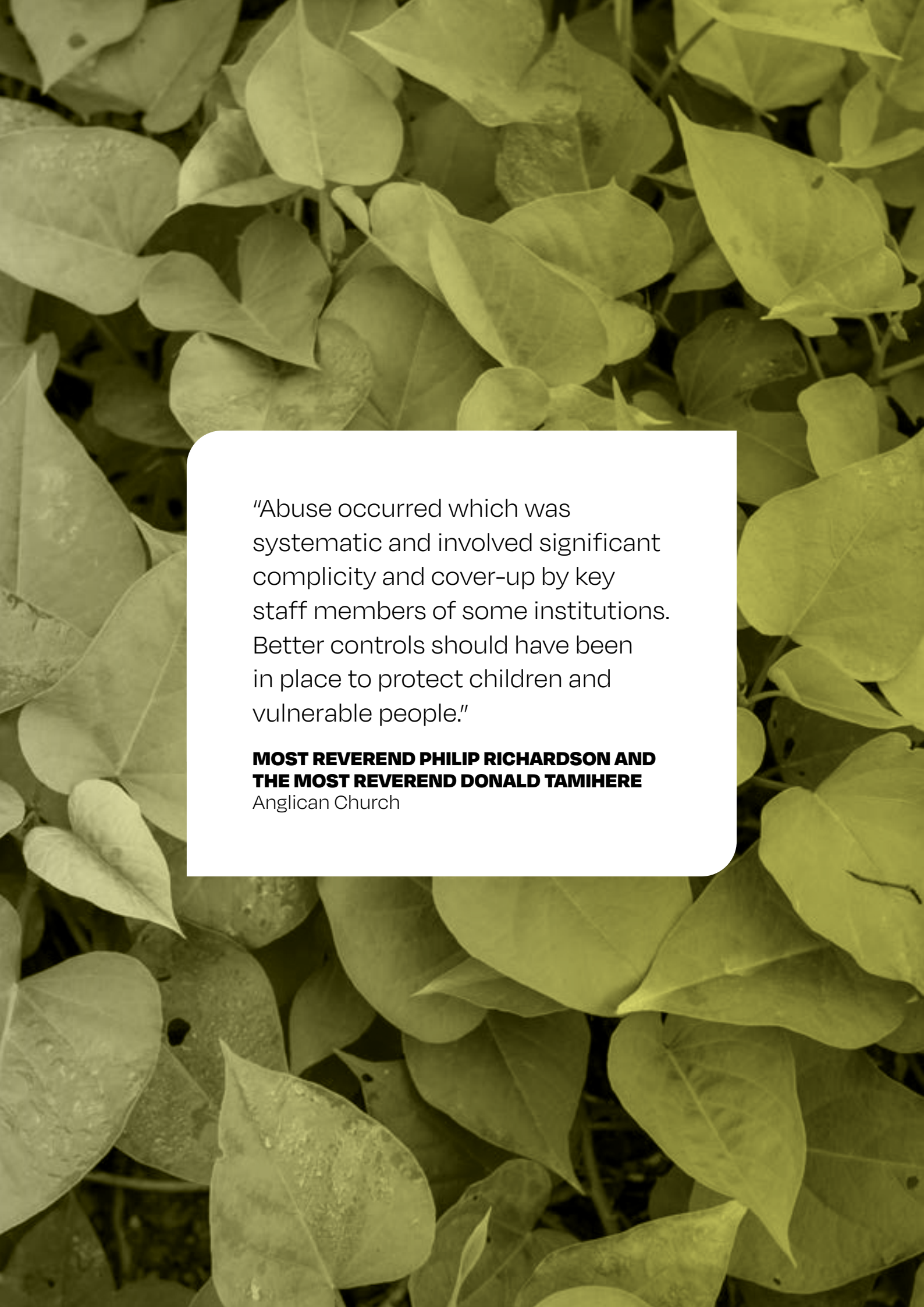
I have now been in Christchurch Women's Prison since 2021. It's hard being down in Christchurch with my whānau in Tāmaki. My kids haven't seen me for months. Two years, and even then, it was only by video calls.

I'm proud to say that none of my kids have ever been in care. Despite my experience, I kept them safe and I still have a strong bond with them. After the 2016 charge, CYFS tried to get involved, saying my whānau who are gang members were a bad influence. The reality is that many Māori and Pacific people have a whānau member who is in a gang. They assumed my whole family were gangsters, but the whānau who care for my kids are good people and hard workers. My children had a bulletproof network of whānau, but not everyone is so lucky.

The system needs to be based around tikanga Māori for all kids in Aotearoa, not just Māori. Other than a few waiata, I had no opportunity to learn tikanga when I was in care, but there is so much that tikanga can teach us as a country. In te ao Māori, it starts with our tamariki, and that's where the whole care system needs to start.<sup>612</sup>

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<sup>612</sup> Witness statement of Ms FT (21 June 2022).

The background of the entire page is a dense, close-up photograph of green leaves, likely from a plant like ivy or a similar species. The leaves are various shades of green, from light lime to a darker, more muted green, and are layered and overlapping, creating a textured, naturalistic pattern. The lighting is soft, highlighting the veins and edges of the leaves.

"Abuse occurred which was systematic and involved significant complicity and cover-up by key staff members of some institutions. Better controls should have been in place to protect children and vulnerable people."

**MOST REVEREND PHILIP RICHARDSON AND  
THE MOST REVEREND DONALD TAMIHERE**  
Anglican Church

# Ūpoko | Chapter 6

## Ahakoā ngā mahi aroturuki iti noa te hua ki ngā wheako o te hunga i ngā pūnaha taurima

### Oversight and monitoring did little to change the experiences of people in care

468. Robust and independent oversight and monitoring is a critical way of ensuring that care providers fulfil their duties to people in their care, including detecting when they are not complying with applicable laws, regulations or policies, or not providing safe and quality care. Monitors' reports and recommendations are crucial vehicles for prompting system improvement and for helping to ensure care providers are held accountable for the services they provide.
469. Inadequate or ineffective external oversight is a key risk factor that can contribute to abuse and neglect in care. Without effective external scrutiny and in combination with other factors, the Inquiry saw how abuse and neglect became normalised and routine for many people in care.
470. Even where effective external oversight or monitoring is in place, it is crucial that decisive action is taken in response to their observations about abuse or neglect that is happening. Nearly all oversight and monitoring bodies during the Inquiry period lacked the ability to require change to prevent or respond to abuse or neglect in care.

# Ngā mahi aroturuki i te wa o te Pakirehua

## Oversight and monitoring during the Inquiry period

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### Ngā mahi aroturuki puta noa i ngā takinga pūnaha taurima

#### Oversight and monitoring across care settings

#### Te Tari o te Kaitiaki Mana Tangata

##### Office of the Ombudsman

471. The Office of the Ombudsman was established in 1962. The Ombudsman's role is to help people in their interactions with government agencies, to carry out investigations, and deal with complaints.<sup>613</sup> During the Inquiry period the Ombudsman had broad investigative powers regarding any complaint brought to them, including the power to enter any premises occupied by any of the specified Departments or organisations (including the Department of Health, the Department of Education and the Department of Social Welfare) at any time and inspect the premises.<sup>614</sup>

#### Kōmihana Tika Tangata

##### The Human Rights Commission

472. The Human Rights Commission was formed in 1977 to promote human rights issues and hear from the public on human rights matters.<sup>615</sup> It monitors human rights under multiple international instruments and publishes its findings in reports to the United Nations.

473. The Human Rights Commission Act 1977 gave the Commission strategic monitoring functions including to promote respect and observance of human rights, to receive representations from the public on matters affecting human rights and to make public statements on matters affecting human rights. The Act did not explicitly give it investigative monitoring powers of entry or inspection.<sup>616</sup> However, in receiving a complaint from the Auckland Committee on Racism and Discrimination (ACORD) in 1979 concerning the treatment of children in Department of Social Welfare homes, the Commission established its jurisdiction under the Act to investigate, question and report on such matters.<sup>617</sup> In carrying out these functions, it conducted interviews, received written submissions and visited and inspected several institutions.<sup>618</sup>

<sup>613</sup> New Zealand Ombudsman, Complaints about government agencies, (n.d.).

<sup>614</sup> Ombudsmen Act 1975, section 27.

<sup>615</sup> Consedine, R, Anti-racism and Treaty of Waitangi activism – Government and community anti-racism organisations, Te Ara – the Encyclopedia of New Zealand, (28 May 2018).

<sup>616</sup> The Human Rights Commission Act 1977, section 5.

<sup>617</sup> Report of Human Rights Commission on representations by the Auckland Committee on Racism and Discrimination, (1982, pages 1–5).

<sup>618</sup> Report of Human Rights Commission on representations by the Auckland Committee on Racism and Discrimination, (1982, pages 8–9).

474. In its report on this complaint published in 1982, the Commission noted that its lack of resourcing had resulted in a significant delay in responding:

*“This report by the Human Rights Commission has been a long time in preparation. The major problem the Commission had was that there was no one able to work on it full-time, and as far as the Commissioners themselves were concerned it could only receive occasional attention among the other responsibilities of the Commission.”<sup>619</sup>*

## **Ngā mahi aroturuki takinga ā-Turi, whaikaha, hauora hinengaro Oversight and monitoring of Deaf, disability and mental health settings**

475. The Mental Defectives Act 1911 set out the monitoring and oversight of disabled people and people experiencing mental distress. The Act provided for an Inspector-General of Mental Defectives, District Inspectors and Official Visitors as necessary.<sup>620</sup> These three roles represented the entire oversight and monitoring mechanism for psychopaedic and psychiatric hospitals until the establishment of the Human Rights Commission, the Children’s Commission and the Health and Disability Commission in the 1990s.

### **Kaimatawai Hauora Matua, kaimatawai a rohe, manuhiri okawa Inspector-General of Health, District Inspectors and Official Visitors**

476. The Inspector-General of Mental Defectives was responsible for the general administration of the Mental Defectives Act.<sup>621</sup> This included the provision of all public mental health and disability services as well as the oversight and monitoring of those services.

477. District inspectors were acknowledged in a 1983 policy proposal as “one of the few legislative safeguards available to patients in the mental health system.”<sup>622</sup> This safeguard was applied inconsistently and with little direction from the Department of Health. Phil Comber, a former district inspector of Kimberley Hospital in Taitoko Levin, explained that before the Mental Health (Compulsory Assessment and Treatment) Act 1992, the role of the district inspector was quite vague:

*“... it wasn’t specified what it was you were supposed to do. You worked it out for yourself.”<sup>623</sup>*

619 Report of Human Rights Commission on representations by the Auckland Committee on Racism and Discrimination (1982, page 5).

620 Mental Defectives Act 1911, section 41(1).

621 Mental Defectives Act 1911, section 42 (1).

622 Ministry of Health, New policy proposal – New initiative, (1983, page 1).

623 Witness statement of Phil Comber (18 August 2022, page 2).

478. The Inquiry saw evidence that when district inspectors raised concerns these were not always taken seriously. A letter from district inspector David Bates on Tokanui Psychiatric Hospital near Te Awamutu to the Minister of Health included concerns that nothing was being done to improve conditions at Tokanui. The letter noted that:

***“despite many inspection reports ... there was no tangible evidence of progress with respect to provision of quality in-patient mental health care in this region.”***<sup>624</sup>

479. Patients were not always aware of the role of district inspectors or how to access them. In 1979 the deputy director-general of health acknowledged that:

***“in most cases psychiatric hospitals take no special steps to ensure that patients are aware of their right of access to the District Inspector.”***<sup>625</sup>

480. Pākehā survivor Ms ON, who spent time at Claybury House at Kingseat Hospital in Karaka in the 1990s, explained:

***“I had never considered that there were people out there whose job description included keeping us safe. I had no idea that people like the District Inspector were not expected to simply field complaints; they were supposed to be actively involved in inspecting the premises and making sure patients were not being abused.”***<sup>626</sup>

481. At the beginning of the Inquiry period, the role of official visitors in monitoring psychiatric and psychopaedic hospitals was already well-established, having been provided for in legislation since 1846.<sup>627</sup>

482. Official visitors could visit any hospital in the area they were responsible for, without previous notice and as often as they thought fit,<sup>628</sup> but had to do so at least once every three months<sup>629</sup> and this increased to once a month for inpatients in 1992.<sup>630</sup>

624 Letter from the District Inspector of Tokanui Hospital, David Bates, to the Minister of Health (22 December 1994, page 1).

625 Letter from the Deputy Director-General of Health to Chief Executives of Health Boards (29 November 1979, page 2).

626 Witness statement of Ms ON (11 May 2022, para 500).

627 Lunatics Ordinance 1846; Mental Defectives Act 1911, sections 70–78; Mental Health Act 1969, sections 5 and 56–65; Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 94–98; Prebble, K, Gooder, C, & Thom, K, New Zealand's Mental Health District Inspector in historical context: “The impartial scrutiny of a citizen of standing”, the Journal of Law, Medicine & Ethics 22(2) (2014, page 416).

628 Mental Defectives Act 1911, section 70 (2); Mental Health Act 1969, section 56 (2); Mental Health (Compulsory Assessment and Treatment) Act 1992, section 96 (2).

629 Mental Defectives Act 1911, section 70 (1); Mental Health Act 1969, section 56 (1); Mental Health (Compulsory Assessment and Treatment) Act 1992, section 96 (1).

630 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 96 (1)(a).

483. In 1982 the Director of Mental Health described official visitors as a “community ‘watchdog’ on behalf of patients”, who had “visible independence from the hospital and public service”, and provided advocacy for the patient when appropriate and acted as “a further safeguard against the dangers of institutionalization”.<sup>631</sup> Official visitors could escalate issues they observed in the hospital or that patients raised. They also reviewed how patient complaints were managed and provided recommendations to hospital management to improve this process.<sup>632</sup>
484. Official visitors’ reports highlighted issues to hospital management like neglect and inadequate facilities, including a lack of wheelchairs, people being confined to beds, a lack of privacy in the toilets, and poor-quality food.<sup>633</sup>
485. In 1974, following the transfer of responsibility for psychiatric hospitals from the Department of Health to hospital boards in 1972, official visitors were no longer considered necessary and the Department recommended they be discontinued. Only Sunnyside Hospital in Ōtautahi Christchurch and Lake Alice Child and Adolescent Unit in Rangitīkei continued to appoint official visitors because they still fell under the control of the Department.<sup>634</sup> Official visitors were then reinstated after the 1983 Gallen Inquiry found that “the presence of an official visitor who was readily available and conducted formal inspections would be a major and significant safeguard”.<sup>635</sup>
486. There were various issues with the effectiveness of official visitors, such as patients being unaware of their existence<sup>636</sup> or viewing them as part of the hospital system.<sup>637</sup> Hospital management sometimes took a hostile approach to official visitors’ reports and recommendations. For example, in 1986 an official visitor for Tokanui Psychiatric Hospital near Te Awamutu noted that the response to matters she raised varied:
- “In some areas it is excellent, yet in others there is difficulty in making a report without provoking what appear to be unreasonable responses.”***<sup>638</sup>
487. The lack of independence, definition and direction for both the district inspector and official visitor roles reduced the potential effectiveness of these roles and contributed to abuse in care.

631 Circular Letter No 1982/169 from the Director of Mental Health to the Chief Executives of Hospital Boards, re: Official visitors to psychiatric and psychopaedic hospitals (15 November 1982, pages 1–2).

632 Official visitor’s report on a complaint made by a patient (30 June 1987, pages 1–2).

633 Letter from Official Visitor to Tokanui Medical Superintendent re: Concerning official visits 9 October 1985 and 22 October 1985 (23 October 1985).

634 Circular Letter No 1982/169 from the Director of Mental Health to the Chief Executives of Hospital Boards, re: Official visitors to psychiatric and psychopaedic hospitals (15 November 1982).

635 Gallen, R, Report of the Committee of Inquiry into Procedures at Oakley Hospital and Related Matters (January 1983, page 136).

636 COPING, An investigation into psychiatric care – Part 1, (COPING: A women’s mental health group, 1981, page 19); Letter from the Director of Mental Health to the Chief Executives of Hospital Boards regarding official visitors (7 November 1985, page 1).

637 COPING, An investigation into psychiatric care – Part 1 (COPING: A women’s mental health group, 1981, page 19).

638 Official visitor’s report to the Medical Superintendent of Tokanui Hospital, re: three monthly report, September 19 to December 18 1986 (22 December 1986, page 2).



## **Te Toihau Hauora Hauātanga Health and Disability Commissioner**

488. In 1994, the Health and Disability Commissioner Act was enacted to establish the role of an independent Health and Disability Commissioner, establish an independent advocacy service, and provide for a Code of Health and Disability Services Consumers' Rights.<sup>639</sup> The Health and Disability Commission provides nationwide, government-funded, independent advocacy through the Advocacy Service<sup>640</sup> for consumers of health and / or disability services who want to make a complaint regarding a breach of their rights under the Code of Health and Disability Services Consumers' Rights. The Advocacy Service was formally established as a free and independent service in 1996. This service operates through a national contract between the director of advocacy in the Health and Disability Commission's (HDC) office (a publicly funded crown entity) and the National Advocacy Trust (the governing body).<sup>641</sup>

### **Ngā mahi aroturuki takinga toko i te ora Oversight and monitoring of social welfare settings**

489. The Child Welfare Act 1925 recognised the need to inspect institutions that were established under that Act and set out who could carry out inspections.<sup>642</sup>
490. Despite this, during the Inquiry period the State failed to properly monitor and oversee the care provided to children and young people in State institutions, family homes and foster homes. This included infrequent and ineffective monitoring visits by social workers and departmental inspectors, and unreliable paper-based monitoring. Until the late 1970s the State failed to ensure there was independent oversight and monitoring of their institutions and when mechanisms were introduced their effectiveness at detecting abuse and neglect was questionable.

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639 Report of the Social Services Committee, Inquiry into the quality of care and service provision for people with disabilities – Presented to the House of Representatives (September 2008, page 35); Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

640 Nationwide Health & Disability Advocacy Service, About us – The Advocacy Process (webpage, n.d.).

641 Nationwide Health & Disability Advocacy Service, About us – The Advocacy Process (webpage, n.d.).

642 Child Welfare Act 1925, section 11.



## **Aroturuki ā-tari ake**

### **Internal monitoring**

491. Internal monitoring mechanisms of residential services by the Department of Education and subsequently the Department of Social Welfare and its successors over the Inquiry period included visits by social workers and head office staff, formal visits and inspection reports by advisors, and principals' annual reports.<sup>643</sup> The evidence the Inquiry received suggests that these mechanisms were focused on adherence with rules and processes, rather than focused on monitoring for issues across the system.
492. In the 1984 Social Work Manual, the Department of Social Welfare recognised "its responsibility and need to be accountable through both external and internal monitoring procedures" and encouraged its officers to welcome any means by which their methods were "evaluated, confirmed and improved".<sup>644</sup>

### **Aroturuki apiha toko i te ora**

#### **Monitoring by social workers**

493. Social workers' visits to children and young people in social welfare care were a critical way of monitoring the standard of care they were receiving and whether there were concerns of abuse or neglect. This function was especially important for children in foster care and family homes because foster parents and family home caregivers were not subject to other forms of oversight and supervision.
494. Social workers should have been a critical lifeline to the outside world for children and young people who were being abused in social welfare care. However, the Inquiry heard from many survivors, as well as former caregivers<sup>645</sup> and social workers,<sup>646</sup> that social workers visited less frequently than departmental policy required them to,<sup>647</sup> and sometimes did not visit at all.<sup>648</sup> State documents reviewed by the Inquiry show that social workers' caseloads were often too high to effectively manage,<sup>649</sup> which meant they visited children less regularly than required.<sup>650</sup>

643 Carson, R, *New horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 78).

644 Department of Social Welfare, *Social Work Manual Volume 2* (1984, Q10.1).

645 Witness statements of Leo and Carla Van de Geer (3 May 2022, para 76) and Marjory van Staaldin (29 August 2022, para 91).

646 Witness statements of Denis Smith (15 December 2021, paras 41–42) and Anthea Raven, (17 October 2022, para 134).

647 Witness statement of Ms HB (9 August 2021, para 28).

648 Witness statements of Kathleen Coster (9 March 2022, para 97) and David Williams (aka John Williams) (15 March 2021, page 10).

649 Ministry of Social Development Historic Claims Team, Transcript of interview with former CYFS supervisor (2 March 2015, pages 3–4).

650 Witness statement of Denis Smith (15 December 2021, para 42).

495. The Inquiry also heard from some survivors who were in foster care that pre-arranged social worker visits allowed foster parents to prepare and present a positive image that didn't accurately reflect their day-to-day experience.<sup>651</sup> Māori survivor Hemi McCallum (Ngāi Tahu, Ngāpuhi), who was in foster care in the early 1970s, told the Inquiry how his social worker visits were "all orchestrated". Social workers did not speak to him alone, and his caregivers would "put on a banquet" and give him new clothes to present a false picture.<sup>652</sup>
496. During the Inquiry's State Institutional Response Hearing, representatives of Oranga Tamariki accepted there were widespread failings where social workers did not monitor the children and young people in their care.<sup>653</sup>

### **Ngā kaimatawai me ngā kaitohutohu ā-tari**

#### **Departmental inspectors and advisors**

497. Departmental inspectors from head office undertook inspections of State residences during the 1970s and 1980s but they lacked regularity, robustness and consistency. Inspections were conducted on notice.<sup>654</sup> Visits typically involved discussions with the principal, interviews with staff and teachers, inspection of the physical premises and examination of the institution's records.<sup>655</sup> No inspection reports that the Inquiry saw referred to inspectors interviewing people in care to understand their experiences. Resident wellbeing and safety were not reported on as discrete topics. From the evidence the Inquiry reviewed, it was unclear whether inspection reports drove any change at head office.
498. Advisors were employed by head office to conduct detailed inspections of the operations of institutions. However, these inspections were rarely carried out due to a lack of staff. A 1982 review noted there was only one residential advisory position in head office, which did not provide the human resources required to visit institutions as frequently as necessary. The review said that the establishment of additional positions was "considered to be necessary to ensure that professional leadership and oversight of the institutions" was achieved.<sup>656</sup>

651 Witness statements of Hemi McCallum (1 December 2021, paras 47–48) and Mereani Harris (17 August 2021, para 20).

652 Witness statement of Hemi McCallum (1 December 2021, paras 47–48).

653 Transcript of Evidence of Nicolette Dickson, Deputy Chief Executive Quality, Practice and Experiences, Oranga Tamariki for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 24 August 2022, page 842).

654 Report of visit to Hokio Beach School (23 February 1982).

655 Social work inspection report of Fareham House (7–9 May 1980, page 1); Social work inspection report of Holdsworth (22 October 1980, page 2).

656 Carson, R, *New horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 79).

## Rīpoata a te Tūmuaki Principal's annual reports

499. The Department required the principal of each institution to provide an annual report.<sup>657</sup> These reports were expected to “have a common format to ensure that essential points are covered, while allowing sufficient scope for Principals to express their primary concerns.”<sup>658</sup> In 1987 the principal of Kohitere Boys’ Training Centre in Taitoko Levin told the Director-General that compiling annual reports was a major task that was seen to be “stupid and of little real value” as they often “bore little resemblance to what actually went on in institutions”. He said that “I hope before I retire, I see a system of inspection emerge that will make me accountable for the overall programme I initiate in a residence”.<sup>659</sup> The Inquiry saw little evidence that annual reports were used by the Department of Social Welfare as an actual monitoring mechanism.<sup>660</sup>

## Kōmiti tūārangi Visiting Committees

500. From 1975 the Minister of Social Welfare could establish visiting committees to enter and inspect each of the institutions.<sup>661</sup> Membership consisted of people from the local community that the Minister deemed suitable.<sup>662</sup> Their role was to be accountable to the public<sup>663</sup> on whether the Department was providing children and young people in residential care with “an acceptable standard of care in suitable surroundings.”<sup>664</sup> During their visits, committee members could speak to any child or young person at that institution and examine their condition, and could report to the Director-General on any matter relating to their visit.<sup>665</sup> However, it was not until 1978 that any visiting committees were appointed.<sup>666</sup>

657 Carson, R, *New horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 79).

658 Carson, R, *New horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 79).

659 Letter from PT Woulfe (Principal, Kohitere) to the Director-General, re: Annual Report (27 August 1980, pages 1–2).

660 Letter from PT Woulfe (Principal, Kohitere) to the Director-General, re: Annual Report (27 August 1980, pages 1–2).

661 Children and Young Persons Act 1974, section 70 (1).

662 Carson, R, *New Horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 81).

663 Notes from Visiting Committee Seminar held at Kingslea on 30 May 1984 (page 6).

664 Carson, R, *New horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 82).

665 Children and Young Persons Act 1974, section 70 (2, 3).

666 Notes from Visiting Committee Seminar held at Kingslea on 30 May 1984 (page 1).

501. Visiting committees had discretion on how frequently they visited residences.<sup>667</sup> This resulted in varying levels of contact, and sometimes no contact at all. In 1980 it was recorded that at Holdsworth School in Whanganui, “[s]ince its setting up the visiting committee has not functioned despite many efforts by the former and present Principal”.<sup>668</sup> The same year the visiting committee for Fareham House in Pae tū Mōkai Featherston was showing “little interest in the institution”, given that one member had visited once for lunch, and one had not visited at all.<sup>669</sup>
502. The role and function of visiting committees wasn’t sufficiently defined, which meant the effectiveness of their monitoring was variable. A 1982 memo from the Director-General to all principals noted that some visiting committees were keeping “a very low profile with little tangible evidence of benefit to the institution for which they were appointed.”<sup>670</sup> A Departmental review published that year found that in some residences, visiting committees had not managed to retain a level of interest. The review recommended legislative amendments to require a clearly defined function, and more regular visits and annual reports from visiting committees.<sup>671</sup>
503. Amendments to the legislation that year made the appointment of visiting committees mandatory for each institution.<sup>672</sup> They were required to visit at least once every three months and provide the Minister with an annual report that was made public.<sup>673</sup> The visiting committee had to ensure that children and young people in the institution were made aware of when their visits would take place and that they could discuss matters with any member of the committee.<sup>674</sup>
504. Even though these amendments strengthened the monitoring role of visiting committees, issues with consistency, quality and accessibility persisted. There was no clear reporting on how many children or young people were seen by visiting committees,<sup>675</sup> and the number of visits and levels of interaction depended on which visiting committee was involved. Infrequent visits were still an issue for some residences, and the principal of Kingslea Girls’ Home in Ōtautahi Christchurch said it was an “enduring frustration” that committee members had not taken their duties seriously.

667 Children and Young Persons Act 1974, section 70 (2)(a).

668 Social work inspection report of Holdsworth (22 October 1980, page 7).

669 Social work inspection report of Fareham House (7–9 May 1980, page 3).

670 Memo from JW Grant (Director-General) to directors/principals, re: Visiting committees (24 December 1982), cited in Parker, W, Social Welfare residential care 1950–1994 Vol. I: National policies and procedures (Ministry of Social Development, 2006, page 47).

671 Carson, R, New horizons: A review of the residential services of the Department of Social Welfare (Department of Social Welfare, 1982, page 82); Parker, W, Social Welfare residential care 1950–1994 Vol. I: National policies and procedures (Ministry of Social Development, 2006, page 46).

672 Children and Young Persons Amendment Act 1982, section 15.

673 Children and Young Persons Amendment Act 1982, section 15.

674 Children and Young Persons Amendment Act 1982, section 15.

675 Parker, W, Social Welfare residential care 1950–1994 Vol. I: National policies and procedures (Ministry of Social Development, 2006, page 46).

505. When there were robust visiting committees, residences reported very positive experiences.<sup>676</sup> For instance, the visiting committee of Miramar Girls' Home in Te Whanganui-a-Tara Wellington were looking out for the wellbeing of residents in 1983 when they notified the Minister of Social Welfare about the poor conditions at the home in their inspection report:
- "We do see the physical environment at the Home as oppressive. We are particularly concerned at the lack of recreation and 'time out' facilities. We are concerned that the girls do not have space in both the physical and mental concept".***<sup>677</sup>
506. Although many survivors the Inquiry interviewed gave evidence about attempting to disclose the nature of their treatment in residential and institutional care, very few indicated that they raised their concerns with members of a visiting committee. In 1984 Mike Doolan noted that a continued concern of the visiting committees was "that they were not being approached by the children with worries or problems."<sup>678</sup> He later reflected that this was probably because residents saw visiting committees as part of the institution's administration, therefore they did not trust them and would never come to them with their problems.<sup>679</sup> Another factor adding to residents' distrust was that visiting committees were often made up of ex-Department of Social Welfare staff.<sup>680</sup>
507. Additionally, many residents still did not know anything about visiting committees. A 1987 audit of Hamilton Boys' Home stated that residents were not aware of the role and function of the visiting committee.<sup>681</sup>

676 Kingslea annual report 1982, cited in Parker, W, Social welfare residential care 1950–1994 Vol. II: National institutions (Ministry of Social Development, 2006, page 271).

677 Report of the Visiting Committee of Miramar Girls' Home (23 November 1983, page 1).

678 Notes from Visiting Committee Seminar held at Kingslea on 30 May 1984 (page 6).

679 Dalley, B & Doolan, M, Child welfare in twentieth century New Zealand oral history project (audio file, 24 June 1996, tape one, side two).

680 Sutherland, O, Justice and race: Campaigns against racism and abuse in Aotearoa New Zealand (Steele Roberts Aotearoa Publishers, 2020, page 104).

681 Parker, W, Social welfare residential care 1950–1994 vol. III: National institutions (Ministry of Social Development, 2006, page 90).

508. In practice, visiting committees appear to have achieved little by way of substantive change and were an ineffective monitoring mechanism.<sup>682</sup> A former staff member of the Department told the Inquiry that although visiting committees could make recommendations, “they couldn’t require anything to happen”.<sup>683</sup> Historian Bronwyn Dalley believes that visiting committees did little to monitor residents’ welfare and failed to report on inappropriate staff conduct, asserting that they did not work properly and “stumbled along until 1987, when they were phased out”.<sup>684</sup> In 1988, following the publication of *Puao-te-Ata-Tū*, they were replaced by Institution Management Committees, which were intended to bring community involvement into the actual management of social welfare settings.<sup>685</sup>
509. Institution Management Committees were comprised mainly of people from the community who had “an interest in the wellbeing of children and young persons”<sup>686</sup> and one representative from the Department.<sup>687</sup> They were appointed by the Minister of Social Welfare to manage and direct the policy for running the institution and ensure that young people received good care and that their social and cultural needs were met while they lived at the institution. To do this the Committee kept in close contact with the institution and reviewed its programmes. Residents could ask to talk to Committee members about any concerns they had.<sup>688</sup>

### **Kaikōmihana mō ngā Tamariki Commissioner for Children**

510. The Commissioner for Children was established as an independent statutory body in 1989.<sup>689</sup> One of its functions was to assess and monitor the policies and practices of the State care system.<sup>690</sup> However, there were restrictions regarding their ability to monitor, including the Commissioner being unable to make adverse comments unless the opportunity to be heard was given.<sup>691</sup>

682 Dalley, B & Doolan, M, *Child welfare in twentieth century New Zealand oral history project* (audio file, 24 June 1996, tape one, side two).

683 Witness statement of Mr PY (6 December 2022, para 195).

684 Dalley, B, *Family matters: child welfare in twentieth century New Zealand* (Auckland University Press, 1998, pages 306–308), cited in Sutherland, O, *Justice and race: Campaigns against racism and abuse in Aotearoa New Zealand* (Steele Roberts Aotearoa Publishers, 2020, page 104).

685 Human Rights Commission, *The use of secure care and related issues in Social Welfare institutions* (June 1989, page 61).

686 Kohitere Resource Centre – Institution Management Committee, *internal policies 1969 to 1989* (page 3).

687 *Historical Notes on the Kingslea Residential Centre, Shirley, Christchurch* (Children & Young Persons Service, 1995, page 8).

688 Kohitere Resource Centre – Institution Management Committee, *internal policies 1969 to 1989* (page 3); *Historical Notes on the Kingslea Residential Centre, Shirley, Christchurch* (Children & Young Persons Service, 1995, page 8).

689 Children, Young Persons and Their Families Act 1989, section 410.

690 Children, Young Persons and Their Families Act 1989, section 411 (1)(b).

691 Children, Young Persons and Their Families Act 1989, section 414; Office of the Children’s Commissioner, *Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 480, Tranche 1* (18 July 2022, page 6).

511. The Office of the Children's Commissioner told the Inquiry that since its inception "it has been chronically underfunded to carry out its monitoring role."<sup>692</sup> As a result, over the years each of the seven consecutive Commissioners have had to be very selective about what and how they monitor. This has limited their ability to effectively monitor the care and treatment of children and young people in care.<sup>693</sup>

## **Ngā mahi aroturuki takinga taiohi ā-ture**

### **Monitoring and oversight of youth justice settings**

512. Youth justice settings, like borstals and corrective training institutions, were governed by the same laws<sup>694</sup> and regulations<sup>695</sup> that applied to adult prisons. Penal institutions were the responsibility of the Department of Justice's Penal Division until it was disestablished in 1995 and the Department of Corrections took over the role.<sup>696</sup>
513. Responsibility for providing monitoring and oversight of people in youth justice care sat with the Inspector of Penal Institutions and Visiting Justices. Both had discretion regarding how often they visited penal institutions.<sup>697</sup> From evidence reviewed by the Inquiry it appears that the time between the Inspector of Penal Institution's visits ranged from about every four years<sup>698</sup> to eight years or more and varied for different institutions.<sup>699</sup>
514. During their visits the Inspector of Penal Institutions looked at things like numbers in the prison, staffing, staff training, supervision, food and facilities.<sup>700</sup> While Inspectors' reports didn't have a specific section on inmate wellbeing, they did identify issues like overcrowding<sup>701</sup> and unnecessarily "cold" secure environments.<sup>702</sup>

692 Office of the Children's Commissioner, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 480, Tranche 1 (18 July 2022, pages 25 & 27).

693 Office of the Children's Commissioner, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 480, Tranche 2 (22 July 2022, page 29).

694 Prisons Act 1908; Penal Institution Act 1954; Penal Institutions Amendment Act 1980.

695 Penal Institutions Regulations 1961.

696 Affidavit of Tina Marie Wakefield for the Ministry of Justice under Notice to Produce 10 (23 September 2020, paras 5–6).

697 Penal Institutions Act 1954, sections 10 (3)(a) and 4 (5)(2).

698 Inspector of Penal Institutions' Inspection Report on Waikeria Youth Centre, date of inspection: 19–23 April 1971, date of previous inspection: 27–29 June 1966 (Department of Justice, page 5); Inspector of Prisons' Inspection Report on Waikeria Youth Centre, date of inspection: 30 June – 3 July 1975, previous inspection: 19–23 April 1971 (Department of Justice, page 4).

699 Inspector of Prisons' Inspection Report on Arohata Borstal Institution, date of inspection: 14–16 June 1966, date of previous inspection: 16 September 1957 (Department of Justice, page 3); Inspector of Penal Institutions' Inspection Report on Arohata Borstal Institution, date of inspection: 16–18 October 1974, date of previous inspection: 14–16 June 1966 (Department of Justice, page 3); Inspector of Prisons' Inspection Report on Waikeria Youth Centre, date of inspection: 27–29 June 1966, date of previous inspection: 5–8 October 1954 (Department of Justice, page 8).

700 Inspector of Penal Institutions' Inspection Report on Waikeria Youth Centre (Department of Justice, 19–23 April 1971).

701 Inspector of Penal Institutions' Inspection Report on Waikeria Youth Centre (Department of Justice, 19–23 April 1971, page 1).

702 Inspector of Penal Institutions' Inspection Report on Arohata Borstal Institution (Department of Justice, 16–18 October 1974, page 7).

515. Any inmate could request to speak to the Inspector or a Visiting Justice on a one-on-one basis.<sup>703</sup> However, to request this the inmate had to engage with staff so the superintendent could put their name on a list.<sup>704</sup> Survivors consistently told the Inquiry that a 'no narking' culture operated in youth justice facilities.<sup>705</sup> Therefore, raising complaints through staff did not feel like a viable option for many survivors.
516. Survivors in youth justice settings were not always aware of these monitoring bodies. Māori and Pākehā survivor Jonathon Stevenson (Kāti Māmoe, Kāi Tahu), who was sent to Waikeria Borstal near Te Awamutu when he was 15 years old, told the Inquiry that he felt as though there was no one to complain to, because "[t]hey didn't tell us about the Office of the Ombudsman or about the prison inspector". He explained that if they wanted to make a complaint, they had to ask staff for a form and tell them what it was about. If they did not tell them then they were told to go away.<sup>706</sup>
517. Only one survivor told the Inquiry that they were seen by a visiting justice. Māori survivor Dion Waikato (Te Arawa, Tūhoe) was placed in Dunedin Prison when he was aged 16. Because he was too young to be with the adults in the mainstream prison population, he was supposed to be in the prison's segregation wing. He said that:

***"... every time a visiting justice would visit Dunedin Prison, I would be locked back down again in segregation. The visiting justice would come and see me and see that I'm sane and that I'm not going to commit suicide and then he would leave. Then the guards would come and unlock me and tell me to go back to mainstream."***<sup>707</sup>

703 Penal Institutions Act 1954, sections 5 and 10; Department of Corrections, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 440 (13 June 2022, para 10.2).

704 Penal Institution Regulations 1961, 74(1–2).

705 Witness statements of Toni Jarvis (12 April 2021, para 180); Brian Moody (4 February 2021, para 88) and Ms HA (22 September 2021, para 95).

706 Witness statement of Jonathon Stevenson (29 March 2022, paras 113–114).

707 Witness statement of Dion Waikato (21 November 2022, para 9.6).



518. The Minister of Justice could appoint a visiting committee for any borstal<sup>708</sup> of no more than seven people.<sup>709</sup> Visiting committees could inquire into any matter referred to them by the Secretary of Justice.<sup>710</sup> Evidence reviewed by the Inquiry relating to visiting committee interviews held at Arohata Borstal in Te Whanganui-a-Tara Wellington in 1953 and 1954 indicated monthly visits,<sup>711</sup> where interviews could be with new inmates,<sup>712</sup> people who asked for an interview<sup>713</sup> and people involved in disciplinary proceedings.<sup>714</sup> Visiting committees at Arohata Borstal produced at least one annual report.<sup>715</sup> A 1970 report from Invercargill Borstal in Waihopai Invercargill notes that their visiting committee met bi-monthly and members took “a keen interest in the institution”.<sup>716</sup>
519. Evidence received by the Inquiry shows that the monitoring and oversight mechanisms in youth justice settings produced some positive recommendations to help improve conditions for inmates, but it is unclear whether these were effective in preventing, detecting and responding to abuse.

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708 Penal Institutions Act 1954, section 11 (1).

709 Penal Institutions Regulations 1961, regulation 7 (1).

710 Penal Institutions Regulations 1961, regulation 7 (3) (b).

711 Report for the month of December 1953 from Lorimer, A E (superintendent, Arohata Borstal Institution) to the Secretary for Justice, page 2).

712 Report for the month of August 1954 from Lorimer, A, E (superintendent, Arohata Borstal Institution) to the Secretary for Justice (5 September 1954, page 3).

713 Report for the month of July 1954 from Lorimer, A, E (superintendent, Arohata Borstal Institution) to the Secretary for Justice (31 July 1954, page 3).

714 Report for the month of December 1953 from Lorimer, A, E (superintendent, Arohata Borstal Institution) to the Secretary for Justice (page 2).

715 Report for the month of March 1953 from Lorimer, A, E (superintendent, Arohata Borstal Institution) to the Secretary for Justice (page 3).

716 Invercargill Borstal Institution, Six-Monthly Report: 1 January 1970–30 June 1970 (Department of Justice, page 4).

## Kaitaki atawhai ā-pae tuatoru

### Third-party care providers

520. From 1927 to 1989, the State was able to enter children's homes that were administered by voluntary agencies to inspect the premises and check on the state and condition of the children and young people living there.<sup>717</sup> This was undertaken by inspectors within head office of the Department of Education and subsequently the Department of Social Welfare and its successors. However, these inspections were not mandatory and there was no requirement to report findings to the relevant Minister, the Secretary of Education or the Director-General of Social Welfare and their successors.<sup>718</sup>
521. In the late 1980s the Department of Social Welfare began to move away from the provision of institutional care for children and young people and towards using more community-based organisations to provide care for them.<sup>719</sup> The Children, Young Persons, and Their Families Act 1989 allowed the Director-General (and later the Chief Executive) to approve third-party care providers under section 396 of the Act.<sup>720</sup> Once approved, the Director-General could use section 396 providers as a placement for children or young people under the care, custody or guardianship of the Director-General.<sup>721</sup> This provided for the section 396 provider to provide for that child's or young persons's care and upbringing and have control over them.

## Tari Hautū Tahua ā Hāpori o Aotearoa

### The New Zealand Community Funding Agency

522. In 1992 the New Zealand Community Funding Agency was established as a business unit within the Department of Social Welfare. They were responsible for the approval, funding, oversight and monitoring of section 396 providers.<sup>722</sup> The Agency had to conduct annual assessments of section 396 providers (otherwise known as third-party care providers) to ensure standards were maintained and those providers could continue providing care.<sup>723</sup> To make sure the Agency had enough information for their assessments they were required to monitor section 396 providers regularly.<sup>724</sup>

717 Child Welfare Amendment Act 1927, section 11; Children and Young Persons Act 1974, section 92; Directory of residential facilities for disturbed children in New Zealand (Department of Social Welfare, 1979, page 2).

718 Carson, R, *New horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 82).

719 *Residential Services: National Profile* (Department of Social Welfare, 1990, para 1.3).

720 Children, Young Persons and Their Families Act 1989, section 396.

721 Children, Young Persons and Their Families Act 1989, section 362 (repealed).

722 Brief of evidence of Barry John Fisk for the Inquiry's State Institutional Response Hearing (8 August 2022, Tab A: A History of Te Kāhui Kāhu, page 1); Brief of Evidence of Barry John Fisk for the Inquiry's State Institutional Response Hearing (8 August 2022, paras 5.8–5.13).

723 New Zealand Community Funding Agency, *Standards for Approval Level one: Child and Family Support Services* (November 1995, pages 6–7).

724 New Zealand Community Funding Agency, *Standards for Approval Level one: Child and Family Support Services* (November 1995, page 8).

523. Monitoring visits were conducted by Community Funding Agency outreach workers.<sup>725</sup> They had to determine whether children and young people were receiving adequate care and make sure they were not being subjected to physical, degrading or humiliating discipline.<sup>726</sup> While onsite, outreach workers were required to talk to staff and where appropriate the children and young people who were placed there. They also had to examine documents and casework records relating to the children and young people.<sup>727</sup> In situations where the Community Funding Agency had serious concerns about the provider's ability to continue to meet the standards and keep children and young people safe, they could suspend or revoke their section 396 approval status.<sup>728</sup>
524. State documents reviewed by the Inquiry show failures by the Community Funding Agency to oversee and monitor third-party care providers.
525. Moerangi Treks was a "specialist youth residential rehabilitation programme in a wilderness setting".<sup>729</sup> It operated from two remote locations, one near Ruatoki in the Urewera National Park and the other on the coast at Omaio.<sup>730</sup> Moerangi Treks was designed to provide a safe environment for socially disadvantaged male youth, based on tikanga principles.<sup>731</sup>
526. The programme started providing residential care for young people referred by Children and Young Persons Service offices in July 1993.<sup>732</sup> In August 1997 the Community Funding Agency granted Moerangi Treks section 396 approval as a Child and Family Support Service under their standards.<sup>733</sup> However, before this in 1995 the Children and Young Persons Service received a complaint from a young person who attended Moerangi Treks that they were subjected to serious assaults from staff and residents at the programme.<sup>734</sup> It is unclear whether the Community Funding Agency considered this complaint when assessing whether to grant approval for Moerangi Treks.

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725 Brief of Evidence of Barry John Fisk for the Inquiry's State Institutional Response Hearing (8 August 2022, Tab A: A History of Te Kāhui Kāhu, page 1).

726 New Zealand Community Funding Agency, Standards for Approval Level one: Child and Family Support Services (November 1995, page 28).

727 New Zealand Community Funding Agency, Standards for Approval Level one: Child and Family Support Services (November 1995, page 8).

728 New Zealand Community Funding Agency, Standards for Approval Level one: Child and Family Support Services (November 1995, pages 8–9); Children, Young Persons and Their Families Act 1989, section 399.

729 Letter from Yvonne McLean (Area Manager, Community Funding Agency) to Mr Rapaera Black (Director, Moerangi Treks, re: Moerangi Treks Level One Standards for Approval (25 August 1997, page 3).

730 Ministry of Social Development Internal Memo from Garth Young (National Manager, Care Claims and Resolution) to Peter Hughes (Chief Executive, re: Approval of settlement offers (5 March 2010, para 28).

731 Moerangi Treks deed of trust (7 January 1997).

732 Letter from Yvonne McLean (Area Manager, Community Funding Agency) to Mr Rapaera Black (Director, Moerangi Treks), re: Moerangi Treks Level One Standards for Approval (25 August 1997, page 3).

733 Letter from Yvonne McLean (Area Manager, Community Funding Agency) to Mr Rapaera Black (Director, Moerangi Treks), re: Moerangi Treks Level One Standards for Approval (25 August 1997, page 2).

734 Letter from Graeme Vincent (Manager, CYPS) to Area Manager (Youth Justice, Grey Lynn, re: Moerangi Trek – Complaint of ill-treatment (3 July 1995, page 1).

527. In December 1997, young people at Moerangi Treks made allegations of physical abuse and neglect.<sup>735</sup> The New Zealand Children and Young Persons Service conducted an investigation that found evidence that suggested physical abuse was a regular occurrence at Moerangi Treks and that the abuse was “inflicted by staff members and other clients on the programme”. Abuse included a staff member hitting a young person around the head with a gun and choking them by tying a rope around their neck.<sup>736</sup> The Children, Young Persons and their Families Service informed Moerangi Treks that this was a breach of Standard 11 of their Level 1 Approval, which required that “Children and young persons are not physically punished, or disciplined or treated in way that is degrading or humiliating or causes unreasonable fear or anxiety. Alternative methods of discipline are employed.”<sup>737</sup>
528. In May 1998, the Community Funding Agency suspended Moerangi Treks’ approval as a Child and Family Support Service under section 399 of the Act.<sup>738</sup> However, the operators of the programme failed to respond to the suspension, so their approval was formally revoked in December 1998.<sup>739</sup>
529. During the operation of Moerangi Treks it is unclear what oversight the Community Funding Agency had and whether their outreach worker conducted monitoring as required under the Standards. Mr QS, who worked for child welfare services for 28 years, told the Inquiry that he is unaware of whether the Community Funding Agency undertook any monitoring of Moerangi Treks.<sup>740</sup>
530. In October 1998 the Community Funding Agency approved Eastland Youth Rescue Trust (Eastland Trust) as a Child and Family Support Service. It operated from a bush camp near Omaio and was run by one of the directors of Moerangi Treks.<sup>741</sup> The Children, Young Persons and their Families Service were aware of the issues at Moerangi Treks and told their staff that safeguards had been put in place to minimise the risk to young people. This included the requirement that social workers contact their clients on the programme once every two weeks.<sup>742</sup>

735 Letter from Wendy Reid (General Manager) to Philip Marshall (Chair Person, Moerangi Treks, re: Allegations of physical abuse and concerns of neglect (29 May 1998, appended: Sorrenson, D, Broadhurst, C & Taylor, R, Report into allegations of mistreatment at Moerangi Treks, pages 1 and 4).

736 Letter from Wendy Reid (General Manager) to Philip Marshall (Chair Person, Moerangi Treks, re: Allegations of physical abuse and concerns of neglect (29 May 1998, appended: Sorrenson, D, Broadhurst, C & Taylor, R, Report into allegations of mistreatment at Moerangi Treks, pages 7–8).

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738 Letter from Wendy Reid (General Manager) to Philip Marshall (Chair Person, Moerangi Treks, re: Allegations of physical abuse and concerns of neglect (29 May 1998, appended: Sorrenson, D, Broadhurst, C & Taylor, R, Report into allegations of mistreatment at Moerangi Treks, page 1).

739 Ministry of Social Development Internal Memo from Garth Young (National Manager, Care Claims and Resolution) to Peter Hughes (Chief Executive), re: Approval of settlement offers (5 March 2010, para 35).

740 Witness statement of Mr QS (8 September 2022, para 23).

741 Letter to Group Manager (Service Delivery, re: Eastland Youth Rescue CFSS (12 May 1999, page 1); Memorandum to CYPFS Area and Site Managers, re: Eastland Youth Rescue Trust (15 October 1998, page 1).

742 Memorandum to CYPFS Area and Site Managers, re: Eastland Youth Rescue Trust (15 October 1998, page 3).

531. However, the Community Funding Agency failed to provide sufficient oversight of the programme and the additional safeguarding measures did not prevent abuse from happening. A young person first complained of abuse in December 1998 and then another in January 1999.<sup>743</sup> After an investigation, the Community Funding Agency allowed Eastland Trust to continue operating with requirements such as having a monitoring support person to maintain regular ongoing contact with the programme and reiterating the requirement for social workers to maintain contact with their clients.<sup>744</sup> State documents show that staff at Eastland Trust were “not responsive to the outreach worker’s attempts to arrange meetings to monitor the implementation of the required changes”.<sup>745</sup>
532. In May 1999, Samoan survivor Mr VT complained that he had been “physically and sexually and otherwise ill-treated at Eastland Trust”.<sup>746</sup> The Department suspended Eastland Trust’s approval while the complaint was investigated,<sup>747</sup> but it appears that some boys remained at Eastland Trust.<sup>748</sup> Following the investigation the Department was not satisfied that Eastland Trust had provided or would provide “proper standards of care to children and young persons placed in its custody” and revoked their approval as a section 396 provider in October 1999.<sup>749</sup>
533. Debbie Power, the Chief Executive of the Ministry of Social Development, told the Inquiry she agreed there was a need for oversight when a director of Moerangi Treks who was alleged to have committed abuse was then contracted again by the State at Eastland Trust.<sup>750</sup>
534. The Inquiry’s investigation into Te Whakapakari Youth Programme also highlighted the failings of the Community Funding Agency in carrying out its oversight and monitoring role.

743 Letter to Group Manager (Service Delivery), re: Eastland Youth Rescue CFSS, (12 May 1999, page 2).

744 Report on allegations of physical abuse at Eastland Youth Rescue Trust (14 January 1999, page 9).

745 Summary of Investigation at Eastland (n.d., page 13).

746 Letter to Group Manager, Service Delivery, re: Eastland Youth Rescue (12 May 1999, page 1).

747 Email from Julie Fido (Department of Social Welfare) to Verna Smith (Department of Social Welfare), re: Eastland trust (24 May 1999, page 1); Report on Eastland Youth Rescue Trust – suspension and breach of standards (20 July 1999, page 1).

748 Email from Joanne Hempleman to Don Sorrenson, subject: interview with [redacted], (23 June 1999); Email from Catherine Bennett to Ken Rand, Ai-Bee Tan and Verna Smith, FWD: Eastland – letter to Opotiki Police (13 July 1999).

749 Letter from Verna Smith (General Manager, Contracting Group, Child, Youth and Family) to The Trustees, Eastland Youth Rescue Trust, re: revocation of approval (20 October 1999).

750 Transcript of evidence of Debbie Power, Chief Executive of the Ministry of Social Development, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 15 August 2022, page 40).

## Ratonga, tamariki, rangatahi me ō rātou whānau Children, Young Persons and their Families Service

535. The Children, Young Persons and their Families Service, a business unit with the Department of Social Welfare, was responsible for monitoring the safety and wellbeing of children and young people in their care. For example, social workers made the decision to place children and young people in the care of third-party providers and had the role of carrying out the monitoring function.
536. Social workers were required to visit their clients every four months<sup>751</sup> and in 1996 this increased to every two months.<sup>752</sup> However, some survivors told the Inquiry that they never saw or spoke to their social worker while they were in the care of third-party providers.<sup>753</sup> A Community Funding Agency report in 1999 noted that social worker visits at Te Whakapakari Youth Programme on Aotea Great Barrier Island were “non existent”, but some did make contact by phone.<sup>754</sup>

## Ngā mahi aroturuki takinga mātauranga Oversight and monitoring of education settings

537. Between 1950 and 1989, the Director of Education (and subsequently the Chief Executive of the Ministry of Education) oversaw the administration and monitoring of the primary and secondary schooling systems through the Department of Education, under the Education Acts 1914, 1964 and 1989.
538. From the beginning of the Inquiry period until 1989, inspectors of schools visited and reported on all primary and secondary schools (private and State),<sup>755</sup> including assessing teacher performance in State schools.<sup>756</sup> Inspections were carried out with few guidelines.<sup>757</sup> Inspectors of schools were officers of the Department of Education, attached to Education Boards. The Education Act 1964 loosened this requirement and private schools only had to be inspected at least once every three years.<sup>758</sup>

751 Department of Education, Child Welfare Division Social Workers Manual (1970–1984, H9.14, J9.35).

752 Child, Youth and Family, Care and Protection Handbook 1996 – Volume Two (1996, section 9–40).

753 Witness statements of Mr V (February 2021, para 103); Scott Carr (7 March 2022, para 46) and Mr PJ (9 November 2021, para 173).

754 Community Funding Agency Level One Standards Approval, re: Whakapakari Youth Trust (February 1999, page 3).

755 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, pages 4–5).

756 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 5).

757 Transcript of evidence of the Education Review Office at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 August 2022, page 456).

758 Education Act 1964, section 186.

539. There were two types of inspections: personal inspections, which focused on individual teachers' effectiveness to teach, and school inspections, which focused on "making sure adequate standards of teaching and effective learning were being achieved."<sup>759</sup> School inspections included "ensuring the 'sympathetic and enlightened treatment of children!'"<sup>760</sup> Following each inspection, inspectors were to provide a copy of their report to either the Education Board (for a public primary school), or the School Board of Governors (for a secondary school), as well as the Department of Education.<sup>761</sup> However, the Director of Primary Education stated in a memorandum to the District Senior Inspector of Primary Schools that despite several years of requests, district senior inspectors had not been providing head office with copies of their inspection reports on all special schools. This included schools for Deaf and disabled children, schools in Department of Social Welfare Institutions, psychiatric and psychopaedic hospitals, health camps and education services in Department of Justice institutions.<sup>762</sup>
540. The Tomorrow's Schools Reforms in 1989 shifted monitoring functions for state and state-integrated schools that the Department of Education had been responsible for to a new independent regulatory agency, the Education Review Office.<sup>763</sup> The Education Review Office's role is to evaluate and publicly report on the education and care of children and young people in early childhood services and schools. The majority of the Education Review Office's reviews are regular, although occasionally they will conduct a review on a particular matter of concern or as directed by the Minister of Education.<sup>764</sup>
541. The Ministry of Education told the Inquiry that from 1989 it had some oversight but little direct influence on what happened day-to-day in private schools.<sup>765</sup> As with boards in State and State-integrated schools, the managers of private schools set the strategic direction for their schools and adopted internal policies and procedures. The boards oversaw the management of staff, finance, property, the curriculum, and administration of the school.<sup>766</sup>
542. The Ministry of Education acknowledged that the statutory oversight regime for private schools and residential special schools established by faith-based institutions was restricted to the concept of 'efficiency' (as detailed in the paragraphs below), meaning that the oversight was more focused on the adequacy of curricula, staff numbers and qualifications, and school property.<sup>767</sup>

759 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 118).

760 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 118).

761 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 118).

762 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, pages 118-119).

763 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 5).

764 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 422 (17 June 2022, page 5).

765 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 468 (7 July 2022, page 19).

766 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 468 (7 July 2022, page 19).

767 Ministry of Education, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 468 (7 July 2022, page 13).

543. The sole sanction available to the Ministry of Education to penalise private schools that ceased to operate efficiently was to deregister them.<sup>768</sup>
544. At the Inquiry's State Institutional Response Hearing, the Ministry of Education acknowledged that historically it had less oversight of private schools than State or State-integrated schools, and this may have provided opportunities for abusers.
545. In 1997, the Education Review Office told the Secretary and Minister for Education that children in hostels were particularly vulnerable, that some hostels were unsafe with issues of illegal behaviour including sexual abuse, harassment, threatening behaviour, assault and bullying, and that the abuse suffered in hostels could have "lifelong effects on the emotional and physical well-being of students."<sup>769</sup> The Education Review Office emphasised the State's responsibility to ensure children in private schools and hostels were safe. Although the Minister had the power to regulate hostels and boarding schools, the response to the report was for the Ministry of Education to release Circular 1997/12 (The Responsibilities of Boards of Trustees for the Personal Safety of Students in Schools). It was not until 2005 that the Education (Hostels) Regulations were introduced.<sup>770</sup>

### **Ngā mahi aroturuki takinga whakatika, mauhere ā-ture**

#### **Oversight and monitoring of transitional and law enforcement settings**

546. Responsibility for oversight and monitoring of children, young people and vulnerable adults that were placed in police cells, police custody, court cells and transportation on the way to, between, or out of State care facilities predominantly sat with NZ Police.
547. There were times when responsibility sat with the Department of Corrections (or its predecessor, the Department of Justice's Penal Division). If, for example, a sentenced prisoner appeared in Court as a witness or a victim for a matter that wasn't related to their sentence, they would be transported to Court and supervised in Court cells by Corrections staff. Responsibility for transporting prisoners from Court-remanded custody to psychiatric hospitals sat with NZ Police.<sup>771</sup>

<sup>768</sup> Education Amendment Act 1921, section 7; Education Act 1964 (No 135, section 186 (7); Education Act 1989, section 2.

<sup>769</sup> Brief of Evidence of Nicholas John Pole, Education Review Office, for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 8 August 2022, page 13); Educational Review Office, Students in boarding schools: Their safety and welfare (April 1997, page 4).

<sup>770</sup> Brief of Evidence of Nicholas John Pole, Education Review Office, for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 8 August 2022, page 13).

<sup>771</sup> NZ Police Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 9 (31 July 2020, para 23).



548. NZ Police told the Inquiry that they have “a limited role as a care provider” because their facilities are used for “holding” people between the time that they are arrested and bailed, or when appearing in Court. NZ Police also hold children and young people for Oranga Tamariki (as well as earlier for the predecessors of Oranga Tamariki) and people experiencing mental distress pending their assessment.<sup>772</sup> NZ Police Youth Aid officers also had considerable interactions with children and young people through their Juvenile Crime Prevention Branch from 1957, which was renamed the Youth Aid Section in 1968.<sup>773</sup> Police Commissioner Andrew Coster explained that NZ Police’s duty of care starts from the time that someone comes into their custody through to the time they are handed over to another carer.<sup>774</sup>
549. Although placements in these settings were only meant to be for a short time, the Inquiry heard that some survivors were there for a couple of days<sup>775</sup> and some for a week<sup>776</sup> or longer.<sup>777</sup> These environments were not designed for long term care and the Police Commissioner explained that “the nature of Police cells and the other people who come to be in those general areas means that they will never be suitable places for young people”.<sup>778</sup> This unsuitability means that children, young people and vulnerable adults placed in law enforcement and transitional care are inherently vulnerable and require robust oversight and continued monitoring to ensure their safety and wellbeing is protected.
550. Monitoring of these settings was conducted internally by NZ Police, and their procedures were governed by their Manual of General Instructions.<sup>779</sup> It is unclear exactly what NZ Police’s internal monitoring involved.
551. Survivors told the Inquiry that while they were in NZ Police cells, they “didn’t see sunlight or go outside for two weeks”,<sup>780</sup> and they were kept in a “cold, concrete spit-infested cell” and the isolation affected their wellbeing.<sup>781</sup> Another spoke of being held in a NZ Police cell until they confessed, with no access to a lawyer, and with food withheld and being physically abused.<sup>782</sup>

772 Brief of Evidence of Police Commissioner Andrew Coster for the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 16 August 2022, para 6.1).

773 NZ Police, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 494 (15 July 2022, para 5.2).

774 Transcript of Evidence of Police Commissioner Andrew Coster at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 16 August 2022, page 110).

775 Witness statements of Dallas Williams (15 July 2021, paras 41–42) and Bernie Pitman (3 October 2022, para 20).

776 Witness statement of Mr CA (17 September 2021, para 73).

777 Witness statement of Mr TK (13 July 2022, paras 1.89–1.92).

778 Transcript of evidence of Police Commissioner Andrew Coster at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 16 August 2022, page 120).

779 NZ Police, Manual of General Instructions (1980).

780 Witness statement of Mr TK (13 July 2022, para 1.91).

781 Witness statement of Mr CA (17 September 2021, para 74).

782 Witness statement of Lindsay Eddy (24 March 2021, paras 130–135).

552. The Independent Police Conduct Authority (IPCA) was established as Aotearoa New Zealand's first Police oversight body in 1989.<sup>783</sup> They can receive complaints alleging any misconduct or neglect of duty by any NZ Police employee, or concerning any practice, policy or procedure of the NZ Police affecting the person making the complaint.<sup>784</sup> The IPCA can also initiate an investigation if satisfied that there are reasonable grounds that it's in the public interest or if the Police Commissioner notifies them of any incident involving death or serious bodily harm.<sup>785</sup>

## **Ngā mahi aroturuki takinga pūnaha taurima ā-whakapono** **Oversight and monitoring of faith-based care settings**

553. During the Inquiry period, there was little oversight and monitoring of faith-based settings. The oversight requirements that did exist in legislation were often poorly enforced by the State and the faith-based institutions and had little impact on the experiences of those in care.

554. The State had a responsibility to ensure that practices in faith-based institutions – many of which were registered care and education settings receiving State funding – were appropriate. Yet State monitoring and oversight and regulation of faith-based care settings has been largely inadequate. The State delegated its care responsibilities to faith organisations without sufficiently ensuring the quality of care being provided was appropriate.

555. In children's homes and other residential settings such as women's homes, survivors explained they did not receive visits from social workers.<sup>786</sup> Institutional witnesses told the Inquiry that the State largely took a 'hands-off' approach after it placed children into faith-based care, trusting churches to act in the best interests of those in their care, as outlined in the examples below.

556. The Inquiry heard that although many of the children at the Berhampore Home (Presbyterian) in Te Whanganui-a-Tara Wellington were State wards, there was nothing in the records to suggest that the Department of Social Welfare was monitoring their wellbeing. Patrick David Waite, former Chief Executive Officer of Presbyterian Support Central, told the Inquiry:<sup>787</sup>

***"I haven't seen any of that [evidence of Department of Social Welfare monitoring or oversight of the wellbeing of State wards at Berhampore] in the papers that I've looked at. There certainly was reports from the director of the home to the State agencies about the people. A lot of that was actually around collecting the money, so it wasn't necessarily about the health."***

<sup>783</sup> Independent Police Conduct Authority Act 1988.

<sup>784</sup> Independent Police Conduct Authority Act 1988, section 12 (1)(a)(i) & (ii).

<sup>785</sup> Independent Police Conduct Authority Act 1988, section 12 (1)(b).

<sup>786</sup> Witness statements of Margaret Wilkinson (17 September 2020, para 49) and Reverend Dinah Lambert (1 December 2021, para 194).

<sup>787</sup> Transcript of evidence of David Waite for Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 258).

557. In evidence provided to the Inquiry in 2022, the Methodist Church explained there was little involvement from the State once a child was placed in the care of the Church:<sup>788</sup>

*“ ... the price that is paid is always the children, they pay the price of these decisions and this type of structure and the lack of rigour when it comes to monitoring and oversight, from both the Church and the State.”*

## **Tē kitea te Tiriti o Waitangi i ngā mahi aroturuki Te Tiriti o Waitangi was absent in oversight and monitoring**

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558. In Part 6 the Inquiry noted that the Crown’s obligations as te Tiriti o Waitangi partner includes monitoring the activities of institutions and auditing institutions’ performance.

559. From 1950 to 1976, there was no independent oversight or monitoring of breaches of the rights guaranteed in te Tiriti o Waitangi in State care settings. From 1975, the Waitangi Tribunal had jurisdiction to enquire into claims regarding Crown acts that were inconsistent with te Tiriti o Waitangi and its principles after 1975. From 1985, this was extended to include historical claims from 1840.<sup>789</sup>


560. The Tribunal was led by the Chief Judge of the Māori Land Court. Edward Taihakurei Junior Durie (Rangitāne, Ngāti Kauwhata, Ngāti Raukawa) was the first Judge of Māori descent to be appointed, in 1980. He held the position until 1998 when Joseph Victor Williams (Ngāti Pūkenga, Waitaha, Tapuika) was appointed.<sup>790</sup>

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<sup>788</sup> Transcript of evidence of Reverend Tara Tautari on behalf of the Methodist Church at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission Inquiry into Abuse in Care, 18 October 2022, page 255).

<sup>789</sup> Treaty of Waitangi Act 1975, section 6(1).

<sup>790</sup> Māori Land Court, He pou herenga tangata, he pou herenga whenua, he pou whare kōrero: 150 years of the Māori Land Court (Māori Land Court 2015, page 84).



561. There was a lack of Māori leadership in other oversight and monitoring bodies between 1950 and 1999. The issues the Inquiry has identified with lack of robust and independent monitoring of care settings meant that the range and scale of abuse and neglect experienced by tamariki, rangatahi and pakeke Māori in care was not as visible as it could otherwise have been. It also meant that disparities in the nature and extent of abuse and neglect experienced by Māori were not revealed. This was a breach of the Crown's obligations of active protection, equity and equal treatment, and good government. The failure in oversight and monitoring was part of the failure to adequately care for Māori, obtain and maintain adequate information or knowledge of any abuse or neglect suffered by Māori while in care, or hold abusers to account.

## **He akonga i kitea ngā mea panoni i hua ki ngā mahi aroturuki**

### **Lessons identified and changes made to oversight and monitoring**

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562. During the Inquiry period the State learned that independent oversight was an important way of monitoring the standard of care received by children, young people and adults in care in State institutions. However, despite increasing the number of oversight and monitoring bodies, there was no single body, or combination of bodies, with the function of oversight and monitoring of all care settings.

# Ūpoko | Chapter 7

## Ngā kōrero mutunga mo ngā takinga pūnaha taurima me ōna whakahaere

### Conclusion on the care settings and people responsible for care

#### Tē kitea ngā mōtika i raro i te Tiriti o Waitangi i roto i ngā takinga pūnaha taurima

#### Rights guaranteed in te Tiriti o Waitangi were absent in care settings

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563. From 1950 to 1999, the rights guaranteed to Māori in te Tiriti o Waitangi were almost always absent across care settings. The Inquiry saw no explicit references to tino rangatiratanga or te Tiriti o Waitangi itself in legislation that applied to care settings' nor in any of the key institutional factors, like standards of care, employment policies, or complaints processes, or in how oversight and monitoring was designed or implemented.
564. The Crown made guarantees to Māori in te Tiriti o Waitangi that were directly relevant to care settings. This includes the guarantee to Māori of tino rangatiratanga and the principles set out in Part 1 including partnership, active protection, options, and good government. As discussed in this Part, these obligations were often not met.
565. The State did legislate changes specific to whānau, hapū and iwi in most care settings (excluding faith-based care and transitional and law enforcement settings) from the 1980s.<sup>791</sup> However, none of these changes used the language in te Tiriti o Waitangi, or referred to te Tiriti o Waitangi, or considered the pre-existing rights of Māori affirmed by te Tiriti o Waitangi, or incorporated the expanse of authority guaranteed to Māori.

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791 See Children, Young Persons, and Their Families Act 1989, sections 20–38; Mental Health (Compulsory Treatment and Assessment) Act 1992, section 7A.

566. The State care system is based on an assumption that the State has an innate responsibility to operate a care system for those deemed to be in need of care, including tamariki, rangatahi and pakeke Māori. This assumption fails to acknowledge the fundamental right of tino rangatiratanga over kāinga guaranteed to Māori by te Tiriti o Waitangi and does not recognise “the Crown’s sustained intrusion into the rangatiratanga of Māori over kāinga”.<sup>792</sup> This assumption also fails to acknowledge the compounding factors that contributed to Māori being overrepresented in care, including the ongoing impacts of colonisation. This is encapsulated in the Waitangi Tribunal’s He Pāharakeke, He Rito Whakakīkīnga Whāruarua report:

*“The signatories to the Treaty did not envisage any role for the Crown as a parent for tamariki Māori, let alone a situation where tamariki Māori would be forcefully taken into State care – in numbers vastly disproportionate to the numbers of non-Māori children being taken into care.”<sup>793</sup>*

## **I te ngaro ngā mōtika ā-tangata i te rahi o ngā takinga pūnaha taurima**

### **Human rights protections were largely absent in care settings**

567. From 1950 to 1986, institutions, foster homes and State-operated family homes failed to take into account the concept of human rights. There were no specific legislative references to the human rights of people in care, and it was left to individual institutions and foster homes to decide whether to respect, protect and fulfil those rights.

568. The 1970s saw the Race Relations Act and Human Rights Commission Act come into force, as well as the ratification of International Human Rights Covenants such as the International Covenant on Civil and Political Rights in 1978. However, it was only from 1986 that there began to be some references to human rights in legislation applying to care settings, and these were scattered, and often oblique, and applied only to some people in care. For example, in social welfare residences, regulations prohibited humiliating or degrading treatment of children and young people and the 1996 Code of Health and Disability Services Consumers’ Rights included some human rights (though the right to make an informed choice and give informed consent excluded people in compulsory care). Further information on steps that Aotearoa New Zealand took during the Inquiry period to specifically incorporate rights from international human rights instruments into domestic law is included in Part 2.

<sup>792</sup> Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry (2021, page 95).

<sup>793</sup> Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkīnga Whāruarua: Oranga Tamariki Urgent Inquiry (2021, page 179).

# I noho tahanga te hunga i ngā pūnaha taurima i o rātou whānau, kāinga, hāpori me o rātou reo kaikōkiri

## People in care were isolated from whānau, kāinga, communities and advocates

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569. Many children, young people and adults in State and faith-based care were isolated from their whānau, kāinga and communities. Some staff and carers deliberately prevented people in care from maintaining connections with their families, whānau and siblings.
570. Parts 3 and 4 describe the evidence the Inquiry heard from many survivors that being separated from their families, culture and communities was traumatic for them, made them vulnerable to abuse and neglect once in care, and stopped them from disclosing abuse or neglect.<sup>794</sup>
571. For Māori, this isolation severed their connections to their whānau, hapū and iwi and contributed to cultural abuse. Many Māori survivors were prevented from speaking te reo Māori and practising their culture when they were in care, and in some cases were abused for doing so. For many tamariki, rangatahi and pakeke Māori who knew their language and cultural practices before entering care, this was lost once in care. The lack of Māori staff and carers also meant tamariki, rangatahi and pakeke Māori were more likely to experience racism, and less likely to disclose abuse or neglect.
572. For Pacific children, young people and adults in care, separation from their kāinga contributed to experiences of cultural abuse and racism, increased the risk they would enter care and experience abuse and neglect once in care, and meant they were less likely to make disclosures of abuse.
573. Many survivors lacked access to an independent advocate to tell them about their rights while in care; to support them or represent them to make complaints; and to prevent and respond to abuse and neglect. Even when provisions were put in place to allow some people in care access to an advocate, many were not told about this or about their rights and their right to complain.
574. Without access to family, whānau, communities or advocates, children, young people and adults in State and faith-based care were at heightened risk of experiencing abuse and neglect.

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<sup>794</sup> Witness statement of Andrew Brown (13 July 2022, para 7.11).



## **He pūputu tonu te whakataurekareka me te parahako i te mana tangata mo te hunga i roto i ngā pūnaha taurima**

### **People in care were regularly dehumanised and denied their human dignity**

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575. Inadequate standards of care, failure to implement existing standards, and breaches of standards contributed to different forms of serious abuse and neglect across all care settings. Part 4 demonstrates that one of the most pervasive and persistent forms or consequences of abuse and neglect was that people in care were regularly dehumanised and denied their human dignity.
576. People are dehumanised when they are treated as less than human and that treatment strips them of their dignity. In Part 3 the Inquiry discussed survivors' experiences of being treated like animals and objects, not people. The abuse of people in care was fundamentally inconsistent with the preservation and promotion of their human dignity.
577. The failure to meet even basic standards of care showed a disregard for the dignity, rights and needs of children, young people and adults in care. Inadequate care standards, or a failure to adhere to these, resulted in inappropriate or unsafe care placements, a regimented and at times violent approach to care, inaccessible and ineffective complaints processes, and inadequate or failed processes for handling and responding appropriately to those concerns or complaints. The upholding of standards of care, when those existed, often depended on the actions and influence of individual carers or staff members.
578. Effective and appropriate care standards that are founded in legislation and that codify people's rights, including their right to dignity, represent a core pillar of any effective safeguarding system and can assist in creating a safe care environment. However, these are not sufficient on their own to ensure the dignity and safety of the people who are being cared for. They require other elements of safeguarding, which are referred to in other chapters of this Part.



## He maha, he taukumekume tonu ngā whakahaere i waenga i ngā tari kāwanatanga

### Government agencies had multiple and conflicting roles

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579. Throughout the Inquiry period, government agencies had multiple and conflicting roles in care. Agencies often:
- designed their own care standards and care policies (such as the Department of Social Welfare's Field Officers Manual)
  - regulated certain care providers (such as the Department of Education registering teachers between 1950 and 1989)
  - owned and operated care facilities (like the Department of Social Welfare's residences, or, in the early part of the Inquiry period, the Department of Health's institutions)
  - delivered care
  - employed and managed staff and carers
  - oversaw and monitored the provision of their own services, or employed or hosted units, bodies or individuals with oversight and monitoring roles (such as in Deaf, disability and mental health and social welfare settings)
  - designed, procured and funded care standards and services from third-party care providers (for example, in Deaf, disability and mental health settings and in social welfare settings)
  - approved, managed, oversaw and monitored care providers (such as IHC, Te Whakapakari Youth Programme and Moerangi Treks)
  - advised the State on its care-related policies and the regulation of care providers and workers.
580. This concentration of power, where an agency could be responsible for all aspects of a situation from decision-making to service provision to monitoring, decreased accountability and increased the risk of abuse. At times, these roles also overlapped with other government agencies and could become complex and confusing when combined with unclear, inconsistent or ad hoc legislation. This complexity and confusion could be exacerbated by significant public sector restructuring (as discussed in Part 2).
581. Chapter 5 of this Part explains that at times, government agencies' confusion about their roles, accountabilities, and the extent of their statutory powers could lead to serious breaches of standards of care. Chapter 5 also explains that many staff and carers in government agencies were under-resourced, or had too many duties, leading to some of them having to 'cut corners' or not being able to carry out some of their duties.

582. The Mason report published in 1996 recommended the establishment of a Mental Health Commission because it would be independent of government.<sup>795</sup> The Ministerial Review of Child, Youth and Family Services in 2000 commented on the “almost impossible and, in some cases, contradictory demands which fall on the Department [of Social Welfare].”<sup>796</sup> This was linked to the Department’s “monopoly position in the Child Welfare field”.<sup>797</sup>

## **I te ngaro, e ngāwari noa rānei te karo i ngā kaupapa whakahaere**

### **Complaint processes were absent or easily undermined**

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583. In comparison to other settings, social welfare settings did have in place complaints processes for much of the Inquiry period. They were set out in the Field Officers Manual and its later versions (including the Social Workers Manual). Like the standards of care set out in these manuals, complaints processes were not accessible to children and young people in care, their family or whānau.

584. For other settings, complaints processes were largely absent, with some processes being put in place late in the Inquiry period for disability and mental health, education, and transitional and law enforcement settings.

585. There were barriers to people in care raising concerns or complaints, including a lack of access to whānau, communities and advocates. When children, young people and adults reported abuse or neglect, they were not believed and sometimes called liars and troublemakers. Staff and carers not believing children, young people and adults in care was underpinned by societal attitudes like racism, ableism and disablism.

586. When there were concerns or complaints about abuse, the abuse was often treated as an employment issue or as a sin to be forgiven, rather than as abusive and possibly criminal behaviour that needed to be investigated, and that abusers needed to be held to account for. Senior leaders or managers prioritised institutional reputations over the safety of people in care (and subsequently, after the Inquiry period, they ‘negate’ or cover over institutional abuse during that period). Senior leaders or managers prioritised abusers’ reputations and future careers over the safety of people in care, including shifting the abuser to other residences or institutions and using confidential settlements. There were also consistent failures to report complaints of abuse and neglect to NZ Police.

<sup>795</sup> Mason, K, Johnston J and Crowe, J, Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services (1996, pages 106–107 and 108).

<sup>796</sup> Brown, M, Care and Protection is about adult behaviour: The Ministerial Review of the Department of Child, Youth and Family Services (2000, page 97).

<sup>797</sup> Brown, M, Care and Protection is about adult behaviour: The Ministerial Review of the Department of Child, Youth and Family Services (2000, page 6).

## He ngoikore tonu ngā mahi aroturuki

### Oversight and monitoring was ineffective

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587. From the evidence the Inquiry has seen, oversight and monitoring did not function effectively during the Inquiry period and this contributed to abuse and neglect in care. Care systems were often decentralised and governed by multiple departments and different pieces of legislation. There was little coordination between the departments responsible for care settings, which meant people in care were at greater risk of abuse and neglect. Once a person was in care, the State consistently failed to provide robust oversight and monitoring of institutions, foster parents, and staff and of the children, young people and adults in care.<sup>798</sup>
588. There was no single external, independent oversight or monitoring body or combination of bodies responsible for the safeguarding of all children, young people and adults in State and faith-based care during the Inquiry period.<sup>799</sup>
589. Instead, there were several independent bodies that had discrete roles in oversight of parts of some care settings. Some oversight bodies were independent of the State and some were part of the State. Monitors were established at different times, under different legislation, with a lack of consistency and coherence; there were gaps in areas of responsibility, and no common guiding principles. This ad hoc, piecemeal approach to oversight and monitoring contributed to abuse and neglect in care settings.<sup>800</sup>
590. Where oversight or monitoring bodies were in place, their effectiveness was limited by resourcing constraints and weak recommendatory powers. The State routinely failed to act decisively on their advice. There were frequent failures by monitors, oversight bodies, and the State to report unlawful behaviour, such as the use of seclusion or corporal punishment after 1990, to NZ Police. This was despite obligations or commitments that required them to report. The State has acknowledged that it did not have adequate processes in place to monitor and prevent abuse in care during the Inquiry period.<sup>801</sup>

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798 Carson, R, *New horizons: A review of the residential services of the Department of Social Welfare* (Department of Social Welfare, 1982, page 78).

799 For example, the Ombudsman (established in 1962), the Human Rights Commission (1977) and the Children and Young People's Commissioner (1989) were relevant in their own right across all care settings.

800 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), *Final Report: Volume 2, Nature and Cause* (2017, pages 174–176, 239), Truth and Reconciliation Commission of Canada, *Honouring the truth, Reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada* (2015, page 20); Wardhaugh, J & Wilding, P, *Towards an explanation of the corruption of care*, *Critical Social Policy* 13.37 (1993, pages 21–22).

801 Transcript of Closing Statement by the Crown at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, page 1102).

## Tata kore nei he whiu mo te mahi tūkinō

### There was little accountability for abuse and neglect


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591. As discussed in Part 4, abuse and neglect were common experiences for many in care and became normalised in some settings.
592. Unlawful and serious breaches of standards of care were rarely reported to the NZ Police. Senior leaders and managers often demonstrated a reluctance to report abuse or neglect to NZ Police and in some cases took deliberate steps to defer or avoid reporting abuse or neglect to NZ Police or to defer or avoid following through with other accountability steps, such as dismissal under employment laws.
593. Other measures taken by some senior leaders and managers included:
- a. denying that the abuse happened
  - b. calling the people who had complained liars or blaming them for the abuse
  - c. taking a litigious response to complaints
  - d. delaying or deferring dealing with complaints
  - e. shifting abusers to other locations
  - f. entering confidential settlements with abusers and providing abusers with positive references to help them move to new positions within care settings.
594. Examples of this are set out in Part 4 of this report, and in the Inquiry's reports on redress (He Purapura Ora, he Māra Tipu: from Redress to Puretumu Torowhānui), Lake Alice Child and Adolescent Unit in Rangitikei (Beautiful Children: Inquiry into the Lake Alice Child and Adolescent Unit) and Marylands School and Hebron Trust in Ōtautahi Christchurch (Stolen Lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust).

595. Across all of the Inquiry's public hearings,<sup>802</sup> senior leaders also deployed other measures to minimise reputational risk as well as cover over institutional abuse during the Inquiry period. These included:
- a. pointing out that their ability to provide evidence would be limited by a lack of information or 'not knowing' as they had not been present when the abuse or neglect occurred, and so limiting their liability, their organisation's liability and avoiding blame
  - b. acknowledging the resilience of survivors while ignoring or providing limited acknowledgement that some survivors were and are angry, that some want a reckoning, and that most survivors want their claims to be resolved quickly and to be provided holistic redress, *puretumu torowhānui*
  - c. shifting the blame to others through:
    - i. shifting blame to another part of the institution they worked at or represented, or to a group affiliated or associated with that institution
    - ii. indicating that another organisation hindered or undermined the work of their institution
    - iii. blaming survivors for either holding up processes, as they were purportedly not credible, or hindering processes with their many requests for information and details
  - d. claiming that abuse and neglect occurred because of the law and the way the bureaucracy is structured – indicating that they had no agency in relation to their settings, policies, processes, practices, organisational culture and ways of working and guidelines
  - e. blaming an identified abuser and naming them a 'bad apple' rather than acknowledging that the settings, policies, processes, practices, organisational culture, ways of working and guidelines contributed to abuse and neglect occurring and becoming pervasive across many care settings
  - f. acknowledging that the abuse and neglect that occurred during the Inquiry period was a historical fact but insisting that it did not reflect the current state of care provided by their institution(s)
  - g. indicating that lessons from the Inquiry period had been identified and that they had learned from previous reports, findings and recommendations, while not confirming that recommendations had been implemented and actioned.<sup>803</sup>

802 See the transcripts for the Inquiry's State Redress Hearing (October 2019); the Inquiry's Faith-based Redress Hearing (Phase 1) (November–December 2020); the Inquiry's Faith-based Redress Hearing (Phase 2) (March 2021); the Inquiry's Children's State Residential Care Hearing (May 2021); the Inquiry's Lake Alice Child and Adolescent Unit Hearing (June 2021); the Inquiry's Tūlou – Our Pacific Voices: Tatala e Pulonga (Pacific Peoples' Experiences) Hearing (July 2021); the Inquiry's Marylands School (St John of God) Hearing (February 2022); the Inquiry's Tō muri te pō roa, tērā a Pokopoko Whiti-te-rā (Māori Experiences) Hearing (March 2022); the Inquiry's Foster Care Hearing (June 2022); the Inquiry's Ūhia te Māramatanga Disability, Deaf and Mental Health Institutional Care Hearing (July 2022); the Inquiry's State Institutional Response Hearing (August 2022); the Inquiry's Faith-based Institutions Response Hearing (October 2022).

803 Stanley, E, Gibson, Z, and Craddock, I, Performing Ignorance of state violence in Aotearoa New Zealand *Journal of Criminology* (2024, pages 4-12).


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596. In addition, senior leaders noted areas they were improving their performance in order to deflect criticism from what had happened and manage their reputational risk. These areas for improvement were that they:
- a. needed to work with whānau, hapū and iwi, be more responsive to upholding te Tiriti o Waitangi and become more culturally responsive having knowledge of tikanga, te reo and mātauranga Māori
  - b. were cognisant of their human rights obligations both domestically and internationally and were upholding them as necessary
  - c. had learnt from the 'bad' past and were now focusing their efforts on transforming themselves into a better organisation, and therefore they were best placed to lead any further change required.

# He kōrero mutunga mo ngā takinga pūnaha taurima me ōna kaiwhakahaere

## Conclusion on the care settings and people responsible for care

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597. Although many institutions, residences, family and foster homes, schools, hostels, boarding houses and transitional care settings may have been successful in safeguarding people in their care during the Inquiry period, those the Inquiry examined were seriously flawed, as was the behaviour of many of the responsible senior leaders and managers.
598. Standards of care were deficient across all State and faith-based care settings and easily breached with little consequence or accountability. Human rights and the rights guaranteed to Māori in te Tiriti o Waitangi were largely or completely ignored, to devastating effect on those in care and their families, communities, whānau, hapū and iwi.
599. Many senior leaders and some managers in State and faith-based care settings undermined policies and laws intended to prevent and respond to abuse, to the extent that such policies and laws existed at the time. It was known for managers to skip vetting processes. There are examples of abusers being employed despite having previously been convicted or accused of serious sexual assault. Abusers were often shifted from place to place as a response to concerns or complaints about abuse, particularly in faith-based care settings. Many abusers who were shifted went on to abuse more people in care. Some senior leaders and managers took care to protect the abuser's professional reputation when shifting them. Sometimes confidential settlements were used to avoid accountability for both the abuser and the institution and to protect their reputations. In some cases, senior leaders or managers gave abusers supportive references that allowed them to apply for new positions where they had continued access to people in care.
600. It is difficult not to observe that senior leaders seemed either oblivious or indifferent to whether they were risking further abuse and neglect of children, young people and adults in care. Their priority appeared to be avoiding any form of accountability for the abuser or their institution and avoiding reporting the abuse, rather than prioritising the safeguarding of people in their care.



"The abuse  
I suffered makes  
me feel dead inside"

**PETER EVAROA**  
Raratongan and Pākehā



# Peter Evaroa

**Hometown:** Te Whanaganui-a-Tara Wellington    **Age when entered care:** 4 years old

**Age now:** 60 years old

**Type of care facility:** Boys' home – Epuni Boys' Home; children's homes – Christian home, Homeleigh Methodist Children's Home; foster families

**Ethnicity:** Raratongan and Pākehā

**Whānau background:** Peter has three older brothers, three half-sisters and seven stepsisters. His biological father was extremely violent, drank a lot and would sometimes desert their family. Peter feels Social Welfare kept his mother from him.

**Current:**ly: Peter's abuse has made it hard for him to maintain relationships, but he talks to his brothers. He has a long-term partner he talks to every day.



## **I spent six years being physically, sexually and psychologically abused in a Methodist Church children's home.**

Years later, when asked what I would want as compensation, I replied that nothing less than the value of a house would be enough. My answer wasn't just for me but for all victims. I feel the value of a child's life is higher than any price that could be paid as compensation. Yet a child's life is exactly what was taken from so many of us when Social Welfare placed us in such toxic environments.

My parents separated when I was very young, and my brothers and I went to a Christian home for a period, before going to live with our father and his new partner. However, Child Welfare started to receive a lot of complaints that we weren't being properly looked after. After my brothers and I ran away we were taken to Epuni Boys' Home for a few weeks and then became State wards.

I was 8 years old when Social Welfare placed us in Homeleigh Methodist Children's Home.

I'd had a hearing impairment since I was young. Shortly after I arrived at Homeleigh, I was fitted with hearing aids. I still couldn't hear clearly because sounds were amplified randomly – but I was punished for not listening. The constant noise also gave me headaches and the aids were really uncomfortable so I'd take them out.

The manager would often hit me around my head if I wasn't wearing my hearing aids. Once he hit me so hard when I had them in that an aid broke and made my ear bleed. He then kicked me around my head because it was broken. I wasn't allowed to go to school for a couple of weeks until my ear healed.

My hearing has been made worse by all the assaults I suffered in care.

At school, my deafness affected my ability to learn. I was mostly forced to sit at the back of the class and I didn't get any additional support. I was also constantly bullied because I was Deaf and I was never taught sign language.

I wet my bed every night at Homeleigh. The manager, a different one, would grab me, drag me out of bed, then make me sit in a scalding hot bath, which made me scream and cry. He would often beat me around the head and body while I was sitting in the bath. I remember him taking me to his apartment at least twice, I think after one of the night-time baths. I have no memory of what happened in his apartment, my mind seems to go blank, but I do remember leaving with a sore bottom on each occasion.

Every time he seriously hurt me, he gave me 50 cents to stop crying and not tell anyone. It was a lot of money for a child back then.

He shot me on three occasions – I'm not sure if it was with an air rifle, a slug gun or a .22. The first time, he shot my big toe then took me to the bathroom to clean the wound. He then put my penis in his mouth and attempted to perform oral sex on me, possibly to stop me crying. This was a total shock and I really struggle with the fact that part of me must have enjoyed it because I did stop crying. Again, he gave me 50 cents not to tell anyone.

The second time he shot me in the stomach. He cleaned the wound and gave me 50 cents to keep quiet. I still have the scar. The third time, he shot me just below the knee. Again, he cleaned the wound and gave me 50 cents. I still have this scar too.

Although I was a State ward, I hardly ever saw a social worker and when they did visit, a manager was always present. I did complain once about how I was treated but I guess they didn't believe me because nothing was done, except I got a hiding when they left. Even my school told my social worker I was having problems but no one ever asked me about it.

I thought I deserved to be treated badly. I really believed it. I think because our father had been so violent towards us, I felt it was normal to be treated like that.

I left Homeleigh when I was 15 years old, just before it closed due to insufficient funding. I was separated from my brothers and placed with various foster families for a few years. At one placement I finally stopped wetting the bed because I wasn't afraid of my foster parents. This was a big deal for me, something I wasn't used to. When I was 18 years old, I was discharged from Social Welfare's guardianship. I felt relieved but lost because I didn't have my brothers or sisters with me.

I then held a series of jobs and studied at university for two years but had to stop due to money issues. In 1983, I had a work-related accident and I've been on a benefit ever since.

At some point in the next decade, I confronted the man who sexually abused me. It took several tries to build up the courage. I couldn't confront him about the sexual abuse, or the shootings, but I did confront him about the beatings as I wanted closure. I wanted to get revenge. But he told me the beatings were just discipline. I felt like he thought he'd done nothing wrong and this made me very angry. I got no revenge and no closure.

In 2004, my father died and I started wetting the bed again. This brought back memories of Homeleigh so I laid a police complaint against the two managers, but as both men had died the police said there was nothing they could do. I wanted to take it further but couldn't afford to. A year later, I visited Homeleigh, hoping that might make the memories go away. But when I got to the manager's apartment I couldn't move any further. I was just frozen to the floor.

In 2007, a law firm agreed to act for me on a legal aid basis. Due to funding issues, until 2013 they could only collect my records, talk to potential witnesses and work on a statement. In 2013, my lawyer and I met with the Ministry of Social Development (MSD) so I could talk about what happened at Homeleigh, and other life experiences. This meeting was so stressful I started drinking.

I don't like to talk about the abuse I suffered as child. It makes me feel dead inside.

In 2014, my lawyers filed a claim on my behalf against the Methodist Church. I was willing to take whatever it offered as long as the church apologised and acknowledged what had happened. In 2015, the church offered to settle for \$10,000 but stated it saw no merit in my claims and refused to give me a letter of apology. After considerable negotiation I agreed to settle for \$15,000. I remember telling myself the fact the Methodist Church was willing to pay me anything was an admission of liability and acknowledgement.

In 2016, I agreed to take part in MSD's Fast Track Process, which is a faster way to assess and resolve historic claims. MSD offered me \$20,000 along with a letter of apology from the chief executive. However, I had been told the apology would come from the Minister for Social Development so I tore the letter up. I wasn't sure if MSD accepted responsibility for what had happened to me or if it was just trying to get rid of me like the Methodist Church.

After I accepted the payment, I found out if I had more than \$900 in my bank account then I'd lose the supplementary payments I received with my invalid's benefit. I was forced to spend the settlement money within six months on whiteware and furniture.

So, the State gave me the money, then forced me to get rid of it.

I feel like my life has been a failure and that it's my fault. I drink heavily to cope and am an excessive smoker. I have attempted suicide on two occasions. I was addicted to gambling, but now I only play for fake money. However, I spend up to 11 hours a day doing it, just to stop thinking about the abuse.

It's hard for me to maintain relationships and I am desensitised to emotion. I am wary of other people and concerned they will hurt me. I also have difficulty trusting people. I've thought about getting counselling but I don't really believe anyone is going to help me. It's down to me to help myself.

In 2022, when I worked with my lawyer on my statement for the Royal Commission, I asked them to contact the Methodist Church to revisit the outcome of my complaint. This resulted in a meeting with the Methodist Church general secretary. Following that, the church made me an additional offer of \$60,000 with an apology in writing, and in person.

Now I think the State should revisit what they offered me too – it put me in Homeleigh, ignored how I was treated there and kept my mother away from me.

The State owes survivors like me our lives.<sup>804</sup>

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804 Witness statement, Peter Evaroa, WITN1228001 (10 October 2022).

# Ūpoko | Chapter 8

## Ngā whakahaere i roto i ngā pūnaha taurima hinonga ā-whakapono

### The faith-based institutions responsible for care

601. This chapter looks at the factors specific to faith-based institutions that contributed to abuse and neglect. In addition to the factors that caused or contributed to abuse and neglect identified in other chapters, there were factors evident in faith-based settings that were not apparent in any other setting. These factors were:
- a. the authority and impunity of religious institutions
  - b. certain discriminatory attitudes, policies, and practices that contributed to abuse and neglect
  - c. harmful use of beliefs and practices that created environments that fostered abuse and neglect.

# Te mana me te arokore o ngā hinonga ā-whakapono

## The authority and impunity of religious institutions

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### I raro i te mana o ngā kaiarataki i ngā hāhi i āhei ai te tupu o ngā mahi tūkinō

#### The authority of religious leaders created opportunities for abuse (clericalism)

602. The authority of religious institutions and of clergy and church leaders created conditions for abuse and neglect in care to occur in faith-based care settings.<sup>805</sup> Christian teachings emphasised the importance of obedience to authority figures, especially parental or parent-like figures.<sup>806</sup> Perpetrators of abuse in religious institutions held unique positions of respectability and moral authority.<sup>807</sup> This power imbalance between clergy / church leaders versus community members was maintained in all the faiths the Inquiry investigated. In Protestant and Catholic Churches it was known as a culture of 'clericalism', which is the result of practices that uphold the power of clergy over others.<sup>808</sup>
603. Clericalism or the authority of church leaders created opportunities for abuse as it allowed for unique access to people in care. People with religious authority, or people associated with the authority of a church such as volunteers and laity, were often closely involved in the lives of families. Some used that opportunity to groom family members in order to sexually abuse their children.<sup>809</sup> Consistent with international findings,<sup>810</sup> many survivors said the trust in and status of clergy and religious leaders meant they were granted unsupervised access to people in care in a way other people might struggle to gain.

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805 Beyer, L, Higgins, D, & Bromfield, L, Understanding organisational risk factors for child maltreatment: A review of literature (Melbourne, Australia: National Child Protection Clearinghouse, Australian Institute of Family Studies, page 43); Pilgrim, D, "Child abuse in Irish Catholic settings: A non-reductionist account" *Child Abuse Review* 21 (2012, page 407).

806 Redmond, SA, "Christian "virtues" and recovery from child sexual abuse" in *Christianity, patriarchy and abuse: A feminist critique* (1989, page 78).

807 Regan, E, "Church, culture and credibility: A perspective from Ireland" *New Blackfriars* (2013, pages 160–177, page 166); Mathews, B, "Child sexual abuse in institutional and non-institutional context, in *New International Frontiers*" in *Child Sexual Abuse: Theory, Problems and Progress* (Springer International Publishing, 2019, pages 161–242, page 163).

808 Plante, TG, "Clericalism contributes to religious, spiritual, and behavioural struggles among Catholic Priests," in *Religions* Volume 11 Number 5 (2020, page 2).

809 *Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Religious Institutions: Volume 16, Book 1* (2017, page 23).

810 Cashmore, J, & Shackel, R, Responding to historical child sexual abuse and the needs of survivors, *Current Issues in Criminal Justice* Volume 26, No 1 (2014, pages 1–4; *Royal Commission into Institutional Responses to Abuse in State Care (Australia), Final Report: Preface and executive summary* (2017, pages 10, 51, 55, 68 & 77).

604. Survivor Mr HU, who was placed at the Christchurch Methodist Children's Home when he was aged 11, described how he was abused by a clergy member. He had no role in the day-to-day running of the residence,<sup>811</sup> yet had free access to the home and was once even in the bathroom while Mr HU was having a bath.<sup>812</sup> Similarly, NZ European and Māori survivor Ms NI, one of many survivors who spoke to this Inquiry about abuse suffered by a Presbyterian Minister, explained:

***“There was so little supervision of what was happening [at the youth group where abuse occurred] by the Church. Parents trusted [the Minister] to look after us girls too because he was a Minister, but he also had older children, sons, a daughter, and a wife.”***<sup>813</sup>

605. Survivors told the Inquiry that clergy or religious leaders could take them away on trips<sup>814</sup> or back to their homes,<sup>815</sup> and it was not seen as inappropriate for children or young people to be in a priest's bedroom.<sup>816</sup>

606. Clericalism created conditions for abuse to occur in faith-based institutions due to the religious power and authority vested in members of the clergy and religious leaders. The religious status and power afforded to abusers in ministry has acted as an integral part of abuse for many survivors who have engaged with this Inquiry about abuse in a faith-based setting.

607. Clergy were often revered with a “mixture of awe and fear” due to their power and spiritual authority<sup>817</sup> and their unique powers of “moral persuasion”, and this created opportunities for abuse and exploitation.<sup>818</sup> Part 4 describes survivors' experiences of spiritual abuse, including how religion was used as a means of control and justification for abuse. The ability of perpetrators to leverage religion in such a way stemmed from the power and elite status they held.

811 Witness statement of Mr HU (30 June 2022, para 23).

812 Witness statement of Mr HU (30 June 2022, paras 23–24).

813 Witness statement of Ms NI (28 April 2022, para 28).

814 Witness statement of Neil Harding (13 October 2020, para 59).

815 Witness statements of Mr NB (16 August 2021, para 40) and Ms C (21 September 2020, paras 8–9).

816 Witness statement of Mr QH (17 January 2021, para 6.6).

817 Benkert, M, & Doyle, TP, “Clericalism, religious duress and its psychological impact on victims of clergy sexual abuse” in *Pastoral Psychology* Volume 58, No 3 (2009, page 224).

818 Raine, S, & Kent, S. A, “The grooming of children for sexual abuse in religious settings: Unique characteristics and select case studies” in *Aggression and violent behaviour* Volume 48 (2019, page 183).

608. For many survivors, obedience to religious authority was so ingrained that they complied with the orders of clergy or other religious leaders even when it involved abuse or made them uncomfortable.<sup>819</sup> This religious status and perceived closeness to God meant at times that survivors and their families felt special if a member of the clergy or a religious leader took an interest in them.<sup>820</sup> The Inquiry heard that this religious authority and obedience was particularly prominent among Pacific survivors and their families, making barriers to reporting particularly strong.<sup>821</sup>
609. The hierarchy of religious institutions also increased the risk of abuse in faith-based settings. Research indicates how institutions with hierarchical structures, such as those that exist within faith-based organisations, can be tightly controlled and difficult to challenge.<sup>822</sup> Many survivors told the Inquiry that clergy were viewed as a separate elite class as they had unique access to God.<sup>823</sup> For instance, within the context of the Catholic Church, clericalism can result from Church teachings such as the understanding that priests undergo an 'ontological change' at ordination, making them different or set apart from others and permanently a priest.<sup>824</sup> Similarly Archbishop Philip Richardson of the Anglican Church told this Inquiry that the process of ordination is believed to cause a change in the nature or essence of the person being ordained – "your being is changed".<sup>825</sup>
610. Many survivors told the Inquiry that this hierarchy and the supreme power held by clergy prevented other staff members from intervening to stop or report abuse. Research has demonstrated that people who work in extremely hierarchical organisations may fear speaking up for fear of repercussions, which can allow the abuse to keep happening.<sup>826</sup> The Inquiry heard from a survivor that he believed nuns were among those who must have known about abuse being perpetrated by priests or religious members, and failed to intervene.<sup>827</sup> Survivors recalled that nuns who would at times show glimpses of kindness or compassion were otherwise disempowered by a hierarchical culture that relied on cruelty to control.<sup>828</sup>

819 Witness statements of Mr MO (4 May 2022, para 29) and Mr NE (17 June 2021, para 54).

820 Witness statements of Vincent Reidy (21 September 2020, paras 2.7–2.8); Neil Harding (13 October 2020, para 57); Mr J (31 August 2020, para 1.20) and Ms Leonie Jackson (21 September 2020, para 2.6).

821 Witness statements of Ms CU (10 June 2021, paras 67–71); Dr Sam Manuela (12 July 2021, para 68) and Folasaitu Dr Julia Ioane (21 July 2021, para 49).

822 Beyer, L. Higgins, D, & Bromfield, L, Understanding organisational risk factors for child maltreatment: A review of literature (National Child Protection Clearinghouse, Australian Institute of Family Studies, Melbourne, 2005).

823 Witness statement of Vincent Reidy (21 September 2020, para 3.17).

824 Slater, J, "The Catholic Church in need of de-clericalisation and moral doctrinal agency: Towards an ethically accountable hierarchical leadership" in HTS: Theological Studies Volume 75, No 4 (2019, page 4).

825 Transcript of Evidence of Archbishop Philip Richardson, at the Inquiry's State Redress Hearing (Royal Commission of inquiry into Abuse in Care, 19 March 2021, pages 388–389).

826 Wardhaugh, J & Wilding, P, "Towards an explanation of the corruption of care" in Critical Social Policy Volume 37 (1993, pages 4–3); Green, L, "Theorizing sexuality, sexual abuse and residential children's homes: Adding gender to the equation" in British Journal of Social Work Volume 35, No 4 (2005, pages 453–481).

827 Witness statement of Mr JB (28 April 2022, page 11).

828 Private session transcript of survivor who wishes to remain anonymous (10 September 2019, page 42); Private session transcript of survivor who wishes to remain anonymous (28 May 2019, page 15).



## Nā te mana matika o ngā hinonga hāhi ka hua āna mahi arokore

### The moral authority of religious institutions created a sense of impunity

611. There was a wider sense of trust in faith-based institutions among survivors' families that led to their placement in care and created a sense of impunity among these institutions, who were well-perceived and therefore could 'do no wrong'.
612. Some survivors said their parents specifically chose to place them in faith-based institutions because they were assumed to be trustworthy places.<sup>829</sup> This broad trust in faith-based institutions meant that beyond clergy and church leaders, reverence was extended to those employed by or volunteering for the faiths. Because of the institutional standing of the churches, abuse often took place in the context of "unquestioned faith placed in sex offenders by children, parents and staff".<sup>830</sup>
613. Several survivors told the Inquiry that staff members and volunteers involved in faith-based residential care provision were viewed as good people who were doing charitable work. Māori survivor Reverend Dinah Lambert (Ngā Rauru Kītahi, Ngāi Porou, Ngāti Kahungunu) was abused by the man in charge of Abbotsford Home (Anglican) in Waipawa, Te Matau-a-Māui Hawkes Bay, in the 1960s. She explained the "utter helplessness" she felt that no one was listening to her, or cared, when trying to disclose the abuse he perpetrated on her:<sup>831</sup>
- "... these were the same people that always looked good. You know that the community thought they were lovely people, looking after you, aren't they wonderful? And you think 'yep, right', you can't say anything. Or you would tell them, and they would just nod and pretend that you didn't say it."*
614. Some survivors recounted the experience of later seeing their abuser receive prestigious awards<sup>832</sup> or glorified on television<sup>833</sup> for their services to the community. NZ European survivor Mr UZ, who was abused at Stoddart House (Anglican) in Kawakawa Bay near Tāmaki Makaurau Auckland, explained that the house father would be praised as a "wonderful man" for "looking after the unfortunates". He told the Inquiry "I hate the hypocrisy that he received that praise while he was abusing me, while I received punishment and abuse."<sup>834</sup>

829 Private session transcript of survivor who wishes to remain anonymous (27 January 2021, page 5); Witness statement of Mrs D (21 September 2020, page 3).


830 McAlinden, 2006, cited in Raine, S., & Kent, S. A, "The grooming of children for sexual abuse in religious settings: Unique characteristics and select case studies" in *Aggression and violent behaviour* Volume 48 (2019, page 187).

831 Witness statement of Reverend Dinah Lambert (1 December 2021, paras 181–183).

832 Private session transcript of survivor who wishes to remain anonymous (3 September 2019, page 20).

833 Witness statements of Nooroa Robert (13 August 2022, page 11) and Ms CI (10 August 2022, page 2).

834 Witness statement of Mr UZ (16 March 2021, para 43).

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615. This perception of faith-based institutions and their staff as virtuous and worthy of the utmost respect created the conditions for a failure to identify abuse, allowing abuse to continue.<sup>835</sup> Clericalism can create a culture of impunity, where religious leaders feel they are beyond criticism due to the absolute power they hold among their communities.<sup>836</sup> This sense of impunity can lead survivors to fear the consequences of disclosure, and / or contribute to the failure of the religious institution to respond to reports of abuse appropriately.<sup>837</sup> These barriers to disclosure mean the true extent of abuse in faith-based settings will never be known, as many survivors will never report their abuse.
616. Many survivors told the Inquiry that because of the religious status of their abuser, they did not think what happened to them could be abuse or thought it must have been their own fault. The internalisation of blame is discussed at greater length in Part 4 of this report in relation to spiritual abuse.
617. Survivors also described a fear of disbelief as a barrier to disclosure, particularly due to the religious status of abusers.<sup>838</sup> Many survivors told the Inquiry that at the time they felt the people they might have disclosed to, including their own families, would not believe that a person with religious status could commit abuse.<sup>839</sup> In some cases, this fear was realised. NZ European and Māori survivor Ms NI, who was abused by a Presbyterian reverend while attending Presbyterian youth group and youth camps in the 1970s, told the Inquiry her mother did not believe her when she disclosed her experience of abuse.<sup>840</sup>

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835 Morton, S, "Getting evidence into action to tackle institutional child abuse" in *Child Abuse & Neglect* Volume 74 (2017, page 112); Pilgrim, D, "Child abuse in Irish Catholic settings: A non-reductionist account" in *Child Abuse Review* Volume 21 (2012, page 408).

836 Tobin, TW, "Religious faith in the unjust meantime: The spiritual violence of clergy sexual abuse" in *Feminist Philosophy Quarterly* Volume 5, No 2 (2019, page 9).

837 Morton, S, "Getting evidence into action to tackle institutional child abuse" in *Child Abuse & Neglect* Volume 74 (2017, page 112); Pilgrim, D, "Child abuse in Irish Catholic settings: A non-reductionist account" in *Child Abuse Review* Volume 21 (2012, page 408).

838 Private session transcript of survivor who wishes to remain anonymous (17 September 2019, page 8).

839 Witness statement of Rūpene Amato (16 July 2021, page 9); Private session transcript of survivor who wishes to remain anonymous (30 November 2020, page 22); Private session transcript of survivor who wishes to remain anonymous (17 September 2019, page 8).

840 Witness statement of Ms NI (28 April 2022, paras 66–68).

# Ngā waiaro whakatoihara, ngā kaupapa me ngā tikanga kei ngā hinonga whakapono

## Discriminatory attitudes, policies and practices in religious institutions

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### Ngā kawenga tane mai, wāhine mai rānei i ngā turanga whaimana

#### Gendered roles and sexism in positions of authority

618. Historically churches have reflected the culture of the time in their approach to the status of women within their institutions, but they have also been conservative in their response to changing awareness of these issues.<sup>841</sup>
619. Traditionally, formal religious roles were restricted to men in all Christian denominations.<sup>842</sup> Although early Christianity was notable for its respect for women, there is also a legacy of constraints on female leadership in the churches, despite frequent challenges from within.
620. Although there have been changes over time, in all eight faiths that the Inquiry investigated clergy and religious leaders have been highly gendered, with control historically held by males.
621. There has been active involvement of women in various leadership roles within the Catholic Church. The Director of the National Professional Standards Office, the office that manages the investigation of all reports of sexual abuse against priests and religious, is a woman, and the Complaints Assessment Committee has female members and a female chair. Women have also held leadership roles within Catholic congregations – for example, Suzanne Aubert founded the Catholic order the Daughters of Our Lady of Compassion in 1892.
622. Despite the instances of female leadership, the Catholic hierarchy remained predominantly male-dominated throughout the Inquiry period. Only men were eligible for ordination under canon law and to hold positions of the highest authority within the Catholic governance structure, such as bishops, cardinals and the pope.

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<sup>841</sup> Expert opinion of Peter Lineham (4 April 2024, page 1).

<sup>842</sup> Expert opinion of Peter Lineham (4 April 2024, page 1).

623. Women could be ordained in the mainstream Protestant denominations by the end of the 20th century, although in practice gaining full equality was difficult to achieve.<sup>843</sup> In the Anglican Church, the decision in 1976 to allow women to be ordained was controversial, and while there have been and are women who are Bishops in the church, women are still underrepresented in the top roles.<sup>844</sup> In the Presbyterian Church, some women have achieved the highest office in the church, but historically women have struggled to be accepted by some parts of the denomination, especially at the evangelical end.<sup>845</sup> The Methodist Church can be viewed as more progressive, with the first woman ordained in Aotearoa in 1958.<sup>846</sup>
624. Within the Salvation Army many officers are women. However, some have noted that historically the distribution of leadership in practice suggested men held the true power, particularly in Aotearoa New Zealand where, in the past, great caution has been exercised in placing a woman over a man.<sup>847</sup>
625. In the Gloriavale community, those in the leadership roles of Overseeing Shepherd, Shepherds and Servants must be male. Roles are defined along Biblical lines, emphasising men as decision-makers and bread-earners, with women in their places as mothers, running the household areas, and in later years, possibly as teachers in the early childhood centres caring for children. Māori survivor David Ready (Ngāti Porou) told the Inquiry:<sup>848</sup>
- “From an early age, women are taught through formal education and observance of social structures, that they are worth less than men in the community.”***<sup>849</sup>
626. In Gloriavale, women's scope of leadership was limited to 'women's work' and women's issues', primarily in the domestic sphere.<sup>850</sup>

843 Expert opinion of Peter Lineham (4 April 2024, page 2).

844 Witness statement of the Most Reverend Philip Richardson, Archbishop of Tikanga Pākehā of the Anglican Church (12 February 2021, paras 57–63).

845 McKay, L, The church through ordained women's eyes: the struggle by ordained women within the Presbyterian Church of Aotearoa New Zealand (Oxford University. Master of Theology thesis, 1996), cited in Expert opinion of Peter Lineham (4 April 2024, page 7); Ellis, LA, Evangelical women and secular society in New Zealand: an investigation into feminism as an ideology of empowerment (Victoria University of Wellington. Master of Arts thesis, 2012, pages 39–40).

846 Methodist Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 452 (24 May 2022, page 8).

847 Raewyn Hendy, "Lasses, live up to your privileges, and stand up for your rights!": Gender Equality in The Salvation Army in New Zealand, 1883–1960 (Massey University thesis, 2017, pages 13–14).

848 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (8 July 2022, para 108).

849 Witness statement of David Ready (8 May 2021, para 3.7.3).

850 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (8 July 2022, paras 108 and 172).

627. A survivor who was born into the Plymouth Brethren Christian Church told the Inquiry that the leadership “is a hierarchical male structure”, and as a woman “you are continually repressed and ... you are expected to be subservient”.<sup>851</sup> NZ European survivor Mr UJ told the Inquiry that women were expected to fulfil their domestic duties as a wife and mother:

***“The [Plymouth Brethren Christian Church] are a male-dominated culture and as such the women are expected to carry out a very narrow role. The expectation is that the women marry, bear children and look after the home. The husband has complete authority over the wife in all matters including marital relations.”***<sup>852</sup>

628. The Plymouth Brethren Christian Church informed the Inquiry that women can serve as elders and that many do, with responsibilities that include providing advice to members and organising fund-raising initiatives.<sup>853</sup> Despite this, the Inquiry found that women serving as elders were often limited to traditional gender roles, such as selecting a hymn to start each of the assembly meetings and who sets the table for the Lord’s Supper (a meal celebrated each first day of the week by every member of the church).<sup>854</sup>

629. Research has previously highlighted that prescribed gender roles and the absolute authority of males within faith-based institutions contributes to the occurrence of abuse and failed responses.<sup>855</sup> Patriarchal leadership structures result in what Susan Ross describes in relation to the Catholic Church as “unchecked, divinely sanctioned patriarchal power”.<sup>856</sup> These patriarchal hierarchies within faith-based institutions contribute to a culture where disclosing abuse is discouraged and victims are unsupported.<sup>857</sup>

630. The exercise of male power over women and children by men can limit freedom of thinking and response among those who are not in this position of power.<sup>858</sup> This constraint was particularly evident where survivors told the Inquiry that female staff, although not abusers themselves but did not act to intervene or report abuse by male clergy.<sup>859</sup> The power held by male abusers often meant their behaviours went unchecked.

851 Witness statement of Ms PP (15 July 2022, paras 34, 37).

852 Witness statement of Mr UJ (7 July 2022, para 3.15).

853 Royal Commission of Inquiry into Abuse in Care, Internal notes from the Inquiry’s meeting with representatives of the Plymouth Brethren Christian Church (29 November 2022, page 13).

854 Royal Commission of Inquiry into Abuse in Care, Internal notes from the Inquiry’s meeting with representatives of the Plymouth Brethren Christian Church (29 November 2022, page 7).

855 McPhillips, K, “Soul Murder: Investigating Spiritual Trauma at the Royal Commission” in Journal of Australian Studies Volume 42, No 2 (2018, page 236); Cullington, E, “Evil, Sin, or Doubt?: The Dramas of Clerical Child Abuse” in Theatre Journal Volume 62, No 2 (2010, pages 245, 255–256 and 262).

856 Ross, SA, “Feminist Theology and the Clergy Sexual Abuse Crisis” in Theological Studies Volume 80, No 3 (2019, page 632).

857 Irenyi, M, Bromfield, L, Beyer, L, & Higgins, D, “Child maltreatment in organisations: Risk factors and strategies for prevention” in Child Abuse Prevention Issues Volume 25 (Australian Institute of Family Studies, 2006, pages 12–16).

858 Special Archdiocesan Commission of Enquiry into Sexual Abuse of Children by Members of the Clergy, The report of the Archdiocesan Commission of Enquiry into the Sexual Abuse of Children by Members of the Clergy, Archdiocese of St John’s, Newfoundland (1990, pages 12–16).

859 Transcript of evidence of Anne Hill at the Inquiry’s Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 1 December 2020, page 160).

## Nga waiaro tōraro e pā ana ki nga taera tangata Negative attitudes about sexuality

### Wāhine mai, kōtiro ake

#### Women and girls

631. Beyond the institutional sexism of the exclusion of women from positions of power in some faith-based institutions, the Inquiry has also heard that women were subjected to interpersonal abuse motivated by sexism and negative attitudes about female or diverse sexuality. Much of this abuse stemmed from a belief that women's sexuality was something to be controlled and/or feared.
632. Christianity has historically encouraged sexual restraint outside of marriage.<sup>860</sup> A 'proper' Christian woman has been deemed one who remains a virgin until marriage so she is not "spoiled goods".<sup>861</sup> In some Pacific communities pregnancy outside of marriage is still associated with shame, although more broadly in Aotearoa New Zealand attitudes towards sex outside of wedlock shifted over the course of the Inquiry period.<sup>862</sup>
633. This deep-rooted stigma associated with female sexuality drove various forms of abuse across all the faith-based settings the Inquiry investigated. As discussed in Part 4, survivors in a range of settings described being verbally abused using gendered slurs that implied they or their family members were promiscuous and were therefore worthless.<sup>863</sup> Such abuse commonly occurred in unwed mothers' homes, institutions that were themselves a product of the understanding that an unwed pregnancy was something to be ashamed of.<sup>864</sup> Survivors felt their perceived promiscuity was justification for poor treatment, as they were told they brought poor treatment on themselves by having sex outside of wedlock.
634. Beliefs about virginity also posed barriers to reporting abuse. Survivors of sexual abuse feared the consequences of reporting in case they were 'tainted' for what might be considered sex outside of wedlock rather than abuse. NZ European survivor Ms QG told the Inquiry that at 18 when she disclosed sexual abuse to her parish priest, he made her feel worthless and convinced her she needed to marry her abuser.<sup>865</sup> She was told "if I had engaged in sex in any form (whether forced or not) then I had no choice but to get married" and "it was God's will that I marry him [her abuser]".<sup>866</sup>

860 Baumeister, R F, & Twenge, J M, "Cultural suppression of female sexuality" in Review of General Psychology Volume 6, No 2 (2002, pages 193–194).

861 Redmond, S. A, "Christian "virtues" and recovery from child sexual abuse" in Christianity, patriarchy and abuse: A feminist critique (1989, page 76).

862 Brookes, B, "Shame and its Histories in the Twentieth Century" in Journal of New Zealand Studies Volume 9 (2010, pages 46–51).

863 Witness statements of Margaret Wilkinson (17 September 2020, para 29), Margaret Robertson (6 June 2021, para 90), June Lovett (14 December 2021, para 38) and Mrs D (21 September 2020, para 64).

864 Brookes, B, "Shame and its Histories in the Twentieth Century" in Journal of New Zealand Studies Volume 9 (2010, page 46).

865 Witness statement of Ms QG (4 August 2021, pages 5–7).

866 Witness statement of Ms QG (4 August 2021, pages 5–6).

## Tāne mai, taitama ake

### Men and boys

635. As discussed in the Inquiry's *Stolen Lives, Marked Souls* report, there was less awareness of the sexual abuse of boys throughout the Inquiry period.<sup>867</sup> It was often perceived as something that did not happen to males, and there was an expectation that boys and men should just 'harden up'. This contributed to it being difficult for boys and men to talk about sexual abuse. This was particularly so when the perpetrator was a male, because of the negative perception of homosexuality and the additional shame inflicted by some faiths about homosexuality.
636. The negative perception of homosexuality created barriers to reporting sexual abuse among some male survivors. A survivor described the hypocrisy of the anti-homosexual sentiment of Catholic teachings compared to his experience of sexual abuse by male clergy.<sup>868</sup> Research has highlighted how boys who are sexually abused by another male can experience shame and stigma associated with homophobia and fear of being viewed as a homosexual.<sup>869</sup>
637. The Plymouth Brethren Christian Church's belief that homosexuality is inconsistent with the teachings of the Bible, coupled with a belief that a person's sexuality can be managed, led to attempts to 'correct' or 'manage' the sexuality of survivors through conversion practices.<sup>870</sup>
638. Pākehā survivor Craig Hoyle and NZ European survivor Mr UJ also described the homophobia and transphobia present within the Plymouth Brethren Christian Church. Craig explained there was "zero tolerance for diversity of sexuality or gender identity" within the Plymouth Brethren Christian Church, and that "homophobic and transphobic slurs were commonplace".<sup>871</sup> Like other settings that denigrated the identity of undesired people through harmful labels, Craig explained that "anyone who deviated from cisgender heterosexuality was seen as a pervert, demon-possessed, or mentally unwell."<sup>872</sup> Mr UJ similarly explained that within the Church, "there is no tolerance for alternative sexual and or gender identification... conversion therapy is imposed."<sup>873</sup>

867 Royal Commission of Inquiry into Abuse in Care, *Stolen Lives, Marked Souls* The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust (2023, page 329).

868 Victim Impact Report of survivor who wishes to remain anonymous (11 September 2019, page 1).

869 Easton, SD, Saltzman, LY, & Willis, D G, "Would you tell under circumstances like that?": Barriers to disclosure of child sexual abuse for men" in *Psychology of Men & Masculinity* Volume 15, No 4 (2014, page 461).

870 Royal Commission of Inquiry into Abuse in Care, Internal notes from the Inquiry's meeting with representatives of the Plymouth Brethren Christian Church (29 November 2022, page 13).

871 Witness statement of Craig Hoyle (14 July 2022, page 12).

872 Witness statement of Craig Hoyle (14 July 2022, page 12).

873 Witness statement of Mr UJ (7 July 2022, para 3.16).

## Ngā mahi kaikiri, toihara ki te Māori Racism and discrimination against Māori

639. Members of the Gloriavale Christian Community, including those of Māori descent, were told that te reo Māori was “Satan’s language” and people in the community were taught that Māori were lazy and thieves.<sup>874</sup> One survivor described how her school education on the colonisation of Aotearoa New Zealand was “factually inaccurate and dangerously incompetent” and Māori were described as “heathens and savages”.<sup>875</sup> Māori survivors at Gloriavale have told the inquiry about racial discrimination<sup>876</sup> and feeling a lot of shame about being Māori.<sup>877</sup>

640. The Gloriavale leadership taught members that “you don’t have ethnicity, you’re just a child of God”.<sup>878</sup> This erasure of Māori identity was reinforced by the education curriculum at Gloriavale. A document titled Gloriavale Christian School Quality Management System, which was prepared as recently as 2021, rejected Māori culture as “un-Christian”:

*“We have our own unique Christian culture based on the teachings of the New Testament. Although we all have European or Māori ancestry or both, we do not think of ourselves as Europeans or Māori, rather we reject both these cultures as un-Christian since both are based on paganism and self-indulgence with a few perverted versions of biblical ideas mixed in. We accept no denominational labels but we are simply Christians. We do not keep non-biblical traditions amongst ourselves, whether of Māori or European origin. For example, we do not keep Christmas or Easter, or use pagan names for the days of the weeks or the months of the year. Nor do we seek to keep the Māori culture alive amongst ourselves. This is not from any racist motivation whatsoever, but as the scripture says, ‘There is neither Jew nor Greek, there is neither bond nor free, there is neither male nor female for ye are all one in Christ Jesus!’”<sup>879</sup>*

641. Rachel Stedfast, acting Principal of the Gloriavale Christian Community School, accepted in the Inquiry’s Faith-based Institutional Response Hearing that there has not been a strong focus on Māori culture at all at Gloriavale, and that there are parents who are opposed to it being taught.<sup>880</sup>

874 Witness statement of Ms KM (10 June 2021, page 5).

875 Witness statement of Ms PQ (June 2021, para 3.5.16)

876 Witness statement of Ms SU (2 June 2021, page 4).

877 Witness statement of Ms KM (10 June 2021, page 5).

878 Private session transcript of survivor who wishes to remain anonymous (page 35).

879 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 84).

880 Transcript of evidence of Howard Temple and Rachel Stedfast on behalf of Gloriavale Christian Community at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 85).



642. Some survivors of the Plymouth Brethren Christian Church described how the church leadership, and the church culture generally, were racist towards and dismissive of Māori.<sup>881</sup> The membership of the church is generally ethnically Pākehā, and one survivor said he was surprised to learn that there were a “smattering” of Māori members.<sup>882</sup> The Plymouth Brethren Christian Church told the Inquiry they see people as equal, regardless of their ethnicity.
643. The Plymouth Brethren Christian Church told the Inquiry that as a faith-based organisation they do not have any formal obligations under te Tiriti o Waitangi and that Māori have the same rights as everyone else.<sup>883</sup> Despite this, a former member said:
- “[Plymouth Brethren] are genetically Anglo-European, as a direct consequence of their religious-social exclusion of all others ... Māori world view, values, concerns, and histories are roundly dismissed. Māori are denigrated along with the denigration of all ‘worldly’, non-[Plymouth Brethren] cultures. [Plymouth Brethren] children absorb these attitudes as a matter of course.”<sup>884</sup>*

## **Te raweke toihara hunga i ngā pūnaha taurima Discriminatory exploitation of people in care**

644. Members of Gloriavale have been subject to forced work from a young age for no compensation. Children are made to do long hours, including working before and after school and on weekends. In a typical week, the female workforce in the kitchen produced more than 11,000 meals; the female workforce in the laundry washed at least 17,000 items.<sup>885</sup>
645. The Inquiry heard about survivors being subject to forced labour from a young age and that health and safety was considered secondary to profit within the community.<sup>886</sup> NZ European survivor Isaac Pilgrim told the Inquiry that Gloriavale’s founder, Hopeful Christian, would say that “people should work themselves to death for the Kingdom”.<sup>887</sup> Members received no direct monetary compensation for their work and described feeling constantly tired.<sup>888</sup>
646. The leaders of the community believe that “saving up money for later use is forbidden in the New Testament,” and so they do not allow any members to contribute to superannuation or any other savings scheme.<sup>889</sup>

881 Submission to the Royal Commission of Inquiry into Abuse in Care of Craig Hoyle (14 July 2022, page 12); Witness statement of Mr UJ (7 July 2022, page 4).

882 Submission to the Royal Commission of Inquiry into Abuse in Care of Craig Hoyle (14 July 2022, page 12).

883 Royal Commission of Inquiry into Abuse in Care, Internal notes from the Inquiry’s meeting with representatives of the Plymouth Brethren Christian Church (29 November 2022, page 24).

884 Witness statement of Mr UJ (7 July 2022, paras 3.12–3.13).

885 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1, Appendix: “A Life in Common” (May 2021, page 29).

886 Witness statement of Isaac Pilgrim (8 July 2021, pages 2–3).

887 Witness statement of Isaac Pilgrim (8 July 2021, page 3).

888 Witness statement of Mr QM (16 August 2021, pages 20–21).

889 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (8 July 2022, page 2).

# Te tūkinu whakamau hē i o whakapono me o tikanga he papa mo ngā mahi tūkinu Harmful use of beliefs and practices fostered abuse

## O pūhere ā-tokai he mea e hua ai te mahi taitōkai Beliefs about sex contributed to sexual abuse

647. Survivors described a culture where discussion of sexual matters was repressed. Norms that prevent discussion of sexual matters were particularly prevalent in faith-based institutions,<sup>890</sup> with evidence that institutional cultures where discussing sex is taboo can elevate the risk of sexual abuse.<sup>891</sup> This elevated risk can be because adults and children may be unable to distinguish between appropriate and inappropriate interactions,<sup>892</sup> and it can also pose barriers to reporting sexual abuse.<sup>893</sup>
648. These barriers were compounded by growing up in a cultural setting where discussing sex was particularly taboo. The taboo of sexual abuse perpetrated by clergy is particularly strong among Pacific communities in Aotearoa New Zealand, posing even greater barriers to reporting abuse. At the Inquiry's Faith-based Redress Hearing, Cardinal John Dew, Catholic Archbishop of Wellington, told the Inquiry:<sup>894</sup>
- "It's a very difficult topic I find with Pasifika families, because often sexuality is not mentioned or spoken about, and there's the added complexity of the culture of the church where they don't want to speak about anything to do with sexuality and they want to keep the church, and especially clergy, at a level that's not real."*
649. The taboo surrounding sex in many faith-based settings meant some survivors did not receive any education relating to sex and sexuality, which impacted on their ability to identify inappropriate sexual behaviour. Research has demonstrated that comprehensive sex education can help prevent child sex abuse by educating children on what is and is not appropriate and teaching them how to disclose abuse.<sup>895</sup>

890 Morton, S, "Getting evidence into action to tackle institutional child abuse" in Child Abuse & Neglect Volume 74 (2017, page 112).

891 Palmer, D, & Feldman, V, "Toward a more comprehensive analysis of the role of organizational culture in child sexual abuse in institutional contexts" in Child abuse & neglect Volume 74 (2017, page 28).

892 Palmer, D, & Feldman, V, "Toward a more comprehensive analysis of the role of organizational culture in child sexual abuse in institutional contexts" in Child abuse & neglect Volume 74 (2017, page 28).

893 Fontes, L A, & Plummer, C, "Cultural issues in disclosures of child sexual abuse" in Journal of child sexual abuse Volume 19, No 5 (2010, page 497).

894 Transcript of evidence of Cardinal John Dew for the Catholic Church at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 26 March 2021, page 869).

895 Goldfarb, ES, & Lieberman, LD, "Three decades of research: The case for comprehensive sex education" in Journal of Adolescent Health Volume 68, No 1 (2021, pages 13–27).

650. In some cases, this secrecy and taboo meant 'sex education' could become an opportunity for abuse. Māori and Samoan survivor Rūpene Amato (Ngāti Kahungunu, Ngā Ariki Kaiputahi, Ngāti Māroko (hapū)), who attended St Joseph's School (Catholic) in Wairoa, told the Inquiry that a priest used one-on-one meetings in his home under the guise of 'sex education' to sexually abuse him and many of his classmates.<sup>896</sup>
651. Sexual abuse was often assumed to be avoidable if survivors behaved properly, and survivors were therefore assumed to be willing participants or otherwise responsible. The emphasis in Christian teachings on sexual purity, particularly among women, lends itself to an understanding of the victim of assault as guilty of some sin or somehow at fault.<sup>897</sup>
652. This victim-blaming was particularly evident in Gloriavale, where founder Hopeful Christian promoted the doctrine that girls and women could avoid sexual abuse by "not having a flirty nature, dressing modestly, and avoiding situations where they could be seen to be 'leading on' a male who was interested in sex".<sup>898</sup> Survivors described being made to feel responsible for their own sexual abuse after reporting it. They described how Hopeful would "remind members that men had a higher sex drive than women so it was up to women to prevent sexual assaults."<sup>899</sup> They were to do this by "controlling their [the woman's] behaviour, their location and their method of presentation in order to avoid provoking sexual reactions in men and boys".<sup>900</sup> Current leader Howard Temple accepted that young women in the community may have felt that sexual assault was their fault as a result of these teachings.<sup>901</sup>
653. In some cases of sexual abuse, some faiths in the past have described it as a consensual affair. For example, Retired Anglican minister Patricia Allan gave evidence in respect of the Anglican Church where abuse carried out by Rob McCullough was described as an affair.<sup>902</sup> There is also evidence of some faiths being primarily concerned with repairing the marriage of the alleged abuser, rather than preventing or responding to the abuse. The Anglican Archbishop, on finding out about several women who had been abused by Rob McCullough said:
- "... what I believe is needed in this very painful situation is more of the spirit of forgiveness."***

896 Witness statement of Rūpene Amato (16 July 2021, pages 7–9).

897 Redmond, SA, "Christian 'virtues' and recovery from child sexual abuse" in *Christianity, patriarchy and abuse: A feminist critique* (1989, pages 76–77).

898 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (4 July 2022, page 7).

899 First witness statement of Louise Catherine Taylor (15 September 2022, page 60).

900 First witness statement of Louise Catherine Taylor (15 September 2022, page 60).

901 Transcript of evidence of Howard Temple at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 63–64).

902 Witness statement of Patricia Allan (12 March 2021, page 8).

654. The Archbishop said that McCullough must be given the opportunity to change and rehabilitate and the church must also consider the needs of his wife.<sup>903</sup>
655. The Christian emphasis on sexual purity as a virtue<sup>904</sup> also sometimes led to an internalisation of blame among survivors of sexual abuse, creating barriers to disclosure.
656. In some faiths, teachings related to sex are particularly strict. Restriction of sexual practices is a particular feature of the Catholic Church, where unlike in Protestant religions, clergy must be unmarried and abstain from sex. The link between celibacy and clerical sex abuse is often contested, but several independent researchers suggest there can be heightened risk associated with celibacy.<sup>905</sup> For instance, Robinson concludes that celibacy can contribute to unhealthy ideas (e.g., homophobia or sexism) and an unhealthy psychological state (e.g., depression).<sup>906</sup> This can manifest as hostility towards children and others they have power over.<sup>907</sup>
657. Research suggests that the requirement to agree to celibacy for Catholic priests, nuns, sisters and brothers may deprive them of romantic and physical intimacy, which when combined with unchecked power over children in care can lead to abuse.<sup>908</sup> Internationally, some men have admitted they entered the priesthood to curb pre-existing sexual problems, such as child sex offending, in the 'sex-free' zone of clerical life.<sup>909</sup>
658. The Australian Royal Commission into Institutional Responses into Child Sexual Abuse, when considering factors that may have contributed to the occurrence of child sexual abuse in Catholic institutions, stated that "for many clergy and religious, celibacy is an unattainable ideal that leads to clergy and religious living double lives and contributes to a culture of secrecy and hypocrisy."<sup>910</sup>

903 Letter from the Archbishop to Patricia Allan (10 August 1990).

904 Redmond, SA, "Christian "virtues" and recovery from child sexual abuse" in *Christianity, patriarchy and abuse: A feminist critique* (1989, pages 76–77).

905 Anderson, J, "Socialization processes and clergy offenders" in *Journal of child sexual abuse* Volume 25, No 8 (2016, pages 853–854); Schepers-Hughes, N, & Devine, J, "Priestly celibacy and child sexual abuse" in *Sexualities* Volume 6, No 1 (2003, pages 19–21).

906 Robinson, GJ, *Confronting power and sex in the Catholic Church: Reclaiming the spirit of Jesus* (John Garratt Publishing, 2007, page 18).

907 Charleton, M, "Abuse of Children in Institutional Care in 20th Century Ireland: An Analysis Using Fromm's Psychology" in *Journal of Social Work Practice* Volume 26, No 3 (2012, pages 331–338).

908 Bosgraaf, E, "Breaking the will: relations between mental mortification in monastic life and the psychological abuse of children in Catholic institutions" in *Mental Health, Religion & Culture* Volume 16, No 6 (2013, pages 589 and 590–591).

909 Schepers-Hughes, N, & Devine, J, "Priestly celibacy and child sexual abuse" in *Sexualities* Volume 6, No 1 (2003, page 17).

910 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), *Final Report: Religious Institutions: Volume 16, Book 1* (2017, page 47).

659. The Inquiry also heard evidence at its Contextual Hearing from Professor Cahill and Dr Wilkinson that abusive priests were sometimes “psychosexually immature maldeveloped and deeply frustrated”.<sup>911</sup> Dr Thomas Doyle, former priest, canon lawyer, and addictions therapist, told the Inquiry that “mandatory celibacy has had a definite influence on the development of dysfunctional sexuality within the context of the closed clerical world.”<sup>912</sup>
660. Some Catholic entities have sought to protect their reputation by maintaining the appearance of a celibate clergy, pushing priests’ sex lives and sexualities further underground and creating a culture of secrecy. Before his ordination, Ian Werder told the Inquiry Bishop Dunn asked him what he would say if someone asked if he was gay. Ian’s response was, “I would not necessarily advertise it, but I would not deny it.”<sup>913</sup> Bishop Dunn later did not ordain Ian.<sup>914</sup> The Inquiry notes that it has not investigated the reason that the Bishop did not progress Ian’s ordination or explored the variety of considerations that would have informed this decision.
661. Research provided to the Australian inquiry into Institutional Responses to Sexual Abuse showed that institutions that code all sexualised behaviours as inappropriate and taboo can create the conditions for sexual abuse to occur. Conversely, research has also highlighted how people who are embedded in ‘sexualised’ institutional cultures can develop sexually harmful behaviour over time.<sup>915</sup>
662. Expressions of sexuality were not universally repressed in all eight faith settings this Inquiry examined. A few survivors of Gloriavale described how children were exposed to graphic sexual content, creating unsafe cultures around sex.<sup>916</sup> Another survivor of the Plymouth Brethren Christian Church described how sins had to be aired in front of other members, and as a result children of all ages were inappropriately exposed to intimate sexual details.<sup>917</sup> The Inquiry notes that the Plymouth Brethren Christian Church does not accept this survivor’s evidence or that this practice of airing sins in front of other members occurred.

911 Transcript of evidence of Professor Desmond Cahill and Dr Peter Wilkinson at the Inquiry’s Contextual Hearing (Royal Commission of Inquiry into Abuse in Care, 8 November 2019, pages 1077–1078).

912 Submission of Dr Thomas Doyle (9 March 2021, para 203).

913 Witness statement of Ian Werder (26 August 2021, page 7).

914 Witness statement of Ian Werder (26 August 2021, page 7).

915 Palmer, D, & Feldman, V, Toward a more comprehensive analysis of the role of organizational culture in child sexual abuse in institutional contexts in *Child Abuse & Neglect* Volume 74 (2017, page 28).

916 Witness statements of Clement Ready (30 May 2022, para 4.1.4) and Virginia Courage (25 June 2021, page 3.7.1).

917 Witness statement of Neville McCallum (19 July 2022, pages 14–15).

## Ngā hiringa whakapono ā-hara, murunga hara, me te mahi huna he take i hua ai te mahi taitōkai

### Religious concepts of sin, forgiveness and secrecy were applied to sexual abuse

663. In many faith-based settings, the interpretation of abuse through a religious lens led to inappropriate responses to reports and a failure to safeguard against ongoing abuse. Forgiveness is a key teaching in Christianity, where people are encouraged to let go of anger and blame and embrace those who have sinned against them.<sup>918</sup> Interpreted through this religious lens, faith-based institutions have sometimes responded to reports of sexual abuse as requiring forgiveness and reconciliation (including confession), rather than necessitating the involvement of secular authorities or a focus on prevention and safeguarding.<sup>919</sup>
664. The Australian Royal Commission into Institutional Responses into Child Sexual Abuse notes that the sacrament of confession practiced by the Catholic Church also often enabled abusers to resolve their sense of guilt without fear of being reported.<sup>920</sup>
665. Retired Anglican minister Patricia Allan told the Inquiry that in her opinion:  
*"[t]he theology of the Church is if you sin, repent and say you're terribly sorry and that you won't do it again, then you're forgiven and get a clean slate."*<sup>921</sup>
666. In 1990 Anglican Archbishop Brian Davis wrote "forgiveness is a costly business but the Gospel both demands this and makes it possible".<sup>922</sup> The Anglican Church has said that while its Title D Canon sets out the theology of discipline for serious misconduct it does not mandate exoneration following an apology by those who commit serious misconduct.

918 Redmond, SA, "Christian "virtues" and recovery from child sexual abuse" in Christianity, patriarchy and abuse: A feminist critique (1989, pages 73–75).

919 Irenyi, M, Bromfield, L, Beyer, L, & Higgins, D, Child maltreatment in organisations: Risk factors and strategies for prevention, Vol 25 (Australian Institute of Family Studies, 2006, pages 12–14).

920 Royal Commission into Institutional Responses to Child Sexual Abuse (Australia), Final Report: Religious Institutions: Volume 16, Book 1 (2017, pages 48–49).

921 Witness statement of Patricia Allan (12 March 2021, page 24).

922 Letter from the Archbishop to Patricia Allan (10 August 1990, page 1).

667. Gloriavale's approach to handling sexual abuse allegations during the Inquiry period used to be to "lead transgressors to a place of repentance, and victims to a place of forgiveness".<sup>923</sup> Until 2012, the community "little to no dealings with police",<sup>924</sup> instead dealing with any sin amongst its own community due to the rule in its doctrinal text "What We Believe", which said the church "must deal with any sin amongst its members".<sup>925</sup> Survivors explained that this approach resulted in a prioritisation of the interests of perpetrators of abuse and prevented them from making meaningful contact with agencies outside of Gloriavale.<sup>926</sup>

668. A similar emphasis on 'forgiveness' as a response to sexual abuse rather than using disciplinary processes has driven failed responses within the Catholic Church. European survivor Vincent Reidy, who survived sexual abuse from his parish priest and when in the seminary, described how the onus has been placed on the survivor to 'forgive':

***"... sexual abuse is seen as a sin, not a crime. Forgiveness is important in the Catholic Church. If a person refuses to forgive then they become a sinner."***<sup>927</sup>

669. Representatives of the Catholic Church have identified this prioritisation of forgiveness over safeguarding as a driver of abuse. At the Inquiry's Faith-based Institutional Response Hearing, Cardinal John Dew said:

***"I think the question that you've just put to us that forgiveness was seen to be more important than safeguarding was probably a thing in the past."***<sup>928</sup>

670. This emphasis on absolving sin encouraged survivors to understand themselves as somehow responsible for their abuse. NZ European and Australian Survivor Leonie Jackson, who was sexually abused as a nine-year-old by two Marist Brothers, told the Inquiry:

***"I have told so many priests about the abuse I have suffered in confession and have only received penance in return. Not one ever told me it was a crime or gave me advice, so I believed it was my sin to carry."***<sup>929</sup>

923 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (8 July 2022, page 3).

924 Gloriavale Christian Community, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 460 (8 July 2022, page 3).

925 What we believe – Basic beliefs (Gloriavale Christian Community, 2015, page 121).

926 Witness statement of Ms PQ (25 June 2021, page 4).

927 Witness statement of Vincent Reidy (21 September 2020, page 11).

928 Transcript of evidence of Cardinal John Dew at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry of Abuse in Care, 17 October 2022, page 230).

929 Witness statement of Ms Leonie Jackson (21 September 2020, para 3.15).

671. NZ European survivor Ms VZ, who experienced sexual abuse by her mother's partners, was subjected to an exorcism by men unknown to her at an Anglican church following disclosure of this abuse. She was told they were "casting out Jezebel", explaining:

*"It was terrifying to have these men hold me down and pray for the spirits of lust and evil to leave me. ... It was terrifying to think that there were unseen evil forces making these men who abused me target me in a way. In my mind it made me just as bad as the men who had abused me, as it was like I had invited them in some way. I felt like they were blaming me for what happened."*<sup>930</sup>

672. The treatment of sexual abuse as a 'sin' can mean it is treated as a mutual act, rather than occurring in the context of significant power imbalance between perpetrator and victim.<sup>931</sup>

673. This view of abuse as requiring religious reconciliation can also mean little non-religious input, such as reporting to NZ Police, is sought for dealing with perpetrators of sex abuse within a faith-based context. This creates further secrecy from the secular world.

674. Dr Thomas Doyle told the Inquiry that the

*"Catholic Church, traditionally, is dependent on secrecy. It prevents ... the vast majority of Catholics and others, from knowing what goes on the inside ... especially covering the bad things."*<sup>932</sup>

## **I whakamahia ngā hiringa whakapono hei whakamana tūkinotanga Religious beliefs were used to justify abuse**

675. The Inquiry heard in the accounts of many survivors how adults in positions of power justified abuse using Christian beliefs and authority. For instance, survivors described being told they had to learn to suffer and fear God while being subjected to physical abuse.<sup>933</sup> The association of suffering with salvation is found in aspects of Christian theology.<sup>934</sup> Suffering is thought to teach humility, and martyrdom – an extreme form of suffering – holds special status within the Christian tradition.<sup>935</sup>

676. Researchers have argued the removal of vulnerable groups from society under the guise of treatment or reform can be used to justify abusive treatment or inhumane practices.<sup>936</sup>

930 Witness statement of Ms VZ (2 August 2021, para 20).

931 Irenyi, M, Bromfield, L, Beyer, L, & Higgins, D, Child maltreatment in organisations: Risk factors and strategies for prevention (Australian Institute of Family Studies, 2006, page 14).

932 Transcript of evidence of Dr Thomas Doyle at the Inquiry's Faith Redress Hearing (23 March 2021, page 510).

933 Witness statement of June Lovett (14 December 2021, para 45); Private session transcript of survivor who wishes to remain anonymous (11 October 2019, page 25).

934 Kienzle, BM, & Nienhuis, N, "Battered women and the construction of sanctity" in Journal of Feminist Studies in Religion Volume 17, No 1 (2001, page 59).

935 Redmond, SA, "Christian 'virtues' and recovery from child sexual abuse" in Christianity, patriarchy and abuse: A feminist critique (1989, page 73–75).

936 Stein, M, "Missing years of abuse in children's homes" in Child & Family Social Work Volume 11, No 1 (2006, page 15).



677. As well as being evident in the accounts of survivors of faith-based schools and children's homes, the use of moral 'reformation' as a justification for abuse was evident in the accounts of survivors of women's homes. The Anglican Church provided evidence to the Inquiry that women's homes were established in the nineteenth century because of a perceived need to support unmarried mothers.<sup>937</sup> The Inquiry also saw literature to suggest that some women's homes were established to impress Christian moral and spiritual values on unwed mothers.<sup>938</sup> Survivors described being subjected to hard labour and physically assaulted in women's homes, during pregnancy and childbirth, as a punishment for their actions and to bring about moral reform.<sup>939</sup>
678. These hierarchical and violent environments, where religious teachings were leveraged as justifications for abuse, were able to emerge because of the isolation and insularity of many faith-based care settings and the societal attitudes of the time. This insularity meant they were not subject to external scrutiny, removing checks and balances that may have moderated behaviour. Abusive behaviour was therefore able to be justified as a 'necessary' or 'normal' part of life without necessarily being challenged.<sup>940</sup>
679. Often abusers used the biblical concepts of shame and humiliation, and the wider fear of religious punishment or repercussion to abuse and control children and young people. Examples of this are detailed in the Inquiry's report *Stolen Lives, Marked Souls*. The misuse of religious teaching and scripture allowed abuse to occur, but it also prevented disclosures of abuse for fear of retribution by God himself.<sup>941</sup>

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937 Greenaway, R, *Threads of Caring* (Commissioned by the Anglican Trust for Women and Children), Chapter 2 – The Women's Home, 1884–1949, Rescuing 'fallen sisters', final draft provided by chair of the Trust Board for the Anglican Trust for Women and Children (2022, pages 6, 34).

938 Tennant, M, *Paupers & providers: charitable aid in New Zealand* (Allen & Unwin New Zealand Limited and Historical Branch, Department of Internal Affairs, 1989, page 132–133).

939 Witness statements of Mrs D (21 September 2020, para 39) and Nancy (Sally) Levy (16 December 2021, paras 55–58).

940 Palmer, D, & Feldman, V, "Toward a more comprehensive analysis of the role of organizational culture in child sexual abuse in institutional contexts" in *Child abuse & neglect* Volume 74 (2017, pages 29–31).

941 Royal Commission of Inquiry into Abuse in Care, *Stolen Lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (July 2023, page 333).

# I te ngaro te Tiriti o Waitangai i te nuinga o ngā hinonga whakapono

## Te Tiriti o Waitangi largely absent in faith-based institutions

680. As set out in Part 1, although faith-based institutions are not te Tiriti o Waitangi partners themselves:
- legislation may require them to act consistently with te Tiriti o Waitangi.<sup>942</sup>
  - te Tiriti o Waitangi is relevant to interpreting legislation (or can be read into legislation) even where the legislation is silent on te Tiriti o Waitangi.<sup>943</sup>  
Therefore, te Tiriti o Waitangi may impact faith-based institutions when they care for tamariki, rangatahi and pakeke Māori, as te Tiriti o Waitangi is relevant to the care of tamariki and rangatahi Māori and it colours all legislation dealing with the status, future and control of tamariki.<sup>944</sup>
  - if faith-based institutions made their own commitments to te Tiriti o Waitangi (for example, in governing documents of public statements) they may be accountable to meet those commitments.<sup>945</sup>
681. How te Tiriti o Waitangi applies in a given context depends on the particular circumstances.<sup>946</sup> In the absence of clear legislative direction, the faiths have taken varied approaches to consideration and implementation of the rights guaranteed in te Tiriti o Waitangi. Most faiths the Inquiry investigated started to make their own commitments to te Tiriti o Waitangi towards the end of the Inquiry period. For example, in 1989 at the Catholic Bishops Conference, te Tiriti o Waitangi was described as a sacred covenant, and in 1995 they went further acknowledging the particular rights of Māori as the indigenous people.

942 Education and Training Act 2020, sections 4, 5, 9 and 127.

943 See *Trans-Tasman Resources Ltd v Taranaki-Whanganui Conservation Board* [2021] 1 NZLR 801, [2021] NZSC 127 (paras 8 and 151); *Ngāti Whātua Ōrākei Trust v Attorney-General* [2022] NZHC 843 (para 589); and *Huakina Development Trust v Waikato Valley Authority* [1987] 2 NZLR 188 (HC).

944 *Barton-Prescott v Director-General of Social Welfare* [1997] 3 NZLR 179 (para 184).

945 See *Te Pou Matakana Limited v Attorney-General* [2022] 2 NZLR 148, [2021] NZHC 2942. Although this case concerned the Ministry of Health's policy commitments to exercise its powers in accordance with te Tiriti o Waitangi, it may be arguable that faith-based institutions exercise public powers and functions when providing care.

946 *New Zealand Maori Council v Attorney-General* [1994] 1 NZLR 513 (PC) at 517 (the Broadcasting Assets case); and *Ngāti Whātua Ōrākei Trust v Attorney-General* [2022] NZHC 843 at [593] and [596].

682. The Anglican Church in Aotearoa, New Zealand and Polynesia has been constitutionally divided into three Tikanga: Tikanga Māori, Tikanga Pasifika and Tikanga Pākehā. Three Archbishops, one from each, form the 'Primacy' of the Anglican Church, or in other words, lead the church.<sup>947</sup> Although the three branches appear to be equal in terms of formal political authority, Tikanga Pākehā controls the bulk of resources. For every \$1 of assets held by Tikanga Māori, Tikanga Pākehā holds \$28 worth of assets.<sup>948</sup> Reverend Dinah Lambert, Chaplain of Te Aute College in Te Matau-a-Māui Hawkes Bay, told the Inquiry that, in describing the sharing of resources with the Tikanga Māori arm of the church, Archbishop Brown Turei had said to her:

*"sometimes, Dinah, it's like you're given a kete but it's empty."*<sup>949</sup>

683. At the other end of the spectrum, Gloriavale and Plymouth Brethren Christian Church did not make any commitments to te Tiriti o Waitangi during the Inquiry period. Plymouth Brethren told the Inquiry that as a faith-based organisation they do not have any formal obligations under te Tiriti o Waitangi and that Māori have the same rights as everyone else.<sup>950</sup>

## Ngā mōtika tangata me ngā hinonga ā-whakapono Human rights and the faith-based institutions

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684. The New Zealand Bill of Rights Act came into force on 25 September 1990. During the Inquiry's Faith-based Institutional Response Hearing, the Crown stated that:

*"Anyone can have obligations in relation to human rights as a result of s3(b) of the [New Zealand Bill of Rights Act], but only if they are performing a public function, power or duty. This is likely to be the case where the State has empowered private citizens and other actors to provide care for vulnerable children."*<sup>951</sup>

947 Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Pūretumu Torowhānui Volume 1 (2021, page 183).

948 He waka eke noa – A waka we are all in together (Anglican Church, 2020, page 22).

949 Transcript of evidence of Reverend Dinah Lambert at the Inquiry's Tō muri te pō roa, tērā a Pokopoko Whiti-te-rā (Māori Experiences) Hearing (Royal Commission of Inquiry into Abuse in Care, 15 March 2022, page 483).

950 Royal Commission of Inquiry into Abuse in Care, Internal notes from the Inquiry's meeting with representatives of the Plymouth Brethren Christian Church (29 November 2022, page 24–25).

951 Memorandum of Counsel on behalf of the Crown, the Inquiry's Faith-based Institutional Response Hearing (21 February 2023, para 22).

685. Despite this, faiths investigated by the Inquiry have taken inconsistent and often limited or no consideration of any positive human rights obligations they may have had towards the end of the Inquiry period. For example, when Gloriavale Christian Community was asked how it had incorporated any international human rights norms and principles into its systems, procedures and policies in respect of caring for children, young people and adults in care, it told the Inquiry:

*“We are a small farming community on the West Coast so we generally do not spend any time reading international human rights treaties and principles. Having said that we are conscious of the need to follow all domestic laws.”<sup>952</sup>*

## **I te ngoikore te aroturukitia o ngā hinonga whakapono Oversight and monitoring of religious institutions was lacking**

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686. There was little oversight and monitoring of faith-based institutions by the State or any independent monitor during the Inquiry period. Similarly, there was little internal oversight and monitoring of the institutions by the faiths themselves. Unsafe practices were able to develop and continue in faith-based institutions partly due to a lack of their own internal and also external State monitoring.

687. In practice, most faith-based institutions operated independently, without a centralised governance structure providing a final level of monitoring and oversight. This meant care settings operated in siloes, with no awareness of issues facing the other care settings affiliated to their faith.

688. For example, the three Methodist Children’s Homes (in Tāmaki Makaurau Auckland, Whakaoriori Masterton, and Ōtautahi Christchurch) operated completely independently, and had their own management committees which were responsible to and reported annually to the Methodist Conference. The Synod and Conference appointed the Board of each home. From the 1960s the Methodist Social Services Association oversaw the homes and took over management reporting to conference annually.<sup>953</sup> The Methodist Church accepted that the Methodist Conference failed to provide sufficient monitoring, oversight and safeguarding of the three Methodist Children’s Homes and that these failures enabled abuse and neglect to occur.<sup>954</sup>

<sup>952</sup> Gloriavale Christian Community, Second Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce No 460 (8 July 2022, paras 209 and 213).

<sup>953</sup> Opening Statement of Reverend Tara Tautari on behalf of the Methodist Church of New Zealand at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 32); Methodist Church of New Zealand, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 452, Questions 2–7 (24 May 2022, page 13).

<sup>954</sup> Transcript of Reverend Tara Tautari for the Methodist Church and Wesley College at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 246).

689. There was a lack of monitoring and oversight of many Catholic institutions by local bishops and religious leaders, with evidence of infrequent and surface-level visits by a local bishop or a board member. The Inquiry has heard that in some Catholic care settings, such as Our Lady's Home of Compassion in Island Bay, Te Whanganui-a-Tara Wellington, and Sunnybank Boys' Home near Whakatū Nelson, the mother superior would have absolute control of the running of the orphanage. In relation to the Home of Compassion, a survivor said the woman in charge "had absolute total control" and some oversight by the Catholic Church would have helped.<sup>955</sup>
690. Similarly, during the earlier years of its existence, the Hebron Trust was informal, largely unregulated, and unmonitored by the Bishop of Christchurch or the leadership of the Order of St John of God. In the Inquiry's report *Stolen Lives, Marked Souls*, the Inquiry found that there was "a lack of monitoring and oversight by the State, the Order [of St John of God] and the [Catholic] Church from the date of application to establish Marylands and the development of Hebron Trust, until [prolific abuser] Brother McGrath's departure."<sup>956</sup>
691. A lack of oversight and monitoring in faith-based institutions can also be seen in Berhampore Home (Presbyterian) in Te Whanganui-a-Tara Wellington, which was open from 1909 to 1985. Chief Executive of Presbyterian Support Central, Naseem "Joe" Asghar acknowledged at the Inquiry's Faith-based Institutional Response Hearing that there were some managerial issues. For example, from the records, there were no reporting systems in place for the board or management to monitor the care of children and young people, despite abuse and neglect occurring.<sup>957</sup> This lack of reporting systems was one reason why abuse and neglect were able to continue, unchecked and often without consequences.
692. The Plymouth Brethren Christian Church told the Inquiry that its assemblies are "autonomous and self-regulating" and that "every local assembly is part of the [broader] assembly in a universal sense".<sup>958</sup> Plymouth Brethren neither has or enforces any national policies or procedures on any matters of individual assemblies.<sup>959</sup> This results in a lack of coordinated oversight and limited external accountability, which may increase the risk of abuse and neglect:
- "The assemblies themselves do not have formal, written policies. Situations are addressed as they arise under the guidance of the elders in accordance with the teachings of the Holy Bible and the ministries of current and former senior leaders."***<sup>960</sup>

955 Private session of survivor who wishes to remain anonymous (10 March 2020, page 78).

956 Royal Commission of Inquiry into Abuse in Care, *Stolen Lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (2023, page 48).

957 Transcript of evidence of Naseem (Joe) Asghar at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 257).

958 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Appendix 1: Overview of the PBCC, para 1).

959 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Appendix 1: Overview of the PBCC, para 19).

960 Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Appendix 1: Overview of the PBCC, para 20).

# Kīhai te nuinga o ngā hinonga whakapono i meinga kia utu mo āna mahi hē

## Most faith-based institutions were not held to account

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693. Most faith-based institutions failed to take accountability for abuse and neglect of children, young people and adults in their care. Most of the faiths that were investigated acknowledged this failure to the Inquiry. These acknowledgements are set out below.

### Hāhi Kātorika Catholic Church

694. Catholic Church leaders in Aotearoa New Zealand have previously issued public statements addressing the abuse and neglect within the Church but have failed to adequately acknowledge the nature and extent of abuse and neglect within the church or accept responsibility for the harm done.

695. In a statement to the Inquiry, John Dew, former Cardinal and Archbishop of Wellington, when acknowledging and apologising for the harm, said:

*“As I have previously noted, I have been shocked and horrified at the way people have been treated and how their trust has been betrayed by clergy and religious, to our great shame. I simply cannot understand how this could have occurred.”<sup>961</sup>*

696. Information released by the Catholic Church revealed that out of the 1,296 abuse reports, there were 592 alleged perpetrators, including diocesan priests, religious orders and lay people. The Catholic Church provided the Inquiry with the names of 27 perpetrators with criminal convictions related to abuse of those in the care of the Catholic Church.<sup>962</sup>

697. Despite the scale of abuse and neglect within the Catholic Church in Aotearoa New Zealand, the Inquiry is unaware of any consideration by the church of the systemic causes of this. Very few senior leaders have been held to account for the systems and environment that allowed members of the Catholic Church to perpetuate pervasive abuse and neglect.

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961 Witness statement of Cardinal John Dew (Royal Commission of inquiry into Abuse in Care, 4 October 2022, para 41).

962 Te Rōpū Tautoko, Information Gathering Project Fact Sheet (1 February 2022, page 3).

698. Catholic Church leaders have not been accountable or transparent to their congregations and the broader community about the nature and extent of abuse and neglect by their members. This has impacted the church's capacity to provide a proper system to prevent further harm and provide meaningful and adequate responses to survivors. It has also increased barriers to disclosure for survivors because information about the abuse of others is an important factor in supporting survivors' disclosure of abuse.
699. The church's comprehension of the nature and extent of abuse of people in its care mostly comes from protocols and advisory committees set up to handle individual reports of abuse. The church leadership has made minimal and inadequate attempts to understand the fundamental and broader systemic factors that have influenced abuse. This has meant the church's prevention of further harm has been limited at best.
700. At the Inquiry's Faith-based Redress Hearing, counsel for the Catholic Bishops and Congregational Leaders of Aotearoa New Zealand acknowledged:
- "The Church recognises collectively [that] there has been a failure. Certain individuals have obviously been failed, and how and why those failures have occurred will need to be examined and remedied."***<sup>963</sup>
701. During the Inquiry's Tō muri te pō roa, tērā a Pokopoko Whiti-te-rā (Māori Experiences) Hearing, the Catholic Church acknowledged the harm caused to Māori in its care:
- "It is to the Church's great shame and sorrow that Māori are among those subject to harm and abuse while in the care of the Church. Many Māori share the Catholic faith and there is a great sadness felt that the Church has failed Māori in its care, leading to loss of faith and identity."***<sup>964</sup>

963 Transcript of opening statement of the Catholic Bishops and Congregational Leaders of Aotearoa New Zealand, at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 22 March 2021, page 489).

964 Transcript of opening submissions by the Catholic Bishops and Congregational Leaders of Aotearoa New Zealand at the Inquiry's Tō muri te pō roa, tērā a Pokopoko Whiti-te-rā (Māori Experiences) Hearing (Royal Commission of Inquiry into Abuse in Care, 7 March 2022, page 3).

702. The Catholic Church also acknowledged the harm caused to those who were in the care of Marylands School and Hebron Trust in Ōtautahi Christchurch. Many of the boys placed at Marylands School were disabled or had learning or behavioural needs, and those in the care of Hebron Trust were often 'street kids'. Many were tamariki and rangatahi Māori in need of safety, shelter and support.<sup>965</sup> At the Inquiry's Marylands School (St John of God) Hearing, the Catholic Church recognised that this group of survivors "were and are still the most vulnerable", and continued:

***"If you needed to be cared for, then you should have been safe in the care of the church. The fact that you were not safe and you were harmed is indefensible and a shame on all the church. For this, and when we didn't respond as we should have to your disclosures and reports of abuse, the bishops and congregational leaders are deeply sorry."***<sup>966</sup>

703. The Catholic Church has acknowledged that harm has taken place at some Catholic educational institutions, including in relation to St Patrick's College Silverstream in Te Awa Kairangi ki Uta Upper Hutt, which had 26 reports of alleged abuse relating to nine Society of Mary members at the college between 1951 and 1985.<sup>967</sup>

704. The Catholic Church leadership in Aotearoa New Zealand, including leadership of St Patrick's College Silverstream, has repeatedly acknowledged that mistakes were made and more should have been done to prevent the harm, pain and suffering of children and young people in the care at St Patrick's College Silverstream<sup>968</sup> and other Catholic boarding schools.

705. Sister Sue France, who provided evidence on behalf of Ngā Whaea Atawhai o Aotearoa, Sisters of Mercy New Zealand, told the Inquiry that the majority of reports made to the Sisters of Mercy related to physical or psychological abuse by religious sisters and took place in children's homes or orphanages.<sup>969</sup> Sister Sue France conceded that:

***"It's clear that because of mistakes made by the Church and by our Congregation, that children were harmed when tragically this could have and should have been avoided."***

***As a Congregation we've changed over time, and this Inquiry has highlighted more changes that were needed."***<sup>970</sup>

965 Royal Commission of Inquiry into Abuse in Care, *Stolen Lives, Marked Souls: The inquiry into the Order of the Brothers of St John of God at Marylands School and Hebron Trust* (2023, page 32).

966 Opening Statement on behalf of the Bishops and Congregational Leaders of the Catholic Church in Aotearoa, at the Inquiry's Marylands School (St John of God) Hearing (Royal Commission of Inquiry into Abuse in Care, 9 February 2022, para 7).

967 Transcript of evidence of Father Timothy Duckworth at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 October 2022, page 131).

968 Transcript of evidence of Dr Rob Ferreira, Dr Clare Couch and Mr Sean Mahony at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 October 2022, page 117).

969 Witness statement of Sister Susan Jayne France (12 February 2021, page 1).

970 Transcript of evidence of Cardinal John Dew, Dr Paul Flanagan and Sister Susan France at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 October 2022, page 214).



## Hāhi Mihinare Anglican Church

706. The Anglican Church acknowledges that children and young people were abused in its care. The Most Reverend Donald Tamihere told the Inquiry at its Faith-based Institutional Response Hearing:

***“On behalf of the Anglican Church in Aotearoa New Zealand and Polynesia we apologise to those who have suffered abuse while in the care of the church. It is horrific, shameful and completely unacceptable that people in our care have suffered abuse. We recognise and acknowledge that abuse has occurred within our church and we apologise unequivocally.”***<sup>971</sup>

707. The Most Reverend Donald Tamihere also told the Inquiry that the Anglican Church “remain horrified and ashamed that children and vulnerable people in the care of the church were subjected to abuse.”<sup>972</sup> He acknowledged the many forms of abuse and stated that it had been “sexual, physical, verbal and emotional”<sup>973</sup> and that “such behaviour is indefensible and completely antithetical to the gospel that we believe in and the values that we uphold.”<sup>974</sup>

708. The Anglican Church also acknowledged the additional harm caused by attempting to hide or cover up the abuse:

***“We are particularly ashamed by the evidence before the Royal Commission that members of our church covered up instances of abuse. We reiterate the sentiment in our past statement: to have ignored or covered up abuse is deplorable. There has been a failure by the church to protect those in its care and hold offenders to account. For that, we are deeply ashamed.”***<sup>975</sup>

971 Joint witness statement of the Primates (Most Reverend Philip Richardson, Most Reverend Donald Tamihere and Most Reverend Fereimi Cama) of the Anglican Church of Aotearoa, New Zealand and Polynesia (12 February 2021, para 4).

972 Transcript of opening statement of The Most Reverend Donald Tamihere at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 March 2021, page 447).

973 Transcript of opening statement of The Most Reverend Donald Tamihere at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 March 2021, page 447).

974 Transcript of opening statement of The Most Reverend Donald Tamihere at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 March 2021, page 447).

975 Joint witness statement of The Most Reverend Philip Richardson and The Most Reverend Donald Steven Tamihere (5 October 2022, para 7).

709. The Anglican Church extended its apologies to those survivors that were abused at Dilworth School in Tāmaki Makaurau Auckland. The Right Reverend Ross Bay, Bishop of Auckland, stated:

*“Especially today I wish to acknowledge and apologise to those who are the survivors of abuse at Dilworth School. This is a school that was meant to offer hope and stability for boys coming from vulnerable situations. Instead, advantage was taken of that vulnerability by various members of the staff. Among those who abused students were two Anglican chaplains. The church recognises its responsibility for these people who were the church’s direct representatives on the staff.”<sup>976</sup>*

710. In addition to the harm caused to those within the care of the Anglican Church, Bishop Ross Bay acknowledged the Anglican Church’s lack of responsiveness to those who tried to report abuse:

*“You did not receive the genuine care to which you were entitled. This failure has been compounded by our lack of responsiveness over the years to people who came forward to report abuse and to seek redress.”<sup>977</sup>*

## **Hāhi Weteriana Methodist Church**

*“The Church carries the primary responsibility for ensuring the protection and wellbeing of those in its care. We failed in this sacred duty and are determined to make amends.”<sup>978</sup>*

711. The Methodist Church acknowledges that children and young people were subjected to sexual, physical and psychological abuse and neglect in Childrens’ Homes, in connected foster placements and at Wesley College in Pukekohe. The Church has taken full responsibility for every person who was abused and neglected while in the care of the church and its related institutions and that it carried the primary responsibility for ensuring their protection and well-being.<sup>979</sup>

976 Transcript of evidence of the Right Reverend Ross Bay, Bishop of Auckland, at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 20 October 2022, page 544).

977 Transcript of evidence of the Right Reverend Ross Bay, Bishop of Auckland, at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 20 October 2022, page 544).

978 Transcript of opening statement of Reverend Tara Tautari on behalf of the Methodist Church of New Zealand at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 250).

979 Transcript of opening statement of Reverend Tara Tautari on behalf of the Methodist Church of New Zealand at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, pages 250–251).

712. The Methodist Church told the Inquiry that as it listened to survivors' stories it has become apparent that some abuse and neglect would likely have been avoided if survivors had been believed when they spoke out. Reverend Tara Tautari (General Secretary of the Methodist Church) told the Inquiry that:
- “Regretfully, the Church has not always accepted and acted on reports of abuse and has not taken appropriate disciplinary action. The Church acknowledges and apologises to the survivors who tried to report their abuse but were not listened to and those for whom the Church’s response inflicted further harm.”***<sup>980</sup>
713. The Methodist Church accepted its failings in addressing complaints of abuse and neglect and in providing redress. It acknowledged that it is likely there has been abuse and neglect in its care settings that remains unreported.<sup>981</sup> The church stated that “it is likely that this is not the only case of genuine concerns being minimised or denied”.<sup>982</sup>
714. At the Inquiry’s Faith-based Institutional Response Hearing, the Wesley College Trust Board acknowledged that the abuse and neglect suffered by children and young people has had significant consequences on those survivors, their whānau, and communities.<sup>983</sup> The Methodist Church took full responsibility for the harm caused by abuse and neglect in the care of all Methodist institutions, including Wesley College.<sup>984</sup> Reverend Tara Tautari (General Secretary of the Methodist Church) accepted that the church failed in its “sacred duty” to ensure the protection and wellbeing of those in its care<sup>985</sup> and apologised to survivors, their whānau, and loved ones.<sup>986</sup>

980 Opening statement of Reverend Tara Tautari on behalf of the Methodist Church of New Zealand at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 56).

981 Opening submissions of the Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa, Wesley College Board of Trustees, and Wesley College Trust Board for the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 3.24).

982 Methodist Church of New Zealand, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 452, Questions 2–7 (24 May 2022, page 10).

983 Opening submissions of the Methodist Church of New Zealand Te Hāhi Weteriana o Aotearoa, Wesley College Board of Trustees, and Wesley College Trust Board for the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 4.13).

984 Closing remarks on behalf of the Methodist Church of New Zealand, Wesley College Board of Trustees, and Wesley College Trust Board at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 21 October 2022, para 3.1).

985 Opening statement of Reverend Tara Tautari on Behalf of the Methodist Church of New Zealand at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 6).

986 Opening statement of Reverend Tara Tautari on Behalf of the Methodist Church of New Zealand at the Inquiry’s Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, para 14).

## Hāhi Hāpori Karaitiana o Gloriavale Gloriavale Christian Community

715. Hopeful Christian (Neville Cooper) (deceased), former Overseeing Shepherd and founder of Gloriavale Christian Community was convicted and jailed in 1995 for sexual offending, including against young people aged between 12 and 17, within the Gloriavale Community.<sup>987</sup> Current Overseeing Shepherd Howard Temple is defending charges of indecently assaulting 10 girls, offending that began in 1998.<sup>988</sup>
716. NZ European survivor Rosanna Overcomer, who is a representative of the Gloriavale Leaver's Trust, told the Inquiry that:

*"What was not dealt with appropriately went on to become the culture I was raised in. When people in positions of power have no accountability, they create a path of hurt and destruction. Systems left unchecked don't improve, they deteriorate. This is what has happened at Gloriavale."*<sup>989</sup>

## Te Hāhi Perehipitiriana me ōna ope whirinaki Presbyterian Church and affiliated organisations

717. Reverend Wayne Matheson told the Inquiry that the Presbyterian Church has a policy of zero tolerance of abuse and neglect of people in their care, and acknowledged this policy has not been consistently and thoroughly applied, and for that the Presbyterian Church was deeply sorry. Reverend Matheson said further that the Presbyterian Church is "extremely troubled that trust placed in the church has been broken by the abuse of people in our care."<sup>990</sup>
718. The Inquiry notes that there is a distinct legal separation between the Presbyterian Church and the support services organisations that ran care settings during the Inquiry period. The Presbyterian Church conceded at the Inquiry's Faith-based Institutional Response Hearing that, despite the separate legal structures, survivors do not see a distinction between the church and its support services organisations, often referring to the two collectively as "the Church".<sup>991</sup>

987 Edwards, J, "Gloriavale: Details of crimes committed by founder Hopeful Christian made public for first time", RNZ News (17 February 2023), <https://www.rnz.co.nz/news/national/484395/gloriavale-details-of-crimes-committed-by-founder-hopeful-christian-made-public-for-first-time>.

988 Naish, J, "Gloriavale overseeing shepherd appears in court for alleged sexual offending", Stuff (2 August 2023), <https://www.stuff.co.nz/national/crime/132657162/gloriavale-overseeing-shepherd-appears-in-court-for-alleged-sexual-offending>.

989 Transcript of Opening Statement for Gloriavale Leaver's Trust at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 13 October 2022, page 27).

990 Presbyterian Church of Aotearoa New Zealand, Response to Royal Commission of Inquiry into Abuse in Care Notices to Produce 523 and 530 (4 October 2022, Introduction (b)).

991 Transcript of evidence of Reverend Wayne Matheson on behalf of the Presbyterian Church of Aotearoa New Zealand at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 314).

719. Most board members for homes that were run by support services were made up of members from the Presbyterian Church. Until the 1980s, governance boards for the support services organisations were comprised largely of Presbyterian Ministers. For example, until the early 1980s, Presbyterian Ministers made up most board members on the Board of Governance for Berhampore Home in Te Whanganui-a-Tara Wellington. Berhampore Home was run by Presbyterian Support Central. Children and young people living there were alleged to have been abused by Berhampore Home's Director and Manager Walter Lake.
720. Presbyterian Support Central told the Inquiry that it has seen no evidence to show that the church ever investigated complaints at Berhampore Home.<sup>992</sup> When there was a complaint made to the church, it was referred to Presbyterian Support Central to deal with.<sup>993</sup> Presbyterian Support Central told the Inquiry that it was not aware of any monitoring of Berhampore Home by the church at the time. Any focus on the home appeared to be on its financial viability.<sup>994</sup>
721. The Inquiry is aware of a complaint made in 1991 by a deaconess to the moderator of the Presbyterian Church, advising that Walter Lake was a sexual predator. There are no records to suggest that the moderator took any steps to respond. The Presbyterian Church accepts that if the moderator was advised, the church should have done more.<sup>995</sup>
722. At the Inquiry's Faith-based Institutional Response Hearing, the Presbyterian Church accepted that there was a moral responsibility for Presbyterian members sitting on boards of its support services organisations to report back to the church when they became aware of reports of abuse or neglect. Reverend Wayne Matheson told the Inquiry:
- "I would think if I was sitting on a board and heard matters that were deeply distressing ... and the board was ... either unwilling or unable to take what I considered appropriate action, I would want to vote against any motion, etc, would also want my vote to be recorded and probably offer my reasons for dissent, so that they were on record in terms of that."***<sup>996</sup>
723. The Presbyterian Church accepted responsibility for the Presbyterian Ministers who sat on the board overseeing Berhampore Home not taking further steps when complaints about Walter Lake were raised.<sup>997</sup>

992 Transcript of evidence of Naseem (Joe) Asghar and Patrick Waite on behalf of Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 267).

993 Transcript of evidence of Naseem (Joe) Asghar and Patrick Waite on behalf of the Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 267).

994 Transcript of evidence of Naseem (Joe) Asghar and Patrick Waite on behalf of Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 257).

995 Transcript of evidence of Reverend Wayne Matheson on behalf of the Presbyterian Church of Aotearoa New Zealand at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 313–314).

996 Transcript of evidence of Reverend Wayne Matheson on behalf of the Presbyterian Church of Aotearoa New Zealand at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 310–311).

997 Transcript of evidence of Reverend Wayne Matheson on behalf of the Presbyterian Church of Aotearoa New Zealand at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 311).

## **Te Pokapū Tautoko o te Hāhi Pehipitiriana Presbyterian Support Central**

724. At the Inquiry's Faith-based Institutional Response Hearing, Mr Asghar acknowledged the immediate and long-term harm that was suffered by survivors and their whānau from abuse and neglect at Berhampore Home:

*"I've really been quite horrified and shocked at the way some children were treated in the home. Their mistreatment is to our absolute and great shame as an organisation. On behalf of Presbyterian Support Central, I offer a deep, profound and unreserved apology to survivors and their whānau for both the harm that they suffered as an individual and as children while in their care ... and the harm that many actually are continuing to suffer as a direct result of their experiences in our care."*<sup>998</sup>

## **Te Pehipitiriana o Otākau Presbyterian Support Otago**

725. Presbyterian Support Otago ran two children's homes, Glendinning Home in Ōtepoti Dunedin and Mārama Home in Lawrence, Ōtākou Otago, between 1950 and 1991.<sup>999</sup>

726. Survivor Ms PN, who was placed in Glendinning Home when she was 5 years old in 1950 or 1951, said she was severely sexually, physically and psychologically abused, including by parishoners of the local Presbyterian Church.<sup>1000</sup>

727. The Inquiry's investigation into abuse and neglect in the care of Presbyterian Support Otago during the Inquiry period was made particularly difficult because in late 2017 or early 2018, Presbyterian Support Otago destroyed its records, apart from registers of names and dates.

998 Transcript of evidence of Naseem (Joe) Asghar and Patrick Waite on behalf of Presbyterian Support Central at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 247).

999 Witness statement of Sam Benton, Sonja Cooper and Amanda Hill of Cooper Legal (28 July 2022, paras 303–305).

1000 Transcript of evidence of Ms PN on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 282–283).

728. The decision to destroy the records was made by the Chief Executive Officer at the time, Gillian Bremner, who instructed a staff member to destroy the records, with the exception of registers of names and dates. When asked by Joanne O'Neill, current Chief Executive Officer, Gillian Bremner confirmed that she obtained informal advice from lawyer and ex-Presbyterian Support Otago Board Chair Frazer Barton when deciding whether the records should be destroyed.<sup>1001</sup> Ms Bremner had contacted Mr Barton about whether Presbyterian Support Otago had to provide a survivor's records to their legal representative. Mr Barton confirmed that Presbyterian Support Otago was legally obliged to provide the records. Ms Bremner then asked whether Presbyterian Support Otago could destroy the rest of the records for all children and young people who had been in its care and keep only minimal information. Ms Bremner suggested she would do so once the staff member responsible for looking after the files retired, which was likely to happen within the next five years. Mr Barton replied that he thought Presbyterian Support Otago could destroy the documents, "but at an appropriate milestone or anniversary."
729. Although Presbyterian Support Otago had no internal document retention policy in 2017–2018, by the time the documents were destroyed they had already been held for at least 27 years since the homes had been closed.<sup>1002</sup> Joanne O'Neill told the Inquiry that she believes "there was an individual who was misguided in their decision-making." She said that she recognised the significance of the documents and that destroying them is not a decision she would have made.<sup>1003</sup>
730. While it is unclear whether the documents were destroyed in late 2017 or early 2018, Joanne O'Neill acknowledged that at the time the decision was made to destroy the documents, Presbyterian Support Otago was aware of reports of abuse and neglect in its care<sup>1004</sup> and "that there was a plan for a Royal Commission to be put in place."<sup>1005</sup> By 21 February 2018, Presbyterian Support Otago Board Minutes record reference to the Inquiry's Terms of Reference.<sup>1006</sup>
731. The documents had already been destroyed by the time the Inquiry made a preservation of documents order on 28 March 2019, which prohibited State and faith-based institutions from destroying potentially relevant information.<sup>1007</sup>

1001 Email from Gillian Bremner to Jo Rowe, CEO, Presbyterian Support Otago, Re: Historical abuse cases (24 January 2021, page 1).

1002 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 290).

1003 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 288 and 290).

1004 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 282).

1005 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 291).

1006 Presbyterian Support Otago, Minutes of Board Meeting (21 February 2018, page 3).

1007 Royal Commission of Inquiry into Historical Abuse in State Care and in the Care of Faith-based Institutions, Notice 1: Preservation of Documents (28 March 2019).

732. Joanne O'Neill told the Inquiry that:
- "first and foremost I want to apologise to all of those who have been harmed while they were in the care of Presbyterian Support Otago. This harm is the complete opposite of what should have resulted from the care provided by Presbyterian Support Otago and I am very sorry that that happened."*<sup>1008</sup>
733. Presbyterian Support Otago has accepted that one of the factors that enabled abuse and neglect to occur in its care homes included that people who were married, part of the church or involved in community objectives were believed to be upstanding and suitable to be involved in the care of children. It accepted that other factors that contributed to abuse and neglect were there was no external State agency review or audit of care standards of any of Presbyterian Support Otago's homes (the focus was on maintaining financial viability), and the culture did not encourage children and others to raise concerns.<sup>1009</sup>

## **Te Ope Whakaora The Salvation Army**

734. The Salvation Army estimated that "thousands" of children and young people were cared for in their children's homes during the Inquiry period.<sup>1010</sup>
735. The abuse and neglect suffered by those in the care of the Salvation Army's children's homes and homes for unwed mothers was wide-ranging and included sexual, physical and psychological abuse and neglect, including inadequate nutrition, hygiene and healthcare.<sup>1011</sup> The Salvation Army operated Bethany Homes where some women told the Inquiry they were made to feel shamed for being unwed mothers and felt pressured to adopt children, while being denied relevant information, medical and emotional help and support.<sup>1012</sup>
736. Murray Houston confirmed that, at 1 August 2020, the Salvation Army had received 238 claims regarding historical abuse and / or neglect.<sup>1013</sup> The Salvation Army has accepted that abuse and neglect in its care was wide-ranging and involved different types of perpetrators, including Salvation Army officers and other staff members, other residents, visitors to the homes and foster parents, among others.<sup>1014</sup>

1008 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, page 278).

1009 Transcript of evidence of Joanne O'Neill on behalf of Presbyterian Support Otago at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 19 October 2022, pages 283–284).

1010 Transcript of evidence of Colonel Gerry Walker on behalf of the Salvation Army at the Inquiry's Faith-based Redress Hearing (Royal Commission of Inquiry into Abuse in Care, 16 March 2021, page 118).

1011 Witness statements of Nikky Kristofferson (21 October 2020, paras 136, 142, 151) and Ann-Marie Shelley (6 August 2020, page 7).

1012 Witness statement of Susan Williams (16 February 2022, pages 3–4); Private session transcript of survivor who wishes to remain anonymous (16 June 2020, page 17); Private session transcript of survivor who wishes to remain anonymous (9 March 2020, page 25); Private session transcript of survivor who wishes to remain anonymous (3 March 2020, page 16).

1013 Witness statement of Murray Houston on behalf of the Salvation Army (18 September 2020, para 3.3).

1014 Witness statement of Murray Houston on behalf of the Salvation Army (18 September 2020, para 3.2).



## **Plymouth Brethren Christian Church**

737. The Plymouth Brethren Christian Church has acknowledged five allegations of abuse,<sup>1015</sup> but does not necessarily accept that these incidents occurred within its care. The number of allegations of abuse acknowledged by the church is significantly lower than the 32 survivors who told the Inquiry about being abused and / or neglected while within the care of the church.

## **Ngā akonga i kitea he mea panoni i hua i ngā hinonga ā-whakapono**

### **Lessons identified and changes made by faith-based institutions**

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738. During the Inquiry period, some lessons were learned by faith-based institutions who provided care to children, young people and adults in care, and they made changes as a result.
739. The large de-institutionalisation of faith-based care for children and women from the late 1970s has meant the closure of orphanages, children's homes and unwed mother's homes.
740. There were changes during the Inquiry period to allow women to hold positions of authority in most of the faiths the Inquiry investigated, however by the end of the Inquiry period (and still today) women were still underrepresented in leadership positions in most of the faiths the Inquiry investigated. To our knowledge no faith-based institution kept on or proactively recruited Deaf or disabled people to positions of authority during the Inquiry period. From the late 1980s some faith-based institutions started to implement safeguarding guidelines and develop processes relating to responding to reports of abuse and neglect in their care. For example, in 1987, the New Zealand Catholic Bishops' Conference released a pastoral letter to priests about sexual misconduct and in 1993, it published guidelines on sexual misconduct by clerics, religious and church employees sometimes referred to as the "provisional protocol".
741. Towards the end of the Inquiry period, the Salvation Army and the Anglican, Catholic, Methodist, and Presbyterian churches made commitments to te Tiriti o Waitangi to create a bicultural relationship within their governance structures. These commitments are relatively recent, with most publicly acknowledging their commitments to te Tiriti o Waitangi in the 1990s.

<sup>1015</sup> Plymouth Brethren Christian Church, Response to Royal Commission of Inquiry into Abuse in Care Notice to Produce 1 (23 April 2021, Schedule A: Response to schedule A of the Notice, page 6, para 10).

742. At the Inquiry's Faith-based Institutional Response Hearing, Reverend Tara Tautari, the first Māori General Secretary of the Methodist Church, explained that it took a long time – from the Methodist Church's beginnings in Aotearoa New Zealand in 1822 to its commitment to become a bicultural church in 1983 – because:

*"The Church did not understand what it meant to be partners, to share power, to share power in very real and tangible ways; for example, resource sharing, decision-making. These in former times were held by a small group of leadership that was largely patriarchal."*<sup>1016</sup>

## Ngā kōrero mutunga e pā ana ki te kawenga pūnaha taurima ā-whakapono

### Conclusion on the faiths responsible for care

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743. It was found that, in many faith-based institutions that provided care for children, young people and adults during the Inquiry period, that unique factors contributed to abuse and neglect, and created barriers to disclosure. These factors included:


- the misuse of religious power
- the moral authority and status of faith leaders and the access this power, authority and status gave them
- sexism and negative perceptions of women
- negative attitudes about sex and repression of sexuality
- racism and ableism based on religious concepts
- the interpretation of sexual abuse through the lens of sin and forgiveness.

744. Reverend Tara Tautari, on behalf of the Methodist Church of New Zealand at the Inquiry's Faith-based Institutional Response Hearing, said:

*"The Church carries the primary responsibility for ensuring the protection and wellbeing of those in its care. We failed in this sacred duty and are determined to make amends"*.<sup>1017</sup>

745. Oversight and monitoring of faith-based institutions providing care was lacking, in terms of both external oversight by the State and internal oversight by the faiths themselves. Most faith-based institutions were not held to account and few lessons were learned during the Inquiry period.


<sup>1016</sup> Transcript of evidence of Reverend Tara Tautari on behalf of the Methodist Church of New Zealand at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 253).  
<sup>1017</sup> Transcript of opening statement of Reverend Tara Tautari on behalf of the Methodist Church of New Zealand at the Inquiry's Faith-based Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 18 October 2022, page 250).



"The Church carries the primary responsibility for ensuring the protection and wellbeing of those in its care. We failed in this sacred duty and are determined to make amends."

**REVEREND TARA TAUTARI**

on behalf of the Methodist Church of New Zealand at the Inquiry's Faith-based Institutional Response Hearing



"Christian  
institutions  
will always choose  
faith-based principles  
over the law"

**TARIA BROWN**  
Cook Island Māori

# Taraia Brown

**Hometown:** Motueka

**Age when entered care:** 5 years old

**Year of birth:** 1975

**Time in care:** 1981–1990

**Type of care facility:** Faith-based school – Shiloh Christian Academy (the school) in Motueka

**Ethnicity:** Cook Island Māori

**Whānau background:** Taraia's heritage includes a Māori Mother and a Cook Island Father. Taraia is the second oldest of four sisters. Her older sister and younger sister both attended Shiloh Christian Academy, but her youngest sister didn't. Currently, Taraia lives in New Zealand with her English husband.



**It has taken me 40 years to have the courage to speak up and tell my story. I was sexually, physically and psychologically abused from 6 years old until I was 15 years whilst I was a student at the school.**

The sexual, physical and psychological abuse at school has caused immeasurable harm to me in so many areas of my life. I have worked hard over the years to heal from the trauma of the hand-on abuse. The physical violence and the regular deprivation of liberty leaves me vigilant and on guard. Every day, I know that three of the teachers who abused me are still teaching in schools. The fact that these teachers are still teaching continues to disturb me 40 years later. This knowledge adds a constant stress and grief to my life.

A male teacher at the school engaged in sexualised behaviour with young girls and provided a role model for the boys. He would expose his male genitals or move me up and down on his knee whilst pushing his genitals into my bottom. I observed him doing this with other female students. On one occasion, whilst reading quietly in the school reading room he entered the room unexpectedly. I was trapped and had to physically fight him off me. During this incident, my school uniform was ripped in several places. I was terrified and the feelings of terror, combined with suffocation is still a vivid memory for me.

This teacher regularly exposed his genitals at school, which seemed to encourage male students to expose themselves as well. It was uncomfortable and frightening.

Even though I was a very young child when the abuse began, I knew that sexual abuse and physical abuse was not right. I pleaded with my parents to change schools for many years. It felt as though no one was listening. I felt trapped and deprived of personal liberty.

I received physical beatings from 5 teachers at the school regularly. One of the female teachers at the school administered the majority of the beatings and she would scream at me that she was beating the devil out of me. At times, it felt as though she would go into a frenzy and the only way to survive was to hold onto your ankles and pray for it to be over.

All beatings were accompanied by a scripture from Proverbs in the Bible – spare the rod and spoil the child. I was physically beaten on my upper thighs, bottom, lower back and middle back on over 1,800 occasions, receiving an average of 4 or 5 blows per occasion. This amounts to a total of approximately 7,200 strikes on my body which started when I was 6 years old.

On two occasions I was hospitalised for severe bruising and swelling. I also saw our GP who discussed his concerns at the welts and bruises on my body with my mother. I still carry some of the scars of those beatings on my upper thighs. I cried constantly, wet the bed and suffered from fear and anxiety every day. My only solace was to self-harm, which released my pain and grief. I considered suicide frequently as a child as the only way out. As an adult I try not to think about this period of my life. It is raw and painful to look back.

I continued my schooling there until I was 15 years old. By then I had grown tall and strong. At my last scheduled beating, I responded with anger and threatened a female teacher with violence. I was suspended for threatening violence towards a teacher who had beaten me for 9 years. A week later, my parents made the decision to withdraw myself and my sisters from the school.

In my late teens, I suffered from bouts of rage and violent thoughts and found myself in constant conflict without understanding its cause. I sought opportunities to release the anger, grief and rage whilst intoxicated on complete strangers in a nightclub or pub. My grief was palpable, and I was unable to control the rage and would suffer from uncontrollable anger and violence directed at strangers. I engaged in self medicating behaviour much to my parent's disappointment. I failed University in my first year and I withdrew from everyone to cope with my grief and depression, and an overall sense of failure.

It is difficult for me to trust people. I suffer from poor attachment and abandonment issues. I still struggle with trauma symptoms especially nightmares, cold sweats, and severe insomnia some 30 years later and after many years of therapy. The memories of the abuse don't fade, I have learned to live with them more easily than 30 years ago. I hoped the memories would fade as I got older, but I suffer from constant stomach complaints, a diagnosis of adenocarcinoma (stomach cancer) and other digestive system related issues as a consequence.

I am aware of internal triggers which could lead to violence due to my long-term exposure to physical and psychological abuse at the school. I am prone to anger and if triggered I need to self-manage my symptoms and engage in de-escalation and calming techniques. It has taken years of therapy to relearn new coping mechanisms and regulate my emotions and behaviour. The physical abuse I suffered at the school continues to require constant effort on my part to regulate my symptoms, emotions and behaviour. I will need to do this for the rest of my life. For this reason, I never fully relax and I am vigilant about self-management.

I have developed a strong and reliable moral compass due to these experiences. Working in the public sector I have gained a greater understanding of the importance of child safeguarding and duty of care responsibilities. My eyes were opened to the 'bystander role' the other teachers and church community played at that time when they provided an environment for the abuse to thrive. I wasn't the only student to raise this issue.

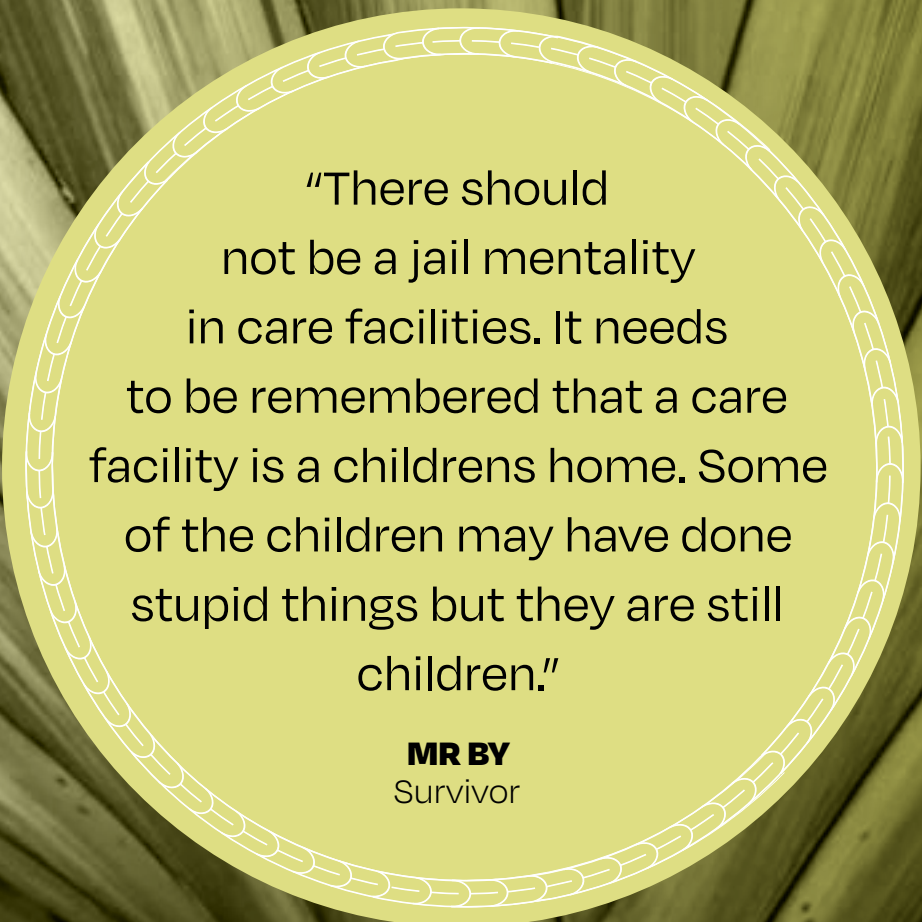
I was diagnosed with complex post-traumatic stress disorder and anxiety as a consequence of my experiences at the school. I have received therapy for over 29 years. The economic and emotional labour to undo all of the negative messaging, self-loathing, shame, grief and depression as a result of abuse at the school has been intensive. I continue to work hard to overcome these entrenched messages to slowly replace the sadness and grief with positive experiences, hope, love and optimism.

I have held discussions with my father about the sexual, physical and psychological abuse experiences at the school. These conversations have helped me to process these experiences. He has explained to me that "if he had his time again, he would not have sent my older sister, myself and my younger sister to this school". It's not an apology, but it's an acknowledgement of the damage that was done.

Children should grow up in a space where they are happy, safe and thriving. This was not my childhood experience. I was robbed of a happy childhood and as an adult I am now re-claiming my childhood by being brave and speaking up. I owe this to my inner child. No child should ever have this experience at school.<sup>1018</sup>

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<sup>1018</sup> Private session transcript of Taraia Brown, (Royal Commission Inquiry into Abuse in Care, 17 August 2022).

A circular graphic with a white chain-link border is centered on a background of green, textured, leaf-like patterns. Inside the circle, the following text is written in a black, sans-serif font:

"There should not be a jail mentality in care facilities. It needs to be remembered that a care facility is a children's home. Some of the children may have done stupid things but they are still children."

**MR BY**  
Survivor



# Ūpoko | Chapter 9


## Ngā kawenga pūnaha taurima ā-Kāwanatanga

### The State's responsibility for care

746. One of the State's primary responsibilities is to ensure the welfare of its citizens. Legislation that pre-dated the Inquiry period, such as the Crimes Act 1908 and the Child Welfare Act 1925, set out the State's responsibilities to enforce laws and standards preventing the abuse and neglect of all people in Aotearoa New Zealand, not only those in care.
747. Another of the State's fundamental roles is that of stewardship. Stewardship is actively planning and managing medium and long-term interests to ensure public investment is sustainable over time and public confidence in them is maintained.<sup>1019</sup> One of the goals of stewardship is to ensure that the parts of the system work well together and will adapt and change to keep working in the long term.<sup>1020</sup>
748. In Aotearoa New Zealand, the State took on increasing responsibility throughout the Inquiry period for directly providing and funding care. From the 1970s on, faith-based institutions, including orphanages and those for unwed mothers, began closing.
749. The State made use of its coercive statutory powers throughout the Inquiry period to:
- remove children and young people from their homes and place them into social welfare care
  - remove disabled people and people experiencing mental distress and place them into institutions
  - arrest and hold people in police cells and police custody.
750. The State had responsibility for people in care even if they were not placed in care using coercive statutory powers. For example, the State was responsible for the education of children and young people in residential special schools, even though the children and young people had been enrolled by their parents.

1019 Public Service Commission, Kaitiakitanga stewardship (<https://www.publicservice.govt.nz/role-and-purpose/principles-and-values/stewardship/>).

1020 The Treasury, Regulatory stewardship (<https://www.treasury.govt.nz/information-and-services/regulation/regulatory-stewardship>).

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751. Throughout the Inquiry period, specific State officials had statutory responsibilities and accountabilities in relation to the treatment of children, young people and adults in State and faith-based care settings.
752. The Crown was responsible for ensuring the guarantees it had made to Māori in te Tiriti o Waitangi were upheld as they related to care. It was also responsible for ensuring that the human rights of families, whānau, and people in care were respected, protected and fulfilled.
753. The State was ultimately responsible for safeguarding all children, young people and adults in care, regardless of the care setting and preventing and responding to abuse and neglect. This chapter explains that the State failed many children, young people and adults who had care or support needs. It sets out that the State should have known the care system was failing people in care and failed to respond adequately due to the information it had about abuse and neglect in care.

## **I hapa te Kāwanatanga i roto āna kawenga pūnaha taurima**

### **The State failed to uphold its responsibilities for the care system**

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754. The State failed to uphold all of its responsibilities for the care system, which contributed to abuse and neglect. This section sets out the following failures:
- a. the State did not give effect to te Tiriti o Waitangi or fulfill its human rights obligations
  - b. legislative and policy settings were discriminatory and ignored people's rights
  - c. this discriminatory approach reflected a lack of diverse leadership
  - d. people in care had limited input into State decision-making
  - e. the State's attempts to address institutional discrimination fell short
  - f. the State did not ensure that people in care were safeguarded from abuse and neglect
  - g. the State lost sight of its core regulatory, enforcement and funding functions
  - h. the State's highest-level decision-makers rarely took accountability for abuse and neglect in their care
  - i. the State did not implement a national care safety framework.

## **Kīhai i eke te whakamana a te Kāwanatanga i te Tiriti o Waitangi i ngā mōtika ā-tangata rānei**

### **The State did not give effect to te Tiriti o Waitangi or fulfil its human rights obligations**

755. As discussed in Part 6, tamariki Māori, rangatahi Māori and pakeke Māori in care are taonga. While assuming ultimate care and responsibility or an oversight role for these taonga, the Crown failed to protect or prevent the abuse that many suffered. This was a grave breach of the Crown's obligations of active protection.
756. The care systems into which Māori were taken and placed during the Inquiry period were generally a "Pākehā-centric one-size fits all" approach that was culturally inappropriate for Māori. Māori thinking, approaches and values were not incorporated into the care systems for tamariki, rangatahi and pakeke in care. The lack of kaupapa Māori options as part of the care systems breached te Tiriti o Waitangi principle of options, partnership, active protection, and equity.
757. In 1989, the State started to include references to whānau, hapū, and iwi in legislation.<sup>1021</sup> However, these legislative references were piecemeal, criticised as lacking cultural sophistication and faced barriers to implementation, such as structural and institutional racism.<sup>1022</sup>
758. The State should have progressively respected, protected and fulfilled the human rights of children, young people and adults in care, their families and whānau, including those in the care of faith-based institutions. Instead, the State generally left it to individual institutions, foster homes and faiths, to decide whether and how to respect these rights.

## **Ko ngā takinga ā-ture, a kaupapa he mea toihara, kīhai i aro ki te tika o te iwi**

### **Legislative and policy settings were discriminatory and ignored people's rights**

759. Earlier parts of this report explain how the State's legislative and policy settings and practices contributed to abuse and neglect in State and faith-based care during the Inquiry period. Māori, Pacific Peoples, Deaf and disabled people, people experiencing mental distress and Takatāpui, Rainbow and MVPFAFF+ people in care were disproportionately affected.

1021 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 5; Children, Young Persons, and their Families Act 1989, sections 4–5.

1022 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 265); Waitangi Tribunal, He Pāharakeke, He Rito Whakakīkinga Whāruarua: Oranga Tamariki Urgent Inquiry (2021, pages 34–44, 63–66, 98–99, 102–103, 109–112).

760. The State pursued a policy of institutionalisation of Deaf and disabled people, and people experiencing mental distress at the beginning of the Inquiry period. Having engaged with international experts and the World Health Organisation from the late 1940s, the Intellectually Handicapped Children's Parents' Association lobbied for community-based care and petitioned this in Parliament in 1950.<sup>1023</sup> The 1959 Burns Report, released by the Aotearoa New Zealand Branch of the British Medical Association, criticised the State's policy of institutionalisation and recommended community-based care.<sup>1024</sup>
761. At the Inquiry's State Institutional Response Hearing, the State acknowledged that the 1973 Royal Commission into Hospital and related services found that the Crown's policy of institutionalisation was inconsistent with international best practice.<sup>1025</sup>
762. The State often failed to provide concrete support or special measures to families, whānau or parents in need, which affected their ability to care for their loved ones at home.<sup>1026</sup> The State often failed to adequately explore other community or family-based options that prevented the need for out-of-whānau care.<sup>1027</sup>
763. Discriminatory legislation, policies and practices reflected the views and attitudes of the people who designed them.<sup>1028</sup> By and large, decision-makers lacked diversity and lived experience of care.<sup>1029</sup> The perspectives of children, young people and adults in care were largely not considered in the design of legislation, policies and practices that affected them.

1023 Millen, J, *Breaking barriers: IHC's first 50 years* (IHC New Zealand, 1999, pages 22–28).

1024 Burns, C, *The mental deficiency services: An analysis of existing policy and the community's requirements*, (Mental Deficiency Sub-committee, British Medical Association, New Zealand Branch, 1959, pages 2 and 20–24).


1025 Transcript of evidence of Dr Diana Sarfati, Director-General of Health, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, page 207); Hutchinson, C, Cropper, J, Henley, W, Turnbull, J & Williams, I, *Services for the mentally handicapped: Third report of the Royal Commission of Inquiry into Hospital and related services* (1973).

1026 Brief of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki, for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, August 2022, para 43); Further Acknowledgements made by Geraldine Woods on behalf of Whaikaha Ministry of Disabled People for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 2022, para 8).

1027 Brief of evidence of Chappie Te Kani, Chief Executive, Oranga Tamariki, for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, August 2022, para 43); Brief of evidence of Dr Diana Sarfati on behalf of the Ministry of Health for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, para 2.8); Further Acknowledgements made by Geraldine Woods on behalf of Whaikaha Ministry of Disabled People for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 2022, para 8).

1028 Brief of evidence of Dr Diana Sarfati on behalf of the Ministry of Health for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, para 2.8 (5)); Crown Closing Statement for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, para 17); Crown Closing Statement for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, para 13);

1029 Transcript of evidence of Peter Hughes, Public Service Commissioner, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 26 August 2022, pages 1064–1065).



"You leave care on the backfoot feeling like you have to start again. Takes a lot to just try to build your life and move on. You have to suddenly learn to do things you haven't been equipped to do – make decisions, trust, have autonomy!"

**ANONYMOUS SURVIVOR**

Rangatahi independent submission

## Ko te toihara o āna mahi he tohu o te kore i whānui te toronga o āna mahi arataki

### Discriminatory approach reflected a lack of diverse leadership

764. Many of the people in policy leadership roles during the Inquiry period lacked diversity and lived experience of care.<sup>1030</sup> At a conference in 1982, the State Services Commission framed the issues as:
- a lack of reliable statistical information on the diversity of the public service
  - different cultural values and needs were not being accurately understood or given due weight
  - the people who made up the public service did not adequately reflect a diverse society.<sup>1031</sup>
765. The State Services Commission said:
- “Clearly, if an effective and efficient service is to be provided for a multicultural society, this means that within the process of planning, policymaking and in the provision of services, the different needs of this diverse population have to be understood and accommodated.”<sup>1032</sup>*
766. The conference resolved that special recruitment and training programmes were needed to increase diversity, with those programmes appointing diverse people directly into positions of seniority and responsibility.<sup>1033</sup>
767. In 1988 the Puao-te-Ata-tu report noted that inadequate diversity in leadership and policy roles were resulting in harm to tamariki and pakeke Māori.<sup>1034</sup> The Inquiry was told that there were attempts to recruit more Māori social workers and managers after this, but they were not “in a position to make decisions”.<sup>1035</sup>
768. In 1998, a review found that little had changed across the public service with diversity recruitment tending to focus on junior entry level positions.<sup>1036</sup>

1030 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, pages 274–283).

1031 State Services Commission, Public Service in a Multicultural Society: Waahi conference 1982 (1983, page 14).

1032 State Services Commission, Public Service in a Multicultural Society: Waahi conference 1982 (1983, page 13).

1033 State Services Commission, Public Service in a Multicultural Society: Waahi conference 1982 (1983, page 32).

1034 The Maori Perspective Advisory Committee, Puao-te-ata-tu (day break): The Report of the Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare (1988, page 25).

1035 Witness statement of Denis Smith (15 December 2021, paras 26–27).

1036 Gardiner, W and Parata, H, Māori recruitment and retention project, (CEO Forum, 1998), as cited in Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 278).

## He kūiti nei te wātea o te hunga i roto i nga pūnaha taurima, whānau, kāinga me ngā hāpori ki te tuku whakaaro ki ngā whakatau Kāwanatanga

### People in care, whānau, kainga and communities had limited input into State decisions

769. The State's decisions about legislation and policy settings had little input from those who would be affected by their implementation.
770. Children, young people and adults in State and faith-based care, their whānau, kainga and communities all played a limited role in policy design and decision making. The perspectives of survivors of abuse and neglect in care were also not considered by decision-makers. This led to the development of inadequate laws, policies and practices that did not reflect the needs of people in care, their whānau, kainga or communities, which contributed to abuse and neglect in care. Many survivors, people in care, whānau, kainga and community members felt ignored, disempowered and excluded from policy design and decisions that affected them.<sup>1037</sup>
771. At the Inquiry's State Institutional Response Hearing, Oranga Tamariki Chief Executive Chappie Te Kani acknowledged that "historically Māori perspectives and solutions have been ignored across the care and protection system".<sup>1038</sup>
772. At the Inquiry's State Institutional Response Hearing, Whaikaha Acting Chief Executive Geraldine Woods, acknowledged that alternatives to care in the health and disability care settings were not adequately considered. This included not always supporting families in need and whānau, hapū and iwi to safely care for their tamariki and whānau hauā.<sup>1039</sup>

1037 Transcript of evidence of Mr VT at the Inquiry's Tulou – Our Pacific Voices: Tatala e Pulonga (Pacific People's Experiences) Hearing (Royal Commission of Inquiry into Abuse in Care, 28 July 2021, page 574); Transcript of evidence of Folasaitu Dr Apaula Julia Ioane at the Inquiry's Our Pacific Voices: Tatala e Pulonga (Pacific Peoples Experiences) Hearing (Royal Commission of Inquiry into Abuse in Care, 30 July 2021, page 701); Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 August 2022, page 577).

1038 Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 August 2022, page 577).

1039 Further Acknowledgements made by Geraldine Woods on behalf of Whaikaha Ministry of Disabled People at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, xx August 2022, para 8)

## I tū poto ngā torotoronga a te Kāwanatanga ki te whakatika o ngā mahi toihara ā-hinonga

### State's attempts to deal with institutional discrimination fell short

773. From the late 1980s onwards, the State did take some steps to address institutional discrimination, particularly racism, and how it impacted the disproportionate numbers of Māori and Pacific Peoples in care settings. For example, the release of Puao-te-ata-tu in 1988 resulted in widespread changes, including the Children, Young Persons and their Families Act 1989. The changes often amounted to incorporating a bicultural element into government business as usual, rather than driving fundamental change. At the Inquiry's State Institutional Response Hearing, Chappie Te Kani, Chief Executive of Oranga Tamariki, acknowledged the Crown failed to fully implement Puao-te-ata-tu in a comprehensive and sustained manner.<sup>1040</sup>

774. Māori survivor Tupua Urlich (Croatian, Ngāti Kahungunu), who was taken into care and protection when he was aged 5, illustrated the gap between the attempts to address racism and the lived reality for survivors when he told the Inquiry:

*"the only time I saw reference to te ao Maori was outside of the education center in a CYPS building, there were koru patterns in the glass frostings of the meeting rooms."*<sup>1041</sup>

775. At the close of the Inquiry period, institutional discrimination persisted and continued to disproportionately influence who entered care and who experienced abuse and neglect when in care.

1040 Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 August 2022, pages 576–578).

1041 Witness statement of Tupua Urlich (10 August 2021, page 10).



## **Kīhai i eke ngā whāinga a te Kāwangatanga ki te tauārai i ngā mahi tūkinō**

### **The State did not ensure people in care were safeguarded from abuse and neglect**

776. The State had a responsibility to ensure people in care had effective safeguarding, with comprehensive and well-resourced oversight and monitoring. However, the lack of effective safeguarding contributed to abuse and neglect, with ineffective oversight and monitoring that did little to prevent or respond to that abuse and neglect.
777. The State generally took a hands-off approach to safeguarding, leaving the development and implementation of safeguarding to individual institutions, foster homes, family homes, schools and hostels and transitional and law enforcement settings. This not only meant there was a lack of a consistent and coherent approach to safeguarding across all care settings but also meant that institutions were not held to account for poor safeguarding practices and policies. As a result, people in care suffered abuse and neglect and little was done to address the harm that occurred.

## **I tahuri kē te Kāwanatanga i ana whāinga matua ā-ture, whakamau kaupapa, toha tahua pūtea**

### **The State lost sight of its core regulatory, enforcement and funding functions**

778. During the Inquiry period, there was no comprehensive regulatory framework enforced and appropriately funded across all State and faith-based care settings. Laws relating to care settings were largely developed in isolation from each other, creating gaps in the overall care landscape.
779. The concept of strategic policy and regulatory stewardship did not exist in government until the late 1980s. It emerged as part of the wider reforms to the public service, with a new framework of performance goals and responsibilities set out in the State Services Act 1988 and the Public Finance Act 1989.<sup>1042</sup>
780. In the early 1990s the government introduced tools to assist with strategic planning, including strategic result areas for the governments major strategic goals, and key result areas for chief executives for each Department.<sup>1043</sup> The first modern strategy documents began to appear, including some relevant to care settings, but the State still lacked a deliberate approach to how it regulated care settings and did not design and implement a coherent and comprehensive regulatory framework for care in Aotearoa New Zealand.

<sup>1042</sup> Scott, G, Public management in New Zealand: Lessons and challenges (New Zealand Business Roundtable, New Zealand 2001, pages 17–18).

<sup>1043</sup> Foreman, M, Working Paper 2016/01: History of strategy stewardship in the New Zealand public service 1980–2016 (McGuinness Institute, page 5).

781. The Inquiry saw little evidence of the State systematically carrying out its regulatory function of monitoring care standards, identifying breaches of care standards and enforcing standards through meaningful penalties and sanctions. If the State had consistently monitored care facilities and held senior leaders and managers of care facilities, and the facilities themselves, to account for breaches of legal care standards, this could have prevented abuse and neglect.
782. The Inquiry heard evidence that the State failure to provide adequate resourcing for the care system contributed to abuse and neglect. For example, inadequate resourcing of State care facilities and their staff contributed to:
- a. high social worker caseloads, which led to fewer (or no) face-to-face visits with children and young people in care
  - b. inadequate or absent training and development of staff and carers
  - c. unsuitable and rundown care facilities.
783. Inadequate resourcing of independent oversight and monitoring entities limited their ability to investigate and report on complaints about abuse and neglect in State and faith-based care.

**He onge te wā i kitea ngā kaiwhakatau kaupapa matua a te Kāwanatanga e kawē ana i ngā mahi tūkinō i ngā pūnaha taurima**  
**The State's highest-level decision-makers rarely took accountability for abuse and neglect in care**

784. Throughout the Inquiry period, specific State officials had statutory responsibilities and accountabilities in relation to the treatment of people in their care, including:
- a. in Deaf, disability and mental health settings, the:
    - i. Director-General of Health<sup>1044</sup>
    - ii. Director of Mental Hygiene<sup>1045</sup>
    - iii. Director of Mental Health<sup>1046</sup>
  - b. in social welfare settings, the:
    - i. Superintendent of the Child Welfare Division, Department of Education<sup>1047</sup>
    - ii. Director-General of the Department of Social Welfare<sup>1048</sup>
  - c. in education settings, the:
    - i. Minister of Education<sup>1049</sup>
    - ii. Director-General of Education<sup>1050</sup>
  - d. in transitional and law enforcement settings:
    - i. the Commissioner of NZ Police.<sup>1051</sup>

1044 Health Act 1956, section 5.

1045 Health Act 1956, section 6(b).

1046 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 91.

1047 Child Welfare Act 1925, sections 4, 16.

1048 Children and Young Persons Act 1974, sections 5–6; Children, Young Persons, and Their Families Act 1989, section 7.

1049 Education Act 1914, section 4; Education Act 1964, section 4; Education Act 1989, section 2.

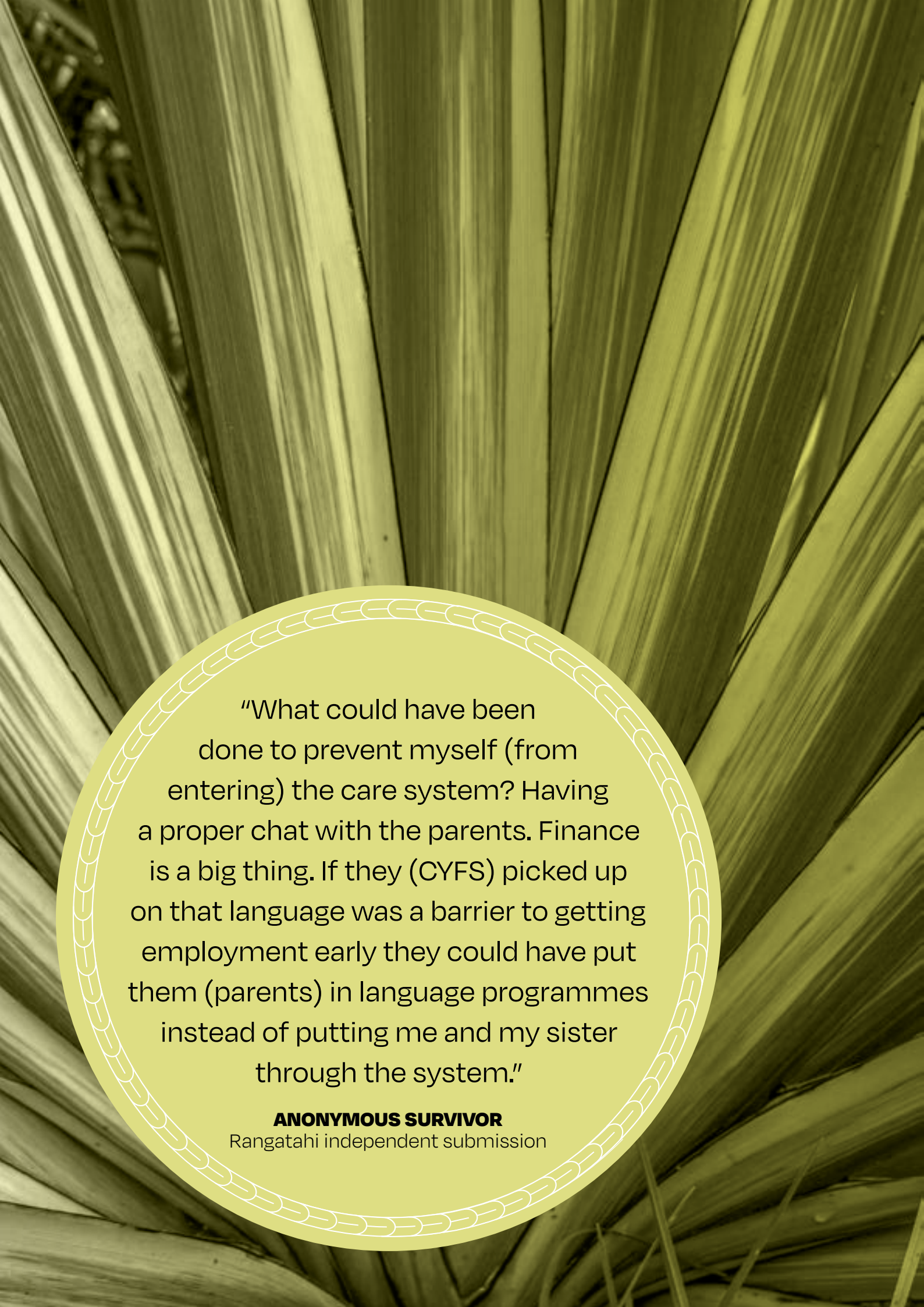
1050 Education Act 1964, sections 5–6.

1051 Police Act 1958, section 3.

785. Despite these statutory responsibilities and accountabilities, the State was often defensive and denied it was accountable for abuse and neglect in care.<sup>1052</sup> The State would often adopt an adversarial or litigious response to disclosures or claims about abuse and /or neglect in care, or delay or defer dealing with disclosures or claims. The State often did not believe survivors, which was at times underpinned by discriminatory societal attitudes, such as not viewing disabled people or people experiencing mental distress as credible witnesses or seeing children and young people in care as manipulative liars.
786. The State failed to consistently hold other State and faith-based institutions and the responsible senior managers and leaders to account for abuse and neglect of people in their care. Across all settings, the State's hands-off approach to accountability contributed to abuse and neglect in many settings, particularly in faith-based care. These failures contributed to a sense of impunity amongst those responsible for abuse because they were rarely held to account.
787. Former Chief Human Rights Commissioner, Rosslyn Noonan, wrote in her statement to the Inquiry that:
- “Over more than 50 years of claims of abuse in care, to my knowledge, no one in a senior position in any of [the] responsible agencies has been held to account.”***<sup>1053</sup>

<sup>1052</sup> Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui Volume 1 (2021, section 2.3, pages 132–165).

<sup>1053</sup> Brief of Rosslyn Noonan for the Inquiry's Contextual Hearing (Royal Commission of Inquiry into Abuse in Care, 4 November 2019, para 92).



"What could have been done to prevent myself (from entering) the care system? Having a proper chat with the parents. Finance is a big thing. If they (CYFS) picked up on that language was a barrier to getting employment early they could have put them (parents) in language programmes instead of putting me and my sister through the system."

**ANONYMOUS SURVIVOR**

Rangatahi independent submission

## E tika kē ana te Kāwanatanga kia mataara ki ngā pāruoretanga o te hunga i ngā pūnaha

### The State knew or should have known that the system was failing people in care

788. Throughout the Inquiry period, the State faced increasing reports of concern and complaints about abuse and neglect in State and faith-based care, across all care settings.<sup>1054</sup> Those concerns and complaints came to its attention through government agencies like the Departments of Social Welfare, Health, Education, NZ Police, and through numerous oversight and monitoring bodies. Many reports and reviews, some commissioned by the State, and others independent, found evidence of abuse and neglect in care. For example, the Auckland Committee on Racism and Discrimination, Ngā Tamatoa, and Arohanui Inc inquired into such matters

*“The Inquiry [by ACORD, Ngā Tamatoa, and Arohanui Inc] was called because of the refusal by the Social Welfare Department to investigate public allegations of cruel and inhuman treatment towards children entrusted to its care in Social Welfare Homes.”<sup>1055</sup>*

789. Almost all of the reviews were focused on specific facilities such as Lake Alice Child and Adolescent Unit, or care settings such as borstals or mental health settings.<sup>1056</sup>

790. The State knew from the 1970s that widespread and unlawful abuse and neglect was occurring, that in some institutions it was prevalent and extreme.<sup>1057</sup> From the 1990s, the State faced growing numbers of claims in the courts about abuse and neglect in State care.<sup>1058</sup>


1054 Waldegrave, S & Coy, F (Department of Child, Youth and Family Services, A differential response model for child protection in New Zealand: Supporting more timely and effective responses to notifications, *Social Policy Journal of New Zealand* (Issue 25) (July 2005, page 33).

1055 Auckland Committee on Racism and Discrimination, Ngā Tamatoa, Arohanui Inc, *Social Welfare Children's homes: Report on an Inquiry held on 11 June 1978* (1979, page 2).

1056 For example, Owen, RE, *Psychiatric services in public hospitals in New Zealand* (Board of Health, March 1960); Burns, C, *The Mental Deficiency Services – an Analysis of Existing Policy and the Community's Requirements* (Mental Deficiency Sub-Committee, British Medical Association – New Zealand Branch, 1959); Shearer, AR, *Review of Borstal Policy in New Zealand* (1969); *Third Report of the Royal Commission of Inquiry into Hospital and Related Services, Services for the Mentally Handicapped* (1973); Mitchell, W, *Report of the Commission of Inquiry into the Case of a Niuean Boy* (1977); Johnston, Archbishop AH, *Report of Committee to Report to the Minister of Social Welfare on the current practices and procedures followed in institutions of the Department of Social Welfare in Auckland* (1982); Ministry of Health, *Inquiry under section 47 of the Health and Disability Services Act 1993 in respect of certain mental health services: Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley* (1996); Witness statement of Grant Cameron (1 June 2021, paras 18–24).

1057 Auckland Committee on Racism and Discrimination, Ngā Tamatoa and Arohanui Incorporated, *Social Welfare Children's Homes* Report on an Inquiry held on June 11 1978 (1979); Human Rights Commission, *Report of the Human Rights Commission on representations by the Auckland Committee on Racism and Discrimination: Children and young peoples homes administered by the Department of Social Welfare* (1982); Human Rights Commission, *The use of secure care and related issues in Social Welfare institutions* (1989).

1058 *Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Pūretumu Torowhānui* Volume 1 (2021, page 132).

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791. While the State took steps to address concerns or implement recommendations related to the specific institutions or care settings in these reports and reviews during the Inquiry period, it does not appear to have taken steps to consider whether any of the problems identified were system-wide. It also missed opportunities to consider coordination and alignment across different parts of the care system. For example, two significant reports about different parts of the care system were released in 1988 – the first, Mason report on mental health services and second, Puao-te-ata-tu on social welfare care.<sup>1059</sup> Both reports eventually led to significant legislative change to improve mental health services (the Mental Health (Compulsory Assessment and Treatment) Act 1992 and care and protection and youth justice matters (the Children, Young Persons and Their Families Act 1989). There is no evidence that the State took the opportunity presented by the timing of the two reports to take a wider system-level view to make consistent changes across the whole care system at this time.
792. Where reports and reviews identified instances of abuse and neglect of children, young people and adults in care, the State did not take steps to understand the full extent of the issue. There is no evidence that the State gathered or analysed data from its own government agencies on the number, nature and location of complaints to understand the nature and extent of abuse and neglect in care. Instead, the State told the Inquiry numerous times that their evidence was limited by their only having access to limited information or being unaware of issues.<sup>1060</sup>
793. The State should have taken steps during the Inquiry period to understand whether:
- a. abuse and neglect in care was systemic
  - b. the care system was failing people in care
  - c. any of the State's changes to prevent and respond to abuse and neglect in care were reducing, increasing or neutral as to rates of abuse and neglect
  - d. to what extent the State contributed to abuse and neglect.

<sup>1059</sup> Mason, KH, Ryan, AB & Bennett, HR, Report of the Committee of Inquiry into procedures used in certain psychiatric hospitals in relation to admission, discharge or release on leave of certain classes of patients (August 1988); Māori Perspective Advisory Committee, Puao-te-ata-tu (day break): The report of the Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare (Department of Social Welfare, 1988).

<sup>1060</sup> See evidence provided by all chief executive and senior leaders at the Inquiry's State Institutional Response Hearing, (Royal Commission of Inquiry into Abuse in Care, 15 August 2022); Stanley, E, Gibson, Z, & Craddock, I, Performing Ignorance of state violence in Aotearoa New Zealand Journal of Criminology (2024, pages 2–4).

## I tāpokihia e ngā tari Kāwanatanga to rātou aro kore ki ngā auheke o ana pūnaha

### The State's structure clouded how it reacted to signs of system failures

794. The structuring of government agencies explains in part why the State failed to take a system-wide approach to abuse and neglect in care. It also explains why there was so much variability to care across and within care settings.
795. Government agencies were structured to implement the policies and priorities of the Minister they reported to, with strong vertical reporting lines and no formal tools for cross agency working. For individual care settings, agencies were only looking at and advising individual Ministers on problems in care relevant to them. When individual government agencies identified a problem relevant to them and designed policy solutions, they were designing policy solutions for discrete parts of a care setting – even though that problem and solution likely applied across all settings.
796. As well as clouding the ability of government agencies and Ministers to see the systemic problems happening across care settings, frequent re-structuring of government agencies during the 1990s also impacted the State's approaches to fixing those problems. When strategic approaches did emerge in the 1990s, they proved to be complex with many stakeholder interests to balance, bureaucratic processes to navigate and often a need to link a strategy and its implementation across multiple Departments, Crown entities and non-governmental bodies.<sup>1061</sup>
797. Many of the strategies relevant to care settings in the 1990s, while they demonstrated strategic thinking and attempts at a cross-departmental strategic approach, failed to deliver widespread change due to factors like a lack of clear targets; lack of progress reviews; changes of government which saw priorities shift; and difficulty navigating agency silos. Different targets and bureaucratic processes across agencies and a focus on individual output arrangements could all act as barriers.<sup>1062</sup> As shown in Inquiry's interim report, *He Purapura Ora, he Māra Tipu: from Redress to Pūretumu Torowhānuī* some people in care only experienced a coordinated State approach when they made a claim in the courts about their experiences of abuse and neglect.

1061 McGuinness Institute, *New Zealand central government strategies: Reviewing the landscape 1990–2007* (McGuinness Institute, New Zealand 2007, page 12).

1062 Ministry of Social Development, *From Welfare to wellbeing and strengthening families: an historical record 1993–1999* (1999, page 14); McGuinness Institute, *New Zealand central government strategies: Reviewing the landscape 1990–2007* (2007, pages 32–38).



## **Kīhai i whaktūria e te Kāwanatanga he tūāpapa āhuru a motu mo ngā pūnaha taurima**

### **The State did not implement a national care safety framework**

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798. The State should have responded to signs of systemic abuse and neglect, and that the care system was failing children, young people and adults in care, with a national framework to safeguard all people in care and prevent and respond to abuse and neglect.
799. A national framework for safety in care should have been designed in partnership with Māori and co-designed with people in care, their whānau, kainga and communities. This national framework for care could have been made up of:
- a. legislating to give effect to the guarantees made to Māori in te Tiriti o Waitangi, particularly tino rangatiratanga
  - b. legislating to respect, protect and fulfill the human rights of people in care and their whānau
  - c. a suite of concrete supports or special measures that prioritised the reduction of inequities for whānau, kainga and communities, supported them to provide care and support at home, and minimised entry into out-of-whānau care
  - d. a single, overarching national strategy for safety in care that applied to all care settings, seeing them as part of one care system inclusive of faith-based care settings
  - e. a set of easily accessible standards of care that applied to everyone in care, that could be tailored to their needs and culture, regardless of who they were and where they were
  - f. transparent, accessible and responsive complaints processes, including access to advocates
  - g. blanket safety checking requirements that applied to all staff, volunteers and carers, regardless of their status and role
  - h. consistent mandatory reporting requirements for staff and carers
  - i. consistent accountability for abuse and neglect in care, with swift and effective penalties for non-compliance
  - j. steps to minimise and ultimately end institutionalised environments and practices
  - k. best practice training and development standards for staff and carers
  - l. independent, strategic, well-funded independent oversight and monitoring that looked across all care settings and consistently reported abuse and neglect to NZ Police.



## Ngā akonga i kitea hea mea panoni Lessons identified and changes made

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800. During the Inquiry period, the State attempted to make some changes to address problems identified in different care settings and to prevent and respond to abuse and neglect in State and faith-based care.
801. Most changes were specific to certain care settings. These changes included the creation of new legislation, policy, rules, standards and practices to prevent and respond to abuse and neglect in care as well as subsequent tweaks to these regulations, as new lessons were learned. Several of these changes had a positive impact on people in care, while some had intentions that were not achieved in practice.
802. Key changes made in response to lessons learned were:
- **The Adoption Act 1955** – This Act tightened controls over who could adopt a baby, it included that all applicants had to be approved by a Child Welfare Officer.<sup>1063</sup> The Act did not, and still does not, recognise disabled parents' rights – section 8 states the Court can dispense with the consent of a parent or guardian where it is satisfied that the parent or guardian is unfit by reason of physical or mental incapacity to have the care and control of a child, where that unfitness is likely to continue indefinitely and following reasonable notice to that parent or guardian.<sup>1064</sup> This means that where certain conditions are met, a court can decide an adoption can proceed without a disabled parent or guardian's consent.<sup>1065</sup>
  - **Child Welfare Division Field Officers Manual 1957**<sup>1066</sup> – The first written policies and practice guidelines for Child Welfare Officers were introduced in 1957. This set minimum standards of care that State wards should receive, for example, that they must have their own bed and they must be visited at least once every four months. It also said the investigation of complaints about danger to a child's life, or suspicions of serious neglect or cruelty, was to take precedence above all other duties. The subsequent iterations of this manual contained the same or improved provisions as lessons were being learned about the standards needed to keep children in care safe. The Inquiry has received evidence of multiple instances where these standards were not met, such as social workers failing to visit State wards as often as required.<sup>1067</sup>
  - **Mental Health Act 1969** – For the first time the Act set time limits for patients being subject to compulsory detention and created three categories of patients – special, committed and informal.

<sup>1063</sup> Adoption Act 1955, section 6(1)(a).

<sup>1064</sup> Adoption Act 1955, section 8(1)(b).

<sup>1065</sup> Adoption Act 1955, section 8(1)(b).

<sup>1066</sup> Department of Education, Child Welfare Division Field Officers Manual (1957).

<sup>1067</sup> See for example: Witness Statement of Scott Carr (7 March 2021, para 46); Witness Statement of Fa'amoana Luafutu (5 July 2021, para 60); Witness Statement of Mr LT (7 March 2023, para 39).

- **Child Welfare Division Field Officers Manual 1970** – replaced the previous 1957 social work manual. It contained many of the same provisions and added some new ones. For example, that NZ Police should be advised in cases of cruelty and ill-treatment, unless the Child Welfare Officer had “good reasons for not wishing to do so, in which case he should consult the Superintendent.”<sup>1068</sup> It also considered additional criteria for assessing prospective caregivers.<sup>1069</sup>
- **Closing of large institutions for Deaf, disabled and mentally distressed persons** – This was first pushed for in the 1950s but did not gain traction until the 1970s which led to three decades of deinstitutionalisation.<sup>1070</sup> It was not until 2006 that the last institution, Kimberley, closed.<sup>1071</sup>
- **Accident Compensation Act 1972** – Introduced no-fault cover for personal injury caused by accident, for all people in Aotearoa New Zealand, including workers who were disabled as the result of accident who were previously covered by the Workers’ Compensation Act”.<sup>1072</sup>
- **Children and Young Persons Act 1974** – Placed the “interests of the child or young person as the first and paramount consideration”.<sup>1073</sup>
- **Residential Workers Manual circa 1975** – This was the first manual that was specific to the field of residential social workers and “the many staff in the department who work in various roles, in different types of institution ... ”
- **Disabled Persons Community Welfare Act 1975** – Provided financial and other assistance for disabled people, and support for private organisations that provide facilities for disabled people to help them stay in the community.
- **NZ Police’s Wanganui Computer System set up in 1976** – This was the first centralised database of criminal convictions. However, initially the Department of Social Welfare was the only department with care responsibilities that could access the database and only in cases of foster care or adoption.
- **Intensive Foster Care Schemes 1980** – The Department of Social Welfare established Intensive Foster Care schemes to match children with carefully selected foster parents, who received training, advice and support. There was a lack of Māori and Pacific parents and some foster carers indicated that they would prefer Pākehā children.
- **Borstals closed 1981** – The last borstal was closed by the Criminal Justice Amendment (No 2) Act 1980.<sup>1074</sup>

1068 Ministry of Social Development, Legislation and social work guidance over the years (page 7).

1069 Ministry of Social Development, Legislation and social work guidance over the years (page 10).

1070 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 291); Stace, H, Sullivan, M, A brief history of disability in Aotearoa New Zealand (2020, page 13).

1071 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 450); Stace, H, Sullivan, M, A brief history of disability in Aotearoa New Zealand (2020, page 13).

1072 Accident Compensation Act 1972.

1073 Children and Young Persons Act 1974, section 4.

1074 Borstal training was abolished when Part II of the Criminal Justice Amendment Act 1975 was finally brought into force in accordance with the Criminal Justice Amendment (No 2) Act 1980, section 7; Williams, D, The abolition of borstal training: A penal policy reform or a failure to reform penal policy? (The University of Auckland, 1984, page 78)

- **Department of Social Work Manual 1984** – This replaced the 1970 Field Officers Manual. It had two volumes and was the most comprehensive practice handbook the department had produced to date, covering both field and residential social work. It saw some new provisions, for example, that “State wards were to be seen on the same day where concerns were raised about safety”.<sup>1075</sup> It also emphasised that it was essential to try and match a foster child to a foster home before any long-term arrangements were made.<sup>1076</sup>
- **The Children’s and Young Persons (Residential Care) Regulations 1986** –The regulations included provisions on professional standards of care, inspection of institutions, grievance procedures for children and young people, access to health and education and so on. It also prohibited the use of corporal punishment and humiliating or degrading discipline.
- **Care and Protection and Youth Justice Handbooks 1989** – The care and protection handbook was the first manual that contained a section specifically on child sexual abuse. It stated that a social worker must involve NZ Police if there was an allegation of sexual abuse.<sup>1077</sup>
- **The Children, Young Persons, and Their Families Act 1989** – Introduced several new legislative provisions, including Family Group Conferences. It distinguished between children being taken into care for the purpose of protection and for the purpose of youth justice.<sup>1078</sup>
- **Education Act 1989** – For the first time, the right of all disabled children and young people to enrol and receive an education at their local state school was recognised.<sup>1079</sup>
- **Corporal punishment** – This was abolished in policy 1987 and legislatively in 1990.<sup>1080</sup>
- **Independent Police Complaints Authority 1989** – Established an independent complaints body. Before this, when anyone made a complaint about NZ Police it was investigated internally by the NZ Police.
- **Mental Health (Compulsory Assessment and Treatment) Act 1992** – Defined the circumstances and manner in which a person may be assessed of the need for treatment, and if that need is established, then how that compulsory treatment should be provided. Emphasis is upon consideration of the need for treatment and the provision of that treatment is the least restrictive environment possible. Established standards of care for patients who were assessed and treated under a compulsory order. The Act set out patient rights at a high level, covering matters such as respect for cultural identity and personal beliefs, the right to company, the right to be informed about treatment, and the right to send and receive mail and make phone calls.<sup>1081</sup>

1075 Ministry of Social Development, Legislation and social work guidance over the years (page 3).

1076 Ministry of Social Development, Legislation and social work guidance over the years (page 11).

1077 Department of Social Welfare, Care and Protection Handbook (July 1989, page 23, section 6.4.3.)

1078 Children, Young Persons and Their Families Act 1989, section 14(1).

1079 Education Act 1989, section 8.

1080 Education Act 1989, section 139A (inserted on 23 July 1990, by section 28(1) of the Education Amendment Act 1990).

1081 Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 5, 63A–75.

- **New Zealand Community Funding Agency 1992** – This became responsible for contracting care providers under the Children, Young Persons and their Families Act 1989. Created additional standards for approval to ensure that the organisations had the capacity to provide care for the needs of disabled children and young people.<sup>1082</sup>
- **Health and Disability Commissioners Act 1994**<sup>1083</sup> – This established an individual complaint system. It protects the rights of patients to be treated with respect, dignity and independence, to have proper standards of care, to make informed choices, to have protection of privacy and to receive support.
- **Oranga Tamariki (Residential Care) Regulations 1996** – This replaced the 1986 regulations. Included the requirement for residences to have an operational complaints and grievance procedure and gave residents the right to “object to the imposition of a punishment or sanction”.<sup>1084</sup>
- **Mental Health Commission 1996** – This was established following the 1996 Mason report into mental health services. The intention was for it to be an independent statutory body with the purpose of implementing the National Mental Health Strategy.<sup>1085</sup>
- **Care and Protection and Youth Justice Handbooks 1998** – These handbooks replaced the 1989 ones and provided “comprehensive information for social workers, coordinators, supervisors and managers in the New Zealand Children and Young Persons Service.” It detailed the responsibilities of these workers under legislation. Some provisions were improved, for example, it changed how frequently children and young people in care should be visited from at least once every four months to at least once every two months.
- **Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999** – Changed several provisions of the 1992 Act to improve the process of compulsory assessment and treatment orders by requiring additional documentation and procedures to protect patient rights and improve their experience of the process, while clarifying the powers and limitations of agencies in relation to the Act. An obligation to consult with family or whānau was included. Changes were also made to strengthen the role of District Inspectors and reporting to the Director of Mental Health, in response to a report by Professor Michael Taggart to the Ministry of Health on the role of the Director, District Inspectors, and Directors of Area Mental Health Services.

1082 New Zealand Community Funding Agency, Standards for Approval Level One: Child and Family Support Services (November 1995, page 13).

1083 Health and Disability Commissioners Act 1994.

1084 Children and Young Persons and Their Families Service, The Children, Young Persons and Their Families (Residential Care) Regulations 1996: Regulation Bulletin for CYPFS Residential Staff (January 1997, page 3).

1085 Mental Health Commission Bill 1996; Mental Health Commission Act 1998.


803. Some settings, like social welfare, experienced continuous changes to legislation, policy and practice across the latter part of the Inquiry period. These changes appeared to be made with good intent and occurred alongside lessons that were learned. Some lessons were highly important and had significant impacts on children in care. These included a greater understanding of the dynamics of sexual abuse, the importance of a child's culture and community, the harm of corporal punishment and psychological abuse and the impacts of past trauma. In response, the State tried to make changes to reflect these learnings, albeit sometimes slowly. The Inquiry heard that other changes however, like tweaks to policy as discussed in earlier chapters, were too frequent for social workers and ground staff to keep up with, which led to inconsistent application across offices and practice not meeting intent.<sup>1086</sup>
804. In other settings, like disability and mental health, there were successive calls for change from families, whānau, communities and advocacy groups. The State, however, was slow to implement change and generally left decision-making powers to institutions themselves as discussed in chapter 4. It was not until 1992 that the State set legislative protections for people subject to compulsory treatment.<sup>1087</sup>
805. While deinstitutionalisation of care was an important step taken during the Inquiry period, there was a widespread practice for many years of institutionalising Deaf and disabled people and people experiencing mental distress, removing them from their families, whānau and communities. The push for deinstitutionalisation began in the late 1950s but it was not until the 1970s that these ideas finally began to take hold. Even then, the State was slow to make real change and it took three decades before the last institution closed.<sup>1088</sup> Deaf and disabled children and young people, and children and young people experiencing mental distress, were segregated and isolated from mainstream education for most of the Inquiry period, only receiving a legislative and equal right to attend local state school in 1989.<sup>1089</sup>
806. As discussed in earlier chapters, faith-based settings were often excluded from State imposed regulations and while some internal standards were introduced as lessons were learned, these did not adequately respond to the scale of abuse and neglect being experienced.

1086 Witness statement of Patricia Williams (12 July 2022, para 26); Mason, K, Review of the Children, Young Persons and Their Families Act 1989: Report of the Ministerial Review Team to the Minister of Social Welfare Hon. Jenny Shipley (February 1992, pages 99–101).

1087 Mental Health (Compulsory Assessment and Treatment) Act 1992 sections 64–75.

1088 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, page 291; Stace, H, Sullivan, M, A brief history of disability in Aotearoa New Zealand (2020, page 13).

1089 Education Act 1989, section 8.

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807. During the Inquiry period, the State knew that Māori were the majority of people in social welfare care settings, and disproportionately represented across other care settings, but generally did not make changes to respond to this until the late 1980s and 1990s.<sup>1090</sup> There were several attempts to address overrepresentation of Māori through changes to policy and legislation, including with the recognition of whānau, hapū and iwi in the Children, Young Persons, and Their Families Act 1989.
808. International and national research informed how the State viewed youth justice and reoffending rates. Before and over the Inquiry period, as well as how this disproportionately affected Māori rangatahi. Following the example of several other countries, Aotearoa New Zealand formally established a children's court in 1925 which separated youth offending from adult offending and had the intention of shifting from a punitive approach to a more welfare-based approach.<sup>1091</sup>
809. The State continued to make certain changes that reflected this intention, for example in 1961 the criminal age of responsibility was raised from seven to ten and in 1985 imprisonment of a person under the age of 16 was forbidden, except for a purely indictable offence.<sup>1092</sup> However, the State also continued to operate care settings for youth offenders that were not reflective of best practice or the lessons being learned at the time. For example, a 1969 review of borstal policy in Aotearoa New Zealand by the Minister of Justice found there were "a number of shortcomings in the present borstal system", these included: overcrowding was a serious problem; most borstals were too large for staff to achieve close personal relationships with trainees, undermining the influence that some of the more difficult inmates had on others; the need to obtain more qualified staff and improve staff training; the need to improve arrangements for after care; and the need for more educational influences in borstal training<sup>1093</sup>

1090 Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999 (Ihi Research, 2021, pages 13, 16, 61, 109, 139).

1091 Child Welfare Act 1925; Watt, E, A history of Youth Justice in New Zealand: Research paper commissioned by the Principal Youth Court Judge Andrew Becroft (2003, page 2).

1092 Crimes Act 1961, section 21; Criminal Justice Act section 8.

1093 Hanan, J, Review of Borstal Policy in New Zealand (Government Printer, Wellington, 1969, pages 9–11).

810. Issues with overcrowding in youth institutions continued from 1970 to 1976. With the Department of Justice noting in their 1976 annual report that they “regret that for the sixth year in succession it is necessary to say that the problem of overcrowding still bedevils our efforts to implement a penal policy which reflects a humane concern for the individual needs of each inmate”.<sup>1094</sup> High inmate numbers also put pressure on staffing and in 1976 it was noted that staff were “being asked to carry a greatly increased load”.<sup>1095</sup> The Department’s 1978 annual report recorded that there had been “some respite from overcrowding in youth institutions”.<sup>1096</sup>
811. Borstals were not closed until 1981 and the youth justice settings for youth offenders that operated throughout the rest of the Inquiry period often operated on a military-style basis in harsh conditions un conducive to rehabilitation. These care settings fostered abuse and led to further offending.
812. A 1984 review on the abolition of borstal training found that although the name of youth justice programmes and the policies relating to them had changed over the years, the places remained the same and “the same old things are done in the carrying out of the new policy”.<sup>1097</sup>
813. In addition, ethnic disparities remained significant. Māori rangatahi continued to come to the attention of the State at a much higher rate than non-Māori and faced custodial sentences at a much higher rate than non-Māori.<sup>1098</sup> The State’s ineffective approach to youth justice throughout the Inquiry period, as well as its failure to adequately address structural racism within the criminal justice sector, further compounded the negative impacts on Māori.
814. These legislative and policy changes can largely be seen as a good faith attempt by the State to address lessons identified and to respond to and mitigate abuse in care. However, as discussed earlier in this chapter and in chapter 11, if these changes do not occur alongside a shift in discriminatory societal attitudes such as racism, ableism, sexism and homophobia, then harm will continue to be perpetrated by the State and by those working within care settings.<sup>1099</sup>

1094 Report of the Department of Justice for the year ended 31 March 1976 (Government Printer, Wellington, 1975, page 10).


1095 Report of the Department of Justice for the year ended 31 March 1976 (Government Printer, Wellington, 1975, page 11).

1096 Report of the Department of Justice for the year ended 31 March 1978 (Government Printer, Wellington, 1978, page 11).

1097 Williams, D, *The abolition of borstal training: A penal policy reform or a failure to reform penal policy?* (The University of Auckland, 1984, page 82).

1098 Watt, E, *A history of Youth Justice in New Zealand: Research paper commissioned by the Principal Youth Court Judge Andrew Becroft* (2003, pages 13–16); Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, *Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999* (Ihi Research, 2021, pages 136–138).

1099 For example, section 21 of the Human Rights Act 1993 which outlines prohibited grounds of discrimination and Aotearoa New Zealand ratifying international instruments such as the Convention on the Rights of the Child and Convention on the Rights of Persons with Disabilities.

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815. With hindsight, much more abuse and neglect could have been prevented if changes had been applied consistently across all settings and implemented differently. At times, the changes did not always reflect the broader lesson learned, such as (but not limited to) the importance of safeguarding or protective factors, or the role of record keeping, complaints, independent oversight and monitoring and a national framework to surface and respond to the true extent of abuse and neglect in care. The changes often reflected discrete elements of a lesson which limited their potential impact for preventing and responding to abuse and neglect in care.
816. Implementation repeatedly frustrated successful change. Common failures of implementation included funding and resourcing constraints, lack of diversity in leadership positions, policy design and service delivery, as well as people in care and their families, whānau, and communities not being informed of change or being empowered to make their own decisions about what supports and care they needed. Some of these implementation issues resulted in further abuse and neglect.
817. Changes generally occurred from the 1980s onwards with a clear correlation between these changes and the Inquiry's finding in Part 4, that the abuse of people in care was at the highest levels in the 1970s followed by the 1960s and then the 1980s. However, as the Crown acknowledged at the Inquiry's State Institutional Response Hearing:<sup>1100</sup>

***“ ... despite all those changes, what is abundantly clear is that there is a bleak history of abuse in care, of behaviour that is unacceptable in any society and in any time period.”***

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1100 Crown Opening statement at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 15 August 2022, page 21).



# He kōrero mutunga mo ngā kawenga Kāwanatanga mo ngā pūnaha taurima


## Conclusion on the State's responsibility for care

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818. The State had a responsibility to provide a coherent and comprehensive care system that effectively safeguarded all people in care. It had a responsibility to monitor that system, to know whether people in care were being safeguarded, and to act decisively when it knew abuse or neglect had happened, to prevent it happening again, and ensure abusers and care providers were held accountable.
819. The State had responsibilities to protect the human rights of families, whānau, and people in care. The State was also responsible for giving effect to the guarantees it made to Māori in te Tiriti o Waitangi.
820. Instead, there were grave breaches of standards of care and te Tiriti o Waitangi across all settings and throughout the Inquiry period.
821. There is evidence to suggest that the State knew the potential nature and extent of the abuse and neglect in care but did not take steps to investigate further. Instead, it took a defensive, adversarial approach to deny, defeat or limit claims of abuse and neglect with the aim of avoiding the financial and legal implications of being found accountable.<sup>1101</sup> There was evidence that the State was not only aware of deliberate steps to move, protect or employ abusers, but in many instances, it was senior leaders within the State taking those deliberate steps. The Inquiry is not aware of any senior leaders being held to account for abuse and neglect, or for taking deliberate steps to avoid accountability.
822. There is consistent and persistent evidence that the State prioritised managing its reputation, limited its liability and accountability, neutralised or covered over institutional abuse, over safeguarding people in care, despite fifty years of evidence and awareness that all parts of the care system were failing people in care.
823. Instead of providing everyone with equal and informed access to the type of care and supports they needed, and were entitled to based on their human rights, or their rights guaranteed to them in te Tiriti o Waitangi, people were treated very differently depending on who they were, or where they were, resulting in discriminatory and inadequate care, contributing to abuse and neglect.

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<sup>1101</sup> Royal Commission of Inquiry into Abuse in Care, He Purapura Ora, he Māra Tipu: From Redress to Puretumu Torowhānui Volume 1 (2021, pages 21–22).



"I remember a staff member repeatedly calling a little girl a bitch."

**WENDY POKROY**

Interview with ACORD

# Ūpoko | Chapter 10

## Ngā kawenga ā-iwi e pā ana ki ngā pūnaha taurima

### Society's responsibility for care

#### Ngā take ā-iwi i hua i te wā o te Pakirehua

##### Societal factors during the Inquiry period

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824. Societal factors can have a significant impact on enabling or preventing abuse. Much of the abuse and neglect experienced by survivors was shaped by entrenched attitudes and systems of power and prejudice within society. These then shaped the different care systems. Understanding and addressing social factors is critical, as institutional and legislative changes alone are unlikely to deliver meaningful transformation. Part 2 sets out the societal backdrop that contributed to abuse and neglect in care.
825. During the Inquiry period, people in care were often seen as not normal or otherwise undesirable or flawed.<sup>1102</sup> Delinquent, defective or deviant were common words used to refer to people in care.<sup>1103</sup> Research shows that “children in residential care also lack value and worth in the eyes of the wider community; they are easily stereotyped and this affects the resources and investment made available for their care”.<sup>1104</sup> Social attitudes towards class, race, gender and disability inform and intensify this pattern.<sup>1105</sup>
826. This chapter examines how the societal factors contributed to abuse and neglect in care throughout the inquiry period.

1102 Expert Brief of Dr Patsie Frawley (April 2022, page 3).

1103 Witness statements of Ms EJ (13 May 2022, para 95); Ms QK (22 November 2022, para 30); Letter from Ann Hercus, the Minister Social Welfare to Dr Oliver Sutherland, Auckland Committee on Racism and Discrimination, regarding a 10 year old State ward held in secure at Owairaka (15 March to 20 June 1985, pages 2–3); Paul, DB, Stenhouse, J, & Spencer, HG (eds) *Eugenics at the Edges of Empire: New Zealand, Australia, Canada and South Africa* (Springer, 2017, page 25); Statement of Dr Hilary Stace for the Contextual Hearing (October 2019, para 5).

1104 Colton, M, “Factors associated with abuse in residential child care institutions.” *Children & Society* 16(1) (2002, page 37).

1105 Colton, M, “Factors associated with abuse in residential child care institutions.” *Children & Society* 16(1), (2002, page 37); Mirfin-Veitch, B, Tiako, K, Asaka, U, Tuisaula, E, Stace, H, Watene, F.R, & Frawley, P, *Tell me about you: A life story approach to understanding disabled people's experiences in care 1950–1999* (Donald Beasley Institute, 2022, pages 117–118).

# Ngā take i whai wāhi ki ngā mahi tūkinō i roto i ngā pūnaha taurima

## Societal factors that contributed to abuse and neglect in care

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827. The Inquiry heard from survivors and expert witnesses that societal factors such as racism, ableism, disablism, sexism, discrimination against Deaf people, homophobia and transphobia were present throughout the Inquiry period. These factors directly contributed to survivors entering care and suffering abuse and neglect in care. The following section sets out the main forms of discrimination the Inquiry heard about, and how these became factors in abuse and neglect. It is not an exhaustive list, or an exhaustive analysis. Each of the main forms of discrimination described below is an academic field in its own right. What follows are the Inquiry's general comments on how societal attitudes contributed to abuse and neglect in care during the Inquiry period.

### Kaikiritanga

#### Racism

828. The Inquiry heard that institutional, cultural, and personal racism directly contributed to survivors, and in particular Māori and Pacific survivors, entering care and suffering abuse and neglect in care.

829. Institutional racism reflects broader racism present within Aotearoa New Zealand society. At the Inquiry's State Institutional Response Hearing, the Chief Executive of Oranga Tamariki, Chappie Te Kani acknowledged:

*"The structural racism that exists in the care and protection system reflects broader society."*<sup>1106</sup>

830. Institutional and structural racism was present in the care system throughout the inquiry period.<sup>1107</sup> It was rooted in the belief "that Pakeha culture, lifestyle and values are superior to those of other New Zealand cultures, notably those of Māori and Polynesian people."<sup>1108</sup> The 1988 Puaoteata-tu report commented on the impact of institutional racism within the care system on Māori, noting:

*"[t]he history of New Zealand since colonisation has been the history of institutional decisions being made for, rather than by, Maori people."*<sup>1109</sup>

<sup>1106</sup> Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 August 2022, pages 576–577).

<sup>1107</sup> Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (22 August 2022, pages 576–577; Brief of Evidence of Dr Diana Sarfati on behalf of the Ministry of Health for the Inquiry's State Institutional Response Hearing (17 August 2022, para 2.8(4)).

<sup>1108</sup> Māori Perspective Advisory Committee, Puaoteata-tu (day break): The report of the Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare (Department of Social Welfare, 1988, page 77).

<sup>1109</sup> Māori Perspective Advisory Committee, Puaoteata-tu (day break): The report of the Ministerial Advisory Committee on a Māori perspective for the Department of Social Welfare (Department of Social Welfare, 1988, page 18).

831. Throughout the Inquiry period this could be seen in “the prevailing deficit views of Māori as lazy, dependents of the state, incapable of providing the right family environment for their children”.<sup>1110</sup>
832. The care system also failed to consistently and meaningfully ensure that Pacific children, young people and adults in care had adequate access to their culture, identity, language and communities.<sup>1111</sup>

## **Ngā whakaāhei me ōna whakakorenga**

### **Ableism and disablism**

833. The Inquiry heard that attitudes of ableism and disableism contributed to Deaf and disabled people and people experiencing mental distress suffering abuse and pervasive neglect in care during the Inquiry period.
834. At the Inquiry’s State Institutional Response Hearing, the Director-General of Health Dr Diana Sarfati acknowledged “that institutional and societal ableism in legislation, policy and systems has contributed to the abuse of disabled people and people with mental health conditions in health and disability care settings.”<sup>1112</sup>
835. Ableism underpinned the views of disability throughout the inquiry period, and disablism was inherent within all care settings.<sup>1113</sup> Throughout the Inquiry period limited understandings of neurodiversity, traumatic brain injury and foetal alcohol spectrum disorder (FASD) contributed to survivors entering and suffering abuse and neglect in care.
836. The Inquiry also heard that audism and a preference for oral communication directly contributed to deaf people entering care and suffering abuse and neglect in care. This is discussed in detail in the case study on abuse and neglect at Van Asch College and Kelston School for the Deaf.
837. The Inquiry heard that ableism and disableism was embedded in Aotearoa New Zealand society,<sup>1114</sup> and that ableist attitudes contributed to policies of institutionalisation that resulted in the invisibility of disabled people throughout the inquiry period. The Inquiry also heard that the whānau of disabled people were not adequately supported with resources and investment to ensure they could care for disabled family members, and that communities were not reasonably or adequately funded to provide supports and deliver programmes.

1110 Stanley, E, *The road to hell: State violence against children in postwar New Zealand* (Auckland University Press, 2016), as cited in Savage, C, Moyle, P, Kus-Harbord, L, Ahuriri-Driscoll, A, Hynds, A, Paipa, K, Leonard, G, Maraki, J, & Leonard, J, *Hāhā-uri hāhā-tea: Māori involvement in State care 1950–1999* (Ihi Research, 2021, page 55).

1111 Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 August 2022, page 578).

1112 Brief of evidence of Dr Diana Sarfati on behalf of the Ministry of Health for the Inquiry’s State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, para 2.8(5)).

1113 Brief of evidence of Dr Brigit Mirfin-Veitch for the Inquiry’s Ūhia te māramatanga Disability, Deaf and Mental Health Institution Hearing (Royal Commission of Inquiry into Abuse in Care, June 2022, para 73).

1114 Transcript of evidence of Dr Brigit Mirfin-Veitch at the Inquiry’s Ūhia te māramatanga Disability, Deaf and Mental Health Institution Hearing (Royal Commission of Inquiry into Abuse in care, 20 July 2022, page 642).

838. At the Inquiry's Ūhia te māramatanga Disability, Deaf and Mental Health Hearing, expert witness Dr Brigit Mirfin-Veitch explained that:

*“understanding how social structures impact on and shape disability, violence and abuse also requires recognition that the way society works is framed by privilege and power, which is embedded in our economic and political and social policies and practices, that focus on the dominant and most productive members of society.”<sup>1115</sup>*

839. During the Inquiry period, disabled people were generally not seen as human, and they were treated as if they had no inherent human value by society. This underlying prejudice underpins the nature and extent of abuse and neglect in care set out in Part 4. The prejudice stems from the societal belief in eugenics at the time, which perceived disabled people as inferior beings that should be segregated from society to prevent reproduction of a subnormal race.

840. Segregating and congregating Deaf and disabled people, and people experiencing mental distress in care institutions, away from their whānau, where they continued to be stigmatised demonstrated that they were not valued equally with able-bodied people. Deaf and disabled people, and people experiencing mental distress in care were denied inclusion and participation. Education opportunities were limited and neglected, especially for disabled people. Disabled people were generally unable to develop their independence or their unique gifts and strengths. For Deaf and disabled people and people experiencing mental distress, being kept away from their whānau and community exacerbated this.

841. Congregating people on perceived disability also led to assumptions of similarity between individuals, and people were not treated and cared for as individuals. This resulted in society continuing to disempower children, young people and adults in care who were Deaf, disabled and experiencing mental distress from participating in decision making processes.

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<sup>1115</sup> Transcript of evidence of Dr Brigit Mirfin-Veitch at the Inquiry's Ūhia te māramatanga Disability, Deaf and Mental Health Institution Hearing (Royal Commission of Inquiry into Abuse in care, 20 July 2022, page 642).

## Aro tōkai

### Sexism

842. During the Inquiry period, women and girls were considered less valuable than men and boys and experienced gender-based discrimination. These sexist attitudes contributed to women and girls entering care and suffering abuse and neglect in care. In Part 4, the Inquiry described the evidence that showed female survivors experienced higher levels of emotional and sexual abuse in care than their male counterparts.
843. Throughout the Inquiry period, and especially from the 1950s to 1970s, women and girls in Aotearoa New Zealand experienced widespread sexism and gender-based discrimination. Society held negative beliefs that women's sexuality was something to be controlled and feared.<sup>1116</sup> Women's bodies were considered unclean and violence against women and girls was seen as acceptable.<sup>1117</sup> Women's employment prospects were limited.
844. Gendered abuse and neglect was particularly evident in unwed mothers' homes. Many unmarried women who became pregnant experienced intense shaming and judgement, often based on perceived promiscuity.<sup>1118</sup> Some were rejected by their families. Until the introduction of the Domestic Purposes Benefit in 1972, many unmarried pregnant women had no option other than unwed mothers' homes for food, shelter and medical treatment during their pregnancies. Once in unwed mothers' homes, women were demonised and subjected to verbal abuse such as gendered slurs and being shamed for having had sex outside of marriage. Many experienced medical neglect during childbirth.<sup>1119</sup>
845. Women in unwed mothers' homes were also forced or coerced into adopting out their babies, based on the belief they were unfit to be parents because they were not married.<sup>1120</sup> While the 1969 Status of Children Act granted equal legal status of children of both married and unmarried parents, the Children and Young Persons Act 1974 still required the birth of a child to an unmarried mother to be notified to a social worker.<sup>1121</sup>

1116 Baumeister, RF, & Twenge, JM, "Cultural suppression of female sexuality", *Review of General Psychology* 6(2), (2002, pages 166–203).

1117 <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

1118 Written account of Christine Hamilton (25 October 2021, page 3); Tennant, M, *The fabric of welfare: Voluntary organisations, government and welfare in New Zealand, 1840–2005* (Bridget Williams Books, 2007).

1119 Witness statement of Nancy (Sally) Anne Levy (16 December 2021, paras 71–72).

1120 Written account of Joss Shawyer (4 May 2021 page 10).

1121 Children and Young Persons Act 1974, section 10.

846. In social welfare settings, girls experienced degrading, traumatic and invasive vaginal examinations that were physically, psychologically, and often sexually and culturally abusive. Girls in children's residences experienced sexist verbal abuse and were often perceived as promiscuous.<sup>1122</sup> Wendy Pokroy worked for the Department of Education as a psychologist from 1975 to 1977. She told the Auckland Committee on Racism and Discrimination about her visits to Dey Street Residence for girls in Kirikiriroa Hamilton:

***"I remember a staff member repeatedly calling a little girl a bitch."***<sup>1123</sup>

847. Sexist attitudes, including the wish to control female sexuality, meant that girls and women in care were regularly targeted for forced venereal testing because they were viewed as potential carriers of sexually transmitted infections.<sup>1124</sup> The Inquiry saw no evidence that boys and men in care were subjected to this treatment as a matter of course. Forced venereal testing of girls and women largely ceased from the 1980s, after the Auckland Committee on Racism and Discrimination raised public awareness of the practice. The 1986 Residential Care Regulations included a provision that no one in a social welfare residence had to undergo a medical examination without their consent, except in limited circumstances.<sup>1125</sup>

848. Māori girls and women experienced sexist discrimination in combination with racism which framed them as lazy, unintelligent and hyper-sexual. This view is evident in a 1965 letter from the Whangarei District Child Welfare Officer about admissions of girls to Fareham House in Pae-o-Tū-Mokai Featherston or Kingslea Girls' Home in Ōtautahi Christchurch:

***"The girls whom I refer are, in the main, the dull backward, affection-starved Māori girls who cannot produce anything near a reasonable day's work and who try and get their needed affection from any male who is handy."***<sup>1126</sup>

849. In faith-based settings, a preoccupation with female sexuality resulted in female survivors being subjected to gendered verbal abuse, particularly being called sinful and promiscuous.<sup>1127</sup> Female bodies were considered dirty and shameful. Some survivors were made to feel unclean for menstruating.

1122 Witness statements of Tracey Margaret Benson (1 July 2021, para 55) and Lee-Ann Smith (16 February 2022, para 4.1); Children, Young Persons and their Families Service, Complaints Form, Complaint of young person at Kingslea Girls' Home (1 October 1998); Letter from LM Uttley, District Child Welfare Officer, to the Superintendent of Child Welfare, Re: Admissions to training centres (24 May 1965, page 1).

1123 Auckland Committee on Racism and Discrimination (ACORD), Notes from interview with Wendy Pokroy (n.d., page 2).

1124 Jackson, L, Sexual assault, criminal justice and policing since the 1880s (University of Edinburgh 2014, pages 3–4).

1125 Children and Young Persons (Residential Care) Regulations 1986, clause 20.

1126 Letter from LM Uttley, District Child Welfare Officer, to the Superintendent of Child Welfare, Re: Admissions to training centres (24 May 1965, page 1).

1127 Witness statements of Margaret Wilkinson (17 September 2020, para 29); Margie Robertson (6 June 2021, para 96); June Lovett (14 December 2021, para 38); Mrs D (21 September 2020, para 64).



850. The Inquiry also heard that the combination of sexism and ableism contributed to abuse and neglect of disabled girls and women in care. The Committee on the Rights of Persons with Disabilities notes that disabled women and girls are “among those groups of persons with disabilities who most often experience multiple and intersectional discrimination”.<sup>1128</sup>
851. Part 4 discusses gendered abuse of girls and women in disability and mental health settings, including being forcibly sterilised, given contraception without informed consent and being forced to have abortions – sometimes without the woman’s knowledge until after the procedure. Part 4 describes the high levels of sexual violence in these settings. Neglect was also an issue. Some girls and women had no access to menstrual products, and others were not educated about menstruation.

### **Mae takatāpui me te taihemawhiti**

#### **Homophobia and transphobia**

852. Homophobia and transphobia during the Inquiry period, homophobic attitudes led to the abuse and neglect of children, young people and adults in care, including verbal abuse, conversion practices and shock treatment. Homosexuality was defined as a mental disorder until 1973<sup>1129</sup> and sexual relations between men were criminalised until 1986. Attitudes that connected homosexuality with mental illness and criminality were especially harmful.
853. The Inquiry saw evidence of strongly homophobic attitudes in both State and faith-based care, particularly the idea that homosexuality was sinful, morally wrong, and needed to be cured or treated. Survivors of faith-based care described a general culture of homophobia in most of the faiths the Inquiry investigated.<sup>1130</sup> In 1963, the Principal of Fareham House in Pae-o-Tū-Mokai Featherston listed lesbianism as a problem that needed to be prevented:

***“Unless it is equipped at the same level as the other places, then Fareham House cannot be regarded as a Training Centre for seriously delinquent girls, otherwise the vandalism, destruction, abscondings, Lesbianism and other sexual aberrations, will continue because there are no means available to prevent them.”***<sup>1131</sup>

1128 United Nations Committee on the Rights of Persons with Disabilities, General comment No 6 (2018) on equality and non-discrimination, CRPD/C/GC/6 (26 April 2018, para 36).

1129 Drescher, J, “Out of DSM: Depathologizing homosexuality”, Behavioural Science, 2015 December, 5(4) (2015, pages 565–575).

1130 Private session of a survivor who wishes to remain anonymous (17 February 2021, page 5); Private session of Ms SP (17 August 2021, page 13); Witness statements of Kevin Lundon (21 April 2021, page 7); Rodney Anderson (20 September 2021, paras 45–54); Joshua Sean Denny (8 July 2021, paras 22–34); Andrew Adams (30 May 2022, page 2.34).

1131 Annual Report from E Naylor, Principal of Fareham House, to the Superintendent of Child Welfare (28 March 1963, page 1).

854. The perception of homosexuality as sexually deviant contributed to abuse and neglect being minimised or ignored. A former staff member at Epuni Boys' Home in Te Awakairangi ki Tai Lower Hutt acknowledged that staff were far more concerned with same-sex activity between boys in the home than with the potential for them to be sexually abused by staff.<sup>1132</sup> Complaints of sexual abuse where the abuser was the same gender were sometimes characterised as a "homosexual experience" or "homosexual relationship" rather than as abuse, even where it was clear that the survivor could not legally consent or where the abuser was in a position of power.<sup>1133</sup>
855. Social attitudes throughout the Inquiry period demonstrated intolerance to variations in gender expression, especially by boys and young men. In May 1985, a social worker noted that a boy in foster care "is playing with girls at school and is taking make-up to school in his school-bag. It is hoped that this more male activity [playing soccer] may bring out the better side of [the boy]".<sup>1134</sup> In February 1986, the same social worker wrote that:
- "... there was some concern [expressed by the school principal] that his feminine tendencies ... were seen at school. They were feeling that perhaps [the boy] should be placed in a foster home away from his sisters."*<sup>1135</sup>
856. Diverse gender expression was also assumed to be related to sexuality. In 1969, the Principal of Miramar Girls' Home in Te Whanganui-a-Tara Wellington recorded his concerns about the "Effect of Feminine Influence on boys" who were temporarily placed in the residence:
- "With the slightly older boys there is a strong tendency for them to develop marked feminine attitudes and habits ... [four boys aged between 8 and 11 years old] left the Girls Home with probably more problems than when they came. It got to the stage where they wanted to spend their spare time cooking, sewing, and playing with dolls etc. This same effect is noticeable with the younger boys where perhaps it is not quite so harmful, but I wonder about the influence this could have on later homosexual tendencies."*<sup>1136</sup>

1132 Witness statement of Gary Hermansson to Crown Law (8 May 2007, paras 73–74).

1133 Letter from D M Burrows (Social Worker) to the Director, Palmerston North District Office, Department of Social Welfare, Recommendation for continued involvement (14 June 1976, pages 6–7); Letter from C A Havill (Social Worker) to the Area Welfare Office, Tokoroa District Office, Department of Social Welfare, Recommendation for discharge (12 May 1982, page 2).

1134 Note for file from TA Weaver, Social Worker (16 May 1985, page 1).

1135 Note for file from TA Weaver, Social Worker (26 February 1986, page 1).

1136 Memo from OT Ryan, Principal, Miramar Girls' Home, to DG Reilly, Superintendent of Child Welfare (28 April 1969, page 3).

857. People in care who were perceived or labelled as homosexual or did not adhere to socially accepted "masculine" or "feminine" behaviour were targeted. The Inquiry heard that in single sex settings such as boy's homes and boys' schools, boys and young men who were considered gay or whose behaviour was associated with femininity were subjected to physical and verbal abuse by their peers.<sup>1137</sup> One survivor, who was placed in Ōwairaka Boys' Home in Tāmaki Makaurau Auckland when he was 12 years old, told the Inquiry that:

*"[if you] had slight indications of being gay, you were in deep trouble".<sup>1138</sup>*

## **Ngā waiaro tāraro ki ngā tamariki me ngā rangatahi** **Negative attitudes towards children and young people**

858. Children and young people throughout the Inquiry period were often viewed as delinquent, troublemakers, inferior and flawed, and deserving of punishment.<sup>1139</sup> These punitive societal attitudes directly contributed to children and young people entering care and suffering abuse and neglect in care.

859. Part 2 discussed the moral panics during the Inquiry period that focused on concerns about juvenile delinquency. Part 3 sets out how children and young people's behavior was misunderstood as being deliberately naughty or criminal. Part 4 describes the dehumanising abuse and neglect that children and young people suffered in care settings, and how this was amplified when beliefs about children and young people as inherently bad or in need of physical punishment intersected with other discriminatory beliefs such as racism, disablism, sexism and homophobia.

860. These beliefs were factors in abuse and neglect in care throughout the Inquiry period, including the tendency to think that children and young people were lying when they tried to report abuse or neglect.

861. These beliefs were still prevalent in 2006, six years after the end of the Inquiry period, when researchers analysed over 1,700 submissions to the Justice and Electoral Select Committee on the 2006 Crimes Amendment Bill. The Bill proposed abolishing the justification for child discipline using force, and the submissions were a window into Aotearoa New Zealand's attitudes towards children.

1137 Witness statements of Rodney Anderson (20 September 2021, paras 45–54); Brock Barriball-Barry (7 July 2021, paras 73–83); Joshua Sean Denny (8 July 2021, paras 22–34). Green, L, & Masson, H, "Adolescents who sexually abuse and residential accommodation: Issues of risk and vulnerability", *British Journal of Social Work* 32(2) (2002, pages 149–168); Palmer, D, & Feldman, V, "Toward a more comprehensive analysis of the role of organizational culture in child sexual abuse in institutional contexts", *Child abuse & neglect* 74 (2017, pages 23–34).

1138 Private session of a survivor who wishes to remain anonymous (27 November 2019, page 16).

1139 Maxwell, G, *Youth offenders: Treatment of young offenders, 1840 to 1980s* (Te Ara – the Encyclopedia of New Zealand, 2011, pages 1–2).

862. The researchers found that people who viewed children as “human beings”, or developing toward adulthood and therefore full status as humans, tended to support physical punishment. People who saw children as “human beings” – fully human in their own right – opposed physical punishment. Additionally, people who saw children as innately bad supported physical punishment, whereas those who viewed children as innocent believed in protecting them. Some of the quotes from submitters who opposed the Bill included:

*“Children need to be forced to do the right thing again and again so that it becomes habitual.”*

*“Use of reasonable force is at times necessary to discipline children and is mandated by God.”*

*“Children today do not need more rights. They need more respect for authority and realise consequences for their actions.”<sup>1140</sup>*

### **He whakamau toihara ki te hunga e pākia ana e te pōhara Discrimination against people experiencing poverty**

863. Throughout the Inquiry period there were negative stereotypes about poverty and welfare. Poverty was seen as a problem with individuals rather than an outcome of wider social, economic, and political circumstances.<sup>1141</sup> In Part 2 the Inquiry set out that society’s view of poorer communities was often negative, categorising people in poverty into the deserving and undeserving poor.

864. People experiencing poverty and deprivation were more likely to be taken into care and to be abused and neglected while in care. Some survivors recall being identified as “welfare children” and “welfare rats”.<sup>1142</sup>

865. Many survivors received charity or financial assistance from faith-based institutions, creating a relationship of dependence. Part 4 covered evidence from survivors who were made to feel indebted and taught to be grateful the church was caring for them. Survivors who attended prestigious schools were told they were lucky to be attending.

<sup>1140</sup> Debski, S, Buckley, S, & Russell, M, Just who do we think children are? New Zealanders’ attitudes about children, childhood and parenting: An analysis of submissions on the Bill to Repeal Section 59 of the Crimes Act 1961, Social Policy Journal of New Zealand: Issue 34 (April 2009, page 106).

<sup>1141</sup> Hackell, M, “Managing anxiety: Neoliberal modes of citizen subjectivity, fantasy and child abuse in New Zealand” in Citizenship Studies Volume 20, Nos 6–7 (2016, pages 867–870).

<sup>1142</sup> Transcript of evidence of Mr EH from the Inquiry’s Foster Care Hearing (13 June 2020, page 26).

## He kōrero mutunga mo ngā kawenga ā-iwi mo te hunga kei ngā pūnaha taurima

### Conclusion on society's responsibility for care


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866. Societal attitudes throughout the Inquiry period have directly contributed to survivors entering care and suffering abuse and neglect in care. These societal attitudes include racism, ableism, disablism, sexism, audism, homophobia, discriminatory attitudes based on gender and sexuality, negative views towards children and young people, and negative views and stereotypes about people living in poverty and deprivation.
867. Societal attitudes are reflected in discriminatory institutional policies and practices. Oranga Tamariki and the Ministry of Health acknowledged respectively that structural racism<sup>1143</sup> and institutional ableism<sup>1144</sup> exist in the care system, and that these are a reflection of broader societal attitudes within Aotearoa New Zealand.
868. The State made efforts to eliminate discriminatory institutional policies and practices. However, many faiths maintain some discriminatory practices. However, because discriminatory institutional policies and practices reflected broader societal attitudes, efforts to eliminate them failed in the absence of a concerted effort to eliminate the societal attitudes that underpin those policies and practices.

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1143 Transcript of evidence of Chappie Te Kani, Chief Executive of Oranga Tamariki, at the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 22 August 2022, pages 576–577).

1144 Brief of evidence of Dr Diana Sarfati on behalf of the Ministry of Health for the Inquiry's State Institutional Response Hearing (Royal Commission of Inquiry into Abuse in Care, 17 August 2022, para 2.8(5)).



"The Public Service has not always worked together in the way that it should and has not been joined up as it should be around children, young people and their families and communities."

**PETER HUGHES**

Public Service Commissioner 2016-2024,  
Chief Executive of the Ministry of Education  
2013-2016 and the Ministry of Social  
Development (including Child, Youth and  
Family Services from 2006) 2001-2011

# Ūpoko | Chapter 11

## Ngā whakatutukitanga

### Conclusion


869. At the Inquiry's Contextual Hearing, Tā Kim Workman recalled his reaction to witnessing the nighttime conditions at Kohitere Boys' Training College in Taitoko Levin as a Youth Aid Officer in the early 1970s:

*"My first response was one of anger. Anger and disbelief. Anger that the state could allow such conditions. Conditions so inhumane they were almost guaranteed to turn vulnerable children and youth into scarred, distrusting and sometimes dangerous adults. Anger that senior public servants and policy advisors could have allowed these conditions to continue for so long, knowing that they were parties and accomplices to the creation of criminals ... It is almost as though the state, having neglected the welfare and needs of children in the first twelve years of their life, was able – once the child inevitably progressed to committing a criminal act – to breathe a collective sigh of relief, reclassify the child as a young offender, and quickly transfer any corporate accountability away from themselves by re-designating it as personal responsibility and laying it on an 'accountable' individual.*

*[I felt] [d]isbelief that successive governments had failed to monitor and correct conditions in these same institutions, which were eventually to become a matter of national disgrace and shame.<sup>1145</sup>*

870. Hundreds of thousands of children, young people and adults in care were cared for by the State and faith-based institutions between 1950 and 1999. Many survivors told the Inquiry about the horrific abuse and neglect they experienced while in care and the lifelong impacts for them, their families, whānau, hapū and iwi. For many survivors, the abuse and neglect they experienced in care resulted in serious and debilitating addictions, an inability to form stable or loving relationships, missed opportunities for educational and vocational achievement and feelings of a deep sense of shame or blame. For some, it set them on a pathway to imprisonment. The Inquiry has heard it led others to take their own lives.

<sup>1145</sup> Witness statement of Tā Kim Workman (5 October 2019, paras 19–20).

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871. Many of the factors that contributed to who entered care were the same as those that increased the risk of abuse and neglect in care – deeply entrenched discrimination, particularly racism, ableism, disablism, sexism, homophobia and transphobia, a lack of understanding or tolerance of gender diversity; negative stereotypes of children and young people as delinquents requiring punishment; negative views about poverty, welfare and a cynicism about societal and State responsibilities to prioritise support for the most marginalised in our communities.
872. These discriminatory, negative views were entrenched at all levels of State and faith-based care and were most obvious in the approach to Deaf and disabled survivors, and survivors experiencing mental distress, at times in direct conflict with their human rights. The politicisation of care during the Inquiry period, at times framed as “tough on delinquents” or “tough on beneficiaries”, exploited and exacerbated this entrenched discrimination.
873. Once in care, several factors combined to increase the risk of abuse and neglect. Standards of care were inconsistent and widely variable, complaints processes and employment processes were ineffective or non-existent; senior leaders and managers prioritised abuser and institutional reputations over the safety of those in care, and there were repeated failures to report abuse and neglect to NZ Police. The State failed to adequately invest in care settings, in staff and carers, and in oversight and monitoring during the Inquiry period.
874. The authority and impunity of religious institutions during the Inquiry period resulted in some of the most extreme cases of abuse and neglect seen by the Inquiry. In part, this was due to discriminatory attitudes and harmful use of religious beliefs and practices within religious institutions, but it was also able to take place during the Inquiry period because of the high moral regard that the faiths were held in and the resultant lack of State regulation, oversight and responsibility for people in the care of faith-based institutions.
875. Throughout the Inquiry period, there was a persistent lack of investment in whānau and communities with care and support needs to enable whānau to care for loved ones at home and to be supported by their communities.
876. Across all of these factors was the lack of legislative direction on giving effect to te Tiriti o Waitangi and human rights in both State and faith-based care settings during the Inquiry period.
877. Unfortunately, Aotearoa New Zealand seemed to fall behind other developed countries during the Inquiry period when it came to both its care settings and the fulfilment of human rights and indigenous rights. Large-scale institutionalisation dominated the Inquiry period, which contributed to high rates of entry into care and abuse and neglect in care, and Aotearoa New Zealand was decades behind other countries in ending this policy.
878. The following chapter sets out the Inquiry’s key findings on why abuse and neglect happened during the Inquiry period, and who was responsible.



# Ūpoko | Chapter 12

## Ngā tohinga matua

### Key findings

#### Ngā takahi paerewa

#### Breaches of relevant standards


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879. Clause 33 of the Terms of Reference allows the Inquiry to make findings that relevant standards have been breached. In summary, during the Inquiry period the Inquiry finds:

#### Ngā takahi i te Tiriti o Waitangi

#### Breaches of te Tiriti o Waitangi

- a. Te Tiriti o Waitangi guaranteed rights to Māori throughout the Inquiry period that should have been protected and upheld.
- b. The Crown deprived whānau, hāpu and iwi of exercising tino rangatiratanga over their kāinga (home), to care and nurture the next generation and regulate the lives of their people, and that this breached the principle of active protection in te Tiriti o Waitangi.
- c. The Crown's failure to address the on-going effects of colonisation that contributed to tamariki, rangatahi and pakeke Māori being placed in care and breached the guarantee of tino rangatiratanga and the principle of active protection in te Tiriti o Waitangi.
- d. The Crown failed to protect Māori survivors from losing their whakapapa and connection to whānau, hapū and iwi. This breached the principles of tino rangatiratanga, kāwanatanga (just, fair, and equitable policies and laws), partnership, active protection, and options in te Tiriti o Waitangi.
- e. The Crown excluded Māori from decision-making, developing and implementing policies that directly impacted the care of tamariki, rangatahi, and pakeke Māori. This breached the guarantee of tino rangatiratanga and the principles of partnership and active protection in te Tiriti o Waitangi.
- f. The Crown's general exclusion of Māori models of care breached the principles of partnership, active protection, equity, and options in te Tiriti o Waitangi.


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- g. The Crown stripped Māori of their cultural identity through structural racism. This breached the guarantee of tino rangatiratanga and the principles of kāwanatanga, partnership, active protection, and equity in te Tiriti o Waitangi.
  - h. The Crown denied the use of te reo Māori through the introduction of policies and practices in care settings and this breached the principle of active protection in te Tiriti o Waitangi.
  - i. The Crown failed to protect Māori from many forms of abuse and neglect once in care. This breached the principle of active protection in te Tiriti o Waitangi.
  - j. The Crown failed to collect accurate records of the abuse and neglect experienced by tamariki, rangatahi and pakeke in care. This breached principle of good governance in te Tiriti o Waitangi.
  - k. The Crown failed to ensure that tamariki, rangatahi and pakeke in care did not experience racism. This breached the principles of equity and equal treatment in te Tiriti o Waitangi.
  - l. Through failing to appropriately address trauma, caused by abuse and neglect in care the Crown failed to prevent inter-generational impacts on Māori, whānau, hapū, and iwi. This breached the principle of active protection in te Tiriti o Waitangi.
  - m. The Crown failed to provide appropriate redress for those who suffered abuse and neglect.

### **Ngā takahi i ngā paerewa atawhai**

#### **Breaches of standards of care**

- n. People in care had rights to standards of care that prevented abuse (ill-treatment) and neglect during the Inquiry period. However:
  - i. In some settings, particularly disability and mental health, education and faith, the government failed to set adequate or overarching standards of care.
  - ii. In Deaf, disability and mental health settings, institutions breached the standards they set. Specifically, survivors' rights to dignity and respect, adequate protection from abuse, neglect and exploitation and proper daily care were consistently breached.
  - iii. In social welfare settings, staff, social workers, and foster parents breached the standards of care set out in Department of Education Field Officers Manual and its later versions (including the Social Workers Manual).
  - iv. In transitional and law enforcement settings, NZ Police breached the standards set in their General Instructions. Specifically, by interrogating young people with violence and without the presence of an adult and by holding them in police cells.

- o. There were regular and routinely breaches of standards of care with significant impacts for many children, young people and adults in care whose standards were breached.
- p. In many institutions, residences, and foster homes, standards were breached every day, due to a lack of resourcing, poor training and confusion about statutory powers and the role of staff or foster parents.
- q. Breaches of standards varied in severity. Many were extremely serious. Some breaches of standards were in themselves abuse, while others allowed abuse and neglect to occur.
- r. Breaches of standards of care included:
  - i. neglect and abuse (ill-treatment), including sexual abuse, that was severe, extensive, extreme or pervasive in some institutions
  - ii. wrongful use of seclusion, solitary confinement and secure care
  - iii. frequent use of corporal punishment, which at times was extreme, perverse punishment involving weapons and humiliation
  - iv. frequent breaches of health care standards, at times unlawfully, including:
    - > lobotomies, sterilisation, forced adoptions, invasive genital examinations, over medicating, and experimental psychiatric treatments without informed consent
    - > in psychiatric facilities, electric shocks and injections of paraldehyde as punishment, and exposing patients to unreasonable medical risks
    - > medical neglect and abuse
    - > medicating people in care for long periods without review
    - > not providing access to doctors or health specialists for extended periods
    - > failing to provide a medical certificate on admission to a residence or institution
  - v. The failure of some social workers to visit State wards in care, a key intervention and rescue point for people experiencing abuse or neglect
  - vi. Serious breaches of transitional and law enforcement standards, such as:
    - > people in care questioned without the presence of a parent, guardian or lawyer
    - > interrogations using physical violence
    - > coercion to confess to crimes, even when innocent
    - > stays in police cells, overnight, sometimes up to weeks.



## Ngā take i hua ai te mahi tūkinō i ngā pūnaha taurima

### Factors which caused or contributed to abuse in care


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880. Clause 31(b) of the Terms of Reference requires the Inquiry to make findings on the factors, including systemic factors, which caused or contributed to abuse and neglect.
881. Clause 10.2 of the Terms of Reference refers to factors that include, but are not limited to, the standards that applied in care settings, the vetting, recruitment, training, development and supervisions of staff and carers, the processes available to people in care for raising concerns or complaints, the processes in place to respond to those complaints and how effective they were.
882. In summary, during the Inquiry period the Inquiry finds:

#### Te hunga i te pū o ngā mahi tūkinō

#### The people at the centre of abuse and neglect

- a. Children, young people, and adults in care were diverse, with different care and support needs.
- b. Children, young people, and adults in care needed support, protection, and safeguarding when in care.
- c. Strong protective factors significantly reduces the risk of abuse and neglect and the likelihood of entry into care.
- d. Strong protective factors include connection to whānau, strong self-esteem, supportive trustworthy adults and friends and an understanding of inappropriate behaviour and what to do in difficult situations.
- e. The rights guaranteed in te Tiriti o Waitangi are a layer of protection for whānau, hapū, and iwi and their tamariki, rangatahi and pakeke. These rights also reinforce protective factors.
- f. Human rights are a layer of protection for children, young people, and adults in care, and their families, whānau, and individual mothers and fathers. Human rights also reinforce protective factors.
- g. Many people entering care had weakened protective factors, contributing to the risk they would experience abuse and neglect.
- h. Many tamariki, rangatahi and pakeke Māori entered care with few protective factors.


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- i. Many of the circumstances that made it more likely a person would enter care often became the circumstances for why they were more susceptible to abuse and neglect in care. Those circumstances included:
    - i. being raised in poverty and experiencing deprivation
    - ii. being disabled with unmet needs
    - iii. being Māori and racially targeted
    - iv. being Pacific and racially targeted
    - v. being Deaf with unmet needs
    - vi. experiencing mental distress with unmet needs
    - vii. being Takatāpui, Rainbow, MVPFAFF+, gender diverse or transgender and targeted
    - viii. experiencing significant or multiple adverse childhood events, including:
      - > experiencing violence, abuse, or neglect in private homes or in other care settings
      - > witnessing violence in private homes or in the community or in other care settings
      - > having a family member or a peer in a care setting pass away, or attempt or die by suicide
      - > aspects of their environment that undermined their sense of safety, stability, and bonding, such as
        - I. growing up in a private home or in other care settings:
          - with parents, caregivers, or peers experiencing substance use problems
          - with parents, caregivers, or peers experiencing mental distress
          - where there is instability due to parental separation or household members being incarcerated
        - II. living in an under-resourced private home or becoming homeless
        - III. experiencing unsupported and weakened family and cultural structures
        - IV. being in families and communities that were unsupported because their needs had not been adequately assessed or met
    - ix. having a deferential attitude to people in positions of authority, including faith leaders and medical professionals
    - x. other circumstances such as age or gender, and
    - xi. experiencing or being any combination of the above

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- j. Abusers were able to misuse their positions of power and control over people in their care to inflict at times extreme and severe abuse and neglect.
  - k. Abusers were often predatory
  - l. Abusers exploited the powerlessness and vulnerability of those they were abusing or neglecting
  - m. Abusers often acted with impunity.
  - n. Some survivors were abused by peers. The risk of peer-on-peer abuse increased when the abuser knew that staff or carers would not hold them to account.
  - o. Most abusers took steps to conceal their actions. They ensured that survivors' complaints about abuse and neglect were ignored or suppressed.
  - p. Many abusers avoided accountability, allowing them to abuse for extended periods and across multiple residences and institutions.
  - q. Many bystanders (staff, volunteers and carers) failed to stop or report abuse and neglect that they observed or suspected was occurring.

## Take hinonga

### Institutional factors

- r. The following institutional factors contributed to abuse and neglect in care:
  - i. inadequate, inconsistent and inaccessible standards (including the lack of commitment to human rights and te Tiriti o Waitangi) of care which were routinely breached with little consequence or accountability.
  - ii. individual care needs were not routinely or accurately identified, recorded and met.
  - iii. poor employment policies and poor senior leadership and management practices, including:
    - > poor or inadequate vetting policies, exacerbated by a lack of access to NZ Police vetting for most settings
    - > senior leaders and managers sometimes skipping vetting requirements
    - > senior leaders and managers sometimes knowingly employing abusers with criminal convictions for sexual abuse
    - > a lack of staff and carer diversity
    - > under investment in staff and carers
    - > recruitment of people with service or military backgrounds that contributed to punitive, command and control models of care in some institutions
    - > poor or inadequate training and development specific to care roles, and on how to recognise the signs of abuse and neglect in care
  - iv. widely variable, absent, or inaccessible complaints processes that were poorly implemented, including:
    - > barriers faced by people in care to raise concerns or complaints, including a lack of access to whānau, communities, and advocates
    - > consistent failures to believe people in care when they reported abuse or neglect, underpinned by societal attitudes like racism, ableism and disablism
    - > concerns or complaints being treated as an employment issue or as a sin to be forgiven, rather than (in many cases) criminal behaviour
    - > senior leaders or managers prioritising institutional reputations over the safety of people in care
    - > senior leaders or managers prioritising abusers' reputations and future careers over the safety of people in care, including shifting the abuser to other residences or institutions and using confidential settlements
    - > consistent failures to report complaints of abuse and neglect to NZ Police

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- v. ineffective, ad hoc and insufficient oversight and monitoring, which did little to prevent or respond to known abuse and neglect
  - vi. consistent accountability failures, that allowed abuse and neglect to continue and gave many abusers a sense of impunity.
  - s. The State did not take the steps it should have when it saw signs its care system was failing people in care. Those steps should have included:
    - i. legislation specific to care settings to give effect to the guarantees made to Māori in te Tiriti o Waitangi, particularly tino rangatiratanga
    - ii. legislation specific to care settings to respect, protect and fulfill the human rights of people in care
    - iii. a suite of concrete supports or special measures that prioritised the reduction of inequities for families, whānau and communities, supported them to provide care and support at home, and minimized entry into care
    - iv. steps to minimise and ultimately end institutionalised environments and practices
    - v. a national framework for safety in care, designed in partnership with Māori and co-designed with people in care, their families, whānau and communities, set out in legislation and made up of:
      - > a single, overarching national strategy for safety in care that applied to all care settings, seeing them as part of one care system inclusive of faith-based care settings
      - > a set of easily accessible standards of care that applied to everyone in care, that could be tailored to their needs and culture, regardless of who they were and where they were,
      - > the core requirements of transparent, accessible and responsive complaints processes, including access to advocates
      - > blanket safety checking requirements that applied to all staff and carers, regardless of their status and role
      - > consistent mandatory reporting requirements for staff and carers
      - > consistent accountability for abuse and neglect in care, with swift and effective penalties for non-compliance.
    - vi. best practice training and development standards for staff and carers, and
    - vii. independent, strategic, well-funded independent oversight and monitoring that looked across all care settings and consistently reported abuse and neglect to NZ Police.



## **Take ā-whakapono ake**


### **Faith-specific factors**

- t. The following faith-specific factors contributed to abuse and neglect in care:
  - i. the authority and impunity of faith-based institutions created opportunities for abuse and neglect to occur and continue
  - ii. discriminatory attitudes, policies and practices that contributed to abuse and neglect
  - iii. harmful use of beliefs and practices which created environments that fostered abuse and neglect

## **Take ā-pūnaha**

### **Systemic factors**

- u. The following systemic factors contributed to abuse and neglect in care:
  - i. people in care, whānau and communities had limited input into State decisions about care
  - ii. the State's attempts to deal with institutional discrimination, which impacted who went into care and who experienced abuse and neglect in care, were lack lustre
  - iii. legislative and policy settings were discriminatory, underpinned by societal attitudes like racism, ableism and disablism, and negative stereotypes of children, young people as delinquents, and negative attitudes towards people living in poverty
  - iv. the State generally ignored the rights of people in care:
    - > the State did not give effect to rights guaranteed in te Tiriti o Waitangi, particularly tino rangatiratanga
    - > the State did not progressively respect, protect and fulfil the human rights of people in care and their whānau
  - v. the State lacked diversity and lived experience of care in its leadership
  - vi. the State did not ensure people in care were safeguarded from abuse or neglect, or had effective oversight and monitoring
  - vii. there was a lack of State accountability for abuse and neglect, particularly those with statutory responsibilities to people in care
  - viii. the State did not ensure there was a comprehensive regulatory care framework that was enforced and properly invested in and resourced
  - ix. the State failed to respond to signs of systemic abuse and neglect, taking no steps to understand if its system of care was failing
  - x. the State's structure clouded its response to signs of system failure

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- v. The State did not take the steps it should have when it saw signs its care system was failing people in care. Those steps should have included:
    - i. legislation specific to care settings to give effect to the guarantees made to Māori in te Tiriti o Waitangi, particularly tino rangatiratanga
    - ii. legislation specific to care settings to respect, protect and fulfill the human rights of people in care
    - iii. a suite of concrete supports or special measures that prioritised the reduction of inequities for families, whānau and communities, supported them to provide care and support at home, and minimized entry into care
    - iv. steps to minimise and ultimately end institutionalised environments and practices
    - v. a national framework for safety in care, designed in partnership with Māori and co-designed with people in care, their families, whānau and communities, set out in legislation and made up of:
      - > a single, overarching national strategy for safety in care that applied to all care settings, seeing them as part of one care system inclusive of faith-based care settings
      - > a set of easily accessible standards of care that applied to everyone in care, that could be tailored to their needs and culture, regardless of who they were and where they were,
      - > the core requirements of transparent, accessible and responsive complaints processes, including access to advocates
      - > blanket safety checking requirements that applied to all staff and carers, regardless of their status and role
      - > consistent mandatory reporting requirements for staff and carers
      - > consistent accountability for abuse and neglect in care, with swift and effective penalties for non-compliance.
    - vi. best practice training and development standards for staff and carers, and
    - vii. independent, strategic, well-funded independent oversight and monitoring that looked across all care settings and consistently reported abuse and neglect to NZ Police.

## Take ā-iwi

### Societal factors

- w. The following societal factors contributed to abuse and neglect in care:
  - i. Discriminatory societal attitudes like racism, ableism, disablism, sexism, homophobia, transphobia and negative stereotypes, directly contributed to survivors entering care and suffering abuse and neglect in care, with Māori and Pacific Peoples, Deaf and disabled people, people experiencing mental distress, and Takatāpui, Rainbow and MVPFAFF+ people being disproportionately affected.
  - ii. negative views about people living in poverty and welfare dependency
  - iii. belief systems that upheld reverence and trust in faith-based institutions and members of faith
  - iv. negative views towards children and young people, as delinquents, naughty and not to be believed
  - v. society condoned and tolerated institutionalisation of people for decades

# Whakatau hē

## Findings of fault

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883. Clause 33 of the Terms of Reference allows the Inquiry to make findings of fault. In summary, during the Inquiry period the Inquiry finds:

### **Te Kāwanatanga**

#### **The State**

#### **Ngā takinga toko i te ora**


##### **Social welfare settings**

- a. relevant Ministers, the Superintendent of the Child Welfare Division, Department of Education and then subsequently the Director-General and Chief Executive of the Department of Social Welfare and its successors were at fault for:
  - i. failing to address structural racism in the care system
  - ii. the adverse effects of structural racism on tamariki, rangatahi, and pakeke Māori in care, their whānau, hapū, and iwi, and has an ongoing detrimental impact on the relationship between Māori and the Crown
  - iii. failing to address structural ableism and disablism in the care system
  - iv. not consistently supporting whānau to prevent people from entering care
  - v. insufficient emphasis on whānau-based alternatives to State care
  - vi. often ignoring Māori perspectives and solutions
  - vii. failing to fully meet the needs of all of those in care
  - viii. failing to ensure people in care were kept safe from harm
  - ix. failing to ensure caregivers in social welfare settings were properly vetted, trained, supported, and monitored
  - x. inadequate policies, processes and practices to always detect and facilitate the reporting of abuse and neglect
  - xi. the ongoing impacts of abuse and neglect for survivors and their whānau;
  - xii. failing to consistently believe or follow up reports of harm in social welfare settings
  - xiii. inadequate protection and preservation of the records and case files of all people in care, which impacts survivors today

## **Ngā takinga ā-Turi, whaikaha, hauora hinengaro**

### **Deaf, disability and mental health settings**

- b. relevant Ministers, Directors-General of Health and Directors of Mental Health were at fault for:
  - i. the policy of institutionalisation from the 1950s to 1970s which resulted in Deaf and disabled people, and people experiencing mental distress being placed in settings where many experienced abuse and neglect. This was despite advice from the World Health Organisation that institutionalisation was opposite to best practice at the time, which was reiterated in the 1959 Burns Report by the Aotearoa New Zealand branch of the British Medical Association.
  - ii. institutional and societal ableism in legislation, policy and systems that contributed to the abuse of Deaf and disabled people and people experiencing mental distress in health and disability institutions
  - iii. institutional racism in legislation, policy and systems that contributed to the abuse of Māori and Pacific Peoples in health and disability settings
  - iv. ableist health and disability care settings that did not always meet the needs of Deaf and disabled people and people experiencing mental distress
  - v. ignoring the perspectives and solutions of disabled people and their whānau
  - vi. Māori, Pacific Peoples, Deaf and disabled people, and people experiencing mental distress being particularly negatively impacted, through being overrepresented in care, or their distinct needs not being met in care, including because of abuse suffered
  - vii. Deaf and disabled people and people experiencing mental distress not always being supported to make decisions about their own lives especially adults
  - viii. legislative and policy settings that did not ensure sufficient emphasis on alternatives to placing Deaf and disabled people and people experiencing mental distress into institutionalised care, like exploring family or community-based care options
  - ix. legislative and policy settings that did not always provide adequate support and resourcing to whānau, including disability support and resourcing
  - x. failing to fully meet the needs of all of those in care

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- xi. not consistently and meaningfully ensuring the cultural needs of all Māori in care were met, including culturally appropriate health care options, causing disconnection from their culture, identity, language and communities, with ongoing impacts for them, and their whānau, hapū and iwi
  - xii. not consistently and meaningfully ensuring the cultural needs of all Pacific Peoples in care were met, including culturally appropriate health care options, causing disconnection from their culture, identity, language and communities, with ongoing impacts for them, and kainga and wider communities
  - xiii. failing to ensure people in care were kept safe from harm when they should have been
  - xiv. inadequate policies, processes and practices to safeguard people in care
  - xv. inadequate policies, processes and practices, including reporting, to detect abuse and neglect
  - xvi. people in care experiencing abuse and neglect, which has had ongoing impacts for survivors and their whānau
  - xvii. inappropriate use of seclusion and restraint in psychopaedic and psychiatric settings and inappropriate use of medication, aversion practices, and shock treatment, and acts that met the Solicitor-General's definition of torture
  - xviii. failing to maintain accurate records, including not recording ethnicity, Deaf, disability or mental distress or impairment, compounded by the loss of records, has resulted in the true number of those in care will never be known

## Ngā takinga mātauranga

### Education settings

- c. relevant Ministers, Secretaries and Chief Executives of Education were at fault for:
  - i. failing to provide education fit for different groups, including Blind, Deaf, and disabled children and young people
  - ii. failing to support New Zealand Sign Language and the language and cultural needs of Deaf people
  - iii. failing to identify and support the needs of neurodivergent people
  - iv. ignoring Deaf and disabled peoples' and communities' perspectives and solutions
  - v. failing to actively protect te reo and encourage its use by Māori, which was in breach of te Tiriti o Waitangi, and has had an ongoing detrimental effect for Māori
  - vi. not sufficiently valuing Māori culture
  - vii. failing to respond to the identity, language, and culture of Māori which has been harmful, and contributed to poor education outcomes
  - viii. having consistently lower expectations of tamariki and rangatahi Māori
  - ix. having less oversight of private schools than state or state-integrated schools, which may have increased opportunities for abusers
  - x. failing to keep children safe, during the school day and in overnight / boarding care
  - xi. failing to keep children in some schools and boarding facilities connected with whānau.



**Ngā takinga whakatika, mauhere ā-ture**  
**Transitional and law enforcement settings**

- d. successive Commissioners of NZ Police were at fault for:
  - i. negative Māori experiences with policing
  - ii. failing to recognise the importance of te Tiriti o Waitangi until the mid-1970s
  - iii. failing to understand the role of NZ Police in the disproportionate representation of Māori in the criminal justice system
  - iv. NZ Police responses to Māori over-representation in the criminal justice system that fell short of a full commitment to the principles of te Tiriti o Waitangi
  - v. NZ Police responses that did not reflect the needs of Māori communities or the best way to resolve situations for Māori
  - vi. failing to value tikanga Māori as part of policing practice, for most of the Inquiry period
  - vii. Pacific Peoples' negative experiences with policing
  - viii. failing to understand whether ableism within NZ Police contributed to disproportionate representation of disabled people in the criminal justice system
  - ix. inadequate policies, processes, and procedures to support Deaf and disabled people and people experiencing mental distress to engage with NZ Police
  - x. during the 1950s to 1970s, a singular focus on enforcement
  - xi. during the 1950s to 1989, not consistently considering alternatives to criminal proceedings for children and young people
  - xii. Before 1989, not being inclusive whānau in the decision-making impacting the person in their care
  - xiii. failing to consistently follow General Instructions and related policies regarding children, young people and adults in their care, such as questioning people under the age of 14 without the presence of any parent, guardian or lawyer
  - xiv. the use of police cells to detain children and young people (due to lack of alternatives), which was, and remains, unsuitable for children and young people, particularly those in care and protection
  - xv. the abuse and neglect people experienced while in transitional and law enforcement settings, including physical abuse
  - xvi. failing to understand or investigate the nature and extent of police abuse of people in transitional and law enforcement care settings



- xvii. General Instructions that limited who could access vetting during the Inquiry period, particularly between 1977 and 1991
- xviii. lacking a universal policy on how to respond to allegations of abuse and neglect in care
- xix. before 1995, lacking a dedicated policy relating to investigation of sexual abuse and serious physical abuse of children
- xx. lacking awareness of the risk of sexual offending by people in positions of authority
- xxi. negative bias against victims of abuse and neglect who were not believed or considered reliable or credible, for example at times assuming that Deaf and disabled people, and people experiencing mental distress may not be credible witnesses, or assuming promiscuity of a young survivor when investigating allegations of sexual abuse in care
- xxii. failures to investigate abuse and neglect against children, young people and adults in care
- xxiii. lacking statistical data on allegations of abuse and neglect in care
- xxiv. the racism and discrimination exhibited by some leaders within NZ Police
- xxv. failing to collect data on the diversity of the NZ Police workforce, specifically ethnicity and the number of Deaf or disabled police



**Ngā takinga ā-pūnaha taurima katoa**  
**Whole of care system settings**


- e. successive governments were at fault for:
  - i. institutional, structural racism and ableism in legislation, policy and systems that contributed to the disproportionate representation, and discriminatory treatment of Māori, Pacific Peoples, Deaf and disabled people, people experiencing mental distress, and Takatāpui, Rainbow and MVPFAFF+ people in care
  - ii. the alienation of tamariki, rangatahi, and pakeke Māori from their whānau, hapū, and iwi, and their culture, identity, language, and the ongoing impacts of that alienation
  - iii. the alienation of Pacific Peoples from their kainga, culture, identity, language, and the ongoing impacts of that alienation
  - iv. the alienation of Deaf people from their whānau and communities, and their culture, identity, language, and the ongoing impacts of that alienation
  - v. the abuse and neglect people experienced while in care
  - vi. failing to ensure that people in care were safe from abuse and neglect
  - vii. failing to consistently stop abuse and neglect in care when it was disclosed or reported
  - viii. record-keeping issues, including gaps and loss of records, which mean the true number and make up of children, young people and adults in care is unlikely to ever be known


- f. successive State or Public Service Commissioners (responsible for the integrity and conduct of public servants, and the appointment and performance of chief executives) were at fault for failing to hold chief executives to account for:
  - i. preventing abuse and neglect in care
  - ii. not adequately identifying and investigating abuse and neglect in care
  - iii. appropriately responding to complaints of abuse and neglect in care by both protecting people in care and holding abusers to account
  - iv. providing holistic redress for survivors of abuse and neglect in care
  - v. addressing the role the public service played in being responsible for the abuse and neglect people experienced and the ongoing impacts of such abuse and neglect while in State care
  - vi. addressing the public servants not following the standards of successive codes of conduct
  - vii. the lack of a cohesive public service to provide joined-up, comprehensive and coherent safeguarding of children, young people and adults in care
  - viii. there being no appropriate public service framework for:
    - 01. ensuring the care workforce were diverse and reflected the makeup of society
    - 02. workplaces were inclusive of all groups in society
    - 03. there was a focus on developing and maintaining public service capability to engage with Māori and understand Māori perspectives





## Ngā whakapono Faiths

- g. the Catholic Church was at fault for:
  - i. the harm that has taken place in some Catholic educational institutions. That harm includes:
    - > serious sexual harm and inappropriate physical punishment
    - > inadequate steps taken in response to complaints of abuse and neglect
    - > putting students at risk of harm by appointing abusers to the school without effective methods in place for protecting students
    - > placing a heavy reliance on the opinions of psychiatrists in determining the ability of an abuser to rehabilitate and continue working in certain areas or in ministry, which resulted in abusers being transferred to other areas of ministry where re-offending occurred
  - ii. being slow to act when sexual abuse was occurring
  - iii. children being harmed in Catholic institutions where they should have been cared for and safe
  - iv. harm caused to children because of mistakes made by the Church which could have and should have been avoided
  - v. not doing more to prevent the pain and suffering of all those who should have been kept safe in the church's care
  - vi. the following factors which caused abuse to occur or prevented its disclosure:
    - > prioritising forgiveness over safeguarding and accountability for those who perpetrated the abuse and the leadership at the time with knowledge of the abuse
    - > creating a power imbalance between religious / clergy and their parishioners
    - > lack of resources of, and investment in, those with the care of children, young people and adults (when they should not have been in those positions)
    - > lack of training for those in care of children, young people and adults
    - > care for the reputation of the church

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- h. the Anglican Church was at fault for:
- i. the failures of those within the Church who were meant to protect and care for people in their care.
  - ii. abuse and neglect in the care of the Church.
  - iii. abuse and neglect that included sexual abuse, physical abuse, verbal abuse and emotional abuse and neglect.
  - iv. perpetuating societal attitudes in its institutions, like corporal punishment, normalised bullying in schools, and suppressing Māori and Pacific Peoples' culture.
  - v. failing to implement institutional monitoring, leaving the responsibility of management up to individual leaders.
  - vi. failing to implement an overarching Church policy or process to guide the handling of complaints of abuse, including record-keeping.
  - vii. leaving allegations and complaints of abuse to be handled by those who knew the alleged abusers well, with some unwilling to accept a fellow clergy member could be an abuser.
  - viii. abuse that was ignored or covered up within the Church, which failed to protect people in care and failed to hold abusers to account.
  - ix. perpetrators of abuse who were protected by the sanctity of their role within Anglican institutions.
  - x. failing to believe the survivor when they first came forward, instead survivors were often deemed untrustworthy or deceitful.
  - xi. survivors having to live with the consequences of the trauma they suffered for decades.
  - xii. the families of survivors having to carry the long-term consequences of abuse and neglect.
  - xiii. the role of patriarchy within the Church in failing to listen and respond to issues of abuse and neglect.
  - xiv. being too trusting of individuals within the Church, which contributed to the Church's failure to address its mistakes sooner.

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- i. the Methodist Church was at fault for:
    - i. failing in its duty to ensure the protection and wellbeing of those in its care
    - ii. the pain and suffering of all those who were abused in the Church's care, including:
      - > those who suffered abuse while at Wesley College
      - > those who suffered abuse in former children's homes, in Christchurch, Masterton, and Auckland
      - > those who suffered abuse by a Minister, foster parents or in other Methodist Church parish settings
      - > those who suffered abuse, which remains unreported.
    - iii. Abuse and neglect, including sexual, physical, emotional and psychological abuse and neglect.
    - iv. insufficient monitoring, oversight and safeguarding of those in their care, which enabled abuse to occur.
    - v. failing to implement protection policies and procedures across all its Church-related entities.
    - vi. failing to implement mandatory NZ Police vetting.
    - vii. failing to consistently implement key changes on an "all of Church" approach to ensure those providing care were adequately trained and resourced
    - viii. failings in addressing complaints, including not always accepting and acting appropriately on reports of abuse and complaints.
    - ix. responding to complaints with a traditional legal approach that included:
      - > requiring survivors to report their abuse to NZ Police before conducting its own inquiries
      - > declining to progress claims in a way that meant survivors had to pursue legal claims in the courts
      - > failing to recognise it had a duty to take action to discipline a member of the Church, particularly a Minister.
    - x. failing to recognise the Church's role to deliver a restorative response to reports or complaints of abuse.
    - xi. the additional harm caused to survivors when the Church initially refused to believe them, sought to contest their concerns, or refer the complaint elsewhere, and failing to recognise the Church needed to address their complaint.
    - xii. the trauma experienced as a result of abuse, which has had long term impacts on the lives of survivors, their whānau and loved ones.
    - xiii. failing to have record keeping policies relating to reports or complaints of abuse and neglect.

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- j. From Gloriavale's inception in 1969 through to the end of the Inquiry period, the Overseeing Shepherd and senior leadership of the Gloriavale Christian Community were at fault for:
    - i. allowing physical and sexual abuse to happen within the community.
    - ii. failing to address intergenerational sexual abuse within the community which perpetrated a cycle of harm.
    - iii. failing to prevent and protect survivors within the community against abuse.
    - iv. responding to allegations of abuse by seeking to create repentance from the offender and forgiveness from the victim.
    - v. failing to recognise the harm of abuse on survivors.
    - vi. failing to deal with perpetrators of abuse appropriately, allowing them to continue living in the community and allowing abuse to continue within the congregation as a result.
    - vii. failing to recognise the scale and extent of abuse in the community.
    - viii. dealing with complaints of abuse themselves and not engaging any other authorities or professionals, including NZ Police or Oranga Tamariki and its predecessors.
    - ix. the role the community's Doctrines had in creating a culture that allowed abuse to occur.

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- k. the Presbyterian Church were at fault for:
    - i. its reluctance to confront abuse.
    - ii. failing to remove people who posed risks to children, young people and adults in their care from unsupervised participation in the Church.
    - iii. its reluctance to make binding rules.
    - iv. failing to recognise ministers, elders or leaders as people who could cause harm.
    - v. its dynamic of protecting the congregation from outside interference, creating a risk of abuse and neglect.
    - vi. discounting complaints of abuse.
    - vii. failing to report complaints of abuse to proper Church authorities or to NZ Police, allowing perpetrators to continue abusing.
    - viii. not supporting survivors to make complaints, making them feel isolated, discouraging them from taking complaints further and not believing them.
    - ix. removing perpetrators from one area but allowing them to continue in other areas without considering the risks.
    - x. deliberately attempting to suppress reports of abuse at times.
    - xi. failing to apply its policy of zero tolerance of abuse of people in the case of the Church consistently and thoroughly.
    - xii. failing to consistently uphold its Code of Ethics in relation to pastoral care adopted in 1995.
    - xiii. failing to consistently report breaches of its Code of Ethics.
  - l. Additionally, Presbyterian Support Services Central was at fault for:
    - i. failing to properly record the ethnicities of Māori and Pacific children in the care of Berhampore Home.
    - ii. failing to prioritise any understanding of how to better deliver care to disabled people.



m. the Salvation Army was at fault for:

- i. lack of understanding of the abuse and neglect of children, young people and adults in their care, and its effects on survivors, sometimes lasting for a lifetime.
- ii. wide-ranging abuse and neglect in their care, which included sexual, physical and psychological abuse and neglect and mistreatment.
- iii. abuse and neglect carried out by staff and officers of the Salvation Army, by other residents or visitors to homes, and foster parents and caregivers.
- iv. abuse and neglect in their homes for unwed mothers, including Bethany homes, including pressure to have their children adopted, while being denied relevant information, medical and emotional help and support.
- v. abuse and neglect in children's homes in Whakaoriori Masterton, Temuka, Tāmaki Makaurau Auckland, Putaruru, Eltham in Taranaki, Te Whanganui-a-Tara Wellington, and Kirikiriroa Hamilton.
- vi. serious neglect in some children's homes and homes for unwed mothers, including inadequate nutrition, hygiene and healthcare
- vii. abuse that included racism, ableism, and discrimination based on gender and sexuality

## **Ngā roopu hunga mātanga**

### **Professional bodies**

n. the New Zealand Medical Association and Medical Council of New Zealand were at fault for:

- i. actions that the New Zealand Medical Association and Medical Council of New Zealand should have taken but did not, to protect the public
- ii. decisions in relation to complaints of abuse, that the Medical Council of New Zealand cannot now explain due to the incompleteness of records.
- iii. the New Zealand Medical Association prioritising fairness to doctors (including psychiatrists) over the safety and wellbeing of patients when investigating complaints
- iv. accepting much of Dr Selwyn Leeks' response to allegations without question when investigating a complaint against Dr Leeks in 1977.

o. the Nursing Council of New Zealand and its predecessors were at fault for not taking appropriate care of survivors, and their whānau, involved in its processes, resulting in unacceptable instances of harm. For some survivors, those processes have had a significant and ongoing impact.

p. the Teaching Council of Aotearoa New Zealand and its predecessors were at fault for not taking appropriate care of survivors, and their whānau, involved in its processes, resulting in unacceptable instances of harm. For some survivors, those processes have had a significant and ongoing impact.

## Ngā akonga i kitea he mea panoni Lessons identified and changes made

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884. Clause 31(e) of the Terms of Reference requires the Inquiry to make findings on the lessons learned, and what changes were made to prevent and respond to abuse. The Inquiry finds:

### Te hunga i te pū o ngā mahi tūkino The people at the centre of abuse and neglect

- a. The State made discrete changes to safeguard against abuse and neglect and increase protective factors for people in care during the Inquiry period, generally from the late 1980s onwards
- b. Some faith-based institutions began to introduce some safeguarding and protective factors from the late 1980s onward
- c. There were discrete changes to support the role of staff and carers in detecting and responding to abuse, mainly relating to training and voluntary reporting from the late 1980s onwards

### Ngā kawenga atawhai a ngā hinonga me ngā kāinga tamariki atawhai The institutions and foster homes responsible for care

- d. The State legislated for standards of care in some settings from the mid to late 1980s onwards
- e. The State made changes to regulate some staff in some care settings, such as teachers, and progressively developed policies in state settings on recruitment, vetting, training, development and supervision from the 1970 onwards
- f. The State introduced detailed regulations on complaints processes for people in social welfare residences and institutions in 1986 and people subject to a compulsory mental health assessment or treatment order in 1996

### Ngā kawenga atawhai ā-whakapono The faiths responsible for care

- g. Faith-based care settings either did not make changes or were slow to make changes to prevent and respond to abuse during the Inquiry period

## **Ngā kawenga atawhai a te Kāwanatanga**

### **The State's responsibility for care**

- h. The State was slow to learn and act on critical lessons identified about abuse and neglect in care and many changes were not made until the 1980s onwards
- i. The State made many changes toward the end of the Inquiry period, including the creation of new legislation, policies and standards as new lessons were being identified and calls for change were being made
- j. The State made changes to prevent and respond to abuse and neglect with good intentions but these were not always realised due to implementation failures
- k. The State learned lessons about the impact of institutionalisation and segregation on Deaf and disabled people and people experiencing mental distress but was slow to take action in response
- l. The State learned lessons about the overrepresentation of Māori across all care settings, but changes were generally not made until the late 1980s to try to address this
- m. Changes made throughout the Inquiry period to prevent and respond to abuse and neglect were inconsistent across care settings
- n. Changes made were substantially smaller than the scale of abuse and neglect in care
- o. Many discrete policy changes were made to respond to abuse and neglect in Social Welfare settings
- p. Changes by the State were slow and few to prevent and respond to abuse and neglect in Deaf, disability and mental health settings
- q. The State did not make changes to prevent or respond to abuse and neglect in many faith-based settings during the Inquiry period
- r. Societal attitudes changed over the Inquiry period
- s. The State made some changes to try and eliminate discriminatory institutional policies and practices

# He waiata aroha mō ngā purapura ora

Kāore te aroha i ahau mō koutou e te iwi I mahue kau noa  
i te tika  
I whakarerea e te ture i raurangi rā Tāmia rawatia ana te  
whakamanioro  
he huna whakamamae nō te tūkinō  
he auhi nō te puku i pēhia kia ngū  
Ko te kaikinikini i te tau o taku ate tē rite ai ki te kōharihari o tōu  
Arā pea koe rā kei te kopa i Mirumiru-te-pō  
Pō tiwhatiwha pōuri kenekene  
Tē ai he huringa ake i ō mahara  
Nei tāku, 'kei tōia atu te tatau ka tomokia ai'  
Tēnā kē ia kia huri ake tāua ki te kimi oranga  
E mate Pūmahara? Kāhorehore! Kāhorehore!  
E ara e hoa mā, māngai nuitia te kupu pono i te puku o Kareāroto  
Kia iri ki runga rawa ki te rangi tīhore he rangi waruhia ka awatea  
E puta ai te ihu i te ao pakarea ki te ao pakakina  
Hei ara mōu kei taku pōkai kōtuku ki te oranga  
E hua ai te pito mata i roto rā kei aku purapura ora  
Tiritiria ki toi whenua, onokia ka morimoria ai  
Ka pihi ki One-haumako, ki One-whakatupu  
Kei reira e hika mā te manako kia ea i te utu  
Kia whakaahuritia tō mana tangata tō mana tuku iho nā ō rau kahika  
Koia ka whanake koia ka manahua koia ka ngawhā  
He houkura mārie mōwai rokiroki āio nā koutou ko Rongo  
Koia ka puta ki te whaiao ki te ao mārama  
Whitiwhiti ora e!

– Paraone Gloyne

# A Love Song for the Living Seeds

The love within me for you, the people, remains unchanged

Left alone, abandoned by justice and order

Subjected to the silent suffering of mistreatment

A heaviness in the core, silenced into stillness

The gnawing of my heart cannot compare to the anguish of yours

Perhaps you are hidden in the depths of the night, Mirumiru-te-pō

A night dark and dense

Where there may be no turning in your memories

But here's my thought: 'Do not push open the door to enter'

Instead, let us turn to seek life and well-being

Is memory dead? No, certainly not!

Arise, friends, let the truth resound loudly from the heart of Kareāroto

To ascend to the clear skies, a sky washed clean at dawn

Emerging from the troubled world to a world of promise

A path for you, my flock of herons, to life

So, the precious core may blossom within you, my living seeds

Scattered across the land, cherished and growing in abundance

Rising in One-haumako, in One-whakatupu

There, my friends, lies the hope to fulfil the cost

To restore your human dignity, your inherited mana from your ancestors

Thus, it will thrive, flourish, and burst forth

A peaceful feather, a treasured calm, a serene peace from Rongo

Emerging into the world of light, into the world of understanding

A crossing of life indeed!

– *Paraone Gloyne*

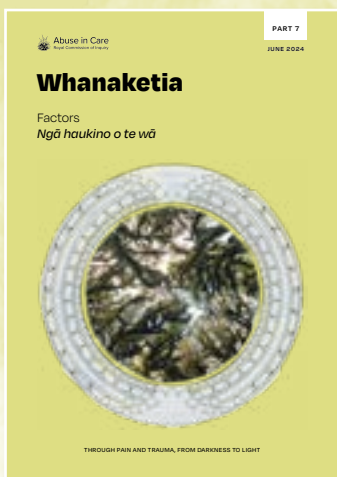
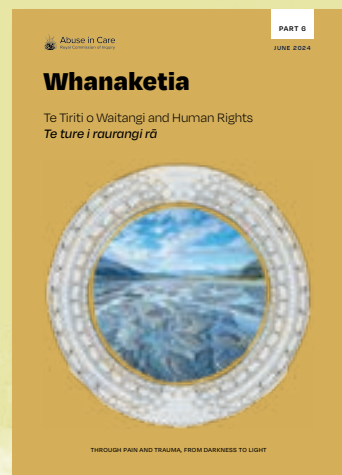
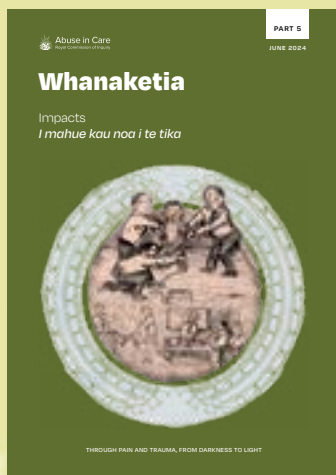
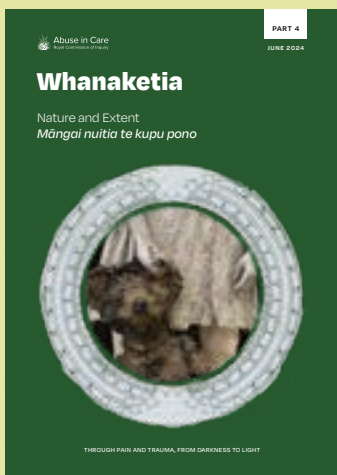
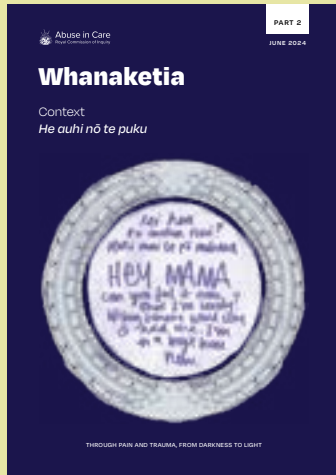


## Whanaketia

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The report is made up of a preliminary, nine parts and five case studies. Whanaketia should be read in full, along with the other reports from the Commission to understand the overall picture of abuse in State and faith-based care from 1950 to 1999.

# THROUGH PAIN AND TRAUMA, FROM DARKNESS TO LIGHT





**Abuse in Care**  
Royal Commission of Inquiry